



Shared embarrassment: (not) talking about sex in HIV-related doctor-patient encounters

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3 **Shared embarrassment: (not) talking about sex in HIV-related doctor-patient**
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5 **encounters**
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9 **Abstract**
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14 Prevention with positives (PP) has occupied a central role in HIV prevention strategies
15 since the introduction of effective therapies. International guidelines present counselling
16 in medical settings as an ideal strategy for promoting safer sex practices among people
17 with HIV and AIDS.
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22 Nevertheless, anthropologists and other social scientists have long been putting under
23 intense scrutiny dimensions of power and conflict in the doctor - patient relationship. In
24 this article, PP is analyzed as a biopolitical technology, part of the larger framework of
25 Public Health as a governmental project. Given the present redefinition of HIV
26 prevention priorities amid a deep economic crisis in Spain, it has become urgent to ask
27 to what extent and how sex and prevention becomes an issue in real face to face
28 interaction, and with what effect: what role PP and its absence play in configuring both
29 the “HIV doctor” and the ‘person with HIV’ as specific subjectivities.
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42 **Keywords:** HIV/AIDS; positive prevention; biopolitics; technology; subjectivity
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49 **Introduction: Safer sex as a technology**
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54 Public health, as a specific modality of relationship between the State and its citizens
55 (Rose 2006; Rose and Novas 2005), has been conceptualized in the field of the social
56 sciences as a governmental project that is “at the heart of politics nowadays” (Fassin
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3 and Memmi 2004, 10). As part of this larger framework, risk prevention and health
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5 education represent a pivotal point of technologies of the self and the politization of the
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7 life of the species (Foucault 1977, 2008; Rose 2006). In this respect, it makes sense to
8
9 approach the practices, techniques, institutions, bodies and subjectivities that we know
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11 as HIV prevention, and prevention with positives (PP) as practised in doctor-patient
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13 encounters specifically, as *biotechnologies*, “hybrid assemblages of knowledges,
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15 instruments, persons, systems of judgement, buildings and spaces, underpinned at the
16
17 programmatic level by certain presuppositions made about human beings” (Rose 2006,
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19 26; see also Davis 2009; Davis and Squire 2010). PP as biotechnology is part of the
20
21 process of “making up” HIV-positive subjectivities and bodies (Hacking 2006;
22
23 Rosengarten 2009). PP also produces a specific form of legitimacy and knowledge
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25 around a naturalized entity, HIV transmission, in a manner that is deeply affected by the
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27 relationship between doctors and patients in a specific historical and institutional
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29 context.
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34 As Menendez (2003) argued, like any scientific discipline or *paradigm*, biomedicine is
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36 by definition a universalistic project, but becomes a social and cultural reality when
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38 considered as a particular practice, carried out by professionals in particular historical
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40 and institutional settings, and in relation to specific social subjects. Biomedicine is
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42 neither a monolithical, universal, static enterprise, nor simply a particularistic and
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44 personalized practice. As pointed out by Haidar (2009) and Lock and Nguyen (2010), it
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46 might be problematic to analyze biotechnologies solely as discursive constructions.
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48 Lock and Nguyen (2010) and Reynolds – Whyte (2009) make a strong point when
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50 arguing the need to account for the articulation of biotechnologies into concrete
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52 practices, without which the program advanced by Rose easily falls into one-sidedness
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54 and the same monolithism and universalism that is constitutive in biomedicine. In the
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3 intricacies of practices regarding and surrounding technologies, the actual meanings,
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5 objects, morals, and social relations of a specific technology as promoted by experts and
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7 as used in specific strategic settings by laypersons (Menéndez 2003) might indeed
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9 render the social relevance of medical technologies quite different from those an
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11 outsider would expect from the sole consideration of the technical and programmatic
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13 discourses underpinning such biotechnological objects and socialities. In a word, we
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15 would like to suggest that micropolitical, everyday relations and practices regarding the
16
17 use of biotechnologies should be taken into account in order to assess their social
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19 meaning and political relevance. As Fassin (2007), Biehl (2007) and Petryna (2002)
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21 show, the relationship between power and life cannot be read from general
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23 legal/institutional arrangements, but its nature must be derived from the concrete form
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25 they acquire as they become social practices carried out by social agents in specific
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27 historical, political and institutional conditions. Thus, apprehending the social character
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29 of medical technologies requires an intensive, ethnographic attention to their social life
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31 (Biehl & Moran-Thomas 2009; Reynolds – Whyte 2009).
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39 It has also been argued that medical technologies affect and are in turn affected by
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41 patients' subjectivities and subjective strategies (Biehl & Moran-Thomas, 2009). From
42
43 this perspective, the relationship between lay and expert knowledges, bodies, and selves
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45 is transactional in nature and must be captured in specific socio-historical and
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47 institutional frameworks (Menéndez 2003; Mol 2008; Pizza 2002, 2005; Rosengarten
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49 2009). Practitioners do value technologies, and make arrangements in doctor-patient
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51 encounters that derive not only from the features of technologies themselves, but from
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53 learned definitions of the situation and their professional role. Patients are not, as
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55 Gramsci said, *trained gorillas* (Pizza 2002). They do not embody technologies
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3 passively, but insert and re-fashion them in strategies that can never be fully predicted
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5 from programmatic discourses or the technical arguments that underpin those
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7 technologies.
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10 11 12 13 14 **Positive Prevention**

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18 Prevention of sexual transmission of HIV is a complex social object (Race 2009;
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20 Rosengarten 2009). It involves a set of institutional arrangements, discourses and
21
22 knowledges, subjectivities, moral economies, subject positions and power hierarchies
23
24 (Treichler 1999). It unfolds in a specific framework of socio-historical relations, which
25
26 both affect and are affected by the social object 'prevention'. Prevention of sexual
27
28 transmission of HIV has seen a steady history of dispute over its specific configuration
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30 (Altman 1994; Martin 1994; Patton 1996; Rosengarten 2009). It has involved various
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32 stakeholders, both at local and supranational level, whose relations have not been stable
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34 (Kippax 2010a).
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39 Historically in Spain, as elsewhere, in the field of HIV tasks had been clearly divided
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41 into prevention tasks and treatment tasks. Non-governmental organizations of different
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43 natures played a key role in the fight against the spread of HIV infection, carrying the
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45 bulk of HIV prevention interventions, especially among the so-called hard to reach
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47 populations. National and regional Public Health authorities provided most of the funds
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49 and the necessary coordination for the prevention activities of NGOs. Health care
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51 providers, until now, had had a less defined role in prevention issues. The expansion of
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53 prevention programs that specifically target people living with HIV seems to imply a
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55 redefinition of the role of the actors involved. While in the first years of the epidemic
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3 process other tasks (fight against stigma, care, and treatment advocacy) were considered
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5 a priority (Davis and Squire 2010), since the advent of ART, if not before, PP has
6
7 become crucial in the management of the epidemic from a Public Health perspective
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9 (Janssen et al. 2001; Wolitsky, Janssen, Onorato et al. 2005). As is known, the role of
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11 Health care services in PP is being redefined and expanded, and not without controversy
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13 (GNP+ and UNAIDS 2009).

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16 In Spain, the international trend towards the integration of prevention in treatment
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18 (Rosengarten 2009) has coincided in time with a weakening of NGOs. In the context of
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20 a devastating economic and fiscal crisis in Spain and particularly in the Region of
21
22 Madrid, the expenditure of public administrations on financing preventive interventions
23
24 of NGOs has suffered deep cuts, while the role of health care institutions and
25
26 professionals in HIV prevention is being explicitly expanded (Sevillano
27
28 2010). Specifically, in the Region of Madrid, funding for NGO activities and
29
30 interventions in prevention has been altogether withdrawn. The rationale for this
31
32 elimination has been that prevention activities should be integrated within existing
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34 health structures and programs (primary care and hospitals) in a context of
35
36 "normalization" of HIV infection and rationalization of state expenditure. Although this
37
38 is in stark contradiction to recommendations issued by international organizations, we
39
40 are witnessing a process likely to result in dwarfing the role of community organizations
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42 while locating positive prevention and support in health care settings exclusively. HIV
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44 should be treated from now on 'like any other disease', de facto putting an end to aids
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46 exceptionalism.
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52 In this paper we propose to reflect on these recent developments from the perspective of
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54 the implicit consequences of what can be termed a process of medicalization of HIV
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56 prevention. While it is not my intention to romanticize the role of community (in fact,
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3 we are well aware of the limitations and shortcomings of the community concept and
4
5 practice), this paper would like to contribute to current debates about the consequences
6
7 of the normalization of HIV and the integration of treatment technologies in prevention
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9 interventions (Kippax 2010a; Kippax 2010b; Mykhalovskiy and Rosengarten, 2009).

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11 We will present some partial results of a research project financed by the Institute of
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13 Public Health of the Region of Madrid, whose objective was to assess the limits and
14
15 potentialities of doctor - patient encounters in relation to HIV prevention and adherence
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17 in hospital units specializing in HIV treatment in Madrid. Fieldwork included 10
18
19 sessions of participant observation, with 50 doctor-patient encounters observed over
20
21 four months and 14 interviews with doctors specializing in HIV treatment in the twelve
22
23 Madrid hospitals belonging to the public Health system. Thirty interviews with people
24
25 with HIV in treatment were also conducted, using the criteria of diversification of the
26
27 sample by gender (16 men, 14 women, including four transgender), age and declared
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29 route of infection (7 through heterosexual practices, 10 through homosexual practices
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31 and 13 through sharing injection equipment). In what follows we will refer mainly to
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33 interviews with doctors and patients.
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43 **The absence of positive prevention in doctor-patient encounters**

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47 The way different technologies of HIV prevention (“safer sex”) and treatment (clinical
48
49 management of HIV infection) are deployed in the interactional setting of the practice is
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51 fundamental in shaping different aspects of the social universe of doctor-patient
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53 encounters: the relationship that is established between doctors and patients around
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55 (safer) sexual practices, the lived and biological body of people with HIV, the nature of
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3 the relationship between doctors and patients, and the specific power relations forged in
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5 doctor-patient encounters. From this starting point we propose an analysis of the
6
7 practices for promoting safer sex in doctor-patient encounters. We will first describe
8
9 these practices, and in following sections proceed to their analysis from the perspective
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11 of how HIV doctors conceive of their role. Finally we will attempt to understand how
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13 this analysis affects the shaping of the relation between doctors and patients.
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17 At first sight, all the clinicians interviewed stressed the importance of promoting safer
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19 sex in their interactions with patients. Nevertheless, they considered that their proper
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21 remit refers to the 'management of HIV infection', i.e. the control of virus replication in
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23 the body and, more generally, keeping the patient in an acceptable health condition.
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28 I work as a physician only seeing patients infected with HIV, I have little to do
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30 with primary prevention of infection out there ... well, if someone asks for
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32 collaboration I gladly agree... but that is not my primary business. It may have
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34 more to do with the job of the primary care physician, keeping people who are
35
36 not infected from becoming infected ... But nevertheless we do have a very
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38 important tool, in that we are the ones who oversee, and monitor and track
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40 infected people who are at any given time doing the wrong thing, and can
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42 transmit it to the rest of the population. This is very important. Among
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44 physicians involved in this there is a clear commitment in this regard. (Md 8)
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49 The importance given to HIV prevention with positives in the discursive level is in stark
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51 contrast with observed interactions and with the practices reported by both patients and
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53 clinicians. From what the interviewed doctors and patients alike told us, a fairly
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55 accurate description of what goes on in the doctor's practice in relation to the promotion
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57 of safer sex could be summarized as follows: sexual practices and means of
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3 transmission are intensively addressed in initial doctor-patient encounters, immediately
4 after diagnosis. Patients are given the chance to ask questions to the doctor to spell out
5 any remaining doubts. Also, doctors leave open the possibility of any further questions
6 whenever the patient chooses to at any point in the future. After that, doctors will not
7 address the issue unless they “detect” that the patient is experiencing “troubles with
8 safer sex” or unless explicitly raised by the patient. If we are to go by both doctors and
9 patients and our own observations, this only happens rarely.
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20 For some physicians, this absence of prevention of sexual transmission represents no
21 further contradiction, since prevention is not considered a central part of their specific
22 remit. Others are aware that this limited role in prevention is less than what is required
23 by international standards, which is explained in terms of the need to prioritize time in
24 doctor-patient encounters. In fact, the time allotted to a patient is quite flexible. A
25 certainly demanding workload does not preclude devoting precious extra time to a
26 particular patient, but this happens only as long as it can be *justified*, and this is more
27 likely when strictly medical reasons can be furnished. This also underlines, by way of
28 contrast, the secondary place of prevention in the day to day of the practice. In this
29 regard, the following quote summarizes a critical opinion -expressed in a tone of
30 resignation - of a situation that is perceived as being motivated in part by the excessive
31 workload, but also by the routinization and technification of medical intervention in the
32 management of HIV infection since the introduction of ART, and, as a consequence, of
33 the doctor – patient relationship.
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55 In this environment there is so much pressure to discuss the latest antiretroviral
56 whatnot, the slightest development... I don't mean to trivialize ... But I mean,
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3 the pressure to pay attention to the slightest advance... in ... Lipodystrophy or...
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5 I don't know, whatever ... the latest, slightest development in an obscure paper
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7 ... I don't know, what effect this specific medication has on whatever ... So,
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9 this information overload, this approach to the problems of HIV by focusing all
10
11 the attention on the medication, even on the part of patients, and on the part of
12
13 many NGOs, and of many ... patient associations, right? I mean, the neurosis is
14
15 such that it's already ... I think it absorbs all our attention. (Md 6)
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20 In the two instances during observation where the question of prevention of
21
22 transmission emerged, it was addressed in a peculiar way: through a display of technical
23
24 information about the mechanisms of transmission and the chance of infection, or about
25
26 infectivity. In a case of post-exposure prophylaxis, the subject initiated an explanation
27
28 of the circumstances of the unsafe practice. The doctor heard what the patient had to say
29
30 but did not encourage any further explanations. In the second case, the patient asked for
31
32 technical information about HIV transmission, conveying through his tone and gestures
33
34 that the motives and circumstances of the unsafe sexual practices were beyond
35
36 discussion. Even so, the physician devoted much of the consultation time to "small
37
38 talk". Most of the doctors interviewed regarded some of their long-term patients as 'old
39
40 friends'. It was not unusual for the doctor to open the interaction by asking them about
41
42 their life circumstances, without resorting to a medical "excuse". In what follows I will
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44 explore the productive effects of this striking silence regarding sexuality in doctor-
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46 patient encounters.
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51 52 53 **Explaining the absence: the concept of medical practice and prevention** 54 55 56 57 58 59 60

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3 In principle, all the clinicians interviewed stressed the importance of promoting safer
4 sex in their encounters with their patients. But what is considered their proper remit
5 refers to the 'management of HIV infection', as suggested above. To understand this
6 paradox it is interesting to note the distinction made by one doctor (Md1) between the
7 "patient" and the "person"; between "the specifically medical" and what he termed "the
8 paramedic". These distinctions replicate the cure / care dichotomy in Medical
9 Anthropology and Sociology.
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21 "We doctors do not only prescribe and diagnose; we listen, we also do
22 supportive psychotherapy." After 15 years of relationship with some of his
23 patients he considers he has "good knowledge" of their personal lives. In this
24 unit, members of staff are open to accepting a "supporting role" from
25 psychologists, but not to be relieved in the management of these aspects. On the
26 other hand, he claims that "in general, we focus on disease, clinical data, and
27 specifically medical things. All the 'paramedical' stuff that every medical
28 activity entails, not only HIV, has to be taken care of because it is part of our
29 day-to-day, but it does not pertain to our formal remit. We insist much more on
30 adherence". He recognizes that he is "biased" towards what are considered
31 medical issues proper. (Md 1)
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45 His work focuses on the patient. Although not ignored, the person is not the center of
46 his activity. This place is occupied by the 'case', a set of reports, records and test results
47 that is set up by the doctor. The *lived body* as experienced and put into play in social
48 interactions is perceived by doctors as a distinct reality whose existence is independent
49 from medical interventions. The relation between the body and the case is nevertheless
50 not adequately grasped as a simple opposition. The 'case' refers to an apparently
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3 external, objective reality, the organism that it actually materializes (Mol 2002). In turn,
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5 the lived body is necessarily constituted in interaction with the 'case' as the patient
6
7 incorporates those records and test results that become part of his/her flesh (Rosengarten
8
9 2009). In a parallel manner, the patient – person dichotomy is problematic at least in
10
11 two senses:

12
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14 First, from a pragmatic point of view, it is worth noting that the distinction between
15
16 person and patient has fuzzier boundaries than the representation held by clinicians
17
18 would predict. The information that doctors collect from their patients, and the
19
20 attributions they make about them based on preconceptions, are plentiful (Heritage and
21
22 Maynard 2006). The information they gather from patients in informal contexts plays a
23
24 role not only in forming a personal relationship with the patient as a 'person' (the 'pact
25
26 of trust' between doctors and patients so cherished in medical self-image), but it can also
27
28 play a role in medical decisions that apparently only affect the case. At any rate, as said
29
30 before, it is the case that is central, both in clinicians' representations and in their
31
32 everyday practice.
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39 Md 5 says he reads "gestures, postures, attitudes," things like whether someone
40
41 is homosexual, and believes to be right "in 98% of cases." "Not everything in
42
43 doctor-patient encounters is standardized or protocolized", he says, distancing
44
45 his discourse from evidence-based medicine. He defends his actions as
46
47 "interpretations" of criteria, based on what he "reads" in the patient, what he
48
49 has learned over the years. "You can not have a protocol for each and every
50
51 situation". The patient's trust in the physician is essential, above all other
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53 "influences that he may have". (Md 5)
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3 Secondly, the pre-eminence of clinical management in the doctor-patient relationship is
4 not without effect (Mishler 1984; Waitzkin 1991; Lindenbaum and Lock 1993). On the
5 one hand, it conceals the person by putting him/her in permanent tension with the *case*,
6 because it is ultimately a prerogative of the doctor to decide at what times and
7 circumstances he/she opens a space for the expression of the person, what counts as
8 relevant information, and when to focus solely on the case. As might be expected, the
9 patient perceives this asymmetry and incorporates it and they refrains from giving
10 information about him/herself as he/she anticipates that it will not be considered
11 relevant.
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25 Erm ... He said to me 'You have to take care of yourself, you have to go on a
26 diet and you have to ask the nurse for a list [*with recommendations on foods to*
27 *eat and to avoid, he notes later*], you have to follow it, you have to take some
28 pills for cholesterol'. I said, 'those pills are expensive and I can not [pay for
29 them]," and he goes, "then you will have to find a way...". I looked at him and
30 said nothing. I thought, I'm quitting, I give up, how am I supposed to
31 explain. I'm unemployed more often than not, you asshole, I'm taking a
32 subsidized course, I have no money to buy expensive medicines.... " It seemed a
33 waste of time to go and explain something that simple. I give up entirely. I did
34 not say anything. It seemed useless to me. (Enrique)
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It is the 'case' that legitimates and gives meaning to the position of the health care provider. The promotion of safe sexual practices forces the practitioner to bring out the person beyond the limits of comfort, as it can exceed the field of knowledge that sustains, and confers authority to, the medical intervention. This is so partly because sexuality is a delicate issue in many contexts in our culture, but also because when

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3 talking about patient's sexual intimacy the doctor is not supported by the legitimacy
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5 granted by his/her privileged relation to the 'case', which is after all the doctor's
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7 creation, responsibility and what they were trained for.
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10 The way doctors elaborate on their specific remit with regard to prevention with
11
12 positives is consistently built around two central axes: the *basic information* to be
13
14 provided to the patient, and the elimination of any *fears* they might have. The basic
15
16 information is included in their representations, namely, using condoms, the idea of
17
18 superinfection and basic epidemiological information, in other words, the precautions to
19
20 be taken in daily life to prevent transmission. Fears are conceived as caused by the
21
22 association of HIV with "death and guilt". Fears are understood as the result of a lack of
23
24 information, which can be replaced with certainties from scientific knowledge
25
26 possessed by health care providers.
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30 The much cited recommendations of the CDC guidelines for counselling in medical
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32 settings rely upon the same narrow concept of health (and individuals' agency, for that
33
34 matter) (CDC 2001). Although the authors explicitly advocate an open approach to
35
36 counselling, the delimitation of what counts as HIV-related problems to be legitimately
37
38 addressed during counselling sessions are ultimately those which can easily be
39
40 incorporated to a strictly medical biological narrative of HIV infection, as we can see in
41
42 the following recommendation:
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47 "Keep the session focused on HIV risk reduction. Each counseling session
48
49 should be tailored to address the personal HIV risk of the client rather than
50
51 providing a predetermined set of information. Although counselors must be
52
53 willing to address problems that pose barriers to HIV risk reduction (e.g.,
54
55 alcohol use in certain situations), counselors should not allow the session to be
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3 distracted by the client's additional problems unrelated to HIV” (Centers for
4
5 Disease Control and Prevention 2001)
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10 In the above analysis, it seems clear that different technologies have quite different
11 values. In fact, sexual practices should be framed as "technical" problems for the doctor
12 to embark on a ground on which his/her authority is not guaranteed. In other words, the
13 sexual subject must be reframed to fit to the logic of the ‘case’. In the process, HIV
14 transmission is divested from its subjective and sociocultural context, and becomes thus
15 naturalized. The conceptions of disease, infection, and of the role of the physician in
16 regard of his patient are ultimately the tenets of the legitimacy and indeed the viability
17 of the doctor’s authority in the doctor-patient relationship.
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30 If the patient is stable and has no problem, the doctor-patient encounter can be
31 what we call a super-fast visit, in other words, the doctor's visit¹ can be very
32 brief. If the patient has a specific problem, then this encounter is stretched out
33 more, and then also depends on the professional you are seeing, not everyone is
34 the same, and some people are not only concerned to see how well you are
35 doing on antiretroviral therapy, CD4 and viral load, but also care about their
36 patients’ overall situation. "How are you doing? How’s your work? Do you
37 have any problems?" (Md 3)
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51 **Concerted discomfort: the patients**

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56 ¹ This is a Spanish phrase meaning “flying visit”, a short and formal visit to a person with whom the
57 visitor has no close acquaintance.
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3 In fact, for most of the people with HIV we interviewed, this lack of reference to sexual
4 practices is not a problem: the representation of what's appropriate in doctor-patient
5 encounters in their view does not differ fundamentally from the clinicians' view as
6 described above. Most patients seem to have incorporated this central element of the
7 framing of the doctor-patient encounter -the agreement on what counts as health and
8 disease, their position in doctor-patient encounters, and the exclusions, silences and
9 invisibilities that are implicitly inscribed in the practice as a social setting. As we just
10 noted, interviewees who express disagreement with doctors in this respect are scarce
11 (Barry et al. 2000).

12
13 We consider this a common sense concordance on biomedical definitions of the
14 situation that give an unproblematic appearance to what is a result of a
15 formative/transformative process (Pizza 2005), as clearly manifested in the "negative"
16 cases where this common sense is not unproblematically accepted. The following quote
17 is exceptional as far as the difficulties in discussing sexuality in doctor-patient
18 encounters are thematized.

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39 I came to the determination not to talk about this [sexual issues] with the
40 doctors. Two or three times I tried to broach the subject but it seems to make
41 them uncomfortable, you notice that they are uneasy, and I've had opportunities
42 to gather information through other means, I prefer to make it simpler, more
43 natural... if you see the person is already, well, embarrassed...because it's hard
44 for you [to talk about] any particular practice ... to bring up questions.

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51 (Alfonso)

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56 As for Fede, he agrees that doctors prefer not to address issues that bother them, but
57 spontaneously remembers a situation when addressing his sexuality was necessary from
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2
3 the point of view of the case, i.e., the problem at issue was an absence of libido as a side
4
5 effect of medication.
6
7

8
9
10 They generally don't ask anything, don't ask about living conditions. In my
11
12 case, for example, with my doctor, he avoided by all means talking about
13
14 sexuality. (...) The normal thing would be to ask you how are you doing, if you
15
16 get an erection, if it has been improving... , but erm, he won't ever mention that
17
18 point, he doesn't even touch on it. (Fede)
19

20
21
22 Fede problematizes the absence of addressing his sexuality in doctor-patient encounters
23
24 in a way that we find highly significant because it displays a particular conception of
25
26 what is appropriate in doctor-patient encounters which is symmetrical to the doctors'
27
28 point of view: doubts concerning issues that fall under the field of expertise of
29
30 biomedicine vs. the impact of HIV stigma on the subject's sexuality. This separation
31
32 between fields of legitimacy is structural to prevention as technology in doctor-patient
33
34 encounters, as we have been insisting on. It reproduces a particular construction of what
35
36 constitutes knowledge about transmission, builds areas of visibility and invisibility in
37
38 doctor-patient encounters, and supports specific relations of power understood precisely
39
40 as the ability to define frameworks of legitimacy and relevance (Grimen 2009).
41
42
43

44
45 Sometimes, respondents reported a complex set of expectations of expectations. Aurora,
46
47 a former IDU (injecting drug user) and currently undergoing methadone treatment,
48
49 aborted on medical advice, but wonders whether she received all the relevant
50
51 information to make the decision. She thinks the doctor made the decision on the basis
52
53 of a prejudice about her way of life. In her view, this bias extends to her sexuality in
54
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3 general, but she made no effort to dispel it, as it would have been useless – or so
4
5 it seemed to her.
6
7
8

9
10 ... From the day I had an abortion, even more so since I became this wasted, he
11 assumes I'm... [not having sex]. I can't say it. If he thought of me as normal
12 girl maybe he would ask himself or ... "Got any problems?" But he doesn't say
13 anything, I think he assumes that I will not sleep with anyone.
14
15

16
17 *Interviewer.* He is wrong, obviously.
18

19
20 *Aurora.* (Laughs). At the moment, yes.
21
22

23
24 She has sexual relations (invisible to the doctor and silenced by herself) with a partner
25 she met on a website (chat room) for people with HIV. They don't use
26 condoms. Andrés, meanwhile, gives an explanation, at the interviewer's request, of why
27 his sexual practices have never come to light again in his encounters with his doctor
28 after the first session, when he was asked about his practices, something he significantly
29 interpreted as exclusively designed to place him in the right statistical category:
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40 Well, as I said I am 75 years old. Sure, seven years ago [when he was
41 diagnosed] I was younger than 75, I guess he thought there was no need to
42 address risky practices, or sexual practices at all, for that matter. (Andres)
43
44
45
46
47

48 Andrés brings up again the issue of patients strategically disguising. Like Aurora, he
49 pretends not to notice the judgments based on stereotypes he is subjected to, calling into
50 question the essential but elusive trust between doctor and patient. It is rather a mockery
51 of it, because obviously the illusion of trust is based upon the patient's interpretation of
52 the physician's expectations as he/she tries to accommodate to them. From all this
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1
2
3 disguising the doctor is very likely to have no clue at all. Elisa makes a similar point as
4
5 she explains why she avoids giving the doctor information she knows he does not 'want
6
7 to hear'. She also has unprotected sex, although in this case with a serodiscordant
8
9 partner, a Sub-Saharan black man.
10

11
12
13
14 Why? He [the doctor] is not going to believe ... that he's sleeping with me
15
16 without a condom and has not been infected. He is not going to believe it, so,
17
18 why would I tell him? (Laughs) Let him be happy, thinking whatever he
19
20 wants. It's because doctors don't want to know certain things. They think
21
22 ... everything has to be straight and clear, and do not put the will of the person
23
24 into the equation, do not take it into account ... [Interviewer: What are those
25
26 things doctors do not want to know?] E: Erm ... anything that's not
27
28 ... "scientific" [ironically]. (Elisa)
29
30
31

32
33 Raul has a partner who has HIV. Since he widowed, he has always chosen his sexual
34
35 partners from among women with HIV, and when he has a stable partner as he has now,
36
37 he does not use condoms. He knows "it is wrong", but:
38
39
40

41
42 ... As I say, why would I say anything if they're going to give me hell? ... You
43
44 take the risks because that is also something that has to do with your freedom...
45
46 (Raul)
47
48
49

50
51 However, it must be stressed that the most common situation is that patients feel
52
53 comfortable with the described situation and consider perfectly acceptable that doctors
54
55 only talk about (safer) sex in the first encounter(s), nor do they question the tone of
56
57 scientific authority they use with the purpose of filling potential gaps of
58
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1
2
3 information. Transactions involving the person, their experience and their life contexts,
4
5 are common, as noted above. However, when it comes to preventing sexual
6
7 transmission of HIV, there is what might be called a *concerted discomfort*.
8
9

10
11 In a few cases patients problematized the difficulty of raising sexuality issues relevant
12
13 from their point of view. These patients perceived their doctor's uneasiness when it
14
15 came to talking about sexuality. Sometimes they even detected their doctor's
16
17 preconceptions about their own sexuality or sexual practices. Nevertheless, it never
18
19 emerged as a conflictive issue during encounters.
20

21
22 Patients seem to prefer to deploy what might be termed strategic disguising (Faizang
23
24 2005): they are well aware of the limits of what can be legitimately addressed in their
25
26 interactions with doctors. They are also aware of their doctor's implicit expectations
27
28 about their sexuality in general and safer practices more specifically, but they don't defy
29
30 them: they rather accommodate to the situation as it comes. In this case, the trust that
31
32 allegedly characterizes the doctor-patient relationship turns out to be more of game of
33
34 mutual delusions and disguising in which the patient simply acts as he perceives he is
35
36 expected to.
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41 **Conclusions**

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45
46 The tendency to "integrate" prevention services into "normalised" health care services
47
48 reinforces the trend towards normalisation already detected in 2000 by Rosenbrock and
49
50 colleagues. It signals the end of 'exceptionalism' and a return to *business as usual* in the
51
52 management of the HIV epidemic, as it is increasingly addressed like any other disease,
53
54 with all the pitfalls and shortcomings this can entail (Kippax 2010a and 2010b). The
55
56 normalisation of HIV in this sense questions the broader alliances between activists,
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2
3 public health experts, and health care providers that characterised the first decades of
4
5 the epidemic. It is true that the recommendations of the CDC, often cited as a rationale
6
7 for integration policies, do not imply the disappearance of other agents. However, the
8
9 uncritical assumption of the argument that medical settings are particularly suitable for
10
11 PP interventions, though based on a common sense conception of trust between doctors
12
13 and patients, and attractive and flattering as it may be for health care professionals, may
14
15 eventually lead to a medicalisation and de-socialisation of PP which will render it quite
16
17 ineffective in supporting People living with HIV.
18
19

20
21 In Spain, with the economic crisis calling every priority into question, at the core of the
22
23 integration of prevention in settings where treatment is provided, is a case of “lifeboat
24
25 ethics” (Scheper Hughes 1993), where the biopolitical role of the state is redefined in
26
27 terms of determining what is absolutely indispensable and what should be left to private
28
29 interest or undone. Although it has never been argued that clinicians should play an
30
31 exclusive role in HIV prevention, at least in Madrid, the role of NGO’s has been
32
33 evaluated as more dispensable than the clinicians’ in a context of deep fiscal crisis.
34
35

36
37 The absence of PP in day-to-day transactions in the surgery is fraught with
38
39 consequences. The familiarity that supposedly characterises the doctor-patient
40
41 relationship (‘wishful thinking’ according to Grimen 2009) is rather a concerted
42
43 framework of implicit assumptions that tend to leave invisible a large part of the
44
45 experience with sex and stigma of people living with HIV – everything that can’t be
46
47 expressed in medical terms. As has been clearly established (see Delor, 2000, Grimberg
48
49 2009), however, risk practices are understood only in reference to complex life contexts,
50
51 and people living with HIV keep unsafe practices for reasons that go far beyond the lack
52
53 of information, which cannot be a problem generally among a population highly
54
55 exposed to, and with every reason to actively seek, ‘basic information’.
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3 As a result, our interviewees deal with the bulk of what really matters to them
4
5 outside medical settings. Nevertheless, prevention with positives, because of its absence
6
7 and the presuppositions it entails, tends to construct and reinforce a set of power
8
9 relations, discourses and subject positions to which people living with HIV must
10
11 unavoidably react. In most cases, this absence is naturalised as mutual and self fulfilling
12
13 expectations among patients and clinicians about what is proper in their relationship; in
14
15 some cases, it gives pace to muted but quite intense conflict. In either case, patients will
16
17 incorporate over time in a practical way in their relationship with doctors the idea that
18
19 the 'right' way to handle these issues is in terms of a demand for technical information,
20
21 assuming that (1) 'subjective' difficulties to maintain safer sex practices are not relevant
22
23 in doctor-patient encounters, and (2) that the patient must assume a subordinate role in
24
25 his/her relationship with his/her doctor when it comes to sexuality, as he/she has been
26
27 dispossessed of the possibility of agency in establishing what is relevant and what is not
28
29 regarding his/her sexuality with their doctor. It seems clear that prevention with
30
31 positives functions as a powerful governmental technology, although not as expected by
32
33 the technical discourses of HIV prevention. In this sense, the context in which
34
35 prevention with positives is inserted determines its concrete form and value. Taking this
36
37 context into account ethnographically is fundamental for its interpretation and
38
39 qualification. Strictly medical technologies impose their own logic upon prevention,
40
41 prioritising specific ways of knowing, viewed as a less central, medical technology and
42
43 as practised in the context of treatment. Different technologies might have different
44
45 values. PP as practised by doctors in Madrid renders PLHIV's strategic interventions
46
47 unintelligible and invisible. In the best of cases, this turns prevention into disciplining
48
49 orthopaedics; in the worst of cases it leads to unattended suffering.
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3 Finally, talking more in terms of what should happen than what in fact happens
4
5 in doctor-patient encounters, the obvious question is whether medical settings are the
6
7 adequate scenario to conduct a more democratic, less rigid strategy to foster safer sex
8
9 among positives; whether a change in the power relations that underpin the doctor-
10
11 patient encounter is possible or even desirable at all. Doctors' authority must play a role
12
13 in contexts where medical knowledge is fundamental; in other contexts, like those
14
15 where the subjective strategies of people living with HIV are at issue, power
16
17 differentials are such formidable obstacles that one is left to wonder if they might be
18
19 overcome; moreover, they represent a framework that tends to produce an extremely
20
21 restricted and medicalised version of HIV prevention that denies the lived experiences
22
23 of people living with HIV and the socio-political contexts in which they are forged.
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