SAMUEL R. DELANY

Occasional Views

Volume 2

“"The Gamble”
and Other Essays
Occasional Views, Volume 2
Other Books by the Author

**FICTION**

*The Jewels of Aptor* (1962):
*The Fall of the Towers: Out of the Dead City* (formerly *Captives of the Flame*, 1963)
*The Towers of Toron* (1964)
*City of a Thousand Suns* (1965)
*The Ballad of Beta-2* (1965)
*Babel-17* (1966)
*Empire Star* (1966)
*The Einstein Intersection* (1967)
*Nova* (1968)
*Driftglass* (1969)
*Equinox* (formerly *The Tides of Lust*, 1973)
*Dhalgren* (1975)
*Trouble on Triton* (formerly *Triton*, 1976)
*Return to Nevèrÿon:*
  *Tales of Nevèrÿon* (1979)
  *Nèveryôna* (1982)
  *Flight from Nevèrÿon* (1985)
  *Return to Nevèrÿon* (formerly *The Bridge of Lost Desire*, 1987)
*Distant Stars* (1981)
*Stars in My Pocket Like Grains of Sand* (1984)
*Driftglass/Starshards* (collected stories, 1993)
*They Fly at Çiron* (1993)
*The Mad Man* (1994)
*Hogg* (1995)
*Atlantis: Three Tales* (1995)
*Aye, and Gomorrah* (stories, 2004)
*Dark Reflections* (2007)
*Through the Valley of the Nest of Spiders* (2012)
*A, B, C: Three Short Novels* (2015)
*The Hermit of Houston* (2017)
*The Atheist in the Attic* (2018)

**GRAPHIC NOVELS**

*Empire* (artist, Howard Chaykin, 1980)
*Bread & Wine* (artist, Mia Wolff, 1999)

**NONFICTION**

*The Jewel-Hinged Jaw* (1977)
*The American Shore* (1978)
*Starboard Wine* (1978; revised, 2008)
*Heavenly Breakfast* (1979)
*The Motion of Light in Water* (1988)
*Wagner/Artaud* (1988)
*The Straits of Messina* (1990)
*Silent Interviews* (1994)
*Longer Views* (essays, 1996)
*Times Square Red, Times Square Blue* (1999)
*Shorter Views* (essays, 1999)
*About Writing* (2005)
*“Ash Wednesday”* (2017)
*Occasional Views, Volume 1: “More About Writing” and Other Essays* (2021)
Occasional Views, Volume 2

“The Gamble”

and Other Essays

Samuel R. Delany
For
Luise White
Jane Gallop
Teresa de Lauretis
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Report from a test for HIV, other STDs, and strep throat: June 1, 2004. See note 2, following this essay.
The Gamble

1.

*What is the nature of the gamble?*

Twenty-five years ago I would have answered that question fairly simply: “I’m gambling on science.” Today, that’s a lot more difficult to say. Is science what scientists say? Is science what doctors say? Is science what the people who write forms (for insurance companies, for patients, for doctors, for “the public”) say, in order to qualify what they say to go along with the reigning wisdom?

2.

Today, when you get an HIV test, and the test comes back negative, the form from the Diagnostic Center that runs the test says:

“HIV–1 AB W/CONFIRM., NY
“HIV–1 AB, E/A nonreactive, no reactive
“No HIV-1 antibodies detected.

“A non-reactive test result does not exclude the possibility of HIV-1 infection, since seroconversion is variable. If clinically indicated, repeat testing of a new sample(s) in three months is suggested.”

In short, the test would seem to prove nothing. It only defers the knowledge of infection by three months, or, indeed, to whenever the next test is administered.
Neither the indication “HIV–” nor the words “HIV negative” occur anywhere on the test results. The term is, indeed, a fiction—a reassuring term of distinction that has been more or less demanded by patients, and that, indeed, doctors have largely accepted—to counter the equally fictitious narrative of the testee who, once he or she is tested, is, by the very force of the act, pulled into a population to which health itself is totally and forever denied but rather deferred, test after test after test, until, presumably, death.

I think this is a perfectly reasonable reading of the text on the paper one receives, of some of the rhetoric that moves around it. The test itself and its results I have no problem accepting as science. The question is: To what extent is the rhetoric around it science?

I got my first HIV test in June of 1988, when I was forty-six years old, six years after I'd first heard of AIDS. It was at the end of a three-year period during which I was certain that I had AIDS. But the results were negative. As well, after the lesions that had appeared on my lower legs in April of 1985, there had been no other symptoms—and the first time I went to a doctor since I’d been convinced I’d been infected, he diagnosed the lesions as a “psoriasis-like” condition (and not the Kaposi’s lesions that, for three years, I’d assumed they were), which have since been much improved with a cortisone cream.

For the next seven years I got tested twice a year. Again, in all cases, by the conventions of that reigning fiction, I was “HIV–.” Since 1988 I have been tested once a year. In all cases I have been “HIV–.” I am now sixty-two years old. My most recent test results were returned on June 1, 2004.

Here is a statement lifted from a conversation recorded in my journal with a twenty-nine-year-old Pennsylvania AIDS educator from late in 2003: “I assume there must be about ten million cases of AIDS minimum, in the United States alone—maybe one out of ten has been detected. The tests are inconclusive—they say so right on the paper they send back to you. I figure that, whatever the official figures says, you can assume there’s a case of AIDS somewhere in the country, for every test that’s been given”—though I note with three afternoons of research online, I have not been able to come up with the number of
ELISA tests performed since they were made available in 1984. The Centers for Disease Control and Prevention (CDC), whose most recent figures date from December, 2002, says that in the United States there were 880,575 tests—that is to say, slightly under a million.

Is there anything “scientific” in what this young man says?

Talking to another young man, in April of 2004, also an AIDS educator, I recorded the following in my journal: “I’ve been instructed by my supervisor to tell my clients that one out of five people in New York City has syphilis.”

Is there anything scientific in either of these claims?

In a recent issue of a New Yorker–sized glossy magazine for women, a health column bylined by a “Dr. Beth” refers to the “virus that causes syphilis.” Since most (responsible, reputable) medical texts tell us that syphilis is caused by a spirochete (Treponema pallidum), is this in any way scientific?

Is there anything scientific about: Acupuncture? Chinese herbal medicine? Reiki? (A mode of “energy healing” in which the practitioner moves his or her hands over the patient’s body, gathering or moving around the “energy,” “concentrating” the “good” energy and “discarding the “bad”—usually without touching the patient.)

Not to mention astrology, tarot cards, and “certified” TV psychics.

The husband of a good friend practices a number of these. “And enough of it works,” she says, “so that I have no difficulty believing he’s providing a useful and needed service. Besides, he’s an extremely responsible man, too. If he thinks for a moment there’s a medical problem involved that falls outside his purview, he’s very quick to tell you to see a Western doctor.” Nevertheless, this same woman was horrified when her best friend of many years in the Midwest was diagnosed with breast cancer and insisted on spending a year in “alternative” medical treatment. “I really had to ask myself how much Tom—yes, and I—had contributed to that. Indeed, it was only when her third herbalist, after three weeks of treatment, announced that the cancer was not responding and demanded she see a Western doctor, that she finally consented. A double mastectomy and a long session of chemotherapy later, the woman is still alive. “But,” said my friend, “you just don’t know.”

And where is the science in all of this?

When “Western doctors” regularly suggest that patients try alternative methods, either because they suspect that the patients want to, or that it won’t hurt, what has happened to the “scientific”? When I was discussing this with a friend, he said: “Well, some of it seems to make people feel better. What do you want? An article in Scientific American?”

To which my personal answer is: You’re damned right I do—and that’s only after half a dozen other refereed articles in notable, respected medical journals have appeared.
5.

I am gambling on the high probability that AIDS is not spread orally, i.e., by mouth-to-penis contact or by penis-to-mouth contact, with or without the passage or ingesting of pre-cum or cum: I am gambling on the fact (a word I use rarely) that studies I have read in reputable scientific venues that strike me as responsibly operationalized show no evidence that the virus can be passed through oral sex (mouth-to-penis; penis-to-mouth) between human males.

What do I mean by responsibly operationalized? First and foremost, that no hearsay is accepted as evidence within the study proper.

Consider the following logic: If what we are trying to determine is transmission routes for HIV (which behaviors will pass the virus on and which will not), then the one thing we cannot under any circumstance accept as evidence is asking someone who has been diagnosed as HIV-positive what sexual behavior transmitted the virus to him or her. The reason we can’t accept such statements as evidence is because to accept them assumes that the answer to our question is known, rather than unknown.

It has nothing to do with whether the informant is right or wrong, mistaken or accurate, honest or lying. Rather, it introduces material that throws off the statistical balance of the portrait of behaviors.

A study that seeks to give an accurate statistical picture of which behaviors lead to seroconversion and which do not, has to start with a sampling of people all of whom test negative. Then, these people must be regularly asked about (and the answers tabulated in writing) the specific sexual acts each indulges in, over a period of time—three months, six months, a year. Finally, they must all be tested for seroconversion again, and the behaviors must be tabulated against the seroconversions and lack of seroconversions.

To my knowledge this sort of study—I call it a monitored study, which is to say, it accepts only monitored evidence and excludes hearsay—has only been done three times in the United States. The results of the first and largest of these studies was published as far back as 1987. Though the study was done in America, its results appeared in the British medical journal The Lancet for Saturday, February 14: “Risk factors for seroconversion to human immunodeficiency virus among male homosexuals,” by Kingsley, Kaslo, Rinaldo et alia, which I republished as an “Appendix” to my novel The Mad Man (Kasak Books, 1995). It involved 2,508 gay men, all of whom were sero-negative at the start of the study. At the end of six months, there had been ninety-eight seroconversions among them.

Briefly, ninety-five of the men who seroconverted had indulged in receptive anal intercourse at least once. For the three others there is a chance of “misclassification,” i.e., they either did engage in receptive anal sex or were misreported. (Something about the study itself makes this a reasonable suggestion: the men’s
reports were incomplete or the questions were poorly administered—easy enough to occur in two-and-a-half-thousand cases.) Five seroconverts, indeed, had engaged in receptive anal intercourse only once during the six months of the study. As well, another population of 147 men in the study only engaged in receptive oral sex, none of whom seroconverted. The study concluded that “Receptive anal intercourse was the only sexual practice shown to be independently associated with an increased risk of seroconversion to HIV in this study . . .” and “The absence of detectable risk for seroconversion due to receptive oral-genital intercourse is striking.”

Since the Kingsley, Kaslo, Rinaldo study there have been two other such studies—one published in *JAMA (Journal of the American Medical Association)* in 1990. The test sample was a thousand male homosexuals from San Francisco. The third test became available online in 2000, with several hundred participants. The statistical portrait of transmission routes is the same for all three studies. No anomalies are reported between them, though the monitoring processes were notably different. In the *JAMA* study, the participants were monitored only at the beginning and the end of the study, but not throughout the entire period.

6.

Why is basing one’s behavior (i.e., indulging in no unprotected anal intercourse with men whose HIV status is not known, but freely indulging in unprotected oral sex) on such studies still very much a gamble—so great a gamble that one could not reasonably suggest that anyone else take the same one?

First, three studies are simply not enough to change a high probability into anything like a scientific certainty. But no more studies have been done. (No studies at all have been done with heterosexual women, so that there is no statistical evidence at all available that AIDS can be transmitted to women though vaginal sex—though there are barns full of hearsay.) Regularly, people send me “studies” in which the statistics wildly contravene those of these reports: this one with six hundred participants, seven of whom “developed AIDS from oral sex” (and the tester has no doubt about their “honesty”), or a friend of a friend (name unknown) who “certainly got it orally.” In all cases, however, it is fairly clear that these are hearsay, at least in the manner described above. Someone, however honest, is making a judgment—either the tester or the participant—from statements gathered about infection after seroconversion.

Two points: seven out of six hundred (more than one percent) contravene the statistic of the monitored studies that have been done so wildly that any statistician would have to raise an eyebrow. Second, in none of the cases that have been shown to me does the set up of the “test” seem even vaguely aware that hearsay must be operationally weeded out of the “evidence” if the study is to be meaningful.
Let me state it right out: There is another aspect of the “gamble” that is equally problematic to discuss—indeed, it is why I want operationalized information based on refereed articles in respected medical journals. A gamble suggests that, for whatever set of reasons, you make your choice, you stake your claim, and you stick to it. You don’t change in the middle.

Unfortunately, however, life does not work that way.

But because it doesn’t, that is precisely why I want the information that I base the explanations of what goes on in my life to be rigorously operationalized. All information that falls outside such rigorously operationalized standards, we call hearsay.

I accept hearsay evidence into my life and base some of my behavior on it all the time. When I decide whether to go to see a movie or not, the evidence that goes into my decision is ninety percent hearsay. I am also blatantly aware that from fifty to ninety-five percent of that hearsay evidence is likely to be not the estimation of friends who have actually seen the picture and returned with a considered judgment, but comes rather from the movie marketers themselves, who have spent hundreds of thousands of dollars on newspaper advertisements, posters, and TV commercials to make the film’s presence known and to make it seem of interest at whatever level they can. That is to say, not only is it hearsay, it is blatantly biased hearsay, with a hugely commercial motive that completely swamps any concept of truth or accuracy.

If the problem of biased hearsay were just a matter of movies, then life would be a wonderful thing. But in a consumer society, biased hearsay controls pretty much the entire field of evidence I have to make my decisions on for pretty much any commodity I purchase or expose myself to; it is the field of the arts, popular to high-brow. It is the field of all household utilities, foods, and daily comforts. It is entirely the field of politics.

What happens to medical knowledge in such a society? What happens when there is a disease, such as AIDS, which can be contracted in the pursuit of public pleasure and is still incurable, if not quite as irrevocably fatal as it was a decade ago?

Highly operationalized evidence is what allows planes to fly, antibiotics to kill bacteria, car engines to turn over, mills to grind (exceedingly small or otherwise), TVs to work, cloth to be woven, lights to come on when we flip the switch, cellphones and computers to function, food to come out of cans unspoiled—and books to be readable, on all levels. (I know of no one in the book
business, writing, publishing, printing, who is not aware of the falling off of
the professional competency in proofreading over the last twenty-five years—
which is purely a lowering of operationalized standards.) One might even say
that a web of operationalized evidence nets the society we live in within a grid
of expectations that even the most skeptical philosopher might call “truth” (or
something close to it); we trust it practically from the moment we first glance at
a clock in the morning, before rising from bed, and throughout the day, along
with whatever work is done, whatever play is indulged in.

Sometimes this grid fails. Perhaps it is simply a phenomenon of the contem-
porary world: But whenever we believe we have fallen out of the grid, hearsay
inflates at a rate that to call exponential is the most inadequate of metaphors.

The last time, during “public sex,” when someone whom I’d never seen or
met before put his cock up my ass and came, was during the spring of 1981.
It was in a place called Fantasy Land, on the corner of Eighth Avenue and
Forty-Seventh Street, in the same building as a pornographic movie theater,
then called the Hollywood. From the street, you entered a minuscule lobby
where the freight elevator for the building opened up. You rode up to the fourth
floor and got off in a room that was a small gay bookstore, which also sold
male videos and sex toys. For the $3 admission, you went through a door into
a loft space that had been decorated to look like Central Park’s “Rambles” at
night: park benches, park lights, plastic bushes, and usually half a dozen guys
wandering around who had come there a few minutes before—though people
rarely did anything, at least when I was there.

Off to one side, around a corner and on a raised platform, stood a wall of
padlocked gym lockers, a wrack of weights, and a bench press—presumably
this was for those who fantasized sex in a high school or college locker room. I
don’t believe I ever saw anyone even hanging out in this area.

To the back was a stairwell leading down into another loft area on the floor
below, this one was fairly roomy. The walls were black. A jukebox stood to one
side, near a couple of pinball machines (not plugged in). Padded with industrial
carpeting, a number of waist-high shelves were fixed to two of the walls—with
ladders up to a second tier, as though they were bunk beds. At one side was a
glass-fronted concession counter, which was completely empty. My sense is that
this was an area the owners had not yet completed—perhaps it was to be a
“gay bar” or a “theater lobby.” Because you could sit or even stretch out on the
shelves around the wall, it’s the only place I ever had actual sex, or saw people
having actual sex in the dozen-odd times I visited.
In November 1981, I was a stocky thirty-nine-year-old—with glasses.

One Thursday afternoon at about four-thirty, when I had dropped in for the afternoon, a fairly ordinary-looking Hispanic fellow, in a tweed cap and tan slacks, half a dozen years my junior, came onto me very heavily—and, soon, had my jeans down about my ankles and, as we stretched out on one of the shelves, grunting and thrusting, shot his load up my ass. As I recall, he was not particularly friendly. I think, once he was finished, he smiled and asked if I was all right. But by the time I had my pants up, he was gone. I recall thinking, as I sat on the rug-covered ledge, “I could have done without that.”

Generally, I tend to get off on what gets my partner off. By and large, however, getting fucked is not my particular thing. During a sex life in which I was easily averaging between a dozen and three dozen encounters of one sort or another a week, I was probably indulging in insertive anal sex perhaps ten times a year, and receptive anal sex perhaps twice a year. The overwhelming number of my encounters—and the ones I enjoyed the most—were oral, with receptive to active three to one.

Perhaps four months later, I heard my first mention of the “gay cancer,” Kaposi’s sarcoma, which had begun appearing, only in the last few months, with unprecedented frequency among gay men.

10.

Sometime in 1983, after I had heard half a dozen mentions of it on various news reports, I asked a doctor about AIDS. He was a young man in his early thirties, who had recently finished his residency and was working in a clinic that specialized in cancer research. “Kaposi’s sarcoma?” I asked him. “What is it? They keep referring to lesions, but where do they show up?”

“I think it’s some kind of skin cancer,” he said. “This stuff they’re talking about is supposed to be transmitted sexually: I would imagine the lesions show up around the genitals.”

Is there anything scientific in the young doctor’s statement?

11.

Kaposi’s sarcoma is a cancer of the mesodermic capillary linings. Often about the size of mussel or clam shells, its irregular purple lesions show up on the skin, anywhere on the body, arms, face or torso, though most often they appear on the lower legs.
Three or four years after I spoke to my young doctor, the above would be a “scientific fact” most urban gay men would “know.”

12.

Chip, how many unprotected oral receptive encounters have you had since 1982?

I can’t be sure, but I would say a conservative estimate is that between 1982 and ’88, when I started at the University of Massachusetts, I was having between three and five hundred encounters a year. Between 1988 and 2000, the number probably went down to about a 175 a year: Heavy cruising was limited to the summers. Since I’ve been teaching in Philadelphia, thanks to venues such as the Sansom Theater and the Forum, it’s probably gone back up to at least 250 a year. Roughly that makes somewhere between 5,800 and 7,000.

While my HIV test is not, certainly everything else I have said above must be considered hearsay: I could be crazy. I could be mistaken. (Few of these encounters—or what I did during them—I wrote down.) I could be making it all up—from either the best, or from the worst intentions.

For what it’s worth, however, mistaken or not, I perceive what I say as “the truth.”

13.

In the warm late afternoon of May 8, 2004, in Philadelphia, I wandered down Twelfth Street’s red brick sidewalk to the corner of Pine Street, by the occasional boxed glass windows slanting out from the cellars of the old houses, under the trees, to Giovanni’s Room, the gay bookstore on the corner, where, later that evening, I was scheduled to read from my autobiography The Motion of Light in Water (Ultramarine, 1988), which in 2004 had just been returned to print by the University of Minnesota Press. I had told a number of my students at Temple University that the reading was at seven o’clock. Dutifully, they’d promised to come. A month before, my doctor had changed my hypertension medication—putting me back on an ACE-inhibitor, Lisinopril; and, as when I had taken Vasotec, a few years before, I had developed a slight but persistent cough: 5 percent of people who take it do. It seemed to be my pattern. Most of the time it was okay, but two or three times a day it produced a two- or three-minute coughing fit: not what you wanted to happen in the midst of a reading. When, at about five-thirty, I stepped up into the bookstore, I told the clerk I’d just wanted to stop by to tell them that everything was on track.
But, even as I was talking with the clerk, with her blonde-tipped hair and
nose ring, I noticed the flyer lying on the counter that announced my reading
said 6:30 p.m.

Yes, the reading was not at seven but a half an hour earlier. That’s what had
gone out on all the announcements to the various local papers.

“Oh, dear,” I said. “I’m glad I stopped by, then.”

I figured I had time to go home—I lived a block-and-a-half away—grab
a quick shower and change my clothes. While I wondered how many of my
students would come in half-an-hour late, that’s what I did. At six-thirty, in the
circle of folding chairs set around the gray rug in the upstairs space, among the
wall bookshelves, only five people had turned out to hear me. One was a young
sociologist from Temple, John, who had come with a friend, and one, Jeff, was
a thirty-one-year-old English graduate student friend. The other two were a
young, pleasant-faced couple, male and female.

With my audience of four (plus the owner and a book clerk), the reading
took about forty minutes. No one came in at seven. A fairly lively discussion
bloomed afterwards, however, which ran on another forty minutes among the
half-dozen of us there. When it was done, the sociologist, John, and his friend
and Jeff cornered me and suggested that we go off to get some dinner at a bar/
restaurant called Fergie’s a few blocks north, just up from Walnut on Sansom
Street.

As we were walking up the tree-lined sidewalk, the leaves silent in summer
under the darkening sky, John introduced me to his friend, a little blond bull
of a weightlifter, probably in his middle thirties. He wore an orange T-shirt
and marine fatigue pants. His head was shaved and he had a boyishly friendly
face. “This is B.J. He’s a prostitute and porn star. I had him in to talk to my
class last week . . .” And little B.J. gave me a warm handshake in a large
meaty hand.

Our graduate student, Jeff (straight and currently having some problems
with his live-in girlfriend, which is why she hadn’t come), looked quite as sur-
prised as I felt—though I did a better job of not showing it. (Only two weeks
before at the cuny Graduate Center up in New York someone else had been
introduced to me more or less the same way.) The conversation with B.J. that
evening was memorable: B.J. was HIV positive—and had been so for the last
ten years, he was quick to tell us. He is certain he picked up the virus through
oral sex: “Oh, yeah. Lots of people say you can’t get it orally. But, believe me,
I’m walking proof that you can.”

In what is certainly more than a hundred conversations over the last
twenty years with people who were HIV positive, while I have talked with
numerous people who were fairly sure you could get the virus orally, B.J. is
the first person I personally have spoken with who claimed to have gotten
it that way.
The conversation went on through dinner—not an argument, by any means. I am, after all, gambling. (I picked at B.J.’s and John’s long, limp French fries, darker than McDonald’s. B.J. and Jeff each took a polite handful of my stained-gold popcorn shrimp.) I could always be wrong. I did a lot of questioning and a lot of listening.

Elbows on the dark wood table under the shadows from his pumped-up forearms, B.J. was very knowledgeable about the biochemistry of the human immunodeficiency virus—though he knew about none of the three transmission route tests and was surprised to find out what they actually said. He was surprised that I knew a fair amount about the biochemistry too: which protein receptors the virus affixes to on the cell membrane, which proteins it has to push aside in order to do it.

Most of that information I first learned when my daughter, who is now thirty, was in the ninth grade and doing a school report on the organic chemistry of HIV; much of it came from a very thorough Scientific American article that we had read and reread.

I’d typed up her report for her. But just because that information is seventeen years old does not mean it’s out of date, any more than is Kingley, Kaslo, Rinaldo et al.

As a gay porn star and prostitute—and probably because, frankly, he’s gorgeous—B.J. has had a great deal more sex than I have, by a large factor. And it’s been a lot wilder. The number of encounters I’ve had in the last ten years you could—for B.J.—easily multiply by three, five, seven . . . We found this out quickly, at dinner. Much of his professional work was before he seroconverted, back at age twenty-three though he has given up on neither profession. He is rigorous about performing with condoms. He, too, calls himself an AIDS educator (as well as a sex worker), and says that he is deeply concerned with getting information out to people.

When Jeff and I finally walked John and B.J. back to John’s ground-floor flat, and we had left them at John’s apartment, with its piles of books around the walls, I said to Jeff: “Oh, you know—I just thought what I really should have asked B.J. Was he ever in an orgy or orgy-like situation, around the time or in the months before he seroconverted, either on a job or during a film shoot, where someone who had taken a load of cum in his mouth might have licked out his asshole within five, ten, or fifteen minutes. I think that would have to count for getting the virus anally—though he might have been unaware of it, or not even noted it—because no one stuck a dick up his ass. Of course that’s something that, if it happened to him, he might not even have remembered it. But I still think, from the kinds of things he was talking about in his general sex life, there’s a greater statistical chance that he picked up the virus that way than that he got it through sucking. The problem is, straight people—who, alas, are the ones doing most of the research—don’t think of questions like that.”
Under darkened trees, Jeff said: “Jesus Christ, Chip—I have never heard people talk about sex the way you guys were talking about it!” He had been silent all through the heated and vigorous dinner conversation about numbers, positions, encounters, when and where . . . “I mean, never—in my life. Over a hundred partners a year . . . I didn’t even know there was sex like that. I mean, people actually doing it. My God—And you say you’re on the low end of gay activity, because you’re getting old . . . !”

I wasn’t even sure he’d heard my question.

A few days later, I left Philadelphia specifically to go up and visit an old fuck buddy of twenty years standing in upstate New York. He met me in his truck at the train station, and we went to get a motel room. For the past two years (and past two years alone), we have been having unprotected anal sex. Why? Because he really likes it. Somewhat to my surprise, I found I really like it too—though, since 1981, he’s the only one I’ve ever done it with. He has showed me his HIV test: It reads the same as mine, and he too gets tested every year. He swears up and down that he has not been fucked since he was twenty. For half a dozen character-related reasons, I believe him. Now in his mid-forties, he’s pretty set in his sexual ways—though what he does, he does spectacularly well. He’s a working-class white guy, Catholic, with a thing for older black men. A hot and heavy six-week affair back when he was twenty-eight and I was forty-five now simmers along at a couple of phone calls a month and two or three meetings a year—often less. He still lives in a trailer park with his parents and a shifting population of cats, nieces, and nephews of several shades and ethnicities. (His older sister had/has the same predilection for non-Caucasians as he does; and grandma loves them all—and has raised most of them.) Those two or three times a year I have sex with him, it’s wild and wonderful and a great change from my main squeeze of fourteen years. And sometimes you really just have to trust people, especially if they are old friends—and this is someone who is an older friend than even my steady life companion, with whom sex is regular, always oral, and, because it’s what both of us really like a lot as day-to-day fare, is always reassuring and emotionally fulfilling.

In terms of the gamble, however, one could easily say the unprotected anal sex that has crept into my last year-and-a-half visits with my fuck buddy is insane—or that it introduces an insane factor. I will be the first to admit it. But there it is. Factor it in.
15.

A day after leaving upstate New York, back in Philadelphia I dropped in at the Sansom Street movie theater, where I sucked off three guys. One came in my mouth. Two didn’t.

16.

Over the next week I developed a major sore throat. This, I thought, has got to be strep. And when, on my way to my office at school, I mentioned that I had a bad sore throat to another one of my graduate students, he told me: “I had strep throat just about a week ago. It’s going around—half a dozen of my students have had it.”

The fact that it was apparently a factor in recent school life greatly relieved me. Schools and work are places where things like that spread like prairie fires. Still, it was not till the last couple of days of the month when I finally visited my doctor’s office back in New York with no encounters at all between then and now: just as responsible as you’d expect a sixty-two-year-old professor to be. Not that I was always thus. (By now, even swallowing olive oil felt like sandpaper over my lower throat and larynx.) Yes, my throat was very red, my Indian Family Practitioner told me, as she sat back after peering in with her conical light.

“What about oral gonorrhea?” I said. (While, between the age of nineteen and twenty-six, I had twelve cases of gonorrhea, since 1968 I’ve had no STDs that I know of, save three or four cases of a specific urethritis, though I have been tested for syphilis and gonorrhea dozens of times. But you have to be certain.) “It’s not thrush or anything like that, is it?” I asked. Like lesions on the lower legs, oral thrush is often an indicator of AIDS.

“No,” she told me. “It’s certainly not thrush. That you can check visually. It could be Chlamydia, though. We usually test for both gonorrhea and Chlamydia at the same time.”

That afternoon, of course, the doctor’s office was out of gonorrhea testing swabs, though they had the Chlamydia ones. So, at a white-topped testing desk by the stand-up scale, besides walls of files with colored tabs, another nurse—this one male, solid, handsome, and dead black—thrust a couple of long wooden white-tipped swabs into my throat, one for Chlamydia and one for strep—and I got another HIV test.

“Look,” the Practitioner told me, returning, “I’m going to proscribe you an antibiotic that, if it’s either of those, will clear it up: Zithromax and Cipro. Take them both at once; and if that’s what you’ve got, you’ll be over it in a day or so.”
And so, that evening, at Albert’s Pharmacy on Eighty-Sixth Street, across from the sprawling new CVS that is pushing Mr. Pommerantz, in his tiny business, toward retirement (his bald head visible just over the top of the boxes piled high on his second counter, in front of which Jennie, his brassy, big-hearted Hispanic assistant, has been helping him run the place for thirty years now), beside the glassed-in shelves of vitamins and holistic medicines and copper bracelets and strap-on magnets (which, he says, all but the vitamins, are embarrassing junk, but which he must sell because people ask for them), I picked up the big red pill and the big white one, and downed them on the way home.

A few days later, the test was back.
It was negative for strep throat.
It was negative for Chlamydia.
No sample had been submitted for gonorrhea.
It was negative for HIV antibodies.

In forty-eight hours the sore throat was gone—or at least it had retreated back to the faint cough that is the standard side effect of some people—like me—to ACE inhibitors.

I hope you can see why I consider my sexual life a gamble. I hope you can see why I would not even begin to think of suggesting that anyone else gamble in the same way. Until many more tests are done—including especially a rigorously monitored test that starts out with only HIV-negative men who engage only in oral sex—the results are simply not conclusive.

I enjoy a certain kind of pleasure. I gamble on getting it.

So far, over six or seven thousand receptive condomless oral encounters since c. 1982, I’ve been lucky. No AIDS. No Chlamydia. And possibly one case of oral gonorrhea (the only time the doctor’s office was out of swabs), though I note that in the two weeks I had the sore throat, neither a genital discharge nor urethral soreness developed—which is simply not characteristic of gonorrhea, whether initially contracted orally or genitally. (Usually, such symptoms develop within three or four days.) Thus, there’s a high possibility it was some other bacterial infection that happened to respond to the Cipro and/or Zithromax—though what it was for sure, we will never know.

One thing that is part of what I am gambling on, however, is the scientific evidence that exists: and, yes, I am ignoring all hearsay, including accounts such as B.J.’s. I do not think he is dishonest. I believe, rather, that when people think that you can get AIDS orally, a certain number will also believe that
that’s how they got it. It doesn’t make it any less a gamble—and possibly makes it more so.

In the past, often science has been like that.

—August 2004

New York

NOTES

1. Several years later this woman indeed died of breast cancer.

2. Facing the first page of this essay is an illustration—yes, a photocopy of a medical form—that illustrated the article as initially published in both Spanish and English in the journal Corpus (Institute for Gay Men’s Health, 2005), edited by Robert F. Reid-Pharr, who is now at Harvard University. On the form itself, there are three redacted lines and one redacted name, that of the doctor who had authorized my HIV test to see if I had AIDS.

Eventually I delivered the essay as a lecture for Gay Pride Day at Dartmouth College, where only one person got up and left, in what I assumed was discomfort over, or disagreement with, what I had been saying. Because her feelings/thoughts were expressed as a protest rather than a comment, it is hard to know for sure.

What I want to talk about here are the redactions. When I handed in the article, they were not blocked out. When it was published I was surprised by them. Eventually I believe I discussed the matter on the phone—though I cannot remember with whom, only that it was not with editor Reid-Pharr—and this is my memory of what I learned.

The name of the doctor, Dr. Steven Tamarin, had been blocked out because they could not get in touch with him to clear if it was all right for them to print the document with his name visible. I told whoever it was that the reason they couldn’t was that he had been dead for a number of years. (Indeed, he had died of a heart attack less than two hours after I had spoken to him on the phone, one Thanksgiving eve, but that’s another story.) So there was no chance of his objecting.

The other redacted lines were other diseases he was having me tested for—chlamydia was one; I don’t recall what the other was. Did I have any symptoms, or did Dr. T. think I might? No. But he did know the kind of life I was living, so he thought: Let’s be on the safe side. And the tests had come out negative. (For what it’s worth, I’ve been tested for chlamydia as many times as I’ve been tested for AIDS, since, after a six-year period of being sure I had it, I bit the bullet, as it were, and started regular testing in June 1988. I never had chlamydia at all.)

So why were they redacted?

Because the editors thought it might be distracting from the point of the article, which was about HIV tests . . .

And this is my point: Here is a medical form that shows nothing but the truth. But a lot of it was suppressed. And it is in the suppression of truth where misinformation—often dangerous misinformation—blooms.

Misinformation flowers where truth is suppressed—what people really wrote, really said, what they really did—whether it is harmless or helpful.