

Fatal attractions : AIDS and syphilis from medical, public and personal perspectives : an exhibition at the Wellcome Institute for the History of Medicine / Ken Arnold [and others].

Contributors

Wellcome Institute for the History of Medicine.
Arnold, Ken, 1960-

Publication/Creation

London : Wellcome Trust, 1995.

Persistent URL

<https://wellcomecollection.org/works/tf2vdd33>

License and attribution

You have permission to make copies of this work under a Creative Commons, Attribution license.

This licence permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited. See the Legal Code for further information.

Image source should be attributed as specified in the full catalogue record. If no source is given the image should be attributed to Wellcome Collection.



Wellcome Collection
183 Euston Road
London NW1 2BE UK
T +44 (0)20 7611 8722
E library@wellcomecollection.org
<https://wellcomecollection.org>

Gay Pneumonia

GRID

American Disease

AIDS

&

Fatal Attractions

Syphilis

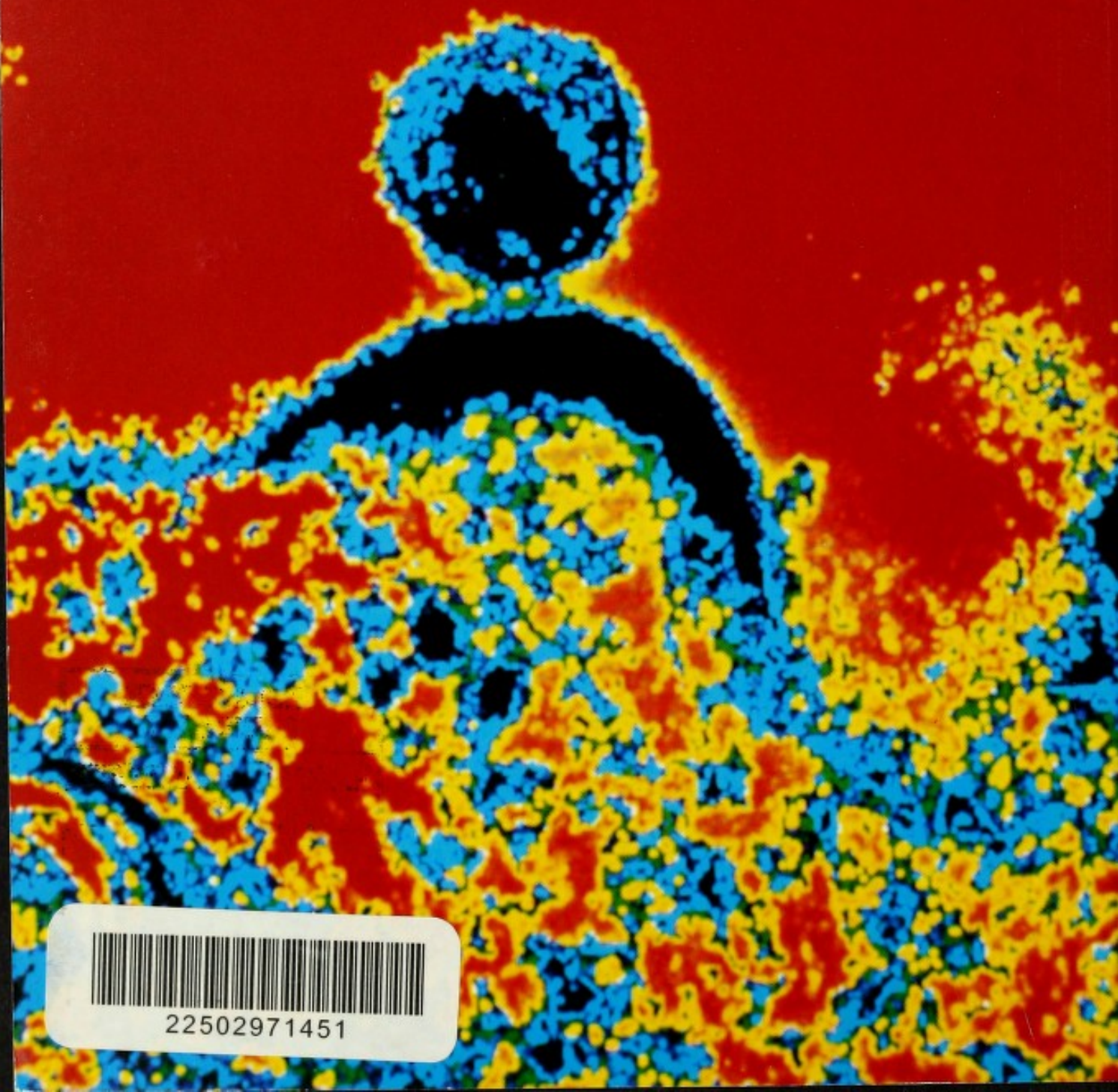
AIDS and Syphilis from Medical, Public and Personal Perspectives

An exhibition

at the Wellcome Institute for the History of Medicine

Chinese Disease

Human Immunodeficiency Virus (HIV).



22502971451

Fatal Attractions

AIDS and Syphilis from Medical, Public
and Personal Perspectives

AN EXHIBITION
at the
WELLCOME INSTITUTE
FOR THE HISTORY OF MEDICINE

May 1995

KEN ARNOLD and FIONA JAMES

BILL BYNUM

GEOFFREY GARNETT

KEITH LIVINGSTONE



CONTENTS

Introduction

page 3

part I

The great imitator: syphilis in historical perspective

W F BYNUM

page 4

part II

The unfolding story of AIDS: an epidemiological perspective

GEOFFREY P GARNETT

page 10

part III

Shame

Intestate

Harsh Reality

KEITH THOMAS LIVINGSTONE

page 18

part IV

Fatal attractions: the exhibition

KEN ARNOLD and FIONA JAMES

page 20

INTRODUCTION

The idea for this exhibition emerged from early discussions with Fiona James. We felt that it was important that a Wellcome Institute exhibition should tackle the subject of AIDS, surrounded as it is both by mountains of knowledge and trenches of ignorance, beset on all sides by passionate debate. We also realized that the particular strength of putting on such a show in the Institute was the opportunity it presented of displaying contemporary and older exhibits in close proximity, encouraging the comparison of histories seemingly separated by the gulf between then and now.

Fatal Attractions attempts not so much to show similarities in the evolution of the two diseases, as to encourage both the contemplation of their multiple facets and the reassessment of each in the light of the other. Rather than parallel biographies, it presents instead two inevitably incomplete collages.

The material relating to both diseases quickly demanded that as much attention be focused on public and personal as strictly medical perspectives. This balance and tension is in turn reflected in the nature of the other contributions to the catalogue. As a work of history, Bill Bynum's essay on syphilis might be claimed for the public domain; while Geoffrey Garnett's scientific analysis of AIDS contrasts markedly with the much more personal responses embodied in Keith Livingstone's poems.

KEN ARNOLD

THE GREAT IMITATOR:

SYPHILIS IN HISTORICAL PERSPECTIVE

‘After the first few weeks I claim [syphilis] as a medical affection. I often tell my students that [it] is the only disease which they require to study thoroughly. Know syphilis in all its manifestations and relations, and all things clinical will be added unto you’. So wrote Sir William Osler in 1897. He was speaking on behalf of the two generations of pathologists and clinicians which had demonstrated just how complex a disease syphilis is.

In 1800, even the word syphilis was used sparingly in medical writings, although it had been coined in 1530 by Girolamo Fracastoro (1483–1553) in his medical poem about the affliction. Until the nineteenth century, however, doctors preferred to use more general phrases such as venereal disease, or the ‘lues’ (from the Greek for plague), or vernacular expressions such as ‘the pox’ or the ‘great pox’. For one thing, medical opinion remained divided about whether gonorrhoea (the clap, the whites, spermatorrhoea, etc.) and syphilis were two separate diseases, or merely two stages within a single venereal disorder. For earlier generations, syphilis was principally an acute disease characterized by the primary sore (the *chancre*), and the rash. The latter meant that the affliction had to be differentiated from smallpox, hence the ‘great pox’.

Various chronic manifestations, mostly of a suppurative kind, were associated with syphilis, but only from the 1830s did doctors such as Philippe Ricord (1799–1889) in Paris begin systematically to study the long-term course of the disease. Ricord staged the disorder into its primary, secondary and tertiary phases, the first two corresponding to the chancre and the rash. Because the tertiary phases might not occur for ten, twenty or more years, or not at all in many patients, it is easy to see how the first two phases conformed to patients’ and doctors’ experiences. Ricord followed, over many years, patients who had contracted primary syphilis and was thus able to associate manifestations of the tertiary phase with an illness occurring much earlier. The tertiary phase might affect the heart and large blood vessels, it could lead to damage of the liver and kidneys, to the joints, to further skin disorders, or the brain and spinal cord. Other doctors such as Paul Diday

(1812–1894) in France and Jonathan Hutchinson (1828–1913) in Britain had described the range of congenital abnormalities that infected mothers might pass on to their infants. No wonder that Osler elsewhere called syphilis ‘the great imitator’.

Much had thus been done within Osler’s lifetime to elucidate the pathology and clinical course of the scourge, and in 1897 Osler would have been confident that the causative organism, which had eluded microbiologists and bacteriologists for two decades, would soon be run to ground. After all, the bacterium of gonorrhoea had been described by Albert Neisser (1855–1916) as early as 1879. In the event, the years just before the outbreak of World War One represent a period of dramatic change in the understanding, diagnosis and treatment of syphilis. The causative organism, difficult to see microscopically with ordinary light sources, difficult to grow in the usual laboratory media or to stain with the usual laboratory stains, impossible to infect most common experimental animals with, and extremely sensitive to changing conditions of moisture and temperature, was triumphantly demonstrated at last in 1905 by Fritz Schaudinn (1871–1906) and Erich Hoffmann (1868–1959). In the following year, August Wassermann (1866–1925) and his colleagues developed a serological test that made it possible to identify individuals who had been infected with syphilis even if they appeared to be completely well. Only three years later, Paul Ehrlich (1845–1915) announced that he and his Japanese co-worker, Sahachiro Hata (1873–1938) had synthesized and tested a arsenical compound, called by the trade name ‘Salvarsan’, which seemed to kill the organism but not the patient.

Osler incorporated all of these developments into the 1912 edition of his *Principles and Practice of Medicine*, pointing out in particular the way in which the Wassermann test had finally enabled doctors to link two specific neuropsychiatric disorders – *tabes dorsalis* and *general paralysis of the insane* (GPI) – to prior syphilitic infection. This had exciting ramifications for the future of psychiatry, since patients diagnosed as suffering from GPI were common in the psychiatric asylums of the period. Ehrlich soon replaced ‘Salvarsan’ with another arsenical, ‘Neo-Salvarsan’, which had fewer side-effects.

These pathological and clinical innovations firmed up the diagnostic criteria of the disease, and permitted investigators to relate syphilis to several other diseases associated with the same organism, viz. yaws, pinta, and a chronic form of syphilis that did not appear to be transmitted like the pox, through sexual intercourse. All of these conditions appear to be caused by the same organism, the *Treponema pallidum* originally identified in the sores of those suffering from venereal syphilis.

The biology of the Treponemal group has in turn informed speculation on the age-old debate: Was syphilis a new disease to Europe when it broke out in 1494 and 1495 among the troops and camp-followers busy laying siege to Naples? It was perceived as such, and even in hindsight, certainly acted like an infectious disease loosed on a population with no prior exposure to it. This 'new disorder' was highly virulent, producing serious, incapacitating and frequently fatal results. The French, assuming that they must have acquired it from the local inhabitants, called it the Italian, or Neapolitan, sickness. The Neapolitans were equally certain that the new affliction had been imported by the invading troops and sailors, and so called it the French disease. Many other national groups – the Spanish, the Flemish, the Poles, the Germans, the Turks, the Russians, the Japanese, among others – have been implicated in the origin of the disease that came to be called syphilis. (By contrast, 'the English disease' has in turn referred to melancholy and to chronic catarrh.) Even in the late fifteenth and early sixteenth centuries, having this affliction stigmatized, and so came the inevitable attribution of its source to the 'Other.' By the mid-sixteenth century, the venereal nature of its person-to-person spread was beginning to be widely accepted, even though men and women of seemingly impeccable morals sometimes came down with it. The 'Other' became women in general, and prostitutes in particular; among young men, syphilitic infection was sometimes looked upon as no more than a mark that the wild oats were being sowed.

The debate still rages about whether syphilis was new to Europe in 1495, and if new, brought back from the New World by Columbus's men; or whether new social circumstances in Europe, or some transmutation of the causative organism, produced this apparently new disease, perhaps via Africa or the Middle East. It took several decades for the 'American hypothesis' to be

articulated, and for sixteenth-century doctors, its main purchase rested on the arrival of a New World remedy – decoctions of the bark of the guaiac tree – which had its advocates. (The assumption was that God placed remedies near to diseases, to encourage man's energetic search for medicines but not to make it impossible to achieve results.) The original mainstay for treating the skin manifestations of the pox was mercury, in the form of salves and ointments, or as calomel, on oral preparation that also produced catharsis. Mercurial compounds were employed because they were already in use for all manner of skin complaints; they seemed to work for both the chancre and rash of the new disease as well, and for 400 years, until Salvarsan, they remained the drug of reluctant choice for most doctors.

The problems with mercurial medications were recognized early on: they were unpleasant to take, could loosen the teeth, make the bones ache and hair fall out, and rot the kidneys and gut. Of more immediate significance, a course of a mercury preparation imparted a metallic smell to the breath so strong that passing strangers (to say nothing of friends and family) might note it and draw their own conclusions. Mercury made the secret disease something of a public affair. Small wonder that guaiac appealed to those who could afford the extra expense, even after many doctors lost confidence in its efficacy.

Venereal diseases would not thrive in a strictly monogamous world. Hence, the chancre and rash could become red badges of shame, and guilt-ridden sufferers the easy prey of sharp-nosed practitioners and quacks. The eighteenth century is often referred to as the golden age of quackery, although in that age of the unregulated medical market place, playing at 'spot the quack' is not so easy. There was clearly money to be made in treating venereal complaints, and one sober commentator remarked in 1747 that three London surgeons in four depended upon VD for their subsistence. Traditionally, skin disorders had fallen to the province of the surgeon (hence, Osler's remark about the first few weeks of the infection), but such were the potential rewards of treating venereal diseases that physicians too strove for their share of the market. Both physicians and surgeons professed to loathe the quack and charlatan, even if self-advertisement, promises of complete cure without resort to mercury,

postal advice and medicines, and a variety of other entrepreneurial activities were common to all groups.

The rise of Victorian values guaranteed the continuation of secrecy and euphemism in matters sexual. At the same time, the State in Victorian Britain became increasingly involved in the regulation of health and of the medical profession. Disease prevention and public health were thrust onto the political agenda in the wake of the periodical cholera epidemics, and the high costs to the military (and hence to the public) of men unfit through venereal disease rankled with apostles of efficiency.

To most people in Britain, Continental solutions of medically-policed brothels were unacceptable as putatively condoning safe extra-marital sex. Nevertheless, with annual sickness rates through venereal disease in some military establishments running as high as 300 per 1000, Parliament finally responded with the first of the euphemistically-named Contagious Diseases Acts in 1864. The Acts made provision for the detention, medical examination and compulsory treatment of suspicious women found in the vicinity of specified military and naval garrisons in Britain. Although the legislation could be justified on public health grounds, moralists could object to the implicit condonation of casual or professional prostitution, and women's groups were outraged at the flagrant double standard (nothing was said about or done to men), and at the degradation of women by male speculum-wielding doctors. The Repeal campaign, spearheaded by the redoubtable Josephine Butler (1828–1906), was successful only after two decades of activity, and an Indian version of the acts continued in force even then. The Contagious Diseases Acts were frequently debated in Parliament. Their object was clear. Nevertheless, the word 'syphilis' was first recorded by Hansard only in 1883.

While purity and prostitution were being delicately handled in Parliament, those in the avant-garde in art and literature were less reticent. Ibsen, Maupassant, Toulouse-Lautrec and many others took on society and its hypocrisies, often drawing on their own experiences of low-life and venereal disease. The death of Friedrich Nietzsche in 1900, mad and demented, seemed to some as simply the inevitable wages of sin. In the *fin-de-siècle*, syphilis and degeneration made awesome bedfellows.

All of this made the discoveries of Schaudinn and Hoffmann, Ehrlich and Hata, and Wassermann, all the more startling. Science and morals became inextricably entwined, as Neo-Salvarsan took the venereal disease clinic to the cutting edge of pharmacological research, and syphilis was one of the few non-surgical diseases that doctors could do something about.

World War I brought more women into the work force, and by giving them more independence, made relations between the sexes easier. The army reluctantly initiated the issuance of condoms to men 'at risk'; and free and confidential venereal disease clinics were established for the civilian population. Public education campaigns of varying degrees of explicitness were initiated in the inter-war years, and there was widespread optimism that perhaps Louis Pasteur had been right: 'It is within the power of man to rid himself of every parasitic disease.' The arrival of penicillin during World War II seemed to some to sound the deathknell for *Treponema pallidum*, which in fact is one of the few susceptible pathogenic organisms not to have developed significant antibiotic resistance over the years. Nevertheless, the optimism of post-war venereologists was unfounded, and as late as 1986, the *Oxford Medical Companion* described syphilis as 'The most serious and the most feared of the sexually transmitted diseases.'

That statement was of course qualified in the second, 1994 edition. History is always about the present as well as the past, and AIDS has brought the history of sexuality and the sexually transmitted diseases into sharper focus. In the early and mid 1980s, as the seriousness of the HIV epidemic was beginning to dawn on politicians and health planners, and every third person at Islington cocktail parties was making a television programme about AIDS, medical historians were in constant demand to draw historical parallels between syphilis 500 years ago and AIDS today. Such parallels as exist are probably more appropriate for twenty second sound bites than serious historical analysis. Nevertheless, the AIDS epidemic has brought with it the message of individual responsibility which was embedded in much of the older literature on syphilis and venereal disease. Medicine and morality have always been hand in glove.

W F BYNUM

THE UNFOLDING STORY OF AIDS: AN EPIDEMIOLOGICAL PERSPECTIVE

AIDS (Acquired Immune Deficiency Syndrome) is the collapse of one part of our body's defences against infections and disease. The human immunodeficiency virus (HIV) must be present for the syndrome to occur, and is probably its sole cause. Since the emergence of AIDS, unprecedented scientific progress has been made in understanding both the complex biology of the virus and the factors which lead to infection and disease, which in turn allows identification of areas where there is a potential for intervention. What follows is a brief review from an epidemiological perspective of some of the salient aspects of the science of AIDS and of society's response to the syndrome.

The cause of the syndrome

The first signs of an emerging problem were noticed by clinicians in San Francisco and New York, where cases of a previously rare pneumonia (*Pneumocystis carinii*) and a rare, and generally more benign, cancer (*Kaposi's sarcoma*) started to appear in gay men. The epidemiologists of the US Centers for Disease Control commenced investigations into the cases. Such 'outbreak' investigations involved retrospective comparisons of the occurrence of potential causes in those with and without disease. This inquiry rapidly revealed that those with AIDS tended to have relatively high numbers of sexual partners. However, this factor was also associated with others such as the use of 'poppers' (inhaled amyl or butyl nitrate). Thus, as well as suspecting a sexually transmitted infectious agent, the lifestyle of the early cases was thought to be a potential cause. The subsequent emergence of AIDS in other groups such as those who received blood, or blood products, female sex partners of bisexuals, haemophiliacs, injecting drug users, and their children, further suggested an infectious agent. The identification of a new virus in the T-cells of AIDS patients, the very cells depleted in AIDS, was a major breakthrough allowing the rapid development of a simple test of whether individuals were infected. The use of this test demonstrated the scale of the hidden epidemic of HIV. At first it was unclear what proportion of

infections led to disease, but subsequent studies have suggested that the risk of developing AIDS increases with time after infection and that there is an average incubation period of 8 to 10 years.

Some still refuse to believe that HIV is the cause of AIDS, and in the past they have been given vigorous support by *The Sunday Times*. Their arguments centre on the lifestyle hypothesis, that a multifaceted assault on the immune system of particular groups of people, rather than HIV, is responsible for AIDS. In these arguments data is used selectively. For example, it is argued that there is a greater number of cases of AIDS in America than Africa, whereas, the prevalence of infection is higher in the latter (this reflects the lack of reporting rather than the lack of disease in Africa). They further argue that some of the infections which result from the collapse of the immune system, such as tuberculosis, can also be found in those not infected with HIV. However, this is only to be expected because AIDS is a syndrome, wherein those afflicted with pre-existing infections cause more frequent and severe disease.

The evidence that HIV causes AIDS is convincing. First, the virus rapidly invades and kills T-cells (so rapidly in fact that at any one time there are only a few infected T-cells to be found in the blood). Second, in more recent epidemiological studies where healthy people infected with HIV, and not infected with HIV, have been observed over time, only those infected with the virus go on to develop AIDS. Furthermore, in those with HIV, levels of drug use have no influence on the rate of progression to AIDS. A direct relationship between HIV infection and disease has been established in experimentally infected monkeys where the virus causes the collapse of the immune system. The challenge to the consensus view that HIV causes AIDS is an artificial one, based upon emotional and rhetorical appeals against a scientific conspiracy rather than on reasoned arguments.

The evolution of the virus

Having identified a causal agent, questions then arose about its origins and biology. In such cases, appropriate reactions to the spread of an infectious disease depend upon a dispassionate recognition that they are simply the outcome of a 'natural' biological process. HIV exists because it can replicate

within its host (i.e. people), and it is epidemic, not only because it can be passed on from one person to another, but also because each case of infection causes more than one further case of infection.

Having isolated the virus it became possible to compare its genetic code to that of other viruses found in animal populations. It is now apparent that very similar viruses can be found in other ape and monkey species, and in 1985 a distinct human immunodeficiency virus, HIV-2, which was infecting many people in West Africa, was described. Further studies have shown that HIV-2 is both slower at causing AIDS and is less likely to be transmitted than HIV-1. Patterns of HIV-2 prevalence suggest that it has been present in populations over a long period of time, and that in areas where it previously comprised the majority of HIV cases, HIV-1 has now become more common than it. Comparison of genetic codes also suggests that the two HIVs entered human populations separately, with HIV-1 being most closely related to simian immunodeficiency virus in chimpanzees, and HIV-2 more closely related to a virus found in West African sooty mangabey monkeys.

The ultimate evolutionary source of immunodeficiency viruses is unclear, but many other species of monkey have such infections. It seems likely that primates have harboured these infections for thousands, perhaps millions, of years. Over this time opportunities for blood-borne transfers between species can easily be envisaged. The time of entry of HIV into human populations cannot be determined with any precision. However, given that it did, it is important to uncover what factors control its ability to spread and to cause disease.

A common misconception is that a parasite harms itself when it kills the host on which it depends. A consequent belief is that pathogens should evolve to become benign. Further, it is argued that disease is the product of newly emergent infections caused by the ecological disturbance of our environment. This view only takes account of one of the selective pressures acting upon a pathogen like HIV. A virus that spreads from host to host will be much more 'successful' than one which remains in only one host. If there is a link between the ability to spread and the severity of disease that an infection causes, then some intermediate level of pathogenicity will be the optimal 'strategy' for the infectious agent.

The exact relationship between transmission of an infection and the survival of the infected will depend on the biology of the interaction between the pathogen and its host. In the case of HIV this is complicated, and it is as yet unclear how exactly HIV destroys the immune system. However, recent evidence on the rate at which virus and immune cells are generated (around a thousand million of each per day) suggests the existence of a titanic struggle for dominance, which, in the long-run, our immune systems lose. On entry, HIV reproduces rapidly reaching high numbers in the blood. The virus is then cleared by the immune response (there is a window of six to twelve weeks after infection when antibodies to the virus are not detectable). At this stage, the virus is kept at low levels for many years by the immune system, until, as it collapses, the virus population resurges. The resulting long and variable incubation period before the onset of AIDS is crucial to the potential for HIV to spread because it extends the period over which the virus can be transmitted to new hosts. Additionally, the fact that the virus spreads widely long before its severe consequences are manifest also underpins many of the severe problems societies have in facing up to the implications of an HIV epidemic.

The dynamics of the epidemic

To be epidemic, an infection *must on average* cause one more new case of infection. Over the long asymptomatic period, when HIV can be transmitted, the virus is spread to new sexual partners. The speed at which the HIV epidemic grows depends upon just how rapidly these new infections occur. In populations where there are many sexual contacts between those infected and different susceptible people many new infections will occur in the early phase when virus levels are high. This would generate a rapid epidemic, over a period of months. Alternatively, if the expansion of an infection in a population required virtually the full period from initial infection to AIDS, then a much slower epidemic, over a period of tens of years would unfold. The absence of the former rapid epidemic in a population does not necessarily imply the absence of a sustained epidemic.

Early cases of AIDS were seen in certain groups such as homosexual men and haemophiliacs where the spread of the virus was rapid. These became known

as 'risk groups'. Because HIV is predominantly a sexually transmitted infection there are certain 'risk' behaviours, such as having a large number of sexual partners, which increases the chances of being exposed to infection. The distribution of these behaviours will determine the rate of spread of infection within a community. However, by definition, an epidemic involves changing levels of infection and hence changing individual risk associated with different behaviours. The identification of groups particularly at risk is likely to change over time. In HIV, the spread of the virus in waves through different populations such as homosexuals, transfusion recipients and injecting drug users, could allow other groups at risk, such as heterosexuals who may have an infected partner, to become complacent about their own risk. Thus, an important public health message is that everyone should be concerned about HIV.

At the same time care should be taken not to over-estimate the potential epidemic; it is difficult to deal rationally with apocalyptic messages. HIV has spread quickly and widely among heterosexuals in sub-Saharan Africa. Take, for example, pregnant women attending a hospital in Blantyre, Malawi; in 1985, 2% of the women were infected with HIV, by 1988 this had risen to 19% and by 1993 it was as high as 32%. There are many potential explanations of why HIV has spread so rapidly in some African heterosexual populations. Chief among them are the high levels of untreated genital ulcer disease, which seem likely to enhance the transmission of HIV. The prospects of communities where a third of young adults are infected should be of great concern. However, it is a mistake to expect the same pattern of spread in the population of the United Kingdom. When such predictions are not born out, complacency emerges both about the scale of the problem globally and the potential for spread locally. There is a need for concerted effort to prevent the further spread of HIV and to alleviate the burden it places on those communities where the impact has been worst. Already in the USA, AIDS is the leading cause of death among young adults, and in some rural areas of Uganda it causes over 80% of young adult deaths.

The protection of the individual and the population

In controlling infectious disease there is a tension between the interests of individuals and populations. How do we protect the individual's rights

to proper care, confidentiality and non-discrimination, while at the same time, allowing society to make the best endeavours to halt the spread of an infection?

Nowhere is this dilemma more evident than in the history of sexually transmitted diseases, and in particular HIV. Because HIV infection is asymptomatic for many years, tests are the only way of showing infection. If those infected could be identified then they could be both treated, when appropriate, and counselled to take action to avoid further spread of infection. Treatment is of particular use in the case of pregnant women infected with HIV, where it can reduce the risk of infection being passed on to the child. Two strategies are possible for identifying those infected, the appropriateness of which alters with the prevalence of infection. For a low prevalence of infection, the most effective way of identifying those infected would be contact tracing, where the sexual partners of those known to be infected are identified. With a higher prevalence of infection, then a scheme in which anyone with a particular risk is screened would be more feasible.

In the United Kingdom, it is not possible to use programmes to identify those infected with HIV. The stigma that society attaches to infection is not countered by the possibility of effective treatment (even though the identification of those infected would allow for their better clinical management), which means that for ethical reasons linked screening and contact tracing is not possible. In the decision not to pursue contact tracing or screening, the right of the individual to privacy, and protection from the knowledge that they may be infected has prevailed. At its crudest, this means that the interests of the individual have outweighed the interests of the population. The central medical relationship between the doctor and the individual patient, and the strength of the medical community to determine public health policy makes the emphasis on an individual's rights a likely outcome. When society disadvantages those infected with the virus, through moral judgements, or discriminatory treatment, then it is difficult to argue that stronger measures should be taken to protect the population as a whole.

The protection and rights of the population should allow for a compromise to be reached with the rights of the individual. Historically, such

attempts have not been successful. For example, as a result of the contagious diseases act of the 1860s, those found to be infected with syphilis were imprisoned until treated. Such extreme action merely serves to drive those infected into hiding thus preventing voluntary controls. Even when these measures are not taken, there is a social stigma and moral judgement made about any disfiguring disease.

The means of transmission adds to the moral opprobrium attached to sexually transmitted diseases (STDs). This disadvantages those people with suspected or known infections. Additionally, in the case of HIV, the long period in which people are not actually ill but still HIV positive makes knowledge of being infected traumatic. Only when judgemental attitudes about, and discrimination against, those infected are removed, will communities be able to easily improve their protection against the spread of HIV. Until then ethical, but also practical barriers (such as refusal to cooperate in contact tracing and to volunteer for testing), will be put in the way of effective control initiatives.

In the light of the stigma attached to STDs a concept in their control, which needs to be used carefully, is the idea that there is a 'core-group' that allows for the persistence of infection. Those who have sex with those infected are most at risk, and the chance of being in this category increases both as the number of people one has sex with increases, and as the prevalence of infection in the social, behavioural, demographic and geographic group ones sexual partners come from increases. Initially the 'core-group' concept helped in allowing the possibility of controlling bacterial STDs, by providing the opportunity of targeting treatment. Variables associated with STD infection such as age, geographic location and social group have been identified and subsequently used as targets. Alternatively, repeated infection has been seen as a marker for a high risk group. In applying such a concept, it is vital to remember that people in groups identified as being at high risk are not necessarily members of the strictly defined core group, rather they are grouped together as a way of reaching those who are. In education about HIV a careful balance needs to be struck between this view that some are at particular risk and the view that everyone is.

The future spread of HIV

Our perceptions of the AIDS epidemic are shaped by the record we build up of it through surveillance. To plan responses to the epidemic we need information on the current incidence of AIDS and also on the number of AIDS cases that can be expected in the future. Cases of AIDS only reflect the incidence of HIV some time ago. Unlinked anonymous screening of infection provides a more accurate indication of future AIDS cases. However, to understand how HIV will spread we need information on sexual behaviour. Our lack of reliable quantitative knowledge about the sexual behaviour of populations was exposed by the HIV epidemic.

Great advances have recently been made in this area in many populations and many countries. For example, in the UK, the National Survey of Sexual Lifestyles and Attitudes has opened up wide areas of the sexual life of the population to informed study. Such studies illustrate just how influential the variation in behaviour will be in the spread of an STD.

However, some questions remain. What are the links between the high activity people who are most likely to become infected with HIV and others within the population? And what are the most important factors in determining when during a sexual partnership the virus will be transmitted? In predicting the future spread of HIV a key area of uncertainty is how much behaviours will change. HIV is likely to show the typical dynamic pattern of epidemics, rising to a peak and then either plateauing or falling off. The stage at which this happens and how great the fall in prevalence will be depends upon behavioural responses to the AIDS epidemic and the mortality it causes.

Our understanding of HIV and AIDS has advanced over the last 15 years. The design of drugs, vaccines and behavioural interventions is being actively pursued. However, the will to combat a problem that involves a pronounced time lag is difficult to generate. Added to this is the tendency for STDs like HIV to occur most frequently among the marginalized and poor. Perhaps it is these factors stalling the will to tackle HIV that act as the greatest barriers to developing effective control of the spread of the virus.

GEOFFREY P GARNETT

Centre for the Epidemiology of Infectious Disease,
Department of Zoology, University of Oxford.

S H A M E

Many a person
has been unsuccessful
in their attempts
to avoid rejection.
Hiding the truth,
keeping to themselves
the reality they face,
for fear of disgrace
and of never again
sharing love's sweet embrace.

I N T E S T A T E

Much too busy being ill,
to contemplate the need for the will,
which everyone tells me would make living easier.

After I'm gone.

H A R S H R E A L I T Y

Sitting alone
in a room made for two,
breathing in deeply
through green and then blue.
Inhaling this drug
with a view to protecting
my body from infections,
which may otherwise
present and attack
my defences, weakened,
less able to muster
the resources,
to triumphantly slaughter,
such blatantly, cowardly,
opportunist, hunters.

My lungs are now coated,
sheltered from harm
temporarily, free!
No need for alarm.
I will be back,
in a fortnight,
to start over again,
this treatment,
from which I dare not refrain.
Immunity compromised,
out in the rain.
Safer than those,
who have yet to discover,
that they too may soon,
be running for cover.

K E I T H T H O M A S L I V I N G S T O N E

FATAL ATTRACTIONS: THE EXHIBITION

INTRODUCTION

Every disease is in effect common property. The meanings people attached to them depend on their view point: those struggling to surmount them, carers and practitioners looking after those who have them, pharmaceutical companies wanting to cure them and at the same time make profits, scientists seeking to understand them, and governments hoping to manage their social effects.

Venereal diseases have an especially high public profile. Their very name takes note of their means of transmission; thus by definition, their histories concern not just medical research into their causes and occurrence, but also changes in human sexual relations and in the public perception of them.

In looking at syphilis and AIDS (Acquired Immune Deficiency Syndrome), this exhibition focuses on two diseases that, in different eras, have been the most famous in the world. For each, it tries to sketch portraits of the disease from medical, public and personal perspectives.

Both syphilis and AIDS produced social conflicts about responsibility and sexual behaviour – conflicts which led to confused reactions from governments and an explosive mix of hopes and disappointments as scientists searched for a cure. As the exhibits make clear, however, the differences between these diseases are just as striking.

INTRODUCTORY POSTERS

Posters have played a key role in public campaigns against both syphilis and AIDS. Differences between those dealing with the two diseases are evident in the technology of production, their use of colour and the manner in which they convey their messages. Whereas those concerned with AIDS display a fairly unguarded boldness, those dealing with syphilis are instead less outspoken, carrying the impression of an unmentionable shame lurking in the shadows.

A.1 'Guard against venereal disease'. Poster designed by Abram Games. London, 1941

The artist was the army's first official poster designer. The rest of the legend reads: "Keep straight. Keep sober. You owe it to yourself. Your womenfolk. Your comrades. Your country".

Iconographic Collections – Catalogue no. 20273

A.2 (a) 'If treated early VD can be cured'. (b) 'At the first sign of VD get skilled advice'. Posters designed by Abram Games. London, 1949

It is interesting to compare the two posters issued by the Ministry of Health: one being aimed at men and the other at women.

Iconographic Collections – (a) Catalogue no 20288 (b) Catalogue no 20287

A.3 'VD can be cured if treated early'. Poster designed by Abram Games. 1949

Iconographic Collections – icv 48531L

A.4 'VD...'. Poster. London, 1960s[?]

Issued by the Ministry of Health. The legend reflects the perception of increased promiscuity at the time: "VD is almost always caught by having sex with an infected person. VD has been increasing among young people. All who have taken risks should seek advice, even if they notice nothing".

Iconographic Collections – icv 48533R

A.5 Directorscut Poster. London, 1995

The poster is taken from a calendar of the same name. The organization's aims are to raise consciousness of the issue of HIV and AIDS within the black community.

A.6 'Going far?' Health Education Authority Poster. 1994

The poster's message reads: "wherever you're going, remember to buy some condoms before you travel". It has been used as part of the British Government's continuing safe-sex campaign, here particularly reflecting worries about the consequences of people losing their inhibitions on holiday.

A.7 'World AIDS day'. Poster. London, 1994

The World AIDS Day initiative is supported by the Health Education Authority and the National AIDS Trust.

A.8 'London Lighthouse residential unit'. Poster. 1991

The poster was designed by Sophie Herxheimer. The London Lighthouse is "a centre for people facing the challenge of HIV and AIDS".

A.9 'London Lighthouse drop-in centre'. Poster. 1991

The poster was designed by Sophie Herxheimer. The 'drop-in centre' facilities include a quiet room, a library, a garden, legal advice, a haircutting service and condom distribution.

A.10 'Love & passion still in fashion...'. Poster. 1992

The poster was designed by Andrew Dineley for the 'Alter Attitudes to AIDS' organization and published by the Liverpool Health Promotion Unit. It encourages the notion that the context for sex should be a caring, loving and responsible one.

FILMS

Syphilis film I

Plain facts.

Produced by the American Hygiene Association. 1941

The film asserts that "everyone should know about gonorrhoea and syphilis", and includes a plea to anyone with venereal infection to be treated and cured.

Shown by permission of the Imperial War Museum

Syphilis film II

Shadow on happiness.

Produced by National Interest Picture Productions for the Army Kinematograph Corporation (War Office). 1949

The film was aimed at service women, to whom it explains the causes, symptoms and treatment of venereal diseases.

Shown by permission of the Imperial War Museum

Syphilis film III

Subject for discussion.

Produced by Seven League, distributed by Ministry of Information. 1943

This melodrama tackles the issue of secrecy and shame surrounding VD, and marks the evolution of an official advocacy of greater openness.

Shown by permission of the Imperial War Museum

AIDS film I

HIV & AIDS.

Produced by Leicestershire Health Authority. 1992

In this clip the nature of the HIV virus and its action are shown using computer generated graphics.

Shown by permission of Leicester Royal Infirmary

AIDS film II

Philadelphia.

Directed by Jonathan Demme and released by Columbia Tristar Films. 1993

This drama concerns a young lawyer's fight to prove that he has been unfairly dismissed from a New York law firm because he has AIDS.

Shown by permission of Tristar Pictures

AIDS film III

Durex Advertisement. 1994

The whole advent of film and TV advertisements for contraceptives is closely tied with the AIDS epidemic.

Shown by permission of LRC Products Ltd

AIDS film IV

The Gill and Mark story.

Produced by Chysalis Multi Media for Educational TV Productions Ltd

This educational video tackles among other issues the HIV test and how people react to the results and support for those who are HIV positive.

Shown by permission of Educational TV Productions Ltd

SECTION I

SYPHILIS: MEDICAL PERSPECTIVES

Syphilis first appeared in Europe at the end of the fifteenth century among warring French and Neapolitan troops and spread across the whole continent within a few decades.

For most of its history, treatment for the disease has been marked more by a mix of experimentation and desperation than by any confidence in a specific cure. Preparations of mercury were adopted early, and, despite many associated problems, were used right up until the twentieth century. Only then was it, and a variety of vegetable-based alternative remedies superseded first by Paul Ehrlich's 'magic bullet' Salvarsan and then by the far more effective penicillin.

Since the 19th century, medical study of the disease formed itself into a separate discipline. Its efforts first distinguished syphilis from gonorrhoea, and then traced the progress of the disease through various phases, and finally, at the start of the twentieth century, isolated the causative organism *Treponema pallidum*.

1.1 Juan Almenar and Niccol Leoniceno, *Libelli duo de morbo gallico*. (Lyons, 1529)

Niccol Leoniceno (1482–1524) was a professor of medicine at Ferrara, who wrote an influential pamphlet on syphilis as early as 1497. He was one of those who held to the opinion that syphilis outbreaks had occurred from the beginning of time. Juan Almenar was a rich Spanish nobleman, astronomer and doctor, who published a work on the 'French sickness' in 1502. Almenar asserted that syphilis was principally transmitted by intercourse, but also by kissing, breast feeding and more rarely by 'corrupt air'. He urged meticulous washing after the sexual act to avoid infection. EPB 227

1.2 Paracelsus, *Schreiben von den Frantzosen kranckheit...* ([Basle], 1577)

The portrait opposite the title page is of Paracelsus (1493–1541). In this work originally written in 1529, he attacked the excessive use of mercury and of guaiacum. Physicians who treated syphilitics incompetently were, his subtitle declared, "impostors". It was Paracelsus who helped make congenital syphilis an issue among the medical profession and health authorities. EPB 7328

1.3 Turned wood herb box for sarsaparilla. European, seventeenth century

Sarsaparilla is a tropical American climbing plant that has large aromatic roots and heart-shaped leaves. Prepared from the plant's dried roots, the medicine was used for a number of complaints including psoriasis and syphilis. Sarsaparilla was one of the alternative vegetable 'cures' favoured by doctors who disliked the sweat-inducing properties of guaiac. 'China smilax' or *squine* and sassafras were other examples, many doctors prescribing a decoction of all four together.

Loaned by the Science Museum

1.4 John Hunter, *A Treatise on Venereal Disease*. Second edition. (London, 1818). Urethral irrigator and nickel-plated nossles. British, early 20th century

In his commentary to the work, Joseph Adams explained that "before Mr Hunter, only the more obvious symptoms and methods of cure had been noticed in a disease, which for three centuries had engaged the pens of the most celebrated medical writers". Hunter was one of the first to distinguish gonorrhoea from syphilis, and he clearly identified two periods following on from the latter's primary stage. Plate II displayed shows a series of canula, by which caustic was applied to the strictures in the urethra of men. The use of irrigators was common in VD clinics from the late nineteenth century, mostly for use with antiseptic fluids to prevent strictures.

EPB 29740/B

1.5 Cased mercury douche with fittings for urethral therapy. French, late 19th century

Until the start of the twentieth century, mercury was the commonest treatment for syphilis. Though it was at least partially effective, it had very unpleasant side-effects. For some, this simply proved that serious diseases required 'serious' treatments. Scientific arguments about both the usefulness and the method of application of mercury continued right up to the twentieth century.

Loaned by the Science Museum

1.6 'Four patients with skin disorders'. Water-colours by Chiang Yee. Late 1930s

These four drawings were copied from the classic Chinese medical work *The Golden Mirror of Medicine* (1742). They were produced by Chiang Yee for the Wellcome Historical Medical Museum. As in Europe, syphilis was given several names in China, most commonly *Guang*, indicating the belief in its spread from Canton (Guangdong). It was treated as part of 'external medicine'; many of the cures used were similar to those tried in Europe. Most Chinese scholars now believe that syphilis was brought to China during the early 16th century by the Portuguese.

Iconographic Collections – icv 18918–9

I.7 Aḥmad b Yūsuf al-Tifāshī, *Rujūʿ al-shaykh ilā ṣabāh fī taqviyat-i bāh*.

Eighteenth century

This Persian manuscript deals with the subject of sexual intercourse, remedies for sexual disorders, barrenness and diseases of the sexual organs. It was translated from an original work in Arabic. It is divided into two main sections relating to men and women respectively.

Persian MS 226

I.8 Two skulls showing signs of damage by syphilis. British, 1828 and 1869

The skull on the right was that of a woman who was frequently under hospital treatment for syphilis. Particular damage can be seen to the bones of the nose. Some deposit of new bone, however, indicates that healing had begun. The skull on the left was originally part of Joshua Brookes's medical museum. It included a large collection of specimens illustrating human and comparative anatomy, used in his lectures on the subject.

Loaned by the Museums of the Royal College of Surgeons of England

I.9 Jean Alfred Fournier, *Leçons cliniques sur la syphilis: étudié plus particulièrement chez la femme*. (Paris, 1881)

Fournier (1832–1915) was a prominent French medical researcher and practitioner who specialized in syphilis. Based at the Hôpital Saint-Louis, he did important work on among other topics the syphilitic origin of general paralysis. He was also a pioneer in advocating effective prophylactic measures to be drawn up by doctors rather than public authorities.

Mod Med WC160 1881F771

I.10 (a) *How to fight venereal disease* and (b) *Venereal Diseases* (London, [1920s]). National Council for Combating Venereal Diseases pamphlets

"More than half of all the cases of blindness among children are the results of Venereal Diseases in the parents" reports one of these pamphlets. While the family tree in the other records "An actual case" of a husband "either through ignorance or criminal folly" passing on syphilis to his wife and children. Medical interest in congenital syphilis started in the sixteenth century. In 1888, the French syphilologist P Diday described the typical congenital syphilitic as follows: "a little, wrinkled, pot-bellied, old man with a cold in his head".

(a) Mod Med (2) pam 126; (b) Mod Med WC140 1920 N 27v

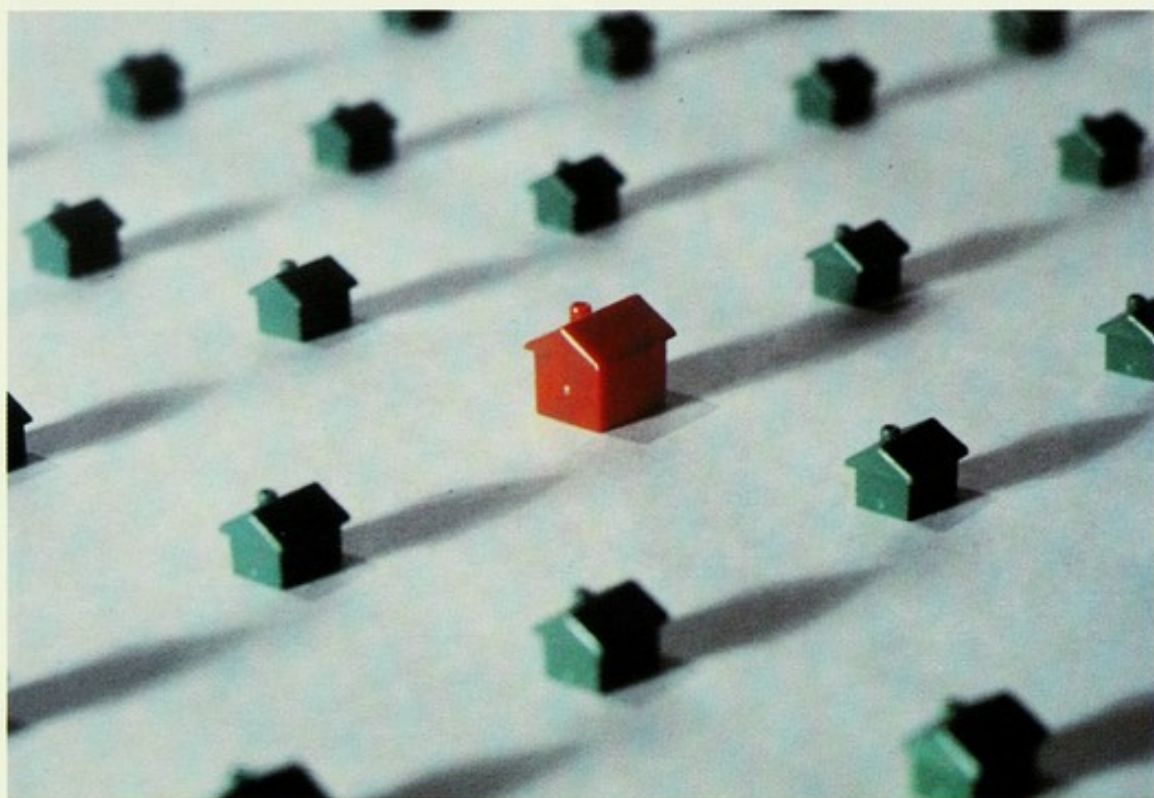
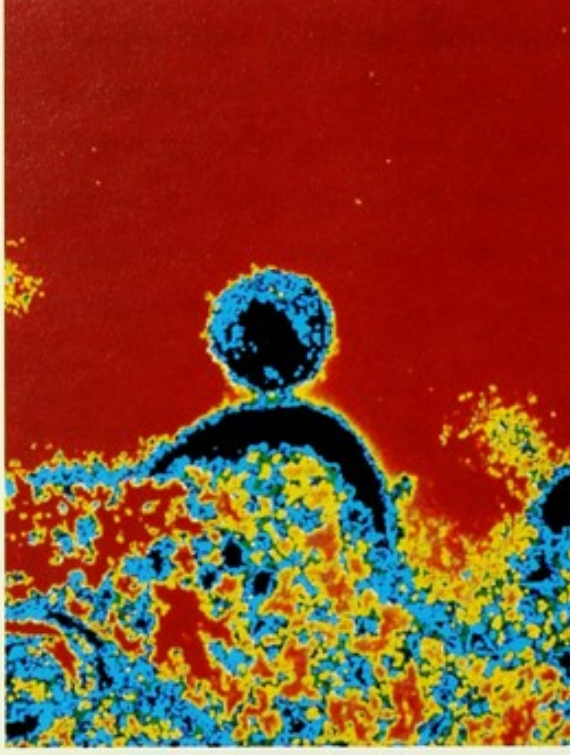
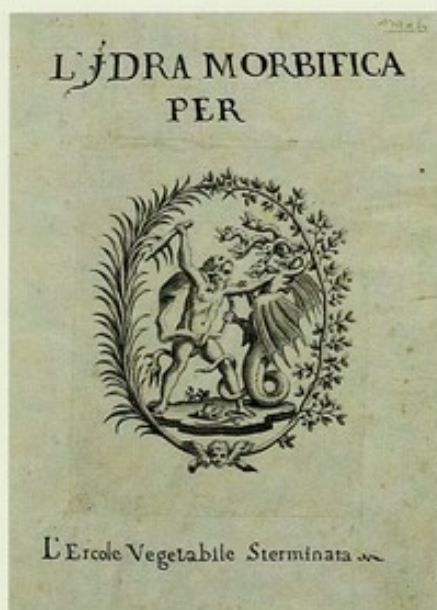


Image by Keith Livingstone and Nicholas Lowe.
From the Artists' Agency, Sutherland, HIV/AIDS project.

Photo micrograph of bacterium causing syphilis
Treponema pallidum. Item I.11

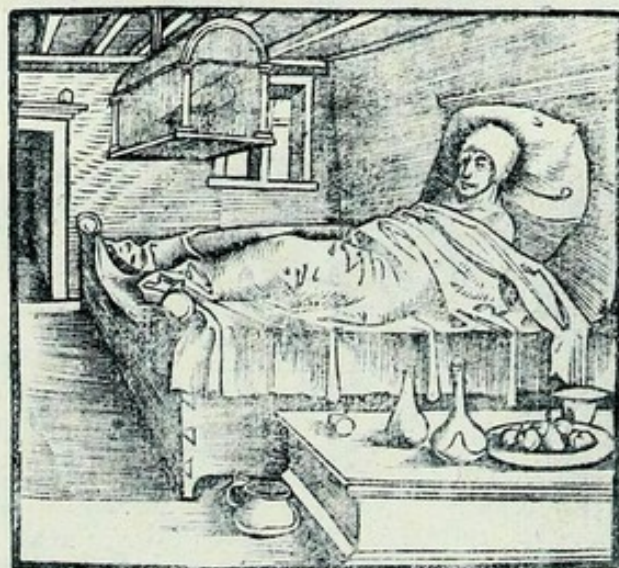


Electron micrograph of Human Immunodeficiency Virus.
 Item IV.2



Pietro Lorenzo Riari,
'L'idra morbifica...' Item II.5

Experiēce & appro-
batiō blrich de hu-
ten notable cheualier. Touchant la medecine du boys
dit Guaiacū Pour circonuēir et dechasser la maladie de
Neaples : traduicte et interpretee Par maistre Jehan
Cheradame Hippocrates estudiant en la faculte & art de
medecine. *Musmes De Paris.* v.



Ulrich von Hutten,
L'experience et approbation... Item III.5

Nouuellement imprimee a Paris : par Phe-
lippe le Noir. Libraire et relieur iure en lumiere
sise de paris Demourant en la grant rue saint Ja-
ques a l'enseigne de la Rose blanche couronnee.



Richard Tennant Cooper, 'Syphilis'. Item III.4



Thomas Rowlandson, 'A sale of English-beauties in the East Indies'. Item II.12



P Galle, A man in bed suffering from syphilis. Item III.14



Photograph of 'Retrovir' (AZT) production. Item IV.3



Andrew Kingham, Red ribbon.
Item V.3



Terrence Higgins Trust material. Item V.1



'AIDS guidelines...' leaflets. Item V.5

London Lighthouse

A CENTRE FOR PEOPLE FACING THE CHALLENGE OF HIV AND AIDS

Residential Unit

Do you or your carer need
a break?
Are you getting over an illness?
Do you need a place to
bridge the gap between hospital & home?

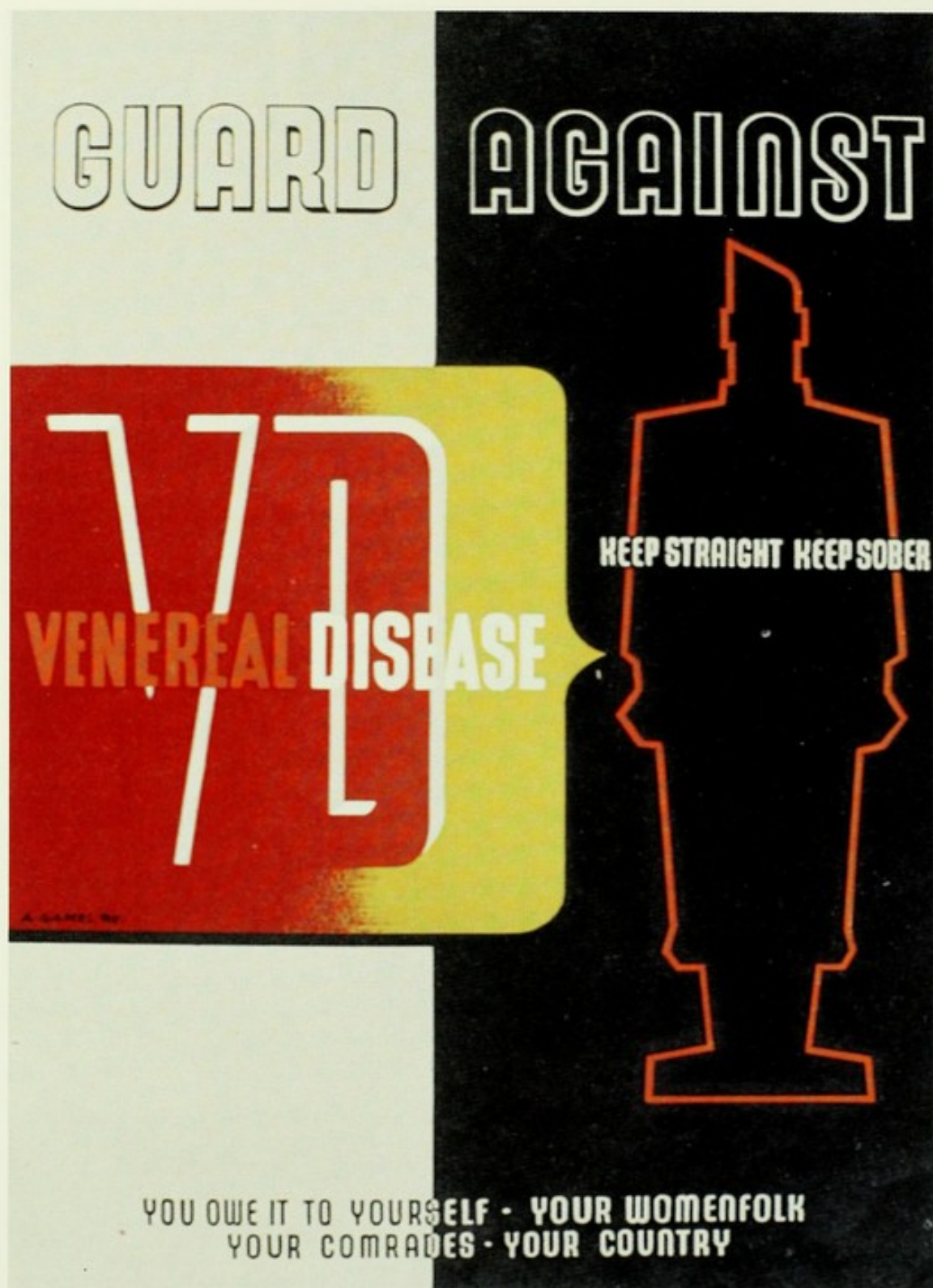
24 hour specialist nursing care 24 hour food service counselling physiotherapy occupational therapy good food 24 hour nursing hours

LONDON LIGHTHOUSE 111 - 117 LANCASTER ROAD LONDON W11 1QT TELEPHONE 071 792 1200

London Lighthouse poster. Item A.8



Red-ribbon shoes. Item V.3



Poster by Abram Games. Item A.1

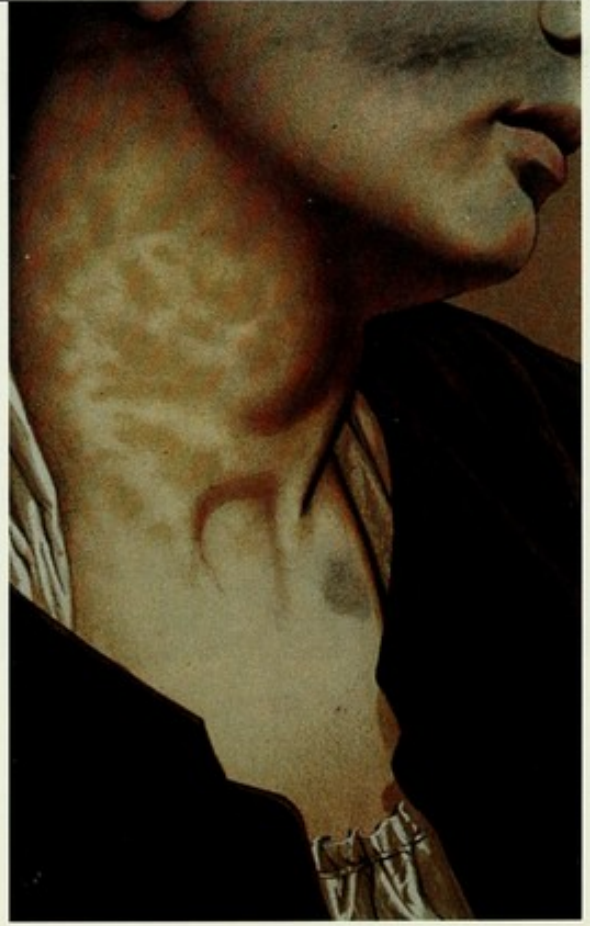


That's Phyllis
... that was!

WATCH YOUR STEP
You can avoid V.D.

Anti-VD poster. Item II.2

George Henry Fox,
Photographic illustrations of syphilis. Item III.9



Directorscut poster. Item A.5

I.11 Colour-enhanced photomicrograph of the bacterium causing syphilis

Treponema pallidum

In 1905 the venereologists Fritz Schaudinn (1871–1906) and Erich Hoffman (1868–1959) identified the spirochete responsible for syphilis. National Medical Slide Bank

I.12 'Varia medicamenta'. Physician's notebook of diseases and remedies. [1563]

The manuscript is open at the start of a section dealing with 'Morbus Gallicus' (the French disease). Guaiacum and sarsaparilla are recommended for treatment. WMS 786

I.13 Photomicrographs of brain-section of girl with congenital syphilis.

Walthamstow, 1912

This image was made from a girl aged 9–10 with congenital syphilis. It was in 1913 that the slow, crippling and fatal brain disease (General Paralysis of the Insane – GPI) was identified as one long-term result of syphilis. WMS 5361/11

I.14 (a) Steven Blankaart, *Venus belegert en ontset* (Amsterdam, 1696). (b) Corked bottles of guaiac bark, berries and leaves. English, late nineteenth century

The work is open at an illustration of 'Guajacum'. This medicinally effective tree was native to the West Indies. Guaiac was sometimes called *saint-bois*, a reference to the holy connotations that the wood was supposed to have. Its importation made a fortune for those involved in its trade. (a) EPB 13990/A; (b) loaned by the Science Museum

I.15 (a) Bronze medals by F Kounitzky commemorating the discovery of Salvarsan. German, 1910; (b) Salvarsan kit. German, c. 1912; (c) Salvarsan kit. German, c. 1912

The discovery of Salvarsan, or '606', by Paul Ehrlich and his co-worker Sahachiro Hata was announced in December 1910. The number relates to the sequence of trials they made leading up to Salvarsan. The medals show the scientists on one side, and, on the other, Hercules fighting the nine-headed monster Hydra. Beneath the beast are two skulls of its victims. The Salvarsan kit was manufactured by W Martindale and Lucius and Bruning. Loaned by the Science Museum

I.16 (a) Letter from Paul Ehrlich to Alfred Bertheim. August 14, 1913.

(b) Container of 'Kharsivan'. (1917)

In this letter, Ehrlich complains that "all opponents have joined together to express their hate against Salvarsan". The drug was initially thought to be something of a 'magic bullet' cure for syphilis. Early hopes were soon dashed, and much criticism of the drug followed. However, it did control contagious lesions and provide a cure so long as the disease was caught in its primary stage. During the First World War in England, when the German product was unobtainable, Burroughs Wellcome & Co. were licensed to produce a version under the name 'Kharsivan'. (a) WMS 6078; (b) Loaned by the Science Museum

I.17 (a) *Die Syphilis...* Edited by Emil Meirowsky and Felix Pinkus. (Berlin, 1923).

(b) Tube for Wassermann test in wooden box. British, early twentieth century

Wassermann's test for syphilis is conducted with blood samples. The illustration shows the negative and positive results. The discovery of the causal bacterium, the development of the drug Salvarsan, and the invention of the Bordet-Wassermann serological test were the three chief developments in the modern science of syphilis. Though not fail-proof, it allowed many more cases of both early and late syphilis to be detected than before. (a) Mod Med WC; (b) loaned by the Science Museum

I.18 Samples of Penicillin Sodium Salt. Produced by Commercial Solvents Corporation, Indiana, USA. 1994.

Alexander Fleming's discovery of penicillin and its subsequent development by Oxford researchers dramatically changed the treatment of syphilis. The first successful use in cases of early syphilis were conducted in the United States in 1943; from the 1950s it began to be widely used. Subsequent dramatic reductions in syphilis cases led some, prematurely as it turned out, to herald the end of syphilis. Loaned by the Science Museum

SECTION II

SYPHILIS: PUBLIC PERSPECTIVES

Almost from its first appearance, syphilis has been a disease wrapped up in shame. As with other sexually transmitted diseases, its public history has in part been one of identifying responsible agents, be they astrological, theological, moral, or, as was most frequently suggested, foreign. Argument has in particular raged over the likely guilt of Columbus's men returning from the Americas.

Medical interest in syphilis was thus from the start inextricable from moral and social concerns. Feeding off a fear of the disease that has waxed and waned ever since, social groups have campaigned against the 'venereal peril', and governments, have as a consequence attempted to police the sphere of public health.

Syphilis, prostitution and the armed forces have long formed a worrisome association for governments and policy makers. In Britain, the legislative outcome of these concerns were the notorious Contagious Diseases Acts – measures aimed at controlling the activities of 'suspicious' women – which were first passed in 1864 and repealed in 1883.

The first and second world wars ensured that syphilis reached new epidemic proportions, with an almost hysterical fear of the disease being fanned by numerous propaganda campaigns. However, this period also saw a shift in campaigning emphasis from punitive control to public education.

II.1 Christopher Columbus. Bronze. Nineteenth century [?]

The idea that syphilis might have been brought back from the Americas by Columbus's men was being suggested by the early sixteenth century. The theory has been argued over ever since, with enormous quantities of scientific, archaeological, biblical and art historical evidence being forwarded on both sides.

Iconographic Collections – icv 18823

II.2 'That's phyllis... that was!' and 'He trusts you'. Original artwork (signed Hooper) for anti-VD posters. 1943–44

These posters were designed for use among the Allied troops. They are from the papers of Major General Sir Ernest Cowell, who was Director of Medical Services, Allied Forces, North Africa, and Chief Surgeon under Eisenhower's Command, 1942–1944. Both the incidence and fear of syphilis dramatically increased from the First World War on, and only waned after the Second World War with the use of antibiotics.

CMAC/466/48

II.3 'West view of the lock hospital and its chapel. Kingsland'. Coloured etching after drawing by Robert Blemmel Schnebbelie, 1815

The Lock Hospital was set up in London in 1746 to accommodate VD patients who were excluded from general hospitals. The vast majority of them were either soldiers or prostitutes. In the nineteenth century, blame for the disease became more and more focused on prostitutes, leading to the setting up of the much reviled Contagious Diseases Acts of the 1860s. One of the elements of these laws was the compulsory hospitalization of any woman suspected of operating as a prostitute near an army camp or naval base.

Iconographic Collections – icv 13704

II.4 'The careless and the careful'. Aquatint by Thomas Rowlandson. 1815

This is no.59 in Rowlandson's series of aquatints 'The English Dance of Death'. Leading the dance is a cloaked skeleton; a dandy with a young woman on each arm follows behind. Throughout its history, the association of loose morals and syphilis has been a constant refrain.

Iconographic Collections – icv 42591

II.5 Pietro Lorenzo Riari, 'L'idra morbifica per l'ercole vegetabile sterminata'. [Bologna, 1780]

Pasted to the work's title page is an engraving of Hercules fighting off the Hydra of Lerna. The image was commonly used as an allegorical depiction of syphilis, and indeed of diseases more generally. Riari's work on a new vegetable remedy for VD contains testimonials relating to its effectiveness. The public's dislike of mercury made any number of alternative remedies popular for a while.

WMS 4199

II.6 'Ten plain facts about VD'. Press cutting from *Manchester Guardian*.

19 February 1943

This Ministry of Health article urged on the public the importance of knowing "of the existence of venereal diseases; their prevalence in war-time; how they are caused; the urgent necessity for early treatment; and where advice and treatment can be obtained". While declaring that "Ignorance and secrecy are highly dangerous", it also explained that "Clean living is the only way to escape infection".

CMAC PP/JRH A341

II.7 'Venereal diseases centres in the ports at home and abroad where seamen can obtain treatment'. (1940). 'Memorandum on organisation of work at venereal disease treatment centres'. (1921) Ministry of Health pamphlets

Omitting 'Enemy ports', the list ran from Abadan to Zeilah. The rationale behind the arrangement of a military VD treatment hut was to enable "medical officers to deal with large numbers of patients with smallest possible expenditure of time and energy". It also includes suggestions for modifications that would allow "Treatment of both sexes at the same time".

CMAC PP/JRH/A339

II.8 Wolff Cyclops, *Antidotarius contra furiosam Veneris frenesim*.

[Nuremberg, c. 1520]

The title page of the work shows an allegorical depiction of syphilis. The figure on the right is a jesting Venus who holds a mask. The heart depicted between her and the man on the left is shown suffering multiple attacks: being sawed in half, engulfed in flames and pierced by an arrow. Such representations of the 'spectre of the pox' occur frequently in the iconography of syphilis.

EPB 1695

II.9 Notes relating to venereal disease rates in the army taken by Dr George Kincaid Pitcairn. From the papers of Sir George Ballingall (1780–1855)

Pitcairn's statistics are for the 49th Regiment from 25 June 1839 to 30 September 1844. Cases of syphilis and gonorrhoea are roughly equal. Ballingall, who collected this material, was Professor of Military Surgery at Edinburgh University, where he used it for case histories to illustrate his lectures.

WMS 6905/39

II.10 (a) 'Anti-venereal diseases campaign'. List of Ministry of Health campaign material (1945). (b) 'Venereal diseases photographic display'. Ministry of Information leaflet

This material was part of national campaign, launched in 1942, to educate the public on the subject of venereal diseases. The posters available included "a shadow on health" (image of man), "a shadow on happiness" (woman) and "a shadow on his future" (young boy). "It is particularly desirable, [explained the leaflet,] that a responsible person, ... should be in the room all the time when the display is being presented, to answer questions and so on".

CMAC PP/JRH A338

II.11 'How to fight venereal disease'. (1922). National Council for Combating Venereal Diseases leaflet

The Council's aims included providing "accurate and enlightened information as to the prevalence of these diseases" and promotion of "greater facilities for their treatment". "It is quite a mistaken idea, [it declared,] that these diseases only come as penalties for wrong doing". It also asserted that providing "healthy recreation for leisure hours" would therefore ensure young people's minds were "kept off sex, and the temptations to sexual misconduct will be very much less for them".

Mod Med pam WC 140 1922 N27h

II.12 'A sale of English-beauties in the East Indies'. Etching and watercolour by Thomas Rowlandson 1810, after James Gillray

The scene shows a group of prostitutes about to be auctioned. In the foreground is a row of barrels labelled 'Leake's Pills', an anti-syphilitic drug popular in early nineteenth-century England. The auctioneer's stand is improvised from a parcel of condoms sent from Mrs Philips's shop in Leicester Square. The caricaturing of syphilis, prostitution and cures like Leake's pills was common enough for it to be used as a trope in other satirical subjects, most notably politics.

Iconographic Collections – icv 48233

II.13 Salt-glazed stoneware jars for mercury ointment and pills. English, late nineteenth century

The unpleasant side-effects of mercurial treatments were numerous: aching bones, loss of hair and teeth, rotting kidneys. Even more worrying, the preparations had a noticeable enough smell that the 'cure' commonly indicated the presence of the disease. Thus mercury turned a secret disease into a public badge.

Loaned by the Science Museum

SECTION III

SYPHILIS: PERSONAL PERSPECTIVES

The sexual connotations of syphilis have often led to those afflicted with the disease being socially ostracized. Symptoms of the disease, and likewise the signs of its treatment, were readily turned into marks of shame. This sense of embarrassment surrounded even the name of the disease, which hid behind any number of euphemisms.

Questions of who had the disease, and where they contracted it were often questions pursued to the point of obsession. Early in its history, the focus of such inquiries was national: hence such terms for syphilis as 'French sickness', 'Neapolitan sickness', 'Polish disease', 'German disease', 'Russian disease', and so on. Later, interest shifted to social identification of syphilitics: men, who were most likely to be identified as soldiers or husbands; women, who if not 'guilty' as prostitutes and the like, were seen instead as 'innocent' wives; and, to continue the family theme, children who were even more innocently infected by their mothers.

By the inter-war period, a whole generation lived in fear of VD. And curiously, though rendered far less fearful by medical breakthroughs, syphilis still figures as a disproportionately shameful, surreptitious disease.

III.1 (a) Douglas White, *An open letter to young men* (1922).

(b) Mary Douie, *How girls can help towards social hygiene*

Aimed at boys and girls, these two booklets were published by the National Council for Combating Venereal Diseases. As White explained, they were about "a subject which is often a matter of laughter and jest", and were written to combat misinformation picked up "in the gutter of dirty conversation". Douie explained that VD attacked "the innocent as well as the guilty". The advice of both was summarized by White: "The only way to keep healthy is to avoid fornication". (a) Mod Med WC140 1922 W58o; (b) CMAC SA/HVA/D8/1

III.2 Franz Peter Schubert. Collotype. c. 1900, after Wilhelm August Rieder, 1825

The occurrence of syphilis among the famous provoked much comment, as well as rumours and accusations. Its association with the arts led some to speculate that the disease could inspire great work, giving it darkly positive associations. Baudelaire, Flaubert, Ibsen, Maupassant, Schumann, Schubert and Toulouse-Lautrec have been claimed as some of its more famous victims. Flaubert observed that "Everybody has [syphilis,] more or less".

Iconographic Collections

III.3 Wyeth's V-Packettes. Two examples. Canada. 1940s

These prophylactic kits were provided to soldiers in the Second World War. They contained one tube of silver picrate and one container of calomel ointment. The instructions informed soldiers that "VD is a master saboteur of Health and War Effort". Though condoms were known to be effective against the spread of syphilis, military authorities were not keen to provide them for fear of encouraging 'loose living'.

Loaned by Imperial War Museum

III.4 'Syphilis'. Gouache and watercolour on board by Richard Tennant Cooper. Paris, 1910

In this illustration an Edwardian man of the world, surrounded by evidence of a sporting life, is shown reacting in despair to the revelation of his infection with syphilis. The ghostly figures to his right depict both the cause of his infection and the effects that the disease will have.

Iconographic Collections – icv 17576

III.5 Ulrich von Hutten, *L'experience et approbation...Touchant la medicine du boys dit guaiacum* (Paris, [1520?])

The woodcut on the title page shows a man (possibly von Hutten himself) suffering from the effects of syphilis. In this spirited work, von Hutten chastized the Church for its pronouncements and the medical profession for its ineffective cures. He poured particular scorn on the use of mercury, the disturbing side-effects of which he described in distressing detail. For his own treatment he preferred the use of guaiac.

EPB 3365

III.6 (a) Girolamo Fracastoro, *Syphilis, sive morbus gallicus* (Verona, 1530).

(b) Portrait of Girolamo Fracastoro. Line engraving. 1688

This is the first edition of the poem by Girolamo Fracastoro (1478–1553) in which the word syphilis first appears. It starts “Through what adventures this unknown Disease/ So lately did astonished Europe seize”. The story concerns a shepherd named ‘Syphilus’ (literally ‘pig lover’), who is struck with venereal disease to punish him for offending the Sun. The use of this name only superseded that of ‘the pox’ from the end of the eighteenth century. The portrait appeared as a plate to *Freher’s Theatrum virorum* (1688).

(a) EPB 2391; (b) Iconographic Collections – Catalogue no. 3123

III.7 Joseph Grünpeck, *De pestilentiali scorra* (Augsburg, [1496])

This is the oldest printed work to deal with syphilis. Sebastian Brant’s woodcut illustration shows the child Jesus looking benevolently at syphilitic patients below him. The reproduction of the other Brant woodcut reveals an astrological concern for the appearance of the disease, which Grünpeck dwelt on extensively. Ironically, Grünpeck was later himself to contract the disease that he had described as the most horrifying, terrible, and disgusting “ever.. known on this earth”.

EPB 2951

III.8 Case notes and photograph of a syphilis patient. London, 13 March 1931

This syphilitic patient is described as aged 28, living in Hackney and working as a casual labourer. Five weeks prior to the consultation he noticed painless swellings beneath both sides of chin which his doctor “told him... were due to bad teeth”. It is also recorded that his wife’s sister was “on the Roads” and that she “kissed him” when last he saw her. These notes are from the papers of Dr Donald Hunter (1898–1977) who may have gathered them in his role as Curator of the Museum of the London Hospital Medical School.

CMAC PP/HUN c1/75

III.9 George Henry Fox, *Photographic illustrations of syphilis* (New York, 1881)

The volume contains “plates from life colored by hand”, which Fox felt would significantly advance the ability of physicians to detect a disease notoriously difficult to diagnose. A life-like record of the “legible lesions” of syphilis rendered by coloured photographs, the book was thus a dictionary of “the written language” of the disease. The production of images like this demanded complete co-operation from patients.

Mod Med +WC160 1881 F79p

III.10 Correspondence and case-notes of Robert Whytt. 1744–1765

Whytt consulted with John Rutherford in drawing up these directions for a Mr Mill, who had contracted VD in 1761. Whytt explained that he suspects that “the quantity of mercury which he has taken at various times must have been much more than sufficient to destroy intirely [sic] any venereal taint which he might have received”. He also revealed that he was “doubtfull [sic] whether the case was originally venereal or not”. WMS 6872

III.11 Four containers of ‘venereal disease prevention’ drugs. German, 1914–18. Packets of bismuth subgallate. German, 1914–18. Jar and confection glass of blue pills. England, late nineteenth century. Bottles of Burroughs Wellcome & Co. ‘Grey Powder Tabloids’. English, 1899–1946

The vast range of medicines that have been used against syphilis have been prone to waves of fashion. Between the World Wars, for example, the use of arsenicals reigned supreme. Frustration with a single cure led many doctors to prescribe mixtures of ‘cures’.

Loaned by the Science Museum

III.12 Medicine man’s ‘muti’ (rag bundles and twigs) treatment for syphilis. Rhodesia, 1880–1925. Amuletic leather and cloth girdle containing secret remedy against VD. Nigeria, 1890–1931. Packet of ‘Babazo’ powder. Ghana, 1987

As this selection of remedies reveals, syphilis is very much a world-wide disease. Practitioners have drawn on any number of medical traditions in their struggle against it. To the distress of their patients, most of them (from traditional folk cures to scientific medicines) have at best alleviated some of the disease’s symptoms.

Loaned by the Science Museum

III.13 Thomas Randolph, *Cornelianum Dolium* (London, 1638)

In the engraved title page to this work, the hero of the play is shown in a sweating-tub – also known as Cornelius’s tub. Allusions to this treatment are to be found in many writers of the 16th and 17th centuries, including Shakespeare. The work is a Latin comedy which deals with various treatments for syphilis undergone by its hero. EPB 5332

III.14 A man in bed suffering from syphilis. Line engraving by P Galle after J van der Straet. Antwerp, c. 1600

Set in a domestic interior, the two characters on the right are shown preparing the anti-syphilitic drug guaiacum. The standard preparation was to make up a concoction from shavings of the guaiac tree. On the left is a syphilitic patient in bed drinking the medicine.

Iconographic Collections – Catalogue no. 5444

III.15 Steven Blankaart, *Die beläget und entsetzte Venus...* (Leipzig, 1690)

The frontispiece shows a series of patients in different stages of the disease, undergoing a variety of cures. In the background, a man in bed is vomiting into a bucket. In the foreground, a man is in a sweating tub. To his right is another seen covered in sores, whose nose is visibly disfigured – both common symptoms of syphilis. Beside him is probably a jar of mercury ointment.

EPB 13991/A

III.16 'Syphilide pustuleuse en grappe'. Coloured stipple engraving by Salvatore Tresca. Plate no. 41, from J L Alibert, *Description des maladies de la peau* (Paris, 1806)

This illustration was made from observations made at the Hôpital Saint-Louis in Paris, where Alibert worked from 1801. There he founded the first specialist clinic in dermatology, devoting himself to the classification of skin diseases. Along with personally specific images like this, Alibert's text gave dramatic accounts of the patient's medical and personal histories. His work helped the Saint-Louis become a pre-eminent centre of dermatology.

Iconographic Collections – icv 9882

SECTION IV

AIDS: SCIENTIFIC PERSPECTIVES

In the late 1970s, physicians in New York and California started noticing cases of previously rare infections among young homosexual men. The first official announcement of a death from a disease that still did not have a settled name came on 5 June 1981.

Further cases of what came to be called AIDS (Acquired Immune Deficiency Syndrome) revealed that groups other than gays were also at risk: intravenous drug users, recipients of blood transfusions, haemophiliacs, and babies *in utero*. The search for a common cause led researchers in French and American laboratories to investigate a human retrovirus. In 1983 they announced the discovery of what was later called the HIV virus. This breakthrough led to great hopes for accurate diagnosis, prevention and treatment for AIDS, only the first of which has so far been forthcoming.

A huge amount of scientific information about the causal agent and spread of the infection has been produced extraordinarily quickly. Within the scientific community, however, some of this work has been characterized less by collaboration towards a common cause than by aggressive competition and bitter dispute. Enormous anxiety and sorrow over the human cost of AIDS have also fuelled extensive criticism of official efforts to cope with the crisis, focusing in particular on commerce and governments.

IV.1 Photographs of changes in nails and lesions on feet related to Kaposi's Sarcoma

The first suspicions about the syndrome that turned out to be AIDS were raised by a series of patients who developed Kaposi's Sarcoma, a previously rare type of cancer. Many were also struck with a rare pneumonia. It is one of the diseases that can be brought on by the HIV virus wearing down the body's defence system. Its onset is a sign that HIV positive people have AIDS.

National Medical Slide Bank

IV.2 Colour-enhanced electron micrograph of Human Immunodeficiency Virus (HIV) budding from a T lymphocyte

It was in May 1983 that the viral cause of AIDS was publicly announced.

Acrimonious disputes between Robert Gallo at the National Cancer Institutes in Maryland, USA and Luc Montagnier at the Institut Pasteur in Paris subsequently surrounded the question of who discovered it first. The name HIV was adopted in 1986.

National Medical Slide Bank

IV.3 (a) Sample boxes of 'Retrovir'. (b) Photograph of 'Retrovir' production at The Wellcome Foundation Ltd's Dartford works (c) 'AZT on trial'. Conference leaflet (1993)

'Retrovir' is the trade name for the drug better known as AZT. It works by inhibiting an enzyme, which the HIV virus requires in order to reproduce itself in the body. Initially synthesized in the 1960s, it was developed as an anti-HIV drug in the 1980s, with the first licences being granted in 1987. Some people initially looked to it as a possible cure. As the leaflet indicates, it also became the focus of much criticism in the wake of disappointments about its effectiveness.

(a) and (b) loaned by The Wellcome Foundation Ltd

IV.4 'Red ribbon'. Work in mixed media by Chris Packam. 1994

It was the emergence in the early 1980s of 'risk groups' other than gays – haemophiliacs, intravenous drug users together with recipients of blood transfusions – that indicated the key role played by blood in the spread of AIDS. Since then, it and the colour red have become inseparably associated with the disease and its culture. Once blood donations started being screened in 1985, giving blood was used by some as a way to test for HIV positiveness.

IV.5 'Sharpak'(sharps bin) produced by DRG Hospital Supplies. 'Safeskin' latex exam gloves

The use of protective equipment like this has become standard practice in all sorts of medical contexts exposed to the HIV virus. Their widespread use has spawned the term 'barrier' nursing. Uncertainty and ignorance about how AIDS was transmitted prompted some to take extreme care in guarding against any contact. The first recorded case of a hospital worker contracting HIV from a patient was in February 1985.

IV.6 Wellcozyme HIV 1+2 testing kit

This testing kit detects antibodies to HIV in blood or sometimes saliva. Relative to other diseases, the time taken by medical scientists to produce a screening test was very short. Some controversy surrounded the introduction of early tests.

Donated by Murex Diagnostics Ltd

IV.7 Selection of printed material relating to AIDS research

The enormous amount of attention and concern raised by the AIDS epidemic has made it the most studied disease of the late twentieth century. An enormous amount of scientific enquiry has focused on HIV, with a number of scientists basing their careers on its study.

Modern Medicine Collection

IV.8 Protective coat, apron, headwear and over-shoes. Biomedical laboratory equipment. Photograph of laboratory at the Institute of Cancer Research. 1995

In this country, some of the most important AIDS research has been done at the Institute of Cancer Research. Scientists there made important breakthroughs in the test format for the HIV virus, produced an early epidemiological analysis of the link between HIV and AIDS and added considerably to experimental knowledge of the cell biology of HIV infection. The laboratory equipment and protective clothing used in this work is typical of much biomedical research involving infectious microbes.

Donated by the Institute of Cancer Research

IV.9 (a) 'The challenge of HIV'. Haemophilia Society leaflet. (b) Screened blood pack produced by the North London Blood Transfusion Centre

The leaflet explains that "1,200 people with haemophilia in the United Kingdom are now HIV antibody positive". HIV-screened blood products were made available in the UK in 1985. Some of the press treated news of the transmission of HIV through the blood supply as examples of infection of the 'innocent' in contrast to other groups.

(b) Donated by the North London Blood Transfusion Centre

IV.10 'Rupert – a life story'. Photographs by Paul Reas, from *Positive lives, responses to HIV: a photodocumentary*. Edited by Stephen Mayes and Lyndall Stein (London, 1993)

These photographs were taken by Paul Reas in collaboration with his subject. "Along the side of my hospital notes, [writes Rupert Haselden,] is a row of little coloured stickers... one for each year of survival.... Currently I have five". Early on in the epidemic, fear of the syndrome was such that it was difficult to get AIDS patients hospitalized or even treated at home.

IV.11 Jim Stott, 'Renewed hope for vaccine against AIDS'. *MRC News* No. 65 (Winter 1995)

This optimistic article in a Medical Research Council magazine explains that "scientists believe that the new knowledge gained will eventually give them the power to outwit the devious HIV virus". The MRC called the first meeting of its working party on AIDS in October 1983. It was chaired by Dr David Tyrrell of the Common Cold Unit.

IV.12 (a) 'Government in sex shock'; and 'Wellcome Trust Sex Survey' cartoon. *Independent on Sunday*; (b) Anne Johnson, Jane Wadsworth, Kaye Wellings, Julia Field, *Sexual attitudes and lifestyles* (Oxford, 1994); (c) Sex survey questionnaire form

The AIDS crisis created a strong scientific and public incentive to investigate patterns of sexual behaviour in the UK. As the cartoon and newspaper headline reveal, the media coverage of the survey as much concerned the funding of the report as its findings.

Loaned by Dr David Gordon

IV.13 'Exchange pack' for HIV behavioural and prevalence study of injecting drug users. Scottish Centre for Infection and Environmental Health, Glasgow

The pack includes a 'sin-bin' for used needles, pre-injection swabs, and condoms. The soft drink and chocolate bar reflect the tendency for drug users to have a sweet tooth. The research was done as part of a international study on levels of infection among injecting drug users.

SECTION V

AIDS: PUBLIC PERSPECTIVES

By the summer of 1982, when the term AIDS first appeared, the syndrome was already spoken of as a 'plague'. As such language indicates, AIDS was never just a medical phenomenon; panic and fear inevitably made it a thoroughly public one too.

Initially, media attention was characterized by a concern with the lifestyles of risk groups. Later educational campaigns sought to diffuse this emphasis, encouraging the population at large to feel potentially at risk and therefore involved. More recently still, concentration is again focusing on particular target groups.

In the face of ineffectual biomedical technologies, governments, initially reluctant to play a significant role, have gradually become energetic proponents of messages about healthy behaviour – particularly 'safer sex'. These 'official' messages have had to compete for public attention with the voices of pressure groups, commercial interests and the rest of the media.

The enormous culture which surrounds AIDS has also settled on a series of symbols that have come to stand in for the public's understanding of the disease, most notably condoms and red ribbons.

V.1 Post cards, leaflets, poster, badges and condom packs produced by Terrence Higgins Trust

Terry Higgins died of AIDS at St Thomas's Hospital on 4 July 1982. Started by his friends, the Terrence Higgins Trust was the first organization in the UK to produce popular leaflets about AIDS, and has had a leading role in the fight against the syndrome ever since.

Modern Medicine Collection

V.2 'Red ribbon' T-shirt from Red Ribbon Art Show, 1994

The red ribbon has become one of the key public symbols of the AIDS phenomena – the 1990s equivalent of the poppy or peace symbol. The Art Show exhibited artworks by artists and celebrities.

V.3 (a) Red-ribbon shoes. Produced by Red or Dead. 1994. (b) Red-ribbon. Work in metal and card by Andrew Kingham. 1994

Andrew Kingham's work transforms the theme into a motif with hands and a heart that, he says, "reflect the love and care that needs to be shown to those who find themselves HIV positive". The shoes mix compassion with fashion. The arts community has been particularly badly hit by AIDS, which possibly as a consequence has prompted an enormous amount of impassioned artistic creativity.

V.4 *From media to metaphor: art about AIDS*. Exhibition catalogue by Robert Atkins and Thomas W Sokolowski. (New York, 1992)

This catalogue is from an exhibition by the Independent Curators Incorporated. As can be seen from the page displayed, the artworks it exhibited drew as much on the negative as positive reactions to the syndrome.

V.5 'AIDS guidelines...' Series of government information leaflets. UK, 1987

Published under the slogan "Don't die of ignorance", this series of leaflets was aimed at among others tattooists, hairdressers, ear piercers, chiropodists and acupuncturists. As figures of known infections mounted, the British Government put more resources into the fight against AIDS. Its first major commitment of some £2.5 million for an information campaign came in December 1985. More followed later. Critics from one perspective felt this was too little too late; others were unhappy with the explicit nature of some of the publicity material and with its 'doom and gloom' tone. Modern Medicine Collection

V.6 'Sex hasn't changed much over the years. Fortunately condoms have'.

Condom advertisement. Selection of condoms and leaflets. 1990s

The almost universally broadcast advice to practice 'safe sex' has made the condom the most readily available agent for preventing the spread of AIDS. The strength of association has also turned it into one of the most potent symbols of the fight against AIDS. It has also meant that at least one industry has benefited from the AIDS epidemic.

V.7 *AIDS: you can't catch it holding hands*, Niki de Saint Phalle. (San Francisco, 1987)

Written as an open letter from a mother to her son, this book provides information about AIDS to audiences from adolescents to adults. In the initial hysterical reaction to AIDS, any number of erroneous ideas about how it was caught were in common circulation, and a considerable amount of effort was expended on exploding these myths.

V.8 (a) Articles clipped from *The Times* and *The Guardian Weekly*. (b) 'HIV & AIDS: a guide for journalists'. Health Education Authority pamphlet

Reporting on something new and unknown is difficult. Much of the early media coverage was at best uninformative; and at worst traded on public fears, myths and bigotry to produce exciting copy. This guide attempts to encourage accurate and responsible reporting of the issue.

V.9 Selection of leaflets, stamps and fliers in many languages from USA, France and the UK. 1990s

In an age of relatively cheap international travel, the AIDS epidemic quickly moved from a series of national crises to a truly international crisis. Each culture has produced a different response to the syndrome.

Modern Medicine Collection

V.10 'The government has blood on its hands', 'Silence = death', 'The AIDS crisis is not over. ACT UP' 'Buy your lies here'. Stickers and leaflet. USA, c. 1990

As is indicated by this material, the response of the communities most affected by AIDS has in the USA has been particularly militant. Growing directly out of the gay liberation movement, the group ACT UP has been particularly influential in this area. The pink triangle was originally used in Nazis Germany to identify homosexuals, and has here been symbolically inverted to represent gay pride. Loaned by the Science Museum

V.11 (a) 'HIV and AIDS'. Resource pack produced by The Wellcome Foundation Ltd. (b) *Positive action around the world*. The Wellcome Foundation Ltd publication (1994). (c) Positive Action cap

The Wellcome Foundation Ltd produces the controversial AIDS drug AZT (trade name 'Retrovir'). The company has also become extensively involved in projects concerned with social and educational aspects of the epidemic. As the resource pack used with 11 to 14 year olds indicates, most of this material focuses on HIV prevention, and is developed for use with particular audiences.

Donated by The Wellcome Foundation Ltd

V.12 'Safer sex resource pack'. Produced by Sutherland Health Ltd

This specially designed carrying case contains an assortment of leaflets, a selection of condoms and a condom demonstrator. Although advice on sexual practices was by some felt to be an infringement of hard-won personal freedoms, in the absence of effective medicines, it has become one of the chief means of AIDS prevention.

Donated by Sutherland Health Ltd

V.13 'AIDS'. Benetton advertisement. 1994

The Benetton company have repeatedly shocked the public and regulatory authorities with their advertisements. A number of them on the theme of AIDS were felt by many to be both prejudiced and exploitative. This particular image may suggest a subtle almost imperceptible difference between people with and without the syndrome.

Donated by Benetton (UK) Ltd

V.14 *Red hot and blue, Red hot and cool and Red hot on impulse*. Three AIDS benefit CDs. 1990-1994

These recordings were made "to benefit AIDS research and relief". Though not free from its critics, the regular use of benefit recordings, shows, television programmes etc. has both raised much money for AIDS causes and ensured that the issue has made a significant impact, particularly on younger audiences.

SECTION VI

AIDS: PERSONAL PERSPECTIVES

First noticed at the end of the 1970s in urban centres on the two coasts of the USA, by 1988 AIDS had been reported in 138 countries. By the year 2000, it is projected that as many as 40 million people will be infected with HIV.

The first indication of being HIV positive may be a small skin lesion, which is gradually followed by other more debilitating symptoms: weight loss, high fevers, swollen lymph nodes, oral and anal thrush and diarrhoea. HIV infection on average precedes the development of AIDS by between eight and ten years.

The responses of those with HIV and AIDS have been as varied as the individuals concerned. While some have experienced it as a tragedy, many have also used it as a positive force in various aspects of their lives: their personal relations, their community, their politics, and their creativity. In the world of art in particular, the AIDS epidemic has produced an extraordinary range of personal reflections, documentary evidence, challenges to indifference and works of public education.

VI.1 Selection of Positively Women leaflets. 'Lesbians, HIV & AIDS' leaflet. 1990s

The 'Positively Women' leaflets cover subjects such as prevention, HIV pregnancy and children, Drugs and African Women's Health issues. The group sought to fill an initial gap in information and help specifically for HIV positive women. The other leaflet, though urging solidarity with gays, describes how few risks lesbians run of contracting HIV through sexual contact with other women.

VI.2 'Scenes from an AIDS ward: a portfolio by Sue Coe'. *The Village Voice*.

22 February 1994, New York

At the invitation of the University of Texas, Sue Coe made these paintings at an Infectious Disease Ward. Accompanying this picture entitled 'Louis' is a description of the patient's father "arriv[ing] and wander[ing] from room to room looking for his son. Louis does not recognize him".

Loaned by Nat Forman

VI.3 (a) 'Buddies listen' cards. Terrence Higgins Trust. (b) 'Lets talk about...' Telekom phone card. German

The German phone card contains the slogan "Give AIDS no chance". The 'Buddies listen' cards relate to a help-line run by the Terrence Higgins Trust for people with AIDS. A Buddy is a specially trained volunteer who is paired with a person with AIDS. They provide help with everyday tasks and, often most importantly, offer emotional support.

Modern Medicine Collection

VI.4 'Quilts of love' brochure. 1994. Photograph of display in Hyde Park

The British 'Quilts of Love' project was inspired by the American Names Project's AIDS memorial Quilt, started in 1987 by Cleve Jones. Some quilt sections bear the names of people to whom they are a personal tribute. Alastair Hume, director of the Names project in Edinburgh has called the quilt "a monument built of our love, tears, joy, rage, compassion and hope".

Loaned by the Names Project

VI.5 'Legendary Children'. *Boyz*. 26 November 1994

The severe effect of AIDS on the arts world has produced a long list of celebrities with the syndrome. Included in this *Boyz* "Hall of Fame of the lads we've lost to AIDS" are Bruce Chatwin, Liberace, Derek Jarman, Anthony Perkins, Rudolph Nureyev, Rock Hudson and Robert Mapplethorpe.

Modern Medicine Collection

VI.6 'May 1995' from Directorscut calendar. London

Directorscut produces a range of products dealing with HIV and AIDS from a black perspective. Focusing on the word 'positive' it aims "to generate an understanding of the myths and realities surrounding HIV". Being black and HIV positive often involves a double dose of discrimination.

VI.7 'The Lighthouse bike ride' leaflet. London Lighthouse advertisement THUD. 10 November 1994

Started in 1987, the London Lighthouse is a centre "for people facing the challenge of AIDS". The advertisement copy reads: "Derek lost his entire family to AIDS. One year later, they're still not talking to him. That's why he called us. We always listen. We never judge. We know that family rejection can sometimes be more distressing than the illness".

Modern Medicine Collection

VI.8 'Tales of gay sex'. Eight leaflets by the Terrence Higgins Trust. 1992

This series of leaflets presented as picture stories sought to convey safer-sex education to the gay community in frank terms that would be taken notice of. From the very first days of the AIDS epidemic, the gay community has been at most risk. One outcome of the AIDS epidemic for some parts of the gay community, has been to make it more outspoken and collective in its identity.

Modern Medicine Collection

VI.9 'Could it be you? You bet your life: the last word on London's AIDS lottery'. *Time Out*. 23–30 November 1994

The title question in this magazine reflects an almost complete reversal from early media concentration on high-risk groups. Now the opposite contention is being made that everyone might be at risk. Attitudes among those most concerned with AIDS continue to fluctuate about the most helpful messages to convey.

VI.10 'In touch, checking in'. Hand-coloured intaglio etching by Howard Hodgkin. 1990

This, and a series of other images by Hodgkin, were inspired Susan Sontag's short story *The way we live now*. In it, she chronicles the responses – the humour, the fears, the conflicts and the sobering adjustments – of a group of New Yorkers to a friend's AIDS diagnosis. Hodgkin's pictures convey the tragedy of AIDS while avoiding any mawkish despair.

Loaned by Edward Cunningham

VI.11 Red ribbons

The red ribbon came into being at the New York based arts group Visual AIDS. In 1991, Jeremy Irons described what it meant for him: "concern for people living with AIDS and those who care for them".

VI.12 'AIDS and you game' produced by Daniels Publishing, distributed by the British Medical Association. 1994

This non-competitive, educational game is used to introduce ideas about HIV and AIDS to children. Through a range of activities using cards and computers, it aims to develop awareness of safe and unsafe social and sexual behaviour, as well as to promote discussion of issues. An estimated 16 million children have been infected with HIV around the world.

VI.13 Selection of 'corrective cosmetics', produced by Dermablend. USA

These cosmetics are particularly recommended for "dark spots and skin discolorations". One of the difficulties faced by some people with AIDS is gaining self-confidence to appear in public. Techniques for camouflaging Kaposi's Sarcoma lesions in particular have, for some, provided a small but important difference in the quality of their lives.

VI.14 Sharps bins for used needles, pre-injection swabs, selection of colour-coded syringes. Material distributed through The Caravan. 1995

The Caravan was set up in 1987 as a free and confidential needle exchange service to help cut down on needle sharing among injecting drug users, a habit that commonly leads to HIV infection. After gay men, intravenous drug users are one of the highest risk groups.

Donated by The Caravan, St Mary's Hospital

VI.15 Arthur Ashe, *Days of grace*. (London, 1994). Holly Johnson, *A bone in my flute*. (London, 1994). Derek Jarman, *Chroma: a book of colour – June '93* (London, 1994)

These autobiographies reflect very differently on the experiences of three men with AIDS. Arthur Ashe begins his account by describing how "of all my possessions, my reputation means most to me". Holly Johnson ends his, explaining that when he was diagnosed HIV positive he "had to get over [his] own prejudices first". And Derek Jarman's work mixes an 'AIDS autobiography' with a general meditation on colour.

VI.16 Bottles of Lavender and Eucalyptus oils; herbal preparations of Pau D'Arco, Echinacea and St John's Wort

Disappointment in the effectiveness and sometimes unpleasant side-effects of orthodox medical treatments has led many people with HIV and AIDS to use alternative therapies such as acupuncture, aromatherapy, homoeopathy and massage. For some, the appeal of these treatments is that they also give the patient a greater sense of control.

VI.17 Collecting box, Annual Report 1993–94, leaflets and part of a sample menu. The Food Chain

The Food Chain is a voluntary organization that delivers nutritionally balanced meals free to people who are house-bound with HIV related illnesses, and who might otherwise be in danger of becoming seriously undernourished. "Probably the best restaurant in London", wrote one grateful recipient of the service.

KEN ARNOLD and FIONA JAMES

ACKNOWLEDGEMENTS

This exhibition could not have been put on without the generous help of:

Jackie Adams, Nigel Allan, Roy Anderson, Richard Aspin, David Baggot,
Virginia Berridge, Chris Betts, Tim Boon, David Brady, Maria Brown,
Bill Bynum, Wayne Campbell, Chris Carter, John Carson, Simon Chaplin,
Michael Clark, John Coblenz, Martyn Cooke, Edward Cunningham,
John Davies, Andrew Dinley, Shirley Dixon, Sally Driscoll, Julie Dorrington,
Clare Dunne, Stewart Emmens, Jonathan Evans, Richard Everett, Patricia Fara,
Jane Fish, Nat Foreman, Sophia Flynn, Patrick Frean, Klif Fuller,
Geoffrey Garnett, David Gordon, Paul Groves, Marybeth Hamilton,
Geoff Harris, Chris Hayes, Wayne Hemmingway, Alastair Hume, Jasper Jacob,
Fiona James, Andrew Kingham, Jeannette Lake, Jane Lawrence,
Keith Livingstone, Nicholas Lowe, Stephen Lowther, Kan-Wen Ma,
Stewart Mayhead, Andrew Melvin, Michele Minto, Ian Muchamore,
Yasmi Naqvi, Chris Packam, Andy Peach, David Penn, Pauline Philips,
Tracy Price, Beverly Priest, Andy Revell, Caroline Reid, Katharina Rowold,
William Schupbach, Edward Shaw, Julia Sheppard, John Stephenson,
Jennifer Smith, John Symons, Avril Taylor, Phylis Teasdale, Robin Weiss,
Darren Whittaker, Marie Williams, Debbie Winroop and Suzanna Woodlea.

ISBN: 1 869835 42 5

Treponema pallidum, the bacterium causing syphilis.





Design and production: The Wellcome Trust Publishing Department. The Wellcome Trust is a registered charity, number 210183