HIV/AIDS LITERATURE:
THE EFFECTS OF REPRESENTATION
ON AN ETHICS OF CARE

DISSERTATION

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ABSTRACT

In my project, I argue that rigid representational constructs move narrators of HIV/AIDS literature away from a position of ethical care in descriptions of illness and the ill, and towards three deliberately assumed subject positions: hero, artist, and prophet. I argue that many narrators assume these roles to achieve some very calculated effects (punitive, dichotomizing, normalizing, socially sanctioning) and that these effects are only eroded when the roles themselves are dismantled. Finally, I examine what such a process of dismantling would look like, and how it would lead to a greater ethics of narrative care. Throughout my argument, I suggest that the unique rhetorical environment of care-taking dictated by HIV/AIDS (such as the undefined nature of the disease and the specter of homophobia which has surrounded discussion of the illness) contributes to a move away from an ethical concerns, and towards a narratorial concern with the control of representations.

First, and primarily through the use of Abraham Verghese’s HIV/AIDS narrative *My Own Country: A Doctor’s Story* (1995), I suggest that the narrator fashions himself as a hero, and explore the implications of such self-fashioning for the plot-line of a text. I then conduct a close examination of Allan Gurganus’s *Plays Well With Others* (1999), with an accompanying discussion of the normalizing work done by the representations within the text. In an examination of
Randy Shilts’s *And the Band Played On* (1987), I argue that the narrator attempts to deliver the message of illness from “on high” through establishing a position for himself as prophet, and through the use of a religiously-inflected language. After examining the means by which the representational strategies used within AIDS narratives cause a narrator or a text to abandon an ethics of care, I turn in the final portion of my project to an inquiry into how an ethics of care might be enacted, and what it might look like, largely within the context of Tony Kushner’s two-part play *Angels in America* (1993-4).
To Diana
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CHAPTER 1

REPRESENTATIONAL STRATEGIES IN ILLNESS NARRATIVES:
AN INTRODUCTION

I will begin with an observation that I take to be central to any examination of HIV/AIDS literature: the representations which surround illness can be a “way into” an intimate connection with another’s experience of suffering, just as surely as they can be a way of safeguarding oneself from any real contact with that experience of suffering. Since the late 1980’s, a body of literature has developed around the narration of HIV/AIDS, a body of literature whose representational strategies present particular challenges to the caring narration of illness. As a result, we find that many narrative accounts of HIV/AIDS do not sensitively or thoroughly represent the experience of illness. Whether this is due to the fact that these narratives recount a disease with unprecedented symptoms or to the fact that accounts of it are written within rigid representational constructs are both possibilities that I will explore.1 An insensitivity to illness came as unexpected to me as I began reading this body of illness literature, given the inroads that have been made in psychoanalytic trauma theory, ethical-medical anthropology, and critical readings of illness narratives.2

How are we to explain unsympathetic representations within the context of HIV/AIDS narratives? What are we to do with narrativized representations formulated out of rigid ethics of principles or inflexible representational constructs? Above all, how do we avoid the formation of narrators and readers who are inadequate to the task of a tolerant,
flexible, or ethical considerations of the narrated illness? To begin to answer some of these questions, I turn to the observation which will become the central argument of this dissertation: many HIV/AIDS narratives contain narrators who are employing specific representational strategies to achieve some calculated negative effects, effects which are punitive, dichotomizing, normalizing, or socially sanctioning. These strategies create a narrative which 1) is less gay affirmative and more ready to employ normalizing rhetoric of all sorts, 2) contains narrators who are more apt to leave the clinical space with work unfinished and to imply closure where there has been none, and 3) represents narrators who become less able to operate outside of the roles they have created for themselves. These implications are marked, in part, by a lack of self-awareness on the part of the narrators, or by a lack of what Thomas Couser in *Vulnerable Subjects: Ethics and Life Writing* identifies as “the acknowledgment of the face and the autonomy of the other even, or especially, when the relationship is consensual… [This] is not just a matter of responsibility but responsiveness. The challenge is to enact or communicate this on the page” (22). A large part of my project examines the reasons why such responsive efforts at communication, initiated by the narrator in the event of illness, fail or come up short “on the page.”

The field of HIV/AIDS narratives is large and comprised of diverse genres. For this dissertation, I have drawn on vastly different genres, in part to suggest that the genre that “houses” the narrator has less impact than the representational strategies he employs. In the interest of narrowing the field of textual possibility and of selecting texts which are archetypal representatives of much HIV/AIDS writing, I have chosen to focus on four narratives: *Plays Well With Others, My Own Country, And the Band Played On*, and
Angels in America. I have chosen to focus on these texts for some specific reasons. First, most came into circulation in the decade which followed after the late 1980’s—after the devastating scope of the pandemic had come into public awareness, before the advent of protease inhibitors, before the public understanding that many people would come to live for many years as HIV-positive, and before the human cost of the pandemic in other regions of the world was fully known. At this time, many of the unknown factors of the HIV/AIDS pandemic began to influence the representational choices that the narrators made. Second, these texts contain narrators who simultaneously occupy the role of caretaker, and thus clearly demonstrate the representational mechanisms behind the selection and sustenance of certain rigid narratorial roles within the text.

An analysis of these specific texts becomes important, given that the texts I am examining were popular and influential at the time they were published (and remain so), and are among the first in a line of narratives which attempt to “tell the story” of HIV/AIDS. They represent one of the first comedic treatments of the epidemic (Plays Well); the first full-scale journalistic treatment (And the Band); and the first popular medical case study (My Own Country). After publication, these authors went on to occupy positions of authority within HIV/AIDS forums. They became “AIDS experts” even if they possessed no medical credentials. Now, their works are listed on university syllabi across the country. In the flurry of post-publication publicity, the narrators who tell these stories have frequently become confused with their authors, and both have met a highly favorable response from a general reading public.

A paradox (which is only occasionally hinted at by the narratives themselves) is at work within many HIV/AIDS narratives: the narrators seem to control the representations
of illness and those who are ill, at the same time as they demonstrate their own ineffectuality in the face of the demands of caretaking. In a neat instance of narrative displacement, they control the representations of illness largely through controlling the representations of themselves. In other words, when these particular narrators look around, they are making no progress against the disease (not by easing the suffering of those who have it, not by curing it, not by naming it, not by discovering its origin, and not by adequately describing the experience of it), so they select three specific overcompensatory roles for themselves: a heroic role, a highly-stylized artistic role, and a prophetic role. Out of these rhetorical acts of overcompensation, the roles these authors forge become grandiose, fostering narratives of intense drama and engagement. But despite the ways in which many texts do portray HIV/AIDS (as a dramatic battle, as a series of climactic moments, as marked by definitive closure), it is the chronic character of this illness that begins to define the disease for these narrators.

Much of the narrators’ rhetoric reflects a resistance to this perpetual and chronic nature. When narrating with an eye for the vagaries and uncertainties of HIV/AIDS, ones that might open up possibilities of achieving a deeper connection to those who are challenged by it, these narrators seem to seek closure. This closure has many narrative iterations: Verghese as a narrator becomes interested in perfecting the “art” of helping his patients die rapidly; Shilts’s narrator searches like Ahab for a coherent “name” for the illness, spoiling all the while for a face-to-face confrontation with it, and Gurganus’s Mims constructs his narrative as an address book with entries he can erase forever. These gestures of drama and of closure are understandable, given a narrator’s need to feel as if he has adequately and completely told his story and thus achieved some sort of control over it.
Furthermore, they contribute to the identities that the narrators assign and sustain for
themselves at the end of the narratives: Verghese as fallen angel-hero, driving into the
darkness at the edge of town; Mims as artist situating himself firmly within the borders of
the land of the living and aesthetically productive; and Shilts as prophet solving the
singular mystery that he believes he has articulated for an entire pandemic. But an
ethically-aware narrative critique would question the rigidity of the effect of these
narratorial subject positions and the impact that rigidity has upon the degree of caring that
the narrative can express.

Placing a modest series of observations about insensitive narrative strategies amidst
a clearly delineated and rigidly formulated ethics of principles which accompany the
analysis of many traumas might seem a naïve, unsophisticated, or even off-base manner in
which to approach a critique of textual representations. Yet I will briefly ground such a
critique of representation using a short definitional place marker suggested by ethicist
Emmanuel Levinas: in the face of suffering, true acts of caring take place in a single
context, at a single moment, between two individuals at a circumscribed location. Levinas’
ethos is a bold and simple one: an ontological approach (which he defines simply as any
system that abstracts, generalizes, projects, or conceptualizes beyond the face-to-face
encounter of two individuals in a closed room) takes a dehumanizing step in the direction
of an inflexible, regulatory code of ethical conduct and moves away from an ethics of care.
Levinas is, fundamentally, a narrative ethicist. As he argues in his essay “Substitution,”
narrative representations of acts of care, philosophical or novelistic, are fundamentally
problematic, because they frequently evade their primary ethical responsibility to the other:
“Responsibility for another is not an accident that happens to a subject, but precedes
essence in it…the word I means here I am, answering for everything and for everyone”

(104). Or, as one commentator suggests:

... Levinas rejects the synthesizing of phenomenon in favour of a thought that is open to the face of the other. The term “face” here denotes the way in which the presentation of the other to me exceeds all idea of the other in me. The proximity of this face-to-face relation cannot be subsumed into a totality; rather, it concretely produces a relation to the commandment and judgment of infinity... It creates an asymmetrical indebtedness on my part towards the Other’s moral summons which is based not on a prior knowledge or Jemeinigkeit, but on the primacy of the other’s right to exist...Consequently, to be oneself is to be for the other.

(Hand 5)

In my discussion of an ethics of care within HIV/AIDS narratives, I will apply a Levinasian-influenced series of ethical considerations to these texts. These considerations are messier, more vexed, more contextually-based (but I will argue ultimately more conducive to a caring narrative) than any overarching virtues delineated by an “ethics of principle,” an assertion which will be more fully explored later in this dissertation.

Some axioms follow naturally from the foundation of Levinas’ ethical assumptions. His ethical approach suggests that we must really see those for whom we care, at the same time as we are aware of the perceptual screen through which we are seeing them.

Furthermore, we must assume that ethical description is often halting, uncertain, and inelegant; that we frequently speak in the face of suffering to find out what we want to say; and that we must remain in intimate emotional contact with a subject and not distance ourselves through our “delight” with the elegance of its representation. My argument is prescriptive: to construct texts about illness marked by caring, we need to move away from rigid ethical and narratorial dictates. This has not been the direction that the most intense
trajectory of bioethical theorizing has moved in. As an example, Thomas Couser, largely a proponent of a principalistic assessment of life writing, notes in Vulnerable Subjects:

“…the cardinal concepts of the approach to biomedical ethics known as ‘principalism’—respect for autonomy, beneficence, and justice—seem pertinent of the sorts of life writing under consideration here” (x). Dispensing with an ethics of principle (comprised of codes of conduct, rules for ethical behavior, and pre-conceived guidelines for “right action” which are formulated without regard to the context in which they are needed) requires the exploration of a more ambiguous narrative approach, one that emphasizes a multiplicity of perspectives and foregrounds both marginalized voices and ideas: non-heroism, non-judgment, a refusal of narrative closure, and even a comfort with being narratively “lost.” The fact that we, in the 21st century, still gravitate towards ontologically-grounded accounts of suffering—accounts which empathetically delineate the contours and conditions under which our ethical actions find their way into Being—is in no way a surprising observation. The fact that such accounts often couch ethical considerations into declarative language, pre-set rhetorical structures, and an assumed common playing field of terminology provides a solid discursive structure out of which theories about trauma can move. In contrast, a lack of such a reified approach to ethical questions is less apparently defensible and more uncomfortably amorphous.

Beauchamp and Childress laid the foundation for an articulation of bioethical principles in their text Principles of Biomedical Ethics—initially introducing the concepts of autonomy, nonmaleficence, beneficence, and justice in what has come to be called the “Georgetown mantra” for guidance in the caring treatment of patients. Of course, these are more finely parsed iterations of the Hippocratic injunction to “do no harm,” and contribute
to a fixed discursive set of guidelines which steer behavior at the site of illness. Not that theorists have not come along to soften the rigidity of those guidelines—they have. In addition to Levinas, the ethical work of both Carol Gilligan and Nel Noddings have been used to move a rigid principalism into a more situationally-applied caring ethic. Gilligan, whose work in *A Different Voice* suggests that women develop a relational mode of moral development, and Noddings, who in *Caring: A Feminine Approach to Ethics and Moral Education* suggests that considerations of care for a given individual should come before any consistent moral guidelines for that care, both begin to contribute to an evolutionary articulation of “caring.” This articulation remains unconsolidated and uncanonized, subjectively evaluated, and comprised of terms so amorphous that they threaten to form a landscape of the “unsayable.” The price that we pay in ethical discussion for using terms which make any final conclusions about “right action” difficult to assess—or which use such terms as “vulnerability,” “care,” “responsiveness”—may be necessary to keep the possibilities of language as expansive as possible. Otherwise, we engage with the semantic conundrum that Ruthellen Josselson identifies in an essay in Thomas Couser’s *Vulnerable Subjects*: “Language can never contain a whole person, so every act of writing a person’s life is inevitably a violation” (15).

At the same time, this openness and this expansiveness in the field of ethical consideration cannot be confused with amorality or a behavioral free-for-all at the site of illness. Instead, a caring ethic must be deeply and continually considered, evaluated, and reflected upon. Arthur Frank, in his discussion of the ways in which John Gardner’s essentially conservative *On Moral Fiction* might be applied to illness narratives in a more liberatory manner, remarks:
I find no contradiction between [John] Gardner’s assertion that morality is too complex to be reduced to any code and his claim that there are—there have to be—eternal verities. To claim that eternal verities are real is not to say that humans have a transparent knowledge of what these are or how they should be applied in any situation that life presents… [instead, the claim suggest that] moral life is founded in dialogue, and the closest humans can get to moral certainty is the dialogic affirmation of others. (qtd. in Eakin 181)

To suggest that these narrators have not always sought the dialogic affirmation of others is to understate the isolation of their narrative approach.

Although ethical discussion often takes place in the context of traumas such as the Holocaust and Hiroshima, ontologically-based characterizations of classes, relations, and functions between elements of disease (assuming such elements exist and can be articulated) do not function in descriptions of a phenomenon that has no coherent definition—no clear beginning, ending, stable set of symptoms, or known cure. But helpfully, in the intimate space of our responsibility to the Other, Levinas believes that we employ “a mode of being and saying where I am endlessly obligated to the Other, a multiplicity of being and saying which refuses totalization and takes form instead as fraternity and discourse, an ethical relation which forever precedes and exceeds the egoism and tyranny of ontology” (qtd. in Hand 1; emphasis mine). The “moral conclusions” arrived at in the narration of illness are not the point; the fact that we are coming together to discuss illness is. Levinas’s argument implies the need for ambiguity, multiplicity of perspective, and a narrative refusal of closure, all recommendations which become consistently relevant to HIV/AIDS narratives. Theorists such as Paul John Eakin, Thomas Couser, and Paul Lauritzen have addressed such issues in the context of what they term
“life writing,” a writing that they see as constitutive of self-identity. In this project, I am interested in the self-identity of the narrators of illness, who then become subject to the ethical evaluation of life writing that Eakin lays out in *The Ethics of Life Writing* (2004):

…life writing emerges as an extension and further playing out of that capacity for narrative understanding which enables us to grasp what [Charles] Taylor calls “life-plans,” our sense of the direction and meaning of our lives. If identity and morality are intimately and inextricably connected in this way, then ethics is not merely one possible perspective on life writing; it constitutes it as a practice. (4)

In addition, medical ethicists such as Rita Charon, Arthur Kleinman, and Arthur Frank have all called for a narrative constructivism which acknowledges many local truths in the descriptions of illness, considers the context in which stories of illness are told, and accommodates ambiguity (“moral” and otherwise) in descriptions of character, action and belief at the site of illness. To retain a sense of caring ethic, and retain it without the moral prompts provided by an ethical principalism, implies enacting this mode of narration which is ambiguous, multiply-voiced, unclosed, contextually sensitive, and resistant to pre-established patterns of story-telling or role-playing on the part of the narrators.

When we, as humans, channel our capacity for suffering into representation (the artfully-chosen word, the artfully-constructed image, the artfully-sustained role), we are capable of inflicting further injury to one who is already suffering. On the whole, there is a chance that art offers very little opportunity for ethical engagement, a fact which concerns Levinas: “The formula [of art for art’s sake] is false inasmuch as it situates art above reality and recognizes no master for it, and it is immoral inasmuch as it liberates the artist from his duties as a man and assures him of a pretentious and facile nobility” (qtd. in Hand 131). Furthermore, an artist is also a nefarious magician: “An image marks a hold over us
rather than our initiative, [and creates within us] a fundamental passivity” (132). I will explore this idea of the artist as maleficent magician more fully in Chapter 2, but for now, as Edith Wyschogrod notes:

In an early article on the nature of art, Levinas shows us the discontinuity between art and the ethical. In its attempts to generate a world, art succeeds only in achieving the “pseudo-presence” of a world…For Levinas, art for art’s sake is simply wrong. It situates art above reality. To go beyond reality is the function of understanding, whereas the function of art is precisely not to understand…According to Levinas the image neutralizes any relation to the object, and since the image can never give rise to the concept, art can provide us only with images; we can never bring them into clear and distinct rational thought…The most fundamental level of art is represented in rhythm where something, sound and interval, is imposed upon us. We are carried away by it, we give up the self to anonymity. The incantatory quality of poetry is basically sorcery…art is for Levinas the absence of seriousness and commitment. One is in the world of things as a thing, as a participant in a spectacle. (78)

My argument, although cognizant of the dangers Levinas identifies in an act of aesthetic engagement, does not take such a hard line, and leaves open the possibility that artful representation may foster (although it usually does not) more ethically-caring attitudes. I have found evidence within some of these HIV/AIDS narratives that if a narrator approaches the descriptions of illness with an ethics of care, then the text may foster a readerly attitude which is more willing to sustain an emotional engagement with those descriptions instead of representing them as spectacles of entertainment, seeking “a happy ending,” or rendering descriptions at a comfortable distance.

But because such audience demands are usually in place, HIV/AIDS narratives become a type of illness narrative particularly prone to tight representational control and aesthetic distancing. The once invariably fatal nature of the illness, the multiplicity of
AIDS-related complexes, and the often-hidden nature of an HIV-positive status, are all features which induce fear and uncertainty in the narrator as well as his audience. An analysis of Abraham Verghese’s *My Own Country*, Allan Gurganus’s *Plays Well With Others*, and Randy Shilts’s *And The Band Played On*, conducted beside an analysis of texts which embody contrasting narrative approaches, will shed light on the central question of this study: when a text is scrambling to achieve some sort of narrative footing in the face of unprecedented aspects of a disease, how do specific representational strategies begin to impact the degree of caring and concern demonstrated by the text and its narrator?

Although I will fully explore a definition of an ethics of care at the end of this chapter, at this point I want to make explicit two assumptions which underpin this project: 1) caring takes place in the context of small, not grand, rhetorical gestures; and 2) the construction of highly-stylized narratives and of normalizing representational strategies are ways for a narrator to erect barriers between himself and the illness he is witnessing, as well as between his own body (which he has some agency in selecting the representations of) and the body of the ill person (whom he representationally disciplines through his text).

I have chosen to examine HIV/AIDS narratives, in part, because they narrate the particulars of an illness whose very existence has been surrounded by the impulses of discipline and punishment, whose representational strategies are marred by the narrative insensitivity of narrators who conceive of themselves as “the healthy and the good,” and whose texts are clearly marked by the emotionally-distancing strategies of self-protective narrators. Thus I start my analysis with an acknowledgement of Michel Foucault’s observation in *The Birth of the Clinic* that “bodies are sites of control and obedience, their ‘docility’ part of the micropower of institutional life of the healthy and the good” (79).
The arguments within this dissertation are structured by observations I have made about three overarching self-representational stances that the narrators assume within these texts: those of hero, artist, and prophet. In the second chapter, I will examine at the narrator’s need to sustain the privileged and normalized position of “heroic doctor” (as constructed within a doctor/patient hierarchy). I will speculate about what the dismantling of such a dichotomy (and related dichotomies) might look like. This analysis will take place primarily within the context of Abraham Verghese’s My Own Country, a highly-stylized medical case-study account of HIV-positive patients in rural Tennessee. To contrast with Verghese’s narrative, I will also look at a sampling of poetry and prose from Dr. Raphael Campo. Raphael Campo’s narrator, a fellow physician-writer, serves as an instructive contrast to Verghese, since he offers an approach which undermines the myth of the heroically individualized consciousness, explores the erotic dimensions of caretaking, and refuses to occupy a singular narratorial persona.

In the third chapter, I examine a narrator-caretaker’s negotiation of his emotional engagement with the narrative he is constructing, largely through the stylization of himself as “artist” and through the use of a highly-aestheticized, but distancing, series of representations. Such a series of representations does some sustained normalizing work in Allan Gurganus’s tightly-controlled novel, Plays Well With Others, and I will examine how that press for normalcy begins to impact the narrative ethics of care. I will also look at the way in which a highly stylized narrative may bring a narrator emotionally closer to the subject he is narrating, through an examination of Mark Doty’s Heaven’s Coast and a variety of more minor contributions to HIV/AIDS literature such as Robert Ferro’s Second Son, Vance Bourjaily’s Old Soldier, Peter Selwyn’s Surviving the Fall, Edmund White’s
An Oracle, and Jed Bryant’s A Cry in the Desert. In the third chapter, Foucault’s notion of disciplinary perceptual mechanisms such as “the gaze” helps elucidate the normalizing rhetoric inherent in Gurganus’s carefully-controlled representations of art, health, eroticism, and emotional self-protection. The fourth chapter of this dissertation inquires into the ways in which the language of religiosity—primarily as it manifests within Randy Shilts’s And the Band Played On and Dale Peck’s Martin and John—shields the narrator and the reader from the realization that we all share a vulnerability to sickness and death. I suggest that Shilts attempts to narrate a journalistic account of a historical moment in the progression of HIV/AIDS, and in the process becomes the unlikely “prophetic-religious voice” of the AIDS pandemic. Although Shilts couches his narrative in the self-protective language of religiosity, his rhetoric of blame serves a far different purpose than the religious rhetoric offered within an illness narrative such as Martin and John, which may give the reader a broader, a more erotic, and ultimately a more humanizing vantage point from which to witness narratives of illness.

In the final chapter, I argue that in Tony Kushner’s Angels in America, we find a complexity of representation that some of the previous narrative examples fail to achieve. In arguing that Angels “tells a story” in a manner more exemplary of an ethics of care than many other HIV/AIDS narratives, I am not attempting to set up the other texts as narrative straw men. Instead, I am suggesting that Kushner’s text instructively ruptures rigid representational strategies found within other HIV/AIDS narratives, largely by collapsing subject/object distinctions, engaging with the erotic, and blurring the boundaries between “sanity” and “madness,” “health” and “illness,” and “the physical” and “the metaphysical.”
Features of the Illness Narrative

A reading of HIV/AIDS narratives benefits from much work that has been done in the field of medical anthropology, especially as that field has defined the illness narrative. Illness narrative theorists such as Arthur Frank, Arthur Kleinman, and Rita Charon identify a number of goals set forth by the typical text about illness. Narrativizing illness may give voice to or impose a voice upon a person who is beset by illness. In this way an illness narrative becomes a method of “reclaiming the self” or, alternately, of defining an ill person’s character to an audience who wants to “understand his story.” A narrative may attempt to induct others into a community of understanding, to make an audience aware that we are all potentially (to use Albert Schweitzer’s commonly referenced phrase) of a “brotherhood of those who bear the mark of pain.” A narrative may seek to supply terms to unfamiliar aspects of disease, to create or preserve memories of illness, or to serve as a document of testimony and witnessing. Perhaps most central to my consideration, an illness narrative may have the subversive goal of investigating the ways in which those who are ill are written into the colonizing domain of medically-situated master narratives.

The texts I examine in this dissertation are written in the context of socially-constructed and medically-based narrative trajectories. The pressure of these influences is one feature that places them under the rubric of “illness narratives” as defined by medical anthropologist Arthur Kleinman. In Patients and Their Healers in the Context of Culture, Kleinman’s characterization of illness as a “psychosocial experience” suggests just how fully the “ill” body must bear the burdens of representation heaped upon it during the narration of illness (71). In the case of any illness, the ill must also live with social
resistance to their illness, resistance that has its own representational impact. But there is a
series of features unique to HIV/AIDS as a disease, beyond the social resistance with
which it has been met, that begins to pressure its representations into normalizing rhetoric.
Any analysis of HIV/AIDS narratives must acknowledge what was unusual or even
unprecedented about the illness at the specific historical moment at which these narratives
were written. First, the fact that the point and time of origin of the HIV-virus was
indeterminate created a “mystery to be solved,” and suggested the need for a hero to solve
it.

This observation about the “mysteries of illness” may hold true for the narration of
many diseases, but the ante was upped in the case of HIV/AIDS narratives, since the
existence of the virus induced a high degree of paranoia at a general social level, even when
risk factors demonstrated that the threat of viral contraction for a general population was
actually very low. This paranoia was comprised of a variety of psychological components:
a personal sense of defamiliarization (a person could be carrying the virus within oneself
unknowingly); alienation from others (there were often no visual signs of a HIV-positive
status, so one met the “other” with a certain degree of suspicion); and a projection of the
possibility of infection exclusively onto others, as narrators undertook the familiar action
of bargaining for personal health. Even when it became clear that the person who was
HIV-positive was more in danger (due to immune system suppression) than endangering,
socially-sustained perceptions of “the menacing ill person” remained in narrative
circulation.

At this point in the pandemic, we are now well aware of the environment that came
to house and control the social rhetoric of AIDS, but certain aspects of that environment
bear repeating, since they help form the representational strictures I am examining. The fact that many socially-prominent voices blamed the pandemic on recently-won sexual freedoms spawned a punitive discursive backlash that had a variety of representational implications.3 First, AIDS education was hindered, as information considered “inappropriate” was suppressed. In the wake of that suppression, misrepresentations of the disease flourished. Second, HIV/AIDS manifested in so many symptoms that many narrators were forced, for simplicity’s sake, to represent it as one concerted phenomenon. This need was initially frustrated—as a shifting acronomic nomenclature indicates (ARC, GRID, AIDS). Third, the pandemic spread so rapidly that it created a time pressure to find a cure and fostered an underlying rhetoric of panic that governed those pressured efforts. The fact that the disease was initially ignored by those governmental entities in the greatest position to provide assistance (i.e., Reagan’s administration, the CDC) created the need for widespread political rationalizations of denial, oversight and inequity. In short, the epistemological framework of the disease became one of sketchy information and unstable characterization.

The three particular narratives I focus on, My Own Country, Plays Well With Others, and And the Band Played On, are situated at the beginning of the pandemic, and in the midst of these representational pressures. As these pressures intersect within the texts, the narratives take on specific narrative trajectories. The pressure to name the disease presents a particular rhetorical challenge, since HIV/AIDS manifests in a diffuse number of symptoms, and essentially finds its way into a series of signifiers varying from individual to individual. Since treatment strategies have been (and still are) so long in coming, the conditions create nearly intolerable levels of frustration for narrators wishing
to tell a story of progress against the disease. The fact that these narrators are telling of an illness whose origins, causes, outcomes, and signs they did not fully comprehend makes them more likely to “fill in the blanks” through controlled and stylized representations. In the drive to define the disease and the narratorial position in relation to the disease, the narrators begin to impose a series of normalizing structures upon the representations of illness. So within many of these narratives, HIV/AIDS becomes the site at which the narrator purports to be staging an intervention in the structures of social inequity and struggle at the site of illness; in short, purports to be constructing a caring ethic. Ironically, all of these narrators define themselves as caretakers: Shilts of the record of the pandemic; Gurganus/Mims of his friends and his notions of Art; Verghese of his patients, his practice, and the record of his initial encounters with the pandemic.

**The Function of the Erotic**

At this point, I want to digress for a moment to describe a portion of my own reader response to the three primary texts I examine here. Anyone who engages with the genre of HIV/AIDS literature is bound to have a variety of strong reactions to a number of aspects of these texts, and my reactions have at times succeeded in distracting me from the ways in which I wanted to write about this topic and this genre of literature. Some reactions I had anticipated in myself: feelings that the textual descriptions were inadequate to the task of representing HIV/AIDS, a consistent taking note of the homophobia within the texts, and at times an almost sneering reaction to what I could only see as the naive limitations of the authors themselves. These responses, although understandable, were not entirely fair or measured. For one thing, the texts that I had chosen in large part to “pick on” were texts
that were written at the onset of the pandemic: before the advent of protease inhibitors, before any notions that one could come to live for a long time as HIV-positive, and before general public knowledge that the pandemic was sweeping other countries as well as devastating the United States, so their perspective would necessarily be limited by their place and time.

Because of their location in a particular historical moment, and because they are pioneering texts, one might be tempted to dismiss them as (at worst) pieces of bad literature, and (at best), artifacts from a unique cultural moment in the history of writings about HIV/AIDS. But, if my reaction was so negative, why couldn’t I just walk away from these books? In my writing, I was certainly not attempting to redeem them, to portray them as of any great value or significance, or even to suggest that they should be widely read. Then what made me want to read, and re-read them? Why did they generate so much productive discussion in classes when I taught them? What was it about these texts that seemed to hold the possibility for engagement, even while I saw them through dismissive, condemnatory, and critiquing eyes?

A hint began to emerge as I was reading—something that had been there all along, operating at a textual level that was implicit but visceral: in these stories of death and of suffering, there was the presence of a heavily-suppressed eroticism. The fact that these texts bear fundamentally erotic undertones, even though the narrators do much to suppress those erotic elements, is clear. Even through most critics and readers (particularly of Verghese and Shilts) would probably deny that they are in the presence of a literature with any degree of libidinal investment, I will argue that they are wrong. The fact that these texts begin to pave the way for a fully-engaged eroticism, but simultaneously suppress an
eroticism available in narratives such as *Angels In America*, is a thread of argument that is taken up throughout my discussion.

My project does not contain a whole-hearted argument for the eroticization of sickness or death as part of the development of a representational ethic of care. At least, not usually. Instead, I see evidence which suggests that eroticism within a text fosters a sense of possibility, of liberation, and, in the highly erotic-spiritual case of *Angels in America*, becomes “The Saving Grace” of a caring ethic itself. In the broadest of generalizations, when eroticism departs from a text under consideration, the life-force of that text itself departs. In the presence of textual eroticism, then, what stands to be liberated? A number of possibilities present themselves: 1) the roles into which the characters are placed by the narrators within these illness narratives, 2) the roles, perspectives and identities into which the narrators position themselves within the texts, 3) the heavy-handed moralizing that accompanies much HIV/AIDS discourse, 4) conventional settings, closure, voice and character development, and 5) the machine-like progression of plot within many of these texts.

When even a tiny, shining strand of the erotic is subtly woven into these narratives, however, its disruptive potential begins to present itself. Even if that potential never comes to fruition, the inherent power of it may be seen when these narratives are read in contrast to texts whose engagement with the erotic is less suppressed. What do we make of a disruptive textual eroticism, an eroticism which *could* (but never quite does) serve to dissolve representational strictures within the text? How do we find critical space to talk about this embryonic eroticism, when it creates texts which have more subversive potential
than they actually appear to, and when it is so consistently denied, repressed, and erased in much of the critical material surrounding HIV/AIDS literature?4

Verghese’s text, for instance, contains many potentially erotic (and even transgressive) moments. These moments might yield an erotic celebration of freedom from rigid representational strategies, move the narrative towards new representational possibilities, and create a narratorial space for a greater intimacy with the experience of illness. In the potentially erotic scenes with a man named Will (as well as other patients), in his erotic friendship with Vikki, and in his engagement with the remote and elusive “Other Woman,” Verghese’s text is full of erotic possibility. But those possibilities are unfailingly truncated or suppressed. That this erotic energy is taken up and then inevitably abandoned throughout the book creates an odd contrast of disciplinary and liberatory rhetoric, largely channeled into narratorial self-representation that pivots on traditional notions of heroism. In sustaining this position as “Hero,” Verghese’s text develops a normative mechanism by which he begins to regulate other dimensions of his illness narrative, as well. But if the disciplinary rhetoric of My Own Country is read next to select samples of another physician writer, Raphael Campo, the contrast highlights some of the values of eroticism for the narrative development of an ethics of care.

In the arena of human relationships and eroticism, the bind that these narrators are placed in ratchets up the tension created by these interactions and pressures the narrator to more tightly control his representations. Thus Verghese must draw close (but not too close) to his patients to hear their stories, yet must not appear to appropriate these stories for his own personal glory or transgressive interest. Shilts’s narrator must come close enough to the descriptions of the pandemic to “accurately” render a detailed account, but not become
so intimate as to lose the mantle of “objectivity” that has been his source of narratorial legitimacy. In *Plays Well*, Mims must come close enough to give himself authenticity as a “spy in the house of love”—but still retain the emotional distance necessary for a distinct and aestheticized rendering of the stories of his friends. Yet a caring ethic would seem to demand the setting aside of the narratorial ego’s considerations of heroism, artistry, and a prophetic status in favor of a more intense consideration of the ill. Or, as Mark Doty writes in “Is There a Future?”, an essay contained within the anthology *In The Company of My Solitude*: “…hope is perhaps simply a stance towards the world, finally, a stance of participation, or inseparability. That which cannot be separated cannot perish. The world has one long-term survivor, which is the world. This is how I see through the wider end of the telescope, when my perspective on the world is wide enough to see us as part of this vast interchange of being, not its center” (11). Eroticism offers one avenue towards that center.

Affecting an erasure between subject and object and forging this “vast interchange of being” becomes one of the textual functions of the erotic. In her landmark essay “The Uses of the Erotic,” Audre Lorde has poetically suggested such a possibility:

> The erotic functions for me in several ways, and the first is in providing the power which comes from sharing deeply any pursuit with another person. The sharing of joy, whether physical, emotional, psychic, or intellectual, forms a bridge between the sharers which can be the basis for understanding much of what is not shared between them, and lessens the threat of their differences. (qtd. in Abelove 341)

But consistently, some HIV/AIDS texts preclude such possibility: the extent to which they continue to erase the erotic is the extent to which they continue to instate and re-instate the
subject/object duality upon which their representations rest. But again, as Lorde writes, it is of the essence that the body and its narratives remain erotically inscribed, flushed through with that transformational energy that holds the possibility for a greater ethics of care: “Recognizing the power of the erotic within our lives can give us the energy to pursue genuine change within our world, rather than merely settling for a shift of characters in some weary drama” (qtd. in Abelove 343). HIV/AIDS narratives, through an acknowledged engagement with the erotic, might open the door for new ways of narrating illness. The erotic has frequently been excluded from the site of illness, and one impact of that exclusion has been the emotional distance established between the audience and the ill. To examine what illness narratives have traditionally included, even while they have often excluded eroticism, I will turn to a discussion of some of the fundamental features of such narratives.

**Traditional Structures of Illness Narratives**

In Arthur Kleinman’s formative definition, illness narratives are constituted at the nexus of disease and illness:

*Disease* refers to a malfunctioning of biological and/or psychological processes, while the term *illness* refers to the psychosocial experience and the meaning of perceived disease. Illness includes secondary personal and social responses to a primary malfunctioning (disease) in the individual’s physiological or psychological status (or both). Illness involves processes of attention, perception, affective response, cognition, and valuation directed at the disease and its manifestations (i.e., symptoms, role impairment, etc.). But also included in the idea of illness are communication and interpersonal interaction, particularly within the context of the family and the social network. Viewed from this perspective, illness is the shaping of disease into behavior and experience…That is, illness contains responses and explanations as well as control. (73)
As this definition suggests, illness narratives begin to negotiate the meaning of illness for an entire culture. They have even been characterized as a type of socially circulated, fear-inspiring travelogue—as Susan Sontag writes, “We are each citizens of two kingdoms: the kingdom of the well and that of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place” (quoted in Frank 9). This realization makes illness narratives a site of readerly fascination, emotional resistance, and intense negotiation of the ways in which we “tell the stories” of illness. Arthur Frank observes that many of us live as dual citizens of the lands of illness and health, and out of that citizenry construct “narratives of remission” in which disease does not manifest, but may possibly return. This psychic space of remission is a liminal space—and is particularly relevant to those who bear an HIV-positive status. At times uncomfortable—when one must monitor medications, check on the status of remission, or even “explain” their involvement with a disease to the people around them—this liminal space is also a distinctly postmodern one, in which the categories of “healthy” and “well” (which are so relevant to modernist meta-narratives of the individual) are blurred.

Frank’s characterization of the remission narrative is notable not only for the fact that the categories of “healthy and well” are conflated within it (if one is asymptomatic, if one’s symptoms are suppressed by medication, if one is tentatively “cured” for example), but also for the fact that it admits a region which Frank identifies as a site of colonization in the construction of personal identity. As an individual takes his place in the space of the sick, he runs the risk of colonization: “Just as political and economic colonialism took over
geographic areas, modernist medicine claimed the body of its patient as its territory, at least for the duration of the treatment” (Frank 10). Illness narratives are often dedicated to the notion of keeping body and mind within the boundaries of culturally-sanctioned and colonizing definitions of “health,” even if that effort comes at the cost of indignity, dehumanization, labeling, or the decreased visibility of one who is “ill.” Just the act of labeling a person as “ill” can be an appropriating gesture, one that has resounding implications for the way a person conceives of his or her own identity within a medical or social hierarchy. Or, as Kleinman writes of a person who goes on to accept the illness descriptor provided within the context of medical care: “the label he applies to subjective feelings or objective signs will in itself exert a powerful influence, and that label is always a cultural category…In applying the label, the afflicted person and his family make use of the explanatory accounts available to them in a particular cultural, historical, and health care sector context” (76). These “explanatory accounts,” in the case of HIV/AIDS, have frequently been normalizing and homophobic, and have contained the impulse to pathologize, not only the body of the ill person, but the sexual and social practices of that person as well.

In short, illness narratives have the potential to accomplish a variety of representational functions, rhetorical interventions, and disciplinary maneuvers. They may attempt to recover the voices of the ill, particularly when medical institutions threaten to overwhelm those voices. In doing so, they attempt to establish the self as it exists in and around illness. The path towards this goal of establishing a self is not always a smooth one. As Frank observes, a common characteristic of the illness narrative is its interrupted and fragmented nature in the context of the representation of the self. While we may expect a
narrative to move in an orderly, linear fashion towards a neat closure, many illness narratives depart from a predictable story-line as surely as a person who is ill must depart from the predictable patterns of their life, encountering interruptions in “speech, schedule, sleep, solvency, and anything else” (Frank 57). But while illness narratives do account for minor interruptions as well as cataclysmic change, they must remain clearly distinguished from other “self narratives” which describe trauma (such as incest narratives or Holocaust narratives), according to Frank (57), because the threat narrated within an illness narrative is ultimately coming from within one’s own body. Illness, in some accounts, is constructed as the self turning upon the self.

Finally, Frank, who offers the perhaps the clearest taxonomy of illness narratives, divides illness narratives into three categories. The restitution narrative recounts stories of success and triumph over a disease (77). Such a narrative is also a sort of “before and after” success story in a way that some of the narratives I look at will play with and reverse. Although the three primary AIDS narratives that I examine here operate under no motifs such as the “return to health,” there is a clearly delineated definition of a time “before AIDS,” which is portrayed as the Edenic garden from which many people have been expelled. The fact that no restitution is possible within these texts does not preclude a narratorial impulse towards such restitution, as well as a rigid series of representations which support that impulse. In his taxonomy, Frank underlines the essentially conservative nature of the restitution narrative, which seeks to preserve status quo notions of health in ways which are often inadequate to descriptions of chronic health challenges: “Metaphoric phrases like ‘good as new’ are the core of the restitution narrative” (Frank 77).
A second category of illness narrative is marked by a structure that is largely undefined, or loops back upon itself, or is deliberately confused. The *chaos narrative* conveys a sense of bearings lost in the face of illness, as well as the confusion inherent in such loss. In the chaos narrative, a story embodies a wound, or “…the hole in the narrative that cannot be filled in, or to use Lacan’s metaphor, cannot be sutured. The story traces the edges of a wound that can only be told around. Words suggest its rawness, but that wound is so much of the body, its insults, agonies, and losses, that words necessarily fail” (Frank 98). Yet the narrative itself is not a textual failure, according to Frank, since it cues the reader into the inherent disorientation induced by illness. Although the three primary texts that anchor my analysis demonstrate a potential for chaotic narrative dissolution, they also tend to resist and erase their potentially-disorienting narrative elements. As a result, a tight hold upon the linearity of the narratives becomes a hallmark of all three, and an additional feature that often precludes a more complex or vexed engagement with the illness they describe. To generalize, within the three narratives I focus on, there is a) a clear-cut story to be told, b) a “moral” point to be made, and c) a secret waiting to be discovered. The potential for satisfaction of all three of these goals is contained within Frank’s third category of illness narrative—the *quest narrative*.

The quest narrative is marked by a much more clearly-drawn sense of narratorial purpose. Most succinctly, within the course of the quest, there is a lesson to be learned. The quest narrative suggests even more explicitly than the restitution narrative the “good opportunities” to be gleaned from illness. Such suggestions are couched in the terms of the mythologies of “perfectibility, regeneration, and ultimately the finest exercise of human freedom” (Frank 125). In Frank’s description, the quest story is a romance between the ill
person and his or her illness, at the same time as it involves a triumphant vanquishing of that illness. Allan Gurganus’s text engages features of this narrative paradigm, for example, as it characterizes a community of sufferers who must learn from this suffering, and one questing narrator who must defeat it.

Admittedly, Frank’s categories are themselves a rather linear, and perhaps simplified, account of illness narratives at large. Although such categorization runs the risk of obscuring real differences between the narratives, or of imposing just another series of Lyotard’s “master narratives” upon a discussion, these categories may also allow us to listen for significant and repetitive narrative patterns. Such patterns emerge, in part, from the fact that an illness narrative is a historical document, created out of the combined context of the narrator’s personal history, the history of other illness narratives, and a complex history of ideas about illness. An illness narrative retains traces of each of these conceptual and evolutionary stages interwoven throughout its discursive structure, and often brings them all into simultaneous operation at any given moment. As a consequence, the site of illness is constructed out of both the personal and social histories contained within it. Often, the impact of these histories is amplified, given that the site of illness is an isolated one that often does not admit the chance for other influences. Thus, illness is a “temple of doom” according to Raphael Campo; the frozen isolation of Antarctica, according to Harper in Angels in America; and Susan Sontag’s “Otherworld.”

As an additional ramification, since narrators of illness have formed their representations within the context of illness, they themselves lose their self-established identity and existential footing outside the site of illness. At the end of the texts I examine here, we see two of the primary narrators attempting to represent themselves outside of the
context of HIV/AIDS, after they have exited the site of illness and death, but finding that they no longer retain the identity they have established for themselves within that site—and finding that they no longer have much to say. (Hartley Mims can only sit on his front porch rocking; Abraham Verghese finds himself alone with, but estranged from, his wife and family.) The narrators are placed in a position of insecurity, only able to “be themselves” (albeit inauthentically) when they are located at the site of illness. As that site becomes more and more isolated, as those around them die or fail to understand their efforts at the site of illness, these narrators become more invested in their self-representations in an attempt to bolster and stabilize their sense of eroding identity. And as the rules governing the text’s representations become more intractable, the narrator’s investment in his own representational schema (governed, as it is, by these rules) increases. He is thus left with no exit from the space of illness, and no alternative to the identity he has developed within that space.

**Unique Characteristics of HIV/AIDS Narratives**

Obviously, illness narratives are located within characteristic spaces or settings: sites of medical care such as the hospital, auxiliary sites such as waiting rooms, laboratories, hospices, and various sites of home-based care. The space of illness is a sequestered environment, a self-contained and constructed region. Illness exists within a space, according to Foucault’s extensive description in *The Birth of the Clinic*, in which its identity is artificially constructed and tentatively sustained: “Like civilization, the hospital is an artificial locus in which the transplanted disease runs the risk of losing its essential identity” (17). The setting of an illness narrative changes perceptions of disease, especially
within surroundings that suggest an unnatural and alienating location, or give the “the unfortunate impression [at] the sight of these places, which for many are nothing more than ‘temples of death’” (17), as well as a sense of isolation (both for patient and for doctor). In Foucault’s analogy, the site of illness becomes a state with rulers and with subjects, a view that is underscored by Roy Cohn in *Angels in America* when he realizes that a hospital is “no place to be sick” if one is used to being in control. Within the settings of illness, these narratives suggest that the “well” work to maintain their hierarchical advantage through ready-made disciplinary mechanisms. But we must also look at the ways that these narrators attempt to establish this advantageously “well” subjectivity and subsequently employ normalizing (and frequently uncaring) representations at the site of illness.

According to Foucault in *The Birth of the Clinic*, a partial explanation is found in the existence of a “medical gaze”:

> What now constituted the identity of the medical gaze was not the circle of knowledge in which it was achieved but that open, infinite, moving totality, ceaselessly displaced and enriched by time, whose course it began but would never be able to stop—by this time a clinical recording of the infinite, variable series of events. But its support was not the perception of the patient in his singularity, but a collective consciousness, with all the information that intersects in it, growing in a complex, ever-proliferating way until it finally achieves the dimensions of a history, a geography, a state. (29)

As Foucault also observes, the “form of composition of the being of the disease is of a linguistic type [as well as] the concourse of the accidents which constitute it” (119).

The space of the clinic is defined in terms of the perceptions made within it, as well as the language developed out of those perceptions. *Place* matters to these narrators; indeed, the heart of their representations is dependent upon it. As a result, the setting of
these narratives has an unmistakable impact on the development of an ethics of care. Or, as Ruth L. Smith observes in her analysis of *My Own Country*: “Because Verghese makes explicit his sensibilities to location, I rewrite his practice as an opportunity to consider place relations as a part of medical ethics… The disciplinary production of medical ethics has been so routinely situated in the modern hospital that we forget that it is situated at all” (qtd. in Cates 298). After accounting for place relations within illness narratives in general, my project can begin to examine the ways in which HIV/AIDS is uniquely situated and represented within texts, and the way that this positioning begins to impact an ethics of care.

Because of the way that HIV/AIDS initially defied definition (bearing, as it did and does, a series of symptoms both fragmentary and diffuse, and beginning to endow the narrators with a sense of responsibility for organizing and characterizing the pandemic); because of the speed at which the pandemic took hold (a speed that sometimes finds its way into the texts at the level of narrative pacing); because of the way an entire culture rushed to quarantine the disease, as well as to isolate those who were closely associated with it (to create clinics which would contain instances of the disease as isolated phenomenon unconnected to any larger patterns), HIV/AIDS narratives begin to bear unique characteristics as a subset category of illness narratives. The three primary narratives I examine contain representative examples of wide-scale responses to the epidemic, responses that are in operation to this day. The responses they elicit also help to account for the popularity of these narratives. These texts are popular partially because of their “comfort factor”: because they re-affirm notions people already have about HIV/AIDS,
because they locate the reader at a safe distance from the narrated events, because they usually do not suggest that the reader is personally vulnerable to illness and suffering.

First, as I have discussed, “AIDS” is not a stable referent, so it creates a wide-scale and generalized sense of insecurity. This insecurity, in turn, creates a series of questions for the narrator: what phenomenon, precisely, am I narrating? How do I handle my anxieties and my desires as I narrate? Most of all, how do I select representations which help stabilize my own subject position in an unstable setting? Because the disease (as both Lee Edelman in “The Mirror and the Tank” and William Haver in *The Body of this Death*) have suggested, was at first marked by its lack of a coherent definition, the textual treatment of it puts an ever-greater pressure on the narrator to achieve a stable subject position for himself in the midst of it. At this point, a question might be directed at the subject of this inquiry: could the narratives surrounding *any* epidemic elucidate the intricacies of representation and subject formation with the same clarity and in the same manner as these HIV/AIDS narratives do? Probably not, and for a number of reasons. First, the unprecedented nature of the epidemic in terms of the definitions which initially arose around it created it as an occurrence which intensely engaged issues of identity. Since it was first defined as a “disease of gay males,” as theorist Lee Edelman points out, it began to arouse and amplify questions surrounding identity for both patient and clinician. As Edelman observes in his essay “The Mirror and the Tank” in *Writing AIDS: Gay Literature, Language, and Analysis*: “The discursive field of ‘AIDS’ thus unfolds as a landscape of displacements, and given those displacements and the slipperiness of the subject, every attempt to resist ideological enforcement in one place carries with it the threat of resowing the seeds of ideological coercion in another” (10). Although Edelman’s
arguments focus upon the construction of subject position (of “the gay male,” specifically) which differs from the representations of illness which is the focus of my inquiry, his central point (that a displaced subject formation is entirely pinioned onto the referent “male homosexual”) is well taken, even if he neglects the fact that this floating “ideological coercion” begins to exert a marked effect on representations of the ill as well.

Other theorists, such as Paula Treichler, have acknowledged HIV/AIDS to be a syndrome which has consistently engaged subject formation and the representation of illness as problematic issues. In “The Mirror and the Tank,” included in Writing AIDS, Edelman quotes Treichler:

“AIDS,” then, can be figured as a crisis in—and hence opportunity for—the social shaping or articulation of subjectivities because, in part, the historical context within which “AIDS” in the West achieved its “identity” allowed it to be presented as a syndrome distinctively engaging identity as an issue. In fact, whatever the direction from which we approach the subject of “AIDS,” we are brought up against our own constitution as subjects of (and in) ideology and the fact that we are forced to recognize that the politics of “AIDS” as a subject of discourse is inseparable from the politics of “the subject” itself— inseparable, that is, from the ideological construction and the cultural fantasmatics of agency. (qtd. in Murphy 12-13)

The implication is clear. Self-representation directs action within a narrative: both in the performances it selects to sustain itself and in the way that performed representation prevents self-reflexivity and the incorporation of diverse perspectives at the site of illness. Simon Watney’s focus on the way in which HIV/AIDS narratives produce an activist aesthetic (as discussed in Chapter 1) or Edelman’s exploration of the ways in which the construction of such narratives yield “falsely naturalized oppositions that give rise to our notions of sex and gender and sexuality” (13) are just two examples of the manner in which
the narrator’s choice of subject position begins to impact the representations offered within the text.

For the narrators within my three primary texts, self construction occurs alongside attempts to villainize the virus. This creates a polarized landscape of good and evil, of intense worship (of those fighting the virus) and devaluation (of that which is associated with the virus). Unfortunately, these narrators frequently slip the grid of this devaluation over those who are HIV-positive. In this way, as Jan Zita Grover observes: “The AIDS virus, then, is a term more projective than descriptive. It imposes a mortal sentence on anyone infected with HIV, a projection of hostility and fear that bespeaks another’s death in order to quell one’s own anxieties” (qtd. in Crimp 21). In her text *AIDS and Its Metaphors*, Susan Sontag addresses the implications of this anxiety for the representations of the disease, when she argues that creating metaphors out of illness opens the door to manipulation, interpretation, exploitation and normalization of those metaphorical representations. Such has unarguably been the case with HIV/AIDS, which has been more used to prove a variety of points (about “morality,” about social exclusion, about power dynamics), than most other illnesses—a pattern that I am well aware that I contribute to. In making their points, however, the narrators of many texts have frequently moved away from an ethics of care.

The three narratives I have chosen to focus my inquiry on are popular, in part, because they feed a readerly needs for heroes, victims, and a stylized story—not because they build a sense of resonance, or assist the readers in aligning with those who are ill.
Narratives of illness can also provide both the narrator and the audience with a sense of control over illness through such rhetorical mechanisms as a stylized story. As Arthur Frank observes:

People define themselves in terms of their body’s varying capacity for control. So long as these capacities are predictable, control as an action problem does not require self-conscious monitoring. But disease itself is a loss of predictability, and it causes further losses: incontinence, shortness of breath or memory, tremors and seizures, and all the other “failures” of the sick body. Some ill people adapt to these contingencies easily; others experience a crisis of control. Illness is about learning to live with lost control.

(30)

Perhaps ideally, an illness narrative may tell of the possibilities inherent in living with such supposed “losses.” Although the story of learning to live with a loss of control is not always a story that people wish to read, the very process of narration may begin to erode the potentially liberatory aspects of a lack of control, through the organization and interpretation of illness.

The discourse arising around illness narratives has led to an expanding body of critical work, one anticipated by ethical theorists: “The ethics of medical care will likely be enhanced by further investigations into the ways that ‘textual analysis, literary theory, and the reading and writing of literature can contribute…to an understanding of how we recognize and deal with ethical issues in medicine’” (qtd. in Cates xix). The discourses which contribute to an ethics of care are divergent: “philosophy, empirical psychology, religious studies, literary studies, women’s studies, education, and other fields once considered disparate” (Cates xx). To this list, I would add the contributions of disability studies as well, particularly the work of Tom Couser and Paul John Eakin. Not
surprisingly, my project, as well as its difficulties, has partially been the result of attempting to bring to bear so many different approaches to issues of representation and ethical reading, and apply them to a body of literature that arouses many emotional issues in those who encounter it.

**Exploring an Ethics of Care**

What, then, would an “ethics of care” look like within the context of HIV/AIDS narratives? We may begin to arrive at a formative definition in response to the question: what sort of readerly actions are we moved to take when encountering these narratives? Are we swayed to maintain our emotional engagement with the narrative or to seek definitive closure? Do we “think with” the narrative or resist it? As Frank points out, “Thinking with stories means joining with them; allowing one’s own thoughts to adopt the story’s immanent logic of causality, its temporality, and its narrative tensions. Narrative ethics seeks to remain with the story, even when it can no longer remain inside the story. The goal is empathy, not as internalizing the feelings of the other, but what [Jodi] Halpern calls ‘resonance’ with the other” (158). This idea of resonance entails a willingness to listen without defensiveness, to assume a non-intrusive and non-judgmental stance towards the person who is ill, to be willing to see oneself—even though one is in the position of caretaking—as equally vulnerable and mortal as the person who is ill. An ethics of care would have us ask the question: what sort of human beings are we as we read a given HIV/AIDS narrative? Do we exhibit the qualities of alignment, “withness,” and “forness” (in the Levinasian sense) that also suggest our capacity as resonant readers? In his essay “Substitution,” Levinas begins to define this idea of being “for” the Other in an act of
reading a narrative: “The more I return to myself, the more I divest myself…of my freedom as a constituted, willful, imperialist subject, the more I discover myself to be responsible…I am ‘in myself’ through the others” (qtd. in Hand 102).

Educational theorist Nel Noddings has suggested this definition of an ethics of care: “We do not begin by formulating or solving a problem, but by sharing a feeling. Even when we move into the problem identification stage, we try to retain alternative phases of receptivity” (qtd. in Cates xvi). A gradually-evolving definition of a caring ethic has incorporated the Aristotelian notion of virtuous emotional cultivation as well as feminist re-workings of St. Thomas Aquinas that consider “the way that care moves us to tend to the bodies of others” (qtd. in Cates xviii). An ethics of care, according to such theorists as Ruth Smith, is not constituted of any fundamental assumption or stance:

…not summarized by a master relationship, virtue, principle, or rule. Ethics is elaborated, invented, and interrupted in activities and gestures (saying—being—doing) that indicate the uncertain character of moral territories and discourses and the place-rhetorical character [the location in which the narrative is physically situated and then articulated] of how morality is produced. (qtd. in Cates 299)

If this conception of ethics sounds unmoored, in reality it is anchored by the fact that it is applied within a specific rhetorical context. This contextually-dependent nature of ethical evaluation allows us to formulate explicit suggestions for ethical action, but at the same time permits us to differentiate an ethics of care from a rigid ethical principalism.

An ethics of care exists in fundamental contrast to an ethics of principles in other ways as well, as Diana Cates observes:

An ethic of principles is ordinarily associated with individualistic conceptions of the self. Persons who adhere to an ethics of principles imagine that they stand alone
before the court of their own impartial reason, and that this is the best position from which to survey their moral obligations towards others. An ethics of care, on the other hand, is rooted in a conception of the self as fundamentally relational. (xvi)

As a defining constituent of an ethics of care, there is also an unembarrassed engagement with emotion in the formulation, according to Smith. An ethics of care charts the extent to which a listener is willing to move away from controlling the progression of the narrative, and, in a sense, to “sit there”—even in the presence of someone who is suffering, or dying, or delusional. Being “for” the other (in the sense of imagining oneself as the other) and being erotically engaged with the other are both precursors to this attitude of sympathetic alignment, and include the “ability to travel deeply and empathetically with the client into uncharted and often frightening territory” (xx), as Kylea Taylor suggests in her book The Ethics of Caring. This attitude is fundamentally one of listening and allowing, grounded in a realization that we cannot dispose of each other as human beings and suggestive of the fact that we are in permanent relationship whether we want to be or not.

A perhaps surprising conception of a caring ethic, also defined by Taylor, includes the sanctification of the ill body—the ability to see another’s body a “holy object,” even if normalizing rhetoric might define that body pejoratively as “sick” or dying (91). With this attitude of sanctification, a sick body is defined as an evolving body; and the passage towards death is conceived of as a passage of growth. When narratives construct illness as failure, however, the notion of “getting well” is necessarily equated with success: restitution illness narratives, for example, are based on this very assumption. But the sanctified definition of illness permits a rupture in normalizing definitions of disease and death, as well as recommendations for the manner in which these processes should take
place. In a definition of illness as an evolutionary process, steps towards “healing” are
determined by the patient, a move which requires a non-intrusive step back on the part of
the “healer.” This stance is counter-intuitive to the belief that the doctor must “save” the
patient, the bedrock assumption of many traditional notions of formalized caretaking, and
one which underpins the representations of caretakers offered within a narrative such as My
Own Country.

Definitions of ethical caring are not always endowed with a liberatory features,
however, as Ruth Smith points out:

…[there are] legacies of care in relations of slavery and servitude. Joan Tranot argues that care must be placed
critically in moral and political power relations… Paul Lauritzen criticizes the associations of moral care with child
bearing and raising [sic]…inasmuch as it identifies agency
and goodness exclusively with biological
motherhood…From another perspective, the narrowness
and romanticism are part of the capitalist regulation of the
erotic: care is a demand for order and obedience, a depletion
of pleasure that never runs rampant, or spills over, or
surprises. (qtd. in Cates 311)\textsuperscript{5}

Frequently, these negative aspects of caretaking are played out within these narratives, as
they are in Plays Well’s themes of care as a substitute for sexual interaction. Such critiques
of care are highly necessary, since the issue is fraught with emotion and the potential for
self-sacrifice and self-abnegation. In attempting to argue for an ethics of care at the site of
these texts, I am not proposing an “eat your vegetables” stance that serves yet another
disciplinary function. I \textit{am} arguing for pleasure, understanding, communion, and even a
celebratory intimacy at the site of care.
In my first chapter, I take an in-depth look at a text which intensely negotiates issues of both intimacy and self-abnegation: Abraham Verghese’s *My Own Country*. Purportedly an autobiographical work, the text describes a period in the life of an infectious diseases specialist who unintentionally becomes the regional AIDS expert for a small Southern community. My examination of the text in Chapter 1 indicates that the narrator manages his anxieties about illness, sexuality, death, and his own self-efficacy as a doctor by fashioning himself as a hero on a mission. Furthermore, this chapter argues that this narratorial heroism accomplishes a variety of disciplinary tasks: extinguishing transgressive erotic potentials that he could have cultivated, catalyzing a dissociation of the narrator from a felt sense of his own body, and permitting a view of illness and the ill body as “aberrant.” Although the value of the commitments that the text articulates are up for debate (and in Chapter 1, I will debate them), its influence is unquestionable. In 2000, Verghese was one of the foremost examples of recommended reading for high school English classes (by *English Teacher* magazine), and the book was voted one of the “Five Best Books of 1994” by *Time Magazine*. From continued reception such as this, the text’s popularity and influence do not seem to be waning, which makes an in-depth engagement with its representations all-the-more pressing. When this “medical case study” is read beside theories of normalizing rhetoric offered by such critics as Michael Warner, Gayle Rubin, and Michel Foucault, the resulting analysis points out how limited and circumscribed Verghese’s influential representations are.

In my next chapter, I suggest that Allan Gurganus’s narrator in *Plays Well With Others*, in the tradition of much writing about illness, attempts to achieve a certain
emotional distance from the site of illness. Through his self definition as artist, and the creation of a highly aestheticized landscape of illness, he also attempts to control his erotic impulses. I examine this contention alongside a discussion of the normalizing work done by the representations within the text, and combine my observations, again, with the theoretical groundwork laid by Warner, Rubin, and Foucault. “Writing,” says Gurganus in a November interview in *Identity Theory Magazine*, “is a cultural intuition. It’s a way of having the world make brief sense for yourself.” But this emphasis on *self* becomes vexing, particularly when the writer/narrator believes that he is somehow acting as an aesthetic antennae for larger shared cultural belief systems.6 Gurganus intends his body of work to insert itself into a cultural hegemony he is influencing or even forming:

> Just as the work becomes essential for you, there’s a possibility that it can become essential for dozens and hundreds and thousands of other readers. It’s a curious bargain that we make as writers to assume that our emotional lives are synchronous in large part with those of every other member of the species. That’s the great lesson of literature, that it’s predicated on the notion that we are not just similar but unanimous. (http://www.identitytheory.com/people/birnbaum29.html)

In this conflation of subjectivities into a sort of collective unconscious, the first suggestions that Gurganus believes in the existence of absolute representational constructs (that it is possible for a narrator to “speak the truth”) emerge. At book signings, Gurganus reports that, “I soon feel like the apostle Paul visiting the actual Corinthians. In all the bookstores there is such a hunger, such a sense of catacomb intimacy, such a yearning for fiction that—across the barricades of sexual politics—will speak the truth in love” (*Advocate*, January 1998).
The hospital is the central comedic setting within the novel. As the location of the dénouement, the hospital becomes the site at which the characters shed their layers of artifice, only to have new layers constructed by the narrator. In this sense, *Plays Well With Others* is an ambitious novel of symbolic and visual accretion. The text entails detailed character sketches of three artists who migrate to Manhattan in the 1980’s—looking for companionship in their dedication to artistic production. Robert Gustafson is a composer, the son of an Iowa preacher, and as famous for his immense sexual energies as he is for his good looks. Angie Byrnes is a painter, a diminutive woman who is larger-than-life in her capacity for self-expression and optimism. And Hartley Mims is the unofficial biographer of the group, a writer who stands somewhat along the sidelines of his friends with cynicism and his jealousy, but who longs for union with the other two. As illness overtakes two of the three friends, the narrator’s need for protective representational strategies intensifies.

Gurganus’s reviews have been highly favorable: “Allan Gurganus is one of America’s great talkers,” Dwight Garner writes. “Gurganus in mid-sentence often seems like nothing less than a Greenwich Village reincarnation of Mark Twain. He’s in constant demand as a lecturer, and he’s among the few living writers who can get away with charging…for his readings” (*Salon*, December 1997). Gurganus places himself within the context of American Letters: “I’m both a Vietnam vet and a vet of this period in New York, so I’ve got purple hearts coming out my yin-yang. In the Fitzgerald-Faulkner-Hemingway era, they were spoiling to get abroad into a war because that meant that they’d have something to write about. And boy, do I have something to write about” (<archive.salon.com/books/sneaks/1997/11/10review.html>). The *Denver Post* characterizes *Plays Well* as a work that should stand beside canonical contributions to
American literature: “Plays Well With Others is an updating, in a sense, of Daniel Defoe’s A Journal of the Plague Years…There are sentences that glisten like black opals.” The Boston Phoenix identifies the novel as “unabashedly artistic, knocking itself out to convey an effect and coming at the reader with more music and color than most Mardi Gras parades” (<weeklywire.com/ww/11-10-97/boston_books_2.html>). Random reviews even suggest that “…the first twenty pages should be anthologized as an example of the very best in American humor writing” (<goodreports.net>). The text describes the process of the formation of Hartley Mims’ character, who shields himself from the very phenomenon he is obsessed with representing, as he becomes “The Artist” in the midst of the illness narrative.8

The impulse towards artistic shielding takes place in a different manner in Randy Shilts’s journalistic narrative, And the Band Played On. In Chapter 3, I argue that this press for normalcy is couched in a subtle but surprisingly religious language, a language that emerges out of the self-stylized prophetic voice of the narrator. Both the uncertain features of the pandemic and the public’s need for comforting guidance from “higher authorities” create conditions conducive to a prophetic narratorial personae. But the prophetic speech acts of foretelling the future and issuing warnings in the face of illness also become representational devices which lead the narrator to tightly control his narrative—by maintaining an aloof prophetic status, carving out a position of omnipotence, and making grandiose claims. This chapter examines the ways in which the attempt to occupy a position of prophetic omniscience often takes precedence over gestures or considerations of care. Furthermore, I argue that a rejection of the erotic, as well as outright celibacy, become hallmarks of the prophetic narrator. Originally published in
1987, Shilts’s text traces a variety of characters though a series of vignettes, into their introduction to the pandemic, and then through their growing realization that they are in the presence of a serious health crisis. From health-care workers, to doctors, to politicians, to activists, the voices of those who become increasingly involved in the pandemic appear to be recorded in a journalistic account.

Upon its appearance, the text was highly acclaimed and has now achieved a status which could fairly be described as canonical. In his February 18, 1994 obituary in the *Los Angeles Times*, Shilts is heralded as a “pioneer whose work propelled AIDS out of anonymity and into the consciousness of mainstream America.” He is the writer whom the *Chronicle* calls the “foremost chronicler of gay life and the AIDS epidemic.” A *Washington Post* obituary stresses that Shilts worked for the “mainstream” media (the *San Francisco Chronicle*) and calls *And the Band Played On* a “well-documented history” (*Washington Post*, February 18, 1994). Translated into seven languages, and made into a film, the reach of *And the Band Played On* has extended far beyond the United States.

Upon the publication of his work, unlike Verghese and Gurganus, Shilts did not seek a prominent position as a spokesperson outside of his role as a journalist—he gave few interviews, rarely published in non-journalistic venues, and did not participate in the public-speaking circuit with any degree of regularity. But the effects of his text were nonetheless resounding. A review by Raymond Smith, the editor of *Body Positive Magazine* (August 2001, Volume XIV, Number 8), suggests that Shilts exhibits a pioneering power in “getting to the story first.” After paraphrasing the book’s summary of the way the pandemic unfolded, Smith writes, “If this outline seems to simply reflect the conventional wisdom, it must be remembered that *And the Band* largely constructed this
conventional wisdom.” The ramifications of Shilts’s “thorough reporting and hard-headed objectivity,” he believes, will be lasting: “A century from now, people will probably still be reading *And the Band Played On…*” There are departures from this opinion, however—departures which suggest just how much a work of authorial construction *And the Band Played On* is: “It is amazing to see, again and again, in the obituaries, Shilts being praised for his sound reporting and for his adherence to fact when *And the Band Played On* is filled with reconstructed conversations, authorial intrusions and interpretations as well as unknowable ‘reportings’ as deathbed visions and inferred thought processes. In spite of all of this, Shilts claims in the introduction of the book that ‘there has been no fictionalization’ here and insists that his book is ‘a work of journalism’” (Michael Bronski, *Gay and Lesbian Community Notes* Column, May 1994).

Upon *And the Band’s* publication, the *New York Times* called the text a “heroic work of journalism.” With exceptions such as Bronski’s characterization, the “journalism” moniker has remained largely unchallenged. Shilts himself always characterized his work as “a failure,” not because it missed the mark of descriptive or objective journalistic accuracy, but because it didn’t implement the full-scale controls over the bathhouses and the sexual practices advocated within it. His nod to the prescriptive function of his own book hints at its foremost representational project: the instillation of normative representational strategies within it, strategies that can be instructively contrasted with the more exploratory and erotic prophetic voice within Dale Peck’s *Martin and John*.

After examining the means by which an ethics of care may be abandoned within HIV/AIDS narratives, I turn in the final portion of my project to an inquiry into how possible dimensions of an ethics of care might be narratively enacted. I conduct this
inquiry through the lens of much theoretical literature about an ethics of care, including that offered by Kylea Taylor and Arthur Frank. In conducting my inquiry, I look at the way in which caring is connected to acts of listening and reading. As Arthur Frank writes in *The Wounded Storyteller*, “Communication is less a matter of content than of alignment: when bodies sense themselves in alignment with others, words make sense in the context of that alignment. When alignment is lacking, even the best semantic content risks misinterpretation or will be unsatisfactory as a message” (50). The attitudes with which we listen to people, or read narratives about them, are studded through with the fundamental urges to embrace or reject their communications. In the fourth chapter, through a reading of Tony Kushner’s *Angels in America*, I will examine the ways in which a caring ethics is a practice that fosters the urge to embrace and accept the Other. Within this two-part play, a series of characters, gay and straight, HIV-positive and negative, begin to explore and define the terms of ethical action and personal responsibility during the Reagan Years. The characters are repeatedly thrown back into relationship with each other, and the play focuses upon the degree to which an acceptance of a position of alignment (or refusal of that position) affects the degree of comfort and caring available to them.

Through *Angels*, I explore the extent to which speakers are allowed to voice their stories without being required to repeat, explain, or justify themselves in ways that lead to dis-empowerment and alienation at the site of care. I will also, at the last, use *Angels in America* to illustrate what could be the potential for a caring rhetoric if the force of the erotic were fully engaged. Within the play, even if there exists a narrative strain which starts to polarize the landscape into “The Material” and “The Metaphysical,” a full-fledged engagement with the erotic is a bridge between these two poles, and ultimately unifies
them. In constructing a visceral, sensually-felt discourse, these plays illustrate the disruptive potential of the erotic upon a rigid representational schema. Although the first three texts might miss such an erotic opportunity at some crucial moments within the narrative, the ways in which eroticism might rescue the inhabitants of a text from representations which restrict them and make expressions of narrative caring difficult is the subject of my final chapter.
In his collection of essays entitled *Ground Zero*, Andrew Holleran suggests that the creation of a narrative hero is a move necessitated by the very project of writing about HIV/AIDS:

Someday writing about this plague may be read with pleasure, by people for whom it is a distant catastrophe, but I suspect the best writing will be nothing more, nor less, than a lament: ‘We are as wanton flies to the gods; they kill us for their sport.’ The only other possible enduring thing would be a simple list of names—of those who behaved well, and those who behaved badly, during a trying time. (18)

Holleran’s observation that we will find a way of talking about the pandemic through the characterizations of “those who behaved well and those who behaved badly” is a dichotomy at the heart of a creation of a heroism seen in many of the HIV/AIDS narratives we encounter, particularly as such a characterization applies to those who are responsible for providing care. On the surface, the construction of a medical hero may appear to be an innocuous-enough representational tactic, and may even seem to serve the ethical purpose of identifying those who fulfilled or evaded their responsibilities towards the ill. But such a dichotomy begins to foster a series of normalizing and disciplinary representations which begin to work against a caring ethic. Fundamentally, such a dichotomous assessment based on “heroic” and hence normalizing representations is at work in the case-study texts.
I will be examining in this chapter: Abraham Verghese’s *My Own Country*, Paul Sergio’s *One Boy At War*, a small sampling of the poetry of Raphael Campo, and a brief discussion of Adam Mars-Jones short story “Slim.”

First, *My Own Country* is an autobiographical account of an infectious diseases specialist becoming an “AIDS doctor” in the mountains of rural Tennessee. In this illness narrative, Verghese recounts his time treating AIDS patients in a geographically isolated region, as the growing dimensions of the pandemic begin to take shape. In doing so, he identifies himself as “the outsider” in the narrative, based on the fact that he is newly transplanted to the region, the fact he is from Ethiopia, and the fact that he is treating what he sees as a highly-stigmatized illness. In his first-person account, Verghese also positions himself as the intervening (i.e. normalizing) force for “good” at the site of illness. This heroic goodness, which we will examine in the context of a caring ethic, is constituted of fundamentally-normalizing beliefs developed within a doctor/patient hierarchy (doctors should remain unattached, distant, and always classify themselves as “healthy”); unexamined representations of those who are ill, and the advocacy of “traditional” social values (heterosexuality, monogamy, adherence to social roles dictated by the institutions of marriage, the military, and the family) and by Verghese’s anti-erotic orientation. To bolster the rigidity of the representational structure, the narrative frequently plays out along the formulaic lines of the adventure and detective story.

In closely examining the rigid representational structures of this narrative, I will suggest that that the heroic definition of a doctor positions both caretaker and patient into a medical relationship which is sustained by a cold and analytical medical gaze, and by the heroic role that Verghese, as narrator, assigns to himself—and from which he exerts that
gaze. In fact, the paradigm of a heroic doctor is used to accomplish a number of disciplinary tasks: to extinguish any transgressive erotic potentials the text might contain, to catalyze a dissociation of the narrator from a felt sense of his own body, and to permit a view of illness and the ill body as “aberrant,” even in the course of providing treatment. Not only does the placement of a “heroic example” within a text potentially suggest standards of normalized behavior for the text’s characters, it may also foster a normalizing paradigm for the genre of the text itself, fitting it into the rubric of adventure story, detective story, quest narrative, and the romance, each of which come with their own set of moralizing suggestions, hegemonic rules, and master narratives. According to John Cawelti in *Adventure, Mystery, and Romance*, the very fact that there is the presence of a hero means, in understood storytelling conventions, that there will be a story marked by conflict, told in ways that lead to an outcome of success (6). The text’s search for a stable genre identity, rooted in such a pre-established story-line, mirrors the narrator’s search for a stable identity in the midst of the shifting, destabilized nature of events that the illness narrative describes.

But at this point, I must acknowledge that I face similar quandaries to the ones faced by the narrators I am critiquing: trying to form coherent characterizations out of an incoherent body of texts, trying to locate relatively new illness narratives within existent illness narrative paradigms, trying to “master” the narrative strategies of a body of writing that is diverse, diffuse, and still in production, attempting to write out of the role of “competent scholar” even as I want to serve as an advocate for an ethics of care that is in some ways antithetical to “objective analysis.” I note these quandaries not to denigrate my analytical attempts, but to take note of the narrative difficulties I face, and to steer myself
away from the assumption of omnipotence, the desire to be a hero, or the coldness of the analytical approach I am critiquing in the narrators.

Frequently, as the narrator assumes the role of heroic adventurer through the terrain of this new illness, he communicates his joy of discovery. In *Policing Desire: Pornography, AIDS, and the Media*, Simon Watney has identified the way in which HIV/AIDS has created “a crisis of representation itself, a crisis over the entire framing of knowledge about the human body and its capacities for sexual pleasure” (9). The fact that many representations of HIV/AIDS may be marked by both homophobic and narratively self-interested dimensions is clear to Watney, even in the rhetoric of scientific research: “Day after day at major conferences on AIDS, and in literally hundreds of published articles, we have witnessed the way in which the institutions of behavioral psychology and quantitative social science have recorded their latent racism, misogyny and homophobia across the fields of epidemiology and health education—into which they have lately trespassed in search of sweeter funding pastures” (qtd. in Parker 405).

Verghese himself treads on such exploitative territory of scientific research when he assumes the role of heroic prospector, excited by the possibility of discovery, scouring the bodies of his patients for clues in the wild outback of rural Tennessee: “I loved bedside medicine, the art of mining the patient’s body for clues to disease… I came to value a good sputum specimen that was not contaminated with saliva as much as I valued gold (25). In passages such as these, the “art of mining the patient’s body” gives way to “the thrill of examination” as Verghese assists a group of medical students in what he calls the establishment of “mastery over the human body” (25). There is nothing subtle, for example, in the description of the ways that “their eyes shone the first time they heard
‘tubular’ breathing” (25). Of course, the adventure story paradigm creates the ill body as colonized territory to be surveyed or toured by a “Heroic Man on a Mission,” a representational maneuver quite at odds with a caring narrative ethos.

This heroic role leads to a certain type, or tenor, of perception—that of success and mastery. In *The Birth of the Clinic*, Foucault has characterized this colonizing and disciplinary manner of medical perception as dependent upon the medical gaze: “The gaze is passively linked to the primary passivity that dedicates it to the endless task of absorbing experience in its entirety, and of mastering it” (xiv). In Foucault’s characterization of the gaze, an impulse towards discovery is not motivated by concern for the patient’s well-being; instead, the caretaker engages with a disease because it is uncharted, mysterious, “virgin” territory, then he indulges in a disciplinary impulse to structure that territory. To Foucault, this act of structuring on the part of the caretaker becomes an act of mastery within the colonizing context of medical care: “Before being a meeting of patient and doctor, a truth to be deciphered and an ignorance, and in order to be such a meeting, the clinic must form, constitutionally, a structured nosological field”—a field which is both highly organized and in need of further organization (59). But a narrator such as Verghese, who is bent on the formation of his own subject position as hero of the narrative (as well as interested in sustaining the status-providing features of his professional reputation) cannot always deliver the kinds of representations which a caring rhetoric would demand. Simply stated, the representational choices, the medically-colonizing gaze, and the motivations of scientific professionalism of the narrators at times debilitate the already-ill within these narratives.11
In anticipating, with pleasure, the outcomes of success and mastery promised by an adventure story paradigm with a heroic narrator, the reader is developed as a selectively-attentive consumer of clichés attendant to heroism. As John Calwelti points out, the tension generated by forces that oppose a hero (in this case, HIV/AIDS) “supports and gives significance to the actions and the highly conventional structures, the fulfillment of conventional expectations [and the provision of] enjoyment and escape” (6). The questionable ethical implications of employing HIV/AIDS literature for the purposes of “pleasure and escape” are worthy of note, but what is equally notable is the fact that the vehicles for this pleasure and escape come with ideologies already built into them. These ideologies begin to give shape to representations of illness within the text, as well as shaping the “lessons” the narrator imbuces his story with. Within the context of his heroic storyteller identity, Verghese has many adjunct paradigms at his disposal: the teller of the adventure story (“overcoming of obstacles”); the war story (“overcoming of fear and defeat of the enemy”); the detective story (“investigation of hidden secrets”); the spy story (“saving of the nation [or a community]”), and so forth—as Cawelti codifies given narrative paradigms (39-40). All of these paradigms have in common the creation of a hero who battles evil; all meet the need of the narrator for a ready-made narrative formula, and all place other narrative agendas on the docket before a narrative ethic of care.

The “hero’s tale” is comprised of a variety of directives: there are “good people” versus “bad forces,” healthy people versus ill, family-situated people versus “aberrant” loners—and people should work their hardest to situate themselves among the good and the normal. The fact that the framework of a hero’s tale fundamentally changes the descriptive power of that tale, and supplants it with a normalizing agenda, is perhaps a
pattern less obvious—both to the narrator himself, and to readers who are consuming the narrative. Verghese’s use of the detective story paradigm, for example, allows him to portray the hero as a man who is hot on the trail of a mysterious killer. Then, this narrative is governed by rhetorical directives of “crime solving” that force the narrator to define his identity within the context of such a mission, and to represent the events of illness (as frightening or as mysterious) in ways that match a pre-selected narrative paradigm. The effects of such a rhetorical move are profound, given that both the representations of illness and the narrator’s subjectivity are governed, not by a caring or intimate awareness of the suffering caused by illness, but by the demands for certain narrative effects of suspense and hierarchy building, and by the narratorial desire to normalize and stabilize the landscape of illness.

**Failures to Stabilize Representations**

Not only are the stories told in the interest of defining what is “normal” (a move often at odds with a caring ethic), they are told in a way designed to consolidate the identity of the narrator. This identity, in turn, has very little to do with a caring ethic, and very much to do with providing and emotionally safe, normalized and invulnerable position for the narrator. The fact that such an effort is marked for failure from the outset, as we will explore, does not stop the narrators from trying. To generalize, *My Own Country*, *Plays Well With Others*, and *And the Band Played On* contain narrators who are attempting to pull fragmented identities together into a coherent whole and use conventional narrative tropes to do so. Frequently, these texts use the notion of heroism, and narrative structures which are built on notions of heroism, as forces of unification. As I argue in this chapter,
Verghese’s narratorial identity is split between family and work, Ethiopia and the United States. In Chapter 2, I will explore the ways in which Gurganus’s narrator is pulled at by the un-coordinated impulses of celibacy and sexuality, participation and observation, criticism and creation. And in Chapter 3, I suggest that Shilts’s narrative voice is fragmented by the centrifugal force of the sheer amount of information his text attempts to incorporate, as well as his simultaneous need to be an “objective” observer and a social critic/prophet.

So it comes as no surprise that these narrators attempt to find a stable referent for themselves, as well as for “AIDS,” through a traditional storytelling trope such as heroism. This attempt to achieve stability of definition, however, creates conditions in which the very project of coherent subject formation—of both the narrator’s self-presentation and that of the disease—is often doomed to failure, precisely because it is based on dichotomies that the notion of heroism has opened the door to. The notion of heroism which these narrators use is founded on and makes possible such dichotomies as insider/outsider, participant/observer, doctor/patient—all of which become opposed terms between which identities and representations begin to oscillate. In short, representations cannot be assigned “a side” of the dichotomy and then permanently be made to occupy that term, because to do so would exclude the rich descriptive possibilities of the “other” side, a move that these narrators never seem willing to make.

Narratorial self representation based on dichotomies such as the ones that grow out of notions of heroism (strong/weak, healthy/ill, caretaker/needling care) break down for another reason as well: they are contextually based upon the widely-varying conditions at the site of illness. As such, a given representation does not “travel well” through a change
in either psychological or physical location—and that includes representations comprising
the narrator’s own identity. The narratorial self-definition of caring hero, for instance,
does not always translate outside of the context of illness—a fact that is illustrated by
Verghese’s neglect of wife, children, and community outside of the hospital walls. Or, as
Cindy Patton points out in “Performativity and Spatial Distinction: The End of AIDS
Epidemiology,” a stable referent will break down as soon as it moves from the location in
which it was developed—for our purposes, the site of illness.\(^{12}\) Patton has a
recommendation for the negotiation of the resulting definitional instability: “What is
needed is a map or a trajectory for evading the effects of the discourse which insist on the
primacy of epistemological rather than, for example, proprioceptive, access to the body”
(qtd. in Parker 181). But characterizing another human being on the basis of external
features or “physical norms” is a move these narrators make more easily than attempting to
“feel with” or “feel for” another in a “proprioceptive” and empathetic encounter. A
legitimate somatic access to another’s sensory state, or even the approximation of such a
somatic access, eludes these narrators for the most part, and as a result they lose
information that would help supply the illness, as well as themselves in relationship to the
illness, with a stable and sustainable set of descriptors—including the descriptor of
heroism. This stability, founded on somatic knowledge, might be a much richer alternative
to the rigid semantic structures out of which many narrators attempt to forge their identities.
In any event, a deep investment in a heroic narrative and heroic identity will inevitably be
frustrated in the case of Verghese (when he does change his rhetorical context), but he will
realize that fact too late, after the possibility for engagement with a more caring ethic has
passed his narrative by.
Epidemiological studies, one of the most consistently legitimized ways of defining the AIDS pandemic, has placed additional pressures upon illness narratives to employ the rhetoric of heroism. At the same time, it has made those heroic identities virtually impossible to sustain. Epidemiology is, as Cindy Patton characterizes it, a “panopticon” which has “situated itself at the center of an optimal place from which to observe the disease phenomenon” (qtd. in Parker 187). For my argument, in any epidemiological account, there is an epicenter of the disease. If one considers a character such as Randy Shilts’s Gaetan Dugas (or “Patient Zero,” portrayed within the text as one of the first men with the disease, and as the one who spread it to as many people as possible), then that epicenter is portrayed as fixed, embodied in one man, and in this case, intensely threatening. Marked by its characteristics of excess and expansive possibility, an epicenter is simultaneously stable, in the sense that it can be pointed to as a discrete entity, and unstable in the sense that it needs to be contained (or it will spread out everywhere). In this contradiction begins a narratorial obstacle to the process of creating heroic representations. In the case of Randy Shilts, the narrator tries to highlight the epicenter as a character who can serve as an evil-doppelgänger and a foil for his own heroically-normalized self-presentation; in short, the narrative’s hero seeks a contrasting and villainous epicenter. But even in a case as representationally-controlled as Gaetan Dugas, these attempts to villainize the “epicenter” encounter a roadblock—the tiniest fragment of an independent subjectivity that will not die: there is always a frustrating and non-compliant subjectivity of even a fictional epicenter to be considered.

The epicenter is uncontrollable even when its representations are tightly controlled: in the case of Dugas, he might receive the sympathies of the audience, be seen as his own
type of unlikely hero, and so on—and thus become unreliable as a foil. At some level, the
narrator knows this, and knows his project of subject formation—as it is taking place up
against an inadequate and ambiguously “evil” personae—to be frustrated and stymied.
These narrators set themselves up to be frustrated in their desires for stability, because the
structures upon which they attempt to form textual identities are ungrounded and shifting.
But instead of causing the narrators to abandon the search for fixed identities, this
frustration only reinforces narratorial resolve to form such identities through a wide variety
of representational mechanisms. So what we have now is a narrator who wants to be heroic
and “normal,” who wants to suggest definitions of normalcy for others, and who is
prevented from achieving his aims through the built-in obstacles provided by the
mechanisms he is trying to control. This leads to a deeply frustrated narrator, one who can
become more concerned with the difficulties and intricacies of his subject formation that he
is with the care provided to those who are ill.

From the outset of many of these narratives, the site of HIV/AIDS is be used for
personal identity development as well as professional and methodological development.
Narrators frequently use their perception of the erotic practices of other men, for instance,
not only to structure professional identity (by portraying themselves as “solving problems”
created by these practices, for instance), but also as a vehicle by which to define their own
sexual subjectivity. Verghese makes a two-part move involving definitions of sexual
identity: 1) he places descriptions of sexual practices in the representational field of illness
in the first place (as do many of these narrators who equate “AIDS” with “gay sex”), and 2)
he begins to employ a consistent set of representational strategies which negatively impact
the portrayals of gay characters within the text.
Defining “heterosexuality” up against “homosexuality,” and endowing the secondary term with pejorative associations, is not a new discursive move, but in the case of Verghese, an accompanying “heroism” is consistently ascribed to the term “heterosexuality” as well, as I will argue towards the end of this chapter. To paraphrase Simon Watney in “The Possibilities of Permutation: Pleasure, Proliferation, and the Politics of Gay Identity in the Age of AIDS,” it is precisely the “taken-for-grantedness” of heterosexuality, the “compulsory heterosexuality” that Adrienne Rich refers to, that motivates the structuring of sexual subjectivity through the creation of a homosexual/heterosexual dichotomy. Through the lens of such a perspective, heterosexuality needs the foil of homosexuality to define itself, to itself. For Verghese, statements about how happy straight men would be if they had the “sexual freedoms” of gay men, or his own expressions of frustration as a straight married man, show him to be coming to conclusions about his own sexual positioning for the first time, as if he has never had to be aware of his sexuality as it relates to or departs from the norms of the existent social contexts. It shows something else as well—that once again, his focus is upon his own identity, instead of upon the ethical narration or the medical treatment which impact the lives he is describing.

Carole Vance, in her article “Social Construction Theory: Problems in the History of Sexuality,” argues that that heterosexuality by nature usually bears what can only be called an incredible lack of consideration for its privileges and its position: “In traditional sexual science, heterosexuality remains an unexamined and naturalized category, and little in popular culture causes heterosexuals to consider their sexual identity or its origins and history” (qtd. in Altman 29). As My Own Country reveals, when that consideration does
come, it is generally parsed by Verghese in terms of normalcy and heroism, in ways that degrade and suppress the second term of a heterosexual/homosexual dichotomy. This suppression has a direct and predictably deleterious impact on a caring textual ethic, since a denigrated sexual subjectivity becomes an integral part of this text’s representations of those who are ill. But this suppression also stems from the need to stabilize sexual identities and definitions of HIV/AIDS into normalized configurations such as “good hero” and “evil villain.” The fact that these efforts usually fail creates an epistemologically insecure (as well as intensely representationally intervening) narrator, as I will explore in the next section.

The Influence of the Heroic Paradigm

Much of the commentary surrounding Verghese’s work sustains the heroic paradigm as well. As I have suggested, the books I have selected enjoy a large audience. But with the exception of rather favorable reviews, the secondary literature and critical commentary surrounding many of these HIV/AIDS narratives is sparse, and the representational maneuvers contained within them, such as the deliberately-assumed position of narratorial heroism, largely remain unflagged and uncritiqued. Overall, much of the dialogue which arises around these narratives is very general, and many criticisms suggest that it is their existence and not their methodology that is problematic. In fact, there have even been debates about the value of “AIDS narratives” in general: Susan Sontag suggests that the amount of writing about AIDS is excessive; Douglas Crimp questions the value of insights offered by those who are at a certain remove from the disease; and Andrew Holleran argues in Ground Zero that HIV/AIDS is almost too
“depressing” for extensive rhetorical treatment (12). In the course of narrating such a trial-by-error dynamic, the narrators encounter a fundamental epistemological insecurity. Unsure of what he does and does not know, the heroic narrator is still responsible for taking action against the illness, and must conceal his lack of knowledge from a frightened audience of patients, families, and general public.

Such a dynamic may be at work in many diseases, but the uncertainties inherent in HIV/AIDS, particularly in the early times of the pandemic, were heightened in intensity. Instead of allowing for these uncertainties, the site of illness within these texts is marked by the suppression of their expression. That fact that My Own Country, Plays Well With Others, and And the Band Played On begin from a starting assumption that such uncertainty is undesirable, and that one of the primary goals for the production of the text involves censoring that uncertainty, also forms a refrain of the narrative line. One of the primary ways these texts attempt to eradicate uncertainty is through the establishment of an omnipotent hero. Much of the discourse arising out of the disease has been interested in determining who is good and who is bad, who is blameworthy and who innocent, who is heroic and who is villainous. Abraham Verghese himself is highly invested in such determinations, and he asks his audience to similarly invest in both his self representations as heroic and his particular representations of illness. As Ruth Smith observes, Verghese is continually “asking his readers to have confidence in his version of things as reliable, even as there are other versions, and to have confidence in his medical practices, even as it includes a range of conventional and unconventional performances” (qtd. in Cates 301).

Smith does have confidence in Verghese’s medical expertise and version of events, and even in her relatively-recent article (published in 2001), she suggests that Verghese is
heroic for his willingness to even touch his patients: “Verghese’s calculated risks in touching would put doctors less trained more at risk…” (qtd in Cates 305). In doing so, she suggests that she herself subscribes to Verghese’s self-portrayal as a hero, and registers her own homophobia and AIDS-phobia. Throughout his own self-representation, Verghese chooses to occupy a series of positions which support his image as heroic authority: a) that of “Doctor-As-Action-Hero” making effective and forceful changes within the environment; b) that of protective “Medical Man”—standing up against the story-line’s “villains,” and reassuring the audience that they will receive a happy ending (because a hero is by definition successful in his quest); and c) that of guardian against the messiness of sickness and death, as well as the one who is invulnerable to those specters (because those are just incidental obstacles which the hero must encounter and vanquish in the course of the narrative’s plot). The roles that Verghese ascribes to himself become dimensions of the sustaining myth of illness that Arthur Frank identifies in *The Wounded Storyteller* as part of the restitution narrative, that all “will be well” in the end (77). Not surprisingly, these roles also undergird the narrator’s impulse to make authoritative statements about illness, and open the door to a whole host of position-taking by the narrators in the development of an illness narrative: an attempt to “rescue” the ill from the illness, without deference or regard for their experience of their own illness, an inability to witness without attempting to intervene in another’s experience of illness through commentary and representation, the intrusive attempt to make meaning out of another’s experience, and a disallowing of the patient’s own voice and experience.

All of these acts of narratorial position-taking (and simultaneous undergirding of authority) are understandable, considering that the site of illness in general, and of
HIV/AIDS in particular, is a space of profound rhetorical, existential, and experiential instability. And while this instability does not excuse instances of uncaring narration, it does point to possible reasons for it. As discussed in the introduction, for example, one of the pressures at work within all illness narratives, and perhaps particularly within the uncharted terrain of HIV/AIDS illness narratives, is a reversal in the cause-and-effect mechanisms of scientific discovery. This reversal has been noted in the earliest examples of medical writing: Francis Bacon pointed out “that medicines and cures were first found out, and then after the reasons and causes were discoursed; and not the causes first found out, and by light from them the medicines and cures discovered” (qtd. in Cousins 3). In early HIV/AIDS illness narratives, the same dynamic of confusion is at work: cures were tried (and often failed), and then reasons for the results of those attempted cures had to be articulated, especially to a public awaiting reassurance and guidance in the face of an unfamiliar disease. This reversal begins to exhibit a marked impact upon the self-representation of the narrator and his representations of illness, a phenomenon that begins to emerge in a reading of My Own Country.

The fact that illness literature at large has had much to do with creating the narrator as hero is evident, for example, in the reassuring, romantic, and omnipotent notions of the doctor which circulate within and around illness literature: “To the writer, the physician is not just a prescriber of medicaments but a symbol of all that is transferable from one human to another short of immortality” (qtd. in Cousins xv). Indeed, there exists an entire tradition that defines “the medical man” as one whose unlimited heroic services and magical powers are available (albeit for a price). William Carlos Williams’ description of the clinic is eerily relevant today:
Today the hospital is a fairgrounds for the commercial racket carried on by the big pharmaceutical houses. Almost every day there are exhibits of the latest drugs put on by the sales force of this or that manufacturer in the doctor’s waiting room… the practice of medicine and surgery is close to the realm of necromancy today; miracles are being looked for and performed; knowledge has increased at such a rate that one should be ashamed to die of anything short of decapitation over the edge of a windshield. (qtd. in Cousins 251)¹³

The doctor’s magical powers are assumed to be built on the exponentially-growing knowledge that William’s quotation alludes to. In the case of HIV/AIDS, that knowledge, at the outset of the pandemic, was illusory—a fact that didn’t stop many doctors from assuming a mantle of omnipotence anyway. Thus, a case text such as My Own Country is marked by a narrator who is much less knowledgeable than his authoritarian role suggests. The insecurity created by fast skating on epistemologically thin ice becomes another factor contributing to the unwavering commitment Verghese has to his heroic identity, as well as to his utterances as a supremely and overcompensatorially-assured narrator.

The geographic setting of Tennessee may be the first place that Verghese omnisciently situates and sustains himself as a hero. Since his text is essentially one long flashback upon a scene he has long since departed, Verghese places himself in the tradition of the “storyteller who has survived to tell the story” and the “Worldly One” giving a retrospective. The fact that the narrative begins with a description of a man with AIDS driving into Johnson Country, and ends with Verghese driving out of the region (actually fleeing the scene under the cover of darkness) suggests both that AIDS occupies a “zone” that can be entered and abandoned, and that some heroes choose to leave that zone. The device of a quest narrative which constructs a treacherous disease zone (a site of struggle,
challenge, and overcoming) is ready-to-hand structure for a quick and easy framing of narrative conflict and plot formation.

As Cawelti points out: “For creators, the [idea of a] formula provides a means for the rapid and efficient production of new works” (9). In the case of Verghese, the subsequent, almost reactive, rhetorical movement into a heroic storyteller’s identity also incorporates his identity as an authoritative detective, a sort of combination Sherlock Holmes and Dr. Watson. This position, in turn, allows him to feature himself as the sole, accurate, and authoritatively assured repository of the narrative’s happenings. Cawelti offers an additional observation that suggests the function of a heroic storyteller dynamic within formulaic fiction: it becomes a narrator’s way of introducing a familiar and readily-assimilatable moral structure into a narrative:

The central fantasy of the adventure story is that of the hero—individual or group—overcoming obstacles and dangers and accomplishing some important and moral mission. Often, though not always, the hero’s trials are the result of the machinations of the villain… The true focus of the interest in the adventure story is the character of the hero and the obstacles he has to overcome. (39-40)

If the motive behind the use of the heroic trope is indeed one of making a “moral point,” then, as we will see in the case of My Own Country, the narrative surrounding the hero’s mission within the context of illness begins to supplant the potential for an ethics of care that the narrative has to offer.

Theorists such as Foucault have questioned the helpfulness of both pre-established narrative paradigms and metaphorical representations of illness in general to the telling of stories of illness. According to Foucault in The Birth of the Clinic, the site of illness “is a space in which analogies define essences” in ways that are often erroneous (6). But the risk
of descriptive error, or the undermining of the ability of a patient to tell their own story, often doesn’t hinder the narrator’s drive for governing tropes or metaphorical representations. This observation holds doubly true if select metaphors cast the narrator in the heroic and hierarchically pre-eminent role he is defining for himself. Indeed, as Laurence Kirnmayer points out in *Narrative and the Cultural Construction of Illness and Healing*: “…metaphorical constructions are presented by both patient and clinician and either stabilized or subverted on the basis of the differential power and rhetorical skill of the participants. Although there is an effort in the clinical encounter to construct a shared narrative, this often fails…” (175). Within the context of these HIV/AIDS narratives, metaphorical rhetoric is often employed with more of an eye for the constructions of a caretaker’s self-representation as the man in authoritative control of the very language of illness, than for the representations of illness.

According to Foucault in *The Birth of the Clinic*:

…it [a narratorially-satisfying metaphor] made it possible to turn the principle of the analogy of forms into the law of the production of essences; and, secondly, it allowed the perceptual attention of the doctor—which, here and there, discovers and relates—to communicate with the ontological order—which organizes from the inside, prior to all manifestation—the world of disease. (7)

The narrator-doctor thus became an Adamic “namer of disease,” a pioneering rhetorical hero. In this role as one who provides both definition and name to the landscape of illness, the caretaker narrates the story of a patient who is dominated both by the role the narrator assigns to himself (one who holds the power and authority to name) and by the metaphors the narrator is constructing around the experience of illness. Kirnmayer observes that “…the meaning of the actions and experiences of an individual patient are always
underdetermined by any existing body of scientific knowledge. In place of the scientific truth of strong causal explanation, the clinical ascription of symptom and illness meanings invokes both poetic and narrative forms of ‘truth’” (174). He goes on to suggest the need for “medical anthropology,” as it begins to examine “…narratives generated by patients, clinicians, and other actors drawing from cultural beliefs and practices to further a specific project of self-presentation or social positioning” (174). When these beliefs are examined and interrogated, the mantle of narratorial heroism may begin to dissolve. The oppositional relationship between a narratorial hero and a caring narrative ethic is one I will examine in the next section.

**The Uncaring Role of Heroic Storyteller**

*My Own Country* offers little doubt that the narrator has firmly stationed himself as a “heroic and grandiose storyteller” in the narrative he is generating. The very subtitle of the book, “A Doctor’s Story,” attests to this fact. The subtitle is taken from Malcolm Cowley’s *Blue Juniata: A Life*, in which the countryside is identified as “mine; its face, its speech, / Its hills bent low within my reach” (*Preface*). The narrator’s identification of his “need” to engage with speech and stories, to embed himself within them as one might embed oneself within the patterns of “speech” of a homeland, becomes even more explicit as the text continues: “I was interested in the patient’s stories for their own sake… the anecdotes they told me lingered…” (126). An over-determined pattern of referral to storytelling is played out at various points throughout the text in a series of references—here, in one paragraph—to “a journal… story… copy… social history…dictation…history of present illness…family history, past history” (126). As the
narrator puts references to the “story” into circulation, his tone is dismissive: “I became curious about their [his patients’] life stories, keen to compare their stories with mine…most gay men whom I got to know in the clinic were forthcoming with their stories, as eager to tell them as I was to listen” (58-59). There is a hierarchical opposition that is suggested here between doctor and patient, and this construction contains the assumption that patients (here, with their lives at stake), will be as eager to speak as the clinician is to listen.

Verghese cements his own authority as he uses his patients as case studies (and eventually turns them into best-selling “medical” writing). In My Own Country, (and I take note of my own subject position in the use of the contentious term “confront”), the specific definition of a given “hero” takes on many faces—medical doctor, family man, educator, and military hero. In these various guises, the dividing lines of identity are traced in ever-proliferating grooves by the repetition of their accompanying ideologies, ideologies which intersect and dictate diverse identities. But these many manifestations of so-called heroism also have one function in common: by supplying the narrative with socially-acceptable guises, the notions of “normal” and “sanctioned” are inscribed and re-inscribed. Not only are we, as readers and critics of these texts, asked to accept that heroes exist, we are also told what form such heroism will take.

As a subset of such a large-scale narrative drive for normalization, Verghese offers a specific set of moral “rules” for his patients as well. As he constructs himself as a hero, he often suggests that his patients are “heroic” on the basis of their identities as “saints” or “martyrs.” Such a move is a disingenuous creation of a faux hero, one who is designed to stand in as a foil for the narrator’s own more substantial heroism. We see this move in
portions of My Own Country that deal with a character named Will Johnson. As his name suggests, “Will” is the text’s primary exemplar of heroic “willpower.” While Verghese constructs himself as the “healthy hero,” Will is the “ill hero,” a man who “valiantly” fights for his health after he contracts the HIV-virus through a drug transfusion. This construction of Will as hero makes Verghese appear generous enough to share the heroic moniker with other characters, and still allows him to maintain the ultimate stronghold of heroic positioning. Will, after all, will ultimately be defeated by death, while Verghese remains standing. Still, Verghese seems highly primed for Will’s introduction into the narrative, an arrival which is described in almost sensuous language of anticipation and admiration. Will is a man who is created by Verghese to meet the category of “innocent victim,” a man lovingly rendered in respectful language, a character who stands in stark contrast to the caricatures that Verghese has created for his other patients.  

The text offers plenty of counter-examples to Will: men who have sickened inelegantly, men who have died, men who have had delusions, men who have shown up for treatment in ballet outfits, men who have cried out in pain—in short, men who are not the stoic “hero” that Will Johnson, the very pillar of Johnson City society, is. In constructing dichotomous heroic configurations, Verghese separates good patients from bad, and moves away from a narratorial stance of being “with” the patient—or even “for” the patient in an empathetic stance. The relationship between caretaker and ill person becomes necessarily hierarchical, as the narratorial caretaker views the patient from the distance of evaluative judgment. Such a distance opens the door to the shaming and blaming of characters as they have been constructed out of the narrator’s representations, and these mechanisms work to inculcate and enforce notions of normalcy. The specter of normalcy that haunts the
psychological manipulations of flattery and shame has been discussed by such theorists as Michael Warner and Gayle Rubin, who argue that the value-laden judgment made about individual identity and projects of social discipline (particularly the disciplining of sexuality) are inextricably linked. As Warner points out in *The Trouble With Normal*, “The culture has thousands of ways for people to govern the sex of others—and not just harmful or coercive sex, like rape, but the most personal dimensions of pleasure, identity, and practice. We do this directly, through prohibition and regulation, and indirectly, by embracing one identity or one set of tastes as though they were universally shared, or should be” (1).

In the end, it is not shame but *stigma* that wields that greatest normalizing power according to Warner: stigma has the capacity to pin a pejorative and unremovable definition upon us, since stigma “attaches not to doing, but to being; not to conduct, but to status” (28). The portraits of patients rendered within Verghese’s illness narrative are painted in the broad strokes of stigma and heroism. Furthermore, the isolation inherent at the site of illness itself houses conditions that are ripe for the creation of heroic saints and degraded sinners, reinforcing them through the panopticon of social discipline. In this way, the clinic becomes a cathedral; the caretakers become the priests of medical ministrations; the judgment of these priests is encased in rigid moralism. Verghese, at times, renders his patients as isolated spectacles for moral judgment by treating them as *cause célèbres* or alternately by labeling them as essentially aberrant (if martyred) victims. But all of this narratorial fascination with labeling, judging, and heroism begins to distract the narrator from the illness he is narrating. This narratorial disregard is at best uncaring. At worst, it creates a reader who shares the same attitude of dismissal and disregard.
As I have argued, evidence from *My Own Country* suggests that as soon as Verghese adopts the subject position of hero, he finds himself in relationship to a pre-established story-line, assuming the power to create villains and heroes, and endowing his tale with a moralizing agenda. The agendas of *My Own Country* begins to rob the text of a deeper engagement with the topics of illness, death, and relationship at the site of illness. As the narrator becomes interested in sustaining the heroic representation he has suggested for himself (as well as the normalizing agenda he is suggesting for others), he tends to abandon the interest in care that seemed to motivate his initial project, and he sets into motion the mechanisms of stigma and shame through a variety of narrative patterns such as the detective story and the adventure story. But one of the clearest examples of “heroic” subjectivity dictating the terms of an entire narrative occurs when narrators locate themselves within a “war story” paradigm.

**The Heroic Narrator’s Use of the War Story**

When the illness narrative is placed upon the metaphorical grid of the battlefield, its placement begins to heighten narrative tension, render the site of illness a nexus of dire machinations, and yield the chance for a narrative climax which amplifies the importance of the characters within the text. Writers as diverse as Steven Krueger, Paul Monette, and Paul Sergious have employed military metaphors within their HIV/AIDS narratives, in part to quickly bolster a “good versus evil” representational economy, and in part to carve out the possibility of creating a heroic narrator. The seemingly simplistic comparison of illness and war quickly comes to have textually-uncontrollable implications, however.
When narrators imply that “some of us are soldiers in the fight against AIDS,” they open the door to insensitive and ethically problematic comparisons of AIDS to actual wars and other cataclysmic events.

The conflation and comparison of highly different traumas have been a representational choice that many of these texts have decided to make: *Plays Well with Others* compares the AIDS pandemic to the sinking of the Titanic; Marlon Riggs’s “Letters to the Dead,” draws a comparison between slavery and HIV/AIDS (in Howe, 146); Jed Bryant’s *A Cry in the Desert* establishes a comparison between AIDS and nuclear annihilation. This pattern is so widespread, in fact, that reference to it requires a sweeping characterization: there have been numerous literary comparisons of HIV/AIDS to the Holocaust, the Plague, and the Biblical Fall, many of which are parsed as a showdown between “good and evil,” heroism and villainy, and triumph and downfall. Even if one overlooks the fact that many of these comparisons are metaphorically forced and historically inaccurate (or simply reductive and bewildering), the act of fitting the “telling of AIDS” into a pre-set paradigm begins to work against the ethically-caring aims of an HIV/AIDS narrative that purports to tell of a highly individualized experience of illness, to listen to the specifics of an individual’s suffering, or to convey the notion that HIV/AIDS occurs on a distinctly personal level. The perspective that there are no “universal truths” which can be extracted from the pandemic, used as constants in descriptions of it, or employed as descriptors across any wide range of “traumas” are views more consistent with an ethics of care, for reasons I will explore in the final chapter.

Some writers have recognized the inherent problems of employing a previously-told tale such as the war story in the course of constructing representations of illness. As Paul
Monette writes in *Borrowed Time*: “I have oceans of unresolved rage at those who ran from us, but I also see that plague and panic are inseparable. And nothing compares. That is something very important to understand about those on the moon of AIDS. Anything offered in comparison is a mockery to us. If hunger compares, or Hamburger Hill or the carnal dying of Calcutta, that is for us to say” (83). While Monette notes the unfairly reductive nature of many such comparisons, Steven Krueger hints at the truly divisive role that the establishment of battlefield metaphors have played in descriptions of HIV/AIDS, particularly in scientific descriptions of the virus: “the narrative of sub-cellular ‘battle’ between conflicting systems of viral and cellular signification should not be read as enacting only tropes of gender and sexuality: in employing a language of foreignness and invasion, it also evokes a racism and xenophobia…” (40). The battlefield comparison also permits an unhelpful vagueness of description at the site of illness. If those involved in the pandemic are engaged “in a war,” it is a general and generic war, a *thing* which is undefined and permits the collapse of distinctions between people’s experiences, allows for a subtle accusation of gay men as containing “enemy” viral agents within their bodies, permits an objectification of the body as a battlefield, and re-iterates the language of the heroism with all of the homophobic exclusions implicit within notions of the military.

Although one may be sympathetic to the desire for a ready-made structure of a war story upon which to hang the narrative of HIV/AIDS, Verghese demonstrates by negative example the limitations of such a structure. In doing so, he is explicit in his employment of battlefield imagery and notions of heroic “nobility,” “morality,” and “normalcy.” For instance, the text includes sugar-coated descriptions of the military setting from which the character of Will Johnson has come. The description of the Virginia Military Institute is
replete with references to pomp and circumstance: “magnificent archways… lush green parade grounds… glitter of parade uniforms” (289). Explicitly, the trials of military life are compared to the trials of Will’s disease: “Any man that [sic] can survive the Rat Line at VMI [Virginia Military Institute] can handle anything in life” (288). The employment of this comparison helps the readers forget some facts: this metaphor does not work for anyone who is excluded from the military, or for anyone who feels no particular sympathy for it. The metaphor is problematic in another way: it recreates the “heroic ill” and “innocent victims” motif which sub-textually pivots on the comparison between the setting of the hospital and the setting of Will’s military training. Will, located in his military grandeur, is placed into an unquestioned paradigm of goodness and nobility—reinforcing the normative values that the military is made to represent, and then becoming the vehicle by which those values are inscribed onto the site of illness.

In the process, the text does not portray “the human face of AIDS” which is its self-identified task. Will’s military association, which would not automatically serve as a metaphor for sickness, is transformed into one by Verghese as he attempts to trace the source of Will’s courage in the face of travail: “He was one of ten members of the honor court. I was beginning to understand something about the construction of his character” (290). Will is portrayed as a fighter (“I’m determined to fight this thing with all I have”) (292), as bearing hardship bravely, and most tellingly, as having taken the bullet of a tainted blood transfusion. In venerating the normalizing notions of “honor and self-discipline” and couching them in militaristic language throughout the text, Verghese begins to narrow the field of the people who are valued in his descriptions. Will, as Verghese’s “star” patient, is not described as other patients are within the text, but is used
to create a representational field of normalizing values, battlefield imagery, and militaristically-inflected notions of heroism, all of which begin to contrast quite markedly with a more caring narrative ethic in their exclusion, their harshness, and their circumscription. But the “dramas” of HIV/AIDS are not only played out on the battlefield, they are also located within the shadowy corridors of the mystery story.

Suspenseful Ministrations: The Narrator as Heroic Detective or Adventurer

When used as part of a detective story, illness becomes “The Great Mystery” to be uncovered, while the narrator becomes the heroic detective positioned to uncover it. While an ethics of care may be narratively undermined through the elements of hierarchy, circumscribed notions of honor, and the preferential treatment of favored characters inherent in the “war story” rhetoric, it is also impacted by a focus upon the excitement, mystery, and intrigue which constitute detective narratives. While Verghese weaves strands of war story into My Own Country, the narrative incorporates other “storytelling” paradigms such as the detective story as well. In fact, Ernest Mandel’s characterization of the treatment of death within crime fiction is relevant to My Own Country: “death in the crime story is not treated as a human fate, or as a tragedy. It becomes an object of inquiry…Reification of death is at the very heart of the crime story” (qtd. Hoppenstand 762). Instead of establishing an illness narrative which is “for” those who are ill, or invites the reader into an emotional resonance with those who are ill, the rhetoric of a detective story creates a reader who is taken with the novelistic thrill of the textual chase. Or, as Harold Toliver observes in his work Animate Illusions: Explorations of Narrative Structure: while certain types of writing, such as historical narratives “seek to lay bare the
event and the cause as distinctly as possible, the novel renders the process of discovery itself and suggests that it is not merely the reader’s but it is inherent in the enigmas the work seeks to clarify” (93). When the actuality of a health crisis becomes a literally-rendered “enigma” that the participants within the narrative seek to clarify, illness becomes an emotionally distant conundrum.

The doctor is given center stage in the narrative structure inherent in the medical story, and imbued with the element of “heroism” accordingly. As Cawelti suggests, the elements of mystery are “the investigation and discovery of hidden secrets… In mystery formulas, the problem always has a desirable and rational solution, for this is the underlying moral fantasy expressed in this formulaic archetype” (43). Verghese himself uses the detective-story paradigm in a self-conscious manner: “Like Sherlock Holmes—a character based on a superb clinician, Dr. Bell—the good internist should miss no clue…” (81). Again, the normalizing goals situate themselves within the attempt to solve a mystery which will lead both narrator and reader to an ultimate moral (and rational) position. But as Mandel notes, “Preoccupation with crime, however, is preoccupation with certain objective rules, with law and order, with individual security [health], the safety of someone’s (or some family’s) personal fate in a limited portion of life… Preoccupation with crime and personal security lead inevitably to a Manichean polarization: personal security is good by definition; an attack against it is evil by nature” (qtd. in Hoppenstand 762). The fact that such dichotomous value assessment is more characteristic of an ethics of principle than a contextually-dictated caring ethic, and the fact that semantic and logical definitude form the representational terms and tenor of “the mystery to be solved,” are illustrated from the very outset of My Own Country.
Such rhetorical elements of the mystery story are built into the language of the text’s first chapter: short, one-sentence paragraphs begin to build suspense, to hint ominously at a concealed mystery:

His immune system had to be abnormal.
The intern remembered his palms pressed against the clammy breast as he did closed-chest massage.
Claire remembered starting the intravenous line and having blood trickle out and touch her ungloved skin.
The respiratory therapist recalled the fine spray that landed on his face as he suctioned the tracheal tube.
The emergency room physician recalled the sweat and the wet underwear his fingers encountered as he sought out the femoral artery. (10)

The syntax, clipped and incantatory, yields staccato sound bites that come as veiled threats, offering a sense of undefined tension. The reader is consequently distanced from the dimensions of the narrative having to do with illness and its symptoms, as the suspense of “AIDS-as-character” slowly unmask itself.

This unmasking is accompanied by a complete disregard for the subjectivity of the patient, as Verghese describes his hospital staff as if they are in the midst of a crime scene, encountering the slippery poison of bodily fluids. Interestingly, the emergency room staff is portrayed as being in grave danger—as heroes in action under an ax which is about to fall—when in reality there is only one dying man in the room. The suffocating rhetoric here manifests itself in the description’s close scopic proximity to the patient’s body, the dense syntax, and the setting’s explicitly-described miasma of wetness. As is the case in the representations of the war story, all of these representational elements work to increase the discursive sense of “the odds” against which the heroes are fighting, but decrease the reader’s “felt sense” of actual illness or men in pain.
The Adventure Story as a Site of Narratorial Situatedness

As an offshoot of the detective story, Verghese employs the trope of the adventure story in the selection and formulation of his narrative structure. As in the case of the detective story, the hero here is a man on a mission, this time to find an ultimate definition for the health crisis he is facing. The adventure narrative within My Own Country becomes another iteration of the “quest narrative” as outlined by Arthur Frank, and as codified in my introductory chapter. Cawelti, too, identifies some defining aspects of the adventure narrative—with or without attendant mystery elements: “At least on the surface, the appeal of the form is obvious. It presents a character, with whom the audience identifies, passing through the most frightening perils to achieve some triumph. Perhaps the basic moral fantasy implicit in this type of story is that of victory over death, though there are also all kinds of subsidiary triumphs available depending on the particular cultural materials employed” (40). This definition is relevant to a host of narratorial positions that are taken by Verghese, not the least of which is the protection from a perception of his own mortality. The quest narrative affords the reader similar protections, as she is set up to identify with Verghese’s struggles: solving the “mystery of the illness,” dealing with a huge caseload, struggling with inadequate knowledge and working conditions. Verghese conceals the fear that these struggles arouse through the use of the overcompensatory discourse of a “Quest Story”: the Man on a Mission, the Central Test, the Insurmountable Odds, the Foe, the List of the Challenges (overcome and succumbed to), and the Climatic Conclusion.
Notably, the turn to narrative structures such as the adventure or quest configuration intensifies at points of narratorial anxiety, particularly anxiety about sexuality and mortality. When Verghese visits a gay bar to conduct a “Safe Sex” class, for example, he narrates the incident as if he is exploring a cultural wilderness: “I felt as if I had returned from a dangerous mission and had emerged unscathed” (69). The homophobic resonances cut left and right in the course of such a “dangerous mission” construction: “I wanted to survey the land… Yes, this was a place where a gay person could give up the pretense of being straight, but it was hardly a natural setting… all of it seemed a bit desperate, anything but relaxed” (67). Yet, for the reader, the truly normalizing, uncaring, and homophobic dimensions of this quest narrative may be obscured by the sheer momentum of the adventure story that makes him want to encounter the next “fascinating scene” of this “dangerous mission.”

Verghese’s construction of the adventure story as told from the perspective of a “doctor-hero” is not an isolated example within the genre of HIV/AIDS illness narratives. There are other adventure stories told within the context of the HIV/AIDS narratives, ones that are still rendered in the terms of a pre-established “storytelling” paradigm, and contain a self-identified narrator-hero. An example of such a narrative is authored by Paul Sergious, in his account of his own experience of being HIV-positive. Sergious’s One Boy at War contrasts markedly with My Own Country in the unvarnished descriptions that characterize it. The text becomes an illness narrative of a writer who tests positive for HIV, falls into an incapacitating depression, and then decides that he will take his treatment into his own hands by experimenting with drugs that have not yet been approved by the FDA.
Although Sergious’s text initially falls into a heroic quest configuration, it quickly becomes structured along different lines. Moving beyond his own story, into a narrative of the stories of many who were involved in an underground drug movement, the account outlines the kind of deception that those initially diagnosed as HIV-positive were up against: the placebo-controlled trials of AZT, which deprived one-half of the participants of a drug that the medical community knew had value, the prohibitive cost of AZT when it finally did arrive on the market, and the unrelenting criticisms (coming from established medical voices) that people with AIDS faced when they tried alternative or renegade therapies. According to Sergious, in 1987, 52% of HIV-positive patients were using a therapy that had not yet been approved (109). Their experimentation and the establishment of underground drug distribution networks (combined with the actions of doctors who were willing to defy protocols) became integral to shattering traditional medical hierarchies of information dispersal and begin to be a record of care that, for better or for worse, is not so formalized and hierarchicized.

Sergious’s account records the destabilization of other traditions as well, such as the assumed active authority of the doctor and the presumably passive position of the patient. Because of the specific and subversive nature of the quest narrative recounted within One Boy At War, the text leaves little opportunity for caretaker/doctors to establish and sustain their authority over patients. Although the text is still constructed as a detective/adventure story, complete with drug spies, clinical trial moles, and intense detective work, Sergious narrates accounts of many of the challenges for patients that Verghese chooses not to. And yet, at no time in the text does Sergious represent himself as a central hero: he always works in combination with others at the site of illness. Perhaps
Sergious is more adept in his deployment of formulaic fictions and blends his representational strategies less obtrusively into his narrative, since his narrative still contains war metaphors, passages of suspense, and notions of heroism. Admittedly, he has constructed a text that becomes an explicit exemplar of the “Restitution Narrative” in the way that Frank defines it. No matter how detailed the descriptions of the “war,” the narrative still asks us to focus upon triumph over disease, victory over the body, and dissociation from the experience of dying. But the ill are given their own voice in the text, and the central narrator is not entirely invested in his own heroic status. Such moves create a narrative that has quite a different rhetorical feel than Verghese’s.

Sergious’s rhetorical touch is somehow lighter than Verghese’s. He doesn’t construct chiseled-out dichotomies of good and evil; he doesn’t render the inhabitants of the text as caricatures. The utterances of the heroic-renegade are less intrusive and less invasive in Sergious’s text. His text inquires, asks, describes, but makes a sharp departure from the medical rhetoric we have seen in Verghese’s text. In fact, Sergious’s illness narrative defines a space that is marked by an experimental treatment free-for-all comprised of a “try anything” research approach. Within this narrative landscape, far away from the calcified representational strategies of Verghese’s text, even the speech act of “telling the truth” is destabilized. When patients at the UCLA Medical Center take instances of medical testing into their own hands by falsifying allergy tests to gain access to medicines, for example, their actions are intended to be deceptive, but to simultaneously serve the purpose of eliciting the truth from researchers, who are attempting their own deceptions in double-blind control studies (82). The cunning that is involved in outwitting the medical authorities contributes to the construction of a proactive patient identity,
ruptures the “heroic” authority of the doctor, and alters the discursive course that the doctor has set for the patient’s treatment as well as for any narratives he may be forming about that treatment. This portrait of the assertive patient is a far cry from the vulnerability inherent in many of Verghese’s constructions of helpless patients.

Sergious’s textual participants speak for themselves, sharing expertise and experience, without having their words highly filtered through the subjectivity of a narrator. In *One Boy At War*, the example of “the midnight chemist” illustrates this point nicely. A man who runs an underground experimental anti-HIV medications laboratory, Rob Springer, allows the narrator to shadow him as he shows him the specifics of what he is doing: “My ‘apprenticeship’ with Springer not only taught me the fundamentals of an antiviral drug or immunomodulatory drug’s pharmacokinetics and modes of action but also reinforced my knowledge of the principles of the pathogenesis of HIV disease, or the ways in which HIV actually destroyed CD4 cells, resulting in life-threatening opportunistic infection” (74). Medical knowledge is shared between the two men, and those who have access to it act in a way that is “for” one another, instead of deploying knowledge as proof of one’s heroic authority.

*One Boy At War* also manages to represent the moral ambiguity of certain treatments at the site of medical discovery, without advocating whole-scale abandonment of those practices: the midnight chemist is a man who recommends drugs before he knows if they help or heal, who knows that there often isn’t time to run sufficient tests upon treatments he is prescribing, and who is willing to risk the lives of those to whom he gives the drugs anyway. Sergious, as narrator, leaves his readers in a position of uncertainty about what is heroic and what is villainous within his narrative, and lets each textual
situation suggest what constitutes an ethical approach in a conception of ethics which is highly situational. This situational orientation additionally puts the reader in the position of “listening with” the narrative, instead of following a “heroic narrator” through his inexorable story-line, dramatic flourishes, and representational acts of emotional protection. In an emotionally open manner, Sergious conceives of himself within an interdependent and inclusive social structure, while Verghese strengthens his heroic position within a more exclusionary concept of human relatedness. One of the primary elements of an ethics of care pivots on the notions of inclusion and exclusion, and the negotiation of questions of who is considered “worthy to speak,” who is involved in the inner circle of “valued human beings,” and who is dismissed as an “outsider.” Such questions reach a peak of intensity in the negotiation of issues of family, particularly the role of hero within that family.

The Familial Hotbed of Heroism

To generalize, Sergious portrays a brotherhood of those who are watching out for each other; Verghese portrays an insular family unit watching out for itself. Within the context of the family unit, Verghese finds another avenue for his heroism: portraying himself in a position of patriarchal authority. Thomas Couser draws a distinction between these manners of situatedness in *Vulnerable Subjects*:

Narratives of disability [or illness] can foster (or stunt) the growth of [a] sense of kinship—and can foster an ethics of caring (as distinct from curing). Some narratives, while protesting the contrary, will in effect draw a new line excluding newly disabled [or ill] family member from a preexisting kinship; others will retrace and reinforce an old border that includes the disabled family member; still others will draw a new boundary that expands kinship beyond the family. (164)
It is this last move that fosters a sense of inclusion, of social responsibility and responsiveness—and it is the move that Verghese ultimately refuses to make.

Perhaps most jarringly, but in keeping with the text’s recurrent equation of the clinic and the battlefield, Verghese’s use of the family hierarchy becomes explicitly militaristic. As he says: “I remember playing the role of brave soldier to the hilt when my parents came to visit me in Boston…. I was, in the face of my mother’s concern for me, valiant and stoic… That quality in me—the pride of the front-rank soldier…was now reawakening” (78). But if the family structure opens up the possibility for undergirding the narrator’s identity as hero, it also directs his identity along some predictably normalizing lines. The nuclear family represents the security of “The Normal” (suggested by such theorists as Gayle Rubin to be heterosexual, middle class, and monogamous) within Verghese’s text, a warm circle designed to keep the actuality of HIV/AIDS outside. In Verghese’s expressed yearning for “family,” this family structure is generically faceless as well as normalized, and the ideals of family do not necessarily correspond to the often-frustrating realities of his family. In fact, the configuration of the family, and Verghese’s heroic role within it, is somewhat-confusingly superimposed upon a variety of social structures within the text: Verghese becomes the wise paternal figure at Indian community gatherings, the protective son in the presence of Will Johnson (willing to lie to cover up Will’s medical condition), and the unquestioned patriarch of his own literal family. Above all, Verghese is the renegade/rebel child within the institution of his medical practice.
Part bad-boy renegade researcher and part good-son conscientious caretaker, Verghese structures his self-representation to maintain his ascendant position within a doctor/patient hierarchy, and to prop up his self illusion of occupying a secure epistemological position in the midst of the complexities of HIV/AIDS. This normalized and heroic method of self-presentation also becomes a performative practice, one which both informs the illness narrative and is informed by it. If we start from the assumption that performances of narratorial identity are as socially-constructed as those of gender identity, the intricacies of Judith Butler’s notion of gender performance can help explain Verghese’s textual fixation upon maintaining his heroic role at the site of HIV/AIDS treatment:

…the repetitive, performative, citational features of identity formation also constantly threaten the self’s [or hero’s] stability; in the act of repetition, there is always the possibility of variation, divergence from the norm. And since the norm depends upon certain exclusions, the excluded is always available for a return that can challenge or subvert that from which it is anxiously cast out. (qtd. in Krueger 195)

As the narrator disposes of those moments which provoke anxieties about mortality, loss of control, and a threatening proximity to sickness and death, the fact that the site of illness is a space of “casting out” is indisputable. The vulnerability of the hero to such anxieties compels him to use his fixed heroic (and performed) subject position within a safe family structure as a defense. Since HIV/AIDS, as an illness, has been marked by so many mutable dimensions (the names initially applied to the disease, the amount of information acquired about it, the rapid increase in the number of people affected by the disease, the geographic regions in which it is located, the myriad ways that symptoms manifest within the body), these illness narratives must work to stabilize some, if not all, of these mutable
elements. A fixed construction of narratorial identity into a normalized family configuration is one method of attempting to achieve such stability.

Yet, as Michael Warner points out in *The Trouble With Normal*, where there are notions of “normalcy” in disciplinary circulation, there is sure to be judgment: “It does not seem possible to think of oneself as normal without thinking that some other kind of person is pathological…The rhetoric of normalization also tells us that the taken-for-granted norms of common sense are the only criteria of value” (60). In his capacity as clinician, Verghese does ask outright about his gravitation towards his so-called “normal” and securely family-situated patients: “Was it easier for me to sympathize and identify with this beautiful couple [Will and his wife] because they were not gay, not intravenous drug users?” (250). If this is the narrator’s attempt to anticipate the objections of the reader, to defuse any critique of his exclusive stance before it can arise, his efforts ring hollow. In questions to himself about the equity with which he treats patients, Verghese only undoes his questionable portrayals of “tolerance”: “After all, how many other patients had I personally escorted up to their hospital rooms? When had I ever carried luggage for patients, spent hours of my evening listening to them and settling them in, allowing them to dictate the pace of my interview, leaving only when I thought they would not mind my departure?” (250). One might pose further questions in the face of the narrator’s attraction to the “normal”: what isn’t Verghese doing for his other patients in his excessive focus upon Will and his wife? Has his application of the label of “innocent” to Will begun to affect the medical treatment he is giving to patients he sees as “guilty,” less "acceptable," and less in keeping with the dictates of social normalcy?15
How deeply do Verghese’s moralizing statements, his judgments, and his
dichotomous assessments of who is heroic and who is not begin to affect the quality of the
medical care, as well as the narrative care, that he gives? In Will Johnson’s case, the more
closely the patient and his family fall within the confines of a normalizing structure of
familial relationship, the more Verghese’s response to them is marked by concealed
affection and covert attachment, concealed and covert out of his need to maintain his image
as a professional hero. And while this attachment might be a precursor to a helpful
intimate engagement between patient and caretaker (one that dismantles a patient/doctor
hierarchy, for instance), it is not. This failure of intimacy occurs, in large part, because the
(broadly defined) erotic potential of such a moment is quickly extinguished. I will quote at
length from a rather odd scene within the text, revelatory of a dynamic of entangling,
sub-textual, and suppressed erotic alliances:

Bess [Will’s wife] was overcome now, sobbing heartrending
sobs. Will and I were crying, too. We sat like that on the
bed, the three of us, holding hands. When Bess went to the
bathroom to compose herself, Will leaned forward and put
his hand on my shoulder as if I were his son. He drew me to
him and said to me softly, “You know I’ve lost all libido. I
have become impotent. What once was an act of love, of joy,
an act of life, has become and act of death for me. It holds
nothing other than horror for me. (293)

The clinical narrative makes a move that could yield an unexpected transgressive moment
if Verghese allowed it to play out. Such a moment might provide the basis of an ethical
“coming together” of patient and doctor on the basis of shared struggle: both feel
exhausted, impotent, and despairing. Instead, Verghese quickly reverts to a
professionalism that robs the moment of the potentially-disruptive insertion of an
uncensored expression of emotion.
Within the narrative, eroticism (suggested here in the coming together within sacred space as the bed is shared, the invitation into the inner workings of a marriage at a point of vulnerability, the mutual crying and the hand on the shoulder) is abandoned as Verghese’s narrative resumes its attempt to sound “medically objective,” heroically detached, motivationally pure, and valorous. The moment contains a potential for communion, but that communion is also open to questions about its propriety if the door to the scene were ever to be thrown open. What has been left unstated in this discursive moment reverberates throughout the room, and although Verghese refuses to acknowledge the erotic potentials of medical care (of whispered fears and desires, of bodies undressed and touched for reasons both related and unrelated to the treatment of disease), the fact that he feels the need to conceal this interaction is telling: “A short time later I stumbled out of their room, hoping no one would see my red eyes. I took the back stairwell down to the parking lot” (293). Like a thief in the night, Verghese escapes with his secret unexposed.

Of course, the thrust of the medical discourse at this point is directed along the lines of an almost incestuous interaction with Will, not a bond in keeping with Verghese’s self-assessment as hero or with the narrative’s investment in a normalized and idealized family structure. Verghese’s earlier establishment of a father/son bond with Will, coupled with Will’s “revelation” of his impotency, work to establish a closed and secretive familial circle, as well as a rhetorically-fostered sense of a “special bond” of private disclosure. But the erotic familial moment is quickly dispensed with, disciplined away as the hero flees the scene of temptation, red-eyed. The fact that eroticism might yield a language beyond language—one of touch, revelation, communion, and caring, is lost on a hero intent on retaining his circumscribed propriety and hierarchized subject position.
Heroism and the Potential for Rupture by the Erotic

The erotic element that underlies the doctor/patient interaction always threatens to rupture the propriety and convention of that interaction. When doctors first argued that “they should be free to make their observations... by placing their hands directly on the heart...but our delicate morals prevent us from doing so, especially in the care of women,” Foucault suggests that “the moral screen, the need for which was recognized, was to become a technical mediation” (163). The fact that the libidinous potentials contained within medical interaction began to affect the nature of medical care was a dynamic at work very early on. Besides our lovers, our medical authorities are the only people granted intimate access to our bodies, and the potential eroticism of that access has been suggested by Foucault in The Birth of the Clinic to be an constantly suppressed subtextual constituent of any doctor/patient interaction: “The libido sciendi, strengthened by the prohibition that it had aroused and discovered, circumvents it by making it more imperious; it provides it with scientific and social justifications, inscribing it within necessity in order to pretend the more easily to efface it from the ethical, and to build upon it the structure that traverses it and maintains it” (163). What is a medical hero to do in the face of this eroticism—particularly when it would remind him of his own embodiment, his own sensations and emotions, his own commonality with the person he is treating, and his own potential for surrender to the unbound nature of libidinal promptings? In the case of Verghese, as Ruth Cates notes, he ignores it or kills it at its root as he concentrates instead on “the pariah status of his patients, the pariah status he often feels for his colleagues and wife, the denial of touch in resisting a weekend fling” (qtd. in Smith 306). Touch becomes
a way of denying himself in acts of heroic asceticism, not a way of maintaining or
celebrating a sense of his own embodiment.

As I have mentioned in passing, Vergheze’s use of the erotic contrasts quite
markedly with the use of the rhetorical eroticism of Raphael Campo. Campo’s
representations of illness and those who are ill ultimately seem more caring, more focused
on the patient, and more ready to erase the hierarchies of patient and doctor which are
constructed at the site of illness. Campo’s use of the erotic for the sense of rhetorical
energy and caretaker-patient connection it provides situates him quite differently in
relation to illness and to those who are ill than Vergheze is situated. Raphael Campo, who
defines himself as an AIDS medical specialist, gay man, and Cuban poet, also consistently
acts as a medical philosopher. As such, he continuously interrogates his own methodology
in the representations he offers of his patients. Unmistakably, his patients are his familiars,
and they hold a place in his awareness even when he isn’t treating them. They have entered
his body; he has become tethered to them through his stories, breath, and blood, as this
example from the anthology Diva illustrates: “My lips, my mouth the temporary vase / In
which I rearrange the flowering / Of breath that are my stories. When I sing, I bleed, my
lungs are the awful hemorrhage / Of wishing that we were the same inside” (62).

The desire, not to evade relationship, but to travel deeply within the grooves of such
relationship, is hinted at by Campo’s suggestion that he shares a vulnerable embodiment
with his patients. His “stories” are an attempt to chart the territory of that vulnerability: in
the process, he chooses not to make the paradigmatic move of assuming the mantle of
heroic or technological “invincibility.” According to his observations in The Other Man,
medical rhetoric need not travel in the direction of technologically-distancing descriptions,
but may instead engage with a felt sense of the body: “If medicine is indeed a kind of poetry, it is a poetry endangered by hubris, with its too many answers and explanations and footnotes and analyses, which need to be tempered with the awful reality of blood and the actual stench of urine” (119). According to Campo, medical discourse cannot afford to move towards abstraction—not through the machinations of “heroes,” not through picturesque representations, and not through the assumption of prophetic or “moralizing” voices. The sanctification of the body that is part of Campo’s poetry is immediate and intimate: “His breath, / I dreamed, had filled my lungs—his lips, my lips / Had touched. I felt as though I’d touched a shrine” (The Other Man 115).

Such sanctification is one element of the erotic connection between the narrator and his work, as well as between the patient and the narrator. This eroticism, the nature of which is explored more fully in my final chapter, offsets the cold mechanical aspects of the clinical site: “I need to know your salts / And chemistries, a kind of intimacy / That won’t bear pondering. It’s more than love, / More weird than ESP—my mouth, for instance, / So small and sharp, a dry computer chip / That never gets to kiss or taste or tell / A brief truth like ‘You’re beautiful,’ or worse / ‘You’re crying just like me; you are alive” (The Other Man 111). To Campo, eroticism holds the potential to blur boundaries and turn us all into lovers, to collapse the distinction between Self and Other which does so much to damage an ethics of care: “One lover held the other’s cock. Slow, tight, / His palm confused me with sensation, / Because a lover was the one location / I had never been to…/ The other man was me that night” (The Other Man 117).

Campo is appreciative of eroticism in whatever location he finds it, as long as blood mingles and nerves sing. As he considers the connotations of danger that representations
of HIV/AIDS have endowed human blood with, for example, he attempts to erotically reclaim the life-giving connotations of that fluid. In *The Hunger*: “When Susan Sarandon and Catherine Deneuve / Make love, it is among the sexiest / Of love scenes ever filmed: the blood is best, / Its trickle delicate across the nerves” (*Diva* 69). The body that is exorbitantly *used* helps create Campo’s sought erotic moment: these moments, when they come, are cause for celebration, as they dissolve the distinctions we attempt to draw between each other at the site of care. At such moments, the site of illness may become a sacred site of communion and intense bodily awareness. According to Ruth Cates, this sacred environment begin to form the stage upon which one conception of an ethics of care can be performed: “The tangibility of place…may be located or constructed, as in sacred sites—the mountain as a locus of divine communication or mystical communion, the geomantic positioning of stone on a cave wall, the tree of life, or the building of a cathedral” (qtd. in Cates 303).

Campo’s representations are not made exclusively of expansive sanctification. He also writes for the sense of control that the act of narration can provide the narrator: “Both poetry and medicine when properly and honestly practiced, are attempts to reintroduce that familiar sense of order into an environment gone out of control—for me, at least, they are the same effort to create a figure of my design, for once, upon painful experience” (*Essays* 111). But accounts of HIV/AIDS themselves have a far different place in Campo’s aesthetic economy of control than they do in many of the texts we have looked at: “[The poem] does not renounce illness; rather, it reinterprets it as the beginning point for healing” (qtd. in Howe 28). Despite the romanticism in Campo’s assessment, there is a marked difference between the manner in which he represents the ill body, and the way the
narrative voices within Verghese, Gurganus, and Shilts do. The objectification of the body into a “case study,” or the “Othering” of the patient through an explicit patient/doctor division is replaced by what I would call an ethical intimacy within Campo. In fact, Campo finds himself needing to hold back his impulse towards this intimacy: “I try desperately not to desire them [his patients], because it is unprofessional, and because it is too human and scary and powerful” (qtd. in Howe 31). This acknowledged proximity between patient and doctor, a proximity which in most clinical accounts remains unstated or subtextual, violates all of the dictates of the clinical institutions as Western, medical culture understands them, as well as suggesting new ways of being in a patient-doctor relationship.

**Narrative Insensitivity and the Heroic Paradigm**

In certain instances, narration at the site of illness calls for pre-established narrative paradigms, strategic representational strategies, and a powerful but suppressed eroticism that begin to supply power to the heroic role of the narrator. For Verghese, such acts of representation, situated in a narrative structure of heroism, take precedence over the act of listening to those who tell their stories at the site of illness. This rhetorical substitution takes place even when *listening* is the stated goal of the caretaker narrator: “I was interested in the patient’s stories for their own sake” (126). Why, then, is there often such a mismatch between stated narratorial intention to listen to the voices of people with HIV/AIDS, and the resulting representations—a mismatch that begins to erode a caring ethic? Why are characters, particularly in the case of Verghese’s text, given no chance to speak without descriptive undercutting? At least part of the answer is found in the fact that this descriptive undercutting insures that the narrator remains in full representational
control. But Verghese is eventually hoisted by his own petard. In the last pages of *My Own Country*, his tendency towards inculcating shame and secrecy, and his attempts to insure his own grandiose and heroic status, intensifies into a sort of paranoia. This paranoia begins to subsume the text, as Verghese’s need to solidify his position as invincible hero and all-knowing protector takes on unprecedented imaginative flourishes. Towards the end of the narrative, Verghese suggests that he occupies the position of hero in the midst of “a grand scheme.” Furthermore, he suggests that he is participating in the patterns of a larger plan (actually, the master narrative of his own creation). He then makes his paranoia explicit: the clinic and its surroundings bear “a strong resemblance to a secret society with me at its head and the various novitiates and initiates dispersed among the townsfolk, disguised as bakers, shoe repairmen, housewives, priests, waiters, blacksmiths, and publicans” (277). This grandiosity, comprised of the sweeping vision of the narrator’s hero role within a landscape, produces a subject position that is ultimately disengaged from the experience of any patient, any aspect of the disease, and any member of a community.

Extrapolated here to its ultimate solipsistic position, the heroic-caretaker paradigm forms the boundaries of a highly restrictive series of performative practices for the narrator, practices which are frequently deleterious to the provision of care. In the face of those performances, we need to ask the question that the text fails to ask: what price, in terms of the care provided to those who are ill, is to be paid for an investment in this self-representational structure? In *My Own Country*, the cost is clear: the fact that Verghese constructs himself as a hero so removes him from his own inner life, as well as from the inner life of his patients, that he comes to occupy a position of utter alienation from his social surroundings. He burns out, finally and definitively, at the end of the
narrative, and walks away from Johnson City. As he departs, he takes the knowledge he has gained along with him, probably undoing the good he has done as a doctor and then some. Actually, he indicates as much in his parting confession: “I tell myself that the umbilical cords that fastened me to eighty-plus HIV-infected people in Johnson City have detached. I feel so guilty over this sense of liberation. I feel such pain when I think of their faces” (428). Perhaps it is better to be no hero at all, than to be a “hero” who makes himself indispensable, and then departs when he is still needed. One might suggest that his need to construct himself as a hero has actually limited his ability to act heroically, and the abstracted feeling of “pain” he reports may hardly be an adequate compensatory moral gesture for the lack of ethical care that the text describes. But Verghese’s departure is a pattern played out at the end of “hero narratives” in other texts as well: just as the doctor-hero leaves the scene with work unfinished in My Own Country, the artist-hero is left without an audience at the end of Plays Well With Others, and the prophet-hero never manages to coalesce his journalistic data fragments into descriptive coherence in And the Band Played On.

There are certainly examples within illness narratives that suggest that many participants present at the site of illness resist the construction of a “heroic identity” and ultimately resist any placement of themselves within the confines of such a paradigm. In Adam Mars-Jones’ short story “Slim,” for instance, the narrator dryly couches his own life in terms of its function as a narrative: “But my case history seems to be unputdownable. A real thriller” (9). The ironically wry tone (“a real thriller”) manages to communicate the main character’s disdain for those who read his illness as a story and him as the hero of a fascinating novel. This “sainted” ill man communicates the sheer tedium which
accompanies the process of being narratively “examined”: “I long for the doctors to find me boring” (9). The undesired nature of being labeled “a hero,” and the irrelevance of that title to those who find “the front lines” to be their own bodies remains unaddressed by the notions of heroism which many HIV/AIDS narratives are dedicated to.

Mars-Jones’ text also manages to communicate an additional dimension to the construction of the “heroic presence” in the clinical setting of HIV/AIDS: the fact that a “heroic-witness” is sometimes free to walk away from illness (just as Verghese is free to drive away):

> I look down on Buddy as he walks to the Tube. In the open air the mystique of his health dissipates, as he merges with other ordinarily healthy people. No one in the street seems to be looking at him, but I follow him with my eyes. There is something dogged about him that I resent as well as admire, a dull determination to go on and on, as if he was an ambulance-chaser condemned always to follow on foot, watching as the blue lights fade in the distance. (13)

Robert Coale also acknowledges the dangers of alienation which attend the placement of those who are associated with HIV/AIDS in many capacities: “every icon embodies a communal act of interpretation, and all one has to do is look at the pictures of AIDS patients to see how isolated we’ve made them, in what a frozen, emptied vacuum we’ve placed them, much like the demonizing tendencies of our distant, medieval cousins” (qtd. in Pastore 99).

As Laurel Brodsley observes in “Defoe’s The Journal of the Plague Years: A Model for Stories of Plagues”:

Shilts, in *And the Band Played On* and Monette in *Borrowed Time* deal at length with the frustration, confusion and impossibility of making prudent choices while the identity, attributes, transmission, and prognosis of HIV infection are
not fully known…. [these narrators] repeatedly show that the prescriptions of medical science, the policies put forth by the government, and the day-to-day decisions people make about their lives are made in a state of potentially lethal uncertainty. (qtd. in Nelson 21)

Certainly, this confusion and frustration make suspect any assumptions about narratorial heroic authority, as well as any claims to have cornered the market on information in times of “potentially lethal uncertainty.” Undoubtedly, the fear and feelings of impotence created by this uncertainty provide the emotional impetus to exaggerate heroism, assess blame, and create a grandiose and satisfying formulaic narrative, all on the backs of people who are ill. The urge to gain control within the context of illness—through the creation of iron-clad heroic or authoritative subject positions, through the setting of boundaries between the “sick” and the “caretakers,” or through the exclusion of patients from a role in their own medical care—are all on record within My Own Country, as well as other illness narratives. But perhaps most pertinent to the topic I examine in the next chapter, uncertainty may lead to the narratorial impulse to turn away from the dimensions of illness that cannot be contained by the text’s strategies of representation. As I inquire into issues of representation next, I will look at ways in which some texts actually attempt to “walk away” from an isolated figure, when they purport to construct a document dedicated to humanitarian witnessing.
CHAPTER 3

THE NARRATIVE IMPACT OF HIGHLY-STYLIZED REPRESENTATIONS

The site of illness within HIV/AIDS narratives frequently contains elaborately-constructed networks of predictable narratorial self-representation (such as the “heroism” that is explored in the previous chapter). In this chapter, I will suggest that this self-representation may also take a form that is premeditatedly and calculatedly artistic. I explore this notion primarily through the use of Allan Gurganus’s *Plays Well With Others*, because the aesthetic strategies are so overt, and the intentions behind them relatively transparent. *Plays Well With Others* is an illness narrative made of copies, of mimesis, designed to further the normalizing functions of the clinic as well as form the subject position of an artist-narrator. As I argue within this chapter, this mimesis incorporates a stylization that is designed to displace painful emotion onto the images, metaphors, and symbols that the text develops, even at the most crucial moments of tension for given characters. Within these texts, this strategy also stabilizes the identity of the narrator as an artist, as a producer of representations. In the latter half of this chapter, I round out my discussion through an examination of narratives whose representations help foster a caring narrative ethic: Mark Doty’s *Heaven’s Coast*, Raphael Campo’s aesthetic theorizing, and Robert Ferro’s *Second Son*, and brief discussion of works by Peter Selwyn, Paul Monette, Edmund White, Vance Bourjaily, and Sarah Schulman.
The clinic creates or molds the identity of the caretaker/clinician/narrator along the lines of an artist—one whose medium is the human body at the site of illness. The tools in the service of this artistry are various mechanisms: a concentration upon the aesthetic, a concentration upon the scopic, and a concentration upon the creation of a deliberately writerly psychic space, comprised of metaphors, conceits, and elaborately-descriptive images. Such a stabilization of narratorial identity is also a point of crucial change in perception within the walls of the clinic according to Foucault in *The Birth of the Clinic*, since that identity opens up the possibility for a stabilized mode of perception of illness:

At this level, all structures are dissolved, or, rather, those that constituted the essences of the clinical gaze are gradually, and in apparent disorder, replaced by those that are to constitute the clinical glance. And they are very different. In fact, the gaze implies an open field, and its essential activity is of the successive order of reading; it records and totalizes; it gradually reconstitutes immanent organizations; it spreads out over a world that is already the world of language, and that is why it is spontaneously related to hearing and speech; it forms, as it were, the privileged articulation of two fundamental aspects of saying (what is said and what one says). The glance, on the other hand, does not scan a field: it strikes at one point, which is central or decisive; the gaze is endlessly modulated, the glance goes straight to its object. The glance chooses a line that instantly distinguishes the essential; it therefore goes beyond what it sees; it is not misled by the immediate forms of the sensible, for it knows how to traverse them; it is essential demystifying. (122)

The glance also becomes a disciplinary mechanism, when, in the crystallized moment at which it exerts itself, the narrator seeks to capture a controlling representation of illness and of those who are ill, and to discharge his own uncontrollable emotion into that representation. Frequently, these representations undermine a caring narrative, serve a
disciplinary or normalizing purpose, speed up or crowd a narrative with intense descriptors, or threaten to erase those who are ill.

*Plays Well With Others* is a text narrated by Hartley Mims, who assigns himself the position of “writer” in a threesome of artists. Published three years after *My Own Country*, and characterizing itself as a novel instead of an autobiography or a medical account, the book is the story of three young artists who arrive youthfully, hopefully, and healthily in New York, and who become affected, in different ways, by HIV/AIDS. Robert (the composer), Alabama (the painter), and Mims (the writer) are bound together by artistic and erotic ties, ties which eventually provide shape to the representations of illness within the narrative. Although Mims is frequently confused with Gurganus himself (both are identified as occupying the role of heroic survivor, for instance), for my purposes, it is the narratorial voice of Mims that does the greater amount of representational work in this text.

As I argue, Mims’ representations lend themselves particularly well to a Foucauldian analysis, given their heavily scopic nature. But while some portions of *My Own Country* and *Plays Well With Others* and less well-publicized novels such as Robert Ferro’s *Second Son* and Vance Bourjaily’s *Old Soldier* attempt to stabilize their subjectivities into tightly controlled or “normalized” configurations, I suggest in this chapter that other representations point the way to a more tolerant, open and caring representations and sense of narrative ethics. Then, at the end of the chapter, I explore the possibility that Mark Doty’s *Heaven’s Coast* is a text which offers a more vexed, less scopic, and more caring approach to the narration of illness, as well as an example of representations that do more than attempt a stylish aesthetic control.
Fundamentally, this chapter will examine the ways in which certain representations undermine or restrict the projects of ethical care or advocacy they purport to further. In the course of “telling stories,” the clinical aspects of these texts impose a series of representational maneuvers that shift the focus of narrator and reader away from the particulars of the HIV/AIDS narratives and towards the specific and highly aestheticized strategies of representation within them. With justification, one might observe that this criticism could be made about any act of representation, but the representations chosen and favored within these illness narratives are particularly organic to the calculatedly literary nature of these texts. More specifically, the representations begin to construct and to further a focus upon the subject position of the narrator as “artist,” as that moniker is defined through a series of stylized personae. As I suggested in the first chapter, these narrators often write of illness through the mediating lens of a need to stabilize their own subjectivity. These methods take on some characteristic and predictable patterns (hero, artist, prophet) against the backdrop of the highly unstable landscape of HIV/AIDS. In this landscape, the doctor becomes an artist, and the body becomes the page upon which his representations are inscribed: “The normal heart tones, a poet would note, are iambic in rhythm: a weaker followed by a stronger stress…” (Coles and Testa 160).

Furthermore, the speed and the pacing of these narratives govern the representations (in what has been characterized in My Own Country) as “a breakneck account of the arrival of a national epidemic in the Smoky Mountains” (Coles and Testa 144) in a way that involves a high degree of emotional manipulation. Speed, locomotion, and momentum all contribute to a landscape of forward-moving change as the events of illness are forcefully impacted by the representational choices the narrators make. The way
that pacing and rhythm find their way into representation is also of concern to Levinas, who observes in his essay “Reality and Its Shadow” that

…the idea of rhythm, which art criticism so frequently invokes but leaves in a state of vague suggestive notion and catch-all, designates not so much an inner law of the poetic order as the way the poetic order affects us…But they impose themselves on us without our assuming them…Their entry into us is one with our entry into them. Rhythm represents a unique situation where we cannot speak of consent, assumption, initiative or freedom, because the subject is caught up and carried away by it. (qtd. in Hand 132)

But perhaps no text makes the impact of such incantatory aesthetic representational choices clearer than Allan Gurganus’s Plays Well With Others, the text that will be the primary focus of this chapter.

One of the hallmarks of a given illness narrative is a landscape which is overcrowded with “unassimilatable elements”—events which have no precedent for description. But according to Foucault, the mechanisms of the narrative attempt to force an assimilation through the representations it offers, particularly those which imprint themselves upon our visual field, or through instances when, as Foucault observes in The Birth of the Clinic: “the absolute eye of knowledge has already confiscated, and re-absorbed into its geometry of lines, surfaces, and volumes, raucous or shrill voices, whistling, palpitations, rough, tender skin, cries—a suzerainty of the visual, and one all the more imperious in that it associates with it power and death” (166). The negotiation of the representations of the “suzerainty of the visual” begins to require an intensely aesthetically-controlling narrator.
In examining the ways in which highly stylized narrative representations begin to impact an ethics of care, Foucault’s work in *The Birth of the Clinic* is particularly helpful. An attempt to represent the multiplicitous and complex dimensions of illness, for one thing, frequently obscures the individuality of the patient in a way that Foucault is always cognizant of. As the narrator encounters more patients, as well as an awareness of a larger number of symptoms, the amount of data that he is forced to account for increases. The outcome of this increase is a formative constituent of representations within the illness narrative, as well as the clinic as Foucault identifies it: “The simple dialectic of the pathological species and the sick individual, an enclosed space and an uncertain time, was, in principle, dislocated. Medicine no longer tried to see the essential truth behind the sensible individuality; it was faced by the task of perceiving, and to infinity, the events of an open domain. This was the clinic” (98).

Of course, the Gaze is frequently unable to penetrate beyond the surface of the sheer number of phenomenon there are to observe: “this projection of illness onto the plane of absolute visibility gives medical experience an opaque base beyond which it can no longer go. That which is not on the scale of the gaze falls outside the domain of possible knowledge” (166). One might assume that this fact will arouse frustration in acts of perception at the site of illness, but *Plays Well With Others* suggests that the alternative is true; in this limitation, the amputation of perception affords a certain relief: once they are located safely in their role as “stylizing artist,” they can bow out, not only of the opportunity for further “possible knowledge” as Foucault identifies it, but also of the emotional engagement that the site of illness asks from them. Mims does not want to be accountable for exploring psychic regions he cannot penetrate, and his circumscribed
subject position of “Artist” suspends him safely within the emotionless substrate of the “opaque base” of illness.

I, too, am perhaps suspended in this opaque base. At this point, I must note how my own situatedness as a critic of these texts vexes my relationship to a caring approach to my textual analyses. As I myself narrate a critique of these illness narratives, I am also attempting to work within a rhetorical paradigm—perhaps not as “hero” or “artist” per se—but as “objective scholar.” One could argue that this self-positioning might inhibit my own caring treatment of the texts or the narrators I am examining. I would respond to this objection in many ways: a) if I do critique the texts in a manner that sounds harsh, I do so with the intention of advocating for more enlightened representations of those connected with HIV/AIDS; b) within the “objective scholar” tradition, to be a critic is often to be critical—those are the strictures of a domain I have consciously chosen to act within; c) perhaps it is a caring act to balance the praise these texts have received with a more negative assessment of them. The public response has been so one-sided, that any criticism certainly works to equalize the texts’ treatment somewhat; d) in reading these texts so closely, and in reading them for some other reason than to satisfy my readerly expectations and needs, I have “been resonant” with them; I have, in a sense, “taken them into me”—while I still wanted their narrators to “tell the stories better.” I do not care for many of the representations offered within them, but I have been “for” the texts enough to spend countless hours trying to see beneath the surface of them, probing beneath levels of text for their subtexts. But still, at times, I have fallen into some of the same representational pitfalls that these narrators do: distancing, aestheticizing and objectifying the narratives I am critiquing. 18
On another cautionary note, in my incorporation of these descriptions of mechanisms of perception within the clinic, I am not suggesting that Foucault is unfailingly relevant to my discussion. For instance, Foucault’s very notion of an ethics of care has little to do with any caring notions I am exploring, since his is largely an ethics of self-care—a concept of the technology of the self which has very little to do with care-taking the Other, and very much to do with notions of self-development:

The recommendation to “take care of oneself” was not new or foreign but native to Greek culture. Several writings, but especially Socrates’ dialogues in Plato’s Alcibiades and Apology, bear witness to the fact that in ancient Greece, rather than being urged to spend a life acquiring wealth, reputation and honor, the Greek citizen was highly recommended to be concerned with himself, with the cultivation of wisdom, truth, and perfection of the soul. (Pinto 77)

Foucault did consider the notion of a care in a formalized and ethical light, but his formulation is a far cry from the concept of ethical care that I am exploring in this project.

Foucault’s considerations of care do not pivot on a recognition of the other, but on the way that others recognize oneself, based on the Greek ethos that took into account “the subject’s mode of being and a certain manner of acting visible to others” (Pinto 86). This concept of self-care is based on a mastery of oneself, and on a wide-scale aesthetic cultivation of the capacities of the self—a self-stylization. According to Foucault, we find our ethical footing in our “practices of the self,” and not in our ethical attitudes towards others. Not that Foucault is averse to caring for others, but such caring is not his first consideration: “And although the care of the self was before the care for others, for the former is ontologically prior to the relationship with others, the latter has always been a fundamental part of the care for the self” (Pinto 86). While Levinas comes close to
advocating a subjugation of the self in caring for the other, Foucault keeps his eye on prospects for self development within issues of the care for the other. Unlike Levinas’s concept, Foucault’s definition of ethical care does not rest on one’s responsibility to others at cost to the self: “Its practices were basically directed to a small elite, to a group exclusively constituted by men. The care of the self did not aim at the normalization of populations, since, in the constitution of the self, one’s exercise of freedom was the axis around which the ascetic path made its way forward. Ethics, as Foucault points out, is ‘the considered form that freedom takes when it is informed by reflection.’” (Pinto 77).

The potential to violate a caring ethic through the representations which are constructed is inherent at the site of illness, and instances of such violation come readily to mind: the refusal to give a patient their own voice, the turning of the ill into the other, the labeling of the ill with pathologizing nomenclature. As Foucault points out: “…to look in order to know, to show in order to teach, is not this a tacit form of violence, all the more abusive for its silence, upon a sick body that demands to be comforted, not displayed? Can pain be a spectacle?… Since disease can be cured only if others intervene with their knowledge, their resources, their pity, since a patient can be cured only in society, [thus society decides that] it is just that the illnesses of some should be transformed into the experience of others; and that pain should be enabled to manifest itself” (84). Foucault suggests that not only are the ill turned into grist for the spectacle mill within the clinic, they are expected to be grateful for the way they have been positioned, because that position makes possible their medical treatment. Within many illness narratives, as I have suggested, the narrator frequently places himself in the role of the colonizer with gaze trained upon the patient.
Within the narratives I am examining, this gaze frequently becomes the dismissive
glance of one who is rendering characters (Verghese); the interrogative glare of the
detective hot on the trail of a mystery (Shilts and Verghese); and the intimidating scopic
intrusion of the artist (Mims). Often, the representations within these texts suggest that all
the world is a clinic to be probed and controlled through the physical processes of artistry
(In Plays Well With Others, Alabama takes the floor out of her apartment to make room for
her large canvasses); by stylized objects made animate (thirty dildoes become the vaguely
menacing instruments of an almost medical intrusion), or by impression-collecting
entrances into the homes and families of patients (Verghese’s narrative includes
descriptions of his house-calls and time-consuming instances of personal treatment).

In the context of the artistic paradigm, then, and in ways that are applicable to Plays
Well With Others, the site of illness becomes a region of intense investment in certain
representations. It also becomes a canvas—smoothed, bordered, and inviting. As Michel
Foucault characterizes this bordered and boundaried condition in The Birth of the Clinic:

> The collective structure of medical experience, the
> collective character of the hospital field—the clinic is
> situated at the meeting point of the two totalities; the
> experience that defines it traverses the surface of their
> confrontation and of their reciprocal boundary. There it
> derives not only its inexhaustible richness but also its
> sufficient, enclosed form. It is the carving up of the infinite
> domain of events by the intersection of the gaze and mutual
> questions. (111)

It is, in part, the bordered nature, the strict containment of representations of illness and the
ill by the walls of formal aesthetic considerations (to write beautifully, cleverly,
entertainingly, for example), that seems to aid the narrator in his attempt to control the
representations into “safe” territory: territory which will not ask for an identification with
the patient, territory which removes the narrator from a felt sense of his own body, territory marked by an explicitly “anti-erotic” and “anti-intimate” treatment of the sexuality with the text. The artistic narrator may not have an intimate perspective of his own motivations, or to ask if an instant, almost automatic impulse to control the representations within the narrative is helpful to the verisimilitude of the story, the justifiability of the representations, or the development of notions of an ethics of care within the narrative. And, he may not take into account the responsibility he has as one who represents: to witness, to explore alternative representations, to surround HIV/AIDS with workable terminology, and to keep his own anxieties from subsuming his considerations of the person who is ill.

The Inherent Responsibilities of Representing “HIV/AIDS”

The stakes of questions about representation at the site of illness are raised by the fact that such narratives often take the notion of bearing witness as one of their responsibilities. According to Michael Denneny in his article “AIDS Writing and the Creation of a Gay Culture”: “To bear witness is to declare oneself, to declare oneself present, to declare oneself in the presence of what has come to be” (qtd. in Pastore 48). To witness with an ethics of care, however, is an act that is dependent upon the quality of and the narratorial intentions behind the text’s representations. For instance, Verghese reaches most consistently for the power of the text to constitute his identity as an artist and a storyteller, instead of writing in a manner that will establish him as an empathetic witness. Both in the writing of his “Doctor’s Tale” and in his medical reading, he looks to the organizing power of the story to make sense of events at the site of illness. He turns to other exemplars of “storytelling” in this process: “…the therapeutic advice wanted, was
surely to be found here in Osler’s text. Osler knew what I was going through” (372). Osler, one of the first physician-writers, begins to work for Verghese as the archetypal narrator, as Verghese reaches for the magical power of an ancient medical text to keep the demon of the vulnerable ill body at bay. As long as we gather around the fire and tell our stories, so his narrative assumes, we just might be able to distance ourselves from threats to the body, to the ego, and to the representational structures which support them. Thus, when these narratives encounter traumatic aspects of illness, their attempt to reach for a ready metaphor or analogy, to stylize the characters into caricatures, or to fashion a distracting story-line, is understandable. But this aesthetic stylization comes at the high price of reduction, melodrama, inappropriate comparison, or pathos—all antithetical to a helpful or caring narrative ethic.

In *The Birth of the Clinic*, Foucault constructs a poetically-stated assessment of what remains possible before the specifics of illness are represented in highly stylized language: “To discover, therefore, will no longer be to read an essential coherence beneath a state of disorder, but to push a little farther back the foamy line of language, to make it encroach upon that sandy region that is still open to the clarity of perception but is no longer already so to everyday speech—to introduce language into the penumbra where the gaze is bereft of words” (169). Toeing that “foamy line” of more open, suggestively articulated representations (as opposed to forming strict borders in the course of constructing those representations) is part of an ethics of care, incorporating acts of listening, moments at which a narrator does not know what to say, and times at which the urge to displace emotion into stylized speech must be slowed. Fixating on an image, a sound, a repetitive style, or a hyperbolic tone (which many of these texts do) leads to the
sacrifice of an entire range of possible representations and “ways of being” at the site of illness—some of which are more in keeping with the aims of caring narrative treatment than others.

The clinic, observes Foucault, is at times nothing more than a space that traces illness, which is itself nothing more than “a certain complex movement of tissues in reaction to an irritating cause: it is in this that the whole essence of the pathological lies, for there are no longer either essential diseases or essences of diseases” (189). This characterization of illness is particularly relevant in the face of the HIV/AIDS pandemic, a site which is comprised of many illnesses and symptoms. But as I have suggested, in the face of such an ephemerally-delineated illness, many narrators seem all the more bent on achieving a stable and definitive representational schema for HIV/AIDS. Pressed by “unknowability” to represent the elements of the identity of the disease as well as their own identities in relation to disease, their representations pivot on a series of questions that are consistently applied to determine the contours of any illness, and then representationally “lock” the disease within the confines of those contours: Does an individual “have it” or not? If we harbor the potential for illness within our bodies, but it is not fully active, can we say that we are ill? Once we receive the diagnosis of a disease, one that may appear and then spontaneously go into remission, how do we define ourselves in relation to a disease? When people live with a chronic illness, a threat partially hidden but always possibly ready to manifest itself, how do they define themselves in relation to those possible manifestations? In the case of AIDS, answers have been attempted to those questions in terms of T-cell count, or in terms of visible symptoms such as lesions and weight loss. But frequently, the sometimes invisible and amorphous qualities of HIV/AIDS, particularly in
its early stages, seem to create an anxiety within many of these narrators surrounding the illness’s unknowability and potentiality for threat, and although such an anxiety is understandable, what’s more difficult to accept is their subsequent attempt to ameliorate their anxiety through aestheticization of the disease or the person with HIV/AIDS.

Through their aestheticizing efforts, representational flourishes, and demonstrated need to craft a well-told tale, these narrators gesture towards other anxieties as well, those that arise as they articulate their own subject position. Thus the central Catch-22 of their projects rears its head: they seek to represent their own identities even as the medium they have chosen arouses incredible anxiety about how they will represent themselves. Lee Edelman, in his essay “The Mirror and the Tank,” from Homographesis, points out that stakes are high for any issues of representation of HIV/AIDS, since those issues are inextricably tied up with issues of self-representation, sexuality, gender, and sex: “Whatever the direction from which we approach the subject of ‘AIDS,’ we are brought up against our own constitution as subjects of (and in) ideology” (12). Thus, as suggested, when the representation of HIV/AIDS is inadequate or highly controlled (misrepresented, pathologized, strategically constructed) the narrators’ very definitions of themselves as subjects is compromised or nullified.

This swirl of anxiety has a further representational impact: the narrator may overlook or eliminate the subjectivity of the Other within the narrative, since the difficult development of his own subject position consumes all of his attention. And if these narrators, as a result, seem intent on eliminating the subjectivity of The Other within the texts (since the books seem primarily focused on the narrator’s representations of himself), then the texts need to be searched for their tendencies to re-traumatize, control, and even
erase the bodies of those who are not narrators within them. At this point, I must say that I
am conflating the notions of “identity performance” and “establishment of narratorial
subject position” because (to the narrators of these HIV/AIDS texts) these two notions are
one and the same. In a sense, these narrators find a theater to perform their most
sought-after selves within their representational strategies. Then, not only does the
narrator assume a role, he also undertakes a series of narrative-controlling actions based on
this role. These actions are designed to help him avoid the discomforts that a caring series
of rhetorical gestures demands of him: the need to sit with the “messiness” of illness and
death, the refusal to pathologize and stigmatize one who is ill, the realization that we all
share the state of being mortal and vulnerable. In avoiding these realizations, the narrator
replaces the wet depths of human intimacy, the bodily fluids of our authentic meetings with
surfaces merely dampened by ink and paint.

In the clinical aspects of the HIV/AIDS narratives under examination, the subject
matter itself permits and even pressures a certain representational distancing, telescoping
the perspective of those under its sway, not only through the anxieties aroused by those
who are articulating their subject position in the midst of illness, but also through outright
grief at the site of illness. Such a distancing is understandable. As Mark Doty observes:
“…the past feels diminished when the future seems to shrink. Mourning contracts the eye
like a camera lens in strong light; the aperture of the soul shrinks to a tiny pinpoint which
admits only grief” (qtd. in Howe 9). This shrinking perspective finds its way into many
representations surrounding illness, and continues to leach into the narrator’s subjectivity.
At this point of distancing, the narrator, the reader, and the text itself may be further
pressured to close down, withdraw, and disengage from further emotional involvement at
the site of illness. Among the texts analyzed in this project, Mims as a narrator serves as a rich example of such aesthetic and calculatedly “artistic” intervention. This narrative contains a consistently-employed gimmick: the production of a surfeit of details, and the attempt to direct reader attention to the surface stylishness of the representations and away from the events of illness. As the text becomes “about the Art,” a readerly sense of being in the presence of illness recedes. For example, an “overloading” at the descriptive site of illness with what the narrator deems as “writerly” rhetoric becomes one strategy of distraction. Whether this re-direction of attention is deliberate or not is unclear, but there are some clear indications of what happens to the subject position of the narrator under the cover of this re-routed attention.

In *Plays Well With Others*, Hartley Mims’s representational strategy of choice seems to be a frenzied mimesis: the compulsion to create a landscape of “young artists and illness” as an over-crowded gallery of images. In his seemingly frantic need to craft lasting and indelible representations, this narrator cannot edit or cease: what begins as a short story becomes a novel. In his descriptive excess, Mims expands his story exponentially in a drive to tell and retell, and simultaneously chokes off the potential for emotion within this retelling. This enlarging and engorged mimesis then becomes a stylistic aspect of the narrative, and a habitual signature style of Mims the Artist. This device is used as a distraction from painful emotional engagement in two ways: first, by quarantining the events of the clinic at a “safe” descriptive distance (the displacement inherent in the copy of a copy), and second, by a numbing and incantatory stylization designed to encapsulate the event in a protective wall of words and the narrator within a self-protective role.
The fact that this role is frequently linked to the narrator’s own feelings and machinations of resentment, duplicity and craftiness—in short, not-so-caring emotions—is the topic of this next section.

**Normalizing Directives Within *Plays Well With Others***

The representational maneuvers of Hartley Mims in *Plays Well With Others* quickly assert themselves in his acts of embedding normalizing, moralizing, and emotionally-protective directives within diversionary aesthetic patterns. The narrator’s identity as Artist, in complete and manipulative control of representations of the disease, serves as a stay against suffering (after all, it’s just a story, one to be carefully crafted); against mortality, since the narrator ensures some sort of personal continuation through the production of an aestheticized illness narrative, and as an expression of a “higher moral” vision. Moving outward in my considerations, although some of these texts may debilitate their participants when they create them as normalized heroes (as I suggested in the previous chapter), they do a greater disservice when they render them as “abnormal” villains. The “guilty” sinner motif or the “sexual-renegade villain” who deserves to be punished for sexuality, become representational tropes which run through much of this literature in ways both overt and subtle. Likewise, the need to create a text with an idealized and moral “artist” at the forefront also becomes a way of pressuring the representations along normalizing trajectories, and away from the potential for an ethics of care.

Texts such as *My Own Country* and *Plays Well With Others* fly in the face of a newer and more revolutionary form of HIV/AIDS writing, writing which Timothy Murphy
points to as formed by AIDS activists who “…are credited with perpetuating… a challenge to the ideology whereby modernism (and the museum or literary canon as cultural establishments that both mirrored and enshrined it) affirmed an order of meaning that could be shaped, transformed, and revolutionized by the genius of the individual artist” (10). But in Mims’s less revolutionary representational economy, the artist remains the savior who embodies transcendent values: the ideals that marked the definition of modernist artist have not been dispensed with within his narrative. He becomes the modernist “individualistic” artist who, if I might generalize, is the antennae for larger social mores, the single-handed violator of aesthetic paradigms, the upholder of larger moral vision, and the encaser of life experience into the “higher form” of art. This “throw-back” aesthetics also contributes to the comfort level of an audience who is protected from distressing realizations about their own mortality and vulnerability to illness. *Plays Well’s* narrative insures that the audience, too, is shielded by a more palatably “shaped and transformed” representational landscape.

Very easily, the representations within the narrative may become the narrator’s calculated crafting of the “moral value” of a given character. *Plays Well With Others* becomes a case study of just such representational strategies. The book is touted as a “lovesong to imperishable friendship,” but a closer look at the narrator, Hartley Mims, reveals something else. The character of Robert, the choir-boy turned composer, is constructed by Mims seemingly as the heroic artist: beautiful, sought after, talented, and doomed. But as the novel progresses, Robert becomes less of a character and more of a symbol of transgression, of “promiscuity,” of the liminal space of bisexuality, of an excess which becomes the primary target of Mims’ condemnation. Robert is someone Mims
loves, but believes he shouldn’t. In his personal style, and in his ability to seduce and to dazzle, Robert’s “artistry” is portrayed as the artistry of one who *performs* himself, as opposed to Mims’ artistry, which is constructed as “real.” Within *Plays Well With Others*, there is a perilously thin line between genuine hero and contemptible “saint,” and “Saint Robert” is made to toe and to cross that line through a variety of representational maneuvers. The construction of a hero is a double-edged sword in this text, and Robert nicely illustrates the essentially ambiguous position of a narratively-constructed artist hero. Because of his ambiguous position, Robert is used as an example upon which Mims can apply his moral experimentation and come to his moral indictments.

First, Mims resentfully suggests that some people just don’t have to work for the success that they achieve, and applies that suggestion to Robert. Robert’s talent is portrayed as sound, but easily won; his efforts are undercut by the facility with which he performs as a musician: “…how gifted Robert was…What had first seemed like an exercise for friends became, with one dynamic change, a composition fit for a group of strangers. It started off as gifted kid stuff then got pushed, by certainty, reiteration, playful community, to a fast hothouse maturity” (157). Robert’s artistic credentials quickly become vaguely disreputable, a little immature, and consistently undermined by the narrator. This undercutting (his art is frivolous, fun, and always a little shallow) is extended to cover the entire portrait of Robert in the novel.

Robert is portrayed as simultaneously teeming with talent and viral infection—allowing Mims to make a direct equation between Robert’s creativity and his HIV-positive status. Mims also becomes the narrator who embodies a fundamental premise of the novel: *real* artist-heroes don’t fully enter the erotic hothouse of creation;
like Mims, they stand outside and represent the goings-on of that erotic space. This is a
cold-eyed monitoring, however, and as the novel moves into descriptions of Robert’s
contraction of HIV, it also delivers many of Mims’ “moral” indictments. Robert is
immature as an artist, according to Mims, partially because of his “promiscuity”:
snickering references to “sexual conquests” which take place in Robert’s giant, four-poster
bed are taken to be the Achilles heel of potential greatness. Of course, the “real hero-artist”
of the novel, Hartley Mims, stands calculatingly in the background for the first half of the
novel, setting Robert up only to have him fall in the wake of illness.

One might think that Mims’ machinations are intentional, that we are in the hands
of an unreliable narrator, or of a vicious character who chooses to build his reputation on
the back of a man he has pretended to love. But does the text really contain such a set up?
There is no doubt that Mims uses illness, and his own contrasting good health, to establish
himself as a “man in control” of artistic forums, moral judgments, and social
interactions—arranging the people around him into configurations of friendship. In doing
so, he chooses to add insult to Robert’s illness. Out of resentment, or out of jealously,
Mims chronicles his own satisfaction in watching the fall of an admired figure. Such a
representational move fleshes out a psychologically-complex portrait of the narrator. But I
would also argue that the portrait of Robert grows organically from a set of prescriptions
Mims offers about what an artist should do within the context of an illness narrative.
Hartley Mims is the artist who channels “dangerous” sexual and emotional impulses into
the energy of his writing, as opposed to Robert, who acts them out. Mims is rewarded for
his “good sexual behavior” (read: abstinence), by health, by artistic success, and by a
comforting distance from the suffering of Robert. In the end, Hartley Mims substitutes
care-taking and artistry for sexual expression, and holds this substitution up as the novel’s standard of morality. Mims says as much himself: “They [Robert and Alabama], maybe the Stronger. I, though, surely kinder” (224). Despite this identification of “kindness,” we see him offer few of the real hallmarks of ethical care, invested as he is in constructing a modern-day morality tale. In addition to the prescriptive and moralizing drives of the novel, we also see a narrator who lives at an emphatic distance from his own sensuality. This distance suggests Mims is an unlikely agent of care, if that care is defined by “suffering for another,” “living in the body,” or living out an erotic interchange between humans.

Mims, for his part, creates himself as a critic of human sexual behavior based upon normalizing constructs—at the same time as he assumes the role of artist in full representational control. Robert, although appearing to be the novel’s central hero, is first characterized as a “park statue [on a] pedestal” (221) (as both a creator of art and as a piece of art himself) and is then subtly villianized in a series of narrative maneuvers. He is constructed as “perverse”: the novel opens with Mims cleaning out Robert’s apartment before Robert’s parents arrive, making sure to remove the huge stash of dildoes and kiddie porn (a synecdochical association between “illegitimate” artifacts)—an incident couched in humorously reductive language. Subsequent examples, such as the moment during the performance of Robert’s symphony in which the sleeve of his shirt slips up and reveals a Kaposi’s sarcoma lesion, are visually-symbolic moments which construct Robert as “irresponsibly” concealing his HIV-positive status and seem “a sign of corruption” to Mims (209). “Signs of corruption” then become opportunities to shame a character within Mims’ narrative.
Michael Warner has written extensively in *The Trouble with Normal* about socially-constructed representations of culpability, particularly as mechanisms for shaming people into compliance with heteronormative directives. Gayle Rubin has theorized that so-called innocent or acceptable “vanilla” sexuality can be constructed only in contrast to a series of given sexual (or in this case, creative) taboos. Given such cultural directives, as Warner goes on to demonstrate, we are “blameless” only if we are in compliance with social mores, not only within the realm of sexuality, but also within the realm of artistic production. Or, as Rubin’s brilliant schema suggests, we are assumed to be responsible for our falls from grace (in a variety of spheres) if we choose to occupy the “wrong side” of the sexual normalcy chart.

In the text, Mims contrasts his own “virtue” with Robert’s habit of mingling—art with life, bisexuality with gayness, body with body, social life with music—a mingling which violates Mims’s sense of social propriety. Robert’s aesthetic engagement is pejoratively portrayed as sensual and erotic as well, while Mims’ definitions of blameless behavior rest on a subtext of tactile sterility, and a well-developed system of isolation that involves no touching, no interchange of fluids, no penetration of boundaries. Mims’ rationalization for such isolation is the maintenance of a hygiene of sorts, but this very hygiene becomes anti-erotic as well as anti-creative in many narrative instances. As Mims says about himself, in a half-proud and half self-effacing reference to obituaries: “The only way you [Mims himself] will ever get into *The Times* is with your next self-paid ‘Needs Work’ ad [as opposed to an obituary or an acknowledgment of his creative output]” (224). His self-congratulatory insinuation that he hasn’t become ill because he is sexually inactive is a theme he continues to reiterate.
The fact that Mims constructs Robert’s bisexual and celebratory sexual interactions as aberrant reveals his own anti-erotic stance. The cynical and anti-erotic portrayal of Robert’s lovemaking with Angie is judgmentally rendered by Mims: “Their eyes were like the only four red vents they had to breathe through. Under Robert was not a boy he was so seriously fucking in the bum, but a person distinctly Angie-like. Yes. Mine, ours, her, it, us. Them. Doing this. He’s the tops, she’s bottom-feeding, really truly getting it. On all fours beneath him, she was stuck in some doghouse” (222). The couple is machine-like, operating in some fiery cauldron of their own lust. The diction is curt, hurt, a series of snapshots recording a dog-like interlude. Robert, in the narrator’s least charitable descriptions, pursues pleasure at the cost of people’s lives and is turned into an object “only all of beef” (222). According to Mims, Robert’s surface beauty conceals a moral vacuity; his erotic interactions are rotten at their core. In this scene, as in many others, Mims misses no opportunity to hit Robert where it hurts, at the root of his very life-force.

Much of the text becomes a sustained mockery of Robert, and eventually Mims punishes “the Saint” for his sexuality with nothing less than death. Although sexuality and erotic creativity are intertwined as constructions that inform the subjectivity of Robert, they are dismissed by Mims as an undesirable, unattractive, and ultimately deadly engagements with gross corporeality. Of course, such representations of Robert’s sexuality must be read beside the fact that Mims deeply desires Robert—that Robert’s beauty, his spirit, and his charms all serve as muses for Mims. And it is also Robert’s scintillating performance of personality that captures the “love” of Mims: when Robert becomes sick, the elements of both his physical and psychological attractiveness begin to disappear. Mims' caring is highly conditional, resting as it does upon the health and vigor
of Robert, and disappearing into contempt as Mims contemplates Robert’s illness and supposed sexual transgressions.

By turns condemnatory and emotionally-over-invested— with no consistently caring orientation to even out its responses—the narrative returns repeatedly to the central “act of betrayal” (the affair between Angie and Robert) as a moment of narrative restructuring that leads to Angie’s contraction of the HIV virus, as well as one more opportunity for Mims to offer a moralizing agenda. In the “After” of the “Before and After” period, the reader is made to understand that there is no turning back from that place of betrayal and the consequent physical and moral “downfall” of the characters. But in this portrayal of the sexual relationship of Angie and Robert, the text (and the narrator) are disingenuous: the entire novel has been a set-up for this particular sexual interaction. One consistently-identifiable motive behind the artistic interactions Mims has with Alabama and Robert is sublimated sexuality. Mims has set up the initial meeting between the two, and the element of attraction is immediate:

And when she saw him first, saw him even from outdoors, even through the big unwashed window of Ossorio’s, saw all six blond caramelized feet of him, saw him gesturing and listening, saw his boots up on the radiator, slung near the trim older man, Angie jabbed glass with her paint-stained index fingertip, not bothering to look back at me, “That one. That one, hunh? Hmm. Hartley Mims, you do have an eye. I mean, for my eye.—Shall we have him wrapped to go or both just eat him here?” (56)

Mims’ deepest fear (that Angie will sexually appropriate “his” Robert) has also been his deepest desire. The pain that Mims exhibits upon the fruition of this fear has been courted throughout the text; he has fed on it as a source of artistic stimulation. Angie is never subtle in her hints about Robert, and Mims has listened to the confession of her deepest
desires for the future: “By then, see, we’re the darlingest, most sought-after, hottest, talent-on-talent couple in town. And our Robert (now mainly my Robert, I fear. Can ya cope?) adores me and eats my pussy as his three squares daily and I am so like fused with him” (96).

In other words, Mims’ libido, primed by the three-way sexual interest which has always been an element of their “quorum,” as he calls the three of them (301), keeps him writing. Sex never is the point for Mims: stimulating his sexual energies and transmuting those energies into art is. The sexual dramas and the tenor of betrayal around him give him something to write about; his frustrated sexual energies give him something to write with. Mims’ adherence to his self-imposed normative sexual directives becomes a stance integral to both the narrative line of Plays Well With Others, and to the generation of frustrated sexual tension that sustains the energy of his narrative voice. When the betrayal comes, Mims is all-too-ready with his artisistic revenge. But it is Mims who serves as a foot soldier of their romance, pulling himself out of the emotional triangle at crucial moments and encouraging the attraction between Robert and Angie, even as he plays the “innocent” and “moral” agent in their midst. Ultimately, Mims has been the one to put Robert and Angie together for the sole purpose of sitting on the outside observing them and writing about them. So who, then, is enacting the betrayal of his friends and his professed “caring” for them?

Mims’ position as an outsider in the triangle allows him to station himself as the normalizing force at the site of illness. For while Angie nurtures the visual and experimental elements of her aesthetic approach, and while Robert has the sheer beauty of his music, Mims has only the human drama supplied by the interactions of those around

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him. He must appear to be in the game at the same time as he has one foot out of it, betraying his friends even as he appears to be making them immortal through his writing. But his festering critiques, his professional jealously, and his sexual Puritanism have all combined to create him as a narrator who is anything but a charitable, or even objective, observer. Mims’ emotionally corroded subject position is understandable: his artistry does not come as easily; his artistic success is less dazzling than either Robert’s or Angie’s; he cannot make a splash, reveal a brilliant piece of music, or whip the covering off of a canvas to gasps of approval from his audience. In a sense, his performance goes unnoticed, and he often feels as if he is unseen, as well. He, for his part, is constantly forced to watch the performances of others, without feeling as if his own performances are attention-capturing. Understandably, then, at the end of the narrative, Mims creates a vision of heaven through his writing as a place of inclusion—where all are welcomed into open arms, open sexual orifices, and scintillating conversation that will never end. Heaven is the state of being sated and accepted and listened to—ultimately, an exemplary caring space.

But even as Mims desires that acceptance, he is not willing to extend it. As Robert is dying, for example, Mims leaves us with a final devastating character analysis of him. This description is a revenge taking, a betrayal so complete that it puts an indelible stamp on Robert’s character through a narrative hit-and-run: “The less he said, the more intricate and interminable his looks became. By the end, he was transmitting through those eyes. For the first time ever I read ‘Bored’ there. That shocked me more than his sickness. What if I was now seeing through to the primer coat? What if Bored has been there, basic, all along?” (304). Under Mims’ pen stroke, Robert’s life becomes dedicated to holding meaninglessness at bay, and the “meaning” his life does have becomes a superficial
attempt to keep himself entertained. In this representational act, Mims appoints himself the storyteller of their little group, only to seize the power to define their characters (negatively), and to relate their story (to his seeming advantage). In the end, it is *his* art that survives, and *his* vision that remains. And that vision is a betrayal of the people he has sworn to love and protect, even as it becomes an account of their sexual betrayal and “physical downfall.”

Furthermore, Mims is the one in whom the others place their absolute trust, since he appears to be the exemplar of integrity. Before she dies, Angie asks, “We played so hard so well together. What happened to us?” “Not a clue,” Mims responds. Angie then hands him complete representational responsibility: “Well, get one. Because, Hart? You figure you can make something out of it? Our all ending up like this?” Angie does not know the nature of the hands into which she has placed the responsibility of her memorial, but “Hart,” whose heart is hardly in the right place, stands with faux humility as the wolf in sheep’s clothing: “Yeah. Slow learner, but he learns” (332). The threatening echoes in his promise to create a lasting memorial are clear, and his need for a personal memorial to himself is contained within these echoes.

Perhaps not surprisingly, the betrayal that Mims has played a large role in orchestrating also leads to a requisite reconciliation between the three friends just before Robert’s death. Although the reconciliation might make way for a rupture in the text’s normalizing rhetoric, we find instead a forceful re-inscription of that rhetoric in a way that precludes an ethics of care. The reconciliation takes the form of a modified menage-a-trois in Robert’s hospital bed: “There came a moment about twelve minutes into our threeway when it really could’ve happened. Everything. Something. Groping each other, we found
each other at least technically ready. Lowering my hand over Robert’s hard dick, unshrunken, Oh Death, where is thy shrinkwrap—the very act put me into such a sweet fraternity-sorority. Membership in the collective love of him, that, as much as anything, was what I’d mainly wanted” (301). The representation of the reconciliation obscure readers from the fact that we are still enmeshed in a continuation of the narrator’s creation of “little scenes.” Hartley Mims is not breaking new emotional ground of fraternity or intimacy in that hospital bed; he is enacting his old narrative habit of finding fodder to write about. As readers, we are led into a narrative endgame that recounts the narrator’s concern for his own representational control of their “three way.” Even in the sexual descriptions, Robert’s physical existence is incidental to the action: “We all touched each other all over each other. As for his ID bracelet, these little clips and nodules and lines tea-potting off him, she and I, we learned to work (and to play) around them” (301). Passively positioned as a silent “tea pot,” Robert is also “worked around” by the text. Since the context for ethical caring in that hospital bed takes place at the site of truncated eroticism, Mims retains his safe place of unconsummated interaction, even as he continues to beg for the protective layer of “Death’s shrinkwrap.” But Mims, although emotionally manipulative, is not necessarily emotionally invested—a dynamic which will be explored in the next section.

**Affective Detachment in Acts of “Artistry”**

The fact that Mims’ betrayal of Angie and Robert takes place through the medium of writing is in keeping with the fact that a large portion of the text is about the power of a socially-constructed notions of artistic production, particularly as those notions manifest
within a 21st-century context. The representations within the text frequently foster a hyper-real emotional simulacrum as defined by Frederic Jameson in *The Cultural Logic of Late Capitalism*: “…this is not to say that the cultural products of the postmodern era are utterly devoid of feeling, but rather that such feelings—which it may be better and more accurate following J.F. Lyotard to call ‘intensities,’ are now free-floating and impersonal and tend to be dominated by a peculiar kind of euphoria” (16). The emotions shared between the characters in this text do take on a certain impersonal, or at least unsentimental, flavor—and the entire tone of the novel is marked by a pervasive and puzzling euphoria. Dancing fast, so that the actualities of the situations are not fully revealed, the characters move from creative high to creative high, skating on the thin ice of sublimated sexuality and histrionic emotionalism. But the “emotions” shared between the characters also suggest something about their lack of a capacity for an ethics of care. In the course of the hospital bed scene, the reader achieves no sense of Robert as an individual: he exists as a central pole (literally) of a sexual quorum, instead of as an individual with whom one might share intimacy. Mims’s refusal to approach Robert as anything but an over-regarded artist, a pretty face, and an example of wasted potential is sustained by the calculated set of representations that the novel applies to Robert.

The role of the artist-narrator offers another method of indirect representation, sneaking a normalizing agenda in the back door while the reader is dazzled with glitzy stylization at the front. This is a story stacked with representations which are so contrived and so excessively descriptive that it begins to erase the patient, the illness, and most potential for a caring ethic. Mims may seem to be gathering his friends towards him for the sake of intimacy, but clearly he is a spy in the house of both fraternal and erotic love. As I
have suggested, the foundation upon which his own subjectivity rests is derived from his position as outsider who retains the power of representation for the events that occur at the site of illness. Not that this is a startling observation about the nature of the artist, but the fact that Mims’ characterizes himself as so straightforward, as it were, makes the complexity of his character unexpected.

For Mims, in *Plays Well With Others*, the aestheticization of illness, and his self-representation as “artist” in an environment of illness, manifests itself in a compulsive drive to tell and retell at many points in the text. Illness and its effects are conveyed by a repetitive representational pattern that serves an emotionally-protective function and makes an entire level of emotional engagement unavailable to the reader. For instance, in the process of the narrative’s development, what began as the narrator’s address book full of friends who have passed away becomes a novel, expanded exponentially in the drive to interpret “what has happened.” *Plays Well With Others* is the record of a manic “adding to” as it becomes part of the descriptions of the clinic, and the structure of the novel reiterates this process of visual accretion and accumulation. We must also make note of the visual, as well as the repetitive aspects, of the representations here.

This is a story told in characteristically sight-centered language at the site of illness as Foucault defines that language in *The Birth of the Clinic*, a language that is a formative of illness narration, constitutive of narratorial identity, and normatively ruled by the dictates of scopic perception:

The descriptive act is, by right, a “seizure of being,” and, inversely, being does not appear in symptomatic and therefore essential manifestations without offering itself to the mastery of a language that is the very speech of things. In the medicine of species, the nature of a disease and its
The connection between visual art as it exists on canvas, and words as they exist to reify illness phenomena, is thus suggested by Foucault’s emphasis on the “seizure and stabilizing mastery” of narratives of illness. As Foucault further argues, illness is the site at which the “perceptual act” and the “elements of language” are consolidated into parallel and disciplinary relations.

In keeping with this scopically-inflected language, Gurganus tells one interviewer that “A certain kind of piling up of detail, a certain visual gluttony is a part of my style and part of what people read me for” (<http://www.identitytheory.com>). But it is this “piling up” of detail that keeps the reader focused on the spectacle of the body, on what should comprise a “normal” physicality, and on the surface images which prevent a deeper and potentially more caring awareness of another’s physicality. The fact that Gurganus’s images are often intended to be excessively rendered and grotesquely repeated becomes just another way of inculcating an anti-eroticism designed to serve a normalizing function—and it is an stylizing approach that Gurganus’s characters employ as well. Such inculcation often occurs at specific clinical sites. For example, in the liminal space of a venereal disease waiting room clinic, Angie rapidly improvises an informal mural. This mural is a hyperbolic and anti-erotic crotch drawing, one which emerges slowly and nauseatingly as an entire waiting room watches:

Soon a yellow structure, like concentric rinds of a pumpkin, emerged, parenthesizing the telephone. Her yellow marker
on coral paint gave off a pumpkin’s pinky orange that exuded power and, soon, an odd well-being. We all slowly saw—since half the bored waiting room had now begun to look her way—that these were huge yellow legs she’d started drawing. Drawn from the waist down, open legs, a giant’s, welcoming. Crosshatching, she soon created a roof of potent guardian thighs around atop this very telephone. She did it unconsciously, head tilting side to side, her conversation unabated….This was like watching another person daydream, but in a thousand nervous yellow lines. (50)

The fact that emotion—nervousness and anxiety—are displaced into the “yellow lines” that exude both the “power and well-being” of Angie’s drawing is a pattern played forward into many of the descriptions within the text. A range of feeling states, from desolation, to euphoria, to bewilderment, is expressed through diverse and repetitively occurring physical media.

Mims’ moments of displacing emotion into aestheticized objects accumulate. The aestheticized account of Robert’s dildoes externalizes the chaotic interiority of an overwhelmed narrator: “They were piled knee-high, like cordwood. Propped, bald, ridged, and spired. Set on end, they formed a little onion-domed Kremlin…Clumped there, the dildo quorum appeared unionized yet disgruntled” (9). When the cowboy pajamas that Angie and Mims purchase to make Robert feel stylish and distinct within the hospital suddenly appear on all of the patients on Robert’s ward, the poignancy of his restricted freedom and anonymity is summed up by the pajama’s frequently repeated fabric pattern. The narrator’s own self-description is as an aesthetic alchemist, altering the physical universe through ritualized repetition: “By now, my newest address book (maroon leather) is as big a Merlin’s cookbook… My address book often seems to me the best book I’ve ever written. Certainly it contains the most complicated characters. Surely it’s the work in
progress longest. Draft after draft, you revise and shape your ideal tome” (46). As readers, Mims directs us into a scopic universe of reiterating copies, neatly formed and aesthetically fascinating, but far from a sense of embodiment, of erotic engagement, or of shared suffering with those who are ill.19

This general definition of the narrator’s subjectivity as comprised of a highly aestheticizing drive is accompanied by a consistent objectification of the body in *Plays Well With Others*. In one instance, the mark of Robert’s Kaposi’s sarcoma is detailed in such imagistic, poetic language that it becomes difficult for the reader to view Robert as anything but a vision of spoiled beauty: “[I] slowly fixed upon what my over-stimulated eyes had found before my mind quite did. Four inches from Robert’s wrist, indentation, a mark no bigger than a tuxedo shirt stud. His skin had sort of sunk in there, like the purposeful perforation atop some bisque salt-cellar. Indented, tinged and angered purple-red-black new to me, this was not a scratch, not quite a bruise” (209). Robert’s health, in a sense, is made available to a scopic assessment and appropriation, leaving both narrator and reader free to diagnose, to judge, to criticize, and then to distance themselves from an empathetic sense of Robert’s body. This distancing is made possible by the subject position of the artist’s discerning eye—cognizant of color and light and shadows—instead of through a sense of intimate or embodied understanding that a reader might share with him. We, as readers, join the artist in the full pleasure of aesthetic appropriation, gazing in the same direction as the narrator, encouraged to direct our attention towards a disturbance of skin instead of occupying that skin. The fact that this mode of perception permits an emotional detachment, allowing the equation of a life-altering lesion with a “tuxedo shirt stud,” is not flagged by the text. Nor is the fact that
the lesion is described as purposeful (serving whose purpose?) or that it seems to be an inanimate aberration, disturbing a statue-like “bisque” perfection. In short, the reader may temporarily forget that she is looking at the living body of Robert.

For the most part in *Plays Well with Others*, the term “HIV/AIDS” is never used explicitly, but is referenced only in indirect allusions such as the Robert’s unnamed Kaposi’s sarcoma lesion. These indirect allusions fulfill an additional function—that of creating a montage of implicit, fragmented, and intensely-rendered images. This landscape of images exemplifies Fredric Jameson’s notion of the “hysterical sublime”: “The world… momentarily loses its depth and threatens to become a glossy skin, a stereoscopic illusion, a rush of filmic image without density” (qtd. in Dellamora 131). Robert’s lesion, the gathering of cowboy pajamas, and Alabama’s crotch drawing form some of the elements of the landscape of this hysterical sublime. With it, they create a narrator’s coldly surveying eye and subject position of flattened affect. These hyperreal aesthetic instances are used to frame the narrative just as purposefully as Angie’s highlighter frames the telephone; the drawing serves as a metaphor for the entire novel—lines spreading outwards, accumulating mass with an obsessive drive, creating a surface illusion of glossy wit designed to lighten the serious pallor of the site, with an artist behind it all—in full representational control of the events within.20 Yet, as I mentioned briefly at the beginning of this chapter, there are examples of narrators who loosen their hold on the reins of representational control. In other words, to aesthetically render a portrait of illness is not always to narratively distance oneself from it. We might ask, then, what representational choices form the crucial differences between those narrators who represent illness “in more caring ways” and those who represent illness with less narrative care?
We may start to answer that question by looking at another text which concerns a caretaker’s narration of the progression of HIV/AIDS—Mark Doty’s *Heaven’s Coast*.

Mark Doty’s *Heaven’s Coast* is an autobiographical account of the death of Doty’s life partner, and serves as an explicit narrative of the impact of the virus itself. The narrative account includes in-depth descriptions of the ways in which life changes for Doty and his partner, Wally Roberts, as Wally becomes increasingly ill. Passages describing the inexorable nature of Wally’s illness (and the rage the two men share in the face of it) exist alongside the descriptions of the evolution of their love at the end of Wally’s life. To characterize *Heaven’s Coast* as a writerly text, with a writerly case to make, is an understatement. But the text also illustrates a self-defined artistic responsibility: Doty’s self-expectation that he will construct a fluid and mutable record of events within the context of illness. Although Doty also positions himself as “Artist,” he sees himself as working within the text comprised of the HIV-virus, as the virus becomes a sort of antithesis of the written word: “The virus seemed to me, first, like a kind of solvent which dissolved the future, our future, a little at a time. It was like a dark stain, a floating, inky transparency hovering over Wally’s body, and its intention was to erase the time ahead of us, to make that time, each day, a little smaller” (2). As opposed to ink which can render permanency to a life, and a degree of immortality to Doty’s narrative, the virus moves forth, whiting out both memories and lives.

The fluidity and mutability of the representations Doty creates foster a felt sense, an embodied sense, of the rhetoric itself. In a way that is tangible and communicates care for the body, Doty’s is a rhetoric designed to be taken into the reader. This representational mutability has a variety of features, including the capacity to alter the sense of temporality
itself at the site of illness. Representations of the virus are also used to expand a sense of space in a landscape where perspective telescopes inwards as Wally is dying. “I mix my metaphors with abandon,” Doty writes, “because I am talking near the edge of the unsayable, at the difficult intersection of what I can feel but barely say. Wally is in my body; my body is in this text; this text is light on my computer screen, electronic impulses, soon to be print, soon to be in the reader’s body, yours—remembered or forgotten, picked up or set aside, it nonetheless acquires a strange kind of physical permanence…” (9).

Although this textual body is still just small symbols upon paper, the narrative makes a tentative and asymptotic approach towards acknowledging a narratorial and readerly sense of embodiment.

Doty does not use his narrative in a thoughtless externalization of interior experience, a classic reach for catharsis, or a cleansing emotional purge. The discourse surrounding illness, here, is pushed into a definitionally-liminal space between text and body, animate and inanimate, life and death—and out of the bounds of some of the aesthetic protections we have been exploring. Doty is on the verge of a different aesthetic effect: an attempt to transform the experience of a partner’s death into one’s own, to incorporate the experience of death into his own body. Like Raphael Campo’s imagined sharing of blood and breath, Doty takes his partner’s illness and death into himself in a visceral way, and asks the reader to do the same.

These acts of intimacy—breathing in the other, absorbing their essence at the moment of death, staying still and receptive in the face of life’s passing—are all representations that might begin to serve and inform a caring ethic. Doty’s narrative is an example of being “for” one who is ill or dying, and even of the intimate movement of the
experience of illness, through writing, into a healthy narrator’s body. At this point, we must consider what it would mean for the subject position of the narrator if he were writing with an awareness of the threat of his own death—the refusal to maintain the strict dichotomy of self and other within the structuring, categorizing and describing of illness. What would it mean to empathize with someone who is dying, as one simultaneously watches for such potential places of entry into narrating the process of the Other’s death? How extensively and how comfortably could the artist and the reader engage with the person who is ill as they become intimate with the very possibility most HIV/AIDS narratives forestall: the destruction or destabilization of a given subject position through death and the loss of control inherent in illness?

I am not arguing that each and every HIV/AIDS narrative would illustrate a single (or even similar) ethics of care, but instead that a narrator’s continual self-construction as a stylizing and aesthetically engaged narrator begins to undermine most opportunities for a caring narrative. Verghese, for example, attempts to “tell a good story” even when it means the sacrifice of some of the most significant moments of the narrative: the acknowledgement of a patient’s real suffering, the journey towards death, or naked self-revelation. As a result, My Own Country turns even death into an aestheticized spectacle, at the same time as hyperbole turns death into the performative practice of: “blood flying everywhere, the chaos and confusion of the rescue squad and emergency room, the paroxysms of coughing” (171). At many points, the subjectivity of the patient is erased in the narrator’s practice of dramatic representation. In contrast, the poet Raphael
Campo offers more layered, subtle, and ultimately more helpful forms of illness representation. Campo’s stance is one of listening—not for an effect he can create—but for a feeling he can externalize:

So-called formal poetry holds the most appeal for me because in it are present the fundamental beating contents of the body at peace: the regularity of the resting brainwave activity in contrast to the disorganized spiking of a seizure, the gentle ebb and flow of breathing, or sobbing, in contrast to the harsh spasmodic cough, the single-voiced, ringing chant of a slogan at an ACT UP rally in contrast to the indecipherable rumblings of an AIDS funding debate on the Senate floor. (qtd. in Howe 27)

This passage does not disparage the ill body, or characterize it as a second-rate machine, or ridicule the uncontrollable nature of its functioning. Campo, as a narrator, listens to the sounds of embodiment, instead of reactively acting upon them; he sits with the body instead of trying to change it to suit his own self-protective project of artistic role-playing. He doesn’t exclusively direct the reader’s focus to the way the body looks or sounds; he doesn’t ridicule the rhythms and spasms of our somatic selves that take place quite outside our expectations, intentions, and control.

The passage of Campo’s quoted above demonstrates not a retreat or a retraction from the events at the site of illness, but an attempted involvement with the events surrounding illness. Thus Campo’s site of illness becomes a space conducive to “partaking,” as Doty writes. This partaking stands in distinct contrast to texts which more actively force the reader to accept a certain representational distance. Campo’s passage, for example, does not contain the elements of emotional resistance we have seen in so many of these narratives. In avoiding such resistance, Campo describes what Mark Doty proposes in *Heaven’s Coast*, when Doty urges that a text become “implicated in another
being, which is always the beginning of wisdom, isn’t it—that involvement which enlarges us, which engages the heart, which takes us out of the routine limitations of the self” (20). 21

Obviously, Doty’s text points to the fact that the relinquishment of a strict and “uncaring” separation between the “artist” and “ill” entails at least a partial relinquishment of moralizing (and thus distancing) representations. But many HIV/AIDS narratives reinforce the moralizing subject position of artist, as that subject position gathers up symbols it finds at the site of illness and uses them to reinforce the text’s version of “right and wrong.” In specific instances of such reinforcement, the materiality of the body itself may be translated into a field of manipulatable symbols, symbols which are made to stand for what is normal, what moral, and what “healthy.” In short, body becomes object, and object becomes subject to pressures to normalize. One consistent use of such representational and symbolic manipulation shows up in Robert Ferro’s novel Second Son, a text where place itself, the notion of a physical home, is consistently mapped onto representations of the ill body striving to master illness. Because of its representations, Second Son might be descriptively placed in the tradition of the restitution narrative: as a home can be renovated, so personal health can be restored. On the surface, the narrative seems like the story of a man struggling to keep the family beach home, against the wishes of the rest of his family members, who want the money from selling it. Beneath the surface, the home becomes a repository for the narrator’s ideas about normalcy.

To the narrator, Mark, who is HIV-positive, the family home is a symbol of continuation, an externalized symbol of invulnerability, even a reason to get up in the morning: “For it was big enough never to be finished, and everything that was done to it—had been done to it—seemed to call up in him a progression of further things, as if it
now itself kept a list for itself, a list far more ambitious than his own” (16). The house, in its “imperfection” and need for renovation, opens itself up to aesthetic control, just as the emerging narrative of Mark’s illness does. The house also becomes, to the narrator, an external indicator of continuation, of “more life,” and of self-efficacy. In a neat displacement of his own convalescent status upon the structure of the house, Mark has dedicated himself to care-taking the home when no one else will. In its position as a symbol for a human who needs caretaking, the house is suggestive of the endless distraction of things that need doing, of an illusive security of ongoing permanence, and of the belief that life can be controlled through the control of one’s environment. The home, even empty, is also a placeholder of the family unit—that ultimately contrived symbol of insular protection. But for Mark, who has become a clinician of the house, this domain supplies what his family does not: a sense of belonging and acceptance, arms that are open, and the ultimate reminder of a family held intact by tradition. In fact, the house becomes a repository of memory in general, since, as Mark says, the “house’s memory…will be here when we are gone” (109).

But beneath the narrative’s surface, the home’s condition (“in need of fixing”) is a displacement of the status of Mark’s own health. As he alters the materiality of the house, he also insures his own identity as the artist in control of a field of representation. While Mark’s family wants to sell the house for the money to supplement the dwindling family resources, Mark stands firm against their pressure. The narrative tension is ratcheted up—mercenary family versus humanitarian caretaker of the home—and the symbolic import of the disregarded house is played out as Mark’s health declines. As the house is shut down for the winter, parallels to a body shutting down in death are clearly drawn:
“awnings down, sprinkler’s drained; porch furniture thinned and stored” (213). The externalization of the struggles of the human body upon an inanimate symbol helps create a subject position for the narrator as an artist-caretaker. The symbolically-functioning house serves both to stand in for a description of the ill body, even as it becomes an object to be fixed and renovated (when Mark’s body cannot be).

The drive to develop the subjectivity of the narrator as artist through the representational manipulation of the actual material landscape surrounding illness is continued in a more pantheistic way in Vance Bourjaily’s *Old Soldier*. Although this novel might be considered a more minor contribution to the collection of HIV/AIDS narratives, it plays out some of the now-familiar representational patterns of longer works, and not always in ways that are helpful or positive. Again, we see the concerted effort to build suspense, and the slow drive of “inevitable decline” after the AIDS diagnosis of the main character’s brother. But this novel, perhaps more than any other, seems to locate the threat of AIDS, as well as the emotional impact of HIV/AIDS, *outside* of an individual human body, and within a highly aestheticized and stylized landscape. Foucault’s “demands and utopias” placed upon the setting of illness are suggested here by a setting of an austere and rocky loneliness, evoking an alienated desolation, and echoing the features of the externalized effects of the virus. In a weird way, the novel attempts to nullify the effects of the HIV virus, globalizing its impact until it is diffused to the point of meaninglessness, writing the disease into the text of the physical earth itself: “Spring, when you lived near the river, was when the lid came off the gray box you’d been living in all winter, and you could see the sky again. Shook loose all sorts of shit in people, animals and birds. Insects. Viruses” (21).
This externalization of the virus, a creation of it as “out there,” beyond any real impact upon the human body, permits this artist-narrator to portray its impact upon the characters as marked by the same distance. When Tommy, the character with AIDS, kills himself (covered in detail by a four-page description which closes the novel), the other characters admire his “consideration” in not making himself a “burden.” And after the novel rests easy in its concluding once-over of Tommy’s life: “He died a clean death, didn’t he?” he is quickly dropped by the novel as both an aesthetic object and a human being. In the end, all of the characters agree that the legacy and best part of Tommy is the son he leaves behind, and once again the value of his human life is packaged, externalized, and dispensed with. Old Soldier also continues some of the homophobic thematic patterns found in other AIDS narratives: the cheap foreshadowing of irreversible decline, the voyeuristic glimpses into the “forbidden” sexuality of Tommy, the large emphasis which is placed upon the smallest gestures of tolerance and acceptance, and the quick dismissal of a man who is never really given his own voice.

Bourjaily’s fictional account of the death of one man’s brother from AIDS is rivaled in its insensitive dismissive approach by the characters in Sarah Schulman’s book People in Trouble. People in Trouble should probably be renamed: People who Capitalize—as we are led through the story of two self-absorbed characters, Kate and Peter, who self-identify as artists, and who locate themselves at a safe and normalized distance from illness through that identification. Kate, who is “trying out” an affair with her young lesbian lover Molly, is also married to Peter, a fellow artist. The husband and wife spend the entire novel trumping up the value of their art (for the diagnosis of social ills, for the classification of social dynamics, and for the cure of social malaise), at the same time as
they attempt to maintain a safe position away from those who might demand a real emotional engagement or demonstrations of care. As visual artists who believe they wield their paintbrushes as tools of social examination, Kate and Peter live out an aesthetic methodology which is unexamined. But as one character says to Kate at the end of the novel, “I’ve read books about the plague, about the Holocaust, about Hiroshima, slavery, apartheid. I have read every novel about AIDS that the publishers can get into the stores and it’s all unsatisfactory in the same way…” It had never occurred to Kate that there were actually novels about AIDS. ‘When a person faces death,’ James said, ‘especially a deliberate, uncalled-for and avoidable death, they only seem to have two reactions. Why me? And I don’t want to die’” (147). People in Trouble leaves the reader with a radical question: if “Why me? And I don’t want to die” comprise the truest utterances of this entire novel as well as central statements of the pandemic, then what justifies the embellished representations that comprise this work as well as many other narratives?

The justification of the subject position of narrator as artist is at stake in the answer to this question, but the threat of destabilizing the identities of these “artistic” characters, of revealing their emptiness to themselves, seems too great to permit a sincere textual engagement with such a question. They, like many narrators who take the stance of the artist in the face of an illness narrative, choose this position for the ways it allows them to distance themselves from the instances of pain that they witness and cause. The novel and its characters state one thesis clearly enough: in a setting which is besieged with AIDS, one is complicitous if one does nothing in the way of social activism. But the actions of these characters undermine their stated ideology through their avoidance of any action—as well as through a refusal of an embodied sense of themselves and their eroticism. Instead,
they channel their “messier” emotions into their highly controlled “artistic” creations, which they are then always free to step away from. In the harshest characterization, these characters don’t care—not about HIV/AIDS, not about each other, and not about their abortive attempts to accomplish anything of artistic value. The novel is a portrait of wasted lives, and the fact that the disingenuous “search for sexual authenticity” takes up a large portion of the narrators’ consciousness is an affront to the more serious issues that confront those who are dying in the novel.

In contrast, to the characters within People in Trouble, Peter Selwyn describes and embodies the sense of “enlargement” that Mark Doty proposes. In his 1980 text, Surviving the Fall, Selwyn sees himself as in the same psychological condition as his patients, and not merely through the lens of his “artistic” identity. Selwyn’s text, like My Own Country, is the story of “an AIDS doctor.” But in place of a heavily-emphasized artistic persona, this narrator offers descriptions of the similarities he bears to his patients: the social barriers he erects (47), the AIDS-phobic impulses that he struggles with, the urges he has to dissociate from his body (48), and of the anesthetizing lures of workaholism as just another addiction. He doesn’t intrude upon his narrative or the stories of his patients, leaving the descriptions at the site of illness unvarnished. This permits him to embody the attitude of “allowing” which is one of hallmarks of an ethics of care. Despite some of its attendant problems (such as the fact that HIV/AIDS only seems to beset interveneous drug users within the book), the text does not fall into a series of the rigid representational patterns that many HIV/AIDS narratives do. Most interestingly, Selwyn’s text argues that
“unprotected sex” is natural and to be expected (there is very little moralizing here). He describes his own unprotected sex with his wife after he believes himself to have become infected with the virus (51).

This narrator is not a distant bystander or detached artist constructing representations of others, and his account is also relatively free of the driving urge to establish a stable or idealized subject position for himself. I quote at length:

Not until I had spent several years around heroin addicts was I able to realize that certain aspects of my work life were very similar to their patterns of addictive behavior: one’s whole life organized around the activity (shooting up or working) to the exclusion of other people and activities; the intense gratification during the activity and the profound letdown once it is over (binge on the drug or writing a grant proposal); the craving of something outside oneself to feel whole and satisfied (obtaining heroin to avoid withdrawal, getting a paper published in the New England Journal of Medicine); and the constant anxiety of being on the edge, just short of being overwhelmed by the constant demands of this all-defining activity, which has taken on a life of its own. (102)

Selwyn addresses the risk of numbing oneself through work, as well as the severing of the connection with others that results from a narrator’s fixation with his own self representation. Selwyn’s writing is self reflective, and his illness narrative portrays the cost of reducing and telescoping his life to the directives of his active obsessions. In the end, this narrator does not give “all for his art,” or sacrifice an emotional understanding of his patients for the sake of maintaining his own representations.

In a similar self-reflective manner, Paul Monette and Edmund White have narrated HIV/AIDS with an eye for the ways in which an artistic subject position might intrude upon an engagement with and narration of illness. In Borrowed Time, Paul Monette has
written an illness narrative which interrogates his tendencies for emotional rigidity during his acts of representation (32), a no-holds-barred descriptions of his own AIDS-phobia (46), instances of his use of the battlefield metaphor (137, 169, 178, 276), and an account of his “pure displacement” of rage at his partner’s illness (186). Perhaps more extensively, Edmund White demonstrates the self-aware subjectivity operating through his representations in his short story, “An Oracle.” Although I will discuss his short story more extensively in the next chapter, “An Oracle” is the narrative of Ray, who is forced to re-conceive of his life and of his subject position as an artist after the death of his partner, George, from AIDS. The narrative is silent on the event of George’s death; Ray serves exclusively as a narrator for his own sickness of self—his lost ability to independently function in the world without simultaneously serving as a performance artist. He is the artist who has constructed himself as a helpless sexual toy: “Ray found it hard to imagine having accumulated so many mannerisms before the dawn of sex, of the sexual need to please, of the staginess sex encourages or the tightly-capped wells of poisoned sexual desire the disappointed must stand guard over” (222).

Because of the character’s emphasis on sexual performativity, his capacity for sexual intimacy is circumscribed, made up of same erotically-tinged yet always distant interactions which form again and again around these artistic caretakers, interactions which are also seen in Verghese’s and Gurganus’s work. In Ray’s clinic of sexual self-construction, however, performance doesn’t wend its way into the very fabric which structures his self, but is instead worn lightly like a piece of decorative clothing. Before making love with a young man from Greece, for example, Ray follows him through the night on foot: “Twice the boy stopped and scented the path—and now he looked like an
Indian brave. Or so Ray thought, smiling at his own way of leafing through his boyhood anthology of erotic fantasies…The boy gave Ray his hand and produced his first real smile, as dazzling as a camel boy’s (a new page in the anthology flipped open)…” (237).

Interestingly, the double displacement of the “boyhood anthology” (sex as a performance of a textual fantasy) has the same superficial and mimetic quality as the constructions of physicality at the site of illness discussed in the previous chapter, incorporating as it does a racist simplification of a person’s being to surface appearances, archetypes, and staged performances. After he has performed as George’s partner and caretaker for so long, Ray’s entire psychological landscape has become a performance, a stage which leads him to a mistreatment of “Otherness,” and which is also couched in terms of a highly aestheticized textuality and sexuality—of a “boyhood analogy of erotic fantasies.” But such contrived sexuality leads to an engagement with authentic emotion and desire as well; the pen becomes penis opening the “tightly capped wells of poisoned sexual desire.” The fact that eroticism, even a highly performed version of it, is a way into the notion of *partaking* in one’s life, as well as a way out of the previous bad-faith actions of a narrator who is performing for his partner, suggests the potential for authenticity offered by narratorial representations which are deployed in a self aware manner.

A reading of the artistic exchange which evolves between two writers about illness suggests just how fully a need to perform and represent at the site of illness can be at odds with the ethical act of listening to the other. To illustrate this failure in communication, we have an example from the collaborative dialogue between two writers, Paul Monette and Carol Muske Dukes, the essay “All Through the Night” emerges. It is Dukes who documents the process of writing a collaborative poem with Paul Monette as the two
fashion their piece through a call-and-response format. As they take turns tailoring their portion of the poem in response to the other’s contribution, they rhetorically delineate a space of illness containing Dukes’ daughter, who is suffering from a summer cold, and Monette’s partner, Roger, who is dying of AIDS-related illnesses. In a theme that is repeated in the text—reiterated beyond the point of insensitivity—Dukes writes: “Paul stared at the thermometer’s red horizon and beyond into a tunnel that narrowed and descended into darkness. Roger would die, there was no hope for him, all of Paul’s patient, tender nursing—all those sleepless nights—would cure nothing” (qtd. Howe 132).

In just this one repeated leifmotif, Dukes seizes all of the chances to voice, analyze, and give definition to Monette’s situation herself, attempting to create herself as understanding mother-figure hero, as well as the “artist” poetically tracing the contours of illness. Her consideration of Paul Monette himself is surprisingly sparse, given the fact that he has written half a poem with her. Instead, the poem is a record of the ways in which Dukes needs to imagine Monette’s experience for him, to define it for him by the light of the “thermometer’s red horizon” and her own need to sustain an artistically-crafted analogy. After the setting has been described, Dukes’ poem goes on to define Monette’s role as caretaker, against his expressed will and wishes. In doing so, she bestows upon him what she believes to be the highest honor in her heterosexual pantheon: granting him the heroic status of “mother” (synonymous with creator) in an affirmation of her own role. In doing so, she demonstrates the urge to establish a vaunted subject position for herself, even if it is on the back of a fellow human being who is experiencing the fallout of illness.

Monette, in his turn, responds to her characterization of him as “mother” with devastating wit: “No. I am not Mrs. Ramsay / nor was asked. / Was further given to understand / this
room would overlook the Spanish Steps” (134). Dukes does wryly note that: “At first he seemed a little resistant to the mother theme” (132). But she is so certain that she has found the moniker he needs that she keeps hammering it home with repeated references to both of their maternal and creative capacities.

More sympathetically, and perhaps more “caringly,” this poem might be read as a projection of the deep need for the security of a parental role on the part of Dukes, of the need for assurance that one’s life goes on in the form of a child, and the stay against death that such an assurance supposedly provides. But the poem itself doesn’t invite such sympathy. Roger is not Monette’s child, and to suggest that this is the nature of their care-taking relationship is reductive, homophobic, and bizarre. Dukes’ poetic contribution seems to grow all the more odd and insensitive as it grows more explicit, such as her references to “the immunological protection breast-feeding is supposed to provide the nursing infant” (135), an “immunological protection” that Roger now lacks. The fact that she sees any connection to be drawn between the protected immune system of the nursing infant, and the compromised immune system of a man with AIDS, reveals a narrator who shows very little capacity for listening, and very little capacity for “suffering for.” In the end, despite the fact that this is purportedly a call-and-response document of exchange and sharing, Dukes does not hear Monette’s requests that she step back from characterizing and assessing his situation for him—focused as she is upon forging her own narratorial role and upon demonstrating the power of her artistry.

When her coup-dé-tâte of “knowing what is best for Paul” comes, she delivers it quickly, publishing their joint poem without his knowledge or consent, and even altering some of his poetic contributions a little bit. He finds out what she has done when he comes
unexpectedly upon his own words in a magazine—but the fact that she has used a narrative bludgeon to violate, control, and categorize someone else’s perceptions does not seem to occur to her. I would argue that the impetus behind her so-called care for Monette is really her own desire to see herself as an artist-by-association. Thomas Couser, in Vulnerable Subjects, observes that “…autobiographical collaborations should be mutually gratifying and maximally egalitarian; neither partner should abuse, exploit, or betray the other…. [All parties] should have the right to audit and edit manuscripts before publication” (36).

Rhetorically, a three-part violation of such narrative care takes place in the poetic exchange between Dukes and Monette (a violation that occurs repeatedly within the clinical portion of HIV/AIDS narratives): 1) the narrative of illness is exploited for the “exciting” aesthetic possibilities inherent in a good-versus-evil conflict, and in a narrative showdown with insurmountable odds; 2) the privacy of self-expression has little sanctity at the site of illness, since the first imperative is that “the story be told”; and 3) the artistic narrator within the context of illness remains free to pull back and retain the spectator’s position of safety.

In contrast to Dukes’ “reality-based” comparison of her daughter’s summer influenza to Roger’s HIV/AIDS, there are examples of the use of stunningly hyperbolic overstatement, most notably in a novel entitled A Cry in the Desert. Jed Bryan’s A Cry in the Desert (1987) is an amalgam of science fiction and HIV/AIDS narrative. As a result, the narrative might be dismissed as unrealistic, were it not for the systematic thoroughness with which it analogizes real threats that have arisen during the HIV/AIDS crisis. The setting is Los Alamos, where “ERAD” (the Emergency Research and Development Program) is set up by a “mad scientist” doctor. Ostensibly, ERAD is designed for the
treatment and research of AIDS. In reality, ERAD is a concentration camp, systematically quarantining all people who are gay. By taking government-administered tests for HIV/AIDS, test subjects unwittingly inject themselves with radioactive markers, and are then tracked down and arrested (95). Within the novel, this full-scale effort at containment has the approval of religious leaders, of politicians, and of the medical establishment.

The majority of the narrative centers upon the narrator, Carl’s, portrayal of his fellow artist-clinician—Alfred Botts—who is represented by the text as “latently gay.” The portrayals of Botts’s sexual pleasures are homophobiaically tinged, and the only explicit sexual descriptions in the book involve the sexual tortures that Botts inflicts upon men. As the novel progresses, Botts’s general attitude of cold hatred becomes increasingly eroticized: “Botts stripped off his paper jumpsuit and joined Carl in the hot spray. Those penetrating snake-steady eyes followed him wherever he went. Carl stole uneasy glances at the body of his nemesis and found it lean and hard, only sparsely patched with long black hair. There was an aching whiteness about the flesh though, that made it seem as cold and sterile as the tile itself. The penis was long and slender with a tiny pointed head, a cock that would become a stiletto upon erection” (198).

Bott’s body is mechanized and begins to stand in as a symbol of ill-intended and even sadistic medical intervention at the site of “care.” But even at points of potential unrealism in this novel, the metaphors, analogies, and over-determinably violent descriptions are combined with elements of effective social analysis. The narrative contains a critique of the logic which says that HIV/AIDS has contributed so much to society, because it has led to the discovery of treatments for other diseases. Even if the novel’s descriptions of the “live subject” experiments seem couched in the unrealistic
terms of torture, the echoes of the same callous disregard have been heard from the conventional medical community, and the novel begins to demonstrate the disciplinary maneuver of medical research’s “autopsy upon the living human being” which Foucault identifies. Although the text itself selects a hyperbolic framework on which to pin its social analysis (and in the process runs the risk of being dismissed out of hand), a closer reading reveals how carefully this novel actually does dismantle many unhelpful narratorial conventions of representation. Political obfuscation, medical hierarchicization, distancing aesthetics, and the search for the safe circle of family are all critiqued here. Even the equanimity and comfort of the quiescent and “enlightened” Eastern religions is open for interrogation, as it comes through Alfred Botts paraphrasing of The Upanishads: “Life is the ultimate curse; death the supreme gift” (224). The text allows itself one solace, one “out,”—and that saving grace is well-used language. Even if that solace is naively self-serving, it is also a well-intended ending to the novel: “Words will save us if anything can,” said Carl. “Feeling them, saying them over and over until we are capable of acting on them” (234). Instead of creating an impressively-stylized text, this rather clumsy framework of an illness narrative permits the “saying” of words that foster emotion and encourage the “feeling” of the narratives they construct. Many texts which have received more air time in representing the pandemic are laden with much more insidious representations, much less “innocent” motives, and much less advocatory aims.

The Clinician and the Artist: Vexing Similarities

In the act of naming what has not yet been named, in the attempt to characterize a disease phenomenon which hasn’t “happened before,” the artist relies heavily on the scopic.
The clinician’s eye and the artist’s eye, according to Foucault in *The Birth of the Clinic*, are very much alike—taking in the hard surfaces, content to stop at that most superficial of level of engagement with illness and with those who are affected by it: “… offering the grain of things as the first face of truth, with their colors, their spots, their hardness, their adherence. The breadth of the experiment seems to be identified with the domain of the careful gaze, and of an empirical vigilance receptive only to the evidence of visible contents” (xiii). And when the “first face of truth” is read in lesions, in hair or weight loss, in the coloring of the skin, in all the possibilities of surface assessments, in all of the scopically-consumable trappings of our bodies, the biographies of our skin are indeed incomplete. But these biographies and their representations give the illusion of being the “whole story” of illness—of being the photographs which are worth a thousand words in an economy of narrative tactics.

Through sight, runs Foucault’s logic in *The Birth of the Clinic*, one gains a totalizing omnipotence, and thus the narrator as artist assumes the ability to create another human being’s essence through descriptive representation:

The gaze is no longer reductive, it is, rather, that which establishes the individual in his irreducible quality. And thus it becomes possible to organize a rational language around it. Clinical experience—that opening up of the concrete individual, for the first time in Western history, to the language of rationality…was soon taken as a simple, unconceptualized confrontation of a gaze and a face, or a glance and a silent body. (xv)

Interestingly, the representational features which arise when the narrator acts as artist become the ones in circulation when the narrator acts as prophet. Many of these highly aestheticized texts are also prophetic texts, in the sense that they are invested in having
their representations become transcendent and authoritarian messages from the site of illness. Such texts are simultaneously paeans to artistic representation and mechanisms for delivering “The Word from On High,” as I will argue in the next chapter.
Although many HIV/AIDS narratives incorporate religious notions, images and symbols in the course of constructing their representations (turning the narrators into prophets and the site of illness into heaven or church), *Plays Well With Others* ends with a particularly pungent example of the language of religiosity. As we see, the culmination of all the pain and struggle of life on earth is the reward of an endlessly discursive and gloriously lingual heaven:

The roar you will be hearing intermittently forever is called Euphoria. You’ll learn to tamp it back a bit should it ever interfere with The Conversation. Nothing must ever obscure one glorious word of that, our communal enterprise: The Conversation, our highest form of folk art. Cerebral, circular, sexual, musical, celestial—you have just arrived midsentence at the longest dormitory bull session on record. *(Epilogue 4-5)*

At the end of Guranus’s highly stylized text, it is religious/aesthetic engagement in a heavenly conversation, and not physical eroticism, that becomes the representation of utopian communion.

Similarly, a great deal of human interaction in *Angels in America* takes place within heavenly territory, where religious imagery quickly becomes a matter of serious representational impact. According to the stage directions for the angelic visitations, for
example, the part of the angel should be played with dignity and earnestness (*Perestroika* 35-36), to offset the natural audience tendency to laugh at the idea of such visitations. When we reach the religious and prophetic dimensions of *And the Band Played On*, any nods towards humor have been erased, and the business of prophesy becomes a real and sustained aspect of the text’s representations. To provide a contrast, I also look at Dale Peck’s *Martin and John* (a post-modern narration of simultaneously being HIV-positive and caretaking another who has AIDS) a text in which religious diction becomes the vehicle by which gestures are made towards a caring stance, even while those gestures may present obstacles to a sustainable ethics of care. I also look at the desire for prophets, the needs they fulfill, and the promises they hold out at the site of illness.

In this chapter, I argue that the representations within many HIV/AIDS narratives are couched in a subtle but distinctly religious language, a language that emerges out of the self-stylized prophetic voice of the narrator, particularly within *And the Band Played On*. I examine the features of such a voice, largely through its presence in Shilts’s text, and I look at how an embodied prophet might lead to a more holistic and contextually-based caring ethic. Furthermore, I suggest that both the undefinable characteristics of the pandemic and the public’s need for comforting guidance from “higher authorities” create conditions conducive to prophetic personae. But prophetic speech acts of foretelling the future and issuing warnings in the face of illness also become representational devices which lead many narrators to control their narratives tightly—by sustaining an aloof prophetic voice, a position of omnipotence, or religious-rhetorical flourishes. This chapter examines the ways in which the attempt to occupy a position of prophetic narratorial omniscience often takes precedence over concerted gestures of care, as “care” is defined by Levinas as 1) a
face-to-face encounter with the Other, and 2) the attempt to fully situate oneself as the Other. I will argue that if a prophetic voice is not used judiciously, if it is made to be more important than the person from whom it issues, then a variety of uncaring narrative elements arise.

First, within *And the Band Played On*, the prophet is a hero who is predictably stylized along religious lines. In a most general definition, derived from Jewish, Christian, Islamic, and even Buddhic formulations, a prophet communicates divine will from a higher plane beyond physical existence, sees into the future to warn the world of coming events, and calls for the immoral to repent. The narrative voice in *And the Band* contains just such archetypal prophetic features: the alienated prophetic presence—soothsaying, delivering moral edicts, and foretelling of doom—issuing from the text’s primary narrator (Shilts himself), as well as from a secondary narrator, playwright Larry Kramer. These two voices, working in tandem, suggest that anything but a politically-active approach and a sexually-restrictive rhetoric is essentially an abandonment of the interests of people with AIDS. An example early in the text begins the circulation of this refrain—as one doctor’s thought processes (incorporating prophetic warnings of doom) are used to critique examples of the “wrong” type of political activism, the dire conditions which will result from it, and the contrasting normalcy which Shilts believes should be present in the context of advocacy:

Ostrow grimaced as the Sisters of Perpetual Indulgence sashayed by. The sight rankled his Midwestern sensibilities. This was all too weird, he thought. The media would play up the open display of sexuality and once again drag queens and half-naked muscle boys would be presented as the emblems of homosexual culture. People like Ostrow, who leaned toward the long, steady relationships, would never
get the press. The bizarre, it seemed, would always overshadow the positive things going on in the gay community, like the doctor’s conference. Doctors weren’t flamboyant enough to get the headlines. They were barely mentioned in the gay newspapers, counting themselves lucky to make it a page ahead of the gossip about the hottest gay leather bar. (18)

The subtext of this passage, with Ostrow serving as a grim-faced but textually-endorsed commentator, is clear: in fulfilling ourselves as subjects with erotic celebration, we have failed morally, and now it is time to pay the bill by becoming politically, rather than sexually, active.

In advocating for monogamy, in criticizing a tenor of “flamboyance,” and in a wide-scale critique of “the gay community,” Shilts formulates a statement of the condemnatory ideology that Lee Edelman sums up neatly in “The Mirror and The Tank”: “In the mirror of ‘AIDS’ the erotic abandon, the luxurious collapse into the ‘black hole’ of desire, must give way, depending on the stripe of the narrative, to death, as the recognition of the wages of sin; to monogamy, as a recognition of the immaturity of ‘promiscuity’; or to ‘activism,’ as a recognition of the political folly of defining gay identity through sexuality alone” (qtd. in Murphy 32). The fact that this view attempts to subvert a particular type of political activism as well to undermine erotic engagement with its righteous and punitive undertones is clearly embedded in *And the Band Played On*’s language of prophesy and rhetoric of religiosity.22

The narrator of *And the Band Played On* is consistently invested in painting a picture of a place and time before “AIDS” (frequently configured as “Edenic”) and then subjecting that place to the desolation of a fall from grace—and he is not alone in constructing this narrative set up. Shilts uses religious language to underscore what he
takes to be the “moral ramifications” of The Fall, attempting to make the case that a
“questionable lifestyle” has been subdued by a force of disintegration and viral mayhem.
In Gurganus's *Plays Well With Others*, the “Before and After” trope is linked to and
sustained by the novel’s central metaphor of mayhem: the sinking of *The Titanic*. In both
texts, characters are represented as paying for “indulgent lifestyles” and fulfilled desires
with their death. Thus, the “Before and After” configuration comes with an accompanying
set of descriptors: “Before” is equated with innocence, health, and irresponsibility.
“After” is defined in terms of jadedness, sickness, and also “irresponsibility.” All three of
these texts, *And the Band Played On, Plays Well With Others*, and *My Own Country*, hint at
a Biblically-metaphorical Fall ushered in by “age of self-absorption,” as prophetic voices
attempt to warn of impending cataclysmic consequences. Or, as *And the Band Played On*
so patronizingly puts it in terms of foretold catastrophe:

> It was as if *these people* [emphasis mine], who had been
> made so separate from society by virtue of their sexuality,
> were now making their sexuality utterly separate from
> themselves. Their bodies were tools through which they
> could experience physical sensation. The complete focus on
> the physical aspect of sex meant constantly devising new,
> more extreme sexual acts because the experience relied on
> heightened sensory rather than emotional stimulation. (24)

Andrew Holleran critiques such stances against sexuality more satirically in *Ground Zero*:

“In the old days weren’t we the first to shatter the oppressive Makeup Myth by telling you,
quite simply, there is no chemical in all of Estée Lauder, Max Factor or Clinique’s
bottomless vats to compare with the GLOW a really marvelous, time-consuming,
no-holds-barred midafternoon *you-know-what* could give you. That’s all over now!
Makeup ’85 is the VERY LITTLE SEX glow” (138). Yet Shilts’s judgmental tone, and not Holleran’s identification of what has been lost, remains the opinion in widest circulation.

In fact, foretelling the future and delivering dire warnings in prophetic terms become narratorial moves employed at many junctures of And the Band Played On: psychics deliver diagnoses of toxoplasmosis, writers deliver portentous warnings of death, doctors become priests who peer into a dim future. This landscape of prophesy is surprising, considering that the narrator portrays the text as “a work of journalism. There has been no fictionalization” (607), as well as the fact that science and “objective reporting” form the ostensible framework of the narrative. Yet, “religious rhetoric” is often found hand-in-hand with more “scientific rhetoric,” as if to point up the aspects of the drier and more technical language of science. At points, even the language of science itself engages in the business of forging a suspenseful prophetic tone: “The different epidemiological trails AIDS was blazing led the small group of people involved in its research to one conclusion: this thing was getting much bigger. Moreover, the spread among such diverse elements of the population meant it was going to get much, much worse before it got even slightly better” (189). Epidemiological studies become explicitly configured as a crystal ball into which the scientific community gazes to foretell the future of the epidemic, delivering its prophesies in language authoritatively objective. This authoritative language is at the heart of the power of prophetic representation.

If they suggest nothing else, traditional features of prophetic language usage bolster the authority of a narrator who wishes to be heard. That the typical prophet’s responsibility
is to *speak* rather than to listen, begins to work to counter the attendant listening which is required by a caring narrative approach. Indeed, the Hebrew world for prophet (*navi*) is part of a phrase meaning “fruit of the lips”—not “fruit of the ears.” Even though there are exceptions (Moses with the tablets, for example) the prophet’s gifts are usually given through acts of speech. Furthermore, delivering prophesies in a logocentric culture is a way to control both the rhetoric surrounding an event and the outcome of an event. As Karen Taylor reminds us in *The Ethics of Caring*: “Knowing [and, in turn, verbalizing that “knowledge”] is a more subtle way of trying to exert control” in a context that demands non-intrusive acts of care (139). This characterization holds doubly true for prophetic messages that evoke “higher” knowledge or “divine” understanding. Prophets appear at times of great need, and usually speak with a voice from “The Beyond”—warning, foretelling, calling for “right action” (consider Moses, Joseph Smith, even the Oracle of Apollo at Delphi).

Powerful prophets have been seen in an explicitly Judeo-Christian context to appear specifically at times of apocalypse or catastrophe, when people are most frightened and open to directive dictates. The same observation holds true in these narratives: in *Angels in America*, the prophet’s words are recorded in apocalyptic blood: “Whisper into the ear of the World, Prophet, / Wash up red in the tide of its dreams, / And billow bloody words into the sky of sleep” (*Perestroika* 48). Or, as Hannah says about Joseph Smith in his time of desperation: “He had great need of understanding. Our Prophet. His desire made prayer. His prayer made an angel. The angel was real” (*Perestroika* 102). Certain conditions create the unique capacity for insight with which prophets are endowed: in *Angels in America*, for example, Harper becomes a prophet because suffering bestows the
gift of a penetrating kind of insight upon her: “I have terrible powers. I see more than I want to see” (*Perestroika* 51). The play includes the offensive and tired trope of the blind seer, granted greater insight out of physical sightlessness: “I’ve seen the end of things, and having seen, I’m going blind as prophets do” (48). Situations of fierce desire give the characters extra prophetic and transcendent power in other ways as well. They may meet in the astral realm, in their delusions, and in their dreams, just as Verghese himself travels late at night on astral wings: “Some nights, in that fugue state between dreaming and wakefulness, I would float down from my bedroom, drawn to the VA hospital…I hovered near the ceiling in my astral voyage, watching over the pastoral scene, as if my vigil were protective” (231). Wishes are granted in this realm, wishes so fierce that reality can be bent to their sway. In *Angels in America*, Louis finds Harper on the common ground of their dreams, and the two come together out of a loneliness so deep they can transcend even the laws of physics (*Perestroika* 52).

As I have argued previously, because so much uncertainty is present in the narrative landscapes of illness, strong categories, definitions, characterizations and dichotomies are constructed and maintained by the narrators, and this includes the development of a particularly authoritative and “transcendent” prophetic voice of certitude. These categories do not comfortably admit the blurring of boundaries between psychological states, people, science, and imagination, even if such a blurring is a more accurate reflection of reality. Kirby Farrell’s account of trauma, outlined in *Post Traumatic Culture*, includes a definition which is relevant to the HIV/AIDS narratives at hand. He defines personal trauma as inextricably linked to the amorphous nature of cultural crisis in a way which paradoxically frustrates a need for psychological certitude:
The present book crystallized when I realized that what had drawn me to these stories from the end of two centuries—what they all share, suffusing and energizing them, latent and yet formative—was a mood of cultural crisis: a sense that something has gone terribly wrong in the modern world, something that we can neither assimilate nor put right. The mood’s special poignancy comes not only from life’s usual struggles and sorrows, but also from the sense that the ground of experience has been compromised. Implicitly, that is, these are fantasies about trauma. But they are also particular uses of trauma to interpret and adapt to the world… (x)

Farrell also suggests that a sense of cultural crisis may subsume concerns about personal identity or social equity. But quite the opposite consideration seems evident within these HIV/AIDS narratives: the preservation of the narrator’s personal identity at the site of illness takes center stage in the midst of cultural crisis.

Farrell identifies a generalized fear of loss of control (fears of decline, exacerbated by postmodernism’s instability of meaning) as the truly devastating element of a given trauma and one which would motivate a narrator to stabilize his identity by assuming what I would call a prophetic role. As Farrell characterizes his own traumatized psyche: “terror made the world around me feel false and ungrounded, a tissue of interpretations” (xii). The need to counteract this sense of ungroundedness locates the representational strategies of many of these texts at a far distance from considerations of the well-being of the patient, but it helps explain the need for a prophet to define his omniscient role and appear to have foreknowledge of the cataclysmic events which surround him.

In this landscape, a prophet holds out the promise of security to the characters (at the very least he warns them of events to come) and of the promise to strengthen the “tissue” of interpretations that surrounds them. Farrell’s definition of trauma also
identifies the existence of a worldview which coalesces in the midst of a crisis around a key fear: that of death anxiety. In this way, traumatic experience “destabilizes the ground of conventional reality and arouses death anxiety….The problem is not simply a victim’s loss of trust in particular guarantees, but the recognition that no life can be absolutely grounded” (12). Instead of embracing this sense of ungroundedness by portraying lives which are evolving and growing even in the face of death and ego dissolution (in ways that are exemplified in Angels in America), many of these texts attempt to evade the threatening and messy ambiguity of this “ungroundedness” through a variety of representational mechanisms, including a fixed prophetic narratorial persona. Not that I am holding Angels in America up as the only text which “does it right,” or suggesting that it is the only standard-bearer for HIV/AIDS narratives. Instead, I am suggesting that even as popular and as formative as it is as a piece of performance art, it still does more than attempt to meet and sate reader expectations and demands about illness narratives, expectations which arise out of the fear of instability, of death, of loss of control, and of an uncertain future.

The Emotional Gratification of the Narratorial Prophet

When the prophet portrays himself as the narrative agent of “truth” in a landscape of death, horror or cataclysm (and the three are often equated), the reader is promised a deliverance to a position of reassurance and safety. This pattern of reassuring prophesy has precedence within many narrative conventions: Ray finds emotional release in The Oracle. Shilts finds a “grand scheme” in And the Band, and Mims has his worst fears fulfilled in Plays Well With Others. I would suggest that when faced with a story of a prophet, we read to verify that the prophesy is coming true—in the same way that we read an adventure
narrative or a detective story with guiding expectations. Reasons for the text and narrator’s investment in a “prophetic narrative” readily suggest themselves: a) It is a familiar narrative convention; readers know the pattern that is to ensue, and are thus set up as expectant consumers of the text, instead of critical interrogators (we wait eagerly for Ray to find the happiness which eludes him); b) The trope heightens the sense of suspense and momentousness within the text, the sense that we are located in a dire landscape of “exciting reading” (as we race over the landscape of Shilts’s devising); c) The voice heightens the sense of insurmountable odds for the participants within a text (as the gradually accumulating deaths in *Plays Well With Others* suggests); d) The authority of the prophet offers comforting guidance within a landscape that is ill-marked and often frightening (again, the voice that Shilts assumes provides an authoritative certainty); e) The prophet’s voice gives yet another avenue of closure to the narrative: (he has spoken; the matter is decided). But all of these aspects of a prophetic construction are at cross-purposes to the task of relating the narrative of HIV/AIDS with immediacy, accuracy, and the power to inspire both a literal and a narratively-caring treatment of the ill within the text, in ways this chapter will explore.

Within the context of many HIV/AIDS narratives, the prophet’s tale plays itself out in some predictable plotlines: a heightened “sense of suspense”; an account of the narrator’s brush with “insurmountable odds”; an “irreversible decline” paradigm, and an account of the slow and inexorable drift towards death that is aesthetically lingered over and almost savored. As I will explore, these plot lines which accompany the prophetic voice have the potential to lead to uncaring elements within the narrative. In a definition of the first plot line, the narrative pattern of “inevitable decline” is identified by Steven
Krueger, in his work *AIDS Narratives: Gender and Sexuality, Fiction and Science* as a way to portray characters as helpless victims who are pinned by an inevitable textual outcome, and then given up for lost by those narrating their stories. But, as Krueger also points out, this description of irreversible decline is erroneously used as a descriptor of disease within HIV/AIDS narratives: “The ‘decline’ associated with HIV illness is in fact interrupted in many and various ways—by its long and variable latency period and by remissions; [and] by preventative measures and treatments” (74). In actuality, there can be no real prophets in the “Land of Doom,” largely because there is nothing that can be accurately configured as one discrete “event” of doom, and thus claims to prophesy in a landscape of apocalypse and cataclysm cannot be substantiated.

Even if patterns such as the “inevitable decline” and “insurmountable odds” contain inaccurate descriptors of what really happens to people who are ill, that does not stop the narrator from using them in a text like *And the Band*. At the zenith of his prophetic position, Shilts portrays himself as utterly alone, abandoned by the people and institutions he has come to count on most, and cut adrift from the environment that surrounds him. In so doing, he paints a picture of his betrayal by the institutions of medicine, politics, the “gay community,” and even his journalistic cohorts. A similar pattern plays out in other texts as well: upon delivering his prophetic message, Verghese is abandoned by his wife and the structuring safety of his marriage; Gurganus's narrator is abandoned by his circle of friends and his life as he knows it. Then, there is a second installment to this prophetic pattern: the subsequent restructuring of life through the predictive power of the narrator’s prophetic voice. This “comeback” becomes an integral follow-up within the narrative, as readers wait to hear what the prophet’s final, definitive message will be.
Despite the textual paces we may have been put through, the prophetic narrative promises us we will end up on the other side—if not “happily ever after,” then at least intact and “in the know.” The “other side” becomes a narrative space which we as readers may be happy to take illusory refuge in.

The Nature of the Prophetic Voice

To insure that he and his readers arrive at just such a position of safety, Shilts constructs himself, from the beginning of the narrative, as a prophetic-renegade journalist who is up against the world. This apocalyptic world is one that will not respond quickly enough in the face of threat, will not acknowledge the portents of danger, will not try to “solve the mystery” with which it is confronted. In short, this resistant world will not listen to the narrator’s prophesy, and that refrain becomes the discursive dictate of the text: danger will visit those who will not hear and heed the persistent narratorial voice of warning. The heroic voice crying out in the wilderness takes on many guises, and appears at many junctures within the text. This voice is not without justification, as Joseph Cody suggests about And The Band: “Its extensive detail, developed individual portraits, direct statements of moral judgment and accusation, and blunt use of emotional language, often in the form of relentlessly repeated leitmotifs (some of Shilts’s favorites are ‘Nobody cared,’ ‘People weren’t listening,’ and ‘They waited and waited’), all fix the reader’s attention on the outrages in our society’s attitudes toward and treatment of AIDS in the first seven years of the epidemic” (qtd. in Pastore 236).
Yet this refrain appears with particular intensity when Shilts describes Gaetan Dugas, the airline steward and “Patient Zero” who is positioned both as the first man with the disease and as a socio-pathic inflictor of contagion.

Shilts’s portrait of Dugas is an aspect of the narrative which has been thoroughly critiqued by theorists such as Douglas Crimp, for the unjustifiable certitude with which Dugas is characterized, for the inherent homophobia of that characterization, and for the morally-inflected simplicity of pointing the finger of blame at one man. At some points in the text, Dugas’s representation seems nothing more than a platform from which Shilts can construct his own image as the prophet speaking from on high, this time through an expose of Dugas’s “devilish” modus operandi. Shilts’s prophetic voice emerges in other instances as well: in the narrator’s clarion calls for the closing of the bathhouses; in his insistence upon the end to the immoral “promiscuity” within the cities of New York and San Francisco; in his requests for personal donations for AIDS research. In his prophetic rhetorical solitude, Shilts creates an ideological companion for himself: AIDS activist and writer Larry Kramer. Kramer, too, is made to occupy the subject position of the “lonely voice” (a man who speaks out against the “frivolity” of the “promiscuous crowd”), and he remains such a mouthpiece throughout the play. Ultimately, the criticisms the play offers of a highly constructed notion of “the gay community” (a concept the play codifies and then critiques) become another repetitive refrain.

There are many motivations for the narrator to assume a prophetic voice at the site of a particular illness, and many outcomes of those motivations which resound throughout
a text. In the case of *And the Band Played On*: a) Shilts seems to have no sense that his “moral promptings” and his prophetic characterizations might work against his intentions of advocacy, b) he gives the reader no sense of the context into which he is deploying those promptings, and c) he exhibits no understanding that the narratorial voice might arouse resistance or resentment in anyone he is attempting to “warn.” One possible reason for the difficulty Shilts has matching his message to many members of his audience is suggested by Foucault, who identifies some of the representational maneuvering that arises when an unfamiliar illness or series of symptoms is narrativized. According to Foucault, the language through which such an illness is represented takes place under the complex conditions of a “pre-lingual setting.” In this setting, discursive acts arise before words have become separated in our minds from the objects which they describe. In other words, Shilts may be attempting to describe HIV/AIDS at such a formative stage of the pandemic (when what is *seen* and what is *said* are one and the same to him), that the landscape becomes highly prone to solipsistic descriptive collapse.

From this limited vantage point, then, the narrator is compelled to act as prophet, invited by his position as the “one who got there first,” into a logocentric universe in which he has the power to arrange phenomenon, to make proclamations, to render judgments, to foretell the future, and to demonstrate a whole-hearted belief in his own narrative constructs. In this event, narrators cannot distinguish a pathological phenomenon as it exists *outside* of themselves from the descriptions they are beginning to formulate *within*: “In order to determine the moment at which the mutation in discourse took place, we must look beyond its thematic content or its logical modalities to the region where ‘things’ and ‘words’ have not yet been separated, and where—at the most fundamental level of
language—seeing and saying are still one” (Foucault xi). Under the explanation provided by Foucault’s formulation, no narrator can get enough distance from his representations of illness to question the inherent limitations, inappropriateness, or “uncaring nature” of them. Shilts, for example, is fully aware of his position at the representational vanguard of an illness “phenomenon.” He places himself in the prophetic position of naming the illness—even as he traces the iterations of names that were first applied to it (GRID, ARC, AIDS). In many of his representational instances, rushing to the scene to tell the story of HIV/AIDS first, and without any real language in which to do so, he gives himself no time to go back and interrogate his representations.

But Shilts is not the only narrator who configures himself as a prophet in these HIV/AIDS illness narratives, and couches his narratives in religious terminology. Walter Prior also does so in Angels in America: “Maybe I am a prophet. Not just me, all of us who are dying now. Maybe we’ve caught the virus of prophecy…” (Perestroika 48). Even Verghese’s description of inserting a catheter in My Own Country, for example, contains the rhetoric of ritual: “We were always ready—should we be first at a Code Blue—to slide needle under collarbone, into the greater subclavian vein, and then to feed the serpent tubing down the vena cava in a cathartic ritual that established mastery over the human body” (25). Even at the level of diction, And the Band Played On is marked by the religious-rhetorical trappings of martyrs, morality, shrines, and priests. The representations at some points even become explicitly Biblical in the text: “As for the dark vision of the future, however, Brandt recommended calm, and he closed the session with a citation from his favorite book, The Bible: ‘This too shall pass.’” (555). Such religious terminology becomes problematic when in the course of the narrative, the ill are pressured
into sacrificial representational rituals, replete with visions of sainthood that when pressed, offer up some chilling implications. Richard Dellamora suggests as much in *Apocalyptic Overtures: Sexual Politics and the Sense of an Ending*, when he observes that there exists a narrative line of martyrdom which runs through much gay literature and is “…compensatory to a fault. [This literature] validates male homosexuality at the price of enlisting homosexual subjects within a sacrificial order whose telos is the greater good of humanity” (3).

Other examples of prophetic narrators fit the pattern of representing such sacrifice. When Paul Monette implies in *Borrowed Time* that AIDS teaches us how to die in the proud tradition of Greek virtue, when he takes as his definition of heroism the Greek concept of *sophrosyne* (equanimity) in the face of death, or when medical researchers claim that AIDS will help humanity discover cures to a whole host of auto-immune diseases, the underlying opportunistic assumption is the same: there is a lesson to be learned, or some larger “good” to be gained from the embodiment of “saintly” heroism by someone who is HIV positive, who has AIDS, or who is associated with the pandemic. Enshrined in this manner, the person whose story is being told is lost to the prophetic/religious mission undertaken by the narrative, and an ethics of care evaporates with the fulfillment of that mission.

The prophetic voice functions in the interest of a variety of ends, not the least of which is to achieve and exemplify “values clarification” in a “spiritually decedent” age. In *And the Band Played On*, this spiritual decadence is characterized outright as ushering in apocalyptic end times. The first words of the text are taken from the heart of prophesy,*Revelations*: “And I looked, and behold a pale horse” (2). A narratorial persona of
savior/foreteller of doom has historical precedence in other narratives surrounding illness as well: the medical persona of a doctor such as Albert Schweitzer, for instance, begins to colonize the representational space of illness through his assumption of a prophetic voice and commentary on existent social “values.” In rhetoric that is amazingly similar to that of Randy Shilts, Schweitzer writes in “Out of My Life and Thought”: “Two perceptions cast their shadows over my existence. One consists in my realization that the world is inexplicably mysterious and full of suffering; the other in the fact that I have been born into a period of spiritual decadence in mankind” (qtd. in Cousins 56). Schweitzer rhetorically positions himself as if he stands abandoned by an entire society, placed irrevocably in the position of prophetic-rescuer deigning to come to the aid of the fallen masses. Grandiose and confusing generalizations mark the rhetoric of his archetypal-prophetic position: “Because I have this certainty, I oppose the spirit of the age, and take upon myself with confidence the responsibility of taking my part in the rekindling of the fire of thought” (qtd. in Cousins 59).

If a given narrator represents himself as being a priestly voice of morality in a spiritually decadent age, then at times he configures the site of caretaking as the Church itself. Raphael Campo’s description becomes illustrative of the prophetic voice contained within the hospital-as-temple: “The hushed and somber hospital, whose hermetically sealed neighborhoods of illness and contagion went in house staff parlance by various quasi-celestial nicknames—the busy cancer unit was sarcastically referred to as the Death Star, and the grim and even more crowded AIDS ward was known as the Temple of Doom—[both] had long been my exclusive place of dark worship and forced atonement” (qtd. in Coles and Testa 13). Omniscience, self-importance, the urging of sacrifice—all of
these functions of the prophetic narrator begin to calcify the representations within the text, and as a consequence move it further from an ethics of care. The perception on the part of the prophet that he is the first to the story, the fact that he is operating at such a formative stage of terminology in a “spiritually decadent” age, and the belief that there is a “lesson to be learned” from illness, can all contribute to a narratorial turn to prophetic and religious rhetoric.

*Martin and John: Rituals of Prophesy*

As I have suggested, the self-aggrandizement inherent in much narratorial prophetic position taking, the offering up of narrative sacrifices to a supposedly “greater good,” and the moralizing of the narrators are all aspects of the prophetic voice within the setting of illness. But to complicate my analysis of the prophetic approach, one of the most explicit illustrations (but also one of the most vexed) of the representational machinations inherent in a prophetic voice is found in Dale Peck’s novel, *Martin and John*. The landscape of prophesy within the text exists in an uneasy but helpfully influential relationship to an ethics of care. *Martin and John* fits the paradigm of Arthur Frank’s chaos narrative in many ways, looping back upon itself in a labyrinthine, interrupted, and re-iterative structure. The novel is a fictional account of two men who have AIDS: John, (the narrator) who is caretaking his partner, (Martin). As he writes his primary account of their relationship, John also narrates parallel hypothetical narratives about their lives, turning his story into the story of many Johns and many Martins. Thus, in a prophetic commonplace, he universalizes his identity: it doesn’t matter *who* he is as long as he is a conduit for a message.
Through the character of John, we begin to have a clear illustration of the prophet as one who speaks in parables and acts (if he acts at all) alone. Or, as Martin says to John in frustration: “I’ve known you for over a year, John, and all you ever let me do is kiss you on the lips with a closed mouth. You cook me overspiced food and I buy you new books which you refuse to read. I tell you what plays are worth seeing, but you take me to the beach instead and refuse to go in the water…You won’t take anything from me, and you won’t give me anything; you beg me not to leave, but you offer me no reason to stay” (107). John, with his distancing and rejecting manner, positions himself as the lonely prophet who will not participate in life or in love. As he hands his tablets down from the mountain of his own isolation, he becomes the solitary monk who has found his existential center: “And I must tell you this: this is the hollow center of my being, the one thing in my life I don’t understand, and from it I have learned not to trust my instincts, not to act, because I have no control over the consequences of those actions” (108). Precisely because John is a prophet of self-distrust, he paradoxically becomes the doubting and uninspired conduit through which a transcendent vision of a caring ethic has a chance of emerging. He doesn’t have the unkind tunnel vision of certitude. As a result, such an ethics may never be fully developed within the novel, but there are points at which distinct rhetorical gestures are made towards it.

In our collective archetypes, prophets do not usually participate in everyday activities, burdened as they are by the responsibilities of possessing divine knowledge. In the habit of issuing edicts, the prophet walks a path of predestination without any real life-choices, as John does at many junctures: “As I walk home from the interview, a car’s lights catch me from behind and cast my pale shadow long and wavering in front of me. As
it speeds past, the driver leans out to yell, ‘Jesus, buddy, get out of town.’” (117). A Jesus-like watchman, John, who is forever walking, tends a lonely night-beat. The image of the prophet in Peck’s text is accompanied at many points by an explicit language of religiosity: quotations taken from the Song of Songs (116); the image of John ministering to the ill: “his pale body pokes from the green blanket like an ocean-bleached bone covered in seaweed. But then I think, He is my handsomest drowned man, I have cleaned and polished him before, and I will do it again” (127).

In such images, as well as in the images surrounding his night job, suggestions of John’s dedication to ritualized, and care only within a ritualized context, begin to emerge. The positions of the lonely prophets in this text (both John and a fellow security guard Charlie) parallel the Jesus-like cliché of the humble and protective shepherds and tenders of men. These prophets may live lonely lives; their edicts may be issued from afar, but they have an urgent realization of the need to attend to and to serve as witnesses for the lives of their flock: “‘We’re not the only night watchman, you know?’ ‘No, I—‘ ‘There was another one, before me. But he’s dead now, no wife, no family, nothing left behind him. Sometimes I think I’m the only one that even knows he existed. But it’s okay, I guess, however you touch other people, as long as you touch them, understand them a little, it’s okay” (137). The same dynamic of the watchful and protective outsider is constructed in And the Band: Cleve Jones speculates that he contracted the HIV-virus on Good Friday (64) (with all of the religious resonances of this timing) and then takes the position of an outsider, foretelling the future as he watches “…the friends, the midnight dancing, the wonderful music…. [Yet] even the champagne couldn’t melt the stone in Cleve’s stomach on the New Year. He knew a dark secret. Something they didn’t know…It had all been
one big party and, now, it was about to end” (215). Cleve is the observer who forecasts apocalyptic end times, brought on by a disease which is itself frequently couched in over-determined religious terminology. In *And the Band*, for instance: “The nightsweats themselves seemed a particularly hellish ordeal that was virtually a rite of passage into this most devilish disease” (153).

John carries the gift, not only of foresight, but of a very isolating kind of oversight (as does Cleve in *And the Band*): “…the virus seeps down into the earth, into the aquifer, into every kernel of wheat and every grain of grass and every human and every animal that eats of the grain and the grass, and I imagined all of them, every human, every animal, all dying, and I did not care” (167). The diction in this description is formal; the passage is marked by a Biblically-incantatory cadence, and the bitter voice of John as the prophetic Man Alone begins to emerge. There is nothing that provides the prophet John with comfort or surcease; no satisfied desire, no sated need, no human comfort. Perhaps a prophet never fully desires; in fact, a highly sexualized prophet seems a contradiction in terms. John lives a little at a remove, no matter how erotic his context: “‘Love is in the morning,’ Martin repeated, mouthing the words into my ear, kissing it with dry lips, moving his wet hand up and down my back, making me, making me want….nothing’” (142). Such isolation, the text suggests, stems from John’s dedication to delivering the message of his vision, and although this vision at times leads him to humanizing action, at other times it leads to conditions antithetical to human connection and a caring ethic. As we will see in the next chapter, it is exactly this position of prophet that the character of Prior refuses in *Angels in
America, precisely because such an alienation from other human beings is demanded of him by the angels. In refusing some of his duties as prophet, Prior’s ethical situatedness seems much less vexed than John’s.

Frequently in these narratives, when a prophet moves out of the sphere of a fully physical existence, his isolated, burdened situation does not seem to improve and his conditions seem no more conducive to the extension of an ethics of care than the “everyday world.” Prophetic alienation is present even in utopian settings, and in these narratives, utopia is frequently represented as a surprisingly sterile environment known for its repetitious conditions. In Angels in America, heaven is a place of continuous card playing; in Plays Well, heaven is characterized by endless conversation; in Martin and John, idealized settings exist without conflict, and are more than a little boring: “This isn’t a story, some would say, because there is no conflict within it; this is an account, long and flawless, multifaceted like a jewel, but forever the same thing” (154). It is the interminable nature of that which touches the Divine that begins to trouble these narrators. Heavenly nirvana is marked by an unceasing perfection that must be endured and gradually eats away at prophetic patience in Martin and John and in Angels in America. Both prophets, no matter how consistently they refuse their job titles, have to bear the relentless demands that their transcendent insight makes upon them. Both are forced to become a lonely tool for the divine; both are initiated by cataclysmic, symbolic, and inhuman rites of passage, designed to destroy any last vestiges of connection to a larger social context. A terrified Prior writhes in his bedroom as the Angel approaches, taking him to a psychological place where no one else can follow. Likewise, John submerges himself in the sensory deprivation of a bathtub full of baptismal crystals: “The last thing I saw before closing my
eyes was the dye of my new pants leaching into the water and surrounding each crystal, and I thought the tub looked like it was full of oil and water, and I thought I could drop a match into it and it would burst into flame” (183). In such conditions of cataclysm, the narrators find themselves far from any shelter of intimacy or caring concern.

The image of the prophetic and controlled communicator who is tested, but continually passes his tests, is repeated in many of these HIV/AIDS narratives, particularly in scenes of a narrator literally looking down upon an uncaring world gone mad, ready to redouble his prophetic utterances of doom. Again, the prophet’s vantage point is distant and judgmental at these moments of looking. In And the Band, Cleve looks over a party with a generalized sense of “society’s” disintegration. Kushner’s angels are continuously watching human struggles from a heavenly vantage point, and Shilts renders such a wide-angled view, a land of details so all-inclusive, that he must become the reader’s prophetic interpreter of that overwhelming landscape. Mark, in Ferro’s novel Second Son, continually looks from the windows of his house upon the roiling sea beneath him. And finally, a disoriented John, after Martin’s death, surveys the land from his lonely vantage point:

I turned from him then, walked to the edge of the balcony, looked up the broad avenue. The wind rushed down it, gathering speed—and debris as well, as it scooped up everything that lay on the street and sidewalks, and the raindrops that had begun to fall seemed thrown. I turned away from the city and looked at my feet. There was that disorienting mirrored floor: my feet seemed unnaturally large, my body impossibly long, my head lost in the night clouds, and, at such a distance, almost unrecognizable as me. (188)
In many texts, illness becomes a site at which explicitly religious figures “watch over” the ill. In *And the Band*, there are many general references to religious characterizations of illness: “Religious leaders had played a key role in demanding more attention for AIDS. In San Francisco, Episcopal Bishop William Swing delivered a seminal sermon in which he argued that if Jesus were alive in 1985, he would not be standing with the moralists condemning gays but with the people suffering from AIDS” (568). Later in the text, Shilts describes Mother Teresa’s famous visit to an AIDS ward in the United States, one in which she doesn’t wear any prophylactic coverings as she touches the skin of the men. Then, he textually-canonizes her for that act of “bravery.” Bravery, burdens, and loneliness seem to be the narratively-assigned characteristics of the prophetic narrator, as he becomes a sort of renegade-hero whose resolve is strengthened by the resistance he meets.

**The Embodied Prophetic Narrator**

Yet there are few examples, even within *Martin and John*, of a prophetic narrator attempting to form human connections and refusing to hold himself apart or above the events that occur at the site of illness. While Randy Shilts as a narrator never addresses issues of his own embodiment (up to and including the fact that he himself is HIV-positive), John—although rarely—does at times seek a physical immersion in distinctly sensual and sexual experience. In one particularly complex scene, John fashions a sexual interaction that is designed to temporarily release him from his own prophetic position, and to give him the sense of comfort in his own body that continues to elude him. At the end of the narrative, his attempts to remove himself from his position as a solely prophetic presence take place in the sexual context of bondage and discipline: “The gag hadn’t been a gag
until the first time I tried to scream against it, and then it was. But even though I knew I couldn’t speak, I continued to try, tried to force the gag from my mouth by the power of my breath alone” (208). Quickly, John realizes the power he has relinquished in assuming a silenced position, even if it allows him to momentarily release the burden of being a prophet.

But in this sexual act, he also attempts to experience his body in a way which is not distorted or defamiliarized by his position as a prophet:

The pain ceased to have meaning in any real way. I simply wanted to be released, but I had no control over that. In realizing this, and accepting it, a wave of heat washed through me and seemed to separate my inner body from my skin. The pain, and the fighting, were outside of me, and inside I was still. I barely noticed when Henry cut off my head and held it above my body so I could look again at myself. My skin, inflated like a balloon, was held to earth only by thin ties at the wrists and ankles. I smiled to think of my real self bouncing around freely inside, painless, weightless, like a child in the Moon Walk at the fair. My mind bounced, too, from memory to memory, and all of them seemed somehow transformed into visions that, no matter how painful they might have been once, were now ecstatic, and it was wonderful, a kind of freedom from the past—it was what I wanted. (208)

Ironically, the more deeply John moves into his experience of physical bondage, the more fully he is removed from a felt sense of his body. The bondage passage is ambiguous in another way as well: it describes an attitude of surrender to the experience of suffering, in a way that transforms that experience into something desirable for the sense of holiness it provides. The ties at wrists and ankles, reminiscent of images of the crucifixion, the visions (particularly ecstatic ones), and the flaying of John’s body all transform him into a martyred—but glorious—figure. In the end, there is a Zen-like quality to the surcease
described in the physical struggle and the flagellation (a part of many religious rituals) that brings a sense of peace to John, even if one could argue that this is the peace of emotional disconnection. But the experience of bondage does something else as well: it backfires as a plan to escape the prophetic role. If bondage leads John into a more spiritually transcendent perspective, it is a perspective that, in turn, only increases his prophetic capacities.

In relinquishing his power of speech, John’s experience of bondage suggests his attempt to move away from a dichotomized world view as well as from a prophetic identity. That the site of bondage and discipline becomes another site of worship, that masochism could yield a greater insight into one’s psychological states, and that bondage might collapse the distinction between self and other are not new notions. The experience of bondage and discipline allows John access to alternatives, both textual and sexual, to some dichotomizing self-other urges built into our very worldviews. If our psychological dichotomizing allows us to retain the sense of “us versus them,” “self versus other” or “ego versus ego-less” self-positioning, then the process of dissolving these polarities can be an unfamiliar and frightening prospect to one in the position of maintaining any subject position, much less an authoritarian prophetic one. As John Wright points out about our sexual concepts in the context of disciplinary leathersex:
If fascism is really about fear of ego disintegration, fear of union with another person, and flight from the feminine, then gay leathersex can easily be seen as anti-fascism. To the extent that leathersex suspends notions of masculine and feminine, replacing them with the polarities of top/bottom, master/slave, butch/femme, or similar symbolic power relationships, it becomes meaningless to equate the biological gender of sexual partners with their sexual roles. (qtd. in Nelson 67)

I would argue that the innovative qualities of leathersex stem not from the establishment of alternative gendered polarities (as Wright suggests), but from the manner in which those polarities can be manipulated, played with, quickly subverted, and used to the ends of physical and psychological union with the Other. Such sexual interaction might then become a method, most radically, of “becoming” the Other, through both the erasure of boundaries and through the empathetic witnessing of the Other’s spectacle of surrender. Although the “caring” inherent at textual sites of discipline and bondage may not be immediately apparent, it is clear in Martin and John that sexual bondage begins to function as a scene of radical intimacy—particularly as John loses some of his sense of discrete and burdensome prophetic narratorial identity.

Within many of these HIV/AIDS narratives, however, the collapse of self and other, the event of ego disintegration through death or vulnerability, and the blurring of boundaries during sexual acts themselves are carefully and calculatingly forestalled by unquestioned dichotomies constructed out of puritanical religious codes. In The Trouble with Normal, Michael Warner argues for the need to dispense with clearly dichotomous categories (between public and private, for example) which are set up within our normative social systems: “When gay men or lesbians cruise, when they develop a love of strangers,
they directly eroticize participation in the public world of their privacy. Contrary to myth, what one relishes in loving strangers is not mere anonymity, nor meaningless release. It is the pleasure of belonging to a sexual world, in which one’s sexuality finds an answering resonance not just in one other, but in a world of others” (179). “Finding an answering resonance,” particularly in a collapse of the distinction between public and private sexuality, has always been John’s quest, (he has been a porn star; he has shared Martin with his mother), and although his sexual experience of bondage seems marked by interiority and self-containment, the description is also marked by a profound recognition of the power of the Other: in the scene of bondage, Henry gives John the capacity to “look at himself” without the screen of his typical performative narratorial identity. Unlike Prior in Angels, however, John can find no permanent way out of his prophetic role. In the best of conditions, he must continue to occupy a disengaged and distant prophetic rhetorical space. He comes to occupy, eventually, an almost Buddhic sense of detachment: “…I have to find a middle ground, a place where I can stand and not feel as if on one side a sea rages to consume me and on the other side a vast open prairie waits deceptively to engulf me in immense emptiness” (228). This position of emptiness, one in which John becomes a conduit for transcendent observations, visions, and messages, is an ambiguous location for any prophet. While he may seek to alleviate himself of the responsibilities of prophesy and the awareness of suffering, John’s efforts only make him a clearer channel for prophetic insight, as well as a more astute observer of suffering.

Some samplings from these narratives seat the mechanisms of prophesy within the physical body itself, a move which has a variety of implications for the prophet’s sense of himself as an embodied being. As just a brief reference from a lesser-known text, such is
the case with Paul Monette’s narrator in a short story entitled “Halfway Home” in an anthology of short fiction entitled *Lavender Mansions*: “For a minute I was scared to breathe too deep, and kept kneading my chest in some fruitless amateur version of CPR. But no, the pain was gone. If anything there was a queer feeling of utter emptiness in the center of the chest, the way you feel when someone walks out on you” (326). When the body speaks through us, with a symptomatic immediacy, an intimacy, and a volume we cannot ignore, it becomes the inescapably prophetic narrator of its own illness.

Interestingly, this prophetic conception of the body in Monette’s short story fulfills some of our cultural expectations about illness, and simultaneously locks the narrator into rigid perspectives of the body itself: a) the ill body as fragmented, and b) the body as powerless in that fragmentation, (consider the focus is upon the “the center of the chest” and the “fruitless amateur version of CPR”). As we will explore in the final chapter, both of these perspectives run counter to a caring sense of the ill body. Or, as Gail Landsman observes her article “Science Fiction: The Rebirth of Mythology” in Gary Hoppenstand’s *Popular Fiction: An Anthology*, “Our culture is at the polar opposite from [any] sense of cosmic unity. We are in the latest stage of a process tending in the direction of more differentiated, comprehensive, and in Weber’s sense, more rationalized formulations…” (756). These rationalized and differentiated formulations may have a place in medical ethics and conceptualizations of the body comprised of discrete principles, but do not contribute much to a more holistic and contextually-based caring ethic. In the next section, I will explore pitfalls to caring ethical narration which arise out a prophetic narratorial position: moralizing, “omniscient prescience,” a doomsday message of inevitable decline, a perceived battle against evil, and the representation of the HIV/AIDS as a character of evil.
The Fallibility of Randy Shilts

In terms of the more global, organic means of defining an ethics of care, a holistic and contextually-based caring ethic is the one which seems most applicable to the HIV/AIDS narratives I am examining. Ironically, the move towards prophesy and religiosity in HIV/AIDS narratives is frequently a move away from a spirituality couched in terms of an awareness of the whole, the unification of fragments, and the psychological integration of those who are caretaking at the site of illness. As I have argued, a prophetic narrator is often a lonely narrator, deliberately alienating himself from his surroundings, unable to rejoin them, but attempting to offer a message which is tailored to fit within cultural norms. Randy Shilts is a fitting example of this attempt, as he finds himself in conditions which encourage a prophetic voice, and then attempts to fit his message within homophobic hegemony. Theorist Douglas Crimp has done the most to address such unhelpful and even homophobic dimensions contained within many HIV/AIDS narratives, as well as mounting a full-scale attack specifically upon Randy Shilts in “Randy Shilts’s Miserable Failure.” He points out that Shilts is famous for his self-serving characterizations of his own writing, his attempts to prove that he is more interested in defending his abilities as a writer than he is in coming closer to an understanding of the pandemic (or learning where he may have gone wrong in his characterizations of the pandemic), and his self-aggrandizing tone: (“It’s a brilliant book, superb”) (122).

In Melancholia and Moralism, Crimp also comments on Shilts’s characterizations of his own book as “largely a piece of self-puffery,” identifies the inherent self-interest involved in the production and presentation of his text, and flags Shilts’s disingenuousness
when Shilts seems to express dismay at the fact that “although his book And the Band Played On made him a media celebrity, it nevertheless failed to affect the way AIDS is perceived by the populace, reported in the media, and dealt with at the levels of policy and funding” (118). Shilts’s characterization of his text as unsuccessful, according to Crimp, has the benefit of being as erroneous as it is self-serving, since it is the first and only contact with the disease that many people had, and since the way the public perceived particularly the figure of Gaetan Dugas did much in the way of representing HIV-positive men as deliberately spreading contagion. As Crimp points out, Shilts is reflecting back a notion in his representations of HIV/AIDS that he fully knows to be in social circulation: “The real problem with Patient Zero is that he already existed as a phobic fantasy in the minds of Shilts’s readers before Shilts ever wrote the story” (124). This “phobic fantasy” is the mirror that Shilts seeks and finds to be a foil in his own process of prophetic identity formation.

Even while he takes his own descriptions of HIV/AIDS to be a very accurate representation of “the reality of AIDS,” he overlooks the distortions in those representations that he himself has created. Or, as Crimp’s generalized critique about the book runs: “I want to suggest that it is only by taking account of reactions to AIDS that operate at the level of the unconscious and by unpacking Shilts’s unproblematized notion of ‘the truth’ or of ‘objectivity’ that we can understand why And the Band Played On is so deeply flawed” (120). While these criticisms are more than valid, they may not identify some of the deepest reasons that Shilts has missed his narrative mark. I would argue that the subject position he has established for himself in the midst of the pandemic allows him
to deploy a method of discourse in which personal preferences and “moral judgments” masquerade as absolute ethical principles and ultimately authoritative prophetic warnings.

For Judith Pastore, “Randy Shilts’s And the Band Played On is so compelling because it combines new journalism techniques with the bitter irony of formal tragedy. Like watching Oedipus, we cannot escape the knowledge eluding the characters, which make all they say and do reverberate with ominous prescience” (Pastore 9). Thus the reader, too, is constructed as a prophet who possesses foreknowledge in the face of the pandemic. But Pastore’s analysis still suggests the contrived nature of Shilts’s narrative—the formalism and deliberate stylization of it. And the fact that she refers to the presence of “characters” (in her references to what is characterized as journalism) indicates just how contrived and distanced Shilts’s representations are. Even in her admiration of the work, Pastore identifies the lengths to which Shilts has gone to create a deliberately literary effect, one even in keeping with such vaunted company as Greek tragedians. In highlighting the reader reception of the work both as a piece of fiction, and the text as a “tragedy,” Pastore evokes all of the Aristotelian resonances of such a characterization as well: normative ethical patterning, the hubris of the self-aggrandizing narrator who believes he knows more than he really does, the narrator’s inadequate knowledge in the face of conflict, the perceived fight against evil—all elements that may encourage an absolutistic and polarized worldview, and present obstacles to an ethics of care.²⁵

In such a polarized landscape of “a fight against evil” and of dire and tragic effects, perhaps the most distorting representations of all occur, not when a narrator projects an identity or a set of feelings onto another person, but when the narrator projects certain feelings or attributes onto the virus itself. The prophetic voice makes natural just such
attributions, and at times primes the reader’s paranoia, fosters a judgmental reader, or begins to leave the reader with an indelible image of a viral “judgment day.” Andrew Holleran’s characterization of the virus in *Ground Zero* may serve as a revealing example of such anthropomorphizing: it was a “dumb, lifeless, blind, greedy microbe that was so stupid it killed the very thing it fed on, reproducing itself with no purpose…wretched as African pestilence” (199 and 214). There are strangely embedded implications within the rhetoric here: Holleran puts “dumb and blind” into circulation with an unexamined host of pejorative implications, and his association of the virus with Africa is suggestive of an unflagged xenophobia. In this binding of implication to viral object, a narrator emerges who has anthropomorphized the elements of illness into a monstrous entity marked by “evil intentions.” In short, the virus itself is personified as a character of evil, narratively developed as the masked villain passing under various aliases, and configured as a world traveler of unknown origin.

All of these portrayals work to create a picture of the virus as something that “good” (read: “normal”) humans are really quite distant from, but must gather forces and fight against. This representation of the virus is also, of course, an artistically-rendered metaphor. Such a representation serves as a testimony to Susan Sontag’s assertion in *AIDS and its Metaphors* that: “the most truthful way of regarding illness—and the healthiest way of being ill—is one most purified of, most resistant to, metaphoric thinking” (3). In the course of many of the representations found within these HIV/AIDS narratives, a metaphor is subject to interpretation, one which is given authoritative weight by a prophetic narrator. A metaphor can make a disease appear to stand for something intentionally evil or “more profound,” even when there is nothing more (or less) profound
than the way a disease necessitates a fight for survival. But the seductions of the metaphor, the ways it places the narrator at a “talking distance” from illness and in the position of a prophet warning of the coming of evil is clear. Many of the texts I have chosen to focus upon are enthusiastic participants in the creation and sustenance of metaphorical portrayals of the HIV-virus, as a prophetic voice warns an “innocent public” about the threats of disease.

Yet as William Haver points out in *The Body of This Death*, there is no justification for a portrayal of AIDS as an enemy to be attacked, with a distinct starting time, a distinct ending time and a distinct set of features which can be vanquished during an apocalyptic showdown at the site of illness. Narratively, such a portrayal is an evasion of the full complexities of the virus itself, and it is an evasion that is partially undertaken in the narrator’s attempt to couch his representations in the language of religion and prophesy. In choosing to represent a virus as a catalyst for some Fall from Grace within the life of a vulnerable human being, these narrators opt to represent AIDS as a coherent entity endowed with serpent-like evil. The attraction of such representations is understandable, but the realities that are side-stepped begin to force the narrator to exist in bad-faith relations to the descriptions he offers. The reality of HIV/AIDS (a medical syndrome of indeterminate nature, giving way to many opportunistic infections, and with a viral origin of partly organic and partly inorganic material) is conveniently sacrificed as the narrator endows the virus with an almost alien subjectivity. As Steven Krueger remarks: “Though AIDS comes for many reasons to be seen as an experience charged with and challenging meaning, one factor contributing importantly to such a construction is the consistent conscious and unconscious, subtle and blatant identification of the viral agent believed to
cause AIDS as itself an intentional entity” (3). The “intentional entity” representation perpetrates a deliberate mapping of the notions of “good and evil” onto the virus. Unfortunately, this representational flavoring also slips onto the bodies into which the virus has moved as well, and allows some of the “good and the evil” dichotomy to flavor the representations of the “well and the ill.” Once this move is made, dichotomous judgments begin to preclude an ethics of care as the “evil virus” and an HIV-positive status are equated.

Theoretically, the language of prophesy and religiosity might begin to foster an ethics of care within an HIV/AIDS narrative to a greater degree. Angels in America, for example, succeeds where And the Band Played On fails on this score, largely because it contains a less definitive and dogmatic central prophet, as well as multiple, and sometimes competing, voices of prophesy. But in the majority of narratives, we find instances of prophesy in HIV/AIDS narratives used as catharsis, to provide emotional distance, to frame or contain an event, to provide a context for an incident, or for the purposes of erasing an event. To provide another brief example, language may also screen a speaker from emotion, as it does in Rebecca Brown’s short story ”A Good Man,” included in Irene Zahava’s anthology Lavender Mansions. The narrator comes to her friend with a prognosis for his recovery: “I start to babble. A rambling, unconnected pseudo-summary of articles I haven’t brought him, a doctor-ed precis of inoperative statements, edited news-speak, jargon, evasions, unmeant promises, lies” (393). This authoritative rambling serves as a prelude to betrayal as the story progresses: “…my good-girl Right-On-Sister sympathies extend only as far as my assurances of my immunity from what is killing him. But once the thought occurs to me that I might be in danger I’ll be the first bitch on the
block to saddle up and leave him in the dust” (393). Brown’s narrator is a prophet on the move, delivering her messages, and then transporting herself back to safety, all the while aware of the potentially unethical implications of that maneuver. But if Brown’s narrator evades her ethically-dictated responsibility to “stay with” the narrative by running from a virus she needs to feel herself immune from, Shilts does so through the moralizing misdirection of reader attention, the insertion of asides, his disingenuously humble self-assessments, and the creation of the virus as a doomsday character of evil. But if there are pitfalls to ethical narration that the prophetic voice introduces into the narrative, there are also promises which that voice delivers on, particularly when it is informed by the erotic. Through a reading of *Martin and John* in the next section, I will explore the rhetorical union of the erotic and the prophetic, and look at the ways at which the combination might begin to point to an ethics of care.

**Points of Development of the Prophetic Voice**

Evasive representational maneuvers, made by a prophetic narrator, may be introduced out a need for emotional protection, the need to delineate a clear landscape of good and evil, or an attempt to sustain a prophetic narratorial identity, all of which are iterations of the need to exert control over the unstable environment of illness. We can see this need to exert control over instability modified and softened slightly in the case of John in *Martin and John* as the text constructs the narrator as a prophetic presence, in a way that makes his narratorial ministrations potentially more provisional of a caring ethic. John becomes a soothsayer, a prophet—one who issues rhetoric from “on high” in an attempt to achieve a religiously-inflected position of infallible authority in conditions of uncertainty.
and fear. According to his narrative, he is placed into a position of care-taking when he is very young, when he finds his mother dying from a miscarriage after watching years of her “suffering from a progressive muscle disorder (8). The remainder of the pages of John’s narrative are an attempt to gain power over a perspective in which: “A too-bright image superimposed itself on a dark one and only occasionally could a piece of that picture reveal itself” (7). In part a priestly interpreter, John is initially placed into the position of translator of sacred texts. As a child, he reads his deceased mother’s handwriting off of her recipe cards for his father: “He listened to the words as if they were a homily I was translating from Latin” (19).

John initially constructs his prophetic identity out of a series of assumptions: to be out of control and to be in the helpless position of a child around illness is emotionally intolerable. He learns early on that speaking has the power to save life, and that silence jeopardizes both self and other: after his mother’s death, he finds himself drowning in silence. In his childish understanding, death makes people, all people, go away: “When it [his mother’s body] had gone, my father put my curled up form to bed. His breathing filled the room for a few moments after he’d set me down and then, after I heard the door behind him, the room—and the house—seemed as quiet as the bottom of the ocean” (10). John learns that suffering is a lesson to be evaded, and also learns that embodiment has repulsive aspects: “I listen to her but I don’t know what to think. Her breath smells bad, her legs feel hard—bony—beneath me. I wait for her to say something that will tell me how to feel but she just sets me down suddenly…” (11). Later, as he cares for Martin, John’s prophetic
persona will serve as an overcompensation for this initial powerlessness, and part of his prophet’s role will involve narrating the story of illness for others so they will know what to feel in the face of it, since he himself never did.

John also learns in the process of developing his prophetic identity that to exist without “divine guidance” is to be lost in the world with no larger metaphysical explanation for our experience. We are lost because the suffering around us quickly becomes our fault; we are guilty of surviving, of being repulsed by a loved one, of feeling resentment for being placed in the position of having to caretake, and by virtue of our ambiguous and complex relationship to the ill person’s body. John watches as his father is placed into just such conditions of guilt by his mother’s illness:

…he kept repeating, “Oh, Bea, I’m sorry, I’m so sorry.” He repeated it so many times that even at ten years old I realized his apology might hold a deeper meaning, a message he directed at me as much as to my mother: he told her he was sorry, but he looked at me when he spoke, as if grief was what poured, no shone, from him with the intensity of light, then guilt—visible, visceral, unavoidable grief—was the sun from which this other emotion radiated. (10)

At this point, grief is the primary element of a transcendent voice, echoing “with the intensity of light,” and delivering a prophesy that John will come to live as a legacy. As he witnesses his mother’s physical deterioration: “…my first impulse was to hide, but I forced myself into the living room just as the front door slammed open…I realized she was sitting and then I realized she was sitting in a wheelchair. Her body was displayed as it had been in the kitchen chair—legs wide, spine bent, head on one shoulder…” (8).

John’s impulse to hide indicates the fear which motivates the development of his prophetic voice, but the passage points to another element of his prophetic care-taking as
well: an erotic dimension. The fact that the description of his mother’s physical openness could easily be applied to a person in a pose of sexual languor highlights the delicate and ambiguous matrix into which this mother-son relationship is set. That illness contains a kernel of eroticism is a suggestion which is absent from Shilts’s portrayals of the ill, despite the potential for eroticism contained within his descriptions of bathhouses, explicit sexual interactions, and narrative focus on the physicality of “the characters.” One might ask again at this point if there are ways in which the prophetic narratorial identity and the language of religiosity increase the potential for an ethics of care, particularly when religiously-inflected representations are intersected by erotic cross-currents. The answer would have to be yes: at points, eroticism provides the potential to rupture the set and rigid patterns of the self-defined prophet—just as it might have ruptured the patterns of heroism in My Own Country, or the patterns of artistic self-positioning in Plays Well With Others.

In some ways, the extent to which the erotic is developed within these narratives is the extent to which calcified narratorial positions have the potential to be unraveled—and here, in Martin and John, the erotic rhetoric is quite fully developed. The space of lovemaking is sometimes synonymous with the space of illness in the narrative, and both are sanctified in one of the text’s crucial scenes. Precisely which “Martin and John” these participants are in the novel’s kaleidoscopic identity-changes is left open to interpretation, but the act itself is clearly one of love: “The light, tiny, handheld candle, wavered for a moment…Its illumination was too ephemeral to really be called light: it was a pallor, a skin-tone glow of marble whiteness. The sheets on the bed were white as well, crisp underneath with hospital corners and turned back on top at the perfect forty-five-degree angle…The faint smell of bleach raised the hair on the napes of our necks. With blind
hands and eyes we made love…there might have been some blood, blotting rose petals on the sheet, but no pain. Then, sleeping, it was over” (61). As a holy hush settles over the scene, the “marble whiteness,” suggestive of pieta-like statues of antiquity, is lit by candles. In this passage, orgasm and death are equated: (“it was over”); as are the sickbed with its “hospital corners” and the place of love making, the blood of injury and the blood drawn in sex, the bleach of sickroom disinfectant and the bleach of freshly-washed sheets.

Embodied eroticism is present in this passage, but the subjects to whom it is ascribed may be figments of John (the real narrator’s) distinctly religious fantasy. If so, John becomes the prophet tempted into warm-blooded union, but simultaneously denying himself the satisfaction of that union. Alternatively, if the scene has actually taken place, it is an isolated incident, one that does not spill out onto the interactions at any other point of the book. Eroticism holds out the promise for a more sustaining and caring narrative, but so does a narrative that only partially assumes a prophetic stance, as the example in Edmund White’s short story which follows illustrates.

**Oracles and the Elusive Prophet**

Prophesy is occasionally a tricky textual occurrence in these HIV/AIDS narratives, one that can be manipulated by the narrator to such an extent that the reader becomes uncertain about the source, the ramifications, and the value of the prophesy. Given the series of shifting narrators in *Martin and John*, we frequently do not know which “John” is speaking with a prophetic tongue. Or, a given prophesy may appear to say one thing, but actually say quite another: Jesus is not the only prophet to speak in veiled parables. As an example of such rhetorical mismatch, much could be made of Edmund White’s
appropriately named short story, “An Oracle,” included in *A Darker Proof*. An oracle, of course, is the quintessential deliverer of prophesies, and this oracle relates the story of a character named Ray after the death of his partner, George. In the short story, Ray has been controlled by George; he has had virtually every aspect of his life dictated to him. At the point of George’s death, Ray has given up his own preferences to the point of utter self-desertion:

> Now he [George] was dead and Ray had to go on with his own life, but he scarcely knew how or why to pick up the threads. The threads were bare, worn thin, so that he could see right through what should have been the thick stuff of everyday comings and goings, could see pale blue vistas. “You must look out for yourself,” George had always said. But what self? (212)

In the case of the story, George seems to be the prophet, giving Ray advice which he has never bothered to heed.

Ray’s self-disregard has become a lens through which he views his life; actually, it has become the organizing principle of his life. In his lost position, he becomes both the prophet and the one who could benefit from the guidance of prophesy. Ray, like John, now finds himself located in a vast silence, waiting for a sign, a message: “George had always been barking at him, scolding or praising him; now the silence was oddly vacant, as though someone were to push past a last gate and enter into the limitless acreage of space and night” (212). George has given him direction, Ray realizes, even if that direction took him away from himself. George’s posthumous prophesy, that Ray needs to “look out” for himself, serves as Ray’s staging area for a departure of sorts—away from his status as a “superior home-entertainment centre” for George (216), and towards a more legitimate position of caring for himself. Ray manages to go on with his life, and in returning to
himself, finds the internal fortitude to leave behind George’s prophetic direction-giving and become his own oracle. As he begins, for the first time, to occupy the role of “older man” in the midst of “younger men,” he also becomes a more reflective observer of the events around him: “He had always been looking around to discover if older men were noticing him, and he’d been distressed if they were or weren’t. He hadn’t read or written anything because he hadn’t the calm to submit to other people’s thoughts or to summon his own” (248).

This account of a lost soul becoming his own prophet forms the compelling basis of the short story. But there is a disturbing element to the narrative as well: although the story contains an absorbing portrait of self-evaluation, that evaluation rests upon the event of a partner’s death from AIDS-related illnesses, without including any real or caring consideration of the one who has died. Instead, in a thematic drive to present the pendulum swing of a “return to the self,” the character of George is forgotten. And so is the fact that George has died: the fact that Ray’s emotional distance from George may have less to do with the fact that George has controlled him, and more to do with Ray’s anger that George’s death has left him alone and lonely. When Ray takes a vacation in Greece to distract himself from George’s death, and begins an affair with a young Greek man, his self-reconciliation is ambiguously rendered with a prophetic gimmick. The young man becomes an oracle for George speaking to Ray from beyond the grave, and uttering the familiar phrase: “You must look out for yourself” (250). At this point, the text becomes an account of veiled mourning, as well as a description of one man, now free, becoming reconciled with his own desire and prophetic promptings: “Ray felt blown back in a wind-tunnel of grief and joy. He felt his hair streaming, his face pressed back, the fabric of
his pants fluttering. In pop-song phrases he thought this guy had walked out on him, done him wrong, broken his heart—a heart he was happy to feel thumping again with sharp, wounded life. He was blown back on the bed and he smiled and cried as he’d never yet allowed himself to cry over George, who’d just spoken to him once again through the least likely oracle” (250). This becomes one instance within these texts in which the prophetic voice (freed from the rigid subjectivity of George and issuing from a more ambiguous or transcendent source) opens up an emotional responsiveness, one which leads him back to a more caring sense of at least himself.

A prophetic voice may find itself speaking through aesthetic objects as well as a human presence. A compulsion to craft oracles out of inanimate objects, to reify pain into narrative, also takes the form of making a statement about one’s pain from “on high.” In his work Last Watch of the Night, Paul Monette uses the rhetoric which Foucault classifies as the “medicalization of the effects of confession” in The History of Sexuality, Part 1 to construct his autobiography. When Monette suggests, as he does within his narrative, that he has written a book that is better than he is, he also suggests that his writing—his capacity to give voice—bears some transcendent value that his individual life and personal challenges do not bear. Twice in Last Watch of the Night, a text whose very title suggests the prophetic nightwatchman’s loneliness, Monette argues that he is not nearly as good as is his writing, not as “wise” or as deep—in effect, that he is not as valuable as his prophesizing (85).

From that point, it is just one step further to the assertion that HIV/AIDS achieves some “transcendent” value because so much literature has come of out the narrations of the pandemic. As an iteration of this concern, in The Queer Renaissance, Robert McRuer
highlights the trepidation he feels in the face of some of the statements made about the literature of AIDS: “[the] belief that ‘we’re on the verge of getting a literature out of this that will be a renaissance’ is insensitive and escapist, and Richard Goldstein’s [comment] that ‘AIDS is good for art’ and ‘will produce great works that will outlast and transcend the epidemic’ is politically reactionary” (9). If HIV/AIDS narratives purport to lead to evermore accurate representations, and evermore convincing arguments for an ethics of care, then we must be wary of the ways in which confessional and prophetic aesthetic rituals have the potential to numb us with their repetition, bind us with their parameters of “conventional morality,” or reduce the lives they claim to represent to “stories” of prophesy and transcendence.

In *Martin and John*, although there are clearly reasons why the prophet must find his prophetic voice: (an overcompensation for feelings of powerlessness, a way to manage a variety of situations for which he feels guilty, or a method of attempting to dictate direction when he and those around him feel lost) the fact that eroticism has the capacity to rupture the rigid nature of that voice is important for the development of alternative narrative strategies, as is the prophetic voice in “An Oracle.” But the voice must be used judiciously, never losing an awareness that it is speaking to (and through) humans.

**The Narrative Pain Inflicted by the Voice of Prophesy**

The prophetic voice may be seen as an especially cruel representational strategy, outlining as it does some fundamental dictates for social approval or disapproval, and often endowing itself with uncontested authority. Furthermore, within the context of many of these narratives, prophets are granted the luxury of speaking for the Other, while the
“un-prophetic ill” find themselves silenced and alone. This is a position that supports what Joseph Dewey calls the “very public campaigns encouraging discipline, celibacy, and abstinence, against the withering away of the urgent, creative combustion of sexual spontaneity, against the acceptance in the gay community to live like Shakers—against, in short, a decade-long drift away from each other” (qtd. in Nelson 31). Silent and alone, those touched by illness are often represented as untouched in other ways, as the vignette-like chapters of Martin and John illustrate. The sound of opening zippers is quickly stilled in many of these texts, and this silence contains the supposedly crystalline perfection of celibacy and “health.” Texts such as Holleran’s “Notes on Celibacy” and “Beauty NOW” in Ground Zero satirize such encouragement of abstinence, and the descent into the anti-erotic: “Celibacy engenders anger. Nietzsche was right. Whether they know it or not, celibates feel deprived and denied, like children whose mother has not given them a good-night kiss…celibacy makes people less than they were before…celibacy leaves you wondering what you will do with the rest of your life” (125). Even in its satirical form, Holleran’s critique of celibacy’s impact on the quality of a human life as well as on attitudes of caring bears consideration.

Even more to the point of my analysis, some texts assign a glorified and sanctioned prophetic identity to the characters on the basis of an HIV-negative status, which is also suggested as the outcome of celibacy—alá Gurganus. The prophetic narrator frequently occupies the “land of the living” and the “healthy”—a condition that is devoid of eroticism as well as any sexual interaction. In this case, the prophet sets forth certain “moral imperatives”: a life alone without sex, a dedication to the anti-erotic, and a sublimation of sexual impulses into artistic and subtly ritualized ones. Once again, this puritanical
position involves a “lesson learned,” a tidy and complete sense of closure in which a point about “morality” is supposedly made once and for all. But in this closure, the field of understanding of HIV/AIDS is not expanded, the impulse towards advocacy or care is not increased, and the emotional impact of the events narrated is reduced to easy narrative clichés such as the “before and after” paradigm and the “happily ever after” ending.

At the beginning of this chapter, I suggested that the prophetic trope helps create a reader who is directed to read with certain expectations of the fulfillment of a prophesy, the encounter with cataclysmic conditions, and the delivery of messages from a “divine source.” Such a reader is primed to encounter without question instances of normalizing representations as well, delivered as they are by the authoritative persona of a prophetic and religiously-inflected voice. Once again, this voice frequently delivers its messages within the context of a “before and after” dualistic structure within the narratives being described, a structure that is Biblically-derived. *And the Band Played On* makes this dichotomy clear: “Before and After. The epidemic would cleave lives in two…” (12). This consistent “before and after” narrative sequencing is intimately tied to the religious notion of an Edenic period, a period characterized by a childlike innocence and frivolity on the part of the members of an idyllic “scene,” which then collapses and gives way to a community of bewildered sufferers. In *And the Band Played On*, Shilts even entitles a chapter from his textual “Before” section “Glory Days,” and provides in-depth descriptions of a community at ease: “Before would encompass thousands of memories laden with nuance and nostalgia. Before meant innocence and excess, idealism and hubris” (12). Shilts chooses to suggest a powerless innocence and naiveté over any politically or
personally more efficacious representations of “community,” even if those representations are simultaneously more truthful and caring.

The choice by many of these narrators to represent others as well as themselves as alienated and alone in the midst of a community of “irresponsibility” is an oversight which both misrepresents the pandemic and supports the myth of the individualized narrator. First, through the use of a Biblical paradigm, these texts frequently represent the virus itself as a catalyst for “The Fall,” and as having entered “The Garden” to deliver the message of mortality. Or, in Shilts’s extended metaphor, “Death was already elbowing its way through the crowds on that sunny morning, like a rude tourist angling for the lead spot in the parade” (12). Obviously, such ominous representations of the virus, death, and community are flavored with a religiously-inflected moralism, instead of becoming avenues which express elements of an ethics of care.

Religiosity and prophesy, as representational strategies, are more intensely employed when the narrators attempt to represent “undefined and mysterious” aspects of the narrative (illness, sexuality, intimate caretaking). Too frequently, the prophet’s message suggests that we have sinned on our way to the site of illness: through our sexual relations, our lack of knowledge, our medical greed, and so forth. In blaming, judging, and critiquing (in the manner of Randy Shilts, for example), these narrators find a ready framework for narrative organization, but one that does not foster the non-judgmental empathy that might more readily inform more helpful considerations of caring. Instead, the prophetic narrator’s strategies take on many different dimensions within the texts I have discussed here: themes and variations upon the Biblical Fall, the moralizing rhetoric of opportunities permanently lost, the insulting characterization of entire groups of people
as “irresponsible” and therefore “damned.” As a result, we find in these narratives, as Joshua Clover writes, that there is no “place which was neither in the nostalgic Before or the heroic-melancholy After” (qtd. in Howe 19). And such an all-encompassing thematic organization becomes a way for a narrator to sustain an authoritative prophetic voice. In the end, there are at least two points to be made about this particular prophetic-authoritative narrative maneuver. First, such a narrative device, initially adopted for strategic representational purposes, begins to slide outside the text’s control and create a circumscribed religious and prophetic rhetoric that touches and constricts many dimensions of the text. Second, in an almost totalizing way, Angels in America will reverse nearly every aspect of this circumscribed and limited prophetic/religious rhetoric.
CHAPTER 5

ALTERNATIVE REPRESENTATIONS AND AN ETHICS OF CARE

The unstable features of HIV/AIDS places pressure on narrators at the site of illness to reach for a series of definitional constants: for HIV/AIDS, for those at the site of illness, for a series of stable, but dichotomizing representational descriptors applied to the manifestations of the disease. But *Angels in America*, Tony Kushner’s two-part play about one main character with HIV/AIDS (Walter Prior) and a network of characters who relate to him at the site of illness, issues a challenge to such dichotomous structures, particularly as the play undertakes a series of narrative refusals: 1) the refusal to construct a self-other dichotomy, 2) the refusal to control the erotic aspects of the narrative, 3) the refusal to delineate and hierarchize the relations of caretaker and caretaken, and 4) the refusal to differentiate “sanity” from “madness.” The play sustains these refusals in a manner which is displaced through distracting spectacle: the “fantasia” which does its ethical work behind scenes of sound and fury of the erotic angels, dramatic delusions, a cast of characters who play dual roles, and the villainous rhetoric of the Red Scare’s Roy Cohn. Furthermore, the play lays out a lot of territory for ethical decision making—at times embodying John Gardner’s idealizing claim in *On Moral Fiction* that life writing “clarifies life, establishes models for human action, casts nets towards the future, carefully judges our right and wrong decisions, celebrates and mourns. It does not rant. It does not sneer or
giggle in the face of death, it invents prayers and weapons. It designs visions worth trying
to make fact” (100). The basic argument of this final chapter suggests that *Angels in
America* shatters the boundaries, identities, dichotomies, and differentiations sustained
within the texts I have previously examined, and that this shattering becomes integral to an
ethics of care.

Using *Angels in America* as a case study, I argue that in it we find an ethically
caring narration of HIV/AIDS, a narrative ethics which moves away from rigid storytelling
and unhelpful constructions of subject position, and “sits there” with the events of the
narrative, with all of their inherent loss of control and “messiness.” *Angels* does so through
the embodiment of a series of concepts which lead to a caring narrative, and a series of
characters who live out the idea of “being the body” as negotiated by Arthur Frank’s
question: “Do I *have* a body, or *am* I a body?” The play houses examples of the
“brotherhood of those who bear the mark of pain” in Walter Prior, and in the character of
the valium-addicted Harper, who finds that “People are like planets, you need a thick
skin… Things get to me” (Millennium Approaches 18). All of the characters within *Angels
in America* are also caretakers in some way, “sitting there” with various aspects of illness
within the text. Belize, Prior’s nurse and friend, is probably the most conventional
caretaker of those who are ill, in terms of traditional conceptions of caretaking. Hannah,
the “mother figure” of the play, is also the literal, physical caretaker for Harper, Prior, and
the Mormon Visitor’s Center. Harper, in her turn, is the delusional ecologist—caretaker of
many fragile ecosystems. Joe, the new lover of Prior’s ex-partner Louis, is the caretaker of
Roy Cohn’s persona. In a most energetic manner, Roy becomes the devilish protector of
rhetorical power itself: “Yes I will represent you… Yes I will sing and eviscerate, I will
bully and seduce” (*Perestroika* 141). The Angel is the caretaker of the Divinity’s holy texts, as well as spokesperson for the Divine. The ideals of service to the “Specific Other,” as well as to service within a specific community, are also contained within the text. The play critiques forms of care which are directed at broad, abstract, and generalized conceptions of suffering: Louis, according to Belize, is “up in the air, just like that angel, too far off the earth…” in the diffuse social “caring” he ostensibly expresses (*Perestroika* 94).

The character of Belize, in contrast, is an exemplar of caring service, as he goes beyond the demands of an ethical principalism in his treatment of Roy and warns him of the need to take precautions during his medical treatment (*Perestroika* 26). There is also the example of ideal caretaking offered by Joe’s mother, Hannah. One of the busiest women in literary history, she sells her house in Utah to come be with her son in San Francisco, takes care of her daughter-in-law, runs the Mormon Visitor’s Center, and finally takes Prior under her angelic wing. Hannah’s protective involvement with Prior eventuates in her own homoerotic interactions with the Angel, a move that blurs the boundary between caretaker and caretaken: “The Angel spreads her wings. The room becomes red-hot. The Angel extends her hands towards Hannah. Hannah walks towards her, torn between immense unfamiliar desire and fear. Hannah kneels. The Angel kisses her on the forehead and then on the lips—a long, hot kiss” (*Perestroika* 118). Hannah is busy in another way as well: the actor who plays Hannah also plays Ethel Rosenberg—so (as is the case in *Martin and John*) the notion of identity is destabilized in *Angels in America*.27 Dualistically-assigned identities are present in other instances as well: through Belize’s
dual role as the tour guide, Mr. Lies, and the Angel’s simultaneous role as Prior’s nurse, Emily. Angels becomes a cornucopia of boundary-blurring between identities, within sexual encounters, and within gender assignments to angelic beings.

A text can encourage or discourage “the lived flow” of experience: for example, the fluidity between border and boundaries that is inherent in the scene between the Angel and Hannah. But a text can also influence and describe the level of resistance that those involved with the text experience: the creation of borders and boundaries in the act of telling the story. Resistance, a concept which is treated in everything from Buddhist literature to present-day illness narratives, is recognized for directly impacting the degree of suffering experienced by those whom illness touches. When Angels in America is read beside the illness narrative theory of Arthur Kleinman, this direct equation of illness with resistance becomes clear: “suffering is the result of processes of resistance (routine or catastrophic) to the lived flow of experience” (170). Because of the existence of resistance in general, narrators of suffering and illness are placed in an impossible bind: they need to tell the story of illness to retain a sense of self in a landscape of change, to interpret the experience, and to teach others about that experience—yet at the same time the very act of telling the story increases a sense of suffering in the face of illness.

Some instances of narrating illness, then, particularly those rendered through a highly stylized, representationally-controlled narrative, increase suffering, by increasing resistance to the “lived flow” of the events which surround illness. Yet as Angels in America illustrates, there exists an alternative, what Levinas calls the “just suffering in me for the unjustifiable suffering of the Other. This just suffering can ‘take on a meaning.’ This meaning is ‘attention to the Other,’ which Levinas calls ‘the very bond of human
subjectivity’’ as well as an instance of boundary shattering (qtd. in Frank 178). But if an ethical relationship of care demands sitting with the other in what might be called an attitude of responsive listening and allowing, there are also plenty of counter-examples to this stance. Even in Angels, there are examples in which people exploit each other for their use value; for example, exploitation is at the heart of the marriage of Harper and Joe, as Harper points out multiple times in her narratives. With their mutual celibacy, their “buddy kisses” and their mockery of communication, they are both fully aware of the paucity of their interactions. Joe needs Harper to live out his suppressed “aberrant” side; he first loved her, he says, because “she was always doing something wrong” (Millennium Approaches 53). But in expecting her to live out the shadow side of himself, he cannot allow her to be herself. She exists to him now as his constructed image of mental illness, of drug-induced dependence, and of dysfunction. Because he is so unaccepting of the very position he has helped put her in, their communication is nothing more than the playing-out of a preconstructed dynamic of manipulation and withdrawal which results in suffering on both sides.

There are many other instances within the play where communication becomes truncated, an empty withdrawal, and a refusal to tread on terrain that is not “normal.” When Joe has his own breakdown, dropping his defenses enough to try to come out to his mother, her only response is a cold rejection: “This phone call…we will just forget this phone call” (Millennium Approaches 76). When Harper and Prior meet on the “threshold of revelation” in the territory of their dreamworld, they agree that “imagination is a dangerous thing” and quickly amputate the chance for support they could have offered each other (Perestroika 67). But if there is to be a chance for ethical care, the stigma
surrounding all manner of “aberrations” must be softened or dissolved. Ironically, *Angels in America* abounds with such moments of dissolution as well, moments of physical and mental functioning, of physical appearance, or of sexuality which fall outside the restrictions of “normal.” When Prior gets Hannah to look at his lesions, she is a calm and allowing witness: “Look at this horror…See? That’s not human. That’s why I run. Wouldn’t you? Wouldn’t anybody?” “It’s a cancer,” Hannah responds. “Nothing more. Nothing more human than that” (*Perestroika* 103). Hannah has placed Prior in a fundamentally human position of illness, as well as succeeded in deflating some notion of “horror” he has internalized.

In the matter-of-factness of Hannah’s caring ministrations, she communicates what narratives conveying the shock value of illness do not—there are no “gory details” for a reader’s entertainment consumption. Her sweetness is subtle and soft, but it does its work; Prior is *accompanied* in the care that he is receiving. Between Hannah, who is “stiffening his spine” (*Perestroika* 104), and the angel, who is stiffening his penis, he is receiving reinforcement of his own life-force. But he is not coddled; he is finding his voice and the strength for his task of going on. The refusal to pathologize the ill becomes a gesture which is extended into other gestures of “allowing” and of being in the presence of illness without judgment. While they refuse to widen the distance between the audience’s emotional responses and the descriptions of illness, narratives which supply “attention to the other,” also continue to remind the reader that she is in relationship with illness and with those who are ill.

An ethics of caring acknowledges that we exist in a network of permanent relationships. We cannot discard the Other when she seems inconvenient, or when a
person mirrors to us an “undesirable” prospect for our lives such as illness or loss of control. Belize must take care of Roy Cohn; Cohn is forced to listen to the ghost of Ethel Rosenberg, as well as fear the prospect that Lillian Hellman is still alive and coming to poison him (*Millennium Approaches* 54). In a relationship the play turns to repeatedly, Louis cannot dispose of Prior, and they both begin to realize that their connection is doomed to last. There are repeated instances in many of these HIV/AIDS narratives of the ideas of permanent union and inevitable re-union: the reunion of people in heaven occurs in the appendix of *Plays Well With Others*, the “delusional” meeting of Prior and Louis is carried out on an astral dance floor, and the dream communion of Joe and Harper forges their ephemeral liaison. Even if the characters never see each other again in the physical realm, they are linked by their memories, dreams, visions and imaginations. These references to the permanency of relationship are among the arguments the play offers for a commitment to ethical care: poor treatment of others comes back to haunt the characters. Roy Cohn becomes the panicked mouthpiece for the threatening nature of this responsibility: “Love; that’s a trap. Responsibility; that’s a trap too….Whatever pulls on you, whatever needs from you, threatens you” (*Millennium Approaches* 58). Louis echoes the same misguided belief system when he says, “Nowadays. No connections. No responsibilities. All of us…falling through cracks that separate what we owe to ourselves and…and what we owe to love” (*Millennium Approaches* 71). The characters of Louis and Roy (as foils to Belize and Prior) continually fail the ethical challenges put in front of them, until finally Joe himself realizes: “Failing in love is not the same as not loving. It doesn’t let you off the hook” (*Perestroika* 140).
Such arguments for sustained responsibility to the Other are echoed in the criticisms that the angels themselves have of human mobility, departure, and separation in the play. The angels try to dissuade the human characters from blurring definitive boundaries through geographic and metaphoric mobility. Prior becomes the recipient of this heavenly message: “As the human race began to progress, travel, intermingle, everything started to come unglued. Manifest first as tremors in Heaven” (*Perestroika* 42). Our mobility, our attempt to escape current conditions, have caused heaven to shake. “Stop moving” becomes the message from on high: “Hobble yourselves! There is no Zion save where you are! If you cannot find your heart’s desire… in your own backyard… You never lost it to begin with” (*Perestroika* 45). The narrative extends this position still further: stillness is death, according to the angelic revelations, and death is heaven. Prior says it best; it is a “reactionary” angel who visits him, one who preaches the gospel of everlasting death through domestic safety and stasis. According to the angels, humans should stop moving and mingling, making trouble through their desire to grow. But the contrasting human vision of heaven remains as a place of mixing, boundary-blurring, and evolution. Belize’s version is not some static utopian one; it is full-blooded, gritty, and luscious—a heaven imagined for Roy complete with voting booths: “Big city, overgrown with weeds, but flowering weeds. On every corner a wrecking crew and something new and crooked going up catty-corner to that. Windows missing in every edifice like broken teeth… Piles of trash, but lapidary like rubies and obsidian… big dance palaces full of music and lights and racial impurity and gender confusion” (*Perestroika* 76). Merry and trashy, beautiful and bold—the human narrators
find themselves imagining a landscape of energy and building and dancing and confusion—all actions breaking down dichotomous representational structures.

**Representational Dichotomies and Stabilized Definitions of HIV/AIDS**

Unlike the other works we have been examining, *Angels in America* largely breaks down dichotomous structures, or refuses to construct them in the first place. The landscape, instead, becomes a celebration of mixtures of “music and lights and racial impurity and gender confusion.” The refusal to construct dualities is an important departure from previous texts, which hang many of their representations on a framework of rigid polarities. In describing such a framework, theorist Paula Treichler has compiled a list of dichotomies that she sees as underlying many representations within HIV/AIDS narratives. This system of dichotomies emerges as part of the process of learning how to use conventions of language and of narration. In a speaker’s attempt to distinguish self from other, he takes his cues from the (dichotomizing) language use around him. Treichler’s list of dichotomies, offered in “AIDS, HIV, and the Cultural Construction of Reality,” and listed in footnote 2, represents the attempt to establish and describe a unique narratorial identity, beginning explicitly with that first component of differentiation “self and not-self” and moving outward from there in concentric descriptive circles. Levinas, then, presents a unique perceptual challenge to the linguistic structure that Treichler has identified, since he suggests that we should view the self *as and in* the Other, particularly the suffering Other.

Yet as Treichler observes in “AIDS, HIV, and the Cultural Construction of Reality,” any collapse of distinctions is atypical of the rhetoric which has arisen in the wake of the homophobic dimensions of these narratives:
…the text constructed around the gay male body—the epidemic of signification so evident in the conceptions cited above and elsewhere in this essay—is driven in part by the need for constant flight from the sites of potential identity [on the part of the narrators] and thus the successive construction of new oppositions that will barricade self from not-self. (371)

But my reading of the narrators’ self-representational rhetoric suggests that they use such oppositions, not out of an attempt to escape a given identity, but to establish an identity, and also to assume the power to assign the traits of “good and bad,” “hero and villain,” and “guilt and innocence” to those whose story they are narrating as well as to themselves.29

Even critics who appear to be interested in ethical narration, or who critique self/other dichotomies, may simultaneously be apologists for or perpetrators of those dichotomies and the judgments contained within them. Some critics of HIV/AIDS narratives may even fall into the trap of the deep desire to stabilize portions of their own identities through the assignment of themselves to a certain “side” of a linguistically-dichotomizing structure. As Sander Gilman illustrates in his comparisons of representations of syphilis to representations of AIDS in his article “The Iconography of Disease,” there is a thin line between a critique of the ways illness is represented, and the re-inscription of the dichotomous structures of those representations—the very representations he is critiquing:

We can begin to understand how such models of disease evoke the most deep-seated sense of the self’s fragility. The construction of various boundaries of disease, of images of the patient as the container and transmitter of the disease, depends on our sense of our own mortality and our consequent desire to distance and isolate those we designate as ill. Those suffering from the very diseases about which such fantasies are spun are themselves not immune to those representations; they respond to the isolation and
stigmatization that is the social boundary of the disease, not part of the disease itself. It is in the world of representation that we manage our fear of disease, isolating it as surely as if we had placed it in a quarantine. But within such isolation, these icons remain visible to all of us, proof that we are still whole, healthy, and sane; that we are not different, diseased, or mad. (qtd. in Crimp 107)

Although Gilman joins Treichler in the critique of dichotomous representations as they are used to separate the “self” from the “other,” under his reading, he also gives voice to a set of fears (fears which have also driven many narrators more deeply into a series of archetypal subject positions): the fear of isolation, the fear that even the ego identity Gilman is attempting to delineate will not save him from the climate of social banishment and control that he himself is helping create (after all, Gilman is helping sustain that environment of social alienation, if only by re-iterating the fact that it exists).

Within many of these illness narratives, the narrator also develops a distinct conception of “the self” as if such a conception exists free of the context of time or place. Theorist Cindy Patton, who originally pointed out the emphasis on the strict delineation of “self” and “other” in the representational structures at the site of HIV/AIDS, has come to modify her position to a certain degree. In her text *Sex and Germs: The Politics of AIDS*, she argues that she formerly “understood the constitution of a ‘self’ through reverse discourse in too unified a manner, a manner that insists too strongly on the bipolar structure of subject-constitution that is required within the self-other model” (179). The revision of her own theory is founded on the fact that she originally ascribed the entirety of her view of identity-constitution to a “system of substitutions and disseminations as if the ‘queer paradigm’ were only a palimpsest from which the traces of the original queer could always still be read. I constructed a discursively ordered self-other model…and did not consider
how the displacements of bodies or categories affected the grip of the controlling forces, or resistance to them” (179). In short, just because there is a center (self) and a margin (other) does not imply that they are “in the same place, subjected to the same discursive and institutional tyrannies” (179). *Angels* suggests a landscape where Patton’s new conception of identity formation may be illustrated—a landscape that changes from scene to scene, heaven to earth, delusion to dream in a series of spatial modifications that shift and inflect the identities of the multiple narrators.

According to Patton, we need to consider the stage upon which the narrative is playing itself out, in order to account for intrusive elements which inflect, pressure and modify the nature of the subject positions within them. The analogy between those who are narratively-constructed as HIV-positive and those who occupy any colonized space becomes a crucial part of Patton’s analysis, as they do in Tom Couser’s and Paul John Eakin’s analysis. That the site of illness is situated in the context of a socially-constructed site made of shifting features is a fact that Patton believes is overlooked in many critical discussions of HIV/AIDS representations. In an attempt to correct this omission, she re-imagines and describes the site of illness within the context of what she calls “tropical medicine”—diseases which Euro-Americans encountered in the course of occupying the regions they had colonized (184). These diseases, and those who fell ill, became the objects of intense observation and experimentation. These illnesses were also treated by the colonizers as commentaries upon the region they beset. Patton’s use of tropical diseases in her discussion of epidemiology underlines the fact that spatial orientation *matters* in the definitions of disease, as it does in representations of the ill body; there is no
simple “those-who-are-diseased-and-those-who-are-not” self/other dichotomy which exists across time and space, as many of these HIV/AIDS narratives suggest.

On the basis of its epidemiological features, any actual illness becomes a social construction, designed to attempt to manage the unmanageable and unstable nature of illness: “Bereft of a stable place of pathology, epidemiology must constantly construct and correlate populations and sub-populations in order to make epidemics visible, hence the interest in technologies of ‘surveillance’ (descriptive) and of ‘sentinel studies’ (predictive)” (Patton 187). Patton’s idea co-ordinates with Foucault’s observations about the disciplinary panopticon which surrounds illness—and such observations will become relevant to Angels in America: 1) there is no illness until it is defined by a narrative; 2) an absolute distinction cannot be drawn between the “ill” and the “well,” and when it is, it is frequently done so for disciplinary purposes; 3) representational dichotomies arise only when narratives attempt to make disease visible. According to Foucault, medical discourse originated from discursive structures of “surveillance and sentinel studies” similar to the ones described by Patton, and then moved into a second step of its historical evolution—a phase which emphasized vision, the potential for “true seeing” (which was anything but) within the clinic: “Not only the names of disease, not only the groupings of systems were not the same; but the fundamental perceptual codes that were applied to patients’ bodies, the field of objects to which observation addressed itself, the surfaces and depths traversed by the doctor’s gaze, the whole system of orientation of this gaze also varied” at different historical points of the development of medical discourse (54). Foucault’s argument is profound: communications based on this “true seeing” are “transmitted beneath the level of words” (52) along the wires of ideology. I would observe that in the case of these texts
that I have examined in previous chapters, the vehicle for that ideology is given shape at the level of individual narratorial “identity.” The fact that this ideology is constantly changing is not a new observation; the fact that it is filtered through the demands that a narrator makes upon his narrative to supply him with a given identity has not been fully accounted for in critical accounts of these HIV/AIDS narratives.

The Impact of Polarized Representations Upon an Ethics of Care

There are ample reasons for narrators we have examined in the previous chapters to maintain the polarities which mark their representations within the narrative. At the structural level of the text, an undercurrent of narrative polarity creates a tension which becomes a catalyst for a “good versus evil” plot structure, and ultimately allows the narrative to identify an originary “crisis” at the site of illness in the form of a distinct source of “evil.” Then, the narrative can put into place a subsequent series of dichotomies which rest on the original differentiation of this “evil” from a definitive “good.” As Sam Coale has suggested in “Red Noses, the Black Death, and AIDS: Cycles of Despair and Disease,” if we can “polarize problems or the meanings of events into symbolic oppositions” (qtd. in Pastore 100), we can then externalize “evil” from the body of “good,” and suggest a movement of progress from “bad to good,” which is satisfying (even if contrived or illusory). Alternatively, the narrative may identify movements of disintegration from “good to bad” (even when none may be occurring). Finally, such a pattern allows the author to deliver a moral impetus—usually in the form of a redemption narrative—which encourages those at the site of illness to cast their lot with the “good,” the “active,” “the healthy” and (most of all) “the living.”
But representations at the site of illness in Angels in America would remind us that even the line of demarcation between “good and evil” is easily dispensed with. The representations remind us of other features as well, features which become integral to a narrative ethics of caring: the need on the part of the narrator to establish empathetic communication with one in his care and the refusal to intrude on the experience of illness with the force of his own perceptions. Both of these ethical narrative actions begin to break down the dichotomous distinctions that many narrative archetypes have helped set up. In exploring these narrative maneuvers, I am drawing heavily from the schema laid out by Kylea Taylor, in her work The Ethics of Caring (1995). First, her definition of care entails the “ability to travel deeply and empathetically with the client into uncharted and often frightening territory” (xx). According to this definition, giving another human being permission to express their experience of illness without fear of censure, critique, or detachment on the part of the listener is an ethical gesture. In this act of ethical listening, care becomes defined by a fundamentally allowing stance, not based on traditional conceptions of “moralizing.” Such communication avoids the polarizing language of judgment, or, as Joe in Angels in America says, it avoids the concept of “…truth restored. Law restored” (Millennium Approaches 26). This emphasis on “law restored” is contrasted with the ability of the characters to communicate in much more ephemeral media, such as their delusions. Harper meets Prior, for example, at the event of a dreamscape, and this supposedly unreal liaison becomes a far more nourishing interaction than the two have with their physically present partners. Their dream interaction is far more poetic and sensual as well, existing in a space of mystery, on “the very threshold of revelation” (Millennium Approaches 33).
In non-dreamscapes as well, the characters move into uncharted territory. Belize is the primary exemplar of a willingness to enter into dimensions that he may not immediately understand, listening with openness to Prior’s descriptions of the angelic visitations. Harper has perhaps the best understanding and acceptance of the world of delusions because of her own, and she embraces the opportunity for self-protection that they offer. After Joe has left her, she travels to Antarctica in a hallucinatory journey: “This is a retreat, a vacuum, its virtue is that it lacks everything; deep-freeze for feelings. You can be numb and safe here, that’s what you came for. Respect the delicate ecology of your delusions” (Millennium Approaches 102). As I have previously discussed, such expressions of acceptance are echoed by Paul Sergious in his text One Boy At War, and they seem to be the same ethical suggestions that Verghese and Gurganus ignore.

Additionally, care entails the ability on the part of the narrator to “sit with” another through the unfamiliar experiences of illness. Belize, for instance, is not just the travelling companion for Harper in the form of Mr. Lies (again, the two characters are played by the same actor); he is Prior’s travelling companion in his encounters with the Angel, listening to his experience and never passing judgment on the validity of it. After one instance of Prior’s “visitation” by the angel, Belize joins Prior in a playful hospital rendition of “Hark the Herald Angels Sing” (Perestroika 21), cheering him up but not dismissing the importance of his experience with the angelic visitor. It is a hallmark of a caring ethic to be willing to remain with one who is ill when the going gets ambiguous. In acts of care, the narrator must refrain from the application of pathologizing labels (even if he desires the clarity of such labels) to one who is ill, these narratives suggest; he must be committed to an open-minded allowing. Such a caring orientation is responsive and hardy, unlike
Louis who “can’t have this talk anymore.” “On the list of things you can’t do,” responds Prior. “So fragile!” (Perestroika 87). There is no place for such fragility in an ethics of care, just as there is no place for sitting back in a patronizing position, as the “well” individual, offering the gift of one’s “ministering presence.”

Many of the illness narratives we have been examining perpetrate the belief that the narrators may easily a) determine and b) represent who is sick and who is well. Such assumptions are not innocent ones, and there is no real material justification for making such distinctions, as Foucault points out in The Birth of the Clinic:

The exact superposition of the body of the disease and the body of the sick man is no more than a historical, temporary datum….The space of configuration of the disease and the space of localization of the illness in the body have been superimposed, in medical experience, for only a relatively short period of time—the period that coincides with nineteenth-century medicine and the privileges accorded to pathological anatomy. This is the period that marks the suzerainty of the gaze, since in the same perceptual field, following the same continuities or the same breaks, experience reads at a glance the visible lesions of the organism and the coherence of pathological form; the illness that is articulated exactly on the body, and its logical distribution is carried out at once in terms of anatomical masses. The “glance” has simply to exercise its right of origin over truth. (4)

The narrators of My Own Country, Plays Well With Others, and The Band Played On have relied on the power of this glance (to determine, to diagnose, to categorize; in short, to exert an active force upon the field of illness) for both their self-representations and for their representations of illness. But in many of the representations of Angels, there is no gaze separating observed from observer; we are in this together; the Other is ourself. Again, Belize may be the primary exemplar of this boundary-collapsing attitude—even in
the face of Roy Cohn’s rantings, he usually listens without harsh or intrusive judgment, still attempting to help Roy by warning him against the double blind drug trials and the use of radiation treatment for Karposi’s sarcoma.

Belize’s attitude of listening demonstrates something else as well: all of the constructs we have erected to keep our vulnerability (physical, psychological, even moral) at bay will crumble when confronted by the demands of care—and that includes our vulnerability to moral ambiguities that arise at the site of illness. Belize, after all, becomes ambiguously positioned as the narrator who steals the AZT that Roy has secured for himself. Just as we, as caretakers, may become ill, we may also fall short of the moral health and perfection we had hoped for ourselves, and we must face those lapses without becoming paralyzed, as Joe and Louis become paralyzed by their “fragility” in the face of illness. In contrast, the play’s acts of listening and allowing which begin to exemplify a caring ethic forge a landscape of fluidity: fluidity of moral action, fluidity of identity (the actors play multiple roles), fluidity of spatial orientation (the characters move from heaven to earth), fluidity of consciousness (as characters move between delusions, dreams, and more typical states of consciousness), and finally, fluidity of the shifting boundary between life and death.

This recognition of the inherent fluidity at the site of illness is crucial to an ethics of care. As Foucault points out in *The Birth of the Clinic*: “With death, the limit had been reached and truth fulfilled, and by the same breach: in death, disease reached the end of its course, fell silent, and became a thing of memory. But if the traces of the disease happened to bite into the corpse, then no evidence could distinguish absolutely between what belonged to it and what to death; their signs intersected in indecipherable disorder” (141).
We thus encounter a twilight arena of human life: “These processes [of the dying body] indicate only in an incidental way the fatality of the disease; they speak of the permeability of life by death…” (142). And, in the case of Angels in America, these processes also indicate the permeability of death by life. The fact that this ambiguity, this “permeability,” leaves many characters struggling to define the boundary between death and life, also occasionally leads them to create faux dichotomies in the form of a series of conceptual spaces: “heavens,” realms of angelic beings, or utopias of unceasing human communion. After all, although Prior enters heaven, he has the option of returning to earth on the rungs of a flaming ladder: “You have prevailed, Prophet. You…Choose” (Perestroika 117). Death is undefinable in the same way that “AIDS” is, a realm that Prior can enter and leave at will, creating a similar set of anxieties for the narrators. Death cannot be defined as one discrete event; “Death is therefore multiple” (141), concludes Foucault, but many textual representations are invested in making it appear to be a singular evil. It is “dispersed in time,” yet many of the HIV/AIDS narratives I have explored attempt to create it as a climactic moment.

Dichotomous representations of death often accompany narratorial attempts to manage anxiety about its occurrence. If Foucault’s suggestion is on target, and death cannot be definitively represented in clear and stable terms, a narrator might seek representational strategies which supply it with a definitive characterization; in effect, cordoning it off and forestalling the threat of its encroachment. In contrast, a caring ethic might represent death as an evolution, a passing on, or even as a passing by of those who remain living. Within such a strictly-bordered representational schema, stasis and stability become notions which oppose (and even make impossible) any evolutionary
conceptualizations of death, ones that might helpfully contribute to the comfort a caretaker is able to supply to one who is dying. Instead, Gurganus is frozen, forever rocking on the porch of the only safety from death he feels he has, a perfectly alienated repose he has forged for himself. Verghese sits locked behind the steering wheel of his escape, leaving behind the changing conditions that an environment marked by death has imposed on his life, his narrative stilled in the midst of vehicular motion. Shilts finds a way to representationally halt the progression of his own life, as he freezes an evolving pandemic into a polished narrative.

Alongside anxieties about physical death within these narratives, there is the ever-pervasive threat of “subject death”: a psychic death that results from the dissolution of the ego. In these narratives, the occurrence of one stands as an echo and ominous reminder of the existence of the other. “Ego-death” is frequently coded in sexist terms (feminine/passive/receptive), as Lee Edelman points out in “The Mirror and the Tank”:

> Within this conceptual paradigm, which is, regrettably, our enduring heritage, to allow oneself to be displaced from the “superordinate side” of masculine self-assertion to the subordinate position of feminine receptivity registers as “suicidal” precisely to the extent that it signifies, and not “merely” as a figure, what could be called the “death of the subject.” (qtd. in Murphy 15)

Even as they represent and configure illness, the idea of death (psychical or physical) hounds these caretaker-narrators, who strive to stand close but not too close to the central dramas of illness (the loss of an identity based on a “personal I,” as well as the loss of life). Whether representations of death exist on the surface or beneath the surface of these narratives, many narrators have placed themselves in a paradoxical position: the very
representations of themselves in such subject positions as heroes, artists, or prophets rests, in part, on the treatment of a topic that threatens to undo all subject position.

One reason that these illness narratives work so hard to establish dichotomies (apart from their attempt to sustain distinct narratorial subject positions) has much to do with the confusion created by the almost unimaginable amount of information circulating around HIV/AIDS. The fact that many of the symptoms and signs of the disease could be classified as “new knowledge” to be incorporated into a lexicon of illness increases this pressure: Foucault suggests that the site of any illness “kills the capacity for observation and stifles the talents of the observer by the sheer number of things to observe” (15). Foucault’s suggestion holds doubly true for a narrator of an unprecedented illness. At times, these narrators suggest that they are frustrated with their inability to answer the fundamental questions: what phenomenon, exactly, am I dealing with at the site of HIV/AIDS? How can I most accurately predict what events will take place at the site of HIV/AIDS? How can I justify a particular representation, one that I have selected out of a nearly infinite field of representational possibilities? How well will that representation be received by a reading public? As Arthur Frank suggests, “To paraphrase the quotation from William James that orients this whole inquiry, no analysis can ever ‘settle the hash’ of testimony [about illness]. Any analysis is always left gazing at what remains in excess of the analyzable” (138). These narrators know that a huge “excess” remains unstated—an excess that places into question the validity of their narratives. This excess works to undermine the unhelpful dichotomies which trouble many representations within HIV/AIDS narratives, as well as unseat the narrators’ rigid sense of their own roles. We
see this dynamic at work in the prominent narrative excess that arises around the domains of “madness,” of eroticism, of the use of technology, and of the negotiation of boundaries and closure, as I will explore in the subsequent sections.

**Narrative Refusals of the Concept of “Madness”**

In *Discipline and Punish*, Foucault suggests that sexuality, “madness,” and “criminality” are given the same treatment when they are disciplined “not to punish the offense, but to supervise the individual, to neutralize his dangerous state of mind, to alter his criminal tendencies, and to continue even when this change has been achieved” (18). In literature, “losing one’s mind” has been a consistent subject of narrative fascination, and the “mad prophet” character/narrator (consider King Lear, Prospero and Hamlet, for example) have become clichéd embodiments of derangement in and of themselves. Among other aims, the psychologically unreliable narrator is used to create tension within the reader (whom are we to trust?), and to build towards a surprise ending in which that narrator reveals “the truth” as seen, now irrefutably, though a psychotic sincerity. From Henry James’ *Turn of the Screw* to William Gass’ *The Tunnel*, we meet narrators in whom our trust is tested or misplaced, but whose madness guarantees an odd narratorial authority in the end. Yet within the mad narrator tradition, such a narrator seldom identifies himself as “mad,” and even more rarely allows the reader to see his awareness of his own atypical mental functioning.

Yet in HIV/AIDS narratives, there are examples of narrators who explore their mental functioning in ways that are liberatory and caring. The first I want to explore is Paul Sergious’s compelling HIV/AIDS narrative, *One Boy At War*, which breaks with
aspects of the tradition of the unreliable narrator as he foretells the coming of his own dementia. Sergious’ text contains a narratorial voice that is as endowed with willpower, as abiding, and as provisional of guidance at the site of illness as some of the narratives of illness contained within *Angels in America*. Sergious voices his driving will to narrate in religious terminology: “I was only one boy at war. I had no formal training as a researcher, no way to scale the walls of Jericho. I had nothing left but my own personal initiative and a subtly undermined left brain. It would have to be enough” (281). This narrator does “scale the walls of Jericho” in his narrative, at the same time as he uses no staged drama of “insurmountable odds,” no recourse to a last-minute “lessons learned,” and no self-aggrandizing role to do so. Instead, he becomes the compassionate witness to the changing capacities of his own mind, and he constructs himself, at times, as both the madman and the fool with all of the resonances of those identities: naive innocence, truth telling through indecipherable koans, and the wisdom of the savant.

Sergious has set for himself the task of trying to write through his dementia and chronicle his challenges as his previously formidable intellectual capacities leave him. His former abilities to assimilate large amounts of information, to write quickly, and to edit unfailingly are replaced by his efforts to articulate his next sentence. He represents his faculties, as they depart, as leaving him “stranded, powerless, alone” (131). Interestingly, Sergious’s description of the process he is undergoing is understated, detached, and almost clinical. He suggests that he is delivering a narrative that almost undoes the ability to tell of itself. As a witness to his own narrative transformation, he writes: “I was unable to store the first portion of a sentence in my mind; by the time I reached its conclusion, I’d forgotten the gist of the thought” (261). Although the medium of writing becomes
ephemeral and threatened with erasure before it reaches the page, Sergious stands firm in his belief in his rhetorical powers, as well as in his narratorial authority. Even as the caretaker of his own writing, he never props up his authority through a contrived narratorial subject position (hero, artist, or prophet). As he narrates his text, he does not set his cognitive vulnerability and his right to speak at odds with each other: “While I spoke far more slowly, I still spoke accurately” (262). Indeed, he feels more qualified to speak in the face of his mental challenges: he is speaking about dementia from the inside; he opens himself to collaborative writing when he needs it, and he allows the frustration created by his intellectual changes full expression: “With every derailed thought, every blunted emotion, every spark of motivation that was extinguished, I found myself confronting a problem larger than any I could ever have contemplated or prepared for… yet with the help of editing, taped transcripts, and my journal—much of it completed prior to the onset of HIV dementia—I was able to write this book” (261). In fact, he begins to use the demands that his changing mental state presents, not as a force which undermines the narrative, but as an integral part of the motivation and determination which fuel his writing process.

But Sergious’s refusal to cover up or cover over dementia is a rare representational maneuver within the HIV/AIDS narratives I examine. Although more enlightened representations of dementia could become a method of collapsing dichotomous distinctions within these narratives (helping destabilize the comfortable distinctions drawn between “mental health” and “mental illness”), these texts most often refuse that opportunity. Instead, the first three texts I have focused on take dementia to be “the worst blow” or the most tragic dimension of the disease, and its effects are almost universally stigmatized in other HIV/AIDS narratives I have examined. When Robert no longer
“knows” the language in *Plays Well With Others* (5), the narrator believes the “real Robert” has departed. When a patient “sees Jesus,” in *My Own Country*, Verghese treats the vision with contempt: “Gordon had not dismissed it; it was as real as the plastic urinal that hung by its handle on his bedrail” (119). The “climactic” ending of *And the Band* has Bill Kraus speaking (according to the narrator) in “gibberish”—frightening those around him with his “inhuman” communication.

Furthermore, I find very little evidence that the voices of so-called madness and dementia have been explored for their narrative or ethical possibilities within the majority of these HIV/AIDS narratives. Portrayals of dementia, instead of being moments of transcendence or evolution, are portrayed as grotesque and frightening. Delusions, hallucinations, and changes in the processes of language usage are not harvested for the symbolic or subtextual import they might yield. If a narrator does incorporate descriptions of “madness” into his representations, he often does so in a sarcastic, mean-spirited, or derogatory manner. In *Plays Well With Others*, Mims observes about Robert: “I had learned the language of his language ending. Not unproud of how my skill had evolved to coil inside the nautilus spiral of Robert’s own exquisite devolving, I translated for my marveling friends” (5). In contrast, as Sergious writes matter-of-factly, with help, “I was able to write this book” (261). His value as a narrator is not predicated on the ability to follow a series of linear thoughts, to read, or to distinguish what is “real” from what is “imagined.” Sergious’s narrative challenges the reader to question those who cringe at the “disintegration of his mind,” and to consider it another possible step in his evolution. His narrative is a testimony which flies in the face of traditional narrative accounts of “madness” or “mental disability”—and invites a reading which suggests that the
ramifications of his condition are more complicated than just a tragic and irreversible decline. This stance, which fosters an attitude of allowing, becomes one of the primary constituents of an ethically-caring attitude, particularly as that attitude intersects changes in mental functioning.

**Refusals to Discipline Sexuality and Eroticism**

Foucault identifies sexuality as subject to discipline and control just as surely as mental functioning is. And as I suggested earlier in the chapter, Paula Treichler argues that many trajectories of discourse surrounding HIV/AIDS are attempts to “construct gay male identity in our representations of AIDS [since gay identity] is a text people so want—need—to read that they have gone so far as to write it themselves” (361). Some critics argue that the representational discipline of sexuality, and not the representation of illness itself or the subject formation of those at the site of it, is the primary concern of the “epidemic of signification” that Treichler has identified. Dennis Altman, in “AIDS and the Reconceptualization of Homosexuality,” in Allan Klusacek’s collection of essays entitled *A Leap in the Dark*, argues that social representations of HIV/AIDS have been impacted by the intense observation applied to gay men from the beginning of the AIDS pandemic, and that there are “few comparable times when sexual behavior has been so closely scrutinized and monitored, which itself raises some real questions: Is gay behavior, even identity, changed by the enormous attention that has been paid to it by both professionals and the media as a consequence of AIDS? When does legitimacy and representation become control and co-option?” (39). Often very quickly in these texts, I would argue, and in ways I will discuss.
Cindy Patton, through arguments made within the context of the social sciences (and directed at the way epidemiological studies fail to accurately represent the HIV/AIDS pandemic), also points out in “Performativity and Spatial Distinction” in Eve Sedgwick’s *Performativity and Performance* that the virus breaks down the distinction between homosexuality and heterosexuality in a manner that begins to threaten notions of those subject positions as well as the representations of them. Patton identifies the potentially de-stabilizing force of:

…situating risk as a form of transient presence in a chain of transmission [in other words, stressing that the risk of HIV is not always present in every encounter] breaks down the line between ‘homosexual’ and ‘homosexual behavior,’ destroying both the idea that homosexual behavior can be considered risky regardless of the presence of opportunistic microbes, and the presumption that heteronormative practices are by definition safe. (qtd. in Sedgwick 175)

But even in the face of epidemiological suggestions that gays and straights are equally at risk for HIV/AIDS, these narrators frequently (although not always) sustain the homosexual/heterosexual distinction in the attempt to guarantee themselves health.

Any breakdown in distinctions in matters of sexual identity is a devastating move for narrators managing their anxiety about sexuality through the belief that the dangers that gay men face can be quarantined and cordoned off through a stable assignment of sexual identity and subsequent disciplining of that sexuality. By contrast, the erotic, particularly as it manifests itself within *Angels in America*, does much to erode disciplinary pressures upon sexuality, as well as erase boundaries created by strict homosexual/heterosexual dichotomies. But outside of *Angels*, within many of these narratives, there is an underlying narratorial resentment that an ill person’s or a gay person’s sexuality or eroticism arouses.
In Verghese’s interactions with the characters who are openly, explicitly sexual in their conversations with him, in Shilts’s response to sexual freedoms of Fire Island and the bathhouses, and in Gurganus’s resentment of Robert’s celebratory sexuality, the representations are rendered with a subtle condemnation and a generalized resistance to homoeroticism.

In *Angels in America*, one finds alternatives to these condemnatory attitudes towards the erotic voiced by the narrators of the narratives I have discussed. The narrative may most thoroughly embed its consistent eroticism in the character of Prior, the play’s main character. Prior discovers he is HIV-positive, is consequently abandoned by his lover, Louis, and is then assigned by heaven to do the “Great Work” of becoming a prophet. Besides the sexually-overwhelming and pantheistically-engaged Angel, Prior’s illness itself is the most sexualized entity in the play. Even the fevers which portend his death bear a strong resemblance to the flush of sexual arousal. An air of celebration surrounds Prior’s sexuality as well: Prior’s nurse, friend, and caretaker, Belize, encourages Prior’s sexuality, seeing it as a cause for hope and celebration. He delights in Prior’s wet dreams: “Well about time. Miss Thing has been abstemious. She has stored up beaucoup de spooj” (*Perestroika* 19).

Erotic representations occur in other contexts of illness as well. Even from the depths of her delusions, Harper is highly sexualized and beset by a driving eroticism: “There’s your breasts, and your genitals, and they’re amazingly stupid, like babies or faithful dogs, and don’t get it, they just want him” (*Perestroika* 16). And death itself, in its most powerful descriptions, becomes the process of filling and being filled, an erotic union with a sanctified being. Surprisingly, it is Roy Cohn who digs deep into an erotic lexicon,
giving a parting speech that contains both the wish for sacred union, and the aching desire for death. He parses his desire in terms simultaneously desperate, seductive, and erotically uncontrolled: “Dark strong arms, take me like that. Deep and sincere but not too rough, just open me up to the end of me” (Perestroika 75). Depth and tenderness, fever and flush, are all descriptors which could be applied with equal validity to the ill body and the eroticized body—as it is in Martin and John, where the space of illness and the space of lovemaking are conflated.

A perpetual wellspring of blood imagery is also used as a sexualized symbol in this text, one which carries a highly erotic charge. Blood is a symbol of grandeur, as well as a medium of communication for the angels who: “billow bloody words into the sky of sleep” (Perestroika 48). Blood becomes a liquid emblem of health, instead of the tainted poison it is in many texts. Angels in America uses blood to suggest life, as well to suggest the capacity for a love which endangers itself in the process of engaging with ethical care: “I want to see blood,” Prior says to Louis, “Because I can’t believe you even have blood in your veins till you show it to me” (Perestroika 87). Religious and prophetic texts within the play become sexualized documents recorded in bloody ink, emerging “…when in the dark vexed night of our ignorance and terror the seed words sprouted and shoved incomprehension aside, when the incredible bloody vegetable struggle up and through into Red Blooming gave us Praxis” (Perestroika 14). Blood becomes The Word, expressive of a throbbing and enlivened sense of life forged out of human struggle.

The words of the angels, preserved as ancient texts, express the aching need of the “American Heart all Hot for Truth” (Perestroika 36). Their utterances are unabandoned, free and reckless: “I am utter flesh, Density of Desire, the Gravity of Skin…Not Physics
but Ecstatics Makes the Engine Run” (Perestroika 39). Angel’s narrative repetition is incantatory; the rhythm becomes the mantra of a holy chant: “The Pulse, the Pull, the Throb, the Ooze…Priapsis, Dilation, Engorgement, Flow: The Universe Aflame with Angelic Ejaculate…the Blood-Pump of Creation” (Perestroika 40). Such a wild and celebratory ecstasy is completed in the image of an Angel with eight vaginas spreading her seed in the presence of Prior and Hannah. At the climax of the play, through a return to archetypal images of hermaphrodites (and through a reminder of Platonic images of original gender unity which occur in The Symposium and are found throughout a variety of sacred traditions), Angels suggests conditions of gender unity, historically found in traditions of tantric sexuality, Hindu notions of the divine forces of Shiva and Shakti, and pagan beliefs that suggest that “masculine” and “feminine” forces are interwoven, inextricable and depolarized.

This depolarization opens the door to a holistic conception of sexual identity—ambiguous, allowing, and caring. The value of this depolarization is made all the more clear in the counter-examples the play offers, because Angels also explores the implications of the anti-erotic upon an ethic of care. Harper, for instance, knows well about the hatred of sex as an attempt to extinguish some essential core of her being. She knows that with Joe she is allowed no more life than the wax statues in the Mormon museum: “I dream you batter away at me till all my joints come apart, like wax, and I fall into pieces” (Millennium Approaches 37). At points, such forceful fragmentation occurs between and within the play’s bodies, and works to extinguish erotic union in all forms. Fragmentation is a method of destroying a person’s sense of comfortable physical embodiment, long before any disease has a chance to. Joe, at a low points of self
abnegation, prays: “...for God to crush me, break me up into little pieces and start all over again” (Millennium Approaches 49). Louis narrates the story of Prior’s illness in a way that is both stylized and fragmented through the diction and the images: “It is. The After Life. Which is not at all like a rainy afternoon in March, by the way, Prior. A lot more vivid than I had expected. Dead leaves, but the crunchy kind. Sharp, dry air. The kind of long, luxurious dying feeling that breaks your heart” (Millennium Approaches 51). But the breaking of Louis’s heart, like the fragmenting of his language, seems primarily designed for a calculated effect which disallows a sense of holism, of unity, or of care.

Boundaries that make up our conceptions of sexuality are blurred in other ways as well through sensual descriptions within the text. The human sense of smell, as well as the human fluid of blood, is another point of eroticization: in the intimacy of smelling and tasting one another, we begin to intermingle physically as human beings. Louis has been afraid of Prior’s smell as Prior begins to sicken, and it is the sense of smell which first forms his erotic interactions with Joe:

The nose is really a sexual organ. Smelling. Is desiring. We have five senses, but only two of them go beyond the boundaries of ourselves. When you look at someone, it’s just bouncing light, or when you hear them, it’s just sound waves, vibrating air, or touch is just nerve endings tingling. (Perestroika 30)

The molecules of smell move inside another’s presence, and smell becomes a precursor to the intimacy of taste. As Louis comes to taste Joe, he gently moves him into an elemental awareness of their interaction, made of: “Iron, clay, copper, chlorine” (Perestroika 31). Louis becomes the caretaker of Joe’s sexuality, spoonfeeding him the broth of his own body: “The nose tells the body—the heart, the mind, the fingers, the cock—what it wants,
and then the tongue explores, finding out what’s edible and what isn’t, what’s most mineral, food for the blood, food for the bones, and therefore most delectable” (Perestroika 31). Such delectable and juicy rhetoric stands in contrast to the cold, dry speech acts of the law, for instance: “We [lawyers] know the words that made America. Out of thin air. We alone know how to use the words” (Perestroika 88). It is the lawyer, Louis, who identifies the danger of narrative to a practice of erotic embodiment: “Words are the worst thing,” the greatest impediment to the erotic because they have the capacity to form boundaries, and to keep us at a distance from a felt sense of others (Perestroika 32).

As it moves fully into its erotic dimensions, Angels enacts an additional aspect of an ethics of care, one that has been articulated by Kylea Taylor. One who is ethically in the presence of a person who is evolving within the context of illness allows the Other instances of “worship (usually without calling it worship) [of] both the force that is emerging within them and the physical bodies of others…” (91). This worship has a sanctified erotic component, although the caretaker does not consummate the interaction. Such an attitude of sanctification is in keeping with an additional dimension of an ethics of care: the ability to let another see his own body as a holy object, even if normalizing perspectives might define that body pejoratively as ill or dying. Angels in America makes a series of such representational moves, from the equation of Prior’s fevered sickness with sexual arousal, to the wet dreams that Prior experiences in his angelic encounters, to the dominatrix angel of his delusions.

In contrast to Prior’s representation as a holy, strong, and complete being, the play’s representations of Louis suggest that there is very little place for squeamishness or inauthenticity (physical or moral) in an ethics of care. Instead, caretaking becomes a
stance of abiding, of accompanying, of allowing another human to encounter the experiences of growth, illness, aging, and change without the need to control, intrude, or supply a commentary. Louis, as a counterexample, “can’t handle bodies” (*Perestroika* 97). In *Angels*, illness becomes a site of endangerment for the caretaker in ethics of care, a place that calls for the willingness to make oneself vulnerable. It even asks the ultimate vulnerability—the point of implicating oneself in the condition of mortality that one always shares with the ill. For there to be love, there has to be something at stake: no back up plan—no safety net. That, too, is part of an ethics of care. There are plenty of counter-examples to this attitude within the play: as Prior says about Louis, “You cry, but you endanger nothing in yourself. It’s like the idea of crying when you do it. Or the idea of love” (*Perestroika* 83). That is also what the angels offer Prior—an alternative to vulnerability. In her offer to save Prior from the conditions of mortality, the Angel pressures him to approach “the Tome of Immobility, of respite, of cessation. Drink of its bitter water once, Prophet, and never thirst again” (*Perestroika* 131). The stagnant sustenance that the Angels offer is contrasted with the water from the Fountain of Bethesda at the end of the play, a water that offers a blessing—“more life”—and not the heavenly realm of certain death in a static utopia. In some sense, the angels are the representatives of artificiality and technology in the play, attempting to secure humans away from their mortality, away from their emotional and erotic contact with each other, and into a sense of unification within themselves.
Technology’s Relationship to the Erotic Within *Angels in America*

If the angel-narrators in their heaven are the avatars of technology in the play, then in their presence, the site of illness becomes a technologically-mediated space. This follows the pattern established by many HIV/AIDS narratives in which technology becomes one of the primary protective mechanisms of the text, and the narrators seek the distance that technological intrusions allow. Medical history’s own nostalgia for an earlier time often has a clear subtext of longing for a less technologically-influenced environment:

> Touching with the naked ear was one of the greatest advances in the history of medicine. Once it was learned that the heart and the lungs made sounds of their own, and that the sounds were useful for diagnosis, physicians placed an ear over the heart, and over areas on the front and the back of the chest, and listened. It is hard to imagine a friendlier human gesture, a more intimate signal of personal concern and affection, than these close bowed heads affixed to the skin. The stethoscope was invented in the nineteenth century, vastly enhancing the acoustics of the thorax, but removing the physician a certain distance from his patient. It was the earliest device of many still to come, one new technology after another, designed to increase that distance. (qtd. in Coles and Testa 123)

This evolution in technology, which has a direct impact on distancing doctor from patient, is one of the fundamental trends that governs the site of illness within these texts. But such patterns exist alongside the narratorial impulse to eradicate this distance as well, in many narrative instances. Bridging the gap between surfaces of skin, then moving in, moving deeper, becomes a theme that plays itself out in all four of the principal texts in my examination.
The attempt to bridge this gap is usually frustrated, but tantalizingly approached. 
Gurganus wants, always, to construct and portray an erotic brotherhood—and is fixated 
on cementing that brotherhood even as he critiques it. Verghese’s suppressed interactions 
with his patients are as fraught with erotic energy as Gurganus’s are—his chosen methods 
of sublimation are just different. This suppression is in keeping with a pattern of medical 
discourse: the calls for intimacy within the clinic are there—the insistence that the cord of 
the stethoscope be short, technological intrusion be minimal, and a degree of physical 
intimacy still be present: “‘the doctor has to be within thirty inches of the patient,’ close 
足够的 to ensure the intimacy and laying on of hands often said to be lacking in medicine 
today” (Coles 160). The “laying on of hands” (a metaphorical concept as well as literal 
one) is a move at the heart of ethical care.

In the case of Angels in America, the play makes an argument for a move away 
from the technological intervention in the treatment of other human beings in the context 
of illness. Machines become a controlling evil, as suggested by Roy’s relationship with 
the telephone: “Roy conducts business with great energy, impatience, and sensual 
abandon” (Millennium Approaches 11). The narrative returns, at the characters’ most 
psychologically vulnerable moments, to an imagery of space-age, 
technologically-inculcated alienation, giving way to a chaotic heat-death of the universe. 
As Harper says, “When you look at the ozone layer, from outside, from a spaceship, it 
looks like a pale-blue halo…But everywhere, things are collapsing, lies surfacing, 
systems of defense giving way” (Millennium Approaches 17). Systems of physical 
defense, systems of emotional defense, and even systems of spiritual defense are eroded 
by the technological interventions within the play.
In this way, technology becomes a force of destruction in a way that, surprisingly, is not entirely negative, since it affects everyone equally and begins to erode an ego even as firmly established as Roy’s. Roy, that master of Machiavellian control, is overcome by chaos: “I see the universe, Joe, as a kind of sandstorm in outer space with winds of mega-hurricane velocity, but instead of grains of sand it’s shards and splinters of glass” (*Millennium Approaches* 13). Since this chaos also heralds growth, a human subjected to it must become open to the transformations in himself and his environment. Healing becomes, at times, a violent evolution; the stages of death a passage of individual growth which must be honored, respected, and not intruded upon by a caretaker or his commentary. The ethics of care which results from this attitude is also an ethics of gentleness, of tenderness: “Soon,” says Belize, “this…ruination will be blanketed white. You can smell it. Softness, compliance, forgiveness, grace” (*Millennium Approaches* 100).

If, instead of accepting the violence of evolution, the characters resist that evolution, or protect themselves from it, the result is both discomfiting and dis-empowering. Joe attempts to shut down his sexual feelings, but he doesn’t succeed: “I try to tighten my heart into a knot, a snarl, I try to learn to live dead, just numb, but then I see someone I want, and it’s like a nail, like a hot spike right through my chest, and I know I’m losing” (*Millennium Approaches* 77). As a counter-narrative, many characters urge the forgiveness of the demands the universe makes upon them. Growth is a dirty, compromising, ambiguous process, akin to surgery, but in less-than-sanitary conditions. Growth is itself an illness; an infected intimacy with God, says Hannah: “God splits the skin with a jagged thumbnail from throat to belly and then plunges a filthy hand in, he
grabs hold of your bloody tubes” (Perestroika 77). The characters cannot protect themselves from that overpowering thumbnail; the embrace of their own particular spiritual system becomes their only salvation. The narrators who fail to articulate such a system to themselves also often fail at the task of their personal growth as ethically-caring beings. In the same way that Joe tries to kill the homoerotic feelings he has, Louis tries to kill spiritual leanings, and he does an effective job of it as his ramblings about a fragmented and abandoned system of spirituality indicates:

Like the spiritualists try to use that stuff, are you enlightened, are you centered, channeled, whatever, this reaching out for a spiritual past in a country where no indigenous spirits exist—only the Indians, I mean Native American spirits and we killed them off so now, there are no gods here, no ghosts and spirits in America, there are no angels in America…. (Millennium Approaches 92)

The unrelenting push of chaotic evolution, the eroticism, and the collapse of dichotomies within Angels in America all create an open and undelineated field of illness. This space contrasts with the boundaries that are created and sustained in many other HIV/AIDS narratives. The creation of the water-tight nuclear family, the gathering of “trustworthy insiders,” the insular circle designed to keep out the dangers of “outside forces” are all mechanisms which work to support borders, borders which make possible the mechanisms of narrative inclusion and exclusion. Forces which shatter those boundaries come from many quarters—erotic and technological included, but this shattering has a profound impact upon an ethics of caring, as I will explore in the final portion of this chapter.
Boundaries Built and Boundary Shattered: Narrative Holism and Fragmentation

As I argue in this section, post-colonial notions of “borderlands” without definitive boundaries begin to present challenges to the mechanisms of control. The conceptual dismantling of borders and boundaries in this fashion has been discussed by such critics as Paula Gunn Allen, Gloria Anzaldua, an Audre Lorde. As AnnLouise Keating points out in her article “Myth Smashers, Myth Makers,” the new theoretical space formed by boundary shattering is drawn out of a series of new conceptual paradigms:

As they replace the Judeo-Christian worldview with modes of perception drawn from Native American, Chicana, and African mythic structures, they offer a far-reaching critique of Western Culture’s binary structures. By displacing the boundaries between inner/outer, subject/object, spirit/matter, and other dichotomous terms, the new myths they create provide radical alternatives to existing social structures. (qtd. in Nelson 76)

Still, in some of these narratives, the very paradigm of an insider/outsider construction may be woven into the fabric of the narrative itself. As just one example, consider Verghese’s remarks about one of his patients: “My visits to him every morning and evening had felt like parentheses that hemmed me in, left me little room to breathe. I always felt like a prisoner in his room, standing next to his bed, up so close to his pain” (198). This feeling of being imprisoned next to pain might be considered a strange one for a doctor to have, given the fact that pain is part of his profession. But the almost claustrophobic response, the image of being locked inside a room with a patient and forced to be with someone who is dying, stems directly from his belief that he is trapped inside the distinct and undesirable domain of illness.
Notions of the isolated and insular space of illness appear in other narrative contexts as well, and often create an internal fragmentation of psychical space as well as an external fragmentation of physical space. The fact is that notions of “Otherness” may potentially be internalized by the reader, and that the duality between the “good normal” and the “bad other” has become a frequent component of the representational schema within HIV/AIDS narratives, as Emmanuel Nelson points out:

“[James] Morrison cites the works of Douglas Crimp, Paula Treichler, Leo Bersani, Lee Edelman, and Steven Seidman as examples—which create ‘a version of AIDS that defines it as radically other in crucial ways: a disease of others, and a disease that is something other, that must be understood by means of figures, extended tropes, free-playing semiosis—something to be looked at, examined from a distance, a spectacle of representation.’” (9)

Frequently, texts pressure the ill as well as illness to become spectacles, and they pressure the audience to accept and internalize the spectacle of “otherness” as it comes to be associated with illness. This move has the potential to crack an ill person’s constructed identity down certain fault lines: subject and object, observer and observed, healthy and sick, helpless and empowered. Such fragmentation is one of the patterns that *Angels in America* attempts to undo. In this attempt, it dismantles maneuvers like Mims’ ungenerous equation of celibacy with the sustenance of life: “There’s the final closeness that two people can have, with nothing at all between them, having gone as far into another body as your own will fit. But, getting shut out of it, knowing you’re just extra and aside, that kind of isolation can do many things to you. Including save your life” (*Plays Well* 225).

Other texts sustain the duality of an insider/outsider identity even more intensely than does *Plays Well*. In the light that this insider/outsider duality casts over the narrative,
even Verghese’s status of hero-doctor begins to fray around the edges as he puts himself into the sort of “exile” that places him in a distinctly colonized and colonizing space: “The exile I felt had less to do with being an AIDS doc than with the fact that most of my patients were homosexuals” (324). Here, the narrative does not even hide his homophobic “othering,” or the fact that the categories of exclusion he uses rest on an “alien” and “exile” motif. This motif continues unabated: entering a gay bar is described as stepping “onto another planet” (60); a “prodigal” son returning to Tennessee becomes “the hometown boy [now] regarded as an alien” (11); a parent hears of an HIV-positive status as if the doctor were “speaking a foreign language” (11); and cells are described as “flying-saucerlike discs” (10). The language of alienation is consistently employed within *My Own Country*, as patients, at various times, are described as “strange” (84) or “as if he came from a different planet than the others” (90). The narrative even goes so far as to draw direct comparison between the dementia-induced behavior of a patient, and the donning of Hindu religious vestments: “a pair of close-set eyes looked at me with suspicion from behind a *purda* of sorts: he had coiled the bed sheet around his head and across his face” (28). Such an instance is not the only example of the text’s pejorative and colonizing use of Indian culture to establish its homophobic images of alienation (45). And of course, once he has set this dynamic into place, Verghese can begin to tug the strings of representational control, granting and withholding “insider status” as it applies to the characters, the readers, and even, in this case, to himself—in the interest of reinforcing such normalizing assumptions of what it means to be a “normal insider” versus an “alienated outsider.”

What many of these texts demonstrate, through their repeated establishment of borders and boundaries, is that their clear lines of dichotomous delineation would suffocate
the narrative inhabitants if they could—all in the name of keeping the characters safe.

Such an instance of safety, played out in the final scene of *My Own Country*, is couched in the language of ultimate enclosure. Surrounded by the night, by the car, by his unconscious family, Verghese has driven his readers into the same corner that he has driven himself into. His own narrative has taken him to this point; he has cut off his own connections to anyone or anything else at the site of illness. In his creation of boundaries and attempts to place others into an alienated position, he has drawn a circle of isolation around himself. He and his text have lost the opportunity for even engaging with the openness of *attitude* which Michael Warner in *The Trouble With Normal* calls the “unrestricted and uncontrolled contact with a world of strangers [that is a] pleasure, a direct cathexis of the publicness of sexual culture, by and large unavailable in dominant culture, simply because heterosexual belonging is already mediated by nearly every institution of culture” (179). He has created an audience of readers who are given a chance to stand in judgment of those on the “outside,” and to believe they are defining, for themselves, an experience of illness that they are not even having. This position makes an ethics of readerly care virtually impossible to conceive of.

By contrast, then, how does eroticism specifically, and *Angels in America* in general, create a boundary-shattering space? Actually, it suggests a series of such spaces: the blurring of bodies joined and the blurring of divine beings and mortals at the site of sexuality; the blurring of voices, since there are many narrators, and at times everyone talks at once; the blurring of generations, and of the past with the present through the arrival of the prior Priors (*Millennium Approaches* 85); the blurring of historical moments when Roy Cohn is haunted by the ghost of Ethel Rosenberg; the blurring life and death, when Prior
returns to earth, and the blurring of heaven and hell (since both are San Francisco). But even in all of these examples of collapsing distinctions, there is probably one that has the most notable impact upon the reader—the narrators’ refusal to form a distinct boundary around the text: the refusal to offer narrative closure.

The Role of Narrative Closure in the Establishment of Boundaries

So far, my discussion of borders and boundaries has bypassed the fact that the texts themselves often impose a distinct boundary upon the events they are relating; they construct a definitive textual ending. Judith Pastore notes that a safe narrative passage to closure becomes one of the standard features HIV/AIDS narratives, and furthermore observes that: “…the conventional novel, with its middle-class orientation and need for closure, in many ways distorts the AIDS experience” (9). The need to impose an often-premature sense of closure that these narratives exhibit seems to have as its impetus a few different sources. Most obviously, closure is a way of containing and controlling something that really has no boundaries. In a variety of circumstances, as Frank Kermode points out in The Sense of An Ending, we live with the myth of closure when we invent paradigms “…to give meaning to what would otherwise be ‘purely successive, disorganized time.’ Apocalypses or ‘fictions of the End’ distinguish…ordinary chronicity from a sense of time that ‘ends, transforms, and is concordant’” (qtd. in Dellamore 109). We want these passages of time in these narratives (as we want them in our lives) to be leading somewhere. Most of these narratives meet this reader demand: giving us an idyllic island at the end of Holleran’s Ground Zero, for example, or delivering us or to a state of
psychological equanimity at the end of *Plays Well With Others*, or leaving us with a summation of the pandemic in *And the Band*.\(^{32}\)

Sometimes, in the narrative act of closure, the narrative implies that “the problem” of HIV/AIDS has been dispensed with—swallowed up by the larger whole (*My Own Country*). Or, it suggests that the sheer dimension of the problem excuses us from further involvement or concern (*And the Band*). The narratorial need to impose a premature ending also contributes to a unique narrative pace, a sense of rushing the text. This “rush,” which serves both as an analgesic and an appeal to shortened attention spans, is seen clearly in the death of Alabama in *Plays Well With Others*, for example. Just moments after her illness is announced to the reader, we see her gasping for breath after walking down the runway of a plane, pale and wan, detached and devoid of her usual liveliness. Within the span of a few pages, she is dead; the major character of this lengthy novel has passed away in a rush of events that leaves the reader with questions: why was Alabama, in her death, granted the privacy that Robert was not? Why was she granted the dignity of having her art speak for her, instead of having the “exquisite devolving” of her language represented? Was it because she was straight—or because the narrative sought an easy ending. The answers to such questions seem to have much to do with the narrative pacing, as we readers sail to safety on the succinct boat of Alabama’s passing.

In a contradictory narrative pattern, premature closure may also lead to the odd tendency to “hurry up” the narrative to the point of a character’s death, and then to describe that death in detail. Steven Krueger labels this phenomenon “telescoping” in *AIDS Narratives: Gender and Sexuality, Fiction and Science*: “In much fiction about AIDS, as here, the discovery of what seems to be a Kaposi’s sarcoma legion (or some other ‘sign’ of
AIDS) contains within it for the character as for the reader, the promise of a whole devastating narrative” (90). And “promise” is an operative word in this description, the promise which is made to a reader who wishes to be entertained and satisfied. One of the implications of the “premature closure” drive of these narratives is that they perpetrate another narrative drive: the “incurability depiction” of AIDS, a trope which has become increasingly irrelevant as the pandemic advanced and the effectiveness of the medications increased. Again, this produces an entire genre of AIDS narrative—what Steven Krueger has identified as “the novel of irreversible decline.”

Alternately, there are examples within these HIV/AIDS narratives of conclusions which do not provide closure, of more amorphous endings that cannot be characterized as “neat,” “satisfying,” “edifying,” or as having some “positive and lasting moral effect.” There are even texts which address the burden that a definitive ending imposes upon a narrative as it truncates a textual life. As one narrator characterizes his brother’s life in Paul Monette’s short story “Halfway Home” in the anthology entitled Lavender Mansions:

Am I still in a rage? Yes, livid. The last thing I need is this mocking reminder that life goes on for straights, mellowing and ripening into an ever richer manhood. In the glint of the moon Brian’s skin fairly radiates with health. The bristling hair on his belly is thick with hormones. He’ll be fifty, sixty, seventy, and still be winning trophies. And I’ll be dead, dead, dead. Of course I know I can’t blame my illness on Brian, but I can still hate him for being so alive. And the deep, deep irrelevance of his shiny life, with the peewee games and the goldens [golden retrievers], I can hate that too. The white-bread sitcom cutesiness and the lies of the Nazi church. (342)

His brother’s life will go on; his own life story will cease. Brian will live out his days in an almost pregnant manner—the references here to generativity are clear: the moon, the thick
belly, the hormones, and the “mellowing and ripening” richness. This is anger which frees
the narrator and the reader from the heteronormative dictates of many of these texts,
because it critiques the inherent unfairness of the power of “normal” without offering the
pabulum of politeness, of understatement, or of the omni-present and irritating demands by
society that ill characters assume an understanding attitude towards oppressive
representations. But there is no such contrived ending in Angels in America.

Angels refuses closure through a perhaps less “angry”—but no more “neat” or
satisfying”—set of representational moves. In the play, we are suspended in a substrate of
on-going ambiguity. First, the phrase “more life” becomes one of the central mantras of
the play: “Bless me anyway,” Prior says to the angels, “I want more life” (Perestroika 133).
The Fountain of Bethesda becomes one symbol of that human cry for “more life,”
suggesting through its presence that the dead can spring to life again: “The fountain’s not
flowing now, they turn it off in the summer, ice in the pipes. But in the winter it’s a sight to
see. I want to be around to see it. I plan to be” (Perestroika 146). The narrative’s
commitment to continuation is revealed in the implicit statements of perhaps the play’s
truest prophet, Harper: “Nothing’s lost forever. In this world, there is a kind of painful
progress” (Perestroika 146). Even Roy Cohn’s life becomes evidence of this continuation
as he lives on in “heaven, hell, or purgatory,” still attempting to demonstrate his verbal
prowess and seductive litigatory skills to the “King of the Universe” (Perestroika 141).

Continuation is advocated over closure within the play, and evolution is advocated
over stasis. As Emerson’s epigraph to Perestroika reads: “Because the soul is progressive,
/ it never quite repeats itself, / But in every act attempts the production / of a new and fairer
whole.” The notion of evolution is related to the images of The Divine in the play. God
himself, that ultimate presence, is so taken with the human capacity for evolution that he abandons his angels in heaven: “Bored with His Angels, Bewitched by Humanity, In Mortifying imitation of You, his least creation, He would sail off on Voyages, not knowing where” (Perestroika 43). God becomes, as Belize points out, the “man that got away” (Perestroika 44). But God longs for something that Heaven cannot supply: the unknown, the mysterious, and the excitement of growth and surprise. The play suggests that illness may offer such gifts as well, when people become, as Prior says, “more spirit than body” (Perestroika 133). The hunger for evolution is the reason that everyone in heaven is a card player; games of chance are the one small, remaining opportunity to insert the unknown back into life: “Cards is strategy but mostly a game of chance. In Heaven, everything is known. To the Great Questions are lying about here like yesterday’s newspapers all the answers. So from what comes the pleasures of Paradise? Indeterminacy!” (Perestroika 134). That which is unknown, that which is left ambiguous, is presented by Angels in America as the greatest gift that humans are given. In fact, the gift of indeterminacy may be the most important constituent of an ethics of care, as a caretaker makes a move away from a forceful intervention at the site of illness to a more gently abiding presence.

Kushner refers to the fact that Harold Bloom translates the Hebrew word for blessing as “more life” (Perestroika 10), and characterizes the nature of his plays themselves, particularly Perestroika, as works in progress (v). In keeping with the play’s resistance to closure, critic Melvin Dixon observes that “As writers, we are a curious lot. We begin our projects with much apprehension about the blank page. But then the material assumes its life, we resist writing that last stanza or paragraph. We want to avoid putting a final period to it all” (qtd. in Howe 185). In another portion of his essay, Dixon points out
the price of closure, the responsibility that comes with imposing it, and even the political ramifications of it that many narrators choose to overlook. But within *Angels*, the easy gesture towards disposal or erasure, made by those who bring a final chapter to a definitive end, is stopped short. The narrative remains unclosed, unsutured, unsealed—just as the play remains broken open for reasons suggested by Theodore Roethke in *Perestroika*’s epigraph: “In a murderous time / The heart breaks and breaks / and lives by breaking.” A broken-open heart and an unclosed narrative become primary features of a narrative ethics of care. *Angels in America* succeeds in moving the narrators intimately through events that other narrators of HIV/AIDS have distanced themselves from: illness and death, social alienation and delusion, rejection and ego-dissolution. After having moved through these states, Kushner’s narrators, joined together in a perpetual conversation at the end of the play, converse without beginning, without end, but with the suggestion of on-going ethical discourse: “And I bless you: *More Life*” (*Perestroika* 146).
Chapter 1

1 HIV/AIDS is marked, according to Paula Treichler in “AIDS, Homophobia, and Biomedical Discourse,” by “an epidemic of meanings or signification” (357). Her proof for this assertion involves a thirty-eight element list, listed in a footnote in the final chapter, of ways in which AIDS has been constructed—a funhouse mirror of representation that makes the process of subsequent representation an exercise in systematic dichotomization and carefully controlled disciplinary mechanisms. We may well try to negotiate this terrain with a metaphor—in fact, Treichler subscribes to the idea of a well-constructed metaphor where Susan Sontag does not. But even a consolidating metaphor is not an antidote to the amount of control a given representation can have upon us. What we are told about HIV/AIDS, the social discourse which slants our perceptions of the disease, has ramifications for everything from civil rights, medical research, perceptions of death and sex, and the care given to those who are ill.

2 Simon Watney offers this quotation from Jacqueline Rose’s “Feminism and the Psychic” as a preface to his article “The Spectacle of AIDS”: “The question of identity—how it is constituted and maintained—is therefore the central issue through which psychoanalysis enters the political field” (qtd. in Crimp 71). In the case of the texts I am examining, the constitution of subject position goes awry when a) there are factors within the field of representation of AIDS which serve as distortions in the mirror into which these narrators are looking to construct and to maintain their identity, b) there is a pervasive set of narratorial archetypes which are both the cause and the result of this failure in successful mirroring, and morph into predictable roles which the narrators assume.

3 In “AIDS, Homophobia, and Biomedical Discourse: An Epidemic of Signification,” Paula Treichler argues (along with such critics as William Haver) that the way in which we approach the representation of AIDS is “multiple, fragmentary, and often contradictory…neither directly nor fully knowable” (357), and that this fact is a source of anxiety for those who are attempting to represent the crisis. In managing that anxiety, the point at which the narrators attempt to develop a language of AIDS begins to resemble the mirror stage of human development:

In multiple, fragmentary, and often contradictory ways we struggle to achieve some sort of understanding of AIDS, a reality that is frightening, widely publicized, and yet finally neither directly nor fully knowable. AIDS is no different in this respect from other linguistic constructions, which, in the commonsense view of language, are thought to transmit preexisting ideas and represent real-world entities and yet, in fact, do neither. For the nature of the relationship between language and reality is highly problematic; and AIDS is not
merely an invented label, provided to us by science and scientific naming practices, for a clear-cut disease entity caused by a virus. Rather, the very nature of AIDS is constructed through language and in particular through the discourses of medicine and science; this construction is “true” or “real” only in certain ways—for example, insofar as it successfully guides research or facilitates clinical control over the illness. The name AIDS in art constructs the disease and makes it intelligible. (357)

But only in this intelligibility is only partial, and it is the part of the disease that remains unintelligible that I am concerned with. It is, I believe, the ways in which the representations of HIV/AIDS through language are not “real or true,” that is of concern—as well as the refusal to make gestures towards narrative care.

4 Just placing the word “erotic” upon the table of illness literature raises a number of questions. Are we calling a disease or its surroundings, as described by the texts, erotic? (Probably not.) How firmly can a definition of “The Erotic” be pinned down? (Not very.) Just who is to determine what is erotic? Are there instances of “bad eroticism”—places at which seeing a facet of illness as erotic is insensitive or exploitative? We even have to consider minute details: how do we negotiate the fact that descriptions of death and of love often run very close together—the fact that both “little” and “big deaths” are often endowed with similar textual descriptions, and that thanatos and eros may share a close representational proximity? If some critics have been afraid of seeming irrelevant or in “poor taste” as they earmark the erotic within these texts, they may be missing the liberatory and subversive points of the erotic, the way the erotic in all of its manifestations, uncontainable and unclassifiable, might serve as a point of narrative rupture. Audre Lorde, in her groundbreaking and now famous article “The Uses of the Erotic,” offers one helpful characterization of the erotic for the inquiry I am conducting: the erotic “…comes from sharing deeply any pursuit with another person” (341). In her article, the notion of eroticism is praised for its capacity to level hierarchies, to erase the divisions between subject and object, to blend and create, and to reinvent endeavors and bring elements into union.

5 Why might these texts be characterized as “unerotic”? First, the lack of descriptions of sexuality, save in the most displaced of ways, marks these texts as unerotic, if not “anti-sex.” But I must also note the exceptions to this observation here: Martin and John, (where a driving sexual charge pushes the story towards its dénouement); the poetry of Raphael Campo, in which the bodies of patients are also desired bodies, or even the more unexpected eroticism of Paul Monette’s Becoming a Man and Mark Doty’s Heaven’s Coast. Second, the ways in which the text represents the body often creates it as a site which can no longer “be sexual” as defined by the text (as well as by many normative standards). Third, many texts’ studied avoidance or condemnation of what they deem “inappropriate sexuality” “distasteful sexuality” or “unrecognized sexuality” is sustained, heavy-handed, and serves a disciplinary function within the texts.
6 Gurganus alludes to such a belief in an interview: “One of the privileges of being a writer-citizen is that since all of us are really thinking the same thing at the same time, if you can get it down you have provided a huge service for other people” (<http://www.identitytheory.com/people/birnbaum29.html>).

7 In a December 1997 interview with Salon magazine, Gurganus demonstrates his awareness of how Plays Well With Others takes its place among the genre of illness literature: “There was some joy in writing this book, writing what I think of as a comic novel about HIV, which I think is the thing that’s most original and useful in the book….What I really wanted to do was replicate the party. And the party, perversely enough, included the hospital stays. The party, 1980, had so much momentum—it’s like 1920 and the parallels are marked. And Gatsby was a real inspiration for this book. The party somehow continued to animate the hospital visits, the balloons, the confetti, the dressing up in silk gowns and trying to make an event of it. And the funerals were the last of the parties; those too were kinds of festivals and celebrations” (<http://archive.salon.com/books/int/1997/12/cov_si_08gurganus2.html>).

8 The book, in actuality, has very few detractors: Peter Kurth writes, “This is a wickedly funny novel, unsentimental, free of self-exculpation and determined to keep a bright face on things despite the subject matter. ‘Don’t worry,’ says Mims/Gurganus [in a conflation of the author and the narrator], ‘I can still be amusing. They always liked that in me’” (<http://archive.salon.com/books/int/1997/11/10review.html>). Ellen Kanner, in Book Page’s November 1997 interview, also wants to equate Mims and Gurganus: “Hartley is much like Gurganus himself, who lived in New York in the 1980’s while teaching at Sarah Lawrence.” (<http://www.bookpage.com/>). He had a reputation established before the publication of the novel, for The Oldest Living Confederate Widow Tells All, and for teaching at Stanford, Duke, Sarah Lawrence, and the Writer’s Workshop at the University of Iowa. His work is also included in the Norton Anthology of Short Fiction, a recognition which he reports to be proudest of. Internet evidence suggests that Gurganus is a cultural phenomenon: a search of the Web reveals 5500 references to Gurganus; 576 to Plays Well With Others, alone. The book has received many awards as well. In 1998, it was a Lambda Literary Award Nominee in the category of Gay Men’s Fiction. It was the New York Times Book Review’s Notable Book of the Year in 1997, and a Booklist Editor’s Choice in that same year. An inventory of syllabi from different universities suggests that it is being taught in universities from Michigan to Florida, and in classes from medical history to literature. Comments Gurganus has made about his own work reveal parallels between himself and his narrator, Hartley Mims—both in the attitude he takes towards art, and the process with which he encounters artistic production. As he characterizes his characters: “they have found an obsession which organizes life for them and who then wind up sacrificing life to protect the obsession they commence to protect them from life. Which is an allegory for what art does, in a way. It shields us and it sometimes cuts us off” (<http://www.identitytheory.com/people/birnbaum29.html>).
Chapter 2

9 Verghese’s reviewers make much of the fact that he is an Indian doctor who grew up in Ethiopia, and who found himself feeling emotionally displaced (but at the cutting edge of HIV/AIDS research) in Johnson City, Tennessee: “Writing with an outsider’s empathy and insight, casting his chronicle in graceful prose, he offers a memorable tale that both captures and transcends time and place” (Publisher’s Weekly, May, 1994). While in Johnson City, Verghese simultaneously feels himself to be excluded from the community in which he finds himself and desperately needed for his expertise. This interplay of acceptance and rejection fuels much of the emotional tension in the work, as well as the dichotomous structure which undergirds many of the text’s representations.

10 My Own Country is a talked-about text: a search of the Web reveals 5090 references to Verghese, including 1400 to My Own Country, alone. After the publication of the novel, Verghese became a sought-after function speaker—delivering “inspirational” talks for the Council and Development board at the University of Texas Health-Science Center, and becoming the director of that center at San Antonio. The work is widely taught in classes such as “The History of Plague” at Allegheny College, and at the Universities of Colorado, Alabama, North Carolina, and Indiana State. The text is considered a foundational book in forums for HIV/AIDS education, (short listed, for example, by the Johns Hopkins AIDS Service Literary Corner). In 1998, the text was turned into a movie which aired on Showtime, and which went on to receive critical acclaim itself. Verghese is a regular contributor to the New York Times, Granta, and the New Yorker, The Washington Post, and The Atlantic (as well as variety of medical journals) and has also received numerous accolades upon the publication of his second novel, The Tennis Partner (2000).

11 Not that Verghese doesn’t have detractors, most notably in the form of Tony Kushner—who criticizes Verghese’s perpetration of the preferential treatment of some of his patients, which he finds to be characteristic of the medical system in general. But Verghese has been consistently defended from detractors by his vocal supporters. In the June 1997 issue of Body Positive Magazine, Paul Harris takes aim at Kushner’s attacks upon Verghese: “Had Kushner bothered to read Verghese’s outstanding memoir, My Own Country, about his life as an AIDS physician in rural Tennessee, he would not have launched such an attack. Verghese’s attitude toward the indifference of the Reagan administration to AIDS, and toward Republicans in general, as well as those physicians who pursue the more lucrative areas of medicine rather than infectious diseases, speaks for itself” (<http://www.thebody.com/bp/june97/aids_lit.html>).

12 As Cindy Patton observes: "Accounts which ground institutional containment strategies in this discursive moment of self-other seem to presume an unproblematized individual practice of psychological differentiation. [And a sustained process of narratorial development definitely problematizes it further.] This homological argument begs the reverse account, in which the individual (or subject—they collapse in this procedure) is presumed to take up her or his position in relation to these discourses of self-other,
implicitly re-inscribing poststructuralism’s supposedly fragmented subject as, in fact, a reservoir for the discourse writ small. This argument makes sense only as long as everyone stays in ‘their place’: when bodies move between or are relocated through discourse, or carry discourse with them into foreign terrains, the work of self-other codes is fractured, transformed, or completely disappears” (qtd. Parker and Sedgwick 180).

13 William Carlos Williams seems slightly more aware of the narrator hero dynamic at work, the motivation behind it, and the very real need for control that underlies the identity construction of a caretaker clinician writer: the belief that there is a truth to be reached, an essential truth that the narrator may uncover during his quest, that he has this power—no matter what the cost: “that somehow or other, whatever the source may be, he has gone to the base of the matter to lay it bare before us in terms which, try as we may, we cannot in the end escape. There is no choice then but to accept him and make him a hero” (qtd. Cousins 312). And the fact that the doctor defines himself as a hero, as well as accepting that definition from others, is suggested by the grandiose language of Williams’ descriptions of a doctor at work: “The real thing is the excitement of the chase, the opportunity for exercise of precise talents, the occasion for batting down a rival to supersede him, to strut, to boast and get on with one’s fellows” (qtd. Cousins 250).

14 According to the text, the foundations of Will’s strength are his associations with the military. His military education has provided the “roots of his character, the wellspring of his integrity” (288). The references to this “courage,” which over-determine the descriptions of Will (and only Will) in the course of the text, are attributed to his time at the Virginia Military Institute: “Any man that [sic] can survive the Rat Line at VMI can handle anything in life” (288). In the descriptions of Will, Verghese ceases to fashion himself as a “folksy story spinner,” and allows Will to speak for himself, in a serious and compelling voice that attests to Will’s belief in his own heroism. At the military academy, Will observes, “…every outward thing that defined you was stripped away and you had to find inner strength. Words like honor, honesty, self-discipline—these can mean nothing in the outside world, but they take on new meaning there” (290). Once we encounter Will, the narratorial rhetoric suddenly straightens up and flies right.

15 This polarity is certainly constructed and maintained within the sub-narratives of this text, and is even identified from the outset: “The story of the young man who had come home from New York and died in Johnson City was not known outside the hospital. Even in the hospital, it was suppressed like a shameful memory” (52). At this point, traces of memory and fantasies of representation both coalesce into a structuring feature of narratorial subjectivity, which can supposedly identify the “shameful” features of sickness in the environment of the clinic. Later, Verghese finds that the local press is interested only in what he calls the “prurient” side of AIDS. Never fully spelling out the specifics of that “prurience,” Verghese assumes the reader will know what he means. As Verghese is becoming acquainted with his new environment, he remarks that he “confides” in someone about “my curiosity about the gay population in Johnson City” (55). The language of confiding, curiosity and prurience suggest the attempt to wash the text in the color of shame and implicit moral condemnation, both of which rest on a dichotomous view of
sexual activities. Gayle Rubin identifies the rewards to compliance with this dichotomous sexual hierarchy in *Thinking Sex*: “Individuals whose behavior stands high in this hierarchy are rewarded with certified mental health, respectability, legality, social and physical mobility, institutional support, and material benefits” (qtd. in Abelove 12). Likewise, Rubin suggests the price that is to be paid for non-compliance: “presumption of mental illness, disputability, criminality... loss of institutional support, and economic sanctions” (12). And, apparently at times, medical neglect.

Chapter 3

This artist narrator also fragments his representations within the narrative. Far from an attitude of allowing that is frequently cited as one of the touchstones of an ethics of care, this dividing and classifying of people, performances, and body parts on the basis of their surface materiality suggests that the narrator-artist is acting from a standpoint of intrusive subjectivity. As Foucault observes, a new way of defining disease took place within the walls of the clinic, when medicine began to concentrate on the way that a disease impacted individual body parts. This way of defining disease justified a dissection of the *living* body (or, for our case the identities of the narrators within the narrative):

With his anatomy, Bichat [that early medical theorist] does much more than provide the methods of analysis with a field of objective application; he makes analysis an essential stage in the pathological process. He realizes it within the disease, in the very web of its history. In a sense, nothing could be further removed from the implicit nominalism of the clinical method, in which analysis was directed, if not to words, at least to segments of perception that are always transcribable into language. One is now dealing with an analysis that is engaged in a series of real phenomena, and acting in such a way as to separate functional complexity into anatomical simplicities; it frees elements that are not less real and concrete for having been isolated by abstraction [whether “scientific” or “artistic”]; in the heart, it reveals the pericardium, in the brain the arachnoid, in the intestines the mucous membranes. Anatomy could become pathological only insofar as the pathological spontaneously anatomizes. Disease is an autopsy in the darkness of the body, dissection alive. (131)

In this act of dissection, the same reckless abandon which marks the method of autopsy is permitted free reign upon the body of the sick patient. When “functional complexities” of identity are transformed into fragmented performative “simplicities” (such as the roles of hero, artist, prophet—and manifestations of those roles such as detective, adventurer, and educator), the unifying features of a caring ethic, exemplified by one holistically-conceived being meeting another holistically-conceived being, is eroded.
Jan Zita Grover joins Crimp in the project of critiquing deliberately distorted representations contained within writings on HIV/AIDS. She argues in “Visible Lesions: Images of the PWA in America” that specific media representations, especially some photographic representations, have been particularly damaging to PWAs, since they have focused on images of helplessness, devastation, and sensationalized physical difficulties. These representations are the mirrors into which society, as well as these narrators, gaze as they form their own narratorial identities—mirrors which allow them to define and form themselves in contrast to existent “negative” representations of those who are ill. In “AIDS: Keywords,” Grover identifies the sheer amount of fragmentation contained within certain representations of AIDS, and thereby refines Crimp’s analysis of social representations of people with AIDS a bit more explicitly: “AIDS is not simply a physical malady; it is also an artifact of social and sexual transgression, violated taboo, fractured identity—political and personal projections. Its key words...are primarily the property of the powerful” (qtd. in Crimp 18). And, again, as Edelman has suggested, if representations of “sick” patients are fragmented, the impetus for establishing a unfragmented subject position of the “well” narrator is increased, since the narrator is frequently defining himself in opposition to the one he is caretaking. Yet these narrators are all up against the way the clinic is positioning them as well: (Verghese recounts his frustration at being an outsider, Shilts complains that no one is listening to his version of the account of AIDS, and Mims stands as the one dismissed, plays the self-proclaimed “lapdog” to Alabama and Robert in the course of the novel.) Of course, in the context of the textual prominence of the narrators, this self-perception of oppression is laughable, but may begin to explain the overcompensatory drive for a vaunted subject position.

I would also say that my own rhetorical intentions are pure, that my desire to see more kinds of narration in the context of caretaking is in itself caring, even if my critique is consistently skeptical of many of the methods I have come across. In a slightly tangential note, but one which runs parallel to my own rationale, Thomas Couser responds to charges that he has tried to “police” representations contained within life writing from his academic post in this manner: “Granted, academic critics derive some power from their professional standing, but vis-à-vis many life writers, whose books are far more widely reviewed and whose audiences are far larger, their actual influence is not very substantial. For better or worse, such critics are hardly in a position to suppress writers who reach audiences quite independently of academic sanction. My third objection is that the term [“police”] suggests a degree of coercion and a motive not usually inherent in the discourse to which it is applied” (199).

Theories of trauma have been much more committed to an explanation of social and psychological contexts within a given illness narrative than more traditional critiques of HIV/AIDS narratives have been (critiques which have concentrated more exclusively upon political outcomes or aesthetic issues), which may be one reason the partnership of trauma theory and HIV/AIDS narratives has been a troubled one. From its Freudian inception, trauma theory has identified one primary feature of narrated accounts of trauma: a pattern of repetition, particularly as it introduced within a highly stylized account of the trauma. Such a mimetic pattern is also a fundamental feature of many of these illness narratives.
But even having acknowledged the mimetic features of both, and although the critical school of trauma theory might seem appropriate to an analysis of these points of mimesis, it really is not. But the idea of a psychologically repetitive encounter does seem helpful to an exploration of narratorial subject formation and control of representations within the text. Trauma theorist Cathy Caruth contends that we do not know trauma at the time we have experienced it, but only through our repetitive imaginings of it once the initial shock is over. We do not know it in its immediacy; we only know it “belatedly” and through the lens of what she calls “repetitive seeing” (qtd. in Parker and Sedgwick 89). This repetitive seeing, the mechanism by which the trauma is known retrospectively, is an aspect of repetition compulsion. In her exemplification of this phenomenon, Caruth cites Lacan and Freud’s landmark interpretation of a father’s dream of his burning child which took place after the child’s actual death:

While Freud introduces the dream in The Interpretations of Dreams as an exemplary (if enigmatic) explanation of why we sleep—how we do not adequately face the death outside of us—Lacan suggests at already at the heart of this example is the core of what would later become, in Beyond the Pleasure Principle, Freud’s notion of traumatic repetition, and especially the traumatic nightmares that, as Freud says, “wake the dreamer up in another fright.” (90)

But I would argue that the generalized mimetic drive within these texts has more to do with an attempt to forge a narratorial identity and control the representations within the text, and less to do with coming to terms with a trauma. In deepening the grooves in the definitions of that identity, narrated repetition has less to do with a defense against the realization of trauma, or an attempt to constitute identity by constructing oneself as the surviving subject (as Caruth argues that the father is attempting to do in his dream). Thus as a critical line of inquiry, trauma theory seems unhelpful to an exploration of these illness narratives. The narrators aren’t recovering from trauma, they are using it to establish a certain pattern of representation, and to secure certain aspects of their own identities (as heroes, not as survivors).

20 Even in works that would not be considered “well written,” the dynamic of rhetorical distancing may still be at work. For example, aestheticization can have an impact at the level of diction itself, as Christopher Davis’s Valley of the Shadow illustrates. This stilted and undistinguished novel has as its strength the selection of a unique defense: rhetorical politeness. As he says about his deceased lover, “…I do miss him so much, and how I wish that I could see him just once again…” (22). The careful diction mirrors the carefulness of the attitudes portrayed and the positions taken, making “muted emotion” seem to be the text’s chosen manner of representation. The language is also designed to push what it describes far into a manageable distance: “…although he only died seven months ago I remember those final months, then days, hours, minutes, as through they were fragments of a distant dream that cannot be recalled in its entirety; only its emotional outlines and general contours still exist” (182). The clichéd and abstracted nature of this
characterization is representative of the writing throughout the novel, and it forms a representational landscape of emotional distance and quiet resignation.

Identity-stabilizing representations are particularly sought out by the narrators and auxiliary characters in David Leavitt’s *The Lost Language of Cranes*. The novel recounts the story of a family who has as its members a gay son, an (at first) closeted gay father, and a mother struggling to come to terms with some of the dishonesty of her life. The three family members are living out identities whose normalized features will collapse, given the least amount of questioning or examination. As a stay against such collapse, the moniker of “artist” is assumed most fully by the mother-caretaker within the novel. Rose is a woman who has never accounted for the many hours that her husband is mysteriously missing during the evenings (when he is in gay moviehouses) because “it wouldn’t be polite” (5). She is also a woman who, as a copy editor, manages her anxiety through her disciplinary but artful handling of language: “...like a monk in a cell, she read with an almost penitential rigor. In moments of tension she calmed herself by thinking up synonyms: ‘feel, empathize, sympathize; rage, fulminate, fly off the handle; mollify, placate, calm.’ It was an instinct to put the world in order that powered her, as sitting at her desk she put sentences in order mending split infinitives and snipping off dangling participles, smoothing away the knots and bumps until the prose before her took on a sheen...” (5). “Putting the world in order” at the site of chaos, emotional uncertainty, or upheaval become a matter of calculated emotional management within the clinic of her life, a task which her work with language helps her accomplish through its classificatory and definitional discursive mechanisms. While the expressed purpose of the text may be to advocate for the characters or to serve as a witness to their traumas, in actuality, the novel serves to illustrate the uses of language and of narrative to manage anxiety.

Chapter 4

Again and again within the texts, we find ourselves in the hands of a narrative which is attempting to inculcate “normalcy,” this time through the assignment of “good” to given attitudes and behaviors. Even activism comes under scrutiny for not being effective enough: in *And the Band Played On*, one character asserts without doubt that

> The freedom to go to a gay bar was not real freedom...Cleve
>
> sometimes wondered whether the new men crowding the Castro had already gone through this personal growth elsewhere or whether they had simply skipped it because being gay in San Francisco was so easy now that you didn’t need to plummet to your psychic depths to make a commitment to the lifestyle. (17)

Besides containing assumptions about the nature of the men’s psychological immaturity, the passage clearly contrasts the “good” outcome of making political inroads with the “bad” outcome of accessibility to gay bars and “lifestyles.” The text continues in this manner, having one character witnessing fist-fucking and thinking to himself, “Certainly, a psychologist would see that this was unhealthy, a corruption of the very gay love that this day was supposed to celebrate” (24), and again exhorting that,

> “The more respectable gays, who talked earnestly of civil rights, seemed more intent on defending the current gay...
life-style than on changing it to something more meaningful. Rather than fight for the right to get married, the gay movement was fighting for the prerogative of gays to bump like bunnies” (27).

Such editorializing leads to a whole host of questions: who exactly, are “respectable” gays? What reductive opinion is behind the use of the phrase “bump like bunnies” within the context of a supposedly journalistic piece? And what attitudes are revealed by the insistently pejorative and reductive use of the word “lifestyles”? In short, how are attitudinal dichotomies sustained by the dichotomizing assumptions about “good and evil” within the text?

23 There are reminders that even in the most scientific of texts, we are not in safe hands, that the dichotomies which sustain normalizing representations are rampant. Stated in the matter-of-fact manner in a text such as AIDS and HIV in Perspective: A Guide to Understanding the Virus and its Consequences, scientific “analysis” has the potential to come across as a authoritative, and thus holds substantial rhetorical power:

Since the earliest days of the AIDS epidemic, sexual promiscuity was alleged to be a major fact in the rapid spread of HIV infection in the male homosexual community. Undoubtedly the profligate sexual trafficking and indiscriminate sexual exchanges which were part of the culture of the bathhouses and other similar institutions were a significant component of the homosexual lifestyle in certain communities and this contributed very significantly to the rapid spread of HIV. (Schoub 98)

The references within the passage are driven by connotation rather than description: “promiscuity, profligate, and indiscriminate” are all words that come to be understood only through their pejorative connotations.

24 James Miller, too, has written about Randy Shilts as an inadequate commentator upon HIV/AIDS, although his attack is directed more at the genre Shilts has chosen than at Shilts’s tone. In Miller’s article, “AIDS in the Novel: Getting it Straight,” he suggests that Shilts text voices a Victorian sensibility and reinforces “family values”:

That Shilts seems to have mistaken his novel for the Facts in no way undermines his right to be hailed as one of the great contemporary masters of straight middle-class fiction. The skill with which he has woven a thousand plots together into a coherent cautionary tale set in a sleazy slum-world writhing with green monkeys, bicentennial sailors, and exotic bathhouse bugs quite dazzles me. I marvel at his Dickensian talent for vivid charicature, villains being his great specialty. (257)

But Miller’s greatest critique is reserved for Shilts’s treatment of Gaetan Dugas, whose appearance in And the Band Played On led him and his family to a series of death threats
after the text was published: “What’s more, he’s a Canadian alien: his weird extraterrestrial name was Gaetan Dugas, we learn, and he hailed from the remote snowbound planet of Quebec via Air Canada. I still shudder—whether with voyeuristic pleasure or zero-at-the-bone fright I can’t tell—whenever I recall the lurid bathhouse scene where Patient Zero exchanges bodily fluids with a Castro Street clone and then cackles vampirically as he reveals his fulminant lesions: ‘I’ve got gay cancer….I’m going to die and so are you.’ That scene is enough to set anyone straight about gay sex” (258).

25 In Trauma and Recovery, Judith Herman outlines many common psychological phenomena seen at the site of a trauma or crisis, most of which seem inapplicable to the way in which the narrators represent their own psyches within HIV/AIDS narratives. To summarize her views, a traumatized mindset exhibits the desire to deny the trauma, unbearable fear, feelings of helplessness, loss of control, and (according to The Comprehensive Textbook of Psychiatry); the longing to be nurtured and taken care of, the endurance of personal boundary violations, the tendency to self-denigrate, the tendency to overly idealize people to whom one becomes attached, habits of obedience and overly-empathetic understanding, and the deeply-ingrained tendency to dissociate, attempt to make destructive situations “come out right,” and feelings that one does not have choice or agency. Herman’s analysis seems irrelevant to the narratives that we encounter here, first, because these traits are not accurately descriptive of what is found in the narratives themselves, and second, because they presuppose a narratorial interiority which is not evident in many of these narratives.

26 Steven Krueger also discusses the way in which the personification of the virus allows for comparisons between man and machine, and encourages textual practices which objectify the body as a technological structure. This discursive practice of a technologically-inflected aestheticization of the body also establishes the narrator’s position as a science fiction writer who is narrating the breakdown of the machine. A reverse discourse is also formed when the machine begins to represent the ill human body. Computer viruses, for instance, are textually-likened to human viruses: “As with AIDS, certain behaviors (e.g., ‘sharing diskettes promiscuously’) are defined as putting one at ‘high risk’” (19). This metaphorical linkage of body and machine in these narratives is not a new representational phenomenon. But the intensity with which such rhetoric is applied to a specific form of representation is surprising. A coldly-extended discussion in The AIDS Crisis and the Modern Self, which offers an explicit commentary upon how the “major awareness of the problem of finitude may turn from a mere nuisance into a technology of the self,” serves as a ready example of such technologically-inflected representation (183). In other words, in clinical considerations of AIDS, the event of death becomes an almost mechanistic glitch in the machine’s technology. But in reality, the virus is not a constituent piece of the “technology of the self,” anymore than it is an ominous element of evil that has infiltrated the human body with intention and malice. The fact is, as Barry Schoub points out, “little is known about the origins of any human virus, let alone HIV” (13). But in the narrator’s race to achieve a stable subject position for this evil, and to point the finger of blame in the process of representing “good and evil,” much discussion has erroneously characterized the virus as ominous and mysterious.
Chapter 5

27 In *Angels in America*, we encounter narrators who play multiple parts within a single narrative, leading to the polyvocal aspects of the play. In *Martin and John*, we encounter a single narrator who finds himself constructing and occupying many parallel narratives, in a polyspatial orientation.

28 Treichler’s list is reproduced below:
- Self and not-self
- The one and the other
- Homosexual and heterosexual
- Homosexual and ‘the general population’
- Active and passive, guilty and innocent, perpetrator and victim
- Vice and virtue, us and them, anus and vagina
- Sins of the parent and innocence of the child
- Love and death, sex and death, sex and money, death and money
- Science and not-science, knowledge and ignorance
- Doctor and patient, expert and patient, doctor and expert
- Addiction and abstention, contamination and cleanliness
- Contagion and containment, life and death
- Injection and reception, instrument and receptacle
- Normal and abnormal, natural and alien
- Prostitute and paragon, whore and wife
- Safe sex and bad sex, safe sex and good sex
- First World and Third World, free world and iron curtain
- Capitalists and communists
- Certainty and uncertainty
- Virus and victim, guest and host (qtd. in 370)

29 Definitions and terms which circulate around “homosexuality” have always been particularly plagued by dichotomous distinctions, ones which work directly against the development and fiber of a caring ethic. As David Halperin points out in “The Democratic Body: Prostitution and Citizenship in Classical Athens”: even as early as the time of classical Athens, there existed a concerted effort to “promote a new collective image of the citizen body as masculine and assertive, as master of its pleasures, and as perpetually on the superordinate side of a series of hierarchical and roughly congruent distinctions in status: master vs. slave, free vs. unfree, dominant vs. submissive, active vs. passive, insertive vs. receptive, customer vs. prostitute, citizen vs. non-citizen, man vs. woman” (102-103). This series of polarities, extended and extrapolated with addendums from other theorists, nicely outline the polarized clinical landscape that these narrators are operating within—even as Halperin characterizes them at a much different historical moment. Lee Edelman suggests that such polarization “connotes a willing sacrifice of the subjectivity, the disciplined self-mastery, traditionally attributed only to those who perform the active or penetrative—and hence ‘masculine’—role in the active-passive binarism that organizes
‘our’ cultural perspective on sexual behavior” (qtd. in Murphy 14). The roles of hero, artist, and prophet delineate a space of self-mastery for the narrators.

30 Other theorists portray the capacity for cruelty in the sheltering arms of “blood relations” as well. In Borrowed Time, Paul Monette paints a picture of “The Family” devoid of Verghese’s romanticizing:

The real hell is the family sitting in green suburbia while the wasting son shuttles from friend to friend in a distant place, unembraced and disowned until the will is ready to be contested. And even that is to be preferred to the worst of all, being deported back to the flat earth of a rural fundamentalist family, who spit their hate with folded hands, transfigured by the justice of their bumper sticker God” (205).

The notion of “family” as a defense in times of trauma is so widely held as to be almost sacrosanct, but it is a defense that is also illusory. Considering the fact that much literature details the abandonment of gay men by their families at the time of their diagnosis, or, previously, at the time they came out, the flimsiness of the family as a trope or metaphor for safety within HIV/AIDS narratives needs to be acknowledged.

31 Interestingly, if a text polarizes its participants into “insiders” and “outsiders” it introduces both a fragmented and an amputated patterning into the narrative. This narrative strategy begins to work at many levels, and contains many narrative ramifications. Even the notions of security that are often proposed within these texts are frequently of a specific kind: one that is insular, barring “outside” influences, and protective against “tainting” or “infecting” intrusions. When this insider/outsider paradigm furthers notions of “tainting” or contamination, a narrator such as Verghese can begin to internalize the “tainted versus untainted” dichotomy, and to make value judgments on the basis of it: “I was, like here, tainted socially by the association with my patients, even if most days I told myself I cared nothing about what others thought” (365). The fact that such value judgments begin to work against the ends of advocacy, that they underscore a consistently normalizing rhetoric within the text, becomes more explicit when Verghese turns the insider/outsider polarity against himself. He categorizes the different doctors on the basis of the different countries they come from, as well as by their surnames: “The names of these doctors—names like Srivastava, Patel, Khan, Iqbal, Hussein, Venkateswara, Menon—bore no resemblance to those of the patients being served…” (17).

32 These narratives play relentlessly upon the reader’s need to want to have something “to show” for the passage of time in the lives of the characters and caretakers—some conclusive and valuable position which has been arrived at. But we pay a price for the indulgence of this need: the verisimilitude of description of trauma. If the doors of a departed trauma can be so easily closed, if it can be quickly made “so long gone,” then we have been deprived of the time to legitimately heal. More ominously, since we didn’t have the time to assimilate and make sense of the experience for ourselves, we are even more prone to accepting other’s version of the events, in this case, the narrator’s interpretation of
the way things have happened. In other words, even if a text does not seem to have a traditional “happily-ever-after” ending, it may fulfill the function of leaving the reader sated and satisfied with a falsely imposed closure. This falsely-imposed ending takes many forms.
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