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The Production and Governance of Risky Sexual Subjectivity in the Era of Pre-Exposure Prophylaxis (PrEP) to HIV

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by

William James Schlesinger

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ABSTRACT OF THE DISSERTATION

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of Risky Sexual Subjectivity
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Doctor of Philosophy in Anthropology
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Professor Salih Can Aciksoz, Chair

Pre-exposure prophylaxis (PrEP) to HIV is a promising yet controversial new technology in the biomedical HIV prevention toolkit. Despite PrEP's demonstrated effectiveness in reducing the risk of HIV acquisition by up to 99% when taken daily, PrEP utilization remains not only modest overall but also inequitably distributed in patterns that directly contradict epidemiological data regarding greatest need and most significant potential benefit. While incidence rates have begun to decrease, disparities are in some cases widening, exacerbating the disproportionate representation of racialized men who have sex with men (MSM) in the epidemic. This dissertation questions: what does the failure of PrEP to catalyze a significant overall reduction in new HIV diagnoses in the United States reveal about the biomedical production and sociopolitical governance of risky sexual subjectivity? Utilizing data collected through semi-structured interviews, participant observation, and autoethnography, this project: i) elucidates PrEP's effects on sexual subjectivity vis-à-vis the historical present of HIV prevention discourse and practice; ii) evaluates how encounters with risk shape access to and persistence on PrEP and vice versa; and iii) contextualizes clinician and PrEP non/user engagement with PrEP within broader processes of biomedicalization. For men who have sex with men (MSM), claims to moral sexual subjectivity are linked to notions of responsible risk management. By enabling condomless anal sex with significantly diminished likelihood of seroconversion, PrEP can work not only as a harm reduction intervention in epidemiological terms, but also to remodel the way MSM experience and relate to risk. The capacity of PrEP as a biopharmaceutical means to achieve these ends, however, is constrained by the risk compensation debate and the "purview paradox," which limit uptake of this vital prevention resource among individuals vulnerable to HIV. While redressing these roadblocks is critical to enhancing PrEP's real-world effectiveness, the goal of ending the HIV epidemic will necessitate addressing the structural conditions that produce HIV acquisition risk. Technological solutions like PrEP to social problems like HIV transmission will continue to exacerbate disparities within a capitalist health care system that profits from pathology.

The dissertation of William James Schlesinger is approved.

Philippe I. Bourgois

Laurie K. Hart

Nina T. Harawa

Marlon Bailey

Salih Can Aciksoz, Committee Chair

University of California, Los Angeles

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Thomas L. Schlesinger (October 8, 1951–August 27, 2020)

And away we go.

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Acknowledgments

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Biographical Sketch

William James Schlesinger graduated from Yale University in 2013 with BA in Women's, Gender, and Sexuality Studies. He was awarded a Fulbright Study/Research Grant in Germany for academic year 2013-14, which supported his ethnographic fieldwork studying the German debate on social integration through the lens of health and body politics as an Associate Visiting Researcher at *Humboldt Universität zu Berlin*. In 2015, supported by the David Geffen Medical Scholarship, Will joined the UCLA Medical Scientist Training Program (MSTP) in the newly established Social Sciences Track as an MD/PhD student in anthropology. Will completed the Gender Studies Concentration Certificate in 2019 and was awarded the UCLA Dissertation Year Fellowship (DYF) in 2021.

Will's publications and presentations while enrolled in the program include:

Publications

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Introduction

"Have you talked with your provider before about setting a goal for condom use?" The nurse smiles encouragingly in my direction and I recognize the trappings of motivational interviewing from medical school training. At the moment, my main motivation is to say whatever is necessary to get out of the room, down to the lab for my blood draw, and out the door to class. The answer is no. Well, not exactly. Less about the crude calculus of condoms, taking pre-exposure prophylaxis (PrEP) to HIV is more about my relationship to sex that may or may not involve a barrier method. "Um, I'm a medical student, so…" I stammer, feeling uneasy at the idea of driving my education as a wedge between myself and the presumed degeneracy marking men who have sex with men in the biomedical imaginary. "So, you sound pretty good. Would you say 80%?" I nod. She smiles. "I'll put in three refills." She hands me a paper bag, bleached clinically white, and tells me it is filled with "goodies." I open it at home and find a rainbow assortment of condoms, lube in condiment-sized packages, and a purple, plastic, beaded necklace. Did I convince her? Does she think I am a goodie? At least 80% of one?

When the combination antiretroviral medication Truvada received U.S. FDA approval as PrEP to HIV in summer 2012, a highly promising innovation entered into the biomedical HIV prevention toolkit. Boasting a 99% reduction in likelihood of HIV acquisition when taken daily as prescribed, PrEP was and is constructed as a core feature of efforts to stem the tide of the epidemic and even bring about its conclusion. Landmark studies conducted among a range of populations at elevated risk of HIV acquisition—men who have sex with men (MSM) (Grant et al. 2010; McCormack et al. 2016); transgender women (Grant et al. 2014); persons who inject drugs (PWID) (Choopanya et al. 2013); and serodifferent couples[1] (Baeten et al. 2012), for instance—demonstrate PrEP to successfully avert seroconversion. Further, they provide evidence for its favorable safety profile (Fonner et al. 2016; Pilkington et al. 2018) and minimal side effects, most of which resolve quickly or can be managed (Tetteh et al. 2017).

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[1] Serostatus (sero- being a prefix denoting serum) is a term used to refer the presence or absence of a particular marker in the blood. In the case of HIV, a positive serostatus indicates the presence of antibodies formed to the virus. Serodifferent is a newer term used to describe sexual partners who have dissimilar HIV statuses. Serodiscordant was commonly used as a descriptor in the past, along with the term "magnetic couples," which was intended to describe a relationship between one positive and one negative partner.

Such clinical research has therefore established PrEP's efficacy: that is, "the capacity of the singularized pill-object to prevent HIV" (Michael and Rosengarten 2014, 351). PrEP's *effectiveness* (Aral and Peterman 1998), however, the impact this biopharmaceutical intervention achieves in the real world, outside of tightly managed, double-blind randomized control trials, invites further investigation. Rather than asking "Does PrEP work?" the principal questions of interest animating my research are rather: "What kinds of work does PrEP do and why?"

Following Kippax (2012), this dissertation adopts, as a point of departure, a deceivingly simple precept: "For *effective* HIV prevention, efficacious tools and technologies," like PrEP, "must be taken up by communities and their individual members and made part of their everyday lives. The protection that a prevention tool/method confers is a function of both (a) the efficacy of the tool/technology *and* (b) whether and how it is used" (1-2). Quantitative, epidemiological research may be best suited to demonstrating the former. In my view, qualitative, ethnographic inquiry is optimal for exploring the latter.

Accordingly, this dissertation explores PrEP's introduction within the broader social, historical, and political economic landscape of the HIV/AIDS epidemic and its responses in the United States. In line with scholars of science and technology, especially those studying pharmaceuticals (Sismondo and Greene 2015; Ecks 2022) and the rollout of antiretroviral drugs used to treat and now prevent HIV (Kalofonos 2021; Epstein 1998; Nguyen 2010), I aim to advance the argument that understanding PrEP's effectiveness entails appreciating biomedical HIV prevention as a dynamic web of relations connecting non/users, clinicians, activists, advocacy groups, pharmaceutical companies, capital, insurance companies, legal structures, patent laws, social movements, drugs (pharmaceutical and otherwise), and racialized homophobia. Mapping that constellation of relations among actors, knowledge, and materials with full fidelity is beyond what can be achieved within the space of this project. What I venture to offer here is an ethnographically grounded entry point into the debate regarding PrEP's promise and pitfalls.

Proponents of PrEP, from activists to clinicians to public health officials at the highest levels of government, have pushed aggressively to center PrEP scale-up as a key pillar of state and federal programs targeted at HIV mitigation, arguing that PrEP's arrival heralds a "once-in-a-generation opportunity to end the HIV epidemic" (HIV.gov 2019). In addition to preventing new HIV diagnoses, research shows that PrEP use reduces anxiety about sex (Keene et al. 2020), enhances intimacy, pleasure, and sexual satisfaction (Marcus and Krakower 2022), and promotes empowerment by granting users enhanced control over their own sexual health (Mujugira et al. 2021). This points to what commentators have labeled the collateral benefits of PrEP: the social and psychological perks that some users perceive as even more significant than biological protection from HIV (Grant and Koester 2016).

Skeptics and detractors, on the other hand, including initially leaders of some of the most prominent HIV/AIDS advocacy organizations, have cautioned that the "sexual irresponsibility" PrEP use ostensibly condones threatens to usher in harms that eclipse the intended benefits of the medication. The staunchest critics have derided PrEP as a "party drug" and defamed PrEP users as "Truvada Whores," demonstrating the degree to which moral claims are imbricated in the assessment of harm and the judgment of how individuals and communities constructed as "at risk" for HIV ought to respond to that perceived danger.

At least in part due to this controversy, engagement with PrEP has generally underwhelmed. While prescription rates have risen gradually over the past ten years and HIV incidence is declining in populations with high PrEP coverage, fewer than 25% of people possessing of indications for PrEP have received a prescription, well shy of the 50% target established as a federal benchmark for the Ending the HIV Epidemic Initiative. Nonetheless, growth in PrEP use—along with increased testing and treatment—has contributed to recent decreases in new HIV incidence. After a period during which HIV rates had essentially stabilized, HIV incidence fell 8% from 2015 to 2019 (CDC 2021).

Those numbers tell an incomplete story, though, because although overall incidence rates are falling, disparities are in some cases widening. Epidemiological studies reveal that the geographic, sex, and racial/ethnic distribution of PrEP prescriptions does not match up with the distribution of new HIV diagnoses that could have been averted. In 2015, rates of HIV among Black and Latino MSM were 10.5 and 4.9 times as high, respectively, as the rate for white MSM (McCree et al. 2019); at the same time, white MSM were significantly more likely to "report PrEP awareness, discussion with a health care provider, and use" (Kanny et al. 2019, 802).

The ongoing inequities in both HIV incidence and PrEP access, in the setting of subpar PrEP utilization overall, raise a pressing question with clear biopolitical stakes: why have efforts to promote PrEP access and adherence failed to bring about the end of the HIV epidemic? To engage that question, this dissertation examines the biomedical production and sociopolitical governance of risky sexual subjectivity in the adolescence of PrEP.

In the clinical encounter described above, at my regular three-month follow-up appointment for PrEP, I confronted my own interpellation as a subject of risk. From a structural standpoint, I am well-positioned to access PrEP. I am white, like an estimated 70% of PrEP users (Huang et al. 2018), and privately insured. These factors are significant in the U.S. health care setting, where racism and insurance status are well known to create barriers to treatment and care (Smedley, Stith, and Nelson 2003; Goldstein, Streed, and Cahill 2018). As a physician-in-training, an MD/PhD student with two of four years of medical school under my belt, I possess further advantages that smoothed my access to PrEP. I self-consciously, but reflexively and somewhat automatically, invoked my cultural health capital (Shim 2010) and the racialized respectability politics adhering to it to reassure my provider that I was well-versed in the norms governing sexual health.

But at the critical moment when I was probed about my condom use, it became clear that these factors alone were insufficient to produce me, wholly, as the proper subject of risk. My ongoing access to PrEP, I felt, was contingent on performing the role of prudent sexual actor who practices consistent condom use, thereby proving myself to be a deserving patient. This is despite, of course, the fact that PrEP's protective benefit against HIV obtains independently of condoms. When the nurse supplied a rate of 80% condom use and correlated that with being "good," I assented to retain my access.

To what extent did this outcome hinge on a "white lie"? Survey data analyzed by Calabrese et al. (2014) indicate that providers perceive Black patients as more likely to engage in condomless sex and that their racist judgments correlated with decreased willingness to prescribe PrEP. In contrast to the prescribing reticence produced through racist stereotypes, the nurse's unquestioning acceptance of my acquiescent nod was likely mediated by my cultural health capital, of which whiteness is constitutive. In this encounter, I registered how bodily practises of risk mitigation are bound up with moral judgments, raising the question of how the historically-sedimented purity test of idealized condom use complicates engagement with PrEP for "high-risk MSM," especially for racialized MSM.

The behavioral interventions premised on condom promotion that aided in dramatically decreasing rates of HIV acquisition through the 1990s also solidified condom use as a principal marker of moral sexual citizenship (Kippax and Race 2003; Cristian Rangel and Adam 2014). Condom use became a litmus test to distinguish between normative subjects demonstrating responsibility through the sanctioned response to HIV risk and pathological subjects who were seen as risks to be managed. This boundary work dividing MSM means that "those deemed sexually irresponsible through their lack of condom usage have come to be labeled as sexually deviant and marked as 'social problems villains'" (Pawson and Grov 2018, 1393). Even though PrEP provides superior protection against HIV acquisition, condom use remains entrenched as a standard against which the respectability and worthiness of MSM is measured.

While I successfully retained my prescription by conforming to normative expectations, the moral test I was given points to the way risky sexual subjectivity is assessed and governed through PrEP. When MSM seek PrEP, they assent to intensified forms of surveillance and moralized behavioral intervention vis-à-vis condoms (Dean 2015). As a result, accessing "the highly regulated intervention" of PrEP "may come at price, not only the cost of accessing the medication, but also medical scrutiny and being seen as potentially suspect," by both biomedical authorities and "other gay and bisexual men" (Holt 2015, 437). This forecloses space for the articulation of how pleasure and condoms fit into real-life strategies of risk management (Mabire et al. 2019). As a result, sticky risk paradigms constrain a clinically efficacious technology from achieving its potential effectiveness on the ground. Moreover, pleasure is denied legitimacy as a factor in decision making around sexual health.

As Marlon Bailey (2016) argues, "Public health paradigms for HIV prevention and overall sexual health promote/require repressing sexual urges and focusing on fear of contracting not only HIV but other STDs as well … Instead of a primary emphasis on sexual desire, urges, and pleasure as healthy sexuality, emphasis is placed on reducing or limiting STD/STI risk the expense of pleasure" (222). The nurse's question to me about condoms, and its underlying premise that being "good" and living out healthy sexuality imply their frequent use, evidences a meaningful tension between clinical constructions and PrEP non/users' embodied experiences of risk. Within this contested field, which extends beyond the walls of the clinic, perspectives on sexual health held by individuals at risk for HIV acquisition can be elided altogether or pressured to conform to what are perceived to be acceptable scripts.

While clinical, biomedical definitions and measures of what constitutes risk have traditionally undergirded HIV prevention efforts, this project stems from a commitment to the notion that the most successful and effective sexual health interventions have hinged on an improved understanding of how risk perceptions and meanings evolve in the communities in question (Meunier, Escoffier, and Siegel 2019). Negotiated safety (Kippax and Race 2003; Holt 2014), serosorting (Mao et al. 2006), strategic positioning (Grov et al. 2015), and reliance on undetectable viral load (Rodger et al. 2019) represent examples of community-derived prevention strategies. These achieve effective HIV prevention not because they reflect compliance with predetermined health directives, but because they engage practices "whose sustainability has derived from processes of reflexive mediation between embodied habitus and medical opinion" (Race 2003, 377). Utilizing an experience-near approach that incorporates autoethnography as queer method (McGlotten 2017; Jones and Adams 2010), this research engages that process of reflexive mediation from both angles.

Starting in fall 2015, I consumed PrEP (almost) daily for a stretch of nearly five years. Over the course of that time, I participated myself in the sexual practices that form a critical object of ethnographic analysis in my dissertation research—specifically, condomless sex on PrEP. The questions of how and to what degree my own erotic subjectivity as fieldworker is epistemologically valuable were, therefore, simply unavoidable. For guidance on how to approach them, I turned to the work of scholars who came before.

Anthropologist Ralph Bolton (1995), describing his ethnographic research on HIV prevention practices in Brussels during the height of the AIDS crisis moment, explained how "the line between the personal and professional was blurred," in that "[a]s a gay man studying the erotic culture of gay men, I was drawn to them for both personal and professional reasons, and my interactions simultaneously affected my work and my private life" (112). Critics may have challenged the legitimacy of Bolton's research on the basis of what they might consider to be inappropriate, even unethical, involvement with his research participants and their broader social milieu. In my view, however, erotic involvement and investment in ethnographic research is not only defensible, but also holds great potential to be analytically profitable, when carried out with careful consideration.

Observation is a hallmark of ethnographic research, but it is easy to understand why sexual practices are challenging, or at least not so straightforward, to observe. In Bolton's research, then, he gleaned much more from participation than by simple observation alone, even when combined with interviewing. "By experiencing them, I came to learn of blow jobs from bartenders when the door was locked at closing time, of jacking off in cruising spots in a park near the Grand Place in partially public view, of sexual encounters in alleyways between someone headed home from the bars and someone on his way to work at dawn, of sexual action in the dunes along the coast and on the piers … and in the backrooms of discos and in the bathrooms of ordinary bars" (Ibid.). As distinct from the formal interview context, for instance, this sort of participation enhanced the degree of "mutuality in the sharing of intimate information, meaningful experiences, and profoundly personal knowledge between the people involved in the interaction" (Ibid.). As Tim Dean (2009) noted, "Despite popular assumptions, anonymous sex frequently is punctuated by interesting conversations. After uninhibited, multipartner sex, men tend to speak more freely … There is some truth to the gay academic's joke that oral history can be conducted better on one's knees" (34). These insights dovetails with Kath Weston's (1993) point that "in an era when many know they are supposed to be practicing safer sex, the only way to determine whether people practice what they preach is for at least some ethnographers to have sex as part of their research" (356). To most accurately depict how risky sexual subjectivity is lived out, observation and interviewing absent participation is a suboptimal strategy.

To refute the notion that this kind of erotic participant observation should be derided as always and only a threat to the community being studied, Bolton states plainly that the much greater threat is posed by HIV itself, compounded by the misguided, under-informed initial responses of the state and the medical and public health communities to the unfolding crisis. Bolton's sexual participation in the scene he studied led to observations that informed policy to advocate for and empower the gay community when their institutions, such as the bathhouses where Bolton carried out some of his research, were under repressive siege. Bolton's work intervened in a prominent political controversy over the closure of bathhouse (referenced in Chapter 2) by "showing that men who attended the baths were more knowledgeable about AIDS, changed their behavior more in the direction of safe sex, and were less likely to engage in unsafe sex," which helped "preserve sexual rights," as well as "protect against the unwarranted destruction of gay institutions" by "homophobia camouflaged as public health" (114). Bolton's positionality and participation in the sexual culture he was studying enabled him to develop a more nuanced understanding of HIV risk practices at the time; with the advent of that understanding, he made his research politically useful in the fight to combat stigmatizing incursions of state power that imperiled men at risk for HIV acquisition.

I remain invested in the promise of such an approach, yet also cognizant of Gloria Wekker's (2006) cautioning that "sexual subjectivity should not be misread as a license for unbridled, honorless exploitation of the Other on a more intimate level than has thus far generally been acknowledged" (4). Bearing this point in mind, though, Wekker also reminds us that "all knowledge is gained at the intersection of race, gender, class, and sexual locations;" anthropologists "must own and acknowledge our locations, and there is no good reason to exclude sexual locations from our work, either as an *a priori* or *a posteriori* excision" (ibid.). In my research for this dissertation, I intentionally incorporated autoethnographic methodology as a strategy to explore the intimate experience of my own risky sexual subjectivity in relationship to the biomedical tool of PrEP, but I also operationalized it as a resource for forming concepts and developing questions to be explored through participant observation and interviewing with my interlocutors.

Similar to Peter Hennen (2005), whose scholarly research on the sexual culture of bears[2] emerged from his own preexisting identification with and involvement in that scene, my auto/ethnographic exploration of PrEP entailed "simply introducing a higher degree of methodological rigor to a familiar activity;" namely, refilling my prescription for PrEP at regular three-month follow-up visits, pursuing sex—including condomless sex—with men, and discussing others' experiences with and reflections regarding the same (42). Being that the

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[2] A subgroup of gay men "who valorize the larger, hirsute body," bears "reject the self-conscious, exaggerated masculinity of the gay leatherman in favor of a more 'authentic' masculinity. This look includes (but is not limited to) jeans, baseball caps, T-shirts, flannel shirts, and beards" (Hennen 2005, 25).

community Hennen was working in was already quite sex positive, he saw little reason for additional concern regarding the sexually explicit nature of his ethnographic practice beyond making confidentially an especially important issue, recognizing that the readership at large may not be as open-minded as his research cohort. Following Hennen, I advocate placing emic, community-derived norms in conversation with disciplinary standards, even and especially when they conflict, because the points of friction and tension help illuminate barriers to and facilitators of knowledge production on sexuality.

A handful (n=4) of the formal participants in my research (N=41), i.e., those who consented to take part in recorded interviews for incorporation into my dissertation, were people with whom I had a previous or ongoing sexual relationship. In these cases, we had discussed my research plans in depth prior to the time I started my fieldwork in earnest. A small number of other research participants orbited around my sexual network to varying degrees, and some of them shared similar views regarding, for example, sex positivity. The diversity of my pool of participants made very clear throughout the course of my research, however, that what it meant to embody, relate to, and/or disidentify with risky sexual subjectivity was not at all monolithic.

In actuality, as I explore in depth throughout my dissertation, an individual's relationship to risky sexual subjectivity can be dynamic and contingent on multiple, intersecting factors both structural, like racial and class positioning, and interpersonal, like experiences of discrimination or stigma in interactions with family, friends, and medical clinicians. Following Weiss (2011) this project therefore "resists the false dichotomies of distance as difference and closeness as sameness" (29). In presenting my research, I highlight individual PrEP narratives, including my own, but overall aim to contextualize them within community debates, tensions, and points of convergence. In doing so, I seek to situate "the words and worlds" of PrEP non/users "within a shared social landscape, highlighting the modes of subjectivity, the political and economic rationalities, and the cultural and community formations that make up everyday dimensions of social power in the contemporary United States" (ibid.). Emplacing individual narratives within broader conversations and contestation over sexual subjectivity and risk is the goal of the dissertation project.

Sample Characteristics and Research Methods

Participants in my research fell broadly into two main groups, which I initially conceptualized as follows: patients and providers. Over the course of developing my research project, two key insights remodeled how I understood and defined each category.

From PrEP Patients to PrEP Non/Users

I realized early on that characterizing the kinds of work PrEP is doing in relationship to the risky sexual subjectivity of MSM would require engaging not only with MSM who are seeking or taking PrEP, but also with those who have discontinued it, who are uninterested in or averse to it, or who have heard little to nothing about it. Because my research aims to describe mechanisms through which PrEP is inequitably distributed among MSM, limiting my sample to patients alone would provide incomplete data on PrEP use and non-use. Accordingly, I sought to recruit MSM with a wide variety of experiences with and relationships to PrEP under the umbrella of MSM PrEP non/users.

The two primary avenues of recruitment for MSM PrEP non/users into my study were through the Mobile Enhanced Prevention Support (MEPS) research study (PI: Dr. Nina Harawa) and via snowball sampling (Lewis-Beck, Bryman, and Futing Liao 2004) through my extended personal network in Los Angeles. MEPS is a public health intervention designed, in part, to promote PrEP access and adherence for recently incarcerated MSM and transgender women

(Edwards et al. 2020; Harawa et al. 2020). I was embedded in the MEPS study for over four years. As a team member on MEPS, I helped design and run focus groups with the study's community advisory board (CAB) before the recruitment phase, trained the peer mentors employed by the study on HIV, STIs, and sexual health, and, once the study began, participated in weekly clinical supervision meetings in which the peer mentors would discuss their caseloads. Throughout my involvement in the study, I acted as a resource for the peers on health-related topics—sexual health and PrEP in particular—and made myself available for phone consultations with their clients when they wanted to have a longer, more in-depth conversations about the medication for PrEP and its use.

When these consultations happened, MEPS study participants were compensated through the MEPS budget. The conversations were neither recorded nor incorporated as research data in my dissertation project. My experiences counseling people considering getting on PrEP, however, did shape the research questions I asked of participants who were formally consented and enrolled in my dissertation study. Likewise within the framework of MEPS, as a recruitment and outreach strategy for that study, I began to give monthly sexual health-focused presentations to the clients, residents, and occasionally also staff at several substance use recovery organizations around Los Angeles. These hourlong, interactive presentations ranging in attendance from 20-60 people created further opportunities for me to expose myself to a range of questions, concerns, and attitudes related to PrEP. While these presentations were not formally included in my dissertation, they constituted a generative dimension of my fieldwork on PrEP and helped me develop and refine concepts to explore with interviewees.

Through my work with the MEPS peer mentors, my phone consultations with MEPS participants about PrEP, and my presentations to MEPS community partners and their clients, I tapped into both sides of my training as an MD/PhD candidate. Clinical, biomedical knowledge gained in medical training helped me answer common questions about how PrEP worked, what research supported the efficacy and safety of the medications, what side effects are most commonly reported, and what to do about them should they arise. Training in ethnographic methods and social theory encouraged me to contextualize these interactions and interpret them as elements of a broader story about sexual health within the history of the HIV epidemic and its present course in Los Angeles. This analysis drew on my experience within MEPS and most heavily on interview data collected over the course of fourteen months starting in March 2021.

In total, I recorded semi-structured interviews (average length = 59.6 minutes) with 21 MSM PrEP non/users, ranging from 25 to 61 years old (average age = 35.7). Several participants in my study, whose stories are told in the pages to follow, initiated PrEP shortly after it received FDA approval in 2012. Some have remained on PrEP since then—nearly ten years, by the time I submit this dissertation—while others have stopped, and still others have discontinued and resumed in various temporal rhythms. Five interviewees were not currently using and had never used PrEP, of whom three expressed some degree of openness to explore it in the future. Two explicitly rejected that notion. Self-reported racial/ethnic identities represented in my sample include Black, Hispanic, Latino, Native American, Native Hawaiian, South Asian American, and White. The majority of MSM PrEP non/users in my sample self-identified as people of color.

From Providers to Clinicians

Steve Shoptaw, psychologist and widely cited translational researcher with an extensive line of research on HIV prevention in the context of addiction, contributed the second key insight, when I first heard his call to distinguish between clinicians and providers. Clinicians perform functions within the medical system, whereas providers earn their designation because they reliably *provide* for especially their most vulnerable patients. Within this framework, being a health care clinician does not necessarily make one a provider.

Bearing this point in mind, I reframed my second category of research participants from providers to clinicians. Recruiting clinicians to participate in interviews was a process aided significantly by my status as a medical student (albeit on leave of absence). When I was first developing my project and describing my plans to interview clinicians, several qualitative health researchers warned me that it would be difficult to find willing participants. Fortunately, in my experience, this was not the case, which I attribute partially to my legibility as a medical trainee in addition to connections made by other clinicians and/or experts in the field of HIV prevention science. Approaching clinician interviewees as a physician-in-training likely granted me privileged access to the field of medicine, which can be quite an insular and exclusive realm (more on this in Chapter 4).

While my affiliation with medicine helped me recruit clinician interviewees, it also highlighted my status as a medical student, which is a station notoriously low in the ranks of a particularly hierarchal field. To varying degrees, in my interviews with clinicians, I found myself slipping into the role of a trainee angling to gain the favor of an attending clinician. While this may be an adaptive strategy for becoming a successful medical student, it was not necessarily the ideal ethnographic subjectivity to inhabit. Because I was always also, if not primarily, a medical student in the eyes of clinicians I interviewed, it was inevitable that our interactions were conditioned by the power structures defining our shared field. Medicine provided a shared language for us to communicate about PrEP, but I also worked intentionally to move conversations as much as possible into explorations of individual clinician's attitudes, perspectives, and feelings.

With some clinicians, certainly not all, achieving this took both time and reassurance. At some point in many of my interviews, clinicians hesitated in response to my prompting and said something along the lines of: “Well, I don’t exactly have any *data* to back this up and this is just my personal attitude/perspective/feeling on the topic, but…” I tried to seize on those moments as an opening to remind my interlocutor that those personal attitudes/perspectives/feelings on PrEP were exactly the sort of data I was hoping to collect in my research. The number of times this scenario arose stuck out to me, and I interpret that to stem from the epistemological exclusions perpetuated through medical training (which are also described in more depth in Chapter 4).

Over the course of my research, I recorded semi-structured interviews (average length = 45.2 minutes) with 20 clinicians. Among them, 13 were conducted with clinicians who prescribe PrEP (average age = 43.1). These clinicians practiced medicine in diverse settings across Los Angeles ranging from federally qualified health centers (FQHCs) to community health clinics to academic institutions; depending on their site, they encountered patients without insurance, as well as patients with public and private insurance coverage. Within the clinician category, I also include seven students in the process of medical training with whom I discussed curricula on PrEP, HIV, and queer health, as well as their paths into and through medicine. Self-reported racial/ethnic identities represented in my sample include Asian American, Black, Hispanic, Latinx, South Asian American, and White. The majority of clinician participants self-identified as people of color. In terms of gender, one participant identified as non-binary, slightly less than half of the remainder identified as cisgender women, and the rest identified as cisgender men. I also collected self-reported sexuality data for the clinicians I interviewed. Eight identified as straight and the rest identified as gay, queer, or pansexual, excluding two who declined to answer.

Regarding my clinician sample, one limitation worth describing in further depth is the fact that all the clinicians I interviewed were either interested or already engaged in incorporating PrEP into their practice. As a result, my clinician data is biased in a PrEP-positive direction. Future research will seek to engage providers who are more critical of PrEP. For this dissertation, the voices of such providers are relayed through PrEP non/users and clinicians I did speak with, many of whom had a lot to tell me about their run-ins with them. As I progress through medical training, I anticipate that my opportunities to encounter such clinicians will multiply, and I plan to try to recruit them for research interviews at that time.

Anonymity

Throughout this dissertation, all research participants are identified by pseudonym only. Identifying information has been removed to the greatest degree possible while still trying to retain the level of specificity necessary for analysis. A (to me) surprisingly large proportion of participants in my research, in both the PrEP non/user and clinician groups, granted permission for their names to be used in the work. Ultimately, I decided to assign them all pseudonyms, or allow them to pick their own.

Chapter Summaries

Chapter 1 introduces risky sexual subjectivity as an historically contextualized theoretical framework and explores how MSM negotiate it on the ground in relationship to bodily practices and their re-presentation. The chapter centers on Richard and Michael, a couple in their late 40s, who separately told me very different versions of the story that led them to starting PrEP. Analyzing the resonances and tensions between the two narratives highlights how claims to moral sexual subjectivity for MSM hinge on notions of responsible risk management. In addition, it demonstrates how accounts of risk management in relationship to HIV are themselves risk managed. Noting this is critical to establishing the utility of anthropological methods in the study of how risky sexual subjectivity is produced, lived, and governed at multiple levels, especially given that the ethnographic approach remains chronically underutilized in research on PrEP.

Chapter 2 highlights how PrEP presents an opportunity to reconfigure the sexual subjectivities of MSM by remodeling their relationship to risk, sexual practice, health, and the body. Drawing on the experience of Raul, a 30-year-old gay man of color with a ten-year history of crystal methamphetamine use, this chapter argues that PrEP can not only work as a harm reduction intervention in biomedical, epidemiological terms, but can also work to remodel the way stigmatized, racialized sexual subjects experience and relate to risk. Raul's trajectory with PrEP demonstrates how MSM engaged in what are considered to be some of the "riskiest" practices—sexualized drug use and seeking out bareback sex in the bathhouse and online—can be both ideal PrEP users *and* advocates within communities that are sometimes constructed as "hard to reach." Raul's reflections on his PrEP use in sobriety and abstinence expand on the collateral benefits of PrEP and provide insight into under-studied rationales for engagement with it.

Chapter 3 examines the "risk compensation" debate: contestation over whether PrEP use may lead to worsening harms in the form of increased rates of other sexually transmitted infections (STIs) and/or Truvada-resistant strains of HIV. Qualitative data illustrate how clinicians' notions of risk are brought to bear on patients' lived experiences, but equally reveal a complex world outside the clinical encounter where risk is constructed, navigated, and negotiated. Fleshing out how the risk compensation debate is put into practice opens a more nuanced exploration of its ramifications: not only on the distribution of PrEP, but also on the distribution of risk, pleasure, and what many participants in my research referred to in terms of "freedom" and "liberation." Interviews with Black MSM in particular demonstrated how the racialized logic of the risk compensation debate—specifically the ideology that constructs Black men as sexually risky and liable to not use or abandon condoms—may inflect the way that Black men who do take PrEP approach condom use, and it may also discourage Black men from seeking out PrEP in the first place. When PrEP use is distributed away from racialized MSM on the basis of an abstract and erroneous association with risky sexual behavior, material risk is generated in the form of increased exposure to harms that manifest in racial health inequities.

Chapter 4 addresses institutional forces conditioning lackluster PrEP utilization by asking how lack of provider knowledge about and comfort with PrEP, a well-known barrier to scale-up, is produced and perpetuated through medical education and training. This chapter draws together interviews with medical providers across the spectrum of training and my own auto/ethnographic participant observation as an MD/PhD dual trainee to interrogate the conditions underlying the "purview paradox," a term describing how neither HIV specialists nor PCPs necessarily understand PrEP to fall within their realm of practice. I position the purview paradox as an outcome of the way physicians-in-training are disciplined out of, rather than into, knowledges and practices that would set them up to provide optimal outcomes for their patients at risk for HIV. Along the way, I detail my own partially frustrated efforts to incorporate a patient-centered, meaning-focused activity on PrEP into the curriculum. Setting the pushback I encountered alongside feedback from attendees at the version of the event that did happen aids in establishing how an innovative approach could help work against the purview paradox and towards the promotion of structurally competent care for queer and transgender patients; yet, it likewise reveals how and why such an approach might be resisted within the tradition of medical pedagogy, which is both conservative and notoriously slow to evolve.

The conclusion sets up a direction for future research in analyzing the political economy of pharmaceuticalized HIV prevention and its relationship to the distribution of risk and harm in the HIV epidemic. Ted, a gay man in his early 60s who has been living with HIV for nearly 30 years, joined a civil proceeding against Gilead Sciences, Inc. alleging the corporation shelved a safer version of their drugs in order to extend the life of products like Truvada. Having taken Truvada for 15 years as treatment for HIV, Ted believes his bilateral hip replacements to be a direct outcome of the company's predatory business practices. Ted's endorsement of PrEP as an HIV prevention strategy with the caveat that Truvada for PrEP can be problematic draws attention to the way vulnerable people and communities, like those living with HIV or at risk for HIV acquisition, are made dependent on biomedical technologies, the industries that produce them, the markets that control their distribution, and the regulatory regimes that are intended to govern them. The dissertation thus concludes with a reminder that the goals of achieving health equity and eliminating HIV necessitate the ongoing struggle, with roots stretching back to the onset of the epidemic, to demand intensified regulation of pharmaceutical companies and fight for single payer health care. In the meantime, technological solutions to social problems will continue to exacerbate disparities within a capitalist health care system that profits from structural vulnerabilities and the risks to which Black and Brown MSM are disproportionately exposed.

Chapter 1

Ethnographic Approaches to Risky Sexual Subjectivity

> … a research strategy which is designed to elicit informants' accounts and explanations of their behaviour (practice) is not only misplaced but liable to (re)produce a misleading picture. As we a have seen, the nature of practical logic implies that a good deal of actors' behaviour is accomplished unthinkingly and unknowingly: much of social life is simply taken for granted and its logic is implicit. It is, therefore, Bourdieu argues, literally asking too much of informants to explain the principles which structure their actions. Rather, what one gets is simply 'official' accounts or discourses about practice in which informants tend to describe what ought to happen because the social nature of the research situation encourages them to justify rather than describe their behavior.
> — Simon J. Williams, "Theorising Class, Health and Lifestyles: Can Bourdieu Help Us?" (1995, 583)

Forged in the crucible of the HIV/AIDS epidemic, which proliferated what Race (2016) characterizes as aggressive forms of normativity, the contemporary sexual subjectivity of MSM is haunted by a visceral and enduring association between sex and death. As a consequence, benign and appropriate forms of intimacy—always involving a condom, never with multiple concurrent and/or simultaneous partners or outside of a monogamous relationship—cropped up as acceptable expressions of an already stigmatized sexuality. Acts contravening these historical standards and their attendant logics risked apprehension as reckless hedonism: an indication of incivility jeopardizing the tenuous toehold on respectability that certain assimilable subjects, especially white and middle-class gay men, were only first beginning to achieve. With the advent of PrEP, condomless sex absent the fear of HIV acquisition and its potential sequelae is now possible for the first time since the emergence of HIV. The residue of the height of the AIDS crisis, however, continues to inflect the relationship of MSM to themselves, their sexual and romantic partners, and their community.

This chapter introduces risky sexual subjectivity as an historically contextualized theoretical framework and explores how two men in a long-term relationship, Michael and Richard, have negotiated it through bodily practices and their re-presentation. When I interviewed them separately, each told me a very different version of the events that led them to starting PrEP. Analyzing the resonances and tensions between their narratives foreground how claims to moral sexual subjectivity for MSM hinge on notions of responsible risk management. Examining their accounts also demonstrates how descriptions of risk management in relationship to HIV are themselves risk managed. Noting this is critical to establishing the utility of anthropological methods in the study of how risky sexual subjectivity is produced, lived, and governed at multiple levels, especially seeing as the ethnographic approach remains chronically underutilized in research on PrEP.

Two takes on a shared path towards PrEP

Michael and Richard have been a committed couple for over 20 years and married for the past ten. When I first met them, they were both in their 40s and had recently relocated from a city on the eastern seaboard to Los Angeles. At the time, Michael was already working remotely, so when Richard created an opportunity to go virtual with his job (pre-coronavirus pandemic), as well, the two uprooted themselves from the city they had called home for the majority of their relationship. I met Michael and Richard a few years before I began my dissertation research in earnest. Once I did, I asked if I could interview them about their experiences with and perspectives on PrEP. Richard was in the middle of a phone call when I arrived at their home, so Michael invited me into his office for us to talk first.

In the late 1980s, Michael moved to New York City to go to graduate school for music. Even though his move to New York landed him in the most sexually permissive environment he had lived in to that point, he remained, in his words, "pretty solidly in the closet" until he turned 25. "I frequently say I didn't have sex for so long, because I just didn't really have an opportunity. I just didn't understand how *any* of that worked. I was in music school; I mean I was surrounded by gay men. Looking back, I think people were making advances, but I just did not recognize it at all. I had a very serious self-esteem issue. It never crossed my mind that anyone would ever even remotely think of me that way," meaning as a potential sexual partner. Michael linked this to his body image and described himself, at the time, as "a compulsive eater. I had a little flirtation with bulimia for a while I was in undergrad. My self-esteem was kinda connected with that, but I think all the eating was my trying to medicate myself in a lot of ways. I look back and I definitely had some depression issues." In that period of his life, Michael found the prospect of exploring his sexuality daunting, even unimaginable. That began to change after he attended the March on Washington for Lesbian, Gay and Bi Equal Rights and Liberation held on April 25, 1993.

"Things were a little more charged back then," Michael explained. "AIDS was still killing people left, right, and center." Michael's participation in this political mobilization in the nation's capital, one of largest protests in American history—which called for an end to discrimination, legislation to protect the civil rights of LGBT people, and a massive bump to AIDS education, research, and patient care, among other demands—was a "profound experience" that also "opened the floodgates" of the closet door. "When I came back to New York, I was coming out to anyone who would stand still long enough to listen to me." The sudden, dawning prospect of sex, although only first actualized a bit down the road, rapidly changed Michael's relationship to his body: "I lost 40 lbs, just like that. All of a sudden it just became easier to do that, and there was a lot of incentive to do that: sex was the biggest incentive of them all." Because that incentive arose amid the ongoing epidemic, however, Michael's early sexual forays were shot through with an ever-present awareness of risk.

As he put it, "every time you had sex, you felt slightly like you were putting your own life in your hands. The statistics were ridiculous, but I remember at the time there was one number that was being thrown around that 50, as in five-zero, percent of all gay men in Manhattan were HIV positive, which seems a little high, but who knows. The idea was that we were all really scared, especially in the earlier 90s when we thought you should be giving blowjobs with condoms." This level of precaution he laughed off in hindsight as somewhat of an absurdity. "The public health people were being very, very, very cautious, because they weren't really entirely sure." An environment of uncertainty surrounding HIV acquisition risk, undergirded by and productive of fear, haunted Michael's sex life.

"At the time, after you would have sex, you would be reviewing everything that happened. I remember when someone was going to fuck me once and he was like, 'I just want to put the tip in [without a condom].' I remember at the time thinking that it seemed *so unbelievable* to me that this person was even proposing that. You often had this notion that you could seroconvert just by the action of doing something unsafe. You weren't even necessarily catching it, it was as if the series of events and actions would spontaneously create the virus, and you really did feel that way, because there were way more questions than answers at that point." Michael's anxiety about HIV acquisition compelled him to see condom use as compulsory.

"There was *no* way I was going to have sex without condoms. When I talk to other guys my age, I realize I was very adherent." Using condoms regularly enabled Michael to pursue an active sex life. "I had a lot of sex through the 90s and [remaining adherent to condoms] never really seemed to be that much of a problem." His motivation to do so was plain to him. "I did not want to die of AIDS. I had a couple of close friends die. It was horrible! I missed them terribly, and it was just not a pleasant exit for either of them. Seeing that was pretty strong prophylaxis." Michael's adherence to condoms, as a prophylactic measure against HIV and his fear of what acquiring it in the pre- and peri-combination-antiretroviral treatment eras might mean, persisted through the 90s.

"It wasn't until Richard when I stopped using condoms," he explained. I asked him how it was he had decided to stop using condoms in his relationship with Richard. "I think I was having problems maintaining an erection with condoms." At some point, a few months into the relationship, Michael and Richard started having raw sex. "Tell me more about that discussion," I asked. "We did not discuss it [laughs]. He sort of just sat on my dick without a condom." Knowing Richard's energetic, fiery, and spontaneous personality, I was somewhat unsurprised to hear that. "We had been seeing each other for a while, and it didn't really freak me out, but we never really had a discussion." Because they had established intimacy, "I trusted him enough at the time to not be really worried about it."

I knew Michael and Richard were now in an open relationship, and that for Richard especially, sex outside of the relationship was a significant part of his social life. Together, the two hosted occasional sex parties at their home, and outside of those, I knew Richard had a circle of "fisting buddies" and tended to play around what are considered to be some of the more adventurous edges of sexual practice. When I asked how and when they decided to open their relationship to outside partners, Michael's answer led us into a conversation about risk, intimacy, and PrEP; furthermore, it steered us directly into theoretical and methodological concerns that lie at the heart of this dissertation project.

"It was very late 2010. We got married in the summer of 2010, and about two months after that, Richard sort of, I mean, there was an abrupt conversational start. I guess it's hard to segue into that, but he just kind of brought it up. 'You know, I've been kind of thinking about monogamy, and I have sort of a different attitude towards it, and I think we should maybe talk about opening things up.'" This caught Michael, the measured and cautious counterpart to the more ardent and spirited Richard, off guard. "I'm like, Ok… We just got married two months ago so this is kind of an odd time to be springing this one me, but ok, here we are. Again, I didn't really understand what it meant. So, I just kind of was like, "Uh, yeah, sure, ok." That was pretty much the discussion. I didn't really know what else to ask, I mean in the moment. Over the next couple of months, more than a couple of months, that was where we really worked through the details." As it turned out, Michael's understanding of what an open relationship might look like in practice was not exactly aligned with Richard's. "I thought the openness was more in a sense of on random occasions, like if you're traveling and something happens, it's ok, and you don't have to worry about it. Richard had a very different idea." The incongruity became glaringly obvious one night in their old loft.

"We were watching TV, sitting in bed, and he got up to use the bathroom. I was checking a flight status or something like that and his computer was right there, so I was like, 'Babe, do you mind if I just check something on your computer?' I turned it on and it went straight to email." What Michael saw jolted him. "There was just all of this, 'Oh hey man that was amazing we need to fuck again next week.' And there were pictures of guys, too. Within those, there was a picture of Richard sitting on a raw cock that was *not* mine. I was *livid*. Absolutely livid. That was kind of how it all, that was the beginning of our really having to figure out how this was working. And we're still figuring it out," now ten years since that night.

Michael held his tongue and decided not to bring up his discovery immediately. "It can be a real minefield," he said, "and that was the beginning where I was like oh my G-d, wow, he's *really* off doing a whole bunch of things. I think I had a gotten a hard-on during a massage and felt wracked with guilt over that. So, I was like, hmm [laughs]. I think we may need to reevaluate how this is working. It took me a little while to say anything, just because I knew I needed to think about what I wanted to say, but that was the beginning of the ongoing, long conversation about having an open relationship."

What disturbed Michael most about the scenario was the sense that Richard's sexual decision-making could very well impact Michael's health; he was galled at the thought that the man he had just married was evidently acting without considering that carefully enough. "I was furious because *my* health was being put at risk and I didn't know it. I have some friends who seroconverted from partners who they thought that they were in a monogamous relationship with, that wasn't really that uncommon a story. I did not want to be that person, so I was really, really angry, and I was hurt that he was off doing this. The arrogance, the narcissism—thinking that was ok to do and putting me at risk. I was not happy." Michael connected his powerful reaction upon discovering Richard's duplicity to the familial dynamic in which he had been raised. "My father was a pathological liar, alcoholic, drug addict. So, there was the outward appearance of my family and then all the stuff that was going on behind the scenes that I knew about. I *hate* lying. I do not like being blindsided by things." Michael's deeply rooted emotional reaction inspired him, once he eventually confronted Richard, to implore him to start taking PrEP.

"That actually is exactly why *I'm* the one—because I had heard about Truvada from some other friends—I'm pretty sure that's when I had the conversation with him that *you* need to be on this drug. He went to our doctor, and our doctor said, 'Oh yeah, I'm recommending this to all my patients.' It was still really, really early on. A lot of people had never heard about it. It did seem like this magical, too-good-to-be-true thing, especially for people my age, where it's like: having people cum in you? They may as well be shooting a bullet in your head. I think he had some rationalization [for the raw sex], like well I knew the guy, and I was like, yeah, no. He got on PrEP shortly after that, and I guess I went on it sometime after." As our interview continued, Michael and I spoke about how his relationship with Richard has evolved over the years, and how PrEP has enabled them to embrace, while not necessarily reconciling, the differences in their attitudes and approaches towards sex.

"Richard is very visual, and I feel like he disaggregates different parts, like parts of his body and parts of his sexuality. Like, fisting is a very specific sensation and it's not, I mean, it just doesn't touch any of the sexual buttons in my brain at all. I'm more about context. I like feeling connected to the person that I'm with. Even sometimes in my head I'll come up with fantasy scenarios that are quite different than what the reality is, but I like the situation, I like the dynamic. For example, I've never really watched that much porn. I read erotica. I read stories. I'm in my brain, I'm creating everything. I can easily put myself into one of the roles, and that really turns me on." For Richard, on the other hand, "to be in a room full of 10 guys going at it, that is super stimulating for him and less so for me. As the years go on, he's always been kind of like that, I've always been kind of like this, and I feel like we've just gotten more like that." Michael described their sexual repertoires as a Venn diagram, the union of the two circles shrinking in area over time. With the addition of PrEP, though, which Michael said, "just seems like such background noise right now," he feels eminently more comfortable with Richard's spunkier proclivities.

Michael and I wrapped up our discussion after talking for almost two hours, by which time Richard had finished his meeting. We picked a quiet corner of the yard, well out of Michael's earshot, and settled in for our interview. I started off inquiring about his early relationship to his sexuality and familiarity with HIV/AIDS. Richard came out when he was 21 and said that, when he did, "I was already very aware of HIV and the risks of that. I learned a lot through instruction in high school. That was in the '80s, so by the time I got to college I had fear already programmed into me about being super, super careful." I asked him what being super careful meant to him.

Without hesitation, he said, "Always condoms. Rarely was it a discussion. Condoms were assumed." What about with your boyfriends, I asked him. "I can't remember what the cut-off was, but if we decided we did not wish to use them any longer, we had to wait a period of time and then test. And you had to *trust* one another that you weren't screwing around with other guys and exposing yourself to other risk factors. So, a couple of times it got to that stage." In Richard's description, condoms were compulsory, an ever-present dimension of sex, except in instances where he tapped his knowledge of testing and intimate, trusting bond with a partner to jointly decide on a reasonable time to dispense with them in the context of a monogamous relationship.

With Michael's narrative about how the two of them got started on PrEP very fresh in my mind, I probed, "If you did have sex outside a monogamous relationship, how often were condoms involved?" His response was unequivocal. "Always. That was my rule. That was my personal rule, anyway." I asked him when that started to change or evolve and whether that had to do with the introduction of PrEP, thinking, again, about what Michael told me about the pre-PrEP raw sex Richard was having after the two of them opened their marriage. In answering my question, though, Richard painted an entirely different picture of the circumstances that led to him seeking PrEP.

"I was on a work visit to Los Angeles and I was having lunch with a friend of mine, and he said I'm on this new drug that basically blocks HIV, so condoms aren't necessary. And I remember thinking: what? That's crazy, I've never heard of such a thing. Impossible. So, then the next time I was at my doctor's office, I asked about this, and I did a little research myself, and they're like yeah it's a real thing, do you want to get on it? I said yes." While the significant discrepancy between Michael's story and Richard's distracted me, I also tried my best to engage with what Richard was telling me on its own terms.

"During the condom universe time-period," Richard explained in a straightforward tone, "I just decided early on that I was going to enter every experience assuming the person I'm about to have sex with is positive. I would let that assumption inform my decisions. That means condoms were always involved, I mean just *always* involved." His full-throated endorsement of condoms directly contradicted Michael, who had just a matter of minutes before explained to me at length how Richard was surreptitiously barebacking before he started on PrEP. According to Michael, his discovery of Richard's lack of condom use was, in fact, the incitement for Richard to start taking PrEP. I scrambled to think if there was some way that I could triangulate their differing stories without violating the confidentiality of my research interview with Michael.

The best strategy I could come up with was to ask, as naively as possible, a general follow-up question. I explained my understanding that many people aim to make consistent condom use a goal, or think of it as a rule, but that sometimes in the heat of the moment achieving that goal or sticking to that rule is unfeasible. I wondered aloud how he related to that, or if that had ever been the case in his experience. Richard deflected. "Well, breakage happened, but not routinely. It would happen every once in a while. So, it would be like, well, I'll hope for the best, but I'm kinda worried." While he endorsed a condom breakage narrative—describing a technological malfunction despite his best intentions—Richard flatly denied ever intentionally having sex without a condom before he started taking PrEP.

In fact, he spun a wholly different story when I asked about the connection between PrEP and his open relationship. “Well, the openness predated PrEP. And then PrEP started. The introduction of PrEP basically, if I remember correctly, compelled a conversation about if we are really on the same page about and comfortable with the notion of having unprotected sex with other people.” I summarized his response: “Because before PrEP, it was more a conversation about having sex with other people, but safe [with condoms] only?” He confirmed: “Safe only. Then PrEP started coming around and, seeing the writing on the wall, we were like yeah well we better have this conversation, because I knew it was something I wanted for sure. So, that prompted the conversation, and we decided: yeah, it’s ok, we’re comfortable with this.” Richard became more animated, “Actually, I remember! I was there the first time I watched another guy cum inside of Michael.” Richard shrugged. “I think. He said it was the first time, so I believe him.”

Negotiating and narrating HIV sexual risk

Qualitative health researchers (Blaxter 1990; Abel, Cockerham, and Niemann 2000) have long noted that “people tend to reproduce the conventional wisdom of health education and health promotion when asked about their health and lifestyles,” even when they do not necessarily implement it in practice (Williams 1995, 598). While this precept may apply across a range of health conditions, it is especially salient for those that are particularly stigmatized, like HIV/AIDS. I chose to open my dissertation with Michael and Richard’s story, because making sense out of my sequence of interviews with them, wherein two very different accounts of a shared history were relayed, introduces the complexity of ethnographic inquiry about sexuality in general and HIV sexual risk practices in particular.

Michael, Richard, and I are part of a shared social and sexual network. The intimacy established through our social and sexual linkages could be seen as a conduit for increased transparency and enhanced access to which differently positioned researchers might not be privy (Newmahr 2011; Simmel 1950; Dean 2009). Richard endorsed that view himself, in answering a question I asked him towards the end of our interview: how, if at all, did he think that our sexual history influenced his participation in the study? He answered quickly. "Well, if I can't speak openly in front of you, then who can I? To me, there's no wall. I say what's on my mind. I may not have said all these things to a stranger."

While I do take Richard's validation of relatively open communication between the two of us to heart, I also interpret his account, like any interview data, as to some degree a product of what Philippe Bourgois is fond of terming "impressions management." Highlighting the incongruities and tensions between Michael and Richard's narratives thereby foregrounds methodological and theoretical considerations at the core of my research: namely, demonstrating the way that accounts of risk management in relation to HIV are, in and of themselves, "risk managed" (Rhodes and Cusick 2002, 211). This insight helps to clarify why and how discrepancies arise not only between the two stories, but also, and more generally, between quotidian approaches to risk and their re-presentation in the research setting.

Bourdieusian scholar Simon J. Williams points out that "the gulf between accounts and actions becomes somewhat less of a puzzle when we realize that much of people's daily lives is, in fact, governed by an implicit, practical logic and that, as a consequence, there is a tendency in the research context to switch from this level of practical logic to a more discursive form of consciousness; one which bears little relationship to the former type of knowledge and tends to be more concerned with 'mentioning the mentionable' and appearing in a favourable moral light" (589-599). Reading my interviews with Michael and Richard through this lens helps to clarify the asymmetries in their recounting. Both Michael and Richard spoke with me extensively about always, unequivocally using condoms for penetrative anal sex before getting on PrEP. In doing so, they were engaging a specific form of what Williams describes as "a more discursive form of consciousness," one forged in relationship to the deployment of risk in the history of the HIV epidemic. To characterize this discursive form of consciousness and its embodiment, I adopt the construct of *risky sexual subjectivity.*

What is sexual subjectivity?

In order to describe a genealogy of the concept of risky sexual subjectivity, it is first necessary to turn to a brief review of analytical frameworks used to understand sexual behavior and identity. French theorist Michel Foucault's seminal *History of Sexuality, Vol 1.* (1990) addresses the historical process by which same-sex sexual practice was reconfigured from behavior into basis for the imputation of a racialized identity: "[t]he sodomite had been a temporary aberration; the homosexual was now a species" (43). Whereas sexual proclivities were once merely *a* fact about a person like any other, they were transformed into *the* fact—the skeleton key to unlock the truth at the core of one's character. As a consequence, identity became a key paradigm in the regulatory normalization of bodies and populations through the deployment of sexuality. Identity as a concept also drove, for a time, social scientific research into sexuality itself, especially inquiry concerning non-normative sexuality.

Early scholarly investigations into same-sex sexual relations (Carpenter 1914; Westermarck 1917; Ford and Beach 1951; Marshall and Suggs 1971) entered a relative vacuum of ethnographic material on sexuality. Initially, this stimulated a documentary impulse and led to a project of "breaking the silence" (Weston 1993, 340). Similar to the how a prominent strand of what some might call pre-feminist anthropology focused on searching for examples of genuinely egalitarian societies to bolster the women's movement, anthropological work on same-sex sexuality was sometimes taken up as a vehicle to advance gay liberation. Scholarship along these lines tended to reify and idealize so-called "traditional" forms of same-sex sexuality observed in non-industrial societies for the benefit of identity-based social movements in North America. Objects of anthropological knowledge production related to sexuality that epitomize this phenomenon include the Native American *berdache* role (Callender and Kochems 1983) and "ritualized homosexuality" in Melanesia (Herdt 1993).

Berdache is an umbrella term that anthropologists used to describe North American natives, usually (from a Western biomedical perspective) assigned male at birth, who transgressed binaristic expectations pertaining to gender and sexuality and often occupied special social roles. Scott Morgensen (2011) deconstructs how "a first generation of anthropologists of homosexuality established disciplinary authority by linking sexual minority politics to progressive anthropology through the scholarship on *berdache*" (57). Excessive attention to *berdache* saturated debates over the cultural and historical roots of putatively modern queer subjects. This phenomenon is part of what Morgensen terms settler homonationalism—a concept to denote how 'a white national heteronormativity ... regulates Indigenous sexuality and gender by supplanting them with the sexual modernity of settler subjects' (Morgensen 2010, 196). Writings on *berdache* represented less the analysis of a cohesive subject position and more the projection of a colonial fantasy.

Similarly, scholarship on what was constructed as ritualized homosexuality in Melanesia improperly imputed a model that "relies on Western ideas about gender, erotics, and personhood, and that ultimately obscures the meanings that hold for these practices" in situ (Elliston 1995, 849). Ethnographic research revealed that many Melanesian groups revered semen as a healing and strengthening substance essential to a young boy's growth and masculinization. In different societies, male initiates acquired semen through what Western observers understood as oral and receptive anal sex, or by rubbing it on the body. Elliston recasts the claim of ritualized homosexuality instead under the rubric of 'semen practices,' comprising just one among 'a range of substance-focused practices that are better understood when analyzed in terms of an ideologically and symbolically based regional pattern" (852).

Critical reevaluations of scholarship on *berdache* and ritualized homosexuality demonstrate how, in the attempt to supply evidence for claims to the "primitive" legitimacy of Western gay identities, anthropological inquiry into non-normative gender and sexuality participated in a colonialist politics of knowledge production. Such correctives articulate with critiques describing the coloniality of gender (Lugones 2007) and culturally imperialist efforts at universalizing "gay rights" frameworks via the forcible assimilation of subjects into a homosexual/heterosexual identity-based binary (Massad 2002).

The concept that sexuality is social—and therefore a suitable object for social-scientific inquiry—was consolidated during the 1950s and 1960s, not by anthropologists but by sociologists of deviance. The pejorative discourse of deviance is an obviously problematic framework in which to address sexual diversity. Still, this shift was significant in loosening the grip of psychiatry on non-normative gender and sexuality (Freud 1949; Krafft-Ebing and Chaddock 1892). The fact that most research on non-normative sexuality in particular operated in a psychological register is unsurprising considering Foucault's point that "the psychological, psychiatric, medical category of homosexuality was constituted ... less by a type of sexual relations than by a certain quality of sexual sensibility, a certain way of inverting the masculine and the feminine in oneself ... a kind of interior androgyny, a hermaphroditism of the soul" (Foucault 1990, 43). Psychological studies tended to always already pathologize same-sex sexuality, even when the findings and analyses were framed in a progressive light. In contrast, Hooker (1961) and Hoffman (1968), for example, proposed sociological typologies associated with same-sex sexuality that, despite their inadequacies and flaws, at least painted a "picture of 'whole' individuals, complex persons in complicated sociopsychological and environmental settings" (Fitzgerald 1977, 395). By employing ethnography to shift focus from individuals to communities and from illness to ways of life, work in this mold effectively displaced attention from the etiology of disordered behavior and redirected it to patterns of socialization.

Scholarship along these lines dovetailed with nascent developments in social constructionist theory bubbling up by the mid-1970s and supplanting traditional cultural influence models. Cultural influence models construe sexuality as a naturalized category, closed to investigation and analysis, on which culture works to promote or censure specific sexual practices and relationships. Anthropological work in this tradition emphasized variability in sexual behaviors across contexts but naturalized sexual impulse as universal and biologically determined. Social constructionist approaches, on the other hand, hold that physically identical sexual acts may carry varying social significance and subjective meaning across space and time. Historian Jeffrey Weeks' (1977) social history of homosexuality kick-started this movement by demonstrating that homosexuality is not a transhistorical category but rather a form of same-sex behavior involving historically situated people, identities, and communities. In this way, earlier lesbian/gay studies in anthropology can be said to have undergone a transition reminiscent of the shift from the anthropology of women to the anthropology of gender, which "broadened the enterprise from data-gathering to theorizing" as "[e]ventually, writers began to question the fundamental categories" that grounded their research like "homosexual and heterosexual, lesbian and gay, feminine and masculine, and even sexuality itself" (Weston 1993, 345–6). In Vance's (1991) pithy formulation: "The physiology of orgasm and penile erection no more explains a culture's sexual schema than the auditory range of the human ear explains its music. Biology and physiological functioning are determinative only at the most extreme limits ... The more interesting question for anthropological research on sexuality is to chart what is culturally possible—a far more expansive domain" (879).

With the introduction of queer theoretical perspectives, dawning in the early 1990s, identity began to lose its prominence as the key theoretical framework for the interpretation of sexual difference (Warner 1993). This shift towards a critical anthropology of sexuality, and further towards queer anthropology (Manalansan 2016; Weiss 2016), challenged the notion that concepts used to describe sexuality, like identity and behavior, characterized extant and discrete entities and relations; instead, such scholarship approached the concept of sexuality as an analytic to interpret human experience more broadly. In "Dubbing Culture" (2003), anthropologist Tom Boellstorff moved to "eschew the identity-behavior binarism" in studies of sexuality "in favor of a language of subject positions (extant social categories of selfhood) and subjectivities (the various senses of self—erotics, assumptions about one's life course, etc.—that obtain when occupying a subject position, whether partially or completely, temporarily or permanently)" (229). Boellstorff described the dichotomous relationship between identity and behavior as conceptually inapt, because identity is always also a "set of embodied practices" and behavior is "culturally mediated through self-narrative" (ibid.). Retaining from the initial concept of identity the idea that selfhood operates as a social fact, the notions of subject position and subjectivity explicitly incorporate history and political economy: they are forged in space and time in relation to particular matrices of power relations and regimes of governance.

Subjectivity, then, confers over identity the advantage of portraying "the formation of a self through social and historical processes. Whereas identities are based on our identification with a concept—race, gender, sexuality, class, and so on—the notion of subjectivity implies that there is no fixed inherent self" (Stout 2014, 25). This insight is particularly germane to the practice of ethnographic research, which aims to explore the means by which a particular sense of self comes into being. As opposed to identity, subjectivity "encompass[es] the idea that we are not fixed selves beholden to racial, gender, or sexual 'truths' about us, but rather shifting embodiments of the moment in history in which we find ourselves" (ibid.). While recognizing the necessity of understanding multiple forms of domination and oppression through an intersectional framework (Crenshaw 1989; McGlotten 2012; Bowleg 2013), thinking with subjectivity contributes the perspective that "age, race, class, and so on don't merely inflect or intersect with those experiences we call gender and sexuality but rather shift the very boundaries of what 'gender' and 'sexuality' can mean in particular contexts" (Valentine 2007, 235).

Building on this insight, scholars of colonialism, race, and sexuality have been instrumental in critiquing the identity framework for importing paradigms that obfuscate, rather than illuminate, emic gender and sexual practices. Gloria Wekker's (2006) beautifully nuanced auto/ethnographic scholarship on *mati work* in Suriname argues, "Conceiving of same-gender sexual behavior … in terms of 'identity' inscribes and reproduces Western thought categories with their legacy of dichotomy, hierarchy, and permanency, thus distorting a phenomenon that is emically experienced in quite different terms" (193). According to Wekker, *mati work*, a form of same-sex sexual relationality among working class Afro-Surinamese women, is experienced as a varying and versatile practice: “no real, authentic, fixed self is claimed, but one particularly strong, masculine instance of the multiplicitous ‘I,’ who loves to lie down with women, is foregrounded” (173). The notion that sexuality is better understood as something that a person *does* rather than a stable identity that a person *has* dovetails with Judith Butler’s (1993) concept of performativity, initially applied to gender, denoting the “reiterative and citational practice by which discourse produces the effects that it names” (2). Jafari Allen’s (2011) ethnography of the erotics of Black self-making in Cuba, for example, approaches sexuality as “multiply constituted and dynamic,” characterizing it as a “deeply personal but also culturally constructed desire, articulated not only to (at least) [his interlocutors’] gender but their nationality, color or race, and spirituality” (12).

Other contemporary scholars of sexuality have explored how sexual desires, practices, and subjectivities are shaped in relationship to racialization (Bailey 2019; Johnson 2011), immigration (Manalansan 2003), neoliberal practices of consumption (Weiss 2011), global capital flows (Stout 2014), and religion (Gaudio 2009; Ramberg 2014), for instance. Rather than reifying sexual identity as a stable construct, work in this lineage critically examines the production of sexuality through and in relationship to broader material and discursive forces. My approach to sexual subjectivity is built on this literature, which foregrounds such forces and simultaneously works to develop an understanding of how they are understood, internalized, and negotiated on the ground. This latter dimension of the research is well described by Deborah Tolman’s (2002) conceptualization of sexual subjectivity as encompassing experiences of self as a sexual being, sexual self-perceptions, notions of efficacy and entitlement to sexual desire, and understandings of sexual pleasure and safety.

Writing within this tradition, my dissertation research focuses on how the sexual subjectivity of MSM has been shaped and is continually reshaped in relationship to the historical present of the HIV/AIDS epidemic, specifically through the prism of risk: hence, *risky* sexual subjectivity.

What is risky sexual subjectivity?

Decades of HIV prevention science and practice have led, over the course of the epidemic, to the solidification of MSM as a risk group of paramount significance. “Homosexual” men were the first patients described in the U.S. Centers for Disease Control and Prevention (CDC) report detailing a cluster of cases of rare lung infections and aggressive cancers among previously health young adults in New York and California (Hymes et al. 1981; CDC 1981). One year later, the CDC released a landmark dispatch suggesting a sexual route of transmission underlying the emerging syndrome, which was given the preliminary moniker gay-related immune deficiency (GRID). The association reflected what was considered to characterize the epidemiology of the epidemic at the time. Mainstream press also circulated the term “4H disease” to describe the key risk groups the syndrome was thought to affect: Haitians, homosexuals, hemophiliacs, and heroin users.

The demographics of the epidemic along with its mediatization have shifted substantially over time. What was first nationally recognized as a health crisis of middle-class, white gay men in cosmopolitan cities has come to disproportionately impact MSM of color, cis and transgender women of color, and persons who inject drugs (PWID). It remains true that the majority of people living with HIV in the United States are men who have sex with men and that most new HIV diagnoses yearly (69%) occur among men who have sex with men (CDC 2021). But even as incidence rates decline overall, racial disparities in the impact of the HIV epidemic persist; in some cases, these inequities are widening. HIV incidence rates are currently eight times higher for Black people and almost four times as high for Latinx people than for white people in the United States.

As Cathy Cohen comprehensively describes in *The Boundaries of Blackness: AIDS and the Breakdown of Black Politics* (1999), “practices of exclusion and ideological narratives of deviance” meant that gay men of color, as well as “injection drug users, poor women, and disempowered children, many of whom were African American and Latino/a, found themselves silenced, invisible, and neglected in the early years of the epidemic” (146). The CDC’s surveillance of HIV relied on data collected through traditional providers, which “effectively made invisible many poor people and injection drug users—significant numbers of whom were people of color—who have limited access to adequate health care.” Furthermore, “[w]hen newspapers relied on medical journals and information about this new disease, they inherited and reproduced all the biases of these sources” (183).

The biases Cohen identifies favored those with access and resources, who were disproportionately gay, white men, and this dynamic tightened the link between male same-sex sexuality and the early understandings of risk in the epidemic. Human immunodeficiency virus (HIV) was first identified in 1984 as the etiological agent of the mysterious and deadly disease, now termed acquired immune deficiency syndrome (AIDS). In the climate of uncertainty surrounding that discovery, a burgeoning moral panic ensued, wherein to be gay was to be both uniquely “at risk” and significantly, from the general public’s perspective, to be dangerously *posing* a risk (Flowers 2001).

As the perceived threat of AIDS and being gay morphed into one, a heated debate was launched concerning the sexual ethics of the so-called “gay lifestyle.” A community-based response to the brewing emergency was mounted through which the first safe sex frameworks were developed, describing what was known about the relative risk of a wide range of practices and suggesting limiting sex acts to those with a lower risk of "contagion" (Berkowitz and Callen 1983). The notion of safe sex has, by now, been thoroughly institutionalized and domesticated within the ambit of mainstream public health; when the term first emerged, however, it "rang as a radical slogan within the urban gay male community" (Patton 1990, 45).[1] Safe sex built on emic knowledge developed within gay male sexual culture. As Douglas Crimp (1987) explained, "We were able to invent safe sex because we have always known that sex is not, in an epidemic or not, limited to penetrative sex. Our promiscuity has taught us many things, not only about the pleasures of sex, but about the great multiplicity of those pleasures" (252).

Only once safe sex "made its way through scientific meetings, the media, and into heterosexual practice" did it take on new meanings, becoming "fixed as if it were an absolute practice which had only one interpretation" (Patton 1990, 45). When the first handful of "heterosexual" cases of HIV emerged in late 1984—"these were heterosexuals who did not fit the previous categories of gay, IV drug user, prostitute, hemophiliac, or partner of the above"—the notion of safe sex was reconfigured. "[S]ince among heterosexuals, or at least in the public culture of heterosexual men, penile-vaginal intercourse is the hegemonic and identity-creating act, the meaning of safe sex shifted toward abstinence, monogamy, or the use of condoms" (47). In line with this transformation, safe sex no longer primarily described a multifaceted practice of sexual pleasure within a richly variegated sexual field encompassing monogamy, open

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[1] A similar argument could be made about "harm reduction." Harm reduction began as a radical political movement in response to the stigmatization of people who use drugs and is increasingly becoming embraced in differential but often sanitized ways, even by institutions and power structures complicit in perpetuating that stigma.

relationships, casual encounters, and anonymous sex of many kinds. Instead, safe sex came to signify the avoidance of sexual danger through officially sanctioned means. This contraction of the definition of safe sex, occurring in tandem with its increasing institutionalization and propagation through health promotion efforts premised on individual behavior change (Race 2003), intensified the responsibilization (Rose 1999) of MSM.

In the context of HIV prevention, the discourse of responsibility maintains that all MSM should recognize themselves through the idiom of risk, be cognizant of the dangers posed by the disproportionate prevalence of HIV in the sexual pool and, as a result, assume the role of prudent sexual actor by practicing self-protection, which is often narrowly defined by the imperative to use a condom every time outside of monogamous sexual relationships. The individualist ethic developed in and through the hegemonic safe sex message—something along the lines of, “[P]rotect yourself from all others who pose a threat of potential infection”—did in fact help to dramatically decrease rates of HIV transmission through the 1990s (Cristian Rangel and Adam 2014, 73). The associated risk discourse, however, also functioned as a form of boundary work among MSM, “creating hierarchies of morally worthy subjects along the lines of responsible selfhood,” obfuscating both structural and interpersonal forces shaping an individual’s willingness and capacity to practice condom use (80). Within this framework, MSM achieved a tenuous “toehold on respectability” (Fellows and Razack 1998) through assent to the condom use paradigm. But this toehold was—and remains—always at risk of being revoked, and it therefore requires continuous renewal through both bodily practices *and* their re-presentation.

Conclusion: Returning to Michael and Richard

Taking this abbreviated historical background into account helps to contextualize the accounts Michael and Richard provided about what led them to getting on PrEP. While differing in terms of specific details, their stories overlapped significantly in how each of them articulated their relationship to risky sexual subjectivity.

Michael emphasized conformity to the normative standards of moral sexual subjectivity by saying "there was *no* way I was going to have sex without condoms" outside of a monogamous relationship. He called it "unbelievable" when a casual partner wanted to put the head of his cock in raw. So, when he accidentally discovered his new husband was getting fucked without condoms outside of their marriage, he reacted explosively: "I was furious because *my* health was being put at risk." In his memory, it was Michael who had heard about PrEP through friends and told Richard he needed to go to the doctor to get a prescription. By making that suggestion, Michael demonstrated himself to be a responsible sexual subject, perhaps even what Thomann (2018) refers to as an ideal neoliberal sexual actor: "a preemptive patient-consumer who is responsibilised not through risk avoidance but through biomedical intervention" (1002). Through his own condom use, followed then by his recommendation of PrEP to Richard and his eventual adoption of PrEP himself, Michael solidified his claim to moral sexual subjectivity in his identification of and response to risk.

Richard made explicit that, pre-PrEP, he committed to engaging every partner as if they were living with HIV, following the individualist ethic described above, and that this orientation determined his sexual practice. In his words, "that meant condoms were *always* involved." By endorsing stringent adherence to the standard of condom use outside of his marriage to Michael, Richard identified himself as a prudent sexual subject: one who recognizes, responds to, and manages risk appropriately. In fact, he said that he only first considered the possibility of condomless sex outside of his marriage once PrEP was in the picture.

The interpretation of Michael and Richard’s PrEP trajectory demonstrates the utility of anthropological methods in the study of how risky sexual subjectivity is produced, lived, and governed at multiple levels. In the words of Robert Power (1998), a social scientist working in the field of HIV and prevention and social and behavioral research since the mid-1980s, “Qualitative research has enabled us to appreciate the subtlety and complexity of HIV-related behaviours and the importance of lifestyle and culture in determining crucial factors, such as risk and negotiation. It has also provided invaluable formative research and development, especially in mapping the profiles of difficult-to-access social networks of target populations” (687). Yet despite this history and testimony to its significance, the ethnographic approach remains chronically underutilized in research on PrEP (Pinto et al. 2019).

As noted by Carole Vance (1991), “AIDS dramatically increased interest in conducting and funding sex research,” but the emphasis on “epidemiological inquiry into the frequency and nature of sexual behavior” also served to encourage the resurgence of biomedical approaches to sexuality “through the repeated association of sexuality with disease” (880). Pressure for what Ralph Bolton (1995) called “quick-and-dirty” results meant that “extended ethnographic research that addresses the process of adaptation and change surrounding sexuality,” the kind involving “prolonged and intimate contact,” was “replaced by one-month consultancies, phone surveys (farmed out to marketing firms), focus group interviews (contracted out to social marketers), and rapid assessment procedures” (108). These predominant research approaches focus on the question of “who does what with whom” and how often at the expense of attending to the meanings associated with sexual practice in context (Lewin 2002, 121). Analyzing meaning, practice, and context may seem, from a contemporary perspective, to be tasks falling squarely within the ambit of anthropology. Historically, however, the study of sexual practice and inquiry into same-sex sexual practice in particular has been marginalized in anthropological research.

Traditionally, graduate mentors strongly dissuaded their students from pursuing dissertations centering sexuality, which risked casting "doubt not only on the research but on the motivates and character of the researcher" (Vance 1991, 875). Certainly, in the earlier years, "conducting lesbian/gay research [was] tantamount to coming out—whether one [was] actually lesbian/gay or not," and the professional consequences that followed could be severe (Lewin and Leap 2002, 12). In "Too Queer for College: Notes on Homophobia," admired feminist anthropologist of sexuality Esther Newton (2000)—whose vanguard study of drag queen in Kansas City entitled *Mother Camp* (1972) is considered to be the first book-length ethnographic study of a "gay" community—attested: "I have been held back, paid less, [and] disrespected by many of the people I work with" for studying same-sex sexuality and being an out lesbian in the academy (224). Nonetheless, trailblazers like Newton along with the other anthropologists of sexuality cited in this chapter have legitimized the work of queer scholars and defended their presence in the academy.

In this dissertation, I stand on the foundation they established to speak back against the marginalization both of ethnographic methods within HIV research and of research on non-normative sexuality within the discipline of anthropology. Epidemics, and the way they are encountered, experienced, and responded to on the ground are "social processes: [s]pread of infectious agents is shaped by political economy, social relations, and culture" (Schoepf 2001). The analysis provided above and in the chapters to follow builds on this conviction to explore the social processes underlying the engagement of MSM with biomedical prevention at this juncture in the HIV epidemic.

Chapter 2

Risk, Subjectivity, and “Good” Sexual Health in the Time of PrEP

Introduction

Because it has thus far failed to achieve its potential, that is, to catalyze a substantial decrease in overall HIV incidence, PrEP has become the subject of a growing body of scholarship, much of it emerging from the field of public health, utilizing either quantitative or mixed methodology to identify barriers to PrEP access (Pinto et al. 2018). This body of literature has been critically important in pointing out how factors including medical racism (Cahill et al. 2017), inequitable access to care in a fragmented, profit-driven private health insurance system (Siegler et al. 2018), and the ongoing marginalization and pathologization of individuals who participate in stigmatized sexual practices (Golub 2018), make getting on (access) and staying on (persistence) PrEP a challenge in the U.S. context. Research along these lines conforms to what Sherry Ortner (2016) identifies as a tradition of "dark anthropology," scholarship highlighting "the harsh dimensions of social life," like power, domination, inequality, and oppression (47). Unquestionably, such analytics map well onto the study of PrEP; in fact, they are indispensable in parsing impediments to widespread PrEP implementation. It is therefore no surprise that the lion's share of research aimed at understanding what is and is not happening with PrEP on the ground proceeds through a deficit-based framework.

What has received notably less scholarly attention and recognition in the conversation about PrEP scale-up, however, is the degree to which PrEP reconfigures users' relationship to risk, sexual practice, health, and the body for those able to access and adhere to it. Qualitative research with PrEP users demonstrates how PrEP may positively reshape life trajectories and improve health and well-being, both for the individuals who take it as well as those in the social and sexual networks they traverse (Hughes et al. 2018; Curley et al. 2022). PrEP care, in turn, augurs an opportunity to redefine what it means for individuals and populations to be designated as “high risk” for HIV acquisition, challenging narrow parameters circumscribing how to inhabit “good” sexual subjectivity. In this way, PrEP holds the potential to reconfigure the sexual subjectivities of men who have sex with men, by productively scrambling the moral frameworks governing “good” sexual health that have developed historically through the discourse and practice of HIV prevention in the U.S.

This chapter spotlights the experience of one particular PrEP user, a young gay man of color with a ten-year history of crystal methamphetamine use, to demonstrate that PrEP not only works as a harm reduction intervention in biomedical, epidemiological terms, but also works to unsettle ossified understandings of risk in the HIV epidemic that have a tendency to perpetuate stigma. Challenging, extending, and updating these conceptualizations of risk opens space to depathologize the social and sexual networks of MSM by interpreting them not solely as vectors of disease transmission, but rather as understudied conduits for mutuality, care, and the dissemination of health promoting information.

As Marlon Bailey (2020), Rashaad Shabbaz (2015), and Jeffrey McCune (2014) show, the simultaneity of structural racism and homophobia underlie the vulnerability of racialized MSM to HIV. Their disproportionate representation in the epidemic is conditioned by circumstances like poverty, lack of health care access, and incarceration, not necessarily participation in risky sex. The sex that racialized MSM have is *made* risky by “the small social/sexual networks in which Black gay men socialize and have sex (with higher HIV and STD prevalence), barriers to prevention and treatment services, and the social stigma experienced within and beyond their families and communities of origin” (Bailey 2020, 221). I am not proposing PrEP as the sole solution to addressing these vulnerabilities. Rather, my aim in this chapter is to examine how the introduction of PrEP has the potential to reshape notions of risk that have historically been disproportionately ascribed to racialized MSM.

Raul's experience of sexualized drug use

Raul is a gregarious and affable 30-year-old who identifies as a cisgender, gay, Hispanic man. Born and raised in Los Angeles, Raul came out to his friends and family at the age of 14. As we first got to know each other, his energetic confidence and self-assuredness made an immediate impression on me. But he quickly and reflexively shared, early on in our conversation, though, that this was not always the case—he used to be quite shy and avoidant, he said. When I asked him when and why his temperament shifted, he explained, "The club scene made me the person I am today."

At the age of 19, when Raul was making his initial forays into gay nightlife, he was also introduced to crystal methamphetamine. From that point forward, the potent central nervous system stimulant, referred to in the vernacular as "tina" or "T" for short,[1] rapidly became a more and more significant part of his social and sexual lives. Methamphetamine is a white, odorless, bitter-tasting crystalline powder, soluble in water and alcohol that can be smoked, snorted,

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[1] Testosterone, another drug that can be injected and is not uncommonly used among MSM (both cis and trans), also goes by "T" for short. The distinction between testosterone and crystal methamphetamine, however, was clear in the context of the interactions I had with my research participants. Because crystal methamphetamine use is stigmatized, both in general and among MSM, too, a developed semantic system has arisen to communicate about its use. For example, dating app users might capitalize the letter "T" in a word (daTe, for example), include "party" in their profile (a reference to party and play, another term for chemsex), or use the balloon emoji (high), cloud emoji (smoking meth), or "." ("point"-ing, i.e., injecting meth). I use each of the terms crystal, meth, and tina in this chapter to reflect their use by my research participants in describing their perspectives on and interactions with the chemical compound crystal methamphetamine. Language choice throughout indexes the valence associated with the term selected. Crystal, meth, tina, and pookie are shorthand closer to the words and descriptions of PrEP users in my study, while crystal methamphetamine is more commonly mobilized in, and more closely tethered to, official public health and medical discourse.

injected, or orally ingested. Similar to other amphetamine compounds both *licit*, like the Adderall and Ritalin widely prescribed to treat ADHD, and *illicit*, like "speed" commonly bought and sold on the street, meth use induces increased activity and decreased appetite while producing feelings of euphoria and a sense of well-being. According to the recent National Survey on Drug Use and Health, methamphetamine is the second most commonly used illicit substance in the country, with an estimated 2 million users 12 years and older on a yearly basis (SAMHSA 2020).

Estimates of the prevalence of methamphetamine use among MSM have been based on extrapolation from smaller behavioral studies (Perry N Halkitis et al. 2014), but researchers suggest MSM may report rates that are 20-fold higher than the general population (Reback et al. 2012). Due to its disproportionate prevalence in this demographic, crystal methamphetamine emerged as a particular substance of concern to HIV prevention science researchers in the mid-1990s, when public health studies began characterizing its use as a significant risk factor for HIV acquisition (Frosch et al. 1996; Reback and Grella 1999). Because crystal methamphetamine enhances sexual desire and reduces inhibitions, factors relevant to its popularity among MSM as an accompaniment or incitement to sex, its use has been linked to what some public health and medical researchers refer to as "risky sexual behaviors" vis-a-vis HIV. These may include forgoing condoms, participating in group sex, exchanging sex for money or non-financial benefits, or being fisted, for example (Berry et al. 2020; Frankis et al. 2018).[2]

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[2] Initial safe-sex guidelines circulating in the early 1980s generally described fisting as categorically unsafe. In "The Catacombs: A Temple of the Butthole," Gayle Rubin's contribution to the edited volume *Leatherfolk: Radical Sex, People, Politics, and Practices*, she points out how "[m]any health professionals simply assumed that fisting was inherently 'unsafe,' regardless of its relationship to AIDS," which "kept fisting in the category of unsafe acts in the AIDS education literature and hindered the development of AIDS risk reduction guidelines for fisting." Rubin's critique speaks to how sexual practices that are considered transgressive, extreme, or offensive to the sensibilities of (straight) observers are readily recast as risky in terms of HIV acquisition. Fisting is tethered to HIV risk because it is considered morally reprehensible and

Additional ethnographic research (c.f. Gideonse 2017) into the life worlds of MSM who use crystal meth could contribute to elucidating patterned sexual practices and the meanings associated with them, alongside and in addition to their connection with HIV status and transmission events. In the meantime, however, quantitative studies clearly identify the parameters of what Halkitis, Parsons, and Stirratt (2001) termed a "double epidemic: crystal methamphetamine drug use in relation to HIV transmission" over twenty years ago. Recent scholarship substantiates the claim that this syndemic state endures. A paper published in the *Journal of Acquired Immune Deficiency Syndromes* (Grov et al. 2020), for example, revealed that one out of three annual HIV acquisitions among MSM occurred in study participants who reported persistent methamphetamine use.[3] Over the course of the study, 14% of such MSM acquired HIV, compared to a 2.5% incidence rate in the study population overall. These data attest to an ongoing connection between crystal meth use and HIV acquisition among MSM, whatever the mechanism may be, which helps to explain how and why crystal meth use and crystal meth use*rs* have been produced as "risk behavior" and "risk group," respectively, over time.

The majority of MSM who take a "tina tour"[4] or two do not end up acquiring HIV. Nor do they necessarily start using crystal meth with regularity and/or administering it intravenously.

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debauched, not because there is a scientifically validated, causal link between fisting as a bodily practice and the transmission of a blood-borne, viral pathogen like HIV.

[3] In the design of this study, persistent methamphetamine use referred to participants endorsing use of the substance in the three months prior to baseline evaluation *and* at prospective follow-up after 12 months had elapsed.

[4] A close friend who is in recovery from meth use once shared a meme with me showing a clip of TV icon Oprah notifying audience members they would all be leaving the taping with a ticket to see Tina Turner live. "You're going on the Tina tour!" Oprah exclaims. The text above the video reads: "When you log onto Grindr at 3 am." The joke is that opening Grindr at that hour is a ticket to another kind of tina tour—one that might involve, as it did for some of my research

A sizable proportion, however, do. In fact, according to recent CDC data (Jones, Compton, and Mustaquim 2020), “Among adults reporting past-year methamphetamine use, an estimated 27.3% reported using on at least 200 days of the year,” more often than every other day on average. Over 22% reported injecting. Raul told me that, in his case, his meth use did progress in this direction, and somewhat rapidly at that. His intermittent smoking evolved into regular, several-time-a-day injecting—“slamming.” When we met, he had just celebrated one year of sobriety, capping off an eleven-year period of sustained, active use.

For Raul, smoking and slamming crystal went hand-in-hand with having sex, eventually becoming deeply intertwined on psychic and material levels. He talked to me about the way his crystal use conditioned many aspects of his sex life—how and where he sought partners, who those individuals and groups were, and what they did together—and also about how those sexual experiences looped back into shaping his crystal use. The phenomenon of sexualized meth use among MSM has been widely documented and explored across a range of genres including documentary film (Crawford 2019; Ahlberg 2006), memoir (Moore 2017), (auto)fiction (Dustan 2021), and even on the pages of mainstream media publications (Mangia 2020). Although diverse in style and approach, such accounts produced by, about, and/or for MSM who use crystal methamphetamine cohere around the interrelation between substance use and sexual practice.

The public health and medical literatures, often oriented towards devising and implementing therapeutic substance use disorder treatment interventions, tend to rehearse the narrative that homophobia (sometimes called “minority stress”) experienced by MSM (as people

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participants, hopping from sex party to sex party on what could turn into a several days long, meth-fueled peregrination.

who are “SGD, sexually and gender diverse”) stigmatizes their sexual desires (Giorgetti et al. 2017; Cimino 2005). In this context, crystal meth enables MSM to overcome self-esteem damaging shame that once constrained their sexual practice and to connect more viscerally to long- and effortfully-suppressed sexual desires and forms of erotic expression. The shadow-side, however, is that these desires and their realization may chafe against or outright violate the dictates of safer sex. Thus, while research along these lines may function in part to destigmatize crystal meth use among MSM by positioning MSM who use meth as victims of structural oppression, it likewise proceeds through categorizing crystal meth users as a “risk group” for HIV acquisition and reiterating that crystal meth use promotes “risky sexual behaviors” like using drugs and having condomless sex with multiple, concurrent semi/anonymous partners. Such portrayals reify top-down, hegemonic notions of risk produced and governed through biomedicine and public health, wherein sexualized crystal meth use is inextricably tethered to the likelihood of HIV acquisition. When aimed at effecting individual behavior change, such approaches may preemptively foreclose space for a more fine-grained analysis of how risk is experienced and understood by members of the risk group and participants in the risk practices in question.

Reproducing the arc of Raul’s engagement with crystal meth and PrEP here, I deliberately take an alternative tack. Seeking to foreground an “emic perspective on how risk experience and rationality is socially situated,” I highlight how Raul lived with, made sense of, and managed risk—through his own words and from his own perspective—rather than assent to an *a priori* framing of the sexual and drug use practices in which he participated as inherently pathogenic or pathological (Rhodes 2009, 198). Attunement to the rhythms, rationales, and ramifications of Raul’s engagement with drugs—both crystal meth *and* PrEP—sensitizes analysis “to the protective agency of individuals, the contexts in which embodied practice is worked out, and the concerns and systems of value that mediate practice” from particular social positions (Race 2003, 370). Proceeding along these lines helps to show how PrEP can open space for a productive rethinking of historically-sedimented understandings of what constitutes “good” sexual subjectivity and how it ought to be and actually is lived out in the quotidian, intimate practices of MSM. Raul’s experience demonstrates how MSM constructed as “high risk,” “bad” sexual subjects can be not merely “good,” but model, PrEP patients. To make that suggestion is to invite public health and medicine to reevaluate their approach to and understanding of risk in order to best promote and support the health of MSM in the adolescent era of chemoprophylaxis.

In Raul’s retelling, crystal meth use led to his enmeshment in what he described as “the whole barebacking scene.” Raul’s understanding of bareback sex, and my analysis of that construct in this chapter, draw on the definition proposed by Junge (2002): condomless anal sex that is willfully intended, whether practiced despite its attendant risks or due to their eroticization (Berg 2009). Used in this way, bareback sex is meaningfully distinct from other forms of condomless sex between and among men.

As an object of analysis, barebacking has accrued multiple, overlapping, and sometimes divergent associations as a contested term with shifting valences and evolving resonances. Anthropological, sociological, and philosophical analyses of barebacking tend towards historicizing, contextualizing, and validating the will to condomless sex or, in the formulation of one of barebacking’s better-known scholars, Tim Dean (2009), the desire for unmediated and therefore unlimited intimacy. Drawing on qualitative interviews and analyses of Black gay men’s profiles on gay sex websites, Marlon Bailey (2016) foregrounds the significance of pleasure in animating the desire for what he terms raw sex. Such scholarship, undertaken from a queer theoretical standpoint, works against the hegemonic framing within which condomless sex is always already pathologized and through which racialized sexual subjectivity is readily produced as requiring surveillance, governance, and regulatory normalization.

Analyses in public health and medicine, including some qualitative social science work conducted from these disciplinary standpoints, tend rather towards an interpretation of willfully intended condomless sex as risky and dangerous behavior that ought to be intervened upon and changed, for example through grant-funded, motivational-interviewing based, condom promotion programs. Responses like these are undergirded by explanations devised through such research for why MSM engage in sex without condoms, expertly summarized by Brisson (2019, 348): "...poor self-esteem (Adam 2005); because they were abused during childhood (Perry N Halkitis et al. 2008); because they are sexually compulsive (Dodge et al. 2008); because they are lonely, angry or suffer from depression (Houston et al. 2012); because they experience internalized homophobia (Thomas et al. 2014); because they have substance abuse problems (Rosario, Schrimshaw, and Hunter 2006); because they need to prove their masculinity (Holmes et al. 2008) or because they are young (Mustanski et al. 2011), irrational (Suarez and Miller 2001), etc." While these may in part describe factors underlying the incitement to raw sex for some MSM, it is not a stretch to see how their mobilization within preventive and biomedical discourses might be perceived as stigmatizing.[5] Although certain strands of public health and medical research and practice have become more implicitly and explicitly sex-positive in their

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[5] The provenance of such an approach towards condomless sex is not only or necessarily external to the sexual culture of MSM. For instance, Michael Shernoff (2005), a gay social worker renowned for his pathbreaking incorporation of AIDS into psychotherapeutic practice, authored a guide for health care clinicians and mental health professionals focused on condom use behavior change.

orientation, the installation of safer sex as the guiding principle of HIV prevention has very clearly entrenched condoms as normative and the prospect of sex without them a deviancy underwritten by trauma and experiences of discrimination. The normative status of condoms in the eyes of public health and medicine, however, did not translate into their presence in the lives of many MSM with whom I spoke in the course of my research, including Raul.

As crystal meth insinuated itself into Raul's sexual repertoire, condoms rather rapidly receded from them. "I can count on maybe two hands the amount of guys I met in the last eleven years who I've used condoms with. So, for the majority, for all of my twenties, it was infused in my brain that sex is, you know, we don't use condoms." It is telling that Raul would choose to describe his pattern of leaving condoms out of sex as encoded into his brain, in that this indexes a cognitive-behavioral approach to both sexual decision-making and addiction common in the discourse of health behavior research. Echoing how addiction is commonly portrayed as a chronic, relapsing brain disease etiologically undergirded by substance-induced derangements in neural pathways (Leshner 1997; Heilig et al. 2021), Raul describes his attitude towards condoms as an orientation that became deeply, neurologically embedded across eleven years of crystal use. Negotiations over condoms were exceedingly rare in Raul's experience, because the vast majority of his prospective sexual partners also sought primarily, if not exclusively, condomless encounters.

Raul knew this to be the case because he very often met them while cruising for sex on a website called barebackrealtime.com, which, distinct from other online venues Raul mentioned utilizing like Grindr and Adam4Adam, is a social networking site where people meet to connect, specifically, for sex without condoms. "I got 90% of my hookups on that website. The name itself says what the guys are there to do. Bareback, realtime, dot com! I mean, hello, it's in the damn website!" For Raul, a typical weekend involved meth-enhanced condomless sex lasting hours at a time with on average five or six different partners, mainly recruited from that website. Sometimes those encounters were one-on-one, other times they involved groups, and still others meandered over the course of a day or two, starting with one or two partners and folding more in over time.

Knowing that condoms were almost never a part of sex in Raul's experience, I asked him how often, if at all, HIV status was something that came up with the people he fucked. He said HIV was very rarely, if ever, mentioned. "HIV was not really discussed. You know, 'Hi, ok so you're gonna come over, you're gonna be here in two hours, right? What's your HIV status?' No. That rarely if ever happened. To be honest with you, the combination of desire for sex—and I'm probably already high when I'm looking for this guy, I'm already on one—and the anticipation of getting more drugs and having sex with somebody who of course based on pictures I'm sexually interested in is so overwhelming that the idea of asking what your HIV status is… That's something that's not at the forefront of my brain. That's just the way it is," he said matter-of-factly. "I mean, 'Hey, you got a big dick and you're a bottom?' I mean, 'Hey, come on, let's do that.'" If someone asked Raul his status explicitly, he would disclose. But he was rarely asked. To Raul, HIV status was far from the most significant question he had about his potential bareback sex partners. "The bigger question was how much crystal meth do you have, do we have enough to last the night, do we need to buy more?"

The risk of HIV was neither irrelevant nor inconsequential to Raul; but at the same time, his will for pleasure and connection in the form of horny, high, and hot sex is what determined his sexual practice, not the dictates of public health prudence. The purpose of that sex was not, as biomedicine might like it to be, to reduce the risk of HIV acquisition. The purpose of that sex was to fuck a lot of big dick bottoms raw. Raul was not lacking in information about the risks of HIV acquisition and how they might be mitigated through condom use. Through his participation as a teen in a gay and bisexual men's youth group organized by a local advocacy group serving the Latinx population, he had learned about HIV/AIDS from health educators and, over time, through the personal experiences of a few of his friends from that group who ended up testing positive. Although his knowledge of HIV, including the epidemiology of the epidemic in LA and specifically the disproportionate burden of HIV borne by Latinx MSM, did not compel him to use condoms, it did cause him to interpret himself, through a biomedical frame, as being multiply configured as "at risk" for HIV. Ultimately, this led him to seek access to PrEP as an alternative way to protect himself from it.

Raul's trajectory with PrEP

"I heard about PrEP in late 2013 as it was coming down the wire. The LA LGBT Center," which is a major hub of sexual health care for queer people in Los Angeles, "actually was offering a study for young gay men who were high risk," he said. "And that was me. At the time, I was homeless, I'm an active drug addict, and I'm not having protected sex, and I'm also a Hispanic male. So, I'm a very high risk factor," Raul explains, revealing how he had internalized the epidemiologically-defined risk discourses that developed through the history and practice of HIV prevention. Within these discourses, risk is stratified in relation to specific demographic "risk groups"—for example, young, low-income MSM of color—and bodily practices—for example, using drugs, especially injection drugs, and not using condoms during sex. By these measures, we can understand why Raul considered himself "high risk" for HIV seroconversion.

The slippage here in Raul's self-identification as a "risk factor" points to the way that discourses of risk are taken up and reworked on the ground. Without placing undue emphasis on what might be explained otherwise as a vernacular variance, it is nonetheless worthwhile to consider what it might mean for a “risky sexual subject” like Raul to describe themselves as a “high risk factor,” rather than “at high risk.” Throughout the history of the HIV epidemic, MSM have been constructed as a risk group of paramount importance; in the process, the line between being “at risk” and “risky” (i.e., posing risk) has been distorted. Discursively, this slippage stigmatizes MSM, leading to the notion that MSM are both “intrinsically risky,” and furthermore that they are “dangerous and to be avoided” (Junge 2002, 196). Raul’s self-identification as a “high risk factor” suggests how his self-understanding is shadowed by these governing dynamics, which locate risk and threat, along with blame and responsibility, within the bodies and practices of individuals, rather than apprehending risk and threat as qualities suffusing and characterizing the structural conditions within which sexual practice is expressed. While the deployment of “at risk” can still have stigmatizing consequences, for example when being “at risk” is perceived as a static state and the preventative agency of individuals to mitigate risk is undermined, it at least offers an opportunity to shift the locus of HIV risk away from stigmatized subjects and onto the forces that produce stigma and harm.

“I went to the Center and signed up on the day I was sober,” Raul told me. “I honestly believe it was that trial that saved my life.” Then he went on to explain why he felt that way.

“It was about three weeks or a month after I started taking Truvada and I was at the Flex Spa.” Flex Spa is a gay bathhouse in the East Hollywood neighborhood of LA, coincidentally walking distance from my former apartment of five years.[6] Bathhouses claim a controversial history in the U.S. As historian Alan Bérubé (2003) writes, at the turn of the twentieth century,

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[6] I was first made aware of my proximity to Flex when I started getting messages on location-based gay dating apps from guys who were hanging out there asking me what room I was in, if I wanted to have sex, and oftentimes if I wanted to do drugs, too.

certain bathhouses in urban centers came to notoriety as venues were same-sex sexual relations were not discouraged, leading down the line to the establishment and popularization of bathhouses catered to MSM. In addition to supplying an environment where men could pursue sex with other men relatively insulated from the threat of state violence, the baths also furnished space for non-sexual interactions, including performances, movie nights, benefits for political organizations, and later, onsite testing for HIV. These "complicated, dynamic spaces" are described by some observers as being, historically at least, "very much a part of a vibrant, safe, and prideful gay male sexual culture," contributing "to the development of emotional empowerment" and functioning as a "site of community-building" (Engel and Lyle 2018, 963–64). While state harassment under the auspices of public morals regulation always haunted such establishments, scrutiny on the baths reached a fever pitch in the early days of the AIDS crisis. Woods and Binson (2003) point out that the self-same public officials underfunding the HIV education, prevention, and care efforts rushed to shut down gay baths—and the "unsafe" sex happening there—for the (ostensibly obvious) good of public health and the national social body. Gay baths continue to operate across the country and around the world, but at least in Los Angeles, they number far fewer now than in the past and occupy a more marginal place in the sexual cultures of MSM.

In response to the regulatory incursions of state power made manifest through public health policy and practice, these venues may portray themselves as intolerant of condomless sex and drug use. Flex Spa's "FLEX HOUSE RULES," for instance, printed on a card available at the door and strategically plastered on the walls throughout, stipulates "WE ARE A SAFER SEX CLUB! ABSOULTELY NO DRUGS OR ALCOHOL!!! Violators will not be allowed back in the club. NO BAREBACKING!!!" My research participants who visited and frequented Flex, however, painted a very different picture—they described drugs, including tina, being bought, sold, and used in the rented rooms and cabins, and copious condomless sex. Online reviews of Flex Spa provide further evidence to this point. I once read an exchange between Yelp users, one of whom had written a screed decrying the rampant use of drugs at Flex; in response, another user shared an aphorism he said he learned from the bar business: "If there aren't lines on the inside, there won't be lines on the outside!" Clearly, despite the objections of some, others like Raul patronized Flex precisely in the effort to engage in chemically enhanced sex.

On the day Raul described at Flex, a few weeks after starting PrEP, he had connected with a sexy guy who wanted to shoot some meth and get fucked by Raul raw. "I had one prepared syringe full of crystal meth melted and ready to go, right? There was only one needle, but there was two of us that wanted to get high. The other guy was HIV positive, and he told me so: 'I'm HIV positive.' I said, 'Well, I'm negative.' And the guy said, 'Oh, well, I can't do myself,'" meaning he wasn't able to administer the injection of crystal meth without assistance. Raul and other crystal meth using MSM I spoke to in the course of my research raised a distinction in technical fluency between smokers and injectors, which became a boundary that those who smoke crystal meth may attempt not to cross by deliberately avoiding learning how to inject. Certainly, it could be so that the other person in Raul's story had never injected before, but it is also possible and was the case for other participants in my study that they would only use intravenously when someone else could inject them. In other words, refusing to develop the knowhow to inject themselves was an intentional stop-gap measure put in place to prevent them from developing a regular injection practice.

"So, I said, 'Well then let me do you first and then I can do me, not thinking of course... So, I went right into his vein, administered half of the shot, and went right into my vein and administered the rest of the shot. Direct blood-to-blood contact exposure of HIV. I *should* have seroconverted that day."

Bracketing analysis around the modal verb "should" here for a moment, CDC educational materials, drawing on a systematic review conducted by Patel et al. (2014), indicate that for every 10,000 exposures, the risk of acquiring HIV from a non-virally suppressed individual through needle sharing is 63. This value is over six times higher than insertive anal intercourse (topping) and surpassed only by the risk of receptive anal intercourse (bottoming), which is by the numerical estimates about twice as risky. Regardless, needle-sharing during injection drug use is popularly understood as a "high risk" practice with regard to HIV acquisition, likely due to aggressive public health efforts targeting injection drug users and the separate but related history of and hysteria surrounding HIV transmission through blood transfusion (CDC 1982). As anthropologist Mary Douglas (1966) famously observed, blood is among bodily fluids that have, cross-culturally, accrued significant symbolic importance. Having "traversed the boundary of the body," blood viscerally represents vulnerability, both of the individual and of the structure of ideas in which they are suspended (122). Scholars of race (Hickman 1997; Smith 2002; Coleman 2013) have likewise explored the symbolic importance of blood, demonstrating how fears about mixing blood are undergirded by discourses of blood purity and racial hygiene that animate eugenic projects, authorize racial violence, and prop up racist structures like anti-miscegenation laws and right of blood citizenship schemes. This context helps set the stage for why the mixing of blood through sharing injection equipment animates a generalized anxiety out of proportion to the statistical likelihood that doing so lead to HIV acquisition. "I honestly thought, if this medication doesn't work, then I'm *fucked*. I'm positive. That's it."

Raul went back to the Center a month later for his next bloodwork appointment. He told the staff there about his exposure at Flex and informed them that he was nearly sure his test would come back positive. Expressions of certitude regarding the inevitability of a positive test result are not an uncommon refrain among men who engage in chemsex. Some in my sample, for instance, described this as a deterrent from testing. Confidence that the test would confirm the presence of HIV antibodies, the logic goes, prevented some of these men from testing in the past; they felt HIV to be an inevitable consequence, to varying degrees one that was "earned" or "deserved," of the way they conducted their sex lives, and shied away from testing to avoid confronting a positive status and having to grapple with what that might mean for them moving forward. Others, feeling certain of their eventual HIV acquisition, maintained a regular HIV testing practice, and in fact described the desire for the test to come back positive sooner rather than later, in that it would alleviate the stress of anticipating what was felt to be inevitable. Raul fell somewhere in the middle: he tested regularly for HIV and understood himself to be "high risk," but nonetheless feared how his life might change for the worse given a diagnosis—"I'm fucked," and "that's it."

The phlebotomist at the LGBT Center drew Raul's blood for the rapid test. His nurse reentered the exam room, in Raul's words, "looking so shocked." She said, "Raul, you're negative," and followed that quickly with, "Can we test you again?" Modern HIV tests, even of the rapid variety, are distinguished by their high sensitivity (Tan et al. 2016), meaning that the likelihood of a false negative (the test indicating the absence of HIV when, in fact, it is present) is quite low. The clinical team's decision to retest nonetheless indicates, then, a high index of suspicion and pre-test probability given Raul's sexual history and their perception of his risk of HIV acquisition. Just as the first, however, the second test also came back negative.

Managing HIV acquisition risk in a game of 'what ifs'

After Raul's powerful, personal, embodied experience with PrEP's efficacy in preventing a positive HIV test, PrEP swiftly became a bedrock of Raul's efforts to remain healthy, well, and HIV free. From that point forward, he was scrupulously adherent to PrEP. He remained on PrEP through periods of sobriety and through relapses, when single and when coupled in a monogamous relationship with a serodifferent partner. "In 2015, I had an HIV-positive boyfriend, and then I was especially med compliant with the Truvada, even though he was bottoming, and I was topping; it was just a precaution for me to take the medication."

His partner had been on treatment for years when they first got together, so as it turns out, Raul was, unbeknownst to him at the time, already at significantly diminished risk of HIV acquisition in this relationship. In 2014, the PARTNER 1 study (Rodger et al. 2016) reported no HIV transmission after serodifferent couples had sex without condoms more than 44,000 times, so long as the partner living with HIV had an undetectable viral load achieved through combination antiretroviral therapy. In 2016, final results were published showing zero linked, meaning connected to the virally suppressed partner, HIV transmissions in this cohort following over 58,000 total sexual acts. That same year, HPTN-052 (Cohen et al. 2016) published research confirming that no participants with an undetectable viral load transmitted HIV to their partner in the course of that study. These data, joining earlier dispatches suggesting a similar principle, including most notably the "Swiss Statement" (Pearshouse 2008), led HIV advocates including those living with HIV to launch U=U, undetectable = untransmittable. This global advocacy campaign works to build consensus around and promote the scientifically validated evidence that people living with HIV who are undetectable have zero chance of passing HIV to their sexual partners. Raul learned about the U=U principle following the dissolution of his serodifferent relationship but expressed that he found the protection from PrEP during that time to be a meaningful way for him to achieve additional security and safety in his sex life. After he and his then-boyfriend broke up, Raul relapsed on crystal. He continued, however, taking his PrEP with the same regularity.

"Here's the thing, I wouldn't take my mental health medication, but I would take the Truvada. I think a big part of it was that the meth was my bipolar medication, so I was using the meth to self-medicate, and I was taking the Truvada as I normally would to help keep me HIV negative." Raul's experience provides one example of how individuals engage pharmaceutical and non-pharmaceutical drugs to achieve stability and continuity in their lives, regardless of the degree to which their use patterns mirror, or conversely are in tension with, biomedical models of health. Although the clinician managing Raul's psychotropic medications for treatment of bipolar disorder would almost certainly view meth as an inappropriate substitute for the SSRI, antipsychotic, or anticonvulsant agents typically prescribed, the fact remained that in this vulnerable period, "meth *was* [his] bipolar medication." Meth relieved Raul's depressive episodes, if potentially over correcting them into some form of sustained mania. Even though meth disorganized aspects of his life, using crystal did not prevent Raul from persisting on PrEP. Throughout his sustained involvement in chemsex, Raul also continued prioritizing HIV prevention through chemoprophylaxis.

A few years down the line, Raul took his most serious swing at sobriety to that point and ended up entering another relationship. He stopped taking PrEP after he and his partner both tested negative several weeks into monogamy. By waiting to test, Raul and his partner allowed time for the window period to elapse, meaning that any potential exposure before they became monogamous would be covered by the assay. He and his boyfriend then stopped using condoms.

Raul also stopped taking PrEP, but he kept his leftover bottles stashed in the medicine cabinet. The extra pills came in handy when Raul intermittently relapsed and, at first unbeknownst to his boyfriend at the time, started having sex with other men who also used drugs. Here, Raul took advantage of PrEP's proven efficacy in a 2-1-1 dosing scheme. Alternately referred to as "intermittent," "event-driven," or "off-label" PrEP use, and demonstrated to reduce HIV acquisition risk by 97% in the IPERGAY trial (Molina et al. 2015), this dosing schedule allows non-daily users of PrEP to nonetheless achieve high levels of protection from HIV by taking two pills 2-24 hours prior to sex, one pill 24 hours after the first dose, and another 24 hours after that.

As of 2019, the San Francisco, New York state, and California Departments of Health formally endorsed the 2-1-1 dosing strategy as an alternative to daily PrEP, although my research indicates that many clinicians are either unaware of or uncomfortable with recommending it. In fact, Raul had learned about it from a friend not from his doctor. With PrEP back in his system, even though he was once again engaged in the sort of sexualized drug use known to increase the likelihood he may be exposed to HIV, his status never changed. His relationship, however, did not survive. This plunged Raul back into a very active stretch of chemsex, concluding with his most recent, and also most successful, experience with sobriety beginning in March 2020.

This time around, recognizing the imbrication of his crystal use and sexual patterns, and the way that dynamic jeopardized his past relationships and overall wellbeing, Raul elected to make not having sex an integral component of his recovery. When we spoke, he had counted more than a year of abstinence from both crystal and sex. Interestingly, however, he had stayed on PrEP that entire time.

"Actually, I'm looking at the bottle right now. It's on my desk, and I take it every night before I go to bed. I have not had sex in over a year, which is fascinating to me, because I was a *beast* when I was younger." Raul told me he's now ready to reintroduce sex into his sober life in an intentional way, as soon as he meets a partner with whom he could see himself pursuing a long-term relationship. "When I meet *him*, then I'll have sex. But now, as horny as I am, I'm not in the mood… I'm not willing to risk relapse and being vulnerable to relapse, because I'm way too far. I'm almost at 14 months clean." Raul's desire for sex has not diminished; what has changed, however, is his own understanding of what he might "risk" by going through with it. Having worked so hard and with so much intention to achieve and maintain sobriety, the possibility that fulfilling his sexual desires might jeopardize his hard-won gains is simply not worth the cost.

Reflecting Raul's trajectory with PrEP back to him, I summarized: "You've had a long history with PrEP. You've been on PrEP when you're using and at time when you haven't; you've been on PrEP when you've been in a relationship and when you've been single. Now you're in a period in which you're not having sex, but you're still taking PrEP." Given this history, I wanted to know: "What does taking PrEP mean to you right now? Why do you stay on it even though you're not having sex or using drugs?"

"To answer that question," he told me, "I gotta think about my favorite game that I like to play with myself, which is called: what if? What if I meet him at the store today? What if I see him on the Gold Line? What if? What if? What if? What if? We've all played that game at some point. That's the main reason why I'm taking PrEP, because just in case I meet him and he comes over to, I'm doing quotes here, 'Watch *Rupaul's Drag Race*,' and we're cuddling in the bed and one thing leads to another and we end up having sex… I'd rather be protected in case that happens. I don't know what's gonna happen."

Raul’s apprehension of his future’s uncertainty and the fragility of his sobriety is conditioned by his non-linear path through crystal meth addiction and recovery. Over the years, he has experienced relapse, seemingly unpredictably and despite his best intentions, like many other former crystal users. In fact, Brecht and Herbeck (2014) demonstrate a 61% meth relapse rate within one year after discharge from a large county substance use disorder treatment system. In light of the ever-present threat of relapse, PrEP confers Raul a meaningful sense of control in the face of un/predictability. While Raul admits he cannot predict where and when he may be lured back into sex and how that could present a challenge in his recovery, the risks he faces are eminently foreseeable and familiar to him. PrEP helps Raul manage those risks, giving him peace of mind that regardless of where his path might lead, a positive HIV test need not be part of his journey. “There’s this guy in North Hollywood I met in my addiction, and we’re both clean now, but he wants to have sex again. It’s like, I want to see him as only a friend. But honestly, I want to be with him, too. I can tell, in case I get weak and say, ‘Hey Roberto, I’m gonna come over,’ I’d rather be protected than not.” While he understands sex as potentially threatening to his sobriety, he likewise finds solace in knowing, through daily PrEP, the danger of HIV is off the table as a concern.

Raul’s relationship to chemoprophylaxis contributes a novel, non-traditional perspective on what Grant and Koester (2016) have dubbed the collateral benefits of PrEP: the social and psychological advantages users experience beyond biological protection from HIV. Research into these benefits has pointed out the diminished anxiety PrEP users experience when engaging in anal sex, whether a condom is involved or not. Raul’s story is unique, in that the primary collateral benefit he describes experiencing is not about lowered anxiety surrounding the sex in which he participates; rather, it is about his sense of self-efficacy and commitment to demonstrating continued protective agency during an extended period of abstinence. Having PrEP on board does not fundamentally alter Raul’s attitude regarding the kinds of sex he’s willing to have or its frequency. What PrEP does do, however, is to offer Raul a firm toehold on the stability of his health and wellbeing in a, by his account, chaotic crystal use trajectory that has, in the past, made Raul feel vulnerable. Regular PrEP use is part of Raul’s pact with himself, a daily demonstration of his commitment to prioritizing his health. He knows he cannot control the future, but one major ‘what if?’ he can remove from his favorite game is the question: “What if I test positive for HIV?”

It has been well-established, and is commonly repeated, that monumental advances in HIV treatment, beginning with the introduction of highly active antiretroviral therapy in 1995, effectively transformed HIV from a death sentence into a chronic manageable condition. But it is likewise worth noting that in retelling his harrowing Flex Spa experience, Raul described a potential HIV diagnosis as a matter of life and death. Is it possible that were Raul to have tested positive, he would have initiated HIV treatment, remained in care, and achieved viral suppression with little to no adverse effect on his overall health and life trajectory? Certainly, and many people do. The support of the LA LGBT Center in linking people who test positive to care, including same day starts of combination antiretroviral therapy and case management services, would substantially increase the likelihood of that outcome.

But in Raul’s retelling, he narrates his experience with PrEP thusly: “I honestly believe it saved my life.” His continued adherence to PrEP, as a symbol of his efforts to protect his health and sustain his life, draws out several significant benefits to chemoprophylactic treatment as a form of care for vulnerable individuals. Whether or not PrEP did in fact prevent Raul from acquiring HIV at Flex Spa when he shared his rig, it has very likely helped him maintain his status in the subsequent years where his drug use and sexual practice patterns persisted largely unchanged. What is certain is that PrEP became an integral part of Raul's efforts to manage the risks that he experienced and continues to grapple with—of HIV, but also significantly of relapse and a spiral back into active use—and stay alive and well.

Raul's PrEP advocacy

The downstream effects of Raul's protection from HIV accrued not only to his individual health, but also benefited others in his social and sexual network. Raul explained to me how he advocated for sex partners in the bareback and chemsex scenes to consider adopting PrEP too. "I started telling people to keep an eye out, especially the younger bottoms I would hook up with, for this medication called PrEP or Truvada, and then of course I would share my story. Because when I was getting high, there would be a moment where I would, there would be like a lull in the sex and, from what I've been told by my partners, I'm actually a really cool guy to hang out with even when I'm high. I do get paranoid, but I'm not like manic level of paranoia, I'm just a little more alert, so people are very comfortable with me already sober and when we were high, they were comfortable with me as well. We'd get to talking after round one or whatever and that's when I would share the information I learned. And over the years I would do that as I got clean and relapsed, got clean and relapsed, and all that."

While chemsex encounters are most commonly framed as interactions suffused with all sorts of risks, Raul's description shows how they can likewise facilitate interactions that promote individual and community-level efforts at risk mitigation, helping to achieve harm reduction in vulnerable populations. Research on community health workers (Scott et al. 2018) has made the benefit of incorporating credible messengers in health-related work abundantly clear. Peer navigation, an extension of the concept of patient navigation—"the direct assistance provided to help low-income, vulnerable patients find their way through complex health care systems and obtain timely diagnosis and treatment"—has been demonstrated to reduce barriers in health promotion efforts across a range of applications, for example in HIV treatment interventions to sustain viral suppression among MSM and transgender women leaving jail in LA (Cunningham et al. 2018, 543). While patient navigation often incorporates public health and social work professionals in a case management capacity, peer navigation utilizes lay staff members to foster trust and improve engagement with health systems among racialized and stigmatized populations who may also harbor medical mistrust that poses a barrier to health care access. Peer navigation extends support beyond the clinical, biomedical realm and more deeply into the lifeworld of patients, thereby enabling the promotion of various forms of harm reduction.

The MEPS Study, in which Raul was a participant and through which I connected with him, employs three peer mentors, individuals with lived experience similar to that of the study population, as a critical part of its HIV prevention intervention. Throughout my involvement in the project, I witnessed time and time again how well the peer navigators were able to connect to and support their participants, who clearly responded positively to the peers' paths in navigating recovery and rebuilding their lives in the wake of experiences like addiction and incarceration. I also noticed how the participants engaged messages, especially about the benefits of promoting healthier sexual practice, more readily when they were coming from individuals who had encountered similar circumstances and/or shared similar identities. I saw how the peers tapped their wisdom and lived experience in offering non-judgmental support to their participants as they worked to lead healthier, more stable lives and remain HIV negative. Through Raul's active participation in chemsex, I would argue that he became a similar sort of credible messenger in his own right by sharing knowledge of and encouragement to start PrEP with his sex partners, albeit outside the auspices of an official intervention and absent formal training.

“One of my regular fuck buddies in Alhambra, I used the bathroom, I was looking for hair gel, because I was getting ready to leave, and I saw a Truvada bottle in his cabinet. I had been trying to get him on PrEP since 2015, and this was in 2016. I remember being so proud. I almost cried. Because he is a *proud* slut. He’s the kind of guy that gets around a lot, and that’s just him! I gave him a big hug and said at least you’re protecting your health in this way, and it was this really great moment for me.”

The sexual networks of MSM are most commonly configured in biomedical and public health practice vis-à-vis contact tracing, which constructs sexual relationships as vectors for pathogen transmission. The “test, track, and trace” strategy, made eminently more recognizable in the context of COVID-19, emerged as a measure to control outbreaks of diseases like smallpox, diphtheria, and measles in “the late 19th century, when bacteriology was a new science” (Mooney 2020, 1806-7). When it comes to sexual health in particular, the principle of contact tracing is rooted in the attempt to identify sexual networks of STI transmission by encouraging individuals who are diagnosed with STIs to either provide contact information for their partners or reach out to them directly and suggest they seek STI testing and, pending a positive test result, treatment. Contact tracing is known to provide a vital opportunity to help draw MSM with asymptomatic and/or undiagnosed STIs into care, which not only improves individual health outcomes for those tested and treated, but also contributes to decreasing the overall burden of STIs by disrupting chains of potential future transmission events. Samarasekara et al. (2021), for example, demonstrate through a cross-sectional analysis involving a cohort of over 6000 MSM in the U.K. who had been diagnosed with HIV, syphilis, or gonorrhea, that contract tracing contributed significantly to overall STI diagnoses. Their finding that MSM attending clinic as notified sexual contacts of patients with HIV, syphilis, and gonorrhea made up 20% of all diagnoses of these STIs in their clinic-based population underwrites the conclusion that efforts to increase the yield from contact tracing are critical to reducing the burden of STIs within sexual networks of MSM.

Undoubtedly, contact tracing measures, sometimes relabeled partner notification services, are fruitful and necessary avenues of research and practice in public health efforts to stem the tide of STI transmission. What Raul's experience points to, however, is a potential alternative, under analyzed valence of partner notification, which likewise functions to reduce HIV incidence among "high risk" sexual subjects, yet that can be initiated not with a positive test result, but rather a negative one. Raul's negative HIV tests since starting PrEP inspired him to reach out to his sexual partners and encourage them to access harm reducing medical care, not in the form of treatment for HIV and other STIs, but in the form of PrEP. This further turn of Raul's story encourages us to depathologize the social and sexual networks of MSM, by interpreting them not primarily as routes of viral contagion, but rather as conduits for mutuality, care, and the dissemination of health promoting information. To be clear, this is not to position contract tracing as an always already stigmatizing project that ought to be abandoned; partner notification is a time-tested, epidemiologically validated strategy to improve individual and community-level health in a population with a disproportionately high level of circulating STIs. Rather, this is an attempt to rethink the premises of sexual network analysis in public health practice and research aimed at improving the health and wellbeing of MSM, including those who use drugs or participate in other practices labelled "high risk."

Raul was motivated to share his knowledge about and experience on PrEP with the bottoms he used drugs with and fucked, because he felt PrEP had a substantial, positive influence on his life. He was well-positioned to share information about PrEP with people biomedicine sees as “high risk” and sometimes also “hard to reach” because he was in touch with, literally and figuratively, individuals and communities vulnerable to HIV acquisition. While previous research emphasizes a role for peer navigation support in promoting PrEP in populations of MSM and transgender women through the provision of social support and role modeling (Salabarría-Peña et al. 2022; Reback et al. 2019; Pagkas-Bather et al. 2020), these approaches most commonly center on clinical spaces. Outreach may often spill onto the streets, but how often does it find its way into the sheets? Raul’s success in helping other MSM engaged in chemsex take steps towards accessing PrEP highlights this potentially fruitful, albeit unorthodox, line of inquiry. What would it look like if MSM engaged in chemsex, like Raul, were understood by biomedicine as potential advocates for PrEP and HIV risk mitigation, rather than primarily as targets of behavior change interventions designed to modify their sexualized drug use patterns? Mobilizing PrEP interventions in this direction entails adopting a harm reduction approach, one capable of recognizing and supporting the protective agency of those who are otherwise sometimes seen as exhibiting poor judgment, making unhealthy choices, and overall participating in bad behaviors. Such individuals can be exceedingly capable of and willing to promote HIV prevention, when given an opportunity to do so.

Raul’s dedication to sharing his story for the benefit of others was made abundantly clear, in that he understood his participation in my research as, in part, a further platform for his own PrEP advocacy: “If you’re listening to or reading this and you’re questioning whether or not PrEP works, just know that from someone who has been on PrEP pretty religiously for almost seven years that it works. It's definitely something that can protect your health, and if you're open to it, please look at getting on PrEP. It's something that's saved my life multiple times over, and I encourage all my brothers and sisters to get on PrEP if they can."

Conclusion: Remodeling risk

The advent of PrEP—a biopharmaceutical, chemoprophylactic technology that functionally eliminates the possibility of HIV acquisition in one daily pill—presents an opportunity to radically revise the way risk is experienced by MSM who are able to access and use it. Theorizing PrEP's potential, then, requires challenging and redefining what it means to occupy "good" sexual subjectivity and achieve "good" sexual health. Foregrounding narratives such as Raul's not only helps demonstrate that PrEP can be highly effective in preventing HIV acquisition among "high risk" individuals, but also points to how established understandings of risk in the HIV epidemic, if they remain static, may continue to stigmatize and imperil *real* sexual subjects—who cannot, will not, or do not use condoms—for failing to conform to the traditional, conservative profile of the *good* sexual subject.

As Rangel and Adam (2014), Thomann (2018), and others have pointed out, in the biomedical and public health discourses, "good" sexual subjectivity is achieved by MSM who identify the risk of acquiring HIV and respond in specific, sanctioned ways. Always wearing a condom, never having sex outside of a monogamous relationship, abstaining from drug use, especially injection drug use, eschewing group sex, and never patronizing public sex establishments like bathhouses or seeking out sex on barebacking websites—appropriate recognition of being "at risk" is thought to entail scrupulous performance of these dictates. Pressure to adhere to such practices has organized what it means to be "at risk" for HIV since even before HIV was identified as the etiological agent underlying AIDS in 1984. This history produced rippling implications not only for the way that sexual health care is conceptualized and delivered, but also for the way that sex, sexuality, risk, and health are understood, experienced, and lived out by MSM.

Even though Raul continued to participate in barebacking and sexualized crystal meth use after getting on PrEP, his adherence to PrEP took the risk of HIV acquisition off the table, which is a significant "good" he recognized and valued. Raul saw himself as "a high risk factor," and he approached a potential HIV diagnosis as a matter of life and death. But during his addiction, he did not prioritize incorporating condoms into sex. Importantly, this in no way meant he was unwilling or unable to prioritize HIV prevention. In fact, he saw great value in PrEP, and credited it for saving his life. Before PrEP, Raul understood himself as a high-risk sexual subject. He knew that rates of HIV incidence are most troublingly high among young MSM of color. He knew that participating in the barebacking scene and engaging in frequent chemsex—combining crystal methamphetamine and condomless anal sex with multiple, concurrent partners of unconfirmed HIV status—would increase his susceptibility to acquiring HIV. In fact, in his own words, he told me that he *should* have. But again, he did not. Neither in that moment at Flex Spa, nor to this day. With PrEP on board, Raul's HIV risk essentially evaporated, even though nothing else about his demographic characteristics altered—age, race, gender, sexuality—and well before his sexual and drug using practices—barebacking and chemsex—changed.

What did, evidently, change over time was Raul's orientation towards the unpredictable future he faced. The tone of finality with which Raul described the prospect of HIV acquisition while active in his addiction indicates that PrEP, and the protection from HIV it provided, offered Raul a new lease on life. PrEP's value to Raul was tethered to, but extended well beyond, its efficacy in preventing him from acquiring HIV. PrEP provided Raul an overall sense of stability in an otherwise tumultuous life: a side effect or “collateral benefit” that was so meaningful that it inspired him to prioritize remaining consistent on PrEP both while active in his addiction, including during times when he was unhoused, and even throughout a year of sobriety and abstinence.

Taking all this into account positions PrEP as a true technology of risk mitigation, one that people vulnerable to HIV can incorporate into their lives to significantly reduce harm without requiring they alter their practices in ways they might not be willing to or capable of, whatever the reason. This framework does not imply a lack of value in HIV prevention programming focused on promoting progressive changes in sexual and drug use practices but is instead an attempt to position PrEP as an adjuvant and non-inferior component of that work.

While fundamentally changing the course of the epidemic will require addressing the structural forces that produce vulnerability to HIV for racialized MSM, distributing PrEP among people most at risk for HIV acquisition can be advanced displacing condom use promotion as the be-all and end-all of efforts to enhance sexual health. To the extent that condoms remain the only option perceived viable, it is at the expense of individuals like Raul and the communities to which they belong that are disproportionately exposed to HIV risk to start. The goal of reducing the burden of HIV in these sexual networks is best achieved when delinked from the pre-requisite to adopt condoms and, for example, abandon drugs. How might the landscape of PrEP access look different if MSM engaged in what are considered to be some of the “riskiest” practices—sexualized drug use, patronizing bathhouses, seeking out bareback sex online—were understood by biomedicine as both ideal PrEP patients *and* advocates? How might prevention paradigms be refined by appreciating the value and utility of PrEP use even during periods of abstinence?

Homing in on Raul’s trajectory demonstrates the potential for PrEP to radically remodel the way stigmatized, racialized sexual subjects experience risk in the context of the contemporary HIV epidemic, characterized as it is by gross and widening inequities in harm. The potential of PrEP to mitigate those harms, however, is directly contingent on access. Being that PrEP is an FDA-regulated pharmaceutical intervention to prevent HIV, intended to be delivered in the primary care setting, the question of access necessarily implicates clinicians and the health systems in which they operate. This chapter laid the groundwork to describe a possible evolution in understandings of risk brought about by PrEP; the following chapter explores the degree to which clinicians, as gatekeepers of access to PrEP, have and have not updated their understandings of sexual health, and questions what the implications are in terms of triaging access away from those who may stand to benefit from it most.

Chapter 3

Practices of Risk Compensation: PrEP, Risk, and Racialization

Introduction: Clinical constructions and lived realities of risky sexual subjectivity

In February 2019, I sat in on a research talk about PrEP hosted by UCLA's Department of General Internal Medicine. The speaker, a professor of public health with decades of research experience in HIV prevention science, presented quantitative data from an epidemiological study on PrEP access and adherence in Los Angeles. About ten minutes into her presentation, midway through the data, a senior physician in attendance interrupted to share his concern about PrEP-seeking patients abandoning condoms. Inhabiting the guise of a hypothetical PrEP patient, he laid out what he imagined a typical PrEP clinical encounter might look like:

"I go to my doctor, and I say, 'I'm a weird person and I have bad sexual behaviors.' And the doctor says, 'You should become a better citizen.' And I say, 'I have no *desire* to be a better citizen, I just want to get to treated for STDs. I heard you can give me short course antibiotics.'" A brief silence ensued. "I've talked to people in Palm Springs[1] about this."

Why was this physician inspired to interject that comment into the discussion about PrEP and what does it reveal about how risky sexual subjectivity is constructed and governed in the era of biomedical HIV prevention? To explore these questions, this chapter incorporates ethnographic data from research—with past, present, and prospective PrEP patients along with clinicians who prescribe PrEP—to provide an experience-near analysis of what has been termed "risk compensation." In the context of PrEP use and sexual routes of HIV transmission, risk compensation refers to the notion that those who believe themselves to be at diminished risk of

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[1] Nearly half of permanent residents in Palm Springs, a desert city in Southern California only a couple of hours away from Los Angeles, identify under LGBTQ. In November 2017, Palm Springs made history for electing the nation's first all-LGBTQ city council. That council was also all white, despite the fact that 25% of the city's population is Latinx. Referencing Palm Springs here can be interpreted then as an appeal to credibility within a homonormative framework racialized as white (Ferguson 2018; Duggan 2003).

HIV acquisition may, in turn, adopt riskier sexual practices. The logic of risk compensation holds that the advent of PrEP may lead users to engage in more frequent condomless sex with a greater number of partners, which could theoretically increase the likelihood that they might acquire and pass along more sexually transmitted infections (STIs) including, potentially, tenofovir-resistant strains of HIV. Were this to happen, these harms would be thought to eclipse PrEP's intended benefit.

The relationship between increased STI incidence and PrEP implementation remains a controversial topic of debate in public health, clinical medicine, and the public forum more generally. The conflicting positions that various stakeholders—researchers, policy makers, clinicians, patients, and those who are constructed as "at risk" for HIV but not using PrEP—take in this debate signal contestations over what risk means and how it should be managed, which often index implicitly held moral values regarding responsibility and sexual normativity. When these various players speak and act, they are talking about and working on the relationship between biomedicine and sexuality, to both discursive and material effect.

The physician in the above vignette, for example, interrupts the PrEP presentation to express his disapproval of and frustration with individuals who, in his eyes, fail to understand and respond to biomedically constructed risk appropriately. He imagines that patients are motivated to seek PrEP because they have given up on, or never cared in the first place about, doing the "right" or "good" thing when it comes to managing the risk that they might acquire HIV through sex. In fact, he stigmatizes them as "weird" people exhibiting "bad behavior," implying that they are dangers to themselves, to moral standards governing normative sexuality, and to the public more generally, vis-a-vis their poor citizenship. He frames the idea of patients on PrEP seeking care in the form of STI treatment as worrisome of evidence of biomedicine's failed governance of sexuality. One implied way to allay such a concern might then be withholding PrEP from patients who cannot, will not, or do not use condoms with perfect consistency.

To what extent does this reasoning shape engagement with PrEP for clinicians and patients, and how is it experienced, lived out, and contested by individuals and communities constructed as “high risk” for HIV acquisition? How do clinicians propagate or challenge these logics in the way they do and do not incorporate PrEP into their practice? From the other side of the swab, what do the voices and perspectives of PrEP patients show about how PrEP use affects sexual practices, encounters with risk, relationships to biomedicine, and life trajectories more broadly? Through ethnographic interviewing, participant observation, and discourse analysis, this chapter asks: How do encounters with and perceptions of risk shape access and adherence to PrEP? Reciprocally, how do encounters with and perceptions of PrEP shape experiences of risk?

The qualitative data to follow illustrate how clinicians’ notions of risk are brought to bear on patients’ lived experiences, but equally reveal a complex world outside the clinical encounter where risk is constructed, navigated, and negotiated. Research with clinicians and (potential) PrEP patients taps into both paradigms of risk and explores the power dynamics underlying their relationship to argue that misalignments between biomedical constructions and patient experiences of risk function to undermine the success of PrEP as a harm reduction intervention.

Fleshing out how the risk compensation debate is put into practice opens a more nuanced exploration of its ramifications: not only on the distribution of PrEP, but also on the distribution of risk, pleasure, and what participants in my research referred to in terms of “freedom” and “liberation.” Within the context of an HIV epidemic marked by widening disparities between MSM of color and white MSM in both HIV incidence (Dodge et al. 2019; Hess et al. 2017) and

PrEP use (Huang et al. 2018), to what extent does racism contour who can experience "liberation" via PrEP and how?

Answering that question entails engaging how the AIDS crisis has intensified stigmatization of MSM through homophobic, racialized tropes of degeneracy. While biomedicine has historically pathologized same-sex sexuality (Spurlin 2019), MSM of color, and Black MSM in particular, face further pathologization through racist stereotypes of promiscuity, which have led them to be blamed for disparities in HIV incidence (McCune 2014). Data show no statistically significant difference in sexual "risk behavior" across race/ethnicity (Goodreau et al. 2017; Oster et al. 2011; Millett et al. 2012; Harawa et al. 2004; Bingham et al. 2003), yet these pernicious associations suffuse the risk compensation debate, shaping racialized inequities in PrEP access and influencing the way that Black MSM who do take PrEP experience it. Ethnographic data, following Brisson's (2019) example, demonstrate how PrEP invokes both: i) the discourse and practice of HIV prevention within which certain assimilable gay men have successfully conformed to the ideal of the risk-averse, autonomous moral individual, and ii) the specter of condomless anal sex, which has been weaponized to impugn gay men participating in it as "reckless, dangerous, and uncivilized" degenerates "in need of social ridicule and management (Bailey 2016, 224). Following critical race scholarship in the field of public health (Gravlee 2009; Ford and Airhihenbuwa 2010), this analysis approaches race as a relation of domination that mediates which bodies are deemed risky, diseased, and pathological (Anderson 2006) and provides evidence to show how, in the case of PrEP, racialized, "risky" individuals may be less likely to receive care.

What is the risk compensation debate?

The theory of risk compensation harkens back to a predecessor principle referred to as risk "homeostasis." Introduced by Wilde in *Target Risk: Dealing with Danger of Death, Disease and Damage in Everyday Decisions* (1994), risk homeostasis describes a system wherein individuals accept a certain level of perceived risk to health in exchange for benefits they expect to receive from a particular activity. The output of this system is thought to be an approximate risk set point around which quotidian decision making is organized and against which it is evaluated. When an intervention is introduced that diminishes the perceived risk of a specific activity, pressure is put on the system, disrupting homeostasis. In response, those who adopt the intervention may adjust their practices in the direction of greater risk, which is thought to result in an increased discrepancy between an individual's perceived risk and the "actual" or "objective" attendant risks to their health. This process of risk set point readjustment is called risk compensation.

The classic example used to explain the concept of risk compensation comes from the realm of automotive safety research. An influential instrumented-vehicle study (Janssen 1994) compared people who wore seatbelts habitually while operating a car to those who did not and found that drivers drove faster and less carefully while belted. The results were explained in terms of risk compensation. Perceiving themselves to be insulated from the worst harms of a potential accident by virtue of wearing a seatbelt, drivers were inclined to drive less defensively: at an increased speed and with a propensity for closer following distances. The protective technology of the seatbelt, proven to decrease accident-related injury and death, was suggested to alter the way individuals perceived the risks associated with driving, which manifested, in the study, in riskier road practices.

Since gaining purchase as a principle of health research on what is often termed "risk behavior," risk compensation has been retrospectively and prospectively applied to the ongoing and multifaceted debates regarding "risky sexual behavior." For example, the availability of oral contraceptive pills was historically criticized for encouraging promiscuity and therefore promoting sexual risk taking (Garris, Steckler, and McIntire 1976). The logic behind this critique holds that a person with a uterus, previously potentially constrained in their sexual practices due to concern over the risk of unplanned pregnancy, may theoretically engage in sex, including condomless sex, with more partners and less trepidation, given the efficacy of a technology designed to substantially decrease the risk of fertilization. Shades of this thought process in action can be traced in contemporary arguments that vaccination against the human papilloma virus (HPV) may lead to earlier sexual debut and a higher number of sexual partners. While epidemiological research studies have supplied ample counterevidence to refute both of these claims (Secura et al. 2014; Kasting et al. 2016), the application of risk compensation as an interpretive framework vis-a-vis sexual risk decision making has nonetheless oriented inquiry into, evaluation of, and policy recommendations regarding technological advances in the arena of sexual health.

Taken together, these two examples show how risk compensation thinking tends to crop up when medical technologies—like oral contraceptive pills and the HPV vaccine—*threaten*, in one perspective, to enable their users to have sex with meaningfully less fear of a certain consequence: in this case, pregnancy or cervical/anal/oral cancer. Debates about sexual risk compensation, then, index biopolitical anxieties about the governance of bodies and the regulatory normalization of populations. Following Foucault (1990, 2008), biopolitics connotes "all the specific strategies and contestations over problematizations of collective human vitality, morbidity and mortality; over the forms of knowledge, regimes of authority and practices of intervention that are desirable, legitimate, and efficacious" (Rabinow and Rose 2006, 197). Sexuality represents a "biopolitical space par excellence," in that it operates as a hinge connecting the anatamo-politics of the human body with a population-focused biopolitics (ibid., 208). Within this framework, debates about sexual risk compensation can be understood as eminently biopolitical—they are contestations over "governance of bodies in the name of health" and "management of life chances, that is, manipulating who will be protected from and exposed to risk" (Atuk 2020, 2). In the cases of oral contraceptive pills and to some degree the HPV vaccine, risk compensation concerns emerged from a fundamentally sex-negative premise: that more sex (or earlier sex) is unhealthy, risky, and dangerous. The putatively proper role of biomedicine and public health, in this formulation, would be to minimize and discourage it.

Regarding HIV/AIDS, anxiety over PrEP-related risk compensation traces antecedents to concerns expressed about the potential consequences to sexual practice following the introduction of nonoccupational postexposure prophylaxis (nPEP) and the widespread dissemination of antiretroviral therapy. So called "post-risk" protection from nPEP, for instance, was anticipated by some to promote riskier sexual practices, although cohort studies found scant evidence to support that claim (Donnell et al. 2010; Martin et al. 2004). The introduction of combination therapy in the mid-1990s has also been argued to underlie increased sexual risk taking and the phenomenon of "relapse" (Hart and Boulton 1992) from safer sex practices including condom use. While HIV rates have trended downwards, thanks in part to the efficacy of ART and ongoing political mobilizations to expand access, bacterial STI rates in the U.S. have, in fact, risen in recent years. The STI National Strategic Plan for the United States (2020) published by the Department of Health and Human Services indicates that the rates of reported cases of primary and secondary syphilis, gonorrhea, and chlamydia all increased significantly between 2014 and 2018. MSM are disproportionately impacted by these STIs. For instance, while gonorrhea incidence increased 63% overall in that period, the rate increase among MSM was 137%. These data are sometimes interpreted as proof positive of sexual risk compensation among individuals at disproportionate risk of HIV acquisition.

Within this context, the rollout of PrEP has, somewhat unsurprisingly, raised hackles because PrEP is a risk mitigation tool promising HIV prevention without condoms and offering no protection against other STIs. Questions about how protection from HIV interacts with attitudes towards and practices related to condom use—in essence, risk compensation—have therefore shaped the discussion about PrEP implementation among policymakers, health care professionals, advocates, and individuals constructed as high risk for HIV acquisition who do and do not use PrEP. This ongoing conversation and the differing positionalities and perspectives of those who participate in or whose lives are implicated by it reflect broader contestations over how and by whom sexual risk should be defined and managed.

These contestations were underway early. Uncertainty about the consequences of PrEP on the sexual practices of individuals prescribed it, and specifically the concern that PrEP users may engage in risk compensation undermining PrEP's potential benefits, structured scientific investigations into PrEP years before it received FDA approval in 2012. For example, a key modeling study published in the medical journal *AIDS* by Desai et al. (2008) proposed that PrEP could be a cost-effective way to significantly reduce new HIV incidence among MSM in the U.S. but tempered this conclusion with the suggestion that "under our base-case assumptions, only a 4.1% increase in sexual partners … was sufficient to fully offset the number of infections prevented" (1835). The authors operationalize this claim to propose that ongoing risk reduction counseling and monitoring of patients taking PrEP are necessary components of ensuring that PrEP use decreases rather than increases sexual risk. The inclusion of this caveat, however, shows risk compensation to be a critical concern that has contoured PrEP implementation efforts dating back to at least the time that HIV chemoprophylaxis was in beginning clinical trial stages.

Anxiety about risk compensation has never been wholly circumscribed within public health and clinical scientific discourses and is likewise found in public circulation. A widely read blog entry, first published in *HuffPost*, coined the term “Truvada whores” to derisively label PrEP users as promiscuous and to position PrEP use as an incitement to unsafe behavior (Duran 2012). While the author concedes that PrEP “potentially works for committed couples, sex workers, or drug addicts who remember to take the pill daily,” he denigrates PrEP as “an excuse” for “gay men who just like bareback sex” to “do what they want to do” by “having unprotected sex and willingly taking that risk,” which he calls “just plain stupid.” This negative sentiment towards PrEP, although first issued in a brief online post, did not languish in obscurity; in fact, it found expression through the voices of figures who are considered to be major players in the national conversation on HIV and sexual health.

Larry Kramer, the firebrand author and founder of ACT UP with a storied history of HIV/AIDS activism, initially suggested in an interview with the New York Times that PrEP users must have “rocks in their heads” for embracing PrEP in lieu of condoms. “There’s something cowardly about taking Truvada instead of using a condom,” he argued. “You’re taking a drug that is poison to you, and it has lessened your energy to fight, to get involved, to do anything.” Kramer saw the putative promise of PrEP as an HIV prevention intervention instead as a pacifying innovation, a pharmaceutical advance that threatened to depoliticize its users and jeopardize the hard-won gains made in the long-running fight for health justice. A year later, Kramer revised his stance by joining an open letter to Truvada's manufacturer calling PrEP an "essential public health tool" and suggesting "any individual who thinks they are at risk of getting HIV should have easy access to it, without judgment."[2] Kramer's initial skepticism, however, demonstrates how risk compensation concerns were voiced not only by researchers, but also by community advocates and institution leaders.

Perhaps most famously, Michael Weinstein—who rose to prominence as an HIV/AIDS activist in the 1980s and later became president of AIDS Healthcare Foundation (AHF), now the largest HIV/AIDS advocacy organization globally—was very public at the dawn of PrEP propagating this view. "If something comes along that's better than condoms, I'm all for it, but Truvada is not that. Let's be honest: It's a party drug" (*Wehoville* 2014). To Weinstein, PrEP threatened a "public health disaster in the making," in that he suspected that "the use of PrEP … carries significant risk that the people who take it haphazardly will mistakenly believe that they are completely protected from HIV and other STDs. These individuals will engage in unprotected sex, which will ultimately lead to an increase in HIV and other infections" (AIDS Healthcare Foundation 2012). Beyond merely propagating skepticism about PrEP, AHF, under Weinstein's leadership, launched a sustained campaign against widespread PrEP implementation as a public health intervention. In 2016, AHF filed an FDA complaint against Gilead Sciences alleging the pharmaceutical company had conspired to promote PrEP for situational, off-label use based on a PrEP ad called "I Like to Party" released by Public Health Solutions. That same year, AHF also opposed Assembly Bill 2640, which was nonetheless approved by the California state legislature, requiring that every Californian who receives a negative HIV test result be

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[2] The letter was drafted by activist James Krellenstein, who would go on to co-found and direct the advocacy organization PrEP4All in March 2018. Kramer agreed to sign onto the letter after a meeting at Krellenstein's apartment in New York City.

educated about PrEP. Premised in large part on risk compensation concerns, AHF’s organizational influence and massive budget, over $1 billion, have been used to create obstacles to widespread PrEP uptake.

The voices of PrEP skeptics and detractors in the conversation on risk compensation, however, have been parried by equally vociferous PrEP proponents. Dr. Demetre Daskalakis, former Deputy Commissioner in the New York City Department of Health and Mental Hygiene in the Division of Disease Control and, since 2020, CDC Director of the Division of HIV/AIDS Prevention (DHAP), tweeted on June 29, 2022: “To be clear, HIV-PrEP does not facilitate behaviors that increase risk of HIV or other STI exposure. HIV-PrEP is INDICATED for people who are placed at risk for HIV because of their circumstance. Smokers have lighters in their pockets. The lighter does not make them smoke.” Dr. Daskalakis has also gone on record saying, “Research regarding PrEP’s association with risk compensation and STI rates may not be productive.” Instead, he suggests resources “be focused on establishing strong PrEP services that address issues of sexual health rather than trying to demonstrate risk compensation.” Daskalakis joins a slew of other experts suggesting STIs should not be used as an excuse to deny PrEP access or to be reluctant about PrEP implementation. Golub (2018), for instance, has argued that the “almost obsessive focus on risk compensation … has been so extensive that some authors have referred to concerns about it as a type of ‘moral panic’ both among providers and within the gay community” (192-193). She suggests that the debate about risk compensation is not “a genuine public health issue,” in that “negative judgments about these behaviors in the context of PrEP stem from negative attitudes about promiscuity or condomless sex *in and of themselves*, rather than resulting from their potential to increase HIV transmission risk” (193).

Such counter claims, that risk compensation concerns are misguided and problematic, are well supported by modeling projections and epidemiological studies demonstrating a clear association between PrEP uptake and significant reduction in HIV incidence (Smith et al. 2020). Furthermore, studies undertaken to evaluate risk compensation have painted an inconclusive picture of whether it occurs, and if so, what the consequences are to individual and public health. While some demonstration projects evidence risk compensation among PrEP users when compared to non-users or to themselves prior to initiating PrEP (Carlo Hojilla et al. 2016; Koester et al. 2017), meta-analyses of nearly 20 PrEP trials uncovered no significant evidence of risk compensation (Fonner et al. 2016; Koechlin et al. 2017). Regardless, there is good reason to believe that concerns about risk compensation persist and continue to fuel stigma and bias constraining PrEP access, particularly for patients of color.

Calabrese et al. (2014) published an experimental study evaluating medical students' likeliness to prescribe PrEP, finding that soon-to-be clinicians were less inclined to prescribe PrEP to patients they suspected would engage in risk compensation. The effect was amplified for Black patients, specifically. The students rated Black patients more likely to engage in risk compensation and also indicated they would be least likely to provide these patients PrEP. According to public health data, the association between risk compensation and race the students subscribed to has no scientific basis. A recently published study in *AIDS Care*, examining risk compensation in PrEP adherence among Black MSM in the HPTN 073 study, for example, found no evidence of risk compensation among Black MSM using PrEP (Whitfield et al. 2021).

Underlying the findings from Calabrese's student survey study, then, are erroneous, racist stereotypes associating men of color and specifically Black MSM with higher risk sexual practices (Malebranche et al. 2004; Valentine 2008). Scholars link these stereotypes to the legacy of racialized science, wherein "the sexuality of Black people is pathologized and that of people of European descent is normalized, and these assumptions affirm the social hierarchy in which people of European descent have been dominant" (McGruder 2009, 102). The projection of promiscuity and risk onto Black sexual subjectivity is seen to date back to colonial encounters. It has been argued that the "limited apparel worn by most Africans was interpreted by Europeans as a sign of lasciviousness or lack of modesty," rather than a response to the climate, and that this impression fueled the racist perception that "the sex drives of Africans were uncontrollable." Perceptions of Black sexual subjectivity are not unidimensional and have shifted over time, but the notion that Black MSM are promiscuous or risky is a specter with deep historical roots that haunts the risk compensation debate.

Despite a growing wealth of evidence to refute risk compensation and position concerns about it as "conscious or unconscious discomfort with the idea of sexual expression unfettered by the threat of HIV," the circulation of stigmatizing beliefs about PrEP certainly "impedes PrEP acceptability, uptake, adherence, and persistence, by creating barriers to acceptance at the patient, provider, and community levels" (Golub 2018, 194). The remainder of this chapter explores how risk compensation is interpreted and lived out on the ground in order to evaluate, empirically, this process at play.

How do clinicians interpret and work with risk in PrEP prescribing?

The clinicians I interviewed employed a range of methods when determining the appropriateness of PrEP as an HIV prevention intervention and deciding which people and what practices to interpret as "high risk" in terms HIV acquisition. Their strategies variously invoked, extended beyond, and, in some cases, critiqued traditional constructions of "risk groups" and "risk factors" for HIV. Their discrepancies notwithstanding, these approaches coalesce around the emphasis on taking a thorough patient history covering partnering, condom use, and substance use practices in evaluating risk and assessing patients for PrEP.

Dr. Alston, an adolescent medicine physician in Los Angeles, trained as an internist during the early years of the HIV epidemic and has since become a leader in HIV prevention and treatment work, especially involving youth. In addition to his research and advocacy, Dr. Alston sees patients at a hospital-based clinic, a job core, and a youth shelter. He described being most likely to raise the topic of PrEP with people who fit into a few specific categories. "Generally, men who have sex with men, trans women who have sex with men, and trans men who have sex with men are probably the primaries. If they have a sexually transmitted infection or they have multiple partners, those are also indications. For cisgender women, they have to be very risky sexually, say sex work or multiple sexual partners or partners with heavy drug use. It would be different if I were in a different part of the country. If I were in the South or maybe the East where cisgender women are at more HIV risk, I would probably be altering my recommendations. But in Los Angeles, fortunately, the risk is pretty low, so I tend not to offer it very often unless there are specific risk factors. But, you know, anytime I see a male having sex with men or a transgender individual having sex with men, I assess them for their condom use and partners and then tell them about PrEP and let them decide whether they feel like PrEP is something they want to do. Obviously, if somebody with multiple partners is coming in with gonorrhea, chlamydia, and/or syphilis, I'd be pushing it much harder because they're at much higher risk, but again, I give them information so that they can choose."

To determine which patients with whom to bring up PrEP, Dr. Alston draws on his interpretation of the epidemiological data about HIV incidence in Los Angeles and works with a "risk group" framework. He sees MSM and transgender people who have sex with men as clear candidates for PrEP, in light of well-described disparities in HIV incidence experienced in these demographics. Cisgender women, however, become candidates for his PrEP “offer” only in the presence of additional “risk factors” that might amplify the chance of acquiring HIV—like participation in exchange sex, sex with a high number of partners, or proximity to “heavy” drug use. Dr. Alston’s comments show that in the process of determining who is “high risk” enough to warrant a conversation about PrEP, clinicians take into account a patient’s gender and sexuality, their reported sexual and drug use practices, and their STI lab test results.

Dr. Garg, an Infectious Diseases physician with experience leading an HIV primary care clinic within the Los Angeles County hospital system, expanded on Dr. Alston’s comment by foregrounding substance use as both a risk factor for HIV and indication for a PrEP discussion. “Generally, I mean, definitely if you’re an injection drug user or high-risk drug user—so, methamphetamine, whether you’re injecting it or not—I’ll definitely bring it up.” In his county position, Dr. Garg worked with many patients over the years who acquired HIV through, or in relationship to, substance use. So, in addition to describing MSM and transgender people who have sex with men specifically as key risk groups to target in PrEP outreach, Dr. Garg highlighted injection drug users and methamphetamine users, regardless of their sexual practices and gender identity, as prime candidates for PrEP. “That’s something we’re trying to focus on more, because that’s probably a gap where we’re not getting people on PrEP.”

Research on PrEP implementation among people who inject drugs corroborates Dr. Garg’s point. Sherman et al. (2019) surveyed 265 HIV-negative individuals recruited through a syringe services program and found that only 25% of the sample had ever heard of PrEP. After learning about PrEP, 63% expressed interest in initiating it; only two of the 265 people surveyed, however, were currently using it. While Dr. Garg described his decision to recommend PrEP as one made on a “case-by-case basis,” pointing to the idea that PrEP is not for everyone, he also told me that he advises colleagues and trainees to “always keep it on your health care maintenance routine plan.” By framing PrEP as a component of routine health care maintenance, Dr. Garg makes an effort to normalize and destigmatize discussions of PrEP, even if they are inevitably motivated by clinical judgments concerning elevated risk of HIV acquisition.

Dr. Parker, an early-career primary care physician working in downtown Los Angeles and near Venice Beach, likewise endorsed discussing PrEP with his patients who fit into the risk groups Dr. Alston and Dr. Garg described. He also elaborated additional indications upon history taking that would encourage him to initiate a conversation about PrEP. “There are a few things that would cue me. If they have trouble telling me how many partners they’ve had recently, if they have to think about it, typically, that’s a cue. If their partners are active with other people that they don’t know, those are kind of the two main areas. In general, [the decision about whether to recommend PrEP] isn’t based on a certain number of partners. I think, initially, it was more about a specific number of partners. Maybe a few years ago it was more like, ‘If you’re at 10 partners a year, you should be on PrEP.’ Now, it’s more along the lines of, ‘If you have multiple partners and you don’t know what your partners are doing, or if you’re not sure how many partners you’ve had, that’s usually a sign of higher sexual activity risk.’” In Dr. Parker’s interpretation, when a patient has a difficult time responding to the question of how many sexual partners they’ve had in the recent past with a hard number, that leads him to believe the number is likely high, and the risk for HIV acquisition might be elevated. While he used to abide by numerical cutoffs, his thinking has evolved to hinge less on a patient’s specific number of partners and more on the situated, relational aspects of their sexual connections, especially the degree of insight they express into their partners’ sex lives.

Adopting this orientation has inspired his PrEP practice to extend beyond the traditional boundaries of risk groups as constructed in the U.S. HIV prevention context. "I had a heterosexual male who told me he had three female partners. I told him, 'Do you know if they're active with anyone else?' He couldn't answer, but he said he was using condoms. Then I asked further, as far as, 'Are you using them consistently?' And if you're not using them consistently, with three partners even, three partners who you don't know what their sexual activity is, you should be on PrEP. The people that PrEP was billed for initially has really expanded in my mind, in terms of if it seems like it's a potentially high enough risk situation [to justify PrEP use]. If he had told me that he wasn't using condoms consistently, I would tell him he should be on PrEP." Over time, Dr. Parker's understanding of for whom PrEP is warranted has expanded to encompass, for instance, a man who only has sex with women, but who does not regularly use condoms and is unaware of with whom his partners are also having sex. In gradually recalibrating the preconceived notions about HIV risk he brings into the clinical encounter, Dr. Parker has intentionally implemented sexual history taking methods designed to elicit information beyond what can be gleaned through the common, but outdated, question: are you sexually active with men, women, or both? [3]

Dr. Bernstein, a nationally renowned HIV specialist and researcher who practices in Los Angeles, offered perhaps the most expansive vision of PrEP candidacy, and in doing so,

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[3] This question has long formed the bedrock of mainstream approaches to clinical sexual history taking. Initially, it was celebrated as an advance on the basis that it was thought to provide patients an opportunity to endorse sexual non-normativity (e.g., by identifying themselves as MSM) rather than presuming their heteronormativity. In light of the recent push to recognize and validate the diversity of experiences and identities encompassed under an expanded view of gender and sexuality, queer and trans health advocates have pointed out its insufficiency as an analytical scheme for i) assuming "men" and "women" to be discrete, stable constructions that can be operationalized to describe all patients and ii) naturalizing heterosexuality, homosexuality, and bisexuality as the key organizing principles of sexual behavior.

explicitly challenged the common "risk group" framework. "The stock answer would be to try to talk to *everyone* about PrEP. What I like to say to trainees about that is, you know, people like to say maybe I'll talk to my gay men or my people who are engaging in sex work or someone who I know uses intravenous drugs, and that's it. My response to that is: 'What about your patients who have children?' And they say, 'Why would I do that?' And I say, 'Well if you have children, that means you had condomless sex, right?' And there's a beat there as people take that in and acknowledge there are multiple reasons, including procreation, that would warrant condomless sex. Depending on what the epidemiology of the individual is, there are some populations for whom condomless heterosexual intercourse *is* a very substantial risk factor for HIV transmission.[4] Unless that circuitry has been connected, I think a lot of people traditionally discount PrEP, because the patient's not from a traditional risk group. I try to move the conversation towards an acknowledgment that anyone who has condomless sex could be at risk for HIV transmission."

Through his teaching, Dr. Bernstein endeavors to provoke an appreciation for the reality that any condomless sex—regardless of who is having it, how they are having it, and why they are having it—is a potential route of transmission for HIV. In doing so, he encourages clinicians-in-training to understand condomless sex not necessarily as an inherently pathological practice associated with deviation from normative sexuality, but rather as a normal part of the overall sexual repertoire which can potentially introduce the possibility of HIV acquisition for anyone who participates in it. In accordance with Dr. Parker's analysis, then, Dr. Bernstein zeros in on condom use practice as a key determinant of HIV risk.

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[4] Although not the case in the US, from a global perspective, "heterosexual intercourse" is, in fact, the HIV transmission route leading to the majority of new HIV diagnoses.

As an expert in HIV prevention and treatment, Dr. Bernstein recognizes and acknowledges clear disparities in HIV incidence falling along specific lines—what he refers to as the “epidemiology of the individual.” At the same time, he endeavors to work against the presumption that PrEP is only for gay men, sex workers, and injection drug users. To determine who may benefit from PrEP, Dr. Bernstein adheres to a simple maxim. “Understanding somebody’s patterns of sexual activity is important. I think getting an understanding of who, how often, and in what context people’s sexual activity is happening is where you need to start before deciding whether or not to bring PrEP into the conversation.”

Dr. James, an Infectious Diseases physician and HIV prevention researcher working internationally in several South American countries and practicing at home in Los Angeles, described implementing a standardized patient interviewing format to achieve that. “I have a fairly structured assessment that I use. We talk about their three most recent sexual partners, what the characteristics of these partners are, and what their sexual practices with these partners are. This is to sort of get an assessment of their level of risk: both for them, and for me, to objectify things.” Here, Dr. James points to two separate but interrelated relationships with risk––his interpretation of a patient’s risk and the patient’s own analysis based on what they report—which are co-constructed in the clinical encounter and synthesized into what he thinks of as objective data. These data can be used, following Dr. Bernstein’s suggestion, to establish a more detailed picture of how sex fits into a patient’s life, in order to aid the clinician in deciding whether or not to bring PrEP into the conversation. Dr. James’ organized approach to sexual history taking is therefore designed to elicit information thought to be beneficial to both patient and clinician in evaluating and treating HIV risk.

He and many of the other clinicians I interviewed were explicit in naming that longitudinal patient relationships provide the most auspicious circumstances for navigating in-depth conversations about risk and sexual health. Nonetheless, the strategies laid out above offer examples of how PrEP evaluation can be achieved effectively in a one-off clinical encounter, given the clinician's willingness to ask specific, directed questions about sexual practices. In their emphasis on the importance of in-depth sexual history taking, the clinicians in my sample highlighted questions about condom use in particular as key determinants in evaluating which patients are thought to be at elevated risk of acquiring HIV and who would therefore likely benefit from PrEP.

Drs. Alston, Garg, Parker, Bernstein, and James interpret non-use of condoms as a risk factor for HIV acquisition and understand that as a reason to prescribe, or at least raise the possibility of prescribing, PrEP. They do not see non-use of condoms, whether predating or following a PrEP prescription, as a justification for avoiding a conversation about PrEP with patients, much less flat out withholding a prescription from them. They did, however, recognize risk compensation concerns, like those articulated by the clinician at the opening of this chapter, as a troubling reason why their colleagues might hesitate to engage with PrEP in their practice. The critiques they issue regarding risk compensation thinking among clinicians speak to their orientation towards and understanding of a clinician's proper function in mitigating a patient's HIV risk.

Dr. Parker explained, "I think the issue for some providers is potentially the concern that why would you subject someone to a daily medication that could have some side effects, when alternatively potentially the patient could also reduce their sexual risk. I'm sure there's some internal dialogue happening for providers, and I would anticipate among people that aren't as behind PrEP, this is probably at play. For me, while that would be true [that a patient could lower their sexual risk through changes in their sexual practice], it’s not really the role of the physician, when we have a tool like PrEP, to tell our patients to change their lifestyle. In general, I talk about sexual risk the way I talk about any other higher risk activity. I make sure I tell them when I meet with them that when I talk to you about these things, this is about trying to make sure that you stay healthy and remain able to do what you want to do long term. Sexual risk is one aspect of that. But so is your dietary choice and every other thing you do. I think putting PrEP in the context of a conversation that’s about reducing risk and thinking about the question of what you are actively doing day-to-day that is increasing your risk is useful. I think some people, as you talk about those sorts of things, they do, over time, try to mitigate their own risk. But in the meantime, it’s good to have a tool like PrEP to reduce their chances of HIV acquisition.”

Clinicians are trained to take into account the risks and benefits of all medical interventions they recommend, whether surgical, procedural, or pharmaceutical in nature. Especially for primary care doctors, who are accustomed to managing patients with chronic conditions for which multiple classes of drugs may be prescribed, the risks inherent in pharmaceutical treatment come to the forefront of clinical decision-making and medical practice. A sizable segment of the primary care clinician’s workday may be spent managing side-effects and medication interactions; in other words, managing the ramifications of treatment, rather than the manifestations of a pathophysiological process itself. From this perspective, Dr. Parker understands why clinicians would balk at the idea of advocating an additional medication, which could introduce additional health risks—whether in the form of side effects or of harms thought to be linked to risk compensation—when the requirement for that medication could potentially be eliminated were a patient to act to sufficiently reduce their sexual risk.

While Dr. Parker appreciates the logic at play, he articulates clearly that he does not believe it to be a clinician's role to "tell our patients to change their lifestyle" when an effective and safe pharmaceutical intervention like PrEP exists. Rather, he makes a concerted effort to work with his patients longitudinally to support them in adopting and maintaining what he thinks of as less risky sexual practices, which could include PrEP along with implementing regular testing, reducing their number of casual partners, and using condoms. Regardless of whether durable changes in sexual practice do come about, however, he advocates for PrEP and views it as a meaningful tool to reduce HIV acquisition risk in the meantime. He sees PrEP provision as just one possible dimension of fulfilling the physician's role in mitigating risk and reducing harm among his patients.

Instructing patients to reduce their personal sexual risk to eliminate the need for PrEP, in Dr. Parker's analysis, is "not really the role of the physician." In fact, practicing medicine in this way may work directly against the goals of mitigating risk and reducing the burden of disease. Nonetheless, clinicians in my research provide evidence for the claim that patients have been talked out of or turned down from PrEP by physicians who withhold it on the basis that the patient would not need it were they committed to managing their own sexual risk through safer sex, meaning condom use or even abstinence.

"I can't tell you how many patients I've seen from other providers where that provider's response to the patient requesting a conversation about PrEP ended with, 'I don't understand why you can't just zip it and keep it in your pants,'" Dr. Bernstein told me. "I don't find that a helpful conversation to have with patients, to try to invoke that argument. It's not a sex-positive approach. A harm-reduction approach is probably a more effective strategy because if you don't acknowledge their reality, you've ended the conversation."

The numerous patients Dr. Bernstein is referring to ended up coming to him, an Infectious Diseases specialist, to get started on PrEP, because their primary care clinician denied them a prescription, apparently on the basis that they should change their own sexual practices in the direction of abstinence to mitigate their risk: “just zip it and keep it in your pants.” The patient’s reality he advocates acknowledging is one in which sex, including sex without condoms, is and may continue to be part of a patient’s life, with or without the protection from HIV afforded by PrEP. Whereas a harm reduction approach would acknowledge this truth and seek to ameliorate the harms that can come along with condomless sex, by preventing HIV through use of PrEP for instance, the “keep it in your pants” reaction he critiques demands compliance with unrealistic expectations. When patients fail to live up to these expectations, they are abandoned from care and denied access to PrEP. Rather than mitigating risk, the clinicians who withhold PrEP produce risk for patients. Evidently, some patients clearly persisted in their efforts to access PrEP and eventually found their way to Dr. Bernstein, a provider willing to prescribe it. Nonetheless, attitudes and practices like these that make obtaining PrEP more difficult needlessly exposed the patients who did not to elevated HIV acquisition risk that, had they been prescribed it initially, could have been nearly eliminated with PrEP.

If the intention of withholding PrEP is ostensibly to promote safer sexual practices in the form of increased condom use, such strategies are also likely to work against their own intended outcomes because they elide patient perspectives on and experiences with condoms. “I think the reality of the following statement is something that is often lost on a lot of providers. You will be vanishingly, infrequently able to find someone who *loves* condom use. I don’t think I’ve *ever* heard anyone say, yes I love using a condom for sexual activity. And so PrEP is a perfect adjunct to the armamentarium of tools we have to keep people HIV uninfected if for whatever reason, and you don’t need to attach judgment to this, people *can’t, don’t, or won’t* use a condom. And there are myriad reasons for which someone in a given circumstance can’t, doesn’t, or won’t use a condom. This is perfect for those situations.”

From Dr. Bernstein’s perspective, clinicians need to get real by recognizing that condoms are, quite frankly, unpopular. Many patients may not be using them already; many more may prefer, with the added protection from HIV afforded by PrEP, to limit or forgo their use. For these reasons, exhorting patients to use condoms without acknowledging their limitations or showing understanding for why a patient may not use them is a strategy that is bound to fail. “The message that I try and give is not to throw away condoms, but you just have to be very clear on why you’re advocating for condom use. I find it challenging when providers argue that someone *should* be able to use a given strategy, like condoms. Because, you know, unless you’re walking in that person’s shoes, I don’t find that *should* helpful. The *should* is sort of tyrannical.” Instead of working within a model where clinicians issue directives about how patients ought to conduct themselves, Dr. Bernstein advocates a harm reduction approach recognizing that condomless sex has always happened and will continue to happen. Healthy sexual lives can and do involve condomless sex, and with the tool of PrEP, clinicians can support real patients, not just the ideal ones who always use condoms, in staying HIV-negative, even, or especially, in the setting of continued or planned condom non-use.

As Dr. Simons, a budding PrEP specialist who works primarily with youth in Los Angeles, explained, “There are some studies showing that people are using less condoms or having more STIs after starting PrEP. And it’s like, ok… that can happen. But is that any reason why we should say: ok, well, you can’t be on PrEP? That’s not really ethical! If you know your patient is not using condoms or going to use less condoms, would you *actually* say you can’t take

PrEP? Because then you’re basically saying, ‘So sorry, but now if you’re going to do that then you’re going to have to deal with the consequences of having HIV.’ It’s like you’re punishing your patients. That doesn’t make sense from a physician’s standpoint. People aren’t then thinking of PrEP as a risk reduction strategy, they’re thinking of it as increasing risk. But that’s not really true, that’s not what the goal of PrEP is. That’s where I think it comes from, from an ignorance standpoint. They think, if we’re doing PrEP, then we’re increasing STIs. But even so, we’re still decreasing HIV! Do you realize how huge that is? I think people are just putting the emphasis in the wrong place.”

Dr. Simons elaborates how the risk compensation debate hangs over efforts at PrEP scale up, pointing out how clinicians act as gatekeepers to PrEP with the power to distribute it away from patients perceived as sexually risky because they are interpreted as likely to engage in condomless sex. To Dr. Simons, restricting PrEP access on the basis of condom non-use and thereby exposing patients to the harms of potential HIV acquisition seems like a punishment, which goes against his fundamental understanding of the clinician’s role. He thinks PrEP should be understood as a risk reduction technology due to its superior efficacy against HIV acquisition and therefore critiques the risk compensation debate for constructing PrEP as a technology that increases risk. Dr. Simons blames this misunderstanding on ignorance of just how meaningful protection from HIV can be.

Taken as a whole, these data elaborate how clinical decision-making about PrEP is shaped by competing frameworks concerning the clinician’s role in promoting sexual health. Clinicians endorsing a harm reduction oriented, sex-positive approach understood PrEP as a valuable and effective tool to significantly reduce their patients’ risk of acquiring HIV. While they did not abandon condom promotion efforts, they recommended PrEP to their patients who “can’t, don’t, or won’t use condoms,” because they understood that taking the risk of HIV acquisition off the table via PrEP would have a meaningful, positive effect on their patients’ long-term health. These clinicians understood their role to start from a validation of their patients’ reality and involve working together to lower their patients’ risk through a combination of pharmaceutical technology—PrEP—and longitudinal counseling. Their goal in discussing PrEP is helping their patients remain HIV-negative, not, primarily, bringing about changes in their sexual practice.

Clinicians influenced by risk compensation thinking, on the other hand, interpret PrEP to be a technology that increases, rather than diminishes, risk. They may, therefore, respond to this perception of increased risk by restricting access to PrEP in an effort to govern their patients by commanding a narrow performance of risk reduction through condom use or even abstinence. These clinicians may thus act out a more disciplinary role, attempting to enforce regulatory normalization of their patient’s sexual practice by bringing it in line with accepted biomedical understandings of risk and definitions of what constitutes safer sex. The consequence for failing to comply with these hegemonic understandings and definitions may be punishment in the form of medical abandonment, leaving patients without a prescription for PrEP and vulnerable to unnecessary harms.

Dr. Simons described feeling “crushed” by the moral injury of witnessing this dynamic play out in his clinical experience. “I have an 18-year-old patient who just got diagnosed with HIV. When he was referred to me, looking back at his STI testing, it was like: gonorrhea, chlamydia, gonorrhea, gonorrhea. Why didn’t anyone talk to him about PrEP? There’s a huge missed opportunity there.” The cost of risk compensation thinking, specifically the way it contributes to triaging prevention resources away from patients who are perceived as sexually risky, is paid by patients whose seroconversion could have been averted through access to PrEP.

The data above explore how clinicians work with and on the notion of risk in the clinical encounter through their approaches to PrEP evaluation, counseling, and prescribing. While most clinicians in my sample expressly condemned risk compensation thinking for “missing the point” and even “punishing” patients instead of fulfilling their obligation as care providers, they also described risk compensation thinking inflecting clinical decision making about PrEP and therefore shaping the governance of risky sexual subjectivity. The section to follow turns to patient perspectives on and experiences with PrEP in the clinic to investigate the other side of negotiations regarding HIV risk and its management. How do (potential) PrEP patients understand and relate to the idea of identifying themselves or being identified as “high risk” for HIV acquisition? While clinicians propose non-judgmental sexual history taking with detailed questions regarding condom use as a mechanism for co-constructing an “objective” understanding of risk, how do patients experience these conversations in practice?

Reflections from the other side of the swab: Patient experiences of PrEP clinical visits

In addition to probes related to condom use frequency, questions about number of recent sexual partners were described by patients in my sample as both intrusive and, furthermore, irrelevant to the course of their treatment with PrEP. Julio, for instance, derisively referred to the portion of his PrEP appointments when he’s asked how many partners he’s had in the last 90 days as a “fuck count.” Another patient, Richard, bristling at his reminiscence on such data collection and inventory taking said, with a tone of clear frustration, “I don’t feel the need to have that conversation, no. What would be the point? Would the doctor do an extra liver test?

Would the doctor do an extra STI test? I mean, there's a finite number of STI tests they typically do. I'm here to test those. I'm here to make sure the drug is not destroying my insides. Let's focus on that. If I have one or a hundred partners, who cares? To me that shouldn't change anything about what I'm there for." Being asked, then, feels like an intrusion into intimate life without a clear indication of how the information gained will benefit the patient or shape their candidacy for PrEP. This ambiguity further instills the notion that, in seeking PrEP or attempting to renew a prescription for it, a patient's moral sexual citizenship is being put on trial. Engaging PrEP therefore entails assent to a regime of heightened surveillance, regulation, and control under the auspices of care.

Writer Marcos Santiago Gonzalez addresses this dynamic in *Blue Dream* (2017), an essay stemming from an autotethnographic reflection on his own PrEP encounters. In his piece, Gonzalez advances the argument that PrEP enables certain, structured relations of care for gay men of color at the expense of their management and being made into data. When accessing PrEP, Gonzalez "acquiesce[s]" to "answer a slew of questions about how I have sex," and he also submits to a series of examinations focused on what goes into and comes out of his body: "undergo an anal examination, piss out a urine sample, give a swabbing of the back of my throat, and have vials of blood drawn," all on "Doctor's orders." He counterposes the extraction of data from his body—his answers to the doctor's questions and the results from his STI screenings—with the affective experience of the encounter: "All of this is done with a soft smile and sympathetic voice. She is asking me my preferred position for having my rectum inspected with her gentle and affirming fingers. The sonic and visual and haptic markers make me believe my health matters. The softness of her method is comforting." This leads him to conclude "the doctor cares." But the care relation Gonzalez describes is deeply conflicted, because it is premised on "[a]n exchange: the body for the little blue pills," PrEP.

He submits to the probing—in the form of questions and otherwise—because he knows that if he does not, he will not receive his PrEP refill. "If the prescription runs out a few days before I return to the office, she will not refill it. She emphasizes on the phone, oh so sweetly, that I must come in if I want the little blue pills. This is her way of caring. This is the business she is in, the dispensation of care. The little blue pill is the agent by which her care is made possible, distributed, and legitimated. It is also how her care is made innocent; It is welcomed and asked for." Gonzalez understands his clinician as the gatekeeper of PrEP, the medication that will help him remain HIV negative. He also understands that his continued access to PrEP requires his continued submission to the biopolitical regime, in which his clinician is an agent, that intensifies the surveillance to which he is subjected. "The doctors will withhold from me that blue pill, which fights off what they have told me to fear, to demonize, to reject: seropositivity. They will make sure I return every two months for an examination, making my body and my queer brown life available for examining. They let me know I need them, and that they will care for me—or else." By framing the relation in this way, Gonzalez illustrates the extent to which PrEP care deepens and naturalizes the dependency of stigmatized and racialized sexual subjects on biomedicine. Biomedicine's governance of risky sexual subjectivity, therefore, becomes further internalized through PrEP.

"We feel we need management and give ourselves over to be managed. Management of our sexualities, appetites, and flesh is not for a second questioned because, for once, finally, thankfully, we feel we are being cared for. Prevention from the illness not-yet-here, though lurking in the foreseeable future, is the lure in which management is accepted, praised, and naturalized. They don’t let you forget: one pill, once a day, no exceptions.” *Blue Dream* highlights the extent to which a veneer of care can conceal racialized relations of domination. In Gonzalez’s eyes, PrEP care promotes the regulatory normalization of sexuality, promising a “future cleansed of its deviants, those deviants future, present, and past.” To secure his place in that future through PrEP, Gonzalez is compelled to submit to a clinical, sanitized narrative of sexuality, wherein “[t]he embodied knowledge that queers of color carry, dance, sing, and fuck with is funneled into a report, a statistic, a number. The intent: immediate intelligibility and serviceability regardless of what realities and imaginaries must be bulldozed over in the meantime.”

Based on my own experience (described further in the introduction), and that of Gonzalez and my interlocutors, the clinical encounter appears to be not always or necessarily an environment where complex, nuanced patient perspectives on risk, pleasure, and sexual health are prioritized, let alone given adequate attention or even basic recognition. Although they may be asked with ostensibly “good” intentions, questions about condom use and number of sexual partners may come across as judgmental and be seen as orthogonal to the desires that motivate patients to access and persist on PrEP in the first place. This assertion comports with Golub’s (2018) argument that “PrEP eligibility assessment is stigmatizing because it is designed to evaluate whether or not to label a patient as high risk. Complete control over the application of this label lies with the assessor (or assessment tool) rather than the patient’s own experience of themselves, their behavior, or the context within which they engage in sexual expression. As such, both the message of this type of PrEP risk assessment and the assessment experience itself can exacerbate and perpetuate PrEP stigma” (192). While clinical interactions may not often afford patients the opportunity to express their desires and motivations vis-a-vis PrEP, my ethnographic interviews with patients conducted outside the confines of the clinical environment were, in contrast, rich with such perspectives. Situating engagement with PrEP within biographical, sociocultural, and historical trajectories (Hughes et al. 2018) aids in fleshing out the truths that are elided, concealed, or strategically distorted in the clinical interaction about how patients understand and experience risk.

Encounters with PrEP and Experiences of Risk and Racialization among PrEP Non/Users

In the context of open-ended, ethnographic interviews, in contrast to the setting of the clinical encounter, PrEP users spoke extensively with me about why they use it, what it means to them, and how it has affected their sexual practices. In doing so, they described how taking PrEP influenced their understandings and experiences of risk, pleasure, and sexual health in the context of the HIV epidemic. Common among participants in my research were narratives describing longtime fears of acquiring HIV, from which PrEP provided "freedom." What this "freedom" meant—specifically, who could experience it and how—pointed to the way that access to "liberation" from stigma through PrEP is mediated by race, therefore drawing attention to the dynamics underlying PrEP non-use.

Zed

Zed, who is white, is an arts administrator turned life coach in his early 50s with a soft, melodious voice and contemplative disposition. He's been growing out his hair again recently, for the first time since he last wore it long three decades ago. Greying strands now frame his handsome face and vibrant yet gentle smile, which glows just as luminously as it did in the photos he showed from his 20s. Zed situates himself generationally as "Gen X on the Boomer cusp," a distinction he makes because, in his young adulthood and during the height of the early AIDS crisis, he established his life in New York City.

“I moved to New York in ’87,” he told me, “So, I was more informed about HIV than some of my peers at the same age who weren’t in a major metropolitan city at the same time. That’s important to note. I was literally at ground zero. My entire sexual career was all about safe sex.” Tracing Zed’s personal trajectory vis-a-vis the HIV epidemic offers a starting point for thinking longitudinally about the relationship of MSM, specifically gay men living in major cities, to safer sex messaging and practice as it evolved from the pre-treatment era to the early days of PrEP and up through the present moment.

Zed reflected on absorbing negative messaging about HIV and “homosexuality” from media coverage of the AIDS epidemic during the formative years of his youth. These stigmatizing portrayals inculcated, early on, fears that physical expressions of his budding same-sex sexuality were interpreted as deviant and may even be fatally dangerous. Through his first long-term sexual relationship with a lover who was in his 30s, however, he began to develop a more nuanced perspective on HIV risk and safer sex. “Some of my earliest sexual encounters were being taught about safe sex,” he said. “I was lucky in that I had an older lover when I was in my teens who taught me about that and sort of put it on my radar. This would have been in ’85 or ’86, when HIV was not at all openly discussed in Northern Virginia,” where Zed grew up. While the topic of HIV was considered taboo in his hometown and therefore avoided, his intimate connection with an older partner created a conduit for the transmission of early, evolving, and often community-derived, knowledge about sex and HIV risk mitigation.

When Zed later left home for New York after high school, he quickly found himself “at ground zero” of the HIV epidemic. Now, immersed in one of the country’s most established and politically mobilized queer communities, the relative silence about HIV and safer sex that characterized his youth abruptly gave way to a deluge of information and proliferation of discourse. “All of a sudden, I was the core demographic of receiving every public service announcement, poster campaign, fundraising initiative, and public action in the city. I remember when Creative Time did the bus posters about safe sex and Keith Herring illustrated them. I remember the clubs handing out condoms. Every bar and club had either some place where you could pick them up or volunteers passing them out as you left. I didn’t have a primary care doctor in those years. I was uninsured, so I would go to the LGBT Center. I would see all the posters, pick up the pamphlets, and have the conversation.” In and outside of the clinical context, HIV saturated Zed’s awareness. He supported friends who had newly tested positive and memorialized those who died of complications of AIDS, including one of his closest friends who only first disclosed his positive status in the final days of his life.

Witnessing the havoc the virus wrought within his personal social circle and on his community overall, Zed’s sexual practices and intimate relationships were shaped by the fear of acquiring HIV and his efforts to avoid it. As a rising it-boy on the arts scene—working as a celebrity stylist and eventually earning the title of fashion editor at an internationally-renowned magazine—Zed had more than his fair share of suitors. To insulate himself from HIV risk, however, he resolved he would only have condomless sex in the context of monogamous relationships, of which he had multiple throughout his decade in New York. His personal commitment to use condoms was so steadfast that, despite his proclivity to go out dancing several times a week, it even prevented him from getting drunk or using party drugs like cocaine and ecstasy, which were exceedingly common in New York’s Tunnel-era club scene heyday. Zed abstained, in part, because he felt that intoxication could potentially lead him to violate his self-imposed condom use pledge, which was not a risk he was willing to take, given that the epidemic raged on around him at that moment with no end, much less an effective pharmaceutical treatment, in sight.

Serial monogamy characterized Zed's sex life from that point forward into the 2010s. After moving to Los Angeles in the early 2000s, he met his now-ex partner, Daniel, kicking off a ten-year monogamous relationship. Although he and Daniel were drawn together initially by a strong sexual connection, the final seven years of the relationship were characterized by celibacy. From Zed's perspective, Daniel's unresolved childhood trauma was surfacing in their sex life in a way that Zed found unsettling. According to Zed, Daniel "wanted to vanish" during sex. Zed, whose current view of sex and intimacy is rooted in the principle of connection and influenced by tantric philosophy's emphasis on energy exchange, experienced Daniel's disposition to be distancing. Daniel refused to acknowledge or engage with Zed's perspective, so they eventually stopped having sex, but they continued living together and raising Daniel's adolescent daughter as co-parents. Due to the looming fear of HIV, the idea of opening their relationship to outside sexual partners felt too threatening to them both to pursue, even accounting for the protection that would have been afforded by condoms.

Zed broke up with Daniel, after ten years together, shortly before he first learned about PrEP. "When the 'Truvada Whore' stuff started coming up in the press, that put PrEP on my radar. I remember on Scruff a couple of guys mentioning it on their profiles, that they were participating in the studies. I remember reaching out directly to someone who I'm still friends with and being like, 'What's it been like?' This was coming out of seven years of celibacy within a monogamous relationship, so I was really kind of exploring what sex would look like for me." The early risk compensation debates about PrEP, what he glosses as "the 'Truvada Whore' stuff," brought PrEP to his awareness. From a liminal station in his sexual trajectory on the tail end of seven years of unwilled celibacy, which was nonetheless seemingly unavoidable due in large part to concerns over HIV, public contestations over condomless sex on PrEP intrigued Zed. Especially because, at that point in his forays back into sex, he viewed condoms as a necessity.

“In those early days [after the break-up], condom use was non-negotiable. I was absolutely going to use them. I was not ok with the risk of unprotected sex at that time. So, the fact that the options could expand by taking PrEP really caught my attention.” The more Zed learned about PrEP, the more he began to think of it as a mechanism for expanding *both* the range of sexual practices in which he would now be willing to participate *and* the definition of what protected sex could mean. “The idea or the promise of PrEP,” Zed described, “was that I could have condomless sex without the fear that I had previously assigned to condomless sex in non-monogamous relationships. Prior to that, I can probably count on one hand how many times I had condomless sex outside a monogamous relationship, and that’s accounting for 20 plus years of my sexual career. I started on PrEP to remove that fear.”

With the advent of PrEP, condomless sex became protected sex in Zed’s eyes. Once he started taking it, his sexual repertoire expanded significantly, and he began to approach the contours of his sex life from a place of curiosity rather than one of fear. He told me, “This medicine has allowed me to feel safer and more secure in my choices, and that is an empowering dynamic.” The protective efficacy of PrEP enabled Zed to explore his sexuality in ways he previously had not thought possible, instigating a significant shift in his attitude towards condoms, but more than that, a sea change in his perspective on pleasure, intimacy, relationships, and risk.

Zed reflects on his last eight years of using PrEP as a formative time of growth and personal discovery, in some ways akin to his initial sexual coming of age in New York but structured by an alternative paradigm of risk and productive of divergent outcomes. His self-exploration led him into his current relationship configuration, for instance, which represents a radical departure from his longtime history of monogamy. He recently began a polyamorous relationship with a new partner, David, who himself is currently abstinent because he is actively recalibrating his own relationship to sex as a component of his recovery from crystal methamphetamine addiction. Although Zed and David are not having sex, Zed continues to have condomless sex with a few regular partners with whom he had formed connections over the past several years. While he occasionally entertains a one-off hookup from a dating app like Grindr or Scruff, he has learned that the sex he finds most fulfilling is that which involves partners with whom he has established a kinship, bond, and mutual affection.

In addition to sex dates with partners like these, every few months, he visits two friends and lovers who host recurring sex parties at their house in the desert outside Los Angeles. Zed helps curate the parties, peopling them with friends he has fucked in the past or still does from time to time. His social and sexual worlds are now more integrated than ever, and he enjoys the feeling of being suspended in a web of loving connections (and this is not a metaphor for a sling, although he has, since starting PrEP, learned his way around one of those, too).

In his last eight years on PrEP, Zed has tested positive a few times for bacterial STIs like gonorrhea and chlamydia at his regular three-month follow-up appointments. Each time, he has been treated, in short-order, with short-course antibiotics, recovering without incident. Zed admittedly prefers not to test positive for bacterial STIs, but he also does not fear a bacterial STI diagnosis, nor does he feel shame when he receives one. If he were to receive several diagnoses in quick succession, which has not been the case, he said he would consider first limiting his number of sexual partners before reintroducing condoms. While condoms were once a non-negotiable part of Zed's sex life, he called his reversal in attitude towards condoms "complete. Like, I don't keep any in the house. I used to always keep them in the house. If a partner wants to use them, I'm happy to, but that's on him. It almost never gets discussed."

Examining the shifts in Zed's sexual practice over time—starting prior to his move to New York during the height of the AIDS crisis, through his multiple monogamous relationships, the last of which was sexless for seven years, into the past eight years of condomless sex on PrEP—helps flesh out one model of the way MSM relate to HIV risk. Zed's story shows how fear of HIV acquisition contoured both his personal relationship to sex and his sexual relationships with others. The measures he took to avoid HIV, like stringent adherence to condom use and serial monogamy were effective in preventing his seroconversion, but they also restricted his exploration of sex and locked him into patterns and modes that, with the advantage of hindsight, he now sees as circumscribed by fear.

Once he started taking PrEP and exploring sex absent the previously ever-present fear of acquiring HIV, he was able to deliberately pursue pleasure and fulfillment to an extent previously not thought possible. The consequences of that exploration include more bacterial STI diagnoses than he had experienced in the past, but Zed accepts these risks and thinks of them as minimal in comparison to what he would be risking were he to stop taking PrEP and return to his pre-PrEP safer sex practices and risk-restrained orientation towards sexual pleasure. Even in view of the possibility he could acquire further bacterial STIs through continued condomless sex on PrEP, Zed understands and experiences PrEP as an "empowering" technology that makes him feel "safe" and "secure."

The themes raised in Zed’s story resonated strongly with the narratives shared by many of the men in my research who initiated and persisted on PrEP. In particular, my interlocutors described how the fear of acquiring HIV shadowed even their most nascent awareness regarding their own same-sex sexuality and compelled them towards sexual practices that would limit their HIV acquisition risk, like condom use. Once they started on PrEP, they reported an increased willingness to dispense with condoms. Rather than interpreting condomless sex on PrEP to represent an increase in their sexual risk compared to their pre-PrEP modus operandi, however, others, like Zed, perceived PrEP to be a “technology of freedom” that furnished an opportunity to explore sex and sexuality unencumbered by previous concerns about HIV acquisition (Martinez-Lacabe 2019).

Priest

Priest, who is also white, is a design student at Los Angeles Trade Technical College in his early 30s who drives for ride share services to make ends meet. Even though he’s twenty years younger than Zed and came out of the closet ten years after effective combination therapy for HIV was introduced, he similarly expressed a fear of HIV shadowing his sexual development. “Basically, since I started to have sex, I was just always afraid of getting HIV. It’s always been a huge fear of mine. Just from the way people talked about gays growing up, like, ‘They all have AIDS,’ or whatever. The narrative is always like, ‘Well the gays just got AIDS and died.’ I came out when I was 14, but I remember before I did being aware of that.” Priest described his coming out process as “in a way, very relieving, because I felt like I was lying and at some point, I felt like a lot of people knew, and I felt like I was being false. But it was also scary, obviously. I was afraid of being rejected by my family and my community.” His family’s initial reaction to the news was mixed. “Basically, they were worried for me. I think they were afraid I'd have a very hard life and not a good life, that I'd be derailed from accomplishing things in my life and being successful. And then also getting AIDS. They were afraid about that. I don't remember if they specifically said that, but they were very afraid, and I knew."

Because Priest himself was worried about acquiring HIV and likewise felt the burden of his family's concern, he was adamant about using condoms. "I was really, really vigilant. Whenever I would have sex with anyone—I would usually bottom, I've basically only bottomed—but whenever I've had anal sex, I'm like, 'Yo, you have to wear a condom.' Even when I'm fucked up, I've never been like oh don't wear one, I've never had that, just out of this fear of getting HIV." Once, in his 20s, "a condom broke and the guy came inside me, and afterwards he said, 'I'm HIV positive, but I'm undetectable.' I was aware what that means, but I also didn't really know him. And he knew people in my friend circle, so I kind of trusted him, but up until then I had never consciously had anal sex with someone who was positive and undetectable. I flipped a shit; I was really scared." The guy who topped Priest and came inside him offered him some Truvada, which he had been taking for treatment of HIV. Priest said he appreciated that, but he had heard about the protocol for post-exposure prophylaxis (PEP) and knew that more than Truvada was needed. Priest had no health insurance at the time and was unclear on how he could access PEP free or at low cost, so he came up with the creative solution. "I had a friend go to the hospital to get PEP for me. He pretended it had been him, got a 30-day supply of three pills a day, and I took it."

When Priest moved to Los Angeles, he ended up seeking out PEP two more times in similar situations "where there was some kind of slip up or a condom broke or something like that. Going to the ER again to get PEP just felt so extreme and dumb," and he was now covered by state-sponsored Medi-Cal health insurance, so he elected to see his assigned Medi-Cal doctor instead. “I remember going to this clinic and seeing a doctor, telling her I wanted to get tested for everything, and she saw I’d just been tested a month before. I was paranoid and wanted to get retested, and she was a little shady. ‘Well, how much sex are you having? I don’t understand why you need to get tested again.’ It felt judgmental.” After that experience, following his second time taking PEP, Priest decided to initiate PrEP instead. Although he sees it as logical in retrospect, it was not a decision he arrived at easily.

“I just have an aversion to taking prescription medication in general, which can be hypocritical because I take a lot of recreational drugs [laughs], but I also just had experiences taking psychotropic medications that didn’t make me feel good. I don’t know if it’s an authority thing, or just being on something all the time that freaks me out. It’s just connected to being sick. I don’t like the feeling of, ‘Oh, you might get sick,” which the idea of daily medication evoked. “I’m still a little bit afraid of long-term side effects from it, but for now it suits my lifestyle, because I’m having sex, and I want to be able to have sex without being afraid of getting HIV.”

Priest sought out his PrEP prescription at the LA LGBT Center, which he described as “honestly really good! It was really easy, they’re just so politically on point and friendly. The experience at the LGBT Center made me feel so much more comfortable.” In contrast to the judgment he perceived from his previous doctor, the LGBT Center clinicians made their lack of stigma clear and have never made Priest feel scrutinized for seeking out testing and prevention resources nor participating in the practices that make testing and prevention resources necessary.

When Priest first got on PrEP, he was seeing a partner he expected he would be having sex with more consistently. He was reluctant not to use condoms at first, even with the added protection of PrEP, but found himself more willing to dispense with them in the context of a nascent relationship with someone he thought might turn into a “regular,” so to speak. That relationship ended up not panning out, but it nonetheless exerted a lasting influence on his orientation towards condoms. "This guy I was seeing a bit, he was on PrEP and was in an open relationship and was having sex with people on PrEP without condoms for some time. Just seeing that he was so relaxed about it made an impression. Then I met other people on Grindr who introduced having sex by saying, 'Oh, well I only have sex without condoms,' and that disturbed me a bit, but it made me feel like if all these people are so down to take this risk, then it must not be as risky as I imagined. If five years prior someone hit me up and said they only had sex without condoms, I would have blocked them." With Priest on PrEP himself, and increasing exposure to others on PrEP who said they were not using condoms regularly or at all, he cultivated a sense of security that eventually led him to dispense with them.

Now, Priest's approach to condoms is the inverse of what it had been in the past. "Since I started taking PrEP, I exclusively use condoms in situations when people say they only have sex with condoms." Reflecting on the experience of condomless sex on PrEP compared to sex with a condom without PrEP, Priest was unequivocal. "It's so much better! Physically, it feels better. As a bottom, the feeling of the condom is horrible. Sex without a condom feels more intimate, it just *feels* better! Mentally, it turns me on more." PrEP has also compelled him to reconfigure his attitude towards sex with partners who are living with HIV. "Four years ago, I would not have been open to having sex with people who are undetectable even, I have to say. And now I would only be willing to do that on PrEP, I think, but since I'm taking PrEP that has opened doors, for sure. It made me realize it's stupid to rule people out because of it. Even at that point, I felt bad about it, but I still had the fear," which was enough to meaningfully constrain his partner choice.

From a biomedical perspective, people who are living with HIV and on pharmaceutical treatment to achieve undetectable viral loads are in fact the least risky sexual partners when it comes to HIV acquisition.[5] Nonetheless, what some commentators label “serophobia” is not uncommon as an organizing principle of MSM sexual communities. Serosorting (Grov et al. 2015), “discussing HIV status with potential partners (particularly casual partners) and limiting UAI [unprotected anal intercourse] to seroconcordant partners,” is a safer sex practice with a long and controversial history (Holt 2014, 219). To some, it represents the perpetuation of stigma against people living with HIV by proposing they confine themselves to sexual networks segmented off on the basis of serostatus. To others, it is seen as part of a community-derived HIV prevention ethic rooted in respect for the desire of people who are living with HIV to lead fulfilling, gratifying, and pleasurable sex lives. Dean’s (2009) work on barebacking and additional scholarship on giftgiving and bugchasing (Graydon 2007; Cole 2007) demonstrate the eroticization of poz subjectivity and critique the idea that all sexual practice is or ought to inevitably be structured around the principle of HIV prevention. At the same time, stigma against people with HIV continues to inflect sexual decision-making.

For Priest, PrEP opened up his partner choice, and likewise increased the latitude of the terrain he was willing to explore sexually. “I guess, yeah, I’ve been more sexually active, because PrEP has mostly removed my fear of getting HIV, which has been a huge thing, always. There will be a month where I have sex with like five guys in one week, and then there will be months where I’ll have sex with no one. It was also kind of like that before I was on PrEP,” but the difference now is clear in his relationship to those patterns and the level of control he feels he has over his sexual health and safety. While the fear of HIV was previously “always” a “huge thing,” PrEP has eliminated it, granting Priest increased access to pleasure.

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[5] Whereas the principle of U=U has been well-established and scientifically validated, a person who may believe themselves to be HIV-negative, even testing negative two or three months prior, could have potentially acquired HIV in the meantime.

Prince

Like Priest, the seeds of Prince’s trajectory towards PrEP were sown through PEP. When, sitting in the park adjacent to his apartment in central LA, I asked Prince what led him to get on PEP, he said, “Um… trade!,” and we both laughed. “This was Grindr. Early days. I met up with this guy. He was very hot. I think I had maybe bottomed once for my ex-boyfriend prior to then, but this guy was a top and he was pretty big. He used a condom at first, but he only had one condom. He wanted to go again, and I allowed him to fuck me raw. But it was too big, so he didn’t cum in me or anything. When we were hooking up, we did a little coke, but then he also pulled out a little tina[6], and I was like, mm, ok, this is sus. No judgment there but I was like, ok, maybe he isn’t the safest partner.” The picture coming together in Prince’s head made him feel like this partner might be risky. He was startled by “the speed with which this guy was ok with not using a condom. He was like, ‘Oh, I ran out of condoms can I fuck you raw?’ There was no questioning of my sex practices at all, so it seemed like that wasn’t something that was important to him, which leads me to think this means he probably fucks raw with a lot of people.” Prince’s partner’s nonchalant attitude towards condomless sex, without any discussion of status, unsettled Prince. But he was also “very hot,” they were both high, and in this situation, Prince “allowed him” to top without a condom.

“I was bleeding the next day, so I went in to address that, and I thought in my head like, ‘Ok, well, you know, if I get HIV then this is it. But I gotta address the pain that I’m having when I use the bathroom. When I told the nurse practitioner about the experience, she said, ‘I think you should get on PEP.’ I was completely surprised. I was like, this exists?” After a month of PEP and a negative HIV test, Prince was bridged to PrEP.

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[6] “Tina” is slang for crystal methamphetamine.

Prior to the potential exposure to HIV he described, Prince said he used condoms for sex "always." In fact, "It never felt like I needed to discuss using condoms, it felt like condom use was compulsory. If there's no condom, we're just not fucking. I always asked about status, but when people said they got tested was always months ago, so I feel like what is asking even doing." Prince attempted to encourage status disclosure with partners as a way to promote his own sexual safety but recognized the limitations of this approach—namely, that a negative test many months prior may not serve as a reliable indication of a partner's current status.

Once on PrEP, unlike Zed and Priest, however, very little about Prince's condom use practices changed. "They remained consistent throughout the entire period that I was on PrEP," which spanned over five years broken up by a two-year monogamous relationship. "I still wanted to use condoms. There was this, not fear, but this *distrust* of it. Like, I trust scientists, but it seems too good to be true. So, I was like, ok, well I'm going to just keep using condoms."

Distrust and mistrust of health care systems, which recently entered the national spotlight in the wake of COVID's mis/management, have long been an area of interest for advocates, researchers, and clinicians working to expand access to and utilization of health care services to promote better management of health conditions (Jaiswal, LoSchiavo, and Perlman 2020). Over twenty years of research has established clear racial disparities in medical mistrust, with multiple studies indicating greater mistrust reported by people of color, particular Black and African American people, compared to their white counterparts (T A LaVeist, Nickerson, and Bowie 2000; Doescher et al. 2000; Thomas A LaVeist, Isaac, and Williams 2009). Dr. Oni Blackstock, a physician, researcher, and founder and Executive Director of *Health Justice*, an organization that centers anti-racism and equity, emphasizes that mistrust and distrust encompass not only a lack of trust in the healthcare system, but also a belief that the healthcare system is acting with ill intent towards marginalized groups. Historical precedent provides ample evidence to validate the rationality of these beliefs.

In *Medical Apartheid* (2007), Harriet Washington traces the roots of medical mistrust and distrust among Black and African American people to the grievous abuses committed at the hands of medical practitioners in the era of slavery. She positions the transatlantic slave trade as a medically managed enterprise, wherein doctors were both charged with inspecting enslaved people before they were forced onto ships and hired to ensure enslaved people, who were considered to be cargo, remained healthy enough to survive the journey. Abuses of power committed in and through medicine against Black and African American people over time have included brutal medical experimentation, exposure to untested pharmaceuticals, and utter disregard for informed consent and the basic underlying principle of "do no harm," which is intended to steward all medical practice.

The infamous US Public Health Service (USPHS) Syphilis Study at Tuskegee exemplified this. In 1932, the USPHS enrolled 600 Black men—399 who had syphilis and 201 who did not—in a research study. The men were told they were being treated for "bad blood," and offered medical exams, meals, and burial insurance as compensation for their participation. A little more than ten years later, in 1943, penicillin was established as the treatment of choice for syphilis and furthermore, was becoming widely available. Despite this, participants in the study were not offered treatment with penicillin. Over the next decades, researchers observed their avoidable, unnecessary suffering and eventual deaths, extracting data about the so-called "natural course" of syphilis from their dying bodies while withholding treatment.

This broader trajectory, presented in an abridged form that could be substantially fleshed out with more examples, historically contextualizes the disparities in medical mistrust along the lines of race that have been documented in scholarship on health. In the arena of HIV prevention and treatment research, medical mistrust among Black MSM has been identified as a barrier to HIV voluntary counseling and testing (St. Lawrence et al. 2015) and routine health care engagement (Eaton et al. 2015). Specifically related to PrEP, race-based medical mistrust has been identified as a deterrent for Black MSM from using PrEP (Eaton et al. 2014), 2014).

Qualitative studies on PrEP have begun to explore the dynamics underlying this finding. For example, Cahill and collaborators (2017) conducted four semi-structured focus groups with gay, bisexual, and other MSM at risk for HIV acquisition in Boston, Massachusetts and Jackson, Mississippi. The participants in Boston were mostly white gay men and the participants in Jackson were primarily Black gay men. The team's research revealed several unique themes emerging from the Jackson focus groups, specifically "medical mistrust, including skepticism of PrEP" and "intense stigma against homosexuality and HIV" (1355). Participants expounded on the historical transgressions made in the name of medicine against Black communities, with some airing skepticism about the effects of the pill, including suspicion that PrEP alone could give its users HIV. While uncertainty about the long-term effects of treatment with PrEP were not exclusive to Black men, researchers identified the medical mistrust expressed in the Jackson group as "more palpable and emphatic," and described participants questioning the motives of U.S. HIV research altogether. Participants in the Jackson group also expressed a greater salience of HIV stigma and homophobic stigma, both in society more broadly and within Black, gay male communities, too.

In my own research on PrEP, mistrust came up much more frequently when interviewing Black participants than it did with participants of other races. Even when mentioned by participants of other races, the discussion of medical mistrust and HIV stigma with Black participants was, as Cahill's team also observed, "more palpable and emphatic." With a modest overall sample size of patients (N=22) and only a subset of interviews with (potential) patients who are Black (n=7), generalizing would be irresponsible. But it seems significant to note the fact that Prince is a Black man and he expressed skepticism about PrEP framed in terms of "distrust." This led Prince to maintain his condom use habits even while taking it, while other Black men I spoke with described medical mistrust as the principal reason for choosing not to take PrEP. Interviews with Black MSM in my sample pointed to how medical mistrust, combined with the careful effort to deflect racialized projections about sexual risk, may lead Black men to use condoms in addition to PrEP, or to turn away from PrEP altogether.

Prince spoke to the effect of HIV stigma and homophobia he experienced growing up in a segregated Midwestern city on shaping his self-image and attitudes towards sex. "I think internalized homophobia contributes to it." Prince's father reacted negatively to learning Prince is gay and many years later still has not expressed acceptance of his sexuality. "Since I came out, my dad has always been like, 'You're going to get HIV.' So, there's this anxiety that I *can't* get HIV, even though it's not a death sentence. As I grew up in the Midwest, being gay has always been like you're very close to dying, so you have to protect yourself. It felt foreign to be able to live and have sex like everyone else does." To Prince, his father's words echoed a cultural ethos more broadly reinforcing the notion that seroconversion was the inexorable "reality of being gay: this is what my life is always going to be, so I have to accept that." As Battle and Barnes (2009) point out in their crucial volume *Black Sexualities*, this logic suffuses not only public debate, but also scholarship, in that "most current academic references to the gay and lesbian experience of Black people focus on HIV/AIDS and risk factors rather than everyday experiences—indirectly suggesting that contracting the disease is an inevitable milestone for members (particularly males) of this community" (7).

Prince sees his determination to remain HIV-negative as an expression of the imperative he feels to prove the stigmatizing prediction, "You're going to get HIV," wrong. Despite knowing HIV can be safely and effectively treated with combination pharmaceutical therapy, Prince is adamant about doing what he can to remain HIV negative. His resolve compelled him to use condoms nearly every time he had sex before getting on PrEP and, once on PrEP, to change little about his regular condom use practices. Prince understands PrEP to afford meaningful protection in the context of a life trajectory in which, as a gay Black man, he has been made to feel vulnerable, even "very close to dying." Prince's concerns about HIV, however, are evidently less motivated by fear of the potential biological consequences of acquiring the virus—"it's not a death sentence"—and more so by the anxiety that acquiring HIV would fulfil a racialized homophobic prophecy: that seroconversion is "the reality of being gay" and "what my life is always going to be, so I have to accept that." Taking action to protect himself from acquiring HIV is, for Prince, part of protecting his self-determination and stake in respectability in the context of structural and interpersonal racialized homophobia.

Although PrEP has had little effect on how frequently Prince uses condoms, PrEP has meaningfully opened up new areas in his sexual practice overall. "I was always spiritually[7] vers," short for versatile, a term used to describe someone who tops as well as bottoms, "but now I've been walking the walk. It's definitely given me sexual confidence. I can do anything! I feel like Simone Biles." Prince's exploration of bottoming, and access to the pleasure, fulfillment, joy,

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[7] Prince is here speaking metaphorically in saying he conducted his sex life in the spirit of versatility, while not always in practice. In other words, he mostly topped but eschewed the label "total top."

and satisfaction of being penetrated owes to PrEP providing him "peace of mind." Before PrEP, "I would spiral every time I had sex, and be like, 'Oh, did the condom break?' and really be so anxious about HIV. My attitude about it has completely changed. My frontal lobe is like it's no big deal, you'll be fine either way, but my limbic system [laughs] is still fearing, because it has been so ingrained from an early age, and that's what still compels me to use PrEP even though I use condoms."

Jerome

Jerome, who is also Black and gay, had a similar experience to Prince when he came out to his mother, and it likewise shaped his approach to sexual risk. But, in his case, this diverted him from PrEP. Jerome and I connected through the peer mentor he was working with as a participant in the Mobile Enhanced Prevention Services (MEPS) study. In his late 20s, Jerome started using crystal meth regularly and then daily. At first, he maintained his rent and car payment, but that eventually became too difficult to manage, and he ended up unhoused. During that period, Jerome faced a number of shorter incarcerations for crimes related to poverty, drug use, and living on the street. Eventually, he was convicted on strong-armed robbery and assault with a deadly weapon charges and spent over three years incarcerated in the late 2010s. When he left prison, he went straight into a residential treatment center for substance use disorder, and when we talked, he had transitioned to recovery bridge housing.

"I remember when I was a junior in high school and I came out to my mom. She didn't take it very well. She said a lot of hurtful things. That conversation has stuck with me all of my life, up until this day, and because of some of the things she said to me, I made it an objective not to contract HIV. To prevent that, I would do my best to control the situations I would participate in, to not allow, to the best of my ability, myself to be vulnerable to contract HIV." To Jerome, fulfilling his “objective” entails limiting the number of partners with whom he has anal sex, getting tested if he has a concern about possible exposure, and generally avoiding what he thinks of as “high risk behavior. I would consider that anal sex. People who work in the sex industry. People who have a large amount of partners or they’re in a relationship where they don’t know who their partner’s hooking up with.” Because Jerome disidentifies with those categories, he therefore does not see himself as needing PrEP. In fact, he eschews it, and tries to do what he can to eliminate the need for PrEP by limiting his sex life and therefore potential exposure risk.

Jerome’s efforts to distance himself from PrEP and what he understands to be high risk sexual subjectivity manifest in his approach to the clinical encounter. He’s been seeing a clinician assigned to him by Medi-Cal annually for the past several years but makes a deliberate effort to avoid most conversations about sexual health unless spurred by a symptomatic STI. “I do have a primary care provider, I typically go once a year, but that’s not a conversation I have with my doctor. I don’t talk about PrEP. I don’t even talk about that kind of stuff with my doctor. Honestly, when I go to the doctor, when I visit my primary care provider, I typically guide the conversation. I allow him to ask the questions that he needs to so he can make a good assessment, but outside of that, I’ll be like I’m not comfortable talking about that or just not talk about it. I don’t want to go down the road of talking to him about PrEP and having him try to convince me to take that shit. In order to avoid the emotions attached to that experience, I’ll keep my answers real like… brief. We’ll get straight to the point.”

When I asked Jerome about the emotions attached to talking about “gay shit” with the doctor that he wanted to avoid, he said, “Probably anxiety, probably guilt, probably embarrassment. Honestly, it’s because it’s deviant behavior. A part of me is just like, yeah, you know you probably shouldn’t be doin’ that kind of stuff. Especially because the infection rates of

HIV are even more prevalent in my community. So, it's like if I go down that road with a professional, it makes me… Fuck! It's just, it's unsettling." He started speaking faster, "It makes me get nervous, it makes my anxiety go up, I start thinking about a whole bunch of bullshit that I don't want to think about."

Jerome connects PrEP with the idea of participating in "deviant behavior," doing things "you know you probably shouldn't." He feels a more acute need to avoid "high risk behavior" because of the disproportionate rates of HIV among Black MSM and the way he is interpellated into that risk group and perceived as risky as a consequence, all despite the fact he intentionally mitigates his sexual risk through other means. I asked Jerome whether he thought his doctor could understand where he was coming from with that perspective were he to express it in the exam room. "Probably not. He's probably like, well, the numbers say this, so you must be risky," referring again to HIV being "even more prevalent in my community," among Black MSM.

Jerome's Medi-Cal assigned doctor is white. When he activates insurance through his new employer, Jerome said he will "probably do my best to find a primary care provider who I'm more comfortable with, who's more geared toward or catered to me as an individual." He would be open to exploring more in-depth conversations about sexual health in the clinical encounter if he felt understood and safe enough to intersubjectively work through the emotions that he described coming up related to sex and risk. "There are conversations that do need to take place. I think for me it's about comfort and *trust.* Those things are earned over time."

He was clear in expressing what would help him to achieve more comfort and develop that trust. "I'm just gonna be honest. I would prefer to have a Black doctor or another doctor who is a minority because of the level of how we relate." Jerome's articulation of the will to seek out a doctor who could identify with his social positioning and experiences aligns with the findings of Devarajan et al. (2020) from their qualitative study on PrEP use with a sample in Atlanta made up of mostly Black or African American MSM. In that study, participants strongly believed clinicians who could understand their sexual and racial identities “would provide better sexual health advice, comfortably discuss sex, and minimize stigma experienced by patients” (389). For now, however, Jerome is content mostly leaving sex and sexuality out of encounters with his doctor as a means to avoid a discussion about PrEP, in which he would risk confronting further stigmatization.

Risk, race, and liberation through PrEP

Prince and Jerome both expressed having made it a personal mission to avoid HIV, which they linked, in their own ways, to racialized homophobia—the ideology that men of color are sexually risky, deviant, and/or irresponsible and therefore bound to acquire HIV. Prince distances himself from that subject position by seeking biomedical protection from HIV through PrEP and continuing to use condoms. Jerome, on the other hand, distances himself from that subject position by generally avoiding anal sex as well as by bracketing his sexuality out of the clinical encounter, to the best of his ability. He steers clear of a conversation about PrEP with his doctor, because going down that road feels threatening, in that he exposes himself to being read erroneously, especially by white clinicians, as participating in “deviant,” “high risk” behavior, just by virtue of being Black and a man who has sex with men.

Prince’s is an account wherein access to PrEP did not lead, in the short or longer term, as risk compensation thinking predicts, to durable changes in condom use practice. While the risk compensation hypothesis holds that protection from PrEP will inevitably lead to decreased condom use, Prince’s story provides evidence to the contrary. For Prince, PrEP is an added layer of protection, not a replacement for condoms, that has granted him “peace of mind” and allowed him to experience a new level of “sexual confidence.” Rather than describing his experience in terms of “freedom,” as in freedom from the imperative to use condoms, Prince thinks of PrEP as a way to secure himself against the possibility of fulfilling a pathologizing script, underwritten by racialized homophobia, by acquiring HIV. Jerome, on the other hand, perceives efforts at accessing PrEP to represent the fulfillment of a related script: that Black MSM are, indeed, sexually risky. To avoid the anxiety that comes with being seen as “high risk” and potentially reinforcing a racialized stereotype about promiscuity, Jerome deliberately avoids using PrEP. While some may understand PrEP to be a technology of freedom, others, who are racialized based on being Black as well as being gay, may experience it differently. As in Jerome’s case for instance, some may choose to keep their distance from it altogether.

By exploring the role of medical mistrust in variegating PrEP outcomes along the lines of race, the above complicates a facile narrative that PrEP equates to freedom. What freedom means in relationship to PrEP is conditioned by and productive of race. The racialized logic of the risk compensation debate, which constructs Black men in particular as sexually risky and liable to not use or abandon condoms, may inflect the way that Black men who do take PrEP approach condom use, and it may also discourage Black men from seeking out PrEP in the first place. When PrEP use is distributed away from Black MSM on the basis of an abstract and erroneous association with risky sexual behavior, material risk is generated in the form of increased exposure to harms that manifest in racial health disparities.

Towards temporal sophistication in risk compensation discourse

Priest’s unchanging attitude towards condoms while taking PrEP was unique in my sample; in fact, most PrEP users I spoke with did endorse using condoms with less frequency once PrEP was in the picture. Seemingly, this would validate one component of the risk compensation hypothesis: the idea that MSM taking PrEP might be inspired to forgo condoms in their sexual encounters. Additional data, however, demonstrate the need to contextualize an initial decrease in condom use within the longer arc of a lifetime sexual career. Hector and Mark, for instance, spoke at length about how their experience with PrEP first led to an absence of condoms in their sex lives, but also identified how, in the longer term, PrEP inspired them to re-evaluate their approach towards sex altogether. Their stories emphasize the need for greater temporal sophistication in the debate on risk compensation. How might the risk compensation discourse shift in light of testimony that PrEP may first enable increased condomless sex but, down the road, lead to a shift in attitudes towards sex promoting fewer condomless casual partners?

Hector

Hector started taking PrEP soon after its FDA approval in 2012. At the time, he was working as an HIV testing counselor in San Francisco. Like Priest and Prince, Hector's path to PrEP led him first through PEP. In fact, more than once. "I got on PEP a few times before I was on PrEP because I think I was a little, I don't want to use the word delusional, but I think in starting to be sexually active I assumed that I was going to be safer than I was. I think I thought I would have more control over my condom use. Or not control, because I had control. I just thought I would use condoms more than I did." When I asked him why he had that impression, Hector said, "I think I was just naive, honestly. There wasn't a logic. I just don't think I realized I was gonna be a ho!" When he came out, in his early 20s, Hector expected that he might have sex with someone "if I went on a few dates with them and liked them." As it turned out, Hector's sex life ended up playing out differently than he had first imagined.

"Halloween, I want to say it was the second year after I had come out, but my first gay Halloween, I had my two friends over and we went to this gay bar, and I fucked some guy in the bathroom. I was drunk, and I didn't realize how my hormones would just *take over* my body. At the time, I was like 23. And I think the combination of alcohol and hormones with being 23, it's kind of a recipe for not using a condom." Looking back, Hector realized how his youth, and specifically the experience of being closeted during what is typically viewed as an expected period of sexual exploration during adolescence, shaped his own early same-sex sexual experiences down the line. "I remember feeling *so* horny when I came out. I don't know about you, but for me, I didn't have sex until I was like 22. You think about the average straight person who has sex, like, I even knew people in my middle school who were having sex."

In his early 20s, then, a decade later than some of his straight peers, he passed through an accelerated and abridged phase of maturation. "You get what would normally, developmentally, be spread out over the course of a decade compressed into like potentially one night. It seems to me there's a predisposition to taking risks that comes down to the chemistry of how decisions are made. There will be miscalculations. You're not a computer. You're going to make mistakes. I wanted to believe I had more control over my actions than I did." Hector is a planner: a Virgo who likes to stick to the program and values the feeling of self-control. Nonetheless, he stated plainly: he's not a computer, and despite his knowledge of HIV risk and intention to avoid exposure, he ended up having condomless sex in a bar bathroom on Halloween. The next day, he went into the doctor and started a thirty-day course of PEP.

After his experience with PEP, Hector delayed starting PrEP, hesitating based on his fear that using it would be tantamount to admitting a lack of control over his own sexual risk and potential exposure to HIV. "And then I think came the PrEP stigma, of like, if I take PrEP, then

I'm accepting that I'm going to be barebacking." At first, the idea of submitting to the bodily practice of taking PrEP daily threatened, Hector worried, to symbolize his relinquishment of what he perceived to be a responsibility to take "control" over his sexual health through using condoms. He thought, "Well, if I do have sex without condoms, it's going to be an exception to the rule." But the rule he imposed, indexing his internalization of disciplinary discourse about condom use, ended up being unrealistic to follow. "I want to say I was on PEP three, four, maybe five times. Eventually I was like, ok… this is logistically ridiculous. It *is* delusional, at this point, if I don't get on PrEP."

Hector reflected on how the cultural health capital he had acquired through working as an HIV testing counselor smoothed his access to both PEP and PrEP. After the bathroom sex on Halloween, and before PEP round one, "I remember they paged my doctor the next day, because I was so mortified that I had done that when I was intoxicated. Me being able to call on the phone and get a hold of my doctor, ain't nobody at county [in the safety net hospital system] going to be able to call and get their doctor paged liked that. I *had* to use my privilege in that moment. Whether or not I knew it, I was doing it." Hector felt that he had to put his cultural health capital to work in advocating for himself, because as a Latinx gay man working daily with Black and brown and queer trans people as an HIV tester, he understood that the system itself was not necessarily predisposed to advocate for him.

Despite his initial reticence to start PrEP, once he received a prescription, he quickly integrated it into his life. Taking PrEP changed both his experience of sex and the sort of sex he was having. "I'll be honest, I think PrEP was a great thing for me. It was *very* liberating. It meant I could have sex without worrying about getting HIV, which is a huge breakthrough for a lot of gay men. *At the same time*, I definitely engaged in unsafe practices, I had a *lot* of bareback sex. I think it depends on the person. I don't think all people use PrEP that way. But I do, as I get older now, think there is a tendency, and I think part of it is just human nature, that when you take PrEP, you… Because condoms really aren't fun! So, I think it is challenging for people to use condoms. I think I had hopes in the beginning that I would use condoms still. It continued, the whole thing, I'm gonna use condoms, I'm gonna use condoms, but practically speaking, the context that I was entering was just so different than what I had anticipated, meaning I was having sex with people I knew for a lot shorter time than I thought I would when I first came out. I was having sex with people while I was drinking, and I was being driven more by hormones than I think I could have ever realized while I was doing it."

In explaining the discrepancy between the sex life he idealized for himself and the one he actually lived out in the real world, I traced in Hector's voice a self-critical tone. Although he contextualized his choices as being made under circumstances that differed from what he expected, he also reflected on them in a way that indicated judgment about a past version of himself. I asked him to tell me more about that ambivalence. "I think it was a lot of things! I think it was good. I think it was fun. I think it was liberating. Eventually, I got too many STDs and I needed to slow down, so the pendulum swung the other way. But, overall, I think PrEP was a great thing in my life. I would never look back and say anything negative about PrEP. I would just say we have to educate and provide resources to people who are marginalized so that they can practice safe sex as much as possible."

I recognized Hector's sensitivity to express a multifaceted view of PrEP, one that is complex and not straightforwardly "good" or "bad." We talked about how his reluctance to say something negative about his time on PrEP was related to the concern that his experience could potentially be interpreted as evidence of the pernicious effects of risk compensation, playing into the hands of PrEP skeptics who may see it as a technology that increases risk. Having known each other for years and discussed our experiences on PrEP at length in the past, we had developed an intimate understanding of each other's position on harm reduction and the sexual politics of gay life. I found it interesting, then, that entering a formal research relationship through participation in an audio-recorded interview that could be incorporated into my dissertation, he toggled back somewhat, at first. While I recognized his desire to foreground the parts of his time on PrEP that were "good," "fun," and "liberating," I was also curious for him to elaborate on what he felt like during the times he "got too many STDS" and "needed to slow down."

"I got prostitis," inflammation of the prostate, "which made me realize that I was basically causing anal trauma from sex, although I was not bottoming that often at the time, so it was more just an accident that happened that can be common. But there was shame in that. I felt super shameful. I felt like I was a moral failure for not being safe enough or taking the correct precautions." In framing his proctitis diagnosis as a physical manifestation of moral failure, Hector expresses how moral discourses of risk management are internalized by stigmatized sexual subjects. Evidencing the disciplinary gaze turned inward (Foucault 1995), Hector interpreted his prostitis as punishment earned for failure to comply with the regulatory normalization of sexuality. The fact that he was not bottoming particularly often at the time, and therefore less likely to experience a rectal STI or its sequelae, did little to dissuade him from feeling like a moral failure. This provides evidence for the claim that the moral discourses regulating sexuality, as experienced by the subjects who are governed by them, are apparently not always directly linked to the epidemiological "facts" defining sexual risk. Rather, they are conditioned by a neoliberal sexual politics that responsibilizes MSM and blames them when they acquire STIs (Adam 2016; Sandset 2019).

Hector's own sense of being of a moral failure was heightened by the circumstances leading to his prostitis diagnosis, both in terms of the setting and the lack of care he experienced in the sexual encounters that led him to call the doctor. "What I remember most about that experience was when the guy pulled out his dick and you could tell he just walked away because he saw blood on it. But he never thought to be like, 'Oh, are you ok?' That's the fucked-up part. That someone would just use you as a sex doll or whatever and that he would not think to be like, 'Are you ok?' It wasn't until the next guy that I wanted to have sex with that I noticed. I can't remember if he said something or also walked away, because I was in a bath house, but at some point, I reached my hand down and saw blood. That's traumatic, dude! To have your sexuality become something that *harms* you."

PrEP liberated Hector from the fear of acquiring HIV, but his story shows how HIV is not the only harm related to sex that people at risk for acquiring HIV contend with and manage. While the risk compensation debate constructs those harms primarily in terms of increased STI diagnoses, Hector's most vivid memory stands out for the way it shows the biomedical *and* psychosocial valences of harm that can accompany sex. Along with the shock of seeing blood on his hand, a stark and visceral indication he was injured, came the upsetting realization that his sexuality was, in his words, harming him. Hector felt that because of PrEP, he was entering into sexual relationships that exposed him to these harms and that provided less in the form of reciprocity and care than he felt was owed him on a basic human level. It all left a bad taste in his mouth. Gradually, he dialed back the amount of sex he was having.

He sees the time he spent having sex before he “got too many STDs” and “needed to slow down” as “part of my development. But I also think it was problematic at times. I mean, I think there is some question about sex addiction that I have, for sure. And Grindr addiction, too. Some people it’s just the messages, other people it’s the actual sex. For me, it was both. But one fed off the other. I think sex was an escape for me from stress. I think I’m still processing it.” In Hector’s case, PrEP was an ambivalent object (Race 2016), one he continues to grapple with even though he’s been in a monogamous relationship for the past two years and has stopped taking his PrEP. “There was a dark side to it, but there was also a really fun side to it: of being free, of not having to worry about having sex with who I wanted to, of meeting people. Things that I think for straight people are normalized but for gay men—suddenly when we do it—it’s pathologized and seen as a bad thing.”

Even though PrEP propelled Hector down paths leading to harms from sex he may not have otherwise experienced, it was also ultimately successful in helping him remain HIV negative. “Honestly, I probably would have had HIV by now if I didn’t have PrEP, just thinking realistically. The more times you do something, the less you’re scared of it. And I think what keeps gay men from getting HIV before PrEP was fear, unfortunately. But I think I had gotten to a point where I was so tired of being afraid of being out, of being who I was, and being just like, wanting to be accepting of myself, that I didn’t want to have to worry about HIV. I was like fuck it. If I get HIV, then it’s what’s going to happen. Having PrEP took a lot of the stress away and it gave me the protection. I honestly don’t know [if I did not take PrEP] that I would have kept the same level of precaution. I don’t think the fear that I had beginning when I started having sex would last. I think I probably would have started having sex at some point. Because I probably would have been stressed at some point. I probably would have been drunk at some point. And I very well in those times could have gotten HIV. I'm lucky to have had access to PrEP, but it does come with its downsides. People aren't aware that safety around sex isn't just about HIV." The extent to which PrEP is liberatory and the degree to which it may usher in harms, Hector thinks, should be dealt with deliberately and thoughtfully in order to make sure that PrEP implementation promotes overall sexual wellbeing, beyond simply keeping people free of HIV.

"PrEP does give us a lot more freedom. But I think that freedom shouldn't be replaced with my experience, which was still being isolated in my sexuality and, having grown up in a rural area, being isolated from having gay mentors and gay sex education. Everyone should get gay sex education. My sexual education was literally the darkroom. Literally, being alone in the dark, on an educational level, not just physically where I was having sex. It shouldn't be something we just teach ourselves, or you happen to be an HIV test counselor like me, and you learn about it. So, I think I was lucky. A lot of people aren't. It's not moral failure. It's luck."

PrEP enabled Hector to explore his sexuality more freely because it protected him from acquiring HIV. He reflects on that period of exploration as a complex part of his overall development. In retrospect, he sees his sexual practice during that time as encompassing a wide range of affective registers. At times it was fun and freeing, at other times it felt dark and concerning. Regardless, he remained free of HIV and was treated for any STIs he acquired along the way. From where he stands now, he considers that time to have been a rich source of personal growth, one that enabled him to cultivate a clearer understanding of where and how he wanted sex to fit into his life. The obstacles he encountered along the way helped him achieve a new level of vulnerability in probing his own approach to sex from a place of experience and self-knowledge rather than naivety and fear. Hector crafted his own sexual education through

PrEP, and while some of the lessons he learned left him in physical and emotional pain, he was also able to pass through them while being protected from HIV.

This sort of longitudinal process—whereby PrEP users' sexual practices are understood to shift dynamically rather than trend inevitably in the direction of risk and therefore harm—is under-explored in the current debate on risk compensation. Especially rare are accounts of individuals whose PrEP use trajectories led, in the longer term, to less sex and lower HIV exposure risk practices. Nonetheless, in my limited sample, Hector's was not the only story I heard from someone who expressed similar changes in this direction over time in their sexual practice and attitude toward sex. Mark's story contributes to the complexity of "liberation" vis-a-vis PrEP and shows how PrEP can be instrumental in prompting a deeper awareness of how to intentionally integrate sex into an individual's life in more thoughtful and fulfilling ways, which do not necessarily imply having more condomless sex or even more sex at all.

Mark

Mark is in his late 40s. We met when he was living and working in Southern California, but he moved several months ago back home to Louisiana, a change prompted, in part, by the dissolution of his fourteen-year relationship. In the space and time created by his breakup and magnified by the early days of the COVID pandemic, he entered a period of deep self-reflection, questioning many facets of his life, including the place of sex in it. Although he had been on PrEP "religiously" for nearly ten years, he decided, post-break up and mid-pandemic, to stop taking it. By placing Mark's decision to stop taking PrEP and its entailments within a broader arc describing his relationship to sex, risk, and intimacy, a dimension of PrEP experience that is rarely documented comes into focus. Specifically, Mark's longtime engagement with PrEP and then calculated, strategic disengagement from it shows how trajectories towards sexual "liberation" shaped through PrEP may, in fact, lead to a substantive re-evaluation of sex but not necessarily towards "promiscuity."

In order to establish the significance of this longitudinal approach to sexual practice, it is necessary to trace Mark's story back a few decades. Mark moved from Lousiana to Texas to go to college in the early 1990s. Prior to leaving home, he had never had a sexual experience with a man, nor had he met any openly gay men. Both of those things changed when he encountered Dennis in a park along the bayou adjacent to the Jewish cemetery in Houston. They were there to cruise. Mark described the practice of cruising at that time this way: "If you were not meeting people in a bar, or like a really lewd bookstore, you had to develop a sense, a nose, so to speak, for where gay people were congregating. As I would ride my bike along the trails that would go along the bayou, you would notice—what are gay men if not observant—a guy. What's he doing there, he looks like he's skulking a little bit. Did he look back at me? When you pass them, of course you don't look at that time, but then 20 or 30 feet later you turn around and find that they're turning around at the same time, so the next loop you make around, you look a little closer. Then you might stop and take a break. And then you find the other person is there. It was kind of a cat and mouse game. That's how I met Dennis."

Mark circled a few times along the bike trail, making eye contact with Dennis in each lap. Both evidently signaled enough interest for Mark to decide to toss his bike in the back of Dennis' truck. Dennis drove them back to his place, and they had sex. The two became sexually involved on a regular basis, and Mark even ended up living with Dennis during a semester in college. Dennis once worked as an orthodontist, but had recently retired, at the age of 42. Testing positive for HIV and uncertain of what the future might hold, Dennis opted to live out the remainder of what might have been a significantly shortened life on his own terms.

Dennis educated Mark about safer sex. Mark was most often topping at the time, but Dennis was adamant about him always using a condom, and Mark thought that was a sensible approach, too. When Mark graduated and moved to California, the two remained in touch, although their contact became less frequent over time. In 2005, ten years after Mark moved away, he got an unexpected call from Dennis telling him he had been injured. Mark found out Dennis had been bashed in the head with a handgun by a younger guy he was seeing and doing drugs with and, Mark thought, "sugar daddying a little." When Dennis tried to break things off, the guy stormed out. He broke back in overnight when Dennis was sleeping and beat him, in Dennis' description with the intention of killing him. Dennis was able to stagger onto the sidewalk and a passerby called for emergency medical services. While he did recover, "he ended up having a brain injury, hemorrhage, he had part of his skull removed, [and] he lost an eye." In Mark's words, this left Dennis "teetering right at the edge of being able to live independently."

Mark moved back to Houston two years later, in 2007, and reconnected with Dennis. When he visited Dennis, he was saddened by what he saw. Mark said Dennis' "wheels were spinning" and he was struggling to complete tasks. He was losing sight in his remaining eye, too. Mark stepped in to provide assistance to Dennis, starting with regular grocery deliveries. Knowing how much Dennis valued independence, Mark attempted to strike a balance that would not undermine him. At the same time, he noticed Dennis declining. Even so, "he was pulling things off well enough that his sister who lived in Dallas didn't even know he had a brain injury. She knew he had facial injuries, but never put it together that it was a brain injury and that he was struggling to keep up with the basics of his life." Less than a year after Mark arrived in Houston, Dennis fell and was taken to the hospital. In the hospital, he acquired pneumonia. "He got HIV in 1982, super early, so he saw a lot of his friends and social circle die. He went through that whole period of treatments and all these experimental medications that he was on and by this time it had been, what, 25 years of living the consequences of long-term HIV." When he was in the hospital, his condition declined precipitously, and he was placed on mechanical ventilation.

Dennis' sister joined Mark at the hospital. Dennis had long been somewhat estranged from his family, and although his sister lived nearby, she knew little about Dennis' current condition, much less what life had been like for him since he first acquired HIV in the early 1980s. When the doctor initiated a conversation about goals of care, Dennis' sister deferred to Mark, saying he probably knew her brother better than she did. Mark found that heartbreaking. "I said, 'I know he does *not* want to go on like this, I can guarantee you. She was the medical decision maker, so we removed the breathing tube and sat with him. He died with me holding his head against my chest, with his sister there. And his sister was like across the room. Even at that crucial moment the, for lack of a better word, gay relationship, you know, kind of was the thing that was driving everything else, above the family dynamic.

"It reminds me of something a gay person told me when I was very young that has stayed with me ever since I heard it. I was at some gay event for a weekend thing, and someone mentioned Black's Beach," which is a notorious cruising destination in San Diego, "and I said something about getting a blowjob in the bushes there. Someone made a comment basically kind of shaming me for doing that. Another older guy said, 'Don't ever let anybody tell you that that is any less important than any other kind of relationship.' It just kinda stayed with me, because Dennis is someone who I had met randomly, in public. And it ended up being such crucial relationship, not only in *my* life, but in turn in *his* life, and in his *death*. We tend to demean those relationships, and maybe a little bit less so now then back then. But it's the people. It's not the situation that is good or bad, it is what it is, but it's the *people* that are brought together."

Opening Mark's narrative with an account his relationship with Dennis highlights the need to treat forms of relationality, like cruising, that are stigmatized or seen as vectors for disease transmission instead with dignity out of respect for the humanity underlying those connections. Of course, the majority of anonymous sexual encounters will not lead to relationships of this existential import. Regardless, Mark sets up an argument that approaching anonymous sex with the idea it is either good or bad is inherently incorrect, because the people brought together by sexual practice have the potential to make a positive impact on one another, whether for a moment, a season, or lifetime. In Mark's view, "It's important for young people to know that and not be shamed. Go get your dick sucked on the beach! More power to you."

Because his entrance to sex was shepherded by Dennis, who showed Mark great care and to whom Mark later returned it, Mark's idea of sexual health in his twenties and thirties always involved condoms. Even with the protection he believed condoms could provide him, "There was always, *always* fear when you had sex. You could be using a condom, but the underlying fear would still be there. I remember just kissing someone that was HIV positive and going to get an HIV test, because maybe I had contracted HIV. From kissing him! I lived under that cloud of fear until probably 2004 or 2005. I even went years without getting tested, because I just knew that I was going to be positive, and I couldn't bear the thought of it. So, I think the fear had the effect of supercharging every sexual encounter with that knowledge of potentially contracting HIV, which was not necessarily a bad mindset to have. That's one of the reasons that allowed me to not contract HIV, when most of my friends were not so fortunate. But it came at the cost of anxiety-tinged sexual experiences for many, many years."

Mark got on PrEP in 2012, the same year it was approved. He was an early adopter of PrEP who followed news of its arrival closely because he had just entered a long-term relationship with a partner who was living with HIV. Before that, “Not for oral sex, but for penetrative sex, anal sex, I would always wear a condom. When I started taking PrEP, eventually I came to feel I had this protective status that allowed me to begin to explore barebacking, which, once I did and flipped the switch and started barebacking, it felt like there was no going back from that. I felt like I couldn’t see using a condom again even though I had used one so many times. Once I started barebacking, that became something I wasn’t willing to give up.”

Mark and his partner had an open relationship, and, once Mark was on PrEP, they were both having condomless sex outside of their primary partnership. Because of this, Mark viewed his use of PrEP as a long-term commitment itself. “I couldn’t imagine a time in life when I would not be sexually active and having sex with multiple people. I didn’t consciously say it was going to be forever, but I thought about it that way. His assumption that he would remain on PrEP indefinitely was challenged over time, when he lived through a period at the onset of the pandemic and after his breakup wherein he was not having sex with multiple people, nor was he in a relationship with a partner living with HIV. Circumstances changed in a way that compelled Mark to reassess what he had come to understand as an axiomatic need for PrEP.

“The COVID pandemic was the thing that kind of started the reassessment of my relationship to PrEP, because if it weren’t for the pandemic, things would have probably continued on in much the same fashion as it had been for the last seven years plus. When the pandemic happened, and sex was not a possibility,” because Mark decided he would not be willing to accept the COVID exposure risk it would entail, “I kind of had to step back and see what my relationship to sex was.” Mark realized he felt under the sway of a “forward momentum” compelling him towards sex, which he attributed to “the availability of Viagra, being on PrEP, being newly single, and having my own space to myself. There were no obstacles in the way of me having sex, so I did. Then the pandemic happened, and the restrictions were in place, and I wasn't having sex. The other fuel I would add into the mixture of Viagra and PrEP is marijuana, which has always been present in some form whenever I've had sex for the last ten years. All those things in combination pointed to a strong likelihood of me having sex." The circumstances Mark found himself in, combined with the "fuel" of Viagra, weed, and PrEP, propelled Mark into sexual situations. Being restricted from contact with others in the early pandemic, however, inspired him to closely probe his motivations.

"I made the decision to stop taking PrEP, not immediately, because my first thought was that I didn't want to interrupt this pattern I had established whereby I was taking the medication daily for so many years. That's not a habit I wanted to break, because when I started taking PrEP, I guess I didn't see that far into the future, but however far into the future I could see, I was visualizing PrEP as basically a lifetime treatment. But the more it went on and the more I saw myself refilling the medication, taking it out of my cabinet—it's not the only medication that I take, but it's one that I take every day—and I just stopped, and I was like, 'Why am I doing this?' I guess my thinking was that I wanted to err on the side of being overly safe, even if that meant taking a medication that for all practical purposes wasn't doing me any good except for the continuity of the behavior I established." Mark made the decision to stop taking PrEP a couple months before he went off it, which he was reluctant at first to do and break his years-long pattern of daily adherence. But, since he was not having sex for an extended period for the first time since he started PrEP, he eventually decided to stop taking his pills.

"When I decided to stop it, I had to learn how to step back into the role of what it was like to lose that layer of protection. When I stopped taking PrEP, I was like, 'Ok, am I gonna use condoms *again*? That's not even a question," he said dismissively. "So the only other option was, well, just don't have sex. So, I decided to see what it was like to not have sex. Without the possibility of having sex, it had the effect of making me reassess my relationship to sex in general and made me stop and reexamine those factors—Viagra, weed, and PrEP—that predisposed me to have sex." Mark stayed off PrEP for over a year. While he did end up restarting PrEP—and still has access to Viagra and smokes weed—"there's something different. I got insight into how all of those things are operating, and it felt like there were some behaviors that were on autopilot for many, many, many years. And stopping those behaviors gave me some insight into how those were functioning to predispose me to having sex. Now, since restarting PrEP, I have had penetrative sex, but I think I have also been making more deliberate choices."

Mark emerged from his year of PrEP nonuse with a "greater desire to be proactive about behaviors, not just sexually, but in general. In terms of my relationship, in terms of my professional career, in terms of social connections. Looking back at my relationship, I had been in it for a while and probably longer than I should have, and I felt like I wasn't able to fully voice my wants and my needs, not only sexually, but personally, as well. Being liberated from that relationship, I had a newfound desire to want to take the reins more in terms of not being swept along by currents that are pulling and tugging at me but wanting to be more forthright in making those decisions. It made me reconsider the notion of consent, even from my early sexual relationships going back to childhood, recognizing that sex is always something that has been *asked* of me, from a very young age. For the most part, I have acquiesced to that. Those factors are always going to be there. If I don't provide this counteroffensive, I'm always going to be the recipient of sexual interest. And for a long time, I just went along with it, and I wasn't using my voice and my personhood to advocate for myself in those situations where I probably didn't want to, or it wasn't something that was very important to me, but I just kind of did it anyway, because it was the path of least resistance."

Whereas in the past Mark recognized an at times reluctant acceptance of sex as something being asked of him from others, his reflection through his year off PrEP instilled in him the desire to express his autonomy, in and outside of the sexual realm. "That meant examining everything that went into the pursuit of sex. It's not only the act itself, but it's the relationships that go along with, whether brief or extended, but there's a person on the other end of the relationship that requires dealing with. The hours that you spend pursuing sex, that can be a lot of your mental real estate that you're devoting to sexual activity. I think as gay people, we had to fight to say that it's ok to have sex, like, full stop. Period. It is *ok*. But that's not the same thing as saying we need to do it 24/7! So, getting past that, that I can have sex, that I can have *bareback sex*, I can do all of those things and not feel shameful about any of those things. But the other side of that is: are you doing it too much?"

PrEP initially provided Mark the opportunity to dive headlong into condomless sex with multiple partners. Over time, and when he got off of PrEP in particular, however, he began to take a hard look at his patterns, probing the role they played in his life and questioning the extent to which they were and were not contributing positively to his overall wellbeing. "The word I keep coming back to is liberation, and those habits and those patterns just began to feel like they were tying me down to a certain way of being that concealed a restlessness and a desire to change. Especially being the younger person in a relationship," as he was with his first regular sexual partner, Dennis, "you're not necessarily driving the relationship. You're kind of the passenger in a lot of ways. And now I feel like I'm on the other side of that, and that feels better for me." Mark reflects on his intertwined sexual and emotional development as shifting from the role of passenger to that of driver. The way he understands his liberation through PrEP is not in that it enabled him to have more frequent condomless sex with multiple partners free of the fear of HIV, but rather that his longer path with PrEP, including when he stopped taking it, liberated him from patterns and practices in his sexual life that were less than desirable, but felt inevitable.

Mark acknowledges his perspective as somewhat heterodox. “You could see sexual liberation as taking PrEP and being immune from the consequences of HIV. You could say liberation is having this medication on board. You could also say that liberation is not having a *need* for that medication, because you’re not having sex. My liberation may not be your liberation. I couldn’t imagine a time when I wouldn’t be having a lot of sex. But the world changes, you age, your testosterone levels drop, your relationship status changes, your geographical location changes, et cetera. I went through a season of relative abstinence because of all that. In a way, that was a kind of liberation.”

This liberation came with a “newfound confidence I had in spelling out the nature of the sexual relationships I was in. In the relationship I was in for 14 years, sex was always assumed to be part of the relationship. As I got older, I saw those two things were not necessarily in concert with each other. You can have a sexual relationship with one person, and you can have an intimate relationship with another person that is non-sexual. Trying to force those two things into the same person became very oppressive, because when sex was an obligation, or it felt like an obligation or a chore, that never felt great either. You want to be a good partner and satisfy their needs. I got to the point where I saw that, for me, a long-term sexual relationship, with my partner or with anybody, is not something I’m interested in anymore. Being at the forefront of this wave of PrEP and barebacking, it’s like, ‘Ok, what’s on the other side of this?’ We’ve come to a cross, or I have at least. A lot of people are still there and no judgment to them, but I’ve been there, and it’s left me wanting in a lot of ways. So, for me, I would like creative collaboration, in whatever way. I like activity-based interactions. And it does make you have to work a little harder, because the path of least resistance is to get together and have sex, which can be great and can be amazing, but [sighs] I need something beyond that.”

What lies beyond PrEP is elided by the risk compensation debate, which shortsightedly constructs PrEP as an inevitable conduit towards long-term, sustained increases in condomless sex and casual partners. Granted that PrEP is a relatively new innovation, it is also true that little research has attempted to explore alternative outcomes. Hector and Mark’s narratives, however, show the value of inquiry that does.

Hector’s use of PrEP kept him safe from HIV, even though it did, at first, lead him into ostensibly riskier sexual situations. Because of his experiences in those situations, he was compelled to reflect on and renegotiate his approach to sex and question how he could bring his sex life closer in line with his overall wellbeing. This led him, in the longer term, towards dialing down his frequency of condomless and casual sex. Mark, at first, perceived PrEP as a lifelong treatment and could not imagine a world in which he was not having condomless sex with multiple partners. When circumstances in Mark’s life and the world around him changed—the dissolution of his long-term relationship and onset of COVID—he paused his sex life and also eventually stopped taking PrEP. In his yearlong PrEP hiatus, he developed significantly different goals for his intimate life. When he started taking PrEP again, sex had been displaced from the center of his understanding of intimate relationships. While sex once represented the path of least resistance in forming connections with other men, Mark’s trajectory with PrEP use followed by nonuse liberated him from a compulsion to travel it. These findings illustrate that longer term trajectories with PrEP may not align with the predictions of risk compensation discourse, and furthermore, that the assumptions made in risk compensation thinking may divert attention from accounts of PrEP use that evidence dynamic change over time.

Conclusion

Tracing the roots of risk compensation thinking in the arena of health research, and specifically its application to "risky sexual behavior," reveals risk compensation debates to represent biopolitical contestations over the governance of bodies and management of life chances. Regarding PrEP and the sexual practices of MSM, such contestations play out through a wide range of forums: epidemiological research, high-profile public statements, the risk assessment and prescribing practices of clinicians, as well as the attitudes and experiences of MSM constructed as "high risk" for HIV acquisition who do and do not use PrEP. By focusing primarily on clinicians and (potential) PrEP patients, this chapter zeroed in on the ways risk compensation is put into practice to show how its pervasiveness in the broader discussion on PrEP implementation contours patterns of access and adherence.

Research examining clinical approaches to PrEP evidenced competing frameworks regarding the clinician's role in managing sexual risk and promoting sexual health. Proponents of PrEP commonly described it as a harm reduction technology, viewing treatment with PrEP as one among several ways to aid their patients in leading healthier lives and remaining free of HIV, regardless of those patients' past, present, and future designs on condom non/use. PrEP-critical clinicians, influenced by the risk compensation debate, instead saw PrEP as a technology that increases risk: a perspective that may lead to efforts towards disciplining patients into the proper risk subjectivity by withholding PrEP, which was constructed as a license for bad behavior. Many PrEP-positive clinicians endorsed non-judgmental sexual history taking centering detailed questions regarding condom use and partner counts as a key mechanism in assessing patients for PrEP. The power relations organizing the clinician-patient relationship, however, meant that these efforts were sometimes still perceived to perpetuate stigma and foreclose space for the articulation and prioritization of patient perspectives on risk, pleasure, and sexual health.

Ethnographic analyses of “high risk” MSM’s own experiences with risk, pleasure, and sexual health provided an on-the-ground, person-centered interpretation of the way risk compensation is lived out and understood. Many participants in my sample who were able to access and adhere to PrEP reported increased condomless sex while taking it, yet still considered their sex lives to be substantially less risky owing to the protection from HIV afforded by PrEP. Many described PrEP as a technology of “freedom” and “liberation,” enabling them to engage a more pleasurable and fulfilling exploration of their sexuality absent the once ever-present fear of seroconversion.

In the accounts provided by Black MSM, medical mistrust came to the fore as a key factor mitigating the extent to which these putative transformations in sexual subjectivity were made im/possible. More so than MSM of other races in my sample, Black MSM described internalizing HIV stigma and the pathologization of their sexuality in particular as risky, which influenced their approaches to and experiences with PrEP. This dynamic prevented one Black participant from dispensing with condoms even with PrEP on board and strongly discouraged another from even considering PrEP, let alone engaging with a clinician in a conversation about it. These data link racial inequities in PrEP access and adherence to the legacy of racialized science, “used to establish and maintain the dominance of one group over another” and “to restrict the activities of the subordinate group” (McGruder 2009, 101). PrEP, therefore, may be understood to augur “freedom” and “liberation” for some MSM while, at the same time, doing little to challenge the persistent pathologization of Black sexuality. As argued by Tapia, McCune, and Brody, (2009) efforts to "uphold 'purity' and 'morality'" undertaken by Black people in the context of racism may result in the elevation of stigma as "the central concern, rather than the material effects of pain and suffering amongst men and women living and dying with HIV/AIDS," or in the case of PrEP, the harms to which people at risk for HIV acquisition are vulnerable (134).

Beyond the risk compensation debate's failure to engage critically with race, another deficiency lies in its inattention to longer term trajectories with PrEP. When examined in the final section of this chapter, these arcs revealed that PrEP may first lead to increased condomless sex, but eventually promote changes in sexual practice in line with hegemonic biomedical constructions of risk. Injecting temporal sophistication into the risk compensation discourse allows for a more comprehensive understanding of the way sexual practices are iteratively and dynamically reshaped over time, providing meaningful counterevidence to the assumption that PrEP is an innovation that threatens the longitudinal degradation of sexual health among MSM, even when understood exclusively from a biomedical, epidemiological standpoint.

The data and analyses presented in this chapter on risk compensation illustrate PrEP's status as a "reluctant object," owing to "its putative association with the supposed excesses of unbridled sex" (Race 2015, 6). Ethnographic evidence demonstrates this alleged association to modulate PrEP implementation, especially by distributing PrEP away from individuals and communities stigmatized as risky based on their sexual practices and racialized identities. Within the context of the risk compensation debate, then, PrEP's potential to depathologize male same-sex sexuality is constrained by misalignment between hegemonic understandings of risk expressed through biomedicine and the way those constructed as at risk for HIV acquisition understand their own vulnerabilities and desires. Efforts to manage the risks of providing PrEP must equally address the risks of withholding access to PrEP, which cause avoidable and unnecessary suffering and underlie widening disparities in access along the lines of race. In order to increase PrEP utilization, risk compensation concerns need to be contextualized through the narratives of PrEP non/users. If and when this is achieved, only then can risk compensation be strategically de-emphasized in favor of interpretations centering the protective agency of individuals and communities facing not only the potential harms of HIV, but also the enduring legacy of racialized science, which continues to pathologize all MSM to some extent, but specifically MSM of color.

Chapter 4

Producing the “Purview Paradox” through Medical Pedagogy

> There can be no education without the charge of sexuality; love, curiosity, and aggression fuel our engagements with knowledge. And yet education—its practices, procedures, rules, structures, and relations—can be undone by the wildness of sexuality. Sexuality will push education to its limit, and education, despite this debt, will try to limit sexuality. This is the charged emotional terrain of teaching and learning about sexuality in schools.
> — Jen Gilbert, *Sexuality in School: The Limits of Education* (2014, x)

On February 11, 2022, ten UCLA medical students, one UCLA staff member, one UCLA professor, one PrEP-prescribing doctor, one PrEP patient, my partner, and I gathered in the Health Equity Hub Space for an hourlong discussion about PrEP and sexual health. Although PrEP had been newly incorporated into medical school lectures in the last few years, this was the first extended and dedicated conversation about PrEP the medical students in attendance described encountering. Why was this their first opportunity to engage in a detailed discussion about PrEP in medical school? Why did this conversation happen in the context of an extracurricular event with a handful of attendees, when there are nearly 180 students in each of the first two years of medical school at UCLA?

Among the barriers to PrEP scale-up highlighted most often during my fieldwork was an overall lack of knowledge about PrEP on the part of clinicians. Oftentimes, this was framed in terms of *comfort*: as in, a clinician expressing discomfort with the idea of delivering PrEP care as an HIV prevention strategy. PrEP is recognized as a U.S. Preventive Services Task Force Grade A-rated, evidence-based best practice to prevent HIV acquisition in patients identified as "high risk," including individuals who are cis and transgender, straight and queer (Owens et al. 2019): why might clinicians not know about it or be uncomfortable with it?

During my research, I observed and heard about discomfort stemming from, or at least framed as, unfamiliarity with the class of medications that are used in PrEP care. Another form of discomfort that was frequently raised was connected instead to a general unfamiliarity with how to lead conversations about sexual health in patient encounters, especially regarding sexual practices outside the ambit of heteronormativity and procreative sexuality. If clincians lack knowledge of and comfort with PrEP, and this is linked to insufficient training on antiretroviral medications, but also sexual health more generally, how do physicians learn what they do come to know about the relationship between infectious disease and sexuality? How do they encounter sexual health in medical school and how do they mobilize their understanding of sexual health in practice? What opportunities may exist to supplement and flesh out approaches to sexuality in medical training? Beyond their relevance to expanding PrEP access, I argue that addressing these questions is critical to improving health care delivery overall.

Drawing together qualitative interviews with medical clinicians across the spectrum of training and my own autoethnographic participant observation as an MD/PhD dual degree student, this chapter interrogates the conditions underlying what the PrEP implementation literature has dubbed the "purview paradox." The purview paradox is a term used to describe the fact that HIV specialists are more familiar with the drugs involved in PrEP care but less likely to see patients at risk for HIV who could benefit from PrEP. These patients are much more likely to be seen by primary care clinicians, who often lack adequate training on PrEP and sexual health and might not understand PrEP care to fall within their realm of practice.

In this chapter, I explore the purview paradox as an outcome of the way physicians are disciplined out of, rather than into, knowledges and practices that would enable them to provide optimal outcomes for their patients at risk for HIV. By positioning the purview paradox as an historically and institutionally conditioned circumstance, rather than an enduring, intractable barrier, I ask whether it can be deliberately unmade through conscientiously designed learning opportunities, beginning in medical school. If not, why? And what do the objections to, or proscriptions placed on, those opportunities reveal about the entanglement between sexuality and biomedicine?

To answer these questions, I first present a focused history of the development of medical education in the U.S., highlighting the rippling effects of a series of reforms instituted in the early 20th century that set the blueprint for the standardization of medical education: circumscribing its focus to encompass pathophysiological processes while excluding necessary attention to health care systems more generally and the social and political context in which medicine functions. I address how non-normative sexuality is brought into focus as the object of education and intervention in medical pedagogy and explore its governance in line with the moral order of biomedicine. When queer health is classed as a "special interest" topic that is optional or even intrusive, too few physicians-in-training encounter substantive discussions of PrEP in medical school. This represents a missed opportunity to educate clinicians on the fundamentals of how to communicate effective with patients around sexuality and gender identity, which beyond being critical to providing competent care to queer and trans patients, is necessary for providing quality, comprehensive health care for all patients, regardless of their sexuality and gender identity.

I go on to explore two mechanisms for how primary care doctors learn to implement PrEP in their practice if they do not encounter it in medical school: 1) in residency or in practice through special trainings, usually because of one advocate or a small group of advocates or 2) through HIV specialists bouncing back referrals with instructions for how to provide PrEP without their future assistance. In closing, I describe the PrEP educational activity I planned and hosted at my own medical school, analyzing the resistance I encountered in attempting to incorporate it into the curriculum. Attendee feedback provides evidence of how it improved upon the PrEP education currently offered and affirms why its integration into the curriculum could work against the purview paradox as a barrier to PrEP access and comprehensive sexual health care in general.

Medical education, socialization, and professionalization: from the culture to the moral order of medicine

The style and content of medical education, in both its "undergraduate"—the confusing term applied in the academy to what we in the U.S. generally call "medical school"—and "postgraduate"—residency and fellowship—guises, has evolved significantly over time. This section traces a brief history of that evolution, highlighting the series of reforms that set the course for the standardization of undergraduate medical education in early 20th century. These reforms perpetuated racial exclusions and narrowed the focus of medical expertise on biological processes at the expense of attention to sociopolitical context and the structural vulnerabilities that produce morbidity and mortality.

Medical education in the United States, unlike in Europe for example, did not originate at universities, nor was it regulated by guilds, two factors that have resulted historically in considerably "more process and outcome variability" in the American context (Custers and Cate 2018, S51). Despite the existence of a smattering of medical schools and faculties—for example, the Medical College of the University of Pennsylvania, founded in 1766—institutionalized forms of medical education remained marginal for most of the 19th and early 20th centuries. Extended apprenticeship typified the principal style of medical training in the U.S. through the mid-1800s when for-profit, stand-alone trade schools became increasingly numerous (Rothstein 1987). These proprietary medical schools, unaffiliated with a college or university and offering sundry curricula with often minimal requirements, offered training that was heterogenous in both quality and character. Students were even eligible to receive their medical diploma from proprietary medical schools without the (now commonsensical) prerequisite of entering a hospital.

The American Medical Association (AMA) played a central role in normalizing and homogenizing medical education. The AMA was established in 1847 following an 1845 resolution to the New York Medical Association calling for a national medical convention to standardize medical education, as well as promote scientific advancement, initiate a program of medical ethics, and improve public health. In an effort to develop and implement nationally upheld guidelines for training, the AMA created the Council on Medical Education (CME) in 1904. From the outset, the CME advocated reform in line with two standards: 1) the establishment of medical school admissions requirements, and 2) the redefinition of medical education to stipulate two years of pre-clinical learning focused on anatomy and physiology followed by two years of clinical training in the setting of a teaching hospital. Fascinatingly, it is only in the most recent round of curricular redesigns that medical schools in the U.S. are departing from this foundational model by shortening the pre-clinical training and transitioning students into the hospital early in year two.

Endeavoring to conduct a systematic evaluation of American medical education in order to roll out these standards, the CME forged a relationship with the Carnegie Foundation for the Advancement of Teaching in 1908. Abraham Flexner, an American educator from Louisville, Kentucky born to German Jewish immigrants, was handpicked by the president of the Carnegie Foundation, himself an advocate of medical educational reform, to carry out the survey. Under these auspices, Flexner visited all 155 medical schools operating in North America at the time. With the exception of Johns Hopkins, which Flexner lauded as a model, and handful of other programs of note in the U.S. and Canada, his impression was resoundingly negative on the whole.

Following his tour, Flexner penned a scathing and now-infamous report summarizing his findings (Flexner 1910). Based on his evaluation, he proposed a series of recommendations to reform North American medical education, including an 80% reduction in the number of schools (from 155 to 31), an increase in the prerequisites for admission to stipulate at least two years of college coursework in basic science, and an across-the-board adoption of the CME's two-part (pre-clinical and clinical), four-year medical education scheme (Barzansky 1992). He likewise advocated ratcheting up state regulation of medical training and licensure. Flexner's work proved highly influential. In short order, medical education was remade in the image he laid out. Within ten years of the report's publication, nearly half of American medical degree granting institutions were shuttered, and nearly all the remaining schools were merged with universities.

To a significant extent, the Flexner Report set the blueprint for the standardization of medical education in the U.S., shaping the contours of medical training to this day. While many observers argue that Flexner's recommendations contributed meaningfully to enhancing the quality of physicians in the country over time, others point out and condemn the pernicious effects of his legacy on physicians and communities of color (Sullivan and Suez Mittman 2010). As Harley (2006) notes, there were up to 14 Black medical schools in the late 19th century; when Flexner penned his report, seven were still training doctors. Following Flexner's recommendations, only two historically Black medical schools—Meharry and Howard—were left operational. Relatedly, the admissions standards established at other schools following Flexner's recommendations severely structurally constrained opportunities for students of color. Completing pre-requisites for medical school was an insurmountable barrier for many students of color in the context of a segregated education system. Overall, the report also “articulated a limited vision of the role of black physicians in America, thus marginalizing black schools and their graduates” (247). Indeed, Flexner wrote that “the practice of the Negro doctor” ought to be “limited to his own race” (Flexner 1910, 24).

More than 100 years later, “Blacks and other ethnic and racial minorities remain vastly underrepresented among physicians and other health professions” as “[p]ersistent educational inequalities and economic barriers continue to make medical education beyond reach for many minorities” (Sullivan and Mittman 2010, 251). Lett and colleagues (2019), for instance, show that while the number and proportion of medical school matriculants of color has risen in the new millennium, the rate of that increase is slower than that of their age-matched counterparts in the national population. Ly (2022) shows the proportion of Black physicians overall has barely budged. Despite ongoing efforts to diversify the physician workforce—which at least at UCLA have made more institutional inroads of late thanks mainly to the activism of faculty of color after the uprisings against racist police violence in summer 2020—numerous studies identify a stubborn and persistent pipeline issue in medical education. Patterned discrepancies in career trajectories between medical faculty of color and their white counterparts (Palepu et al. 2000; Xierali et al. 2021), stemming from an “inhospitable academic climate, perceived institutional discrimination in promotions and tenure, inadequate mentoring, and ‘academic isolation’ of minority faculty in academic health centers” have produced a “shortage of minority faculty to serve as mentors and pathfinders for minority students” (Sullivan and Mittman 2010, 249). At all stations on the long path toward a career in medicine, the structurally limited lack of vertical mentorship takes a toll. Commenting on recent Association of American Medical Colleges (AAMC) data showing meager improvement in representation among faculty—5.5% Hispanic, Latinx, or of Spanish origin; 3.6% Black or African American; 0.2% Native American or Alaskan Native—Guevara et al. (2021) ask, as many others before them have: "Why has there been little or no progress?" The above presentation of the Flexner Report and analysis of the reforms it ushered in shows how racial exclusions in medical training, which perdure today, trace roots to the turn of the century.

Flexner's legacy has also been critiqued for circumscribing the focus of medical education to encompass pathophysiological processes while excluding necessary attention to health care systems more generally and the social context in which medicine operate (Cooke et al. 2006). Flexner's vision, in which medical training hews most closely to human physiology and biochemistry, ostensibly to bring the profession into alignment with the standards and practices of scientific research, resulted downstream in the installation of evidentiary standards and epistemological orientations that undermine the relevance of social, cultural, and political processes in shaping health and the meaning of health care. Duffy (2011) describes this as a "maldevelopment in the structure of medical education in America in the aftermath of the Flexner Report," whereby "infatuation with the hyper-rational world of German medicine created an excellence in science that was not balanced by a comparable excellence in clinical caring. Flexner's corpus was all nerves without the life blood of caring" (275). Even though retrospection reveals the Flexner Report to be problematic, harkening back to it nonetheless provides a genealogical jumping off point for understanding the development and standardization of American medical education as an ongoing historical project animated by underlying ideologies, including racist and epistemologically narrow ones.

In the post-WWII years, with the publication of seminal works including *The Student-Physician: Introductory Studies in the Sociology of Medical Education* (1957) and *Boys in*

White: Student Culture in Medical School (1961), scholars began unpacking these ideologies by carrying out ethnographic studies exploring how they are reproduced and contested within the context of medical training. Such research projects began to make clear that medical education implicates not only the transmission of medically relevant information, a category itself constructed through medical pedagogy, but also the production of particular subjectivities among becoming-physicians via the inculcation of a specific set of norms and values governing medical practice. Employing a cultural studies framework, scholars including Byron Good (1994), Deborah Lupton (2012), and others picked up on these threads in their analyses of medicine and health care as sociocultural constructions. Their scholarship demonstrates how students "come to embody the medical gaze as they learn to see what is relevant data and to speak the language of medicine" as they enter, early in their training, into "the molecular worlds of diseases and therapeutic interventions, the world of medical practice and medical *culture*" (M.-J. D. Good et al. 2003, emphasis mine).

Apprehending biomedicine as a culture furnished a conceptual framework for social scientists to understand how education and socialization function hand-in-hand to produce professionals who think, speak, act, and intervene in accordance with historically sedimented webs of meaning and relation. Biomedicine's webs of significance, to borrow a term from Geertz (2017), have proven tremendously sturdy over time, withstanding shifts in the demographics of medical practice, especially along the lines of gender and somewhat along the lines of race, and ongoing efforts at curricular reform. As many scholars of medical education note, calls for and progress towards redefining medical education have been slow and underwhelming overall.

The biomedicine as culture framework helped to open up to scholarly scrutiny the durable and patterned processes through which norms and values are passed down to and instilled in fledgling physicians. Contemporary scholars, however, have argued that this framing fails to engage sufficiently with power relations and the degree to which biomedicine operates as "a form of social control and cultural authority, perpetuating dominant-class interests by detaching human suffering from the socioeconomic systems that produce it" (Wendland 2010, 12). Inspired by Marxist political philosopher Antonio Gramsci (1971), who popularized the term hegemony to point out how the ruling classes dominate not only through state power but also through coalitions with diverse others including civil society structures like medical clinics, physician-anthropologist Claire Wendland proposed biomedicine be thought of not merely as a culture, but as a moral order. Viewed this way, "biomedicine could be understood as a set of norms, values, tools, and technologies with which the powerful think about, measure, impact, discipline, and work upon the bodies of the disempowered, with nearly everyone involved accepting such interventions as appropriate—or even as moral goods" (Wendland 2010, 12). The culture concept directs analysis towards a body of learned beliefs and behaviors, whereas the moral order concept, Wendland suggests, lends greater precision: "It is *moral* because it is about assigning value, about deciding what is good or bad, and it is an *order* because it is an organizing schema with which we understand our own and others' actions" (ibid.).

In the context of my research on the encounters between biomedicine and queer sexuality, conceptualizing biomedicine as a moral order rather than merely a culture opens up an exploration of how power relations both condition and are reified through medical education. Thinking with hegemony, rather than culture, enables a more nuanced investigation of how dominant modes of thought and action, which become internalized as commonsense norms, are reproduced in ways that trouble a facile distinction between consent and coercion. Like other institutions, biomedicine is neither inherently stable nor immutable; on the contrary, it must be “continually renewed, recreated, defended and modified” (Williams 1977, 112). With this in mind, I turn now to provide an example from my own experience as a medical trainee that illustrates these processes at play.

“Now there’s a great way to go out there and get syphilis!”

Starting in fall 2017, David Geffen School of Medicine (DGSOM) at UCLA began charting the course towards an ambitious new curriculum. Under the propitious moniker DGSOM HEALS, medical learning at UCLA was reimagined and redesigned to “empower students to become physicians committed to excellence and leaders in innovation, research, health, education, advocacy and humanistic care” (UCLA Health 2021). The fall prior, 2016, marked the beginning of my second year of medical school in the now-defunct curriculum, which historically (though no longer) separated the two pre-clinical years of medical school into a first year of physiology followed by a second year of pathophysiology.

While the first year was intended to familiarize and orient students to the *normal* functioning of cells, tissues, organs, systems, and bodies, the second year focused more *negatively*, although no less productively, on aberration, illness, and disease. Within this context, professors and students alike constructed the transition from first into second year as a particularly meaningful juncture: a rite of passage (Gennep 1960) not only pedagogically, but also in the professionalization of us would-be doctors, in that the onset of second year entailed our confrontation with the circumstances and mechanisms that would most often bring us into contact with patients down the road. In line with this scheme, the first six-week learning block of second year covered immunology, microorganisms, and infectious disease: commonly glossed in med school vernacular as "Bugs and Drugs."[1]

About two weeks into the block, on Friday, August 19, 2016, our class played host to a lecture on spirochetes, members of a phylum of highly invasive, helically coiled, gram-negative bacteria known to cause prevalent, and potentially life-threatening, illnesses, such as leptospirosis, Lyme disease, and relapsing fever. The specific spirochete of interest at the center of this hour-long presentation was *Treponema pallidum*, the etiological agent underlying the bacterial infection called syphilis. Syphilis can be transmitted "vertically," meaning from birthing parent to child during pregnancy, or most commonly in the U.S., through direct contact with a *chancre*—a primary syphilis lesion, a single, painless, red sore—during oral, vaginal, or anal sex. Like rates of other bacterial STIs, including gonorrhea and chlamydia, syphilis incidence has risen precipitously in the last decade. In 2019, 129,813 cases of all stages of syphilis were reported: over twice as many cases recorded just five years before (CDC 2021).[2]

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[1] Merely the name "Bugs and Drugs" in and of itself serves as an indication of the way patient experiences and perspectives can be bracketed out of medical pedagogy. Focusing primarily on the pathogen (bug) and antimicrobial agent to combat it (drug) leaves little space to consider the social, political, and historical context conditioning the encounters between individuals, communities, and microorganisms.

[2] Climbing rates of syphilis inspired AIDS Healthcare Foundation—backed by a $1 billion budget, the largest AIDS non-profit globally—to unveil a national advertising campaign in 2014 that included subway ads and massive billboards with the phrase SYPHILIS EXPLOSION spelled out above an erupting volcano set against a Stygian landscape. In a 2016 interview, AHF's senior creative director, Jason Farmer, described his plans for future projects this way: "I have this idea for a vintage horror-film style poster featuring gonorrhea, chlamydia, and syphilis as movie monsters. People could say it's kind of fear-based, I guess. The idea is to have an unknown, unseen monster, like The Fog, that is attacking [people]" (Blum 2016). Peeking inside Farmer's imagination shows how fear as prophylaxis is continually retapped as a mitigation strategy in some public health efforts to stem the spread of STIs. The use of horror-film style visual tropes is obviously intended to evoke an affective regime dominated by fear, which I have argued is counterproductive to, rather than beneficial for, public health praxis.

These troubling data underscore the need for future clinicians to familiarize themselves with this increasingly prevalent infectious disease.

Curricular lectures in medical school are most commonly delivered by practicing physicians. The significant microbiological content of the infectious disease block, however, meant that a good number of talks were presented by "basic science" researchers.[3] As a consequence of the fact that their engagement with the topics in question would most often be organized around the scale of a cell rather than the scale of a body, let alone a population, such researchers typically restricted their commentary in medical school lectures to topics like cell signaling. In the case of this lecture, however, a signal of another order was transmitted, one communicating to doctors-in-training specific associations between pathology and sexuality that were, as I will go on to argue, both pathologiz*ing* and, in and of themselves, actively pathological: that is, generative of morbidity and mortality on the level of the individual and social bodies (Scheper-Hughes and Lock 1987).

Shortly after introducing the subject of his presentation, the professor clicked forward to a slide displaying a graph of overall syphilis incidence in the U.S. beginning in the 1970s. Noting the disproportionate prevalence of syphilis among men who have sex with men, he pointed to a dip in syphilis rates after the onset of the HIV/AIDS crisis, which he attributed to increased condom use. Without pausing to contextualize the emergence of safer sex practices like condom use as the outcome of a community-derived prevention ethic, he plodded ahead to point out a steep rise in syphilis incidence spanning the late 1990s. With the emergence of highly active antiretroviral therapy in 1996, he explained confidently, men were less concerned about

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[3] "Basic science" is a common and essentially neutral term of art for bench researchers who do not claim an expressly translational, i.e. clinical, component to their work.

acquiring HIV, which was then, thanks to the advent of combination treatment, beginning a now clichéd transition from death sentence to chronic, manageable condition. Lack of HIV/AIDS-related fears, he asserted as fact, led to the abandonment of condoms, which in turn resulted in climbing syphilis rates as we headed into the new millennium. Reverting to a discourse of "relapse" (Ekstrand & Coates 1990; Stall 1990; Graham et al. 1998; Roffman et al. 1998) once commonly used in public health to describe a reversion to pre-safer sex practices, he linked diminished concerns about HIV to the increased likelihood of MSM practicing condomless sex.[4] This, he said, reflected MSM's "willing[ness] to go out there and expose themselves to a lot of things."

The speaker clicked forward to the next slide, leaving his audience no time to consider the veracity and underlying logic of his terse explanation—let alone its multiple implications for the way safer sex and the risk-related decision-making of stigmatized sexual subjects should be understood by future doctors in setting the stage for a meaningful care relation. Instead, glowing on a bright yellow background, matching the company's very literally *iconic* brand identity, was a logo I had grown accustomed to seeing on the small, private real estate of my personal cellphone screen and one that I most certainly had not anticipated seeing emblazoned on a projector screen in front of a hundred or so colleagues. As soon as the logo for Grindr—one of the most popular mobile platforms used by MSM to connect for friendship, dates, and sex—

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[4] As Holt (2014) summarizes, "The term relapse was seen to imply failure, recidivism, and a return to bad habits" within a model of HIV prevention focused on the maintenance individual behavior change, specifically regarding the use of condoms for anal sex (217). This model was critiqued for *a priori* designating any form of condomless anal sex pathological and eventually fell out of vogue; nonetheless, the way it shaped the discourse represents a mechanism by which American public health research obfuscated risk mitigation strategies, principally negotiated safety, employed by individuals "at risk" on the ground. Such strategies were, however, observed by researchers in Australia, Canada, and the United Kingdom and to varying extents successfully incorporated into national public health strategy.

appeared, I feared I might not be in for the nuanced and well-contextualized discussion of social networking apps in same-sex sexual communities I believed my classmates and I deserved (Landovitz et al. 2013; Rendina et al. 2014).[5]

At the front of the classroom, the professor, continuing with his lesson, spoke authoritatively about the app and its use. He told us students that Grindr is, above all else, a way for men to meet each other for anonymous sex, linking anonymous sex directly if implicitly to the prior slides on syphilis and positioning its normalization as dangerous and risky. Graphically, Grindr occupied the space that pathogens occupied in other presentations. The message to students, then, was to recognize Grindr as functioning like any other pathogen: a threat to the health and well-being of their future patients. Perhaps unlike most other pathogens, however, Grindr was presented as a pathogen to which subjects (themselves by implication pathological) are apparently wantonly, irresponsibly, and unjustifiably exposing themselves. He punctuated this point in concluding his exposition on Grindr with the jibe: “Now there’s a great way to go out there and get syphilis!”

My immediate feeling was one of embarrassment, followed closely on its heels by a sense of frustration at his gloss, which I saw not only as an incomplete, but also as a deeply unjust portrayal of the relationship between stigmatized sexual subjects and infectious disease. From my studies, community involvement, and personal experience, I knew that queer people, especially MSM, had been compelled to seek clandestine ways of meeting sex partners, fearing

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[5] This would include reference to the history of cruising, highlighting the relationship between oftentimes (semi)anonymous sexual encounters and the criminalization of same-sex sexuality. It would likewise cover how a significant focus of contemporary efforts to end the epidemic involve the use of apps like Grindr as platforms for transmitting health-promoting information (Hoenigl et al. 2020). In fact, research has shown that meeting partners over Grindr may promote serostatus disclosure, condom use negotiation, and communication regarding sexual practices, which can help lower sexual risk (Paz-Bailey et al. 2017; Cruess et al. 2017).

potentially life-upending legal and reputational repercussions for pursuing their desires openly (Humphreys 1970). With the landmark *Lawrence v. Texas* (2003) Supreme Court opinion ruling criminal punishment of sodomy unconstitutional only a little more than a decade in the rearview mirror at that point, I felt that it was both ignorant and disrespectful to impugn stigmatized subjects for seeking out discrete avenues for intimate connection. Beyond that, it struck me as fundamentally unfair to single out MSM for using mobile apps to find sex and to cast that practice as pathological, given the nearly ubiquitous utilization of apps like Tinder, Hinge, and Bumble, which are *not* marketed specifically to queers but *are* framed in public health literature as "just another tool used by young people for their romantic and/or sexual interactions, *without any negative connotation*" (Barrada and Castro 2020, 1). I worried about the implications of Grindr being summarily pathologized as a conduit to a syphilis diagnosis, instead of being framed as a means of forging social and sexual connections, involving various degrees of intimacy, and in line with human drives generally normalized in society.

The weekend following, I wrote an email to the course chair, expressing my concern:

> "While I do find it upsetting that a single provider may hold such beliefs, I am more disturbed at the thought that my 180 classmates might go on in their medical training with this as one of their principal reference points for same-sex sexuality. Although this was a small portion of the lecture, I fear the consequences of not providing a different perspective could be much larger in proportion. Grindr means much more to many people and patients than what it was reduced to in the lecture: 'a great way to go out there and get Syphilis.' For MSM who are in many places and in many ways barred from creating connections and community, Grindr can be a lifeline; in fact, it is even used as a platform for sexual health counseling. Respecting and understanding this is indispensable to providing quality care for MSM; conceiving of Grindr only in the way it was presented does nothing to improve patient care, and instead contributes to the stigma and marginalization that continue to threaten the lives of queer people."[6]

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[6] The course chair responded within a day and, after hearing from a number of other students in the class who shared similar views, swiftly initiated a review process. The lecturer met with faculty and students who shared their concerns and he apologized, privately. Ultimately, the course chair decided not to invite the professor back to lecture in following years, which was seen by the students as an appropriate decision.

While the professor’s glib comment was likely intended to land as a joke, my analysis takes its underpinnings and ramifications with deadly seriousness. It treats them as an invitation to explore the ways that sex’s associations with disease and shame are inculcated in clinicians through their education. Homophobia and sex negativity, both latent and overt, structural and interpersonal, haunt medical education, operationalizing comfort and discomfort to produce specific forms of knowledge and ignorance. Medical education therefore functions as an “orienting device” (Greteman 2019) that can direct medical trainees away from learning how to deliver competent, comprehensive care to patients and populations who are stigmatized and pathologized on the basis of their sexual practices, whether perceived, material, or both. While these circumstances are not at all restricted to the case of PrEP, I argue that the expansion of PrEP access and by extension the efforts to end the epidemic through biomedical means are hamstrung before they leave the starting blocks by the inadequacy of a regressive, conservative pedagogical tradition—medical education—which recognizes its shortcomings to a degree yet takes only halting steps forward. In the meantime, the status quo of medicine, which normalizes illness and death for queers, is conveyed to the next generation of clinicians. Looking more closely at the way this occurs and how it has been analyzed to this point is the focus of the following section.

Bringing the hidden curriculum to light

One of the traditional frameworks through which the transmission of knowledge to medical students has been critiqued invokes the concept of the “hidden curriculum” (Hafferty and Franks 1994; Hafferty 1998). Hidden curricula are the messages conveyed through medical training that are “embedded in culture” and “not explicitly intended,” yet nonetheless “powerfully influenc[e] student and resident norms and values” (Lehmann, Sulmasy, and Desai

2018, 506). Philip Jackson coined the term hidden curriculum in *Life in Classrooms* (1968), wherein he described elementary education as a process of socialization through which values and attitudes, in addition to skills and information, are inculcated in learners. The hidden curriculum concept was first adapted to medical pedagogy in an *Academic Medicine* article published in 1994; since then, it has become one of the principal approaches used to analyze the way that what some observers would call the culture, and others would call the moral order, of medicine is reproduced. Following the hidden curriculum logic, this occurs not only via coursework (i.e., the "formal" curriculum), but also through the examples set by superiors: the stories those individuals share, the attitudes they express, and the rituals in which they participate (Mossop et al. 2013). Because medical training entails learning in highly pressurized, sometimes disorienting environments, hidden curricular messages, while consequential and meaningful, often evade sufficient reflection and critique (Schlesinger et al. 2021). My analysis here joins that of anthropologists who have recently begun to use the hidden curriculum concept to characterize how heteronormativity is reproduced and internalized through biomedical practices (Robertson 2016).

The ontology of a distinction in medical education between knowledge transmitted in "official" settings and knowledge conveyed less formally is substantiated by survey studies of recent medical school graduates. In one such study, conducted in 2016, over half of graduating medical students described dissonance between explicit teaching about professional standards and the example they saw being modeled by faculty (Association of American Medical Colleges 2016). Scholars and physicians engaging the hidden curriculum concept propose that such discrepancies need not always imply a negative valence. "Positive role models may reinforce the character and values the profession seeks to cultivate;" however, "negative ones directly contradict classroom lessons and expectations of patients, society, and medical educators. These positive and negative lessons, which are embedded in organizational structure and culture, are the hidden curricula conveyed in medical schools, residency programs, hospitals, and clinics" (Lehmann, Sulmasy, and Desai 2018, 506). This conceptualization suggests that uncovering the hidden curriculum—making it visible—may enable its positive aspects to be leveraged to bring medical practice closer in line with its supposed core values.

I agree with that supposition and affirm the need to bring hidden curricula to light, especially because the structures underlying medicine's moral order are often black boxed in training. Only when this is achieved can medicine begin to reckon with its true operating nature. Where my perspective differs, however, is regarding the notion that negative instances of hidden curricular messaging directly *contradict* classroom lessons and expectations of patients, society, and medical educators. In the experience of my research participants and that of my own, the extent to which heteronormativity is reproduced may more accurately *align with* "formal" learning and the expectations of medical educators, patients, and society in a broader sense.

Chris, a current DGSOM student, reminded me of an orientation activity intended to address bias that was offered both in my year and in hers but that has since been removed after critical student feedback. "There was one lecture in orientation week where they took a live poll.[7] One of the statements to vote on said, 'I believe LGBTQ people are immoral.' I was like, I don't want to know people in my class think that [laughs]. Luckily, most people responding to the poll marked that they disagreed, something like 98%. But you still look around and you think: what about that two percent? And who is just saying they disagree because they feel like

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[7] Live polling, which involves students responding to questions in real time using remote controls to register votes that are then displayed on the screen, is a common technique used to engage learners in medical school during lectures.

they're supposed to disagree?" Granting the coordinators of orientation the benefit of the doubt, we could imagine that the intended effect of that poll question may have been to demonstrate just how widespread support for queer and trans people is among the entering medical student class. After all, the vast majority of respondents did end up indicating their dissent to a statement stigmatizing LGBTQ people. To Chris, however, the phrasing struck an unsupportive chord; because the question was worded in the affirmative, the positive and homophobic responses were one and the same.

After the updated results were projected, there was no follow-up discussion or contextualizing conversation. The presenters moved on, missing what might have been an opportunity to express institutional support for queer and trans students in the matriculating class, as well as all the medical students' future patients who may identify that way. In reflecting on the orientation activity, Chris felt she and other queer students were made visible in this moment through the formal curriculum, but due to lack of follow-up, the implications of that visibility were left unaddressed, and thus privately interpreted and felt differently by queer and trans students and their cisgender and straight counterparts. An experience of mine in anatomy lab during the first year of medical school provides additional data to support the claim that, where stigmatizing discourses are concerned in medical training, the formal/hidden dichotomy is analytically imprecise.

As scrub-clad first-year medical students, we spent the afternoon studiously stooped over what our instructors referred to as "our bodies"—one of the fourteen cadavers propped prostrate on stainless steel tables, frozen as if feigning an exaggerated response to the feeling of cold metal beneath them. Their utility to us in that moment, however, was that they no longer felt.[8] In the computer lab, during a quick breakout session, we then took turns practicing an abdominal ultrasound exam on each other, and in the quick transition from working on the lifeless to the living, there could be no doubt that feeling fit in somewhere. The sticky blue gel squirted onto the stomach, the slow and methodical gliding of the probe, the nervous darting glances and awkward giggles of titillated nerds. The scene was uncanny in its starkly unsexy eroticism. "Gross Anatomy Lab" acquired another valence.

The exercise wrapped with five minutes to spare. "What else can I tell you guys?" asked the Emergency Medicine attending physician teaching the session, scanning the room eagerly for interest. A hand crept up in the back. "What kind of cases do you usually see?"

"Oh, you name it, we see it," he said with a proud smirk. "Let's see, what can I show you?" He unholstered his phone and began to scroll. Swipe. Long swipe. Pause. "Eh." Long swipe. Suddenly, a pointed finger punctuated the search. "Check this out!"

Whipping the screen around, we saw an anterior-posterior X-ray of a pelvis. We were not meant to identify a fracture, but rather a radiolucent foreign object glowing in the middle of the frame. "It's a Maglite [flashlight]!" His exclamation was met with a swell of laughter as the implication sank in. "He said he slipped and fell… They always do." I wondered, who are "they," why are "we" laughing, and what does that teach "us"?

This reflection, drawn from a field note written early in my medical training, documents just one among many miniature rites of socialization through which physician subjectivity is shaped during training. In his bawdy bid to impress eager students, the instructor humiliated a

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[8] c.f., Young 1997, Ludmerer 1999 for a more thorough discussion of cadaveric dissection as a core component of medical training.

person who became a patient who became the butt of a joke. His actions conveyed, more than simply an attempt at tasteless entertainment, a meaningful lesson to us future doctors. We had been frequently admonished to honor as sacred the fact that our patients entrust us with their stories, bodies, and lives. What was learned in this moment, however, was that this precept is not upheld equally for all patients. In fact, the ridicule of certain patients—particularly those who are already stigmatized—can function to craft community among (future) clinicians.

The vignette above describes an experience that took place within the context of the formal curriculum but implicated informal and hidden curricula, as well. One could reasonably argue that the homophobic undercurrents were hidden, in that they were neither stated explicitly nor necessarily even recognized as such by other students in attendance. Naming these messages hidden, however, rings ironic, in that they were communicated in and through the display of an image. The professor in question presented this image as a, very literally, *glowing* example of practices and pleasures that are evidently pathological and worthy of derision and scorn. If we are to understand this moment as part of the hidden curriculum, and therefore out of line with the expectations of students, medical educators, and patients, we are asked to ignore how pervasive and generally unremarkable stigma against practices associated with anal sex and the people who participate in them truly is.

Imposing a scaffolding on the critique of medical education that relies on the formal/hidden binary is ultimately a distraction from, rather than vehicle for, analyzing the way heteronormative and homophobic discourses are propagated in medical training. A more effective way to apprehend, as a pretext to combatting, heteronormativity and homophobia in medicine is to understand them as structuring forces shaping the field of power relations in which medicine operates. Whether formal or informal, hidden or overt, these forces need to be addressed. Once conceptualized this way, the project of bringing the hidden curriculum to light can be recontextualized as the project of interrogating how the status quo of medicine produces pathology for queers. This, I would argue, is a necessary first step toward developing collective strategies for reorienting medical learning towards the promotion of healing and care instead.

Developing structural competency from a "fractured habitus"

In recent years, MD/PhD physician-scholars with training in anthropology and medicine have made substantial contributions towards this goal by identifying and critiquing the power relations that shape medical training and practice and steward the socialization and professionalization of medical students. Helena Hansen, Jonathan Metzl, and Seth Holmes, along with their collaborators and students, have led the way in advocating a "structurally competent" medical pedagogy that teaches clinicians and trainees to recognize and intervene on the "upstream" forces that condition the presentation of clinical problems and even "the very definitions of illness and health" (Metzl and Hansen 2014, 128). Learning of this sort foregrounds, rather than conceals, how the moral order of medicine is secured and perpetuated.

In their paper coining the term structural competence, Metzl and Hansen critique its predecessor framework, cultural competence (Cross et al. 1989), which proposed training health care professionals to "communicate with patients of different ethnic backgrounds and understand the cultural factors that influence patients' health behaviors" (Hansen and Metzl 2019, vii). Noting that cultural competence did help bring to light what drives the stigma and bias that affect treatment decisions, they question the notion that producing more culturally sensitive medical clinicians will necessarily lead to better health outcomes for stigmatized and vulnerable patients. Metzl and Hansen (2014) hone their attention instead on the "forces that influence health outcomes at levels above individual interaction," by interrogating "how the clinical presentations of persons at both ends of the economic spectrum are shaped by 'cultural' variables, and also by the *economic and political conditions that produce and racialize inequalities in health* in the first place" (127, emphasis mine). In light of this insight, the framework of structural competency necessarily "seeks to expand medical educational approaches to social realms by infusing into medical canon scholarship on the hierarchies, economies, and networks through which health and illness are produced and maintained" (129). Central to the mission of structural competency is the understanding that medicine is political, but that physicians ought not to conceive of "the clinical encounter as the primary site of politics" (132). Rather, they should be trained to recognize, attend to, and fight in coalitional struggles to address the structural problems that produce illness and death for the marginalized, "that make people sick and keep them from getting well" (Hansen, Braslow, and Rohrbaugh 2018). These structures are oftentimes rendered invisible in medical education, reinforcing the notion that "the biological and behavioral world of a patient's body is more important than the social world outside it" (Stonington et al. 2018, 1958). Medical education, then, represents a reasonable place to start in forging new and potentially generative zones of contact where social science analyses encounter medical knowledge about disease and bodies.

To shift medical education away from pedagogical approaches to stigma and inequality that emphasize the relevance of cross-cultural understanding in individual patient encounters and towards macrostructural critique and intervention, Metzl and Hansen enumerate five core components of structural competence: "1) recognizing the structures that shape clinical interactions; 2) developing an extra-clinical language of structure; 3) rearticulating 'cultural' formulations in structural terms; 4) observing and imagining structural interventions; and 5) developing structural humility." The framework they construct and its application by other scholars (c.f. the 2018 “Case Studies in Social Medicine” series published in the New England Journal of Medicine) inspired me to think about how to use PrEP as a vehicle to promote structurally competent sexual health education at DGSOM.

Key to understanding how, and also why these scholars in particular, developed structural competence as an intervention into medical pedagogy is recognizing the specificity of what Braslow and Bourgois (2019) call the “fragmented occupational and institutional habitus” of the dually trained clinician-academic. Braslow, a psychiatrist with a history PhD, and Bourgois, a medical anthropologist with a storied track record of training MD/PhD students dating to the 1990s, argue that MD/PhD students “rise to the challenge of merging theoretical perspectives and practices from the medical and social sciences” (78). The “seemingly intractable epistemological contradiction” embodied by these trainees generates “a productive ‘fractured [discliplinary/vocational clinician-social scientist] habitus’ that makes these budding MD/PhDs reflexively uncomfortable (on both conscious analytical and also preconscious emotional levels) in the two occupational worlds (clinical practice versus social science academic) that organize their lives, shape their intellectual maturation processes, and fund them” (78-79). This has the tendency to promote creative, non-doxic, critical thinking, which, in the best case, compels these trainees to develop careers that synthesize a practical commitment to the provision of medical care with an intellectual commitment to advancing critical social science perspectives on health, illness, and healing. If executed well, this could advance a vision for social medicine grounded in an applied medical anthropology and a theoretically engaged clinical practice.

At UCLA, Braslow and Bourgois have helmed innovative educational efforts towards these ends, engaging not only MD/PhD students, but MD students at DGSOM, in clinically informed, social science projects. These include a regular clinical ethnography field note sharing group and a summer research practicum exploring unmet mental and physical health needs of unhoused people in Los Angeles. Over the years, they have "learned that the most effective way to teach social medicine more sustainably in a way that reinforces idealistic commitments to social justice is to engage students in the same social and medical research problems and urgent human existential contradictions that animate [their] research" (84). While not relinquishing all hope in the future possibility of a core, didactic curriculum of social medicine being required for all students, they have noticed, in the meantime, the promise of pedagogical approaches that immerse medical trainees in social science research settings shaped by and suffused with the structural forces that produce health inequities.

Completing the first two years of my own dual training at DGSOM while formulating research questions about how homophobia, transphobia, and racism produce risk and poor health outcomes for queer, trans, and racialized people, my experience resonates with what my mentors observed. As I carried out the research towards my dissertation, epistemological tensions I saw cropping up at the intersection of medicine and social science inspired me to consider how I might act from my own fractured habitus in a way that could extend structural competence education to medical students. This led me to reach out to queer medical students to learn more about their experiences with and perspectives on training.

Student reflections on the LGBTQ climate in medical training

Queer medical students (n=7) in my broader sample of clinicians (N=23) articulated the need for a structurally informed update to medical training not at all dissimilar to that advocated by dually trained clinician-scholars. Overlapping with but distinct from the fragmented occupational and institutional habitus driving clinician-scholars' interventions in medical pedagogy, however, these students described a specific fracture, rooted in their queerness, between their personal and (budding) professional subjectivities. Their reflections on negotiating that fracture help to identify the ways that both queer students and attention to the structural forces constraining queer health can be marginalized in medical school. Their narratives show that peer support structures function not only as havens, but also as critical jumping off points for organizing collective strategies aimed at desired reform. Dovetailing with a structural competency informed approached, these strategies start from the needs of affected communities and in the best cases plug into their ongoing movements, working against individuation and atomization to transform circumstances that could be alienating into collective struggles for change.

Larissa, a student at DGSOM, discussed with me how her path to medicine unfolded through personal, emotional growth she underwent in her process of coming out. “Roughly at the same time that I was figuring out what I wanted to do with my life career-wise, I was figuring out this important part of myself. Having to ask those questions about myself made me become more empathetic, and that period of time really opened me up to having emotional conversations in general. Discovering my own queerness and starting to probe myself in that way allowed me to be a better listener and learn from the experiences of others more.” Those experiences, which intersected with Larissa’s own and did not, enlightened and politicized her. She had wanted to become a neuroscience researcher, but shifted into pursuing medicine, seeing it as a more direct route into working to combat health disparities produced through structural vulnerability.

Her intention to engage with other queers in medical school emanated from her effort to expand on the web of relations that supported and nourished her in college. “I had built a really good community of queer students during undergrad, and I knew that, to me, that would be an important part of my medical training and where I was going to end up living for the next years.”

Larissa raises here the imbrication of the professional and the personal in her considerations regarding training. When I asked her why she felt that building a network of support with other queers would be meaningful, her answer echoed a message many I spoke with in the course of my research shared. “For me, it might stem from the fact that queer community is oftentimes synonymous with family. I’ve never been quite as close with my family at home, and I found that the queer friends that I made really became my chosen family.” Here, Larissa invokes a kinship dynamic developing outside of the framework of the nuclear family as the reproductive unit of heterosexual normativity—a longtime topic of interest for scholars of sexuality (Weston 1997; Povinelli 2003; Bailey 2013). “I knew this community could become a main support system and a crucial part of my life in this new chapter,” a point Larissa went on to connect directly to her positioning vis-á-vis hegemonic power structures.

“Coming in, I wanted to be sure to stay involved in some kind of larger social movement or stay in touch with that side of myself. Especially in medical school, where you’re trained to focus on the details of everything, I just wanted to make sure I could stay active within some broader social and political context.” Through her engagement with the Pride Alliance, the queer medical student group at DGSOM, Larissa not only drew individual support from, but contributed her energies and allyship to, efforts aimed at improving both queer health education and the climate for queer students at medical school. For Larissa, this involved taking a leadership role in planning a regional conference on LGBTQ health, which in its most recent iteration foregrounded the effect of racism on differential health outcomes for and among queer people. Larissa understood her co-organizing role as an opportunity to support and foster an explicitly intersectional learning environment, which demanded that homophobia, transphobia, and racism be thought together as structural forces undermining health and well-being (Malebranche et al. 2004; Bowleg 2013; Howard et al. 2019).

Larissa's involvement with the Pride Alliance neither always nor necessarily meant occupying leadership roles or being at the forefront of intersectional struggles. For instance, she discussed with me a time when a faith-based organization at another medical school in southern California hosted a speaker on their campus who made transphobic comments in his lecture. The fallout of that event led the Christian Medical Student Association at UCLA to reach out to the Pride Alliance in an effort to initiate a discussion and affirm their condemnation of the transphobic incident. Together, Larissa and Pride Alliance members worked collaboratively with representatives of the other group to craft a statement in response. Larissa, who is cis, said she "felt privileged to be part of the process. I wasn't really the target of the offensive remarks, but I was angry for my trans friends." Larissa let those friends direct the response, and in lending her presence and support, "had an opportunity to try to practice allyship as best I could." Ultimately, in taking a supportive but backseat role, she was able to stand in solidarity with the targets of the remarks and participate in a reconciliation process that strengthened relationships across the lines of identity and experience.

Larissa became active with the Pride Alliance at DGSOM to build community and continue her engagement in movements targeted towards addressing and dismantling the forces that make queer, trans, and racialized people sick. Eli, a medical student at another university in southern California, on the other hand, was drawn into the queer medical student group at his school by a personal experience with discrimination that marred his matriculation.

"You know, I hadn't gotten involved in college with LGBTQ groups and I had always wanted to. Unfortunately, the reason why I got involved at my current institution was less shiny than I would have wanted. I was about to enter my first year of medical school and I was planning to live with another student in a house. We had been talking for almost two months." Eli was moving from out of state to start school and had used an unofficial but university-sanctioned online forum to find roommates. "Right before we signed the lease, the person I had planned to live with said, 'Hey, I noticed that you wanted LGBTQ-friendly housing or whatever. I'm not comfortable with that, so you're not any of *those* are you?" Eli was taken aback.

"I remember feeling confused how someone like that could get into medical school, especially given that this person was awarded a scholarship, too. They were actively recruited, so I think that was both disappointing and confusing that someone who holds those views could get in and almost be rewarded for it." Eli's experience caused him to question the values of the institution, because he believed the university should be accountable for promoting an environment that is, at the very least, tolerant. "I was also confused that someone like that would want to go into medicine, especially at a place like my school, where we're serving a diverse set of patients. So, for someone to discriminate against one underserved community, I just was confused why you would want to go to a school like this." While Eli's start to medical school was tainted by this experience, it also compelled him to connect quickly after the beginning of the school year with the queer medical student group at his institution.

"I felt like after that whole experience, I wanted to work with others to be in a position where I could advocate more directly with the administration to make changes to stop such things happening to future medical students." He told me that because his situation involved a formal complaint with potential legal implications, his school had been tight-lipped and not particularly transparent in their response. "I can tell you from experience that not knowing where they're at is incredibly frustrating because it feels as though nothing's happening." In the meantime, though, he noted “the students that I’ve talked to are enraged and outraged by it, and as much so, if not more than me, demand action.” To Eli, the reactions of his classmates represent meaningful support.

Despite the lack of transparency regarding the school’s response to this particular complaint, Eli described the situation as “a one-off experience” in our interview. In fact, he expressed optimism and eagerness about working to improve the overall climate in meaningful ways for queer students at his school. Together with his colleagues, Eli has helped co-organize panels on queer health topics hosted at his university’s large hospital. He has worked to strengthen mentorship relationships between medical trainees and faculty by aiding in the development of an internal roster of doctors at his institution who identify under LGBTQ. He has also helped develop curricular activities for his classmates. Currently, the most substantial curricular offering his institution provides on LGBTQ health involves groups of students meeting with two guest speakers, one trans or non-binary individual and another gay/lesbian/queer/pansexual individual. Eli called the platform a meaningful opportunity to bring the voices of queer and trans people into medical training and described how they shed light on the embodied experience of interacting with the health care system from a marginalized subject position. Their contributions helped educate learners about the structural and interpersonal barriers faced by queer and trans people in their efforts to access quality medical care and also highlighted how health is constructed and lived out in relationship to broader social forces.

Opportunities to learn that lesson, especially through direct interaction with patients, are rare in the pre-clinical years of medical school. With regard to the way HIV is presented, for example, students I spoke with at various medical schools lamented what they perceived to be a major missed opportunity in the form of a glaring lack of attention to social and political context.

“I’d say in terms of explicit education, they focus on HIV as a virus and its properties,” but “there’s not a lot on the history behind it and the impact it’s had on society,” even though “you really can’t divorce it from social context,” Larissa explained. “HIV has been directly politicized and connected to moral questions in a way that other viruses haven’t,” making it all the more important to explicitly acknowledge that history and the way it perdures in the present as stigma against people living with and at risk for HIV. Salvador, a gay graduate of DGSOM who was and remains very active in advocacy, especially on behalf of queer people of color, put it this way:

“It’s presented so poorly. It’s presented in a way that marginalized bodies are used as teaching tools. AIDS is a perfect example of that. They love to show, ‘Look at this interesting finding in the lung from someone who had fungal pneumonia,’ and they’ll make it all about how interesting the finding is without talking about the humanity of the individual. What’s it like for someone to be diagnosed with HIV? With AIDS? What’s the stigma? What are the non-cellular aspects?” Salvador’s understanding of what comprehensive education on HIV should entail—including, especially, the “non-cellular aspects”—was not represented in the medical curriculum. Instead, a focus on the properties of the virus and its physical sequelae formed the focus of the lesson, obscuring the significance of context and, as Salvador suggested, erasing the humanity of the individual affected.

Queer medical students I spoke with therefore painted an ambivalent picture of the current climate surrounding queer health in several major medical schools across southern California. Larissa and Eli described how their paths to and through medical school were shaped in relationship to experiences of othering, which did not respect a boundary between the out- and inside of medical school or the personal and the professional. They likewise explained how peer support and coordinated action, often organized through queer medical student groups, worked against the potentially atomizing effects of marginalization and towards furnishing meaningful, collective solutions. The students involved in such efforts built power by being explicit in calling out experiences of stigma and discrimination. Naming the social and political underpinnings behind messages conveyed about queers through medical pedagogy—whether specific to HIV or not, part of the formal curriculum or not—is key to supporting queer medical students during training, but more than that, to improving medical education in general and with it, hopefully, health outcomes for stigmatized people.

Curricular concerns

The more that I heard from my research participants about the need to enhance curricular offerings on queer health topics—and bring aspects of the hidden curriculum into the light—the more I wanted to find a way to incorporate my research on PrEP and sexual health into the curriculum for medical students at DGSOM. Lack of clinician knowledge on PrEP and familiarity with queer health in general, which was cited countless times in my interviews with patients and clinicians, seemed to be a logical jumping off point, so I started brainstorming potential contributions to the DGSOM curriculum that could answer the call for improved clinician education on PrEP (Lu, Shearer, and Edelman 2016; Hurt 2018) by extending it to medical students. My conceit was that early exposure to biomedical prevention in medical education might meaningfully improve PrEP access and uptake, thereby positively influencing the trajectory of the HIV/AIDS epidemic. In addition to strengthening students' foundation in the biomedical and clinical aspects of HIV prevention, I additionally wanted to use PrEP as a vehicle to explore the social, cultural, historical, and political dimensions of the HIV/AIDS epidemic through the voices of people it personally impacts.

I thought about the potential of putting together a lecture using data from my research but decided a much more engaging option would be to invite a PrEP-providing clinician along with queer and trans PrEP-using patients into the classroom for a panel discussion. The participants could speak from their experience directly to medical students on topics including PrEP and HIV stigma, queer and trans health, and the structural and interpersonal barriers queer and trans people encounter in their efforts to access competent medical care. Within this educational setting, students would learn the clinical indications for PrEP, but also leave with a strengthened framework for understanding health disparities, especially as they pertain to infectious disease and stigmatized populations.

My panel idea percolated for a couple of months while I emailed up and down the chain of command to find a point of access to the redesigned curriculum. Mentors and former instructors, some occupying high-powered roles in the medical school and curriculum redesign process, expressed their support. They connected me to faculty leaders who could help me determine where my panel might fit. Eventually, a month or so into the academic year, these faculty and I were able to meet over Zoom, late in the evening on a weeknight, to discuss the idea.

I began by describing my rationale for the panel. The expansion of the biomedical toolkit for HIV prevention in the last decade has failed to achieve its potential, I said, because PrEP remains both underutilized and inequitably distributed. Here, I highlighted the racial disparities characterizing both PrEP access trends and defining the contemporary epidemiology of the epidemic. I explained that while lack of physician awareness of PrEP and knowledge on how to implement it has been identified as a significant barrier to scale-up, evidence points to the notion that physician education promotes familiarity with, and increased willingness to prescribe, PrEP.

I went on to enumerate seven discrete learning objectives, parroting a familiar idiom in medical education, describing the goals I hoped the panel session would achieve. These objectives were designed keeping Metzl and Hansen's agenda for structural competency in mind.

By the end of the event, I wanted learners to be able to: 1) Explain the contemporary epidemiology of the HIV epidemic in the United States from a historical perspective; 2) Appreciate where biomedical prevention strategies (specifically, PrEP and TasP) fit into the broader trajectory of HIV prevention efforts; 3) Understand the study data leading to PrEP's approval; 4) Describe features of a sexual history that identify patients as being at elevated risk for HIV acquisition and indicate PrEP use; 5) Identify the tests that should be performed prior to starting a patient on PrEP and the monitoring that should be conducted while a patient is on PrEP; 6) Discuss the interpersonal and structural barriers queer and trans people encounter in accessing health care; and 7) Implement strategies for effective sexual history taking and competent communication with patients from stigmatized populations at risk for HIV acquisition. I identified potential panel participants and explained that with only two-to-three patients participating, the goal of representing the full diversity of identities and experiences encompassed under the rubric of HIV prevention and treatment would be foolhardy. Nonetheless, I said that I wanted to prioritize including perspectives from patients who are men who have sex with men, transgender women, people of color, people who access PrEP through a state, federal, or manufacturer patient assistance program, and those who represent a range of ages, meaning it would be ideal to have *both* younger people as well as people who were adults during or practiced medicine through the earlier days of the AIDS crisis. I described my vision for the format of the panel and included twenty-three sample questions I was planning to ask the clinician and patient participants.

I concluded with a caveat, which one faculty member in attendance had indicated the importance of addressing in an email prior to the meeting. I acknowledged that the event entailed the risk that the breadth and diversity of queer health might be perceived as limited to a discussion of HIV prevention and treatment, which has understandably stigmatizing consequences. I said I thought we could be explicit in the panel about how these associations can be pernicious, and I reassured them that I would make clear that the goal of the session is to situate HIV prevention and treatment as health topics that are significant to understand in order to provide quality, competent care to queer and trans patients (and beyond), but *not* sufficient for a comprehensive understanding of queer health. With that, I closed in saying that my hope was to complement the efforts already underway and not to create more work for anyone or add responsibilities onto already full plates.

The first of four physicians to speak agreed that physicians lack knowledge on PrEP, but said he thought that my activity would be more appropriate for residents and practicing clinicians than medical students. The second agreed, questioning the benefit of speaking with medical students about PrEP; after all, they were at least a couple of years from earning their prescription pads. What would be the point of engaging them on PrEP now? I was prepared to respond to that question but waited to collect all of the feedback before I spoke again. That's when doctor number three jumped into the conversation.

From in front of a virtual background displaying the UCLA Health logo redesigned in rainbow (to signal his identification with or allyship towards queers?), this physician expressed his agreement with the others, but added additional reasoning. He expressed concern that the discussion I wanted to stage could "overwhelm" first year medical students. He said that they, meaning medical educators at the school, wanted to be very careful not to "send the wrong message.” I waited to hear what that message was. He elaborated that they wanted to “avoid associating or delimiting being gay with sexual behavior.” He went on to explain, “You know, like it’s all about PrEP because gay guys just want to have sex.”

In response to their concerns, I first explained that my effort to address medical students was not meant to exclude the education of current clinicians, but rather to extend it. I did not disagree with the premise that clinicians do not know enough about PrEP, in fact this was the justification I shared for planning the panel to start, but nor did I see discussions about PrEP with medical students as inconsequential. It is correct that medical students do not prescribe yet, but they are taught about countless other medications used for treatment and prevention nonetheless, so why not PrEP? Furthermore, the panel’s educational value was intended to extend beyond pharmaceutical awareness to encompass a much more nuanced conversation about sexual health than is typically available to medical students. The fact that these students do not yet hold a prescribing license has no bearing on this goal.

I then addressed the concern that having a frank discussion about queer sexuality would leave students with the impression that being gay is associated with or delimited by sexual behavior. I explained that I understood the premise that dedicating a further portion of the queer health education time allotted in the medical school, which for this academic year was 20 hours, to HIV could potentially fortify stigmatizing links between HIV and queerness. But I expressed my opinion that if one session on PrEP makes it seem that being at risk for HIV is the only significant aspect of being gay, that is a justification for more sessions on queer health, not an argument against the curricular event I proposed.

Lastly, I responded to the claim that conversations about sex and sexuality like the one I wanted to stage could overwhelm first year medical students. I referenced the experience I had in the syphilis lecture (the vignette near the beginning of this chapter) to explain that much is already being communicated to students about gay men's sexuality both within medical school and from messaging they have likely received throughout the years that might be homophobic. The point of my panel was to invite students into a structured conversation where these topics could be addressed in an organized way. If first year medical students are uncomfortable talking about sex with their patients, they will be unable to provide them adequate care, period. This I had heard repeatedly in my discussions with patients on PrEP. If students are not comfortable with that yet, I said, they are in a setting where they can be educated thoughtfully into becoming clinicians who are. If it is the case that this cannot be achieved in medical school, why not? And where can it?

A few beats of silence followed, before the second doctor who spoke asked me what my next steps were now that I had heard there would not be space for the PrEP panel in the curriculum. I thanked them for taking the time to listen to me and reassured them that I got the message. At that point, the fourth physician in attendance suggested I consider staging the panel as an extracurricular event sponsored by the Pride Alliance. He said he understood that the goal was ultimately to find a home for the event in the curriculum, but he saw a lunch talk or evening event for interested students as a pilot project that could be carried out in the meantime. I could sense his intention to express support for the idea, although the ultimate scheduling determination was evidently out of his hands.

I thanked him for his suggestion and explained that while I would likely pursue that avenue, the reason I wanted to make my event part of the curriculum, and therefore mandatory for all students, was that my hope was to reach beyond the community of queer and trans students and their allies. They are likely already familiar with PrEP and more comfortable talking about sexual health than their straight counterparts, according to my research, at least. The final physician, who had been the warmest as well, gave me a virtual pat on the back before signing off. “I just want to say it’s so inspiring to see a student so enthusiastic about an idea.” I knew he meant that to be a compliment, but in the moment, it landed differently. I clicked the button to end the meeting, closed my computer, and cried a little.

Disciplining clinicians: demystifying the purview paradox

In the days following my meeting, I ruminated on a particularly poignant observation a seasoned physician in my research made when reflecting on the state of LGBTQ health in medical school curricula. “Recent stats that I've been looking at indicate that a third of all medical schools don't even teach anything about LGBTQ health. UCLA medical school, which has,” now thumping out each word on the table, “*a gay man's name* on it doesn't teach a whole lot about gay men's health.” In fact, a “curriculum inventory” report released by the AAMC showed that about three-quarters of participating schools included some queer and trans health themes; half of the schools surveyed, however, reported three or fewer learning activities (Streed, Siegel, and Davis 2019). A survey of over 130 medical schools in the country conducted ten years ago revealed the median time dedicated to specific teaching on LGBTQ health was a mere five hours over four years of undergraduate medical education (Obedin-Maliver et al. 2011). This minimal exposure underlies limited self-reported competence in caring for so-called “sexual and gender minority (SGM)” patients (Zelin et al. 2018). Together, these data suggest the need for a more substantial integration of queer and trans health into formal medical curricula in order to reach all learners and prepare them for the inevitability of working with and caring for patients who are part of those populations.

This is what I had hoped to play a part in pushing forward by staging the PrEP panel event. Nonetheless, the physicians I met with expressed concern: they thought the panel and its frank discussion of PrEP and sexual health would be ancillary to or inappropriate for the education of medical students. They also thought the event might be dangerous in that it could threaten to instill an erroneous conception of gayness, perpetuating its associations with risky sex and HIV. Framing an extended conversation about PrEP as a "special interest topic" that either did not warrant inclusion in or could be disruptive to the main curriculum, they suggested I stage it in an optional setting.

The treatment of queer health topics as separate from and intrusive in medical pedagogy was a dynamic raised by several clinician interlocutors in my research. Dr. Lopez, for example, shared the challenges they faced when attempting to integrate queer health into their medical residency training. These obstacles *discipline* clinicians—in Dr. Lopez's case, very literally, leading to six-months of probationary review and intensified surveillance—while simultaneously producing *disciplinary* exclusions whereby queer health is bracketed from general medical knowledge. Such disciplinary mechanisms thereby actively produce lack of physician facility with topics relevant to queer health, which is a well-documented barrier to increased PrEP access and uptake.

Dr. Lopez is an early career family medicine physician in Los Angeles who both identifies under LGBTQ and provides care to patients in a practice serving primarily queer patients. When I met them, they had already made their name as an outspoken queer health advocate online interspersing infographic posts about topics like STIs with full fantasy photo shoots and memes covering the abc's: anti-capitalism, bottoming, and chemoprophylaxis. As they are a trusted source of medical information for so many queer people, one might reasonably expect them to have had exposure to sexual health, HIV prevention, or queer health topics in medical school. In light of the statistics shared at the opening of this chapter, however, I was unsurprised to hear that this was not the case.

"None! None. I had to make it up for myself while I was in residency, because as a med student, I was exposed to none of it. There was no talk about sex, no talk about queer health, nothing." Dr. Lopez first saw the unique health care needs of queer people acknowledged in a medical context during their final year of medical school when a preceptor suggested they read a ten-page article, "Best Practices in LGBT Care: A Guide for Primary Care Physicians," published in the *Cleveland Clinic Journal of Medicine* (McNamara and Ng 2016). Reading that piece led Dr. Lopez on a path of self-learning, setting about to siphon up all the queer health content they could find online. In residency, Dr. Lopez endeavored to share what they learned by educating their colleagues.

Trainee-led presentations are a cornerstone of graduate medical education, ritualistically incorporated into residency. Delivering morning report, leading a case-based didactic session during lunch, teaching on rounds—these pedagogical practices structure and organize medical education "on the wards," meaning in clinical settings. Dr. Lopez felt compelled to integrate their queer health knowledge into the residency curriculum through these avenues, because neither their co-residents nor attendings were proactive about doing so. When Dr. Lopez was, however, that was not received well; in fact, they believe they were retaliated against for it.

"I made it my effort, that if I was talking about diabetes, hypertension, what have you, I would incorporate some sort of LGBT health component, without coming off as a one trick pony. I was still talking about general medicine but including queer health with it." Dr. Lopez thought they were simply filling a gap and did not perceive their intervention to be at all out of line, much less a liability. Quite the opposite, they saw it as a unique and valuable contribution to a program where this realm of knowledge would otherwise not receive sufficient, if any, airtime. As it turned out, though, they were alerted to a cause for concern when they were abruptly placed under review for a period of six-months. Their initial reaction was shock, because in their first year of residency, they were awarded the distinction “Most Impressive Intern of the Year,” and on top of that, their reviews were consistently positive. When they followed up, flummoxed, with the faculty member who initiated the review, that attending hedged, before settling on what sounded like a specious explanation: the faculty thought, as a group, that Dr. Lopez “lacked basic medical knowledge.”

“After that, I cornered each of my attendings one by one and, being the petty person that I am, I singled them out. I said, ‘Hey, so I heard the faculty had a meeting and you all expressed concern that I lacked basic medical knowledge. I'm trying to improve upon my skillset. Can you please tell me about a time that I lacked basic medical knowledge that you found concerning?’” By requesting this sort of feedback directly from their supervisors, Dr. Lopez was behaving exactly as medical trainees are instructed, but apparently, in this case, to no avail. “Not one of them could give me a point in time, and they all tried to throw each other under the bus.” Exasperated, Dr. Lopez put their head down and plodded forward, but also cloistered themself and withdrew their energy from extracurricular interaction. “I kept my mouth shut. I didn't make small talk. I didn't look [the faculty] in the eyes. The only time I spoke to them was when I had to present a patient. The few months were up, and they were like, 'You've done so well [said in a patronizing tone].’ But that was a really stressful and weird time.”

When I asked Dr. Lopez why they thought that concerns about their medical knowledge were raised despite a lack of corroborating evidence, they said, “I still don't know. One person vocalized that they were concerned that I was so focused on LGBT health that I wasn't focusing on other topics. But that wasn't true. I've looked back at the list of all the presentations that I've done.” When they did, Dr. Lopez saw how the queer health content constituted only a small number of slides in each deck. “But even if I was [focusing on LGBT health and not other topics], nobody else is giving lectures on HIV. Nobody else is giving lectures on trans health. If these were things that lots of other people were already talking about and replicating, I get it. But nobody was doing it. So, for me to sort of come under fire for it… It just sucked. That whole thing left a bad taste in my mouth.”

Dr. Lopez’s good faith attempt to enhance queer health education ended up almost costing them their career. Even though they passed through the disciplinary review process at the conclusion of the six-month period, they were not unscathed by the experience: their relationship to their colleagues and to their profession in general was damaged. Theirs is one of the most severe stories along these lines shared with me by recent medical graduates. I recognize the consequences for Dr. Lopez to be far more damaging to them than a case of hurt feelings in my situation was to me. At the same time, I trace in Dr. Lopez’s story a dynamic that likewise haunted the curricular meeting: the construction of queer health education in medical training as somehow part of a zero-sum game.

Dr. Lopez was sanctioned, in their understanding, because the attendings in their program thought that attentiveness to the specificities of queer health impinged upon, rather than enhanced, their basic medical knowledge. This leads to the question: why is queer health content readily positioned as both ancillary to and in competition with basic medical knowledge? Grappling with this question is key to demystifying the “purview paradox,” a well-established barrier to PrEP access (Pinto et al. 2018).

In 2014, two years into PrEP's FDA approval, *AIDS and Behavior* published a notable qualitative study characterizing HIV clinicians' perceived barriers to and facilitators of PrEP implementation across care settings (Krakower et al. 2014). In this paper, researchers introduced the term "purview paradox" to describe a pattern in the data "whereby neither HIV specialists nor PCPs considered PrEP implementation to fall within their clinical domain" (1716). HIV specialists are, among clinicians, most familiar with the management of patients taking tenofovir-based pharmaceuticals (or other antiretroviral agents which may become part of the PrEP repertoire in the future, for that matter). They are less likely, however, to encounter patients who are HIV-negative and therefore candidates for PrEP. These patients are more likely to be seen by primary care providers (PCPs), who, due to lack of appropriate training, are often less familiar with the medications involved in PrEP care, as well as the candid conversations about sex useful in identifying patients who would benefit from it. They are thus less likely to provide PrEP.

HIV specialists in my study affirmed the ontology of the purview paradox and its deleterious consequences while also sharing their strategies in working to overcome it. Dr. Simons directs a large clinical program on PrEP in a network of primary care clinicians. Over the years, he has presented on PrEP to medical students, residents, practice groups, and even the audience of Grand Rounds—a regular, institution-wide, multidisciplinary assembly—at a large hospital in LA. Hesitancy he has encountered from primary care providers in these settings stemmed, he explained, from unfamiliarity with the medications used for PrEP coupled with a general discomfort in leading conversations with patients about sex. Leaving the latter aside for now, he continued, "When you have more in-depth discussions about prescribing PrEP, PCPs tend to focus so much on the class of medications and the side-effects, because they're just not used to that entire set of medications. Really, the medications that were chosen for PrEP were chosen because they're easy medications to take with pretty rare, simple to manage side-effects, and I make sure to share that." Here, Dr. Simons supplies evidence to support the purview paradox hypothesis. Whereas HIV specialists would not balk at the sight of an antiretroviral prescription, PCPs, lacking experience with these medications in the setting of HIV *treatment*, are more reticent to incorporate them into their practice for the purpose of HIV *prevention*. In Dr. Simons' experience, however, this barrier can be anticipated and overcome through basic training.

Dr. Wu, a family medicine physician who completed an HIV medicine fellowship and describes himself as "PrEP passionate," corroborated Dr. Simons: "PCPs feel like PrEP and HIV are not within their realm of practice." Dr. Wu developed his own creative way of managing the purview concern around the pharmaceuticals when speaking with such physicians. "My motto or little spiel about that is that there's no easier chronic condition to manage than HIV. Primary care providers are so comfortable prescribing x, y, and z oral diabetes drugs that have way more significant side effects, way more hoops to jump through in monitoring, and not even the same level of efficacy in terms of disease-oriented outcomes as PrEP vis-á-vis HIV prevention." Dr. Wu's strategy, when faced with reticence rooted in concerns regarding the class of medications, is to draw a parallel between HIV and other chronic conditions, the prevention and treatment of which are unquestionably seen to be within a PCP's scope of practice. His basic message is that physicians *ought* to learn, and be taught, about the medications used for PrEP. As another physician in my sample, Dr. Alston put it, "It's like, it's not brain surgery [laughs]. It's pretty simple, but yet getting it off the ground has been hard."

Even though the HIV specialists I spoke with expressed their frustration at the dearth of general knowledge regarding PrEP among PCPs, they were sensitive to the struggles of their generally overburdened generalist colleagues. Dr. Simons expressed empathy for the challenges PCPs face in their attempt to stay up to date with the latest recommendations, especially in a highly technologized era of biomedicine characterized by a seemingly endless deluge of novel diagnostic and therapeutic advances (Clarke et al. 2010). "PrEP was not a thing when a lot of providers practicing now were still in training. So, especially with regard to community providers who don't do as much continuing education [as academic medicine physicians do], it means that often the only people who are going to actually get training on PrEP are people who have some motivating factor where they're seeking out their own training. There are *a million* things primary care providers are trying to do with their patients and so it's much easier for providers to then be like, 'I don't know exactly how to do this, but I'll find out where you can have it done.'" Even that scenario plays out less often than Dr. Simons would like, because although he "would hope that most providers are pretty open about the fact that no doctor knows everything, I mean, let's be real, there are lot of providers that don't feel comfortable saying, 'I don't know,' right? Even having a conversation saying, 'I don't know everything about this medication, but I know it can do this, this, and this and I can hook you up with someone who knows more about it.' I mean, even having that open of conversation could be hard for providers; that's something I've encountered."

Dr. Lopez communicated a similar argument when describing unwillingness among physicians to admit the limits of their knowledge—a necessary precondition to learning more. "The other thing is that doctors are a certain type of person. In a cis, white dominated field," which I have argued post-Flexner reforms helped secure, "they're very much like, I've learned what I've learned, and that's what it is. Even as a med student, when you do rotations, you find that doctors do not tend to go out of their way and update themselves on new medical information, because what they learned is what they learned and that's what it is. I have found it's very hard to open up their mind to learn more."

With respect to this dynamic, Dr. Simons sends a simple message to residents in his teaching on chemoprophylaxis: “PrEP is very easy to do. If you don’t feel comfortable doing it, you can always reach out, and we can try to help you feel comfortable. But if not, for the good of the patient, *refer*. By all means. If that’s what it takes to get your patients what they need, then send them to us.” Even though Dr. Simons knows “we would have much better uptake of PrEP if it was just coming from a patient’s PCP,” he recognizes the reality of the situation and, to prioritize patient access, promotes referral as a last-ditch option. Knowing how many patients are “lost to follow-up,” and how especially more vulnerable patients might be less likely to make it to yet another appointment (when it might mean taking several buses, asking for additional time off work, needing to find alternative care arrangements for loved ones, etc.), this is far from the ideal outcome. During my research, I did hear stories from patients and clinicians about HIV acquisitions that happened in the time between visits. In the past, I have heard medical and public health professionals frame these acquisitions, which should have been averted, as patients “falling through the cracks.” Ultimately, that orientation veers easily into victim blaming discourse, when an examination of structures and practices that create these “cracks,” gaps in purview in the context of a patchwork (and threadbare) health care system, is what would be more productive. Even though the referral patch Dr. Simons proposes does not fundamentally subvert the logics structuring the purview paradox, it represents a single physician’s best effort to achieve the highest quality of care for patients.

Dr. Bernstein, an internationally renowned expert on PrEP, echoed Dr. Simons' point about the pace of medical advance and the burden on PCPs. "Unfortunately, the volume of information that technology has allowed doctors to now have access to has moved forward medical progress at an exponential rate that's also made it virtually impossible to keep your fingers on the data and current thinking and standards across every discipline. I would *not* want to be a primary care doctor today, because it seems to me like an unthinkably complicated and difficult task to be a Jack-of-all-Trades in that way." Reflectively, he continued, "It's very easy for me to sit here and say giving somebody Truvada-based PrEP is not rocket science, it's not chemotherapy, and anyone should be able to do it." He then toggled back, saying, "In fact, everyone *needs* to be able to do it, because as an HIV specialist, I'm not seeing the people who are negative and at risk—*you* [the PCPs] are." But while underscoring the necessity of overcoming the purview paradox, Dr. Bernstein also recognizes the particularity of his position in the debate and does not seek to cast aspersions on clinicians who know less. In fact, he relates to them.

"When I have an HIV patient who I'm seeing who has diabetes and they're refractory to metformin, I'm sending them to endocrinology immediately. When I have someone who is hypertensive and refractory to one or two agents that I'm comfortable with, I'm sending them to cardiology. It's a little bit of 'those who live in glass houses shouldn't throw stones,' because the complexity of each of these fields at some point becomes beyond the purview of a generalist." Dr. Bernstein acknowledges the absolute necessity of collaborating with specialists; to secure the best outcomes for his patients living with HIV, he consults experts with a differentiated set of skills and does what is called "referring out," meaning coordinating the hand off of a patient to another clinician or care team. Regarding PrEP, however, Dr. Bernstein, much like Dr. Simons, sees PCPs referring their PrEP patients to specialty care as a prime opening for education.

"I try to ask myself, if this provider is sending me this patient, is it because they just don't know? I've had a couple providers who've referred me a bunch of patients. I see them, do the consults, and I send them back to them and let them know this is what you do. The next time, they're comfortable doing it and they only send me more complicated cases. That's great because I feel like we've advanced their fluency in this way of thinking." On an individual level, Dr. Bernstein responds to the purview issue from his position as a specialist by empowering the primary care provider consulting him to learn how to implement PrEP effectively without his future assistance. If we imagine that those providers make PrEP more accessible for their patients following this interaction, we can see how small-scale improvements to PrEP implementation can be made when specialist physicians *resist* the logic of the purview paradox by teaching their colleagues how to prescribe PrEP. We can likewise understand how this would lead to an improvement in care from the patient perspective, too. As noted by Dr. Bernstein, "I try not to judge, but I think [PCPs who do not prescribe PrEP] are doing patients a disservice by not being able to provide them a more holistic approach to their health. I'm sure the patient would prefer to do PrEP in a one-stop shopping environment if that were possible to do in a competent way." Through my research, I learned that the environments Dr. Bernstein describes are, in fact, real. Creating more of them will be enhanced by providing clinicians the training and perspective necessary to make this vital innovation in HIV prevention science, PrEP, work *in situ*. The bounce-back model of learning to refer and then adopt is a commonsense measure that could be promoted in the meantime.

The voices of clinicians on the specialist side of the purview paradox demonstrate that the feeling among PCPs that PrEP falls outside their scope of practice does in fact limit the provision of PrEP care. But importantly, they also indicate that the purview paradox can be relatively easily overcome when clinicians are simply educated about PrEP and how it can be implemented as a clear best practice in preventive care. Will there still be physicians who, regardless of training, fail to engage with PrEP because of stigma undergirded by a moral judgment about the "bad behavior" they fear it might authorize? According to the HIV specialists in my study, yes. But I also heard from them that such clinicians constitute a small fraction of the PCP population, at least in Los Angeles, and that a significant portion of PCPs can successfully learn to integrate PrEP into clinical care.

Dr. Shockley heads up PrEP programming at a 30+ clinic network of federally qualified health centers (FQHCs) in Los Angeles. During her tenure, she has overseen the rollout of a training program on PrEP, funded through a California Department of Public Health Office of AIDS grant, intended to improve physician and pharmacist education on PrEP and PEP.[9] The training is structured in two parts, each of which addresses one of the two major areas of concern that Dr. Simons and others described encountering when introducing PCPs to PrEP. "The first part is more on the social side, so explaining sexuality, gender identity, how to take a sexual history, and how to make your practice more inclusive." This, according to Dr. Shockley, is a necessary precondition for bolstering PrEP care, but more than that, it is a compensatory form of education that makes up for a lack of training on these topics, in medical school and after, which

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[9] Under Senate Bill No. 159, passed on 9/11/2019, California pharmacists are authorized to dispense 30 to 60 days of PrEP and PEP without a prescription, after a negative HIV test and counseling. Pharmacy-based PrEP interventions are a vital and active area of research in public health, especially work focused on utilizing pharmacies to distribute PrEP among MSM who may prefer to avoid the doctor's office (Crawford et al. 2020).

are relevant well beyond the realm of HIV prevention and treatment. Even if PrEP were not in the picture, educating clinicians on the basics of how to communicate effectively with patients around sexuality and gender identity is critical to providing competent care to queer and trans patients, as well as their straight and cisgender counterparts. “The second training covers more of the clinical side of PrEP and PEP: labs, follow-up, things like that.” Across both sections of the training, Dr. Shockley’s team emphasizes the disparities in PrEP access, on the basis that “if you know that your patient population is affected by HIV, but few are taking PrEP, you have more of an impetus to provide it.” Dr. Shockley’s own interest in PrEP was sparked when she learned about the disparities in access, especially for people of color and cisgender women at risk for HIV. Without mentioning structural competence explicitly, the approach Dr. Shockley created in the training program resonates with its tenets by educating clinicians on the structural vulnerabilities that put marginalized people at risk for HIV.

In the year 2021 alone, Dr. Shockley’s grant-funded educational programming reached 176 primary care providers (physicians, nurse practitioners, and physician assistants), 7 RNs, 121 clinical staff, 38 pharmacists, and 36 other employees, totaling a whopping 372 individuals trained. Pre- and post-training surveys completed by 117 and 84 of PCPs, respectively, showed that education on PrEP, LGBTQ topics, and sexual health significantly increased *both* self-reported *and* tested PrEP/PEP knowledge among PCPs in a large FQHC setting encountering underserved communities disproportionately impacted by HIV. PCP comfort discussing gender identity improved from 32.1% to 52.4%, the percentage of attendees rating their knowledge on PrEP as “good” went from 38.2% to 83.1%, and knowledge assessment score averages increased from 11 to 18. Comfort discussing sexual orientation jumped from 47.7% to 64.3%, and the proportion of attendees reporting they were completely willing to prescribe PrEP changed from

58.7% to 70.2%. The efforts of Dr. Shockley and her team to improve clinicians' ability to lead conversations about sexual health and to enhance clinical acumen regarding the medications and monitoring involved in PrEP care are a shining example of the way that the purview paradox can be progressively unmade. With grant funding support from the state, Dr. Shockley and her mission-driven team have utilized their organization's sizable clinical footprint to disseminate PrEP knowledge. Their success in this endeavor demonstrates how networked, coordinated strategies implemented on the level of health systems (rather than between or among individual clinicians) are a promising avenue through which to promote PrEP.

Even so, Dr. Shockley acknowledges, "There's a group of providers who many never join the trainings. I have not gotten a chance to talk to the people who are against it. I reached out to at least one person who I heard may have concerns, but that individual has not responded to my emails. You'll have people who will absolutely not want to join, and they will be the hardest to reach." Despite that, the feedback to the training program has been overwhelmingly positive.

The collected voices of HIV specialist interlocutors in my sample demonstrate that while the anchoring realities behind the purview paradox are material and meaningful, the purview paradox itself does not represent an enduring, intractable barrier. I would argue that the purview paradox is an outcome of the way physicians are disciplined *out* of, rather than *into*, knowledges and practices that would enable them to provide optimal outcomes for their queer and trans patients. The purview paradox is merely a construction—a historically conditioned circumstance, not an ineluctable fact—that can and should be deliberately unmade through enhanced training for physicians that orients them *towards* being able to provide PrEP care.

This is precisely the justification for the PrEP event I planned, which was designed to reach medical students before they differentiate. My aim was to spread information regarding the medications used for PrEP and the clinical indications for PrEP, while also providing a platform for a discussion about best practices for approaching conversations about sex and prevention with patients at risk for HIV, including queer and trans patients. My premise was that if this were to be achieved, all graduates of DGSOM, most of whom will not go on to be HIV specialists, will be aware of PrEP and understand that providing it is not outside a PCPs scope of practice. Yet, when I presented the concept to this particular group of faculty, it was treated as a beside-the-point distraction unworthy of occupying time in the curriculum. I was questioned why I would want to initiate conversations about PrEP with medical students. If they only first earn prescribing privilege after a few more years of training, why bring up PrEP to them now?

I argue that deferring these conversations and refusing to engage medical students in them propagates a disciplinary distinction bracketing queer health from general medical knowledge. This artificial division, which my interlocutors confirm to be present across various levels of medical training and practice, is ultimately destructive. It is deleterious not only to the individual health of the specific patient, but also to the health of the broader communities to which they belong. Furthermore, it works against the capacity of biomedicine to promote the health and well-being of those communities. The positioning of PrEP and queer sexual health topics outside the purview of undergraduate medical education represents an early way station on a much longer trajectory towards reifying the purview paradox. Through this mechanism, PrEP care, and comprehensive sexual health care for patients marginalized based on their non-normative sexuality or gender identity, is reinscribed as the proper object of niche, specialized subfields within medicine; in reality, as the USPFTF 2019 recommendations state clearly, it is best practice, full stop.

Extracurricular Activity: Staging the Biomedical Prevention Panel

When I reached out the Pride Alliance, they were eager to help bring the PrEP panel to life as an extracurricular event. In addition to advertising to their membership, they supported it by applying for gift cards from DGSOM to compensate the panelists for their time. I was fortunate that the first clinician and first patient I asked to participate were willing. The clinician participant was Dr. Alonzo, a primary care provider board certified in Family Medicine who specializes in HIV, as well as queer and trans health. Dr. Alonzo brought to the event their experience using and prescribing PrEP, their perspective on best practices in promoting sexual health, and their reflections on training and practice as a queer physician of color. The patient participant was Camila, a community health worker currently employed by a large service organization in a role providing peer support for transgender women and MSM including by helping navigate them to PrEP care. Camila had herself been taking PrEP for over a year. She therefore brought to the panel not only her professional experience helping others access PrEP, but also her personal perspective as transgender Latina who has incorporated PrEP into her life.

I began by introducing the panelists and providing a short, structured introduction to biomedical HIV prevention within the broader landscape of the ongoing epidemic. I brought up the data supporting PrEP’s efficacy and safety and pointed to its potential, given increased uptake, to substantially decrease rates of HIV incidence. I highlighted current disparities in both rates of HIV incidence and PrEP utilization, providing a broad overview of the barriers to more widespread PrEP uptake—for example, cost concerns, poor access to health care, medical mistrust, and the intersection of HIV-stigma with transphobia and homophobia. I explained that while each of these barriers could be the focus of its own educational activity, the one I intended us to discuss today was the fact that studies show lack of clinician knowledge of and comfort with PrEP to be a significant roadblock. “Part of that is because clinicians may not know about how to incorporate the medication into their practice from a technical perspective,” I said, “which we will discuss today. But part of that is also because clinicians may not have had opportunities in medical school or through training to learn about and engage with what it means to provide comprehensive sexual health care, including medications like PrEP, to queer, trans, racialized, and stigmatized people, who may already face challenges accessing care.” With that, I began a moderated discussion between Dr. Alonzo and Camila.

Dr. Alonzo described their path to personal PrEP use, which provided a foundation for implementing PrEP in their clinical practice. “I became really interested in PrEP because my primary care doctor brought it up with me at some point while I was in med school, and I had never heard of it. When I started to want to prescribe PrEP in residency, none of the attendings had ever heard of it. I was shocked nobody knew what it was. At first the attendings were very skeptical, saying we don’t know how it works or how to implement it. I said, ‘It’s literally just a medication you prescribe, you see patients every three months, you do the labs. It’s not difficult. So, I added it into a bunch of lectures and implemented it that way. Eventually, people just got the gist of it.”

From the patient side, Camila explained, “I had heard about PrEP here and there, but I didn’t really know what it was. I was thinking it was an HIV medication. When I went to go see my primary care doctor to start my medical transition is when I really learned about PrEP. I wasn’t sexually active then, but I told him that I would think about it when I was thinking about becoming sexually active. At my next hormone bloodwork, 90 days later, I told him I wanted to know more, especially about side effects, which was my main concern.” Camila did experience side effects initially, which resolved in a couple of weeks. “At first, I did get a little bit sick in my stomach, but that went away. Now I take it faithfully. Like even if I'm running late, it's the last thing that I grab and I take it on the way to work. It will be two years in July."

I asked Camila if she received any encouragement from her medical team in persisting on PrEP. "One thing that helped me understand it more and how important it was is that there was a nurse who checked up on me for the first 30 days once per week. At first that kinda had me concerned a little bit, like why is she checking on me for this pill? Like, it's just a pill. But I think that helped me a lot. Because of that support and her being present and calling me, it made me feel like it was more than just a pill. It was something to prevent me from contracting HIV, which is something that I've always feared. That support helped me a lot."

Dr. Alonzo underscored how the students in attendance could, in their role as clinicians, help provide that support. "Remember that just because you know things and they're common sense to you medically, it doesn't mean it's that way for everyone. You should explain what the medications are, why you're giving them, what the possible risks and benefits are, and follow up with people. Granted, patients may not follow up, but it's your responsibility to make sure they understand what's going on before they walk out the door. The last thing we want to do is just talk over somebody, tell them what they're going to do, and they walk out the door leaving with no idea of what's going on."

Camila shared, from her personal experience, why the approach Dr. Alonzo critiqued could be not only suboptimal for, but also dangerous to patients. "It matters a lot when you have somebody that will show you how to take care of your health. Especially being a transgender woman, my first fear because of experiences was: is this doctor going to be good to me? Is this doctor gonna really prescribe what I really need and tell me the truth or are they just gonna sign this paper and give this medication. For me, my experience with medical treatment was totally different before I transitioned. When I got on my hormones, the doctor who prescribed me the hormones didn't really explain how the hormones work or what it did to my body. I was really confused. You're supposed to get checked every 90 days to make sure everything's fine. He was prescribing my hormones but wasn't doing follow ups. On my ninth month, I started feeling sick, I would get really hot and start breathing hard out of nowhere. I'd be standing or sitting down and feel like that. I got really concerned when the feeling made me fall once. I went to go get checked and my estrogen level was at 1200 and it's supposed to be around 200. I could have been more seriously hurt—heart attack, blood clots. After that doctor, I changed doctors and my doctors now are wonderful. My new PCP is very attentive. I'm familiar now with how estrogen works." Camila thought that her doctor was not only ignorant of best practices for patients on hormone replacement therapy, but also inattentive to her health in general because of his judgment of her.

"I'm speaking for myself a transgender woman but also for my sisters, because I work with transgender women, and they share things with me and it's so familiar with what I have lived through with medical care. Opening up to a doctor as a transgender woman is very hard. But if the doctor is open and attentive to the patient, I know that for me it helped me a lot to open up without wondering: is he going to judge me or is he going to help me?"

From their perspective, Dr. Alonzo expressed how they saw clinician biases forming a barrier to care. They stressed that non-judgmental communication is the foundation of developing a caring physician-patient relationship. Achieving the best outcomes for patients, particularly when it comes to sexual health, hinges on it. "I just think that we should normalize conversations about sex. I mean, people are gonna have sex. And if you have a tool that you can utilize to help decrease the transmission of HIV, use it. There's a lot of studies that like to point out that people who are on PrEP have higher rates of STIs. But you also have to take into consideration that these same people are getting tested every three months compared to the regular population, who sometimes you have to pull teeth to get STI testing at annual physical. You don't have to agree with everyone's sex practices, but as a physician your job is to provide good care to people. You don't have to agree. You don't have to get it. Your job is to make them feel comfortable, give them a space where they can have conversations with you, and do adequate STI testing. Even here in LA I have people who have never had three-site STI testing. Only urine tests, never a throat swab or rectal swab, even though they use those things for sex, too. I'll diagnose gonorrhea or chlamydia that they've had for a long time, because no other provider wanted to talk about sex and properly test for STIs."

One of Dr. Alonzo's patients at their practice in Los Angeles presented with severely swollen joints, which were a symptom of disseminated gonococcal infection from rectal gonorrhea. The patient initially went undiagnosed and untreated because no previous clinician had asked him about his sexual practices or recommended a rectal swab. Dr, Alonzo did. "We all have our own judgments and our own biases, but you should leave those behind when you come in the room and just provide the patient a space to talk about whatever they want so that they are more comfortable and honest with you. If you can't get a patient to be honest with you, you're not doing your job."

Before I opened the floor to student questions, Dr. Alonzo ran through the clinical basics regarding what goes into the monitoring and management of patients on PrEP: bloodwork before prescribing to ensure the patient is HIV-negative and immune to hepatitis B, as well as follow-up clinical visits every three months to complete STI testing and draw blood for a complete blood count and comprehensive metabolic panel to ensure that kidney and liver function have not been compromised.

The students in attendance were enthusiastic when given the opportunity to ask questions to the panelists. One student asked about the 2-1-1 dosing scheme (discussed in Chapter 2), and Dr. Alonzo described how they typically led conversations about event-driven PrEP with their patients. Another student asked a technical question about the differences between Truvada and Descovy in terms of bone mineral density decrease while on the medications, which gave Dr. Alonzo an opportunity to describe the biochemical mechanism behind the side effects. A third student asked how Dr. Alonzo thinks about which regimen, Truvada or Descovy, to start patients on: both from a clinical perspective, but also in terms of which is more commonly covered by private and public insurers. While there was not much time left at that point to discuss the insurance schemes governing PrEP in depth, this question and Dr. Alonzo's response brought a structurally informed, systems-based practice approach into the broader conversation.

The session officially ended after an hour of discussion, but students lingered behind for another fifteen or so minutes to chat with the panelists more. I thanked everyone for being there and for their contributions. I also invited audience members to complete a post-event survey evaluating the event and making suggestions for how to improve it in the future. Nine audience members filled out the post-event survey, of which seven were DGSOM students, including students in their first and second years as well as some completing other degrees and currently on leave of absence from the medical school.

The survey asked respondents to rate the event based on a series of domains. Did the panel: contribute valuable content about PrEP to what is currently offered at DGSOM? Add valuable content about LGBTQ health to what is currently offered at DGSOM? Provide an opportunity to reflect more on the interpersonal and structural barriers queer and trans people face in accessing care? Help you learn more about strategies for effective sexual history taking and competent communication, especially with patients who are queer and/or transgender? Increase your desire to seek out other resources and opportunities for learning more about the care of queer and transgender patients? One respondent rated each statement 4/5 (agree) and the rest rated each statement 5/5 (strongly agree).

I also queried: should this activity be included in the DGSOM curriculum to reach all DGSOM students? The following are written comments I collected in response to that question. "Yes! This event was so helpful and informative. Its [sic] important for every medical trainee to understand this subject as we will all inevitably enounter [sic] patients who are taking or would benefit from taking PrEP." Another student wrote, "This event would be essential to include in the formal DGSOM curriculum because of the way it highlighted sexual health in such a nuanced, intersection way. Both panelists brought complementary expertise that really fleshed out what it means to access this vital medication and how. All of us are going to treat queer patients in our careers, and panels like this that combine lived experience and clinical practice are ideal for cultivating these skill sets." Beyond developing skills for working with queer patients, another student responded, "Absolutely. Sexual health is something that all folks encounter in their lives."

I requested students write about one or two of their biggest takeaways from the event, to better understand their experience in their own words and not only within the framework of what I was hoping to achieve. "1. I feel more comfortable about PrEP and the care it entails. 2. Sexual health is an important facet of primary care and needs to be addressed competently!" Someone else said they were leaving having learned "that PrEP is life giving in multiple ways for those who choose to take it and PrEP can play different (but all very useful) roles in patient's lives; also, highlighting non-medical perspective is always enriching for our educations." Another student likewise found that latter point meaningful, naming "the importance of facilitating peer support networks with accurate information to get folks to practice responsible sex" as a key lesson.

Reviewing the post-event survey data helps to draw out what was valuable about the session: the panel provided practical, clinically useful information about PrEP and communicated the message that sexual health is a key dimension of providing competent primary care, especially for people who are marginalized on the basis of their sexuality and/or gender identity and who may experience worse health outcomes as a consequence. The panelists spoke from experience about how the clinical encounter can be a site of stigma and judgment, but also a site of healing and care. Their insights provided students with not only motivation, but also a better set of tools to develop into clinicians who can provide comprehensive sexual health care, including prescribing PrEP.

Conclusion

This final dissertation chapter focused on unpacking the purview paradox as a barrier to PrEP scale-up, interpreting it as an outcome of the way physicians are disciplined out of, rather into, knowledge and practices that would promote optimal outcomes for patients at risk for HIV. Drawing together a body of literature concerning the education and socialization of physicians along with research conducted with queer medical students, I interrogated how lack of clinician knowledge on and comfort with PrEP and sexual health in general are both produced and perpetuated in training, and I explored how this might be reformulated and reversed moving forward. Through interviews with clinicians who prescribe PrEP, I discussed two pathways for overcoming the purview paradox to improve utilization of PrEP among primary care doctors—special trainings offered in residency or practice and through HIV specialists bouncing back referrals with guidance on how to provide PrEP.

Chronicling my own efforts to incorporate a patient and clinician panel on PrEP into the formal medical school curriculum and the resistance I encountered along the way, I discussed how PrEP was framed as a special interest topic that is inessential or intrusive and the event was shunted to a smaller audience. Describing the extracurricular panel that was eventually staged and reviewing attendee feedback supplied evidence for how it enhanced the current minimal messaging on PrEP and affirmed why integrating it into the broader curriculum would work to diminish the effects of the purview paradox. Doing so could not only improve PrEP utilization, but also could improve health care delivery overall by enhancing students' skills for providing quality health care to all patients, their sexuality and gender identity notwithstanding.

While PrEP is commonly described by its advocates as "like any other medication," its provision relies on education of clinicians in comprehensive sexual health care, which is not merely de-emphasized, but, as I showed, strategically silenced, in formal medical curricula. Most vexingly, it can even be through a paradoxical pretense towards queer affirmation that medical trainees are disciplined out of and oriented away from developing into clinicians prepared to deliver an intervention like PrEP. As a downstream result, the burden of figuring out how to access PrEP care is downloaded onto the patient. This process of shuffling off obligations functions as a key mechanism through which biomedical HIV prevention resources are triaged away from the most vulnerable. In response, this chapter proposed a different, structurally informed, patient-centered education for medical students, infused with lessons drawn from ethnographic research, as a sorely needed corrective if this generation of physicians are to play their critical role in ending the epidemic.

Conclusion

“I had no *idea* what Truvada was doing.”

Ted and I met up outside a coffee shop in central Los Angeles on a cloudy and atypically windy day. In his early 60s, Ted carries an athletic frame; he keeps fit through an intensive swimming regimen honed since his high school years. In fact, he missed the Olympic team one year in the 70s by just a few tenths of second. Now, he walks with a slightly impaired gait, which is far less perceptible than might be expected after having both hips replaced over the course of the past 15 years. The etiology of his hip bone pathology, which Ted attributes to his some fifteen-year treatment with Truvada, is the centerpiece of our conversation.

Ted learned he was living with HIV in the 1980s but only first started on medication, Zidovudine (AZT) to begin with, in the early 1990s. This delay he calls “lucky.” He explained, “I didn’t go through the big dousing of AZT that everyone else did, because my T cells didn’t drop below 500 until 1992.” When he did start antiretroviral treatment, however, the side effects were sudden and severe. “I had AZT headaches that were just massive, and that’s basically why I retired from the practice of law.” He also told me about how Stavudine (D4T) and Lamivudine (3TC), drugs he started in 1993, led to peripheral neuropathy that permanently impaired sensation in his hands and feet. While these early HIV treatments forever changed Ted’s career path and transformed his body, they also may have contributed to maintaining his T cell count, in his memory, at levels above 300 cells per cubic millimeter of blood. This would have helped to prevent the opportunistic infections that cause morbidity and mortality in people living with HIV and forestall a diagnosis of AIDS, which follows when T cell counts dip below 200.

“Then Truvada came, and I was on Truvada for like 15 years. My view is that I would stay on a drug as long as I could and burn through it, because I figured I just had to stay healthy enough until the next set of drugs came out. With Truvada, at the time, I thought, ‘Oh, thank G-d,' this is the one that doesn't have any side effects. It's not making me feel sick, at least as far as I could tell. It's not destroying anything." Ted paused and gave me a piercing look. "I had no *idea* what Truvada was doing. But everyone said they're not reporting any major side effects, so you can stay on this one."

In 2008, Ted "started having hip problems that came on pretty quickly. I didn't know what it was, because I just thought I was sore from walking around, or maybe I had twisted something." Ted's doctor ordered an X-ray and then phoned urgently to say, "You need to go see a hip specialist really soon." He finagled Ted an appointment with the orthopedist at the end of the next day, during which Ted learned his hip was broken and needed replacement immediately. Ted was admitted to the hospital through the emergency room on a Sunday and went under the knife on Monday morning.

"It didn't go so well. They had screwed up the anesthesia, so when I came out of it, I was in massive pain. They gave me some more pain medication and sent me back to the room, but the nurses didn't have the order, so I woke up again in massive pain and it was two hours before they ever sent a doctor in." Ted eventually recovered from his first hip replacement. Seven or eight years later, he was back in the operating room again for his second.

I asked him if he or his care team anticipated that there might be a second hip replacement on the horizon after his first. "No. I had no idea it was related to medications, I thought maybe it could be related to being positive, or I had no idea why this was happening. Nobody ever mentioned to me that it was medication related or could be. After my second one, when I mentioned to my new doctor that I had just found out from a friend that Gilead was being sued for issues with Truvada, he said, 'Yeah, Gilead has been under-reporting this stuff for years.' I was like, 'Is anybody ever going to tell me anything about this?'" Ted's desire for answers and accountability spurred his personal and dogged engagement in litigation against Truvada's manufacturer.

Developing disparities: an abridged history of Gilead's TDF pharmaceuticals

In January 2020, Ted joined a Judicial Council Coordinated Proceeding (JCCP)[1] organized under the rubric of a Plaintiffs' Steering Committee filing litigation in the Superior Court for the State of California against Gilead Sciences, Inc. The suit seeks trial for injuries sustained secondary to Plaintiffs' ingestion of Gilead's tenofovir disoproxil fumarate (TDF) prescription drugs: Viread, Atripla, Complera, Stribild, and, most relevant to this research project, Truvada. According to the legal filing, Gilead "intentionally, knowingly, willfully, recklessly, and/or carelessly marketed its first TDF-based medication, Viread, in 2001, and withheld the safer tenofovir alafenamide (TAF)-based formulations from the market until November 2015, resulting in injuries to the Plaintiffs"—specifically, decreases in bone mineral density and impairment of kidney function (4). In building this case, the Master Long Form Complaint for Damages and Demands for Trials by Juries (2020) details Gilead's exclusive development of tenofovir and its prodrugs.[2]

Without getting too deeply into the weeds of patent law, retelling an abbreviated version of this history helps to contextualize the promise of Truvada for PrEP as an HIV prevention intervention within the political economy of the pharmaceutical industry under capitalism. Although Gilead persistently attempted to represent PrEP as a public health intervention rather

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[1] Civil actions based on a common question of fact or law may sometimes be filed in different courts. These cases, under specific conditions, may be transferred to a single court, at which point they become known as Coordinated Proceedings. In California, mass-tort cases are commonly consolidated in a JCCP so that pre-trial discovery, motions, and the first "bellwether" trial takes place in front of a single judge.

[2] Prodrugs are molecules or compounds with minimal pharmacological activity, which are converted into an active drug through enzymatic reactions that occur in the body.

than a commercial vehicle, evidence consolidated in the complaint reveals the pharmaceutical company to have intentionally and strategically prioritized the health and longevity of its profitable portfolio of drugs over the health and longevity of the patients consuming them. Beyond highlighting Gilead's alleged culpability in harming patients like Ted, reviewing the corporate practices outlined in the complaint is key to understanding why pharmaceutical solutions to the HIV epidemic, when implemented within a corporatized, capitalist health care system, may cause unnecessary harms and exacerbate inequities.

Tenofovir was first synthesized in 1983 by an international team of scientists working to identify new antiviral compounds. The (now known to be multibillion dollar) question before Gilead scientists who started working with the compound in the early 1990s was how to engineer precursor versions of tenofovir capable of delivering therapeutic levels of the key compound in a dosage tolerable to the kidneys.

By the mid-1990s, scientists at Gilead made significant strides forward towards this goal by synthesizing two tenofovir prodrugs: tenofovir disoproxil fumarate (TDF) and tenofovir alafenamide (TAF). Gilead's first patent application on TDF dates to 1996, and its first patent application on TAF was filed only four years later. Initial pre-clinical and clinical studies of both compounds were conducted by the year 2000, revealing their relative potency, efficacy, and cellular toxicity profiles. By this time, the litigation alleges, Gilead understood TDF was less stable than TAF and therefore more disposed to conversion into active tenofovir in the gastrointestinal tract, liver, and blood prior to reaching target cells. In contrast to TDF, TAF was better able to reach target cells before its conversion into the free, active, and potentially toxic tenofovir. Recognizing TDF's somewhat limited bioavailability,[3] Gilead established 300 mg as the lowest dose necessary to achieve desired inhibition of HIV-1 replication, as the complaint alleges, in full knowledge that this minimum effective dose of TDF would result in abnormally high active tenofovir concentration in the kidneys.

Preliminary studies referenced in the document indicate that TAF was known by Gilead at this time to be significantly more viable; in fact, in Gilead's studies, TAF achieved the same amount of active tenofovir as TDF at 10% of the dose and the same antiretroviral efficacy at only 0.1% of the dose. As summarized in the filing, "Gilead found that because of the differences in bioavailability between TDF and TAF, patients need approximately 12 times more TDF (300 milligram dose) than TAF (25 milligram dose) in order to achieve the same therapeutic effect on viral replication" (8). Gilead submitted pre-clinical and clinical data to U.S. and European regulators reinforcing this discrepancy in July 2000, published a paper to that effect in *The Journal of Nucleosides, Nucleotides and Nucleic Acids* in July 2001, and presented their findings at the 9th Conference on Retroviruses and Opportunistic Infections (CROI) in February 2002. Between 2002 and 2004, Gilead carried out Phase I and II testing of TAF with the explicit goal of "deliver[ing] a more potent version of tenofovir that can be taken in lower doses, resulting in better antiviral activity and fewer side effects" (10).

Also in this period, Gilead secured joint development agreements and preferred entry arrangements with competitors in the pharmaceutical industry "wherein Gilead would license competitors' antiviral compounds for use in combination with its TDF-based medications in exchange for restraints on generic competition" (11). With these agreements in place, Gilead

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[3] Bioavailability is a pharmacological parameter describing the fraction of an administered drug that reaches the systemic circulation after entering the body.

insulated TDF from potential financial threats posed by comparable products, enabling the corporation to withhold TAF from the market without facing business repercussions. In October 2004, Gilead publicly announced discontinuation of TAF development due to an "internal business review" revealing that "[b]ased on the safety, tolerability and efficacy of [TDF] established in clinical studies and commercial use," TAF did not have a "profile that differentiate[d] it to an extent that support[ed] its continued development" (11). Gilead then went on to promote TDF as its flagship antiretroviral agent while shelving TAF, which counter to their claim Gilead allegedly knew to be safer and more effective.

Having carved out a favorable niche in the pharmaceutical industry, Gilead aggressively marketed five TDF-based medications between 2001 and 2015, in chronological order: Viread, Truvada, Atripla, Complera, and Stribild. Sticker prices for a month's supply of these medications ranged between $1600 and $2000. Their high cost notwithstanding, these TDF drugs were quickly taken up as a cornerstone of HIV treatment. As reported in a petition filed with the U.S. Patent and Trademark Office against Gilead by the activist group PrEP4All (2021), over 80% of patients initiating HIV treatment in the United States take one or more of Gilead's products daily. This is an eminently profitable situation for Gilead: their HIV pharmaceuticals gross over $11 billion annually in national sales.

Viread, a 300 mg/dose TDF drug approved on October 26, 2001, alone netted over $225 million in sales in its first two months on the market. Yet as early as 2002, post-market clinical studies and adverse event reports (notably, inaccessible to the public) showed an association between TDF administration and severe kidney toxicity, even in patients without any preexisting history of kidney problems. Concurrently, TAF clinical research demonstrated it to be more effective and less toxic. Gilead suppressed the emerging picture favoring TAF over TDF and, by the conclusion of 2003, Viread comprised 68% of Gilead's total product sales. Consequently, Gilead pivoted towards designing new TDF combination drugs, as the lawsuit alleges, to maintain patent exclusivity and extend Gilead's capacity to charge exorbitant prices.

Composed of 300 mg of TDF and 200 mg of emtricitabine (FTC), a second potent reverse transcriptase inhibitor, Truvada (TDF/FTC) was the first and most financially successful TDF-based combination medication marketed by Gilead. Between 2004 and 2015, Truvada alone grossed Gilead an estimated $36.2 billion in profits, becoming one of the company's most important sources of revenue. The mark-up was massive, to the tune of 25,000%. TDF/FTC was priced in excess of $1800/month, while costing around $6/month to manufacture.[4] In 2012, Truvada received FDA approval for use as HIV PrEP, significantly expanding the market for the pharmaceutical beyond patients diagnosed with HIV to those considered to be at elevated risk for HIV acquisition.

Gilead's exclusivity on standalone TDF was set to expire in 2017 and the corporation was unable to broker agreements to reduce or delay generic competition that threatened to drive down the price of their blockbuster drugs. As a result, they began a push to strategically re-introduce TAF. Despite public claims of abandoning TAF development on account of a similar safety profile to TDF, Gilead had in fact worked since 2004 to acquire seven discrete patents related to TAF; Gilead likewise continued to conduct clinical studies comparing TDF and TAF. Gilead investors were made aware of this as early as October 2010, when Gilead's then-Chief Scientific Officer, Norbert Bischofberger[5] stated on an earnings call: "You can take a lower dose, and

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[4] Generic TDF/FTC is now available to consumers outside the U.S. for a cost of around $40/month.

[5] Bischofberger is an Austrian scientist known as one of the inventors of the antiviral drug Tamiflu used as treatment for influenza A and B, as well as the H1N1 strain.

actually, our clinical study would indicate one-sixth to one-tenth of the [TDF] dose, and you actually get higher efficacy with less exposure" (19-20).

Then-President and COO of Gilead John Milligan, who would later become CEO, delivered a similar message on March 2, 2011, at the RBC Capital Markets Healthcare Conference: "One of the reasons why [Gilead was] concerned about developing [TAF] was [that Gilead was] trying to launch Truvada versus [a competitor HIV drug] at the time. And to have [Gilead's] own study suggesting that [TDF] wasn't the safest thing on the market … It didn't seem like the best … There are some concerns still on kidney toxicity and there are some concerns about bone toxicity" (20). According to Milligan, the introduction of TAF, as a successor drug to the TDF-based formulations, would "bring quite a bit of longevity to the Gilead portfolio" (20). What the legal filings against Gilead allege is that this prioritization of portfolio longevity came at the expense of the longevity of consumers' kidney function and bone integrity.

In early 2012, Gilead concluded Phase II clinical trials showing a 10 mg dose of TAF-based medication demonstrated less renal and bone toxicity compared to the 300 mg dose of TDF in Stribild, which is the same dose as in Truvada. Entering (the final) Phase III, the company changed its tune on TAF. Instead of underplaying the differences between TDF and TAF, they began to herald TAF as an ostensibly novel agent for HIV treatment. On November 5, 2015, the FDA approved Gilead's first TAF-based drug, Genvoya, ushering in a period between 2015 and 2019 in which three additional TAF antiretroviral medications were brought to market: Odefsy, Descovy (Truvada's TAF-based successor), and Biktarvy. These TAF-based pharmaceuticals would supplant the TDF-based medications as the flagship products in Gilead's highly profitable HIV treatment and prevention portfolio.

Taken together, the evidence accumulated in the JCCP complaint shows how “Gilead misrepresented that TAF was ‘new’ despite knowing the relative benefits and safety compared to TDF long before Gilead brought any TDF-based drug to market in or about 2001” (23). It likewise supplies evidence for the assertion that “Gilead misrepresented the reasons that it purportedly abandoned the development of TAF in 2004, asserting that TAF could not be differentiated from TDF when it knew that TAF was, in fact, more effective and safer than TDF” (23). In essence, the JCCP alleges that Gilead intentionally withheld the safer TAF from market, acting in reckless disregard, in order to extend the lifecycle of the less safe TDF drugs. This strategy is referred to in the industry as “product hopping,” whereby a firm combats generic competition and preserves monopoly profits by shepherding its customers from one branded drug (like Truvada) to another similar drug with a longer patent life (like Descovy) to extend market exclusivity.

The first bellwether trial in the JCCP arguing this point is scheduled to begin in June 2022. As no official legal opinion has yet been rendered, further analysis will be delayed until after this dissertation has been filed. In the meantime, the evidence already collected supports a key conclusion drawn from scholarly inquiry into the political economy of the health care industry. Namely, within a capitalist context, pharmaceutical companies operate to generate surplus economic value, not primarily to leverage technology to improve the health of individuals and communities or to insulate them from risk.

In Ted’s analysis, Gilead has unequivocally “profited off of the pain of others. I really feel that what Gilead did was a really hateful and horrible thing in a way that probably goes far beyond reprehensible. I don’t even have the words for describing how awful their behavior is. It impacted me, but it’s impacted millions of people. It’s cruelty, and I’m angry! I think that I was viewed as a profit center and that they probably thought that I was not going to survive to contest their activities. One of the things I like is surviving to hold them accountable. A lot of people in this litigation will not survive the litigation. There are a number of people that have died, at least from what I read in the court filings, that are either on hospice or they're dying and they're not going to be here to hold them accountable. I think that's a major part of my motivation for participating in this. I would love to see the people who made those decisions at Gilead just be taken down and exposed for being horrific individuals… With Gilead, I really hope that it hurts. I hope it hurts their stock price, I hope it hurts their bottom line, I hope it makes shareholders aware of what management has done."

Ted is not necessarily optimistic that these outcomes will come to fruition. Nonetheless, he sees the suit as a "necessary step forward. But that's all it is, it's a step. The law should be improved to address situations where drug companies offer inferior drugs so that they can maximize their profits, and reintroduce a better drug at a later time, knowing that they have a choice. Justice is often delayed, it's often elusive, sometimes it's never even obtained. But I think you have to try and do it so that other people don't go through what you went through… That's philosophically how I get there. Angry? Yes. I absolutely want to take them apart. They are deserving of so many more consequences than they will ever suffer. And that's on a good day! [laughs]. I think I'm one of the lucky ones compared to at least the many people who died from kidney [failure]. I lost a couple of hips, which was horrific, but I'm still here to give them hell."

Through their spokesperson, Gilead released a statement maintaining, "Ongoing collaboration with, and input from, the medical and advocacy communities have always played a key role in helping inform our development programs and decisions. Patient safety is of foremost importance to us," yet "Gilead believes these lawsuits are without merit and we intend to defend against the claims." The consequences to Gilead of the JCCP, if any, remain to be seen. The behavior pattern laid out in the complaint, however, persists in Gilead's operations.

Exorbitant drug cost has been consistently called out—by activist groups like PrEP4All, clinicians, and community members—as a significant barrier to PrEP scale-up and contributor to inequities in PrEP access and HIV incidence. PrEP4All's National Action Plan for Universal Access to HIV PrEP (2018) calculated that if all 1.2 million people in the country with indications for PrEP took it daily, the cost would amount to $23,000,000,000 annually, which is 7% of the estimated total cost of prescription medications in the country each year. "It is simply inconceivable for coverage systems to sustain that sort of annual spending for one regimen; the clear incentive is for public and private payers to under-promote PrEP and ration access" (21).

Meanwhile, Gilead has acted—both surreptitiously and in plain view—to protect PrEP's price tag and Truvada's earning potential. In doing so, "not only does Gilead perpetuate pathologies and suffering by making life-saving drugs inaccessible as a result of high prices and lack of generics, but also it openly causes those who take its drugs to suffer easily preventable life-threatening side-effects," demonstrating how "life is protected only insomuch as it promises financial returns" (Atuk 2020, 4). When the goals of increasing earnings and shareholder value are the driving motivation behind life-saving technological advances in biomedicine, as is the case in the U.S. pharmaceutical market operating within a profit-driven health care system, pharmaceutical companies' efforts to expand access to PrEP couched in a language of health equity must be viewed with cynicism.

Tankut Atuk (2020) has argued forcefully against what he terms Gilead's brand of "philanthrocapitalism," whereby the company ensures that earnings increase along with "global recognition for its corporate social responsibility" (5). For instance, Gilead vaunts its Co-pay Assistance Program of $7200/year and foregrounds its 2019 commitment to donate two million bottles of Truvada yearly for up to eleven years to the federal Ready, Set, PrEP program all under the banner of expanding access. But at the same time, Gilead maneuvers strategically to ensure prices on their proprietary medications remain as high as possible. While raking in profits hand-over-fist from expensive prescriptions paid for by private health insurers, as well as state health insurance programs, Gilead perpetuates an image of magnanimity. At the same time that concerns about cost are known to underly inequitable access to PrEP, Gilead attempts to launder their reputation by pointing to the money and resources they are ostensibly giving away in the form of co-pay assistance and medication donations. Conveniently, as Ecks (2008) points out, this tactic diverts attention from the underlying forces that make co-pay assistance and donations necessary; namely, the lack of drug price regulation, the lack of universal health care, and the lack of a properly functioning health care infrastructure overall. These are among the structural drivers of the HIV epidemic, which produce the climate in which biomedical HIV prevention becomes both necessary and highly profitable.

Near the end of our interview, I asked Ted: "Given everything you now know about Gilead and the way you feel about this litigation, what do you think about PrEP as an HIV prevention strategy?" He took a deep breath. "Oof. I think you have to be closely monitored on it. I've known friends who've gone off of it because of bone density issues. I think *some* sort of PrEP is necessary. I think the concept of PrEP is terrific. The involvement of Truvada, to me, is very problematic. I kind of view it now that within three to four years there's going to be another alternative to it, so it's better than seroconverting for the moment. As long as you're monitored, and you know what the risks and the dangers are, and you know what to look for, you can make that judgment on your own. Having to take the full range of HIV medicine is even more problematic, so it's kind of like, the community shouldn't have to have that choice made for them."

Ted's qualified endorsement of PrEP, given his animosity towards Gilead and concerns about Truvada, draws out an ambivalence shadowing this dissertation. There is a fundamental conflict inherent in, on the one hand, wanting to promote PrEP scale-up as both a commonsense public health measure and meaningful intervention for people on a personal and community level, and, on the other hand, recognizing how the promise of insulation from risk, let alone "freedom" or "liberation," through PrEP is bound up with the extractive practices of pharmaceutical corporations in the context of weak state regulation and a non-functioning health care system on a national scale.

I approached my research with an optimism about PrEP's potential role in ending the HIV epidemic that I now in retrospect see as somewhat naïve. I was impressed with the data supporting PrEP's effectiveness; furthermore, I was excited by what I was hearing from PrEP users and experiencing myself regarding how PrEP use was opening new avenues for intimacy and changing how MSM embodied their relationship to risk. Clinicians I admired and PrEP users I encountered were enthusiastic about PrEP's promise to be an *effective* form of prevention. I was therefore primarily interested in the question of why Truvada for PrEP had not been more widely embraced by biomedicine.

As my fieldwork unfolded, my ambivalence about PrEP deepened. My research participants did speak to the potential of PrEP to remodel how MSM embody risky sexual subjectivity. They endorsed how taking PrEP had expanded their understanding of safe sex, opened up new forms of sexual practice, and enhanced their sexual health. Raul's story, in line with his own advocacy orientation, was portrayed as an argument for PrEP to be adopted as a harm reduction intervention. I felt the need to make that argument, because interviews with PrEP non/users and clinicians, especially on the topics of risk compensation and the purview paradox, highlighted stigma as a key barrier to scale-up. My research affirmed that the goal of engaging more MSM in PrEP will require combating stigma among clinicians. At the same time, my research underscored how the interactions between my participants, their social milieu, and the health care system were playing out within a broader context where structural forces produce risk for MSM, especially for MSM of color, impede their access to biomedical prevention, and condition their disproportionate representation in the HIV epidemic.

This conclusion therefore lays out a direction for future research in analyzing the political economy of pharmaceuticalized HIV prevention and its relationship to the distribution of risk and harm in the HIV epidemic (Biehl 2007). Ted's story draws attention to the way vulnerable people and communities, like those living with or at risk for HIV acquisition, are made dependent on biomedical technologies, and therefore also the industries that produce them, the markets that control their distribution, and the regulatory regimes that are intended to govern them. The dissertation thus concludes with a reminder that the goals of achieving health equity and eliminating HIV necessitate the ongoing struggle to demand intensified regulation of pharmaceutical companies, fight for single payer health care, and address the structural vulnerabilities that produce poor health outcomes. In the meantime, technological solutions to social problems will continue to worsen disparities and ramify harms in the context of a capitalist health care system, which extracts value from the illness and suffering of marginalized people.

PrEP, and biomedical prevention in general, can play a significant role in diminishing the harms of the HIV epidemic. It already has. Will PrEP bring about the end of the epidemic? I doubt it. What will, however, help create that future is advocacy, organizing, and action to address the structural vulnerabilities that produce illness and death for people who are stigmatized and racialized.

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