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Peter Hegarty & Joe Rollins

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Viral forgetting, or how to have ignorance in an syndemic

Peter Hegarty^a and Joe Rollins^b

^aSchool of Psychology and Counselling, The Open University, Milton Keynes, UK; ^bPolitical Science, Queens College, City University of New York, New York, NY, USA

ABSTRACT

This paper argues for the concept of viral forgetting to understand how and why the lessons of HIV were not easy to remember in the context of COVID. Building on recently drawn analogies between the two epidemics, we argue that new normative injunctions to ‘flatten the curve’ and ‘stay at home’ individualise responses to COVID that make memory of the first decade of HIV vital in recent viral times. Individualistic responses, including those that bind individuals to social identity groups, obscure the ways in which effective care for others and the self requires a recognition of the partiality of community, the inevitability of vulnerability, and a complex interpretation of scientific evidence and human ontology. We draw on Eve Sedgwick’s thinking about ignorance and power to critique how political leadership in 2020, particularly in the USA, created chaos that suggested that an individualist masculine response to the epidemic was the only thing that could save us.

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Introduction

Memory and forgetting, knowledge and power, are among the most prevalent materials from which social worlds are wrought. As Marita Sturken offers in the opening paragraph of *Tangled Memories: The Vietnam War, the AIDS Epidemic, and the Politics of Remembering*:

Memory forms the fabric of human life, affecting everything from the ability to perform simple, everyday tasks to the recognition of the self. Memory establishes life’s continuity; it gives meaning to the present, as each moment is constituted by the past. As the means by which we remember who we are, memory provides the very core of identity (Sturken 1997, 1).

At the heart of Sturken’s enquiry is the question of what it means for a culture to remember. She asks: How is the national imaginary formed and solidified in moments of trauma? She insists further that ‘memory and forgetting are co-constitutive processes; each is essential to the other’s existence’ (Sturken 1997, 1). Relatedly, as Sedgwick

CONTACT Peter Hegarty  peter.hegarty@open.ac.uk

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pointed out, '[k]nowledge, after all, is not itself power, although it is the magnetic field of power. Ignorance and opacity collude or compete with knowledge in mobilising the flows of energy, desire, goods, meaning, persons' (1990, 4). Or as Sullivan and Tuana (2007, 1) have pointed out, 'Especially in the case of racial oppression, a lack of knowledge or an unlearning of something previously known can be actively produced for purposes of domination and exploitation'. We take it as premises that the two pandemics, COVID and HIV, have been traumatic. Both have called into question what we once thought were basic, fundamental truths about the world prompting us to inquire what, how, and why viral times occasion us to forget the lessons of the past.

HIV and COVID have both propelled the relationship between memory, ignorance, opacity and knowledge in some unexpected directions. On the one hand, as relationships between scientific bodies and ruling politicians became strained in the USA, UK and elsewhere, both epidemics seemed to call for a clear demarcation of reality from fantasy. On the other hand, in both epidemics, the 'translations' between science and politics, which refuted the 'pure' categorical distinction between these two, were very easy to observe (c.f. Latour 1993). Science and experience both tell us that there are also significant differences between the viruses' relationships with us. HIV is transmitted through intimate physical contact and sharing bodily fluids, and the long period between infection and the presentation of symptoms meant that millions died before the institutions of biomedical science developed effective treatments and prophylaxis. COVID moves among human bodies much readily than HIV; airborne transmission makes it particularly difficult to avoid. Imagined first as a disease that was confined to the four-H groups, homosexuals, Haitians, heroin users and people with haemophilia, HIV was long ignored by politicians and overlooked by most of the population that thought itself conveniently outside the bounds of risk. Despite great current uncertainty about why some seem to contract it and suffer more than others, everyone seems more evidently at risk of COVID. When the risk of HIV transmission became clearly less contained than expected, legislators in the UK and elsewhere, began to explore the possibility of criminalising it, assuming that the risk of transmission depended on some groups being simply reckless in their behaviour (Weait 2007). In the case of COVID in the USA, recklessness in regard to prophylaxis was fostered from the top by former President Donald Trump's narratives of toxic masculinity and cowboy individualism. Nevertheless, discursive practices of memory and forgetting have had some unexpected and pernicious effects on the flows of power throughout culture and politics. In what follows, we turn attention to these discursive practices in order to assess the ways they transmit viral formations of another sort: in the form of knowledge, information and power, but particularly in terms of what, how and why viral times exhort us to forget.

The curve is always already flat

In the time of COVID we have all become, once again, the avid consumers of medical statistics. Graphs are potent means of representing and intervening in large realities by representing seeming immutable and incontrovertible facts. The epidemic itself, the virus, the infections, the illnesses, the deaths, they all begin to seem like merely

particular examples of the more important abstract aggregation in the 2-D curve. Florence Nightingale's campaign for improved nursing standards in the Crimean war once led her to represent the relative loss of life from combat and infection in a new kind of pie chart. Like her 19th century coxcomb diagrams, COVID curve draw together an avalanche of numbers to re-present people's lives and deaths as if no representation had happened at all. (Latour 1986; Hacking 1990).

Indeed, that apparent lack of translation is what makes graphs so persuasive and convincing. Early in 2020, a new norm sought to recruit citizens to the new goal of 'flattening the curve', an injunction that seemed to forget the metaphorical relationship between a COVID curve and real infections, hospitalisations and deaths. Beyond this imperative, COVID curves rank and naturalise nation states, erasing those whose citizenship and residence differ, organising competition about where and when economic activity is first projected to speed up again, and where economic investment might rationally occur. This norm invites us to reason abstractly, or as if we were *in* the graph itself (Ochs, Gonzales, and Jaccoby 1996). Exemplifying this forgetting in a display on national bravado, President Trump's approach to the pandemic attended to what he called *his* numbers, behaving as if 'flattening the curve' could be done in the same way that a hurricane's path might be re-directed with a marker pen.

When times change dramatically, not only are we urged to reason with new statistic abstractions, historical analogies also re-run stories from an apparently more settled past to relocate the unpredictable present in a larger class of knowable historical events (Ghilani et al. 2017). In the early crisis days of the AIDS pandemic much was unknown: was there an underlying causal agent; was it transmissible and, if so, how, and who was at risk? Could tests, treatment or a vaccine be developed? Some social historians engaged in such analogical thinking with urgency, breaking disciplinary norms against engaging with the present at all (Fee and Fox 1992). Like AIDS, COVID-19 arrived shrouded in mystery. Unlike AIDS and owing in large part to research inspired by HIV, SARS, Ebola and other intervening pandemics, the Coronavirus was identified quickly, initiating large-scale collaborative research into transmission and treatment.

In 2020, several short articles and editorials framed the historical lessons of HIV for COVID and the risks of forgetting those lessons (e.g. Bowleg 2020; Jones 2020; Logie and Turan 2020; Shiao et al. 2020; Whiteside, Parker, and Schramm 2020). The risk of drawing analogies resembles the risks of graphical metaphors; both forget that a representation has taken place at all. HIV-COVID analogies in particular risk forgetting the continuing impact of HIV in COVID times. For people living with HIV, COVID may constitute a syndemic, i.e. a simultaneous, overlapping epidemic (Shiao et al. 2020). In Ward 86, San Francisco's 'safety-net clinic' for people living with HIV, there was a 31% increase during the month of April 2020 in HIV patients whose viral loads are no longer suppressed (Bernstein 2020). Researchers who conducted an online survey of more than 13,000 lesbian, gay, bisexual, transgender and intersex people in 138 countries in April and May 2020 found 1,140 individuals who reported that they were HIV-positive, 26 percent of them said they had experienced 'interrupted or restricted access' to the antiretroviral medication they take to treat the disease, and 55 percent of those said they had less than a month's supply on hand. Because pre-exposure prophylaxis

(PreP) is harder to obtain for those who have lost jobs and therefore health insurance, new HIV infections began trending upwards in the San Francisco area in the summer of 2020 (Bernstein 2020). Lived experience of HIV changes the ways that well-drawn historical analogies can feel. As writer and activist Alexander Chee (2020) observes in an article comparing COVID-19 to HIV, - commenting on the fact that the latter killed millions because of neglect and misinformation, and yet many people see themselves as exempt from that pandemic. He writes, 'you, like me, have also lived through it. If you didn't know this, it is because it was made invisible to you, perhaps even *by* you, if you ever believed AIDS didn't or couldn't affect you'.

Knowledge, ignorance, and unknowable constructions

By the summer of 2020 it seemed in the USA that knowledge about COVID-19 fell into four major categories: what was known; what was unknown; what was rendered unknowable; and outright lies and misinformation. The relationship between what was known and what was unknown changed rapidly; virologists began to grasp how the virus attacks the body, how it replicates, how it is transmitted, and the measures to prevent transmission that might be informed by this new knowledge. This is not to say that scientific research readily swept away the unknown, or that the limits of scientific epistemology were the only reason that ignorance is real (Alcoff 2007).

There are several reasons why the very best science does not determine the course of the pandemic. First, politicians can choose among different versions of 'nature' as the basis for the government of their peoples, creating profoundly different states of affairs in different times and places (Jasanoff 2011). By February 2021, people in the UK were experiencing the roll-out of a vaccine – to over 20% of the population – that had not yet been approved by the FDA in the USA. Long before COVID, science had been under assault in the USA from a modern conservative movement, increasingly powerful within the Republican party, that made matters of scientific consensus from climate change to sex education amenable to religious, corporate and political influence as if they were matters of freely-held opinion (Mooney 2005). Trump upped the ante against knowledge and truth from the first gross over-estimate of the size of his inaugural crowd. Tallying his lies became something of a national pastime (see Kessler, Rizzo, and Kelly 2020). Epidemics expose the weaknesses of leadership that fails to allow science to play 'its interpretive part' at all within an epidemic (Treichler 1987).

Second, even when science is not corrupted in this explicit way, its part is not the whole. It is not rational to base practices of caring for others and selves whose health may be vulnerable on biomedical knowledge alone (Mol 2006). Biomedical research does not expunge the possibility of politics, and its successes can form the basis for moralising scripts. In the summer of 2020, the competing narratives about how sick individuals who had had been ill and tested positive for Coronavirus had become framed by claims about the extent to which COVID-19 antibody positivity indicates immunity (Taylor and Eunjung Cha 2020)? A second lesson from HIV times for COVID is that the individualising knowledge produced by biomedicine can block the recognition that sometimes the answer is 'we don't know yet, might never definitively know, but still have to care on the basis of that uncertainty'.

Knowledge about HIV and COVID differ for socio-technical reasons that may easily be forgotten. In the pre-digital 1980s (Hoskins 2013), Simon Watney (1987, 13) noted that people in the UK would struggle to stay informed of what AIDS activists in New York were doing in part as publications such as *The Advocate* and *The New York Native* were subject to censorship laws. In the Summer of 2020, global publics were bombarded with information, some of which was deliberately false, and much more of which was framed in competing narratives about the news' truth or falsity, particularly in the social media. In the USA, this situation enabled the Trump administration's assault of lies and misinformation. The administration had reorganised, and largely closed the Global Health Security and Biodefense Unit in 2018. That office, established largely through the efforts of Susan Rice, was a direct response to the earlier Ebola outbreak of 2014. The dispersal of expertise from the office hampered the administration's response to COVID-19 from the start (Reuters 2020). The Trump administration subsequently withdrew from the World Health Organization, stripped the US Centers for Disease Control and Prevention (CDC) of its responsibility to track and report infections and deaths, placed misinformation on the CDC's official website, and insisted US high case numbers were a result of too much COVID-19 testing. Following the President's lead, many governors and public health officials allowed the administration to manipulate policy by removing or altering public health data in their states.

Political attacks on science in the USA have often been bound up strategies of confusing the public and its policymakers (Mooney 2005). By reducing the capacity of organisations to establish matters of fact with appropriate caution, Trump created space for deliberate manipulations and outright lies – enthusiastic support for quack remedies such as hydroxychloroquine, ingesting or injecting bleach or other disinfectants, and shining ultra-violet or very strong light into the body were all presented as reasonable topics for research into COVID prevention. Such health advice occasioned Sarah Connor's viral 'how to' parodies of the President's response to COVID (Poniewozik 2020). Poison control centres across the USA began seeing spikes in calls within hours of Trump's false announcement (Glatter 2020).

During January–March 2020, poison centres received 45,550 exposure calls related to cleaners (28,158) and disinfectants (17,392), representing overall increases of 20.4% and 16.4% from January–March 2019 (37,822) and January–March 2018 (39,122), respectively. (*Morbidity and Mortality Weekly Report*, April 24, 2020: 69(16);496–498).

President Trump also bullied the government's own agencies to produce facts differently, in line with his denial of the spiralling impact of the pandemic, in the run up to November's Presidential Election. On August 23, 2020, the US Food and Drug Administration (FDA) bowed to this pressure when it announced that it would begin investigating the therapeutic properties of convalescent plasma. In an interview with the *Journal of the American Medical Association* online network, virologist and paediatrician Paul A. Offit, described the FDA's action as a response to Trump's pressure on the agency (JAMANetwork 2020). Stephen Hahn, Director of the FDA apologised for 'misleading Americans – as part of a PR exercise by the administration – by grossly exaggerating the efficacy of blood-plasma treatment for covid-19' (Rubin 2020). On August 27, while Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases was literally unconscious undergoing surgery, the Trump

administration bullied the CDC into changing its policies regarding testing for COVID-19. The Center's new policy mandated that tests should not be administered to individuals who were asymptomatic even if they knew they have been exposed to the virus. As Alison Galvani, director for the Center for Infectious Disease Modeling and Analysis at Yale School of Medicine described events, 'This change in policy will kill' (Rubin 2020).

Epidemics of inequality, stigma and signification

As the first tranche of writing on HIV and COVID made clear, there were epidemics of inequality, stigma and signification behind the AIDS statistics and COVID curves. As Alcott (2007) notes, in addition to the ignorance produced by the limits of scientific epistemology and political ideology, privileged group identities, such as Whiteness, are characterised by ignorance. Bowleg (2020) foregrounded the social injustices and inequalities increased by COVID most likely to be glossed over by the COVID-times slogan 'we are all in this together'. For Bowleg, the ongoing history of HIV showed how inclusive calming narratives about 'all' go together with the ongoing and uneven material risks of illness. She noted that the HIV curve has flattened since the 1980s in the USA when its impact seemed to centre on 'predominantly White and class-privileged gay and bisexual men', but the curve was not flat 'for people marginalized by intersections of racism, sexism, classism, and transphobia'. Indeed, beyond and within the USA, a consistency across epidemics and syndemics is that they exacerbate the health vulnerabilities of poorer people, immigrants and others with comparatively little power, who are also often portrayed as the causal vectors of infection (Jabour 2020; Kraut 1995). 'We are all in it together' particularly forgets lived inequalities through the injunction to 'stay home' or 'shelter in place'. As Hemmings (2020) put it – the category of the household can 'only ever see queer as divergence, single mothers as pathology, migrant remittances as sad necessity, and single living as selfishness'. In the USA, White people are more likely to be able to work from home than are Black and Hispanic people, who are more likely to have jobs in health care, food industries, public safety and public utilities. Black people at risk are more likely than White people at risk to share their households with health care workers (Selden and Berdahl 2020).

A second, related way in which to conceptualise epidemics in human terms is to remember that 'stigmatization follows close on the heels of every pathogen' (Jones 2020, p. 1682). Drawing lessons from HIV, Ebola and other epidemics, Logie and Turan (2020) point out that public health responses to COVID, including social distancing, travel bans and the risk of misinformation may all exacerbate stigma, and call for research that engages the communities most likely to bear the brunt of that stigma. Several decades earlier, the US social psychologists Herek and Glunt (1988) argued in favour of the term 'AIDS stigma' over earlier terms such as 'AIDS-phobia' and 'AIDS hysteria', to emphasise how reactions to people believed to be infected with HIV were socially constructed, and not isolated individual pathological reactions. The understanding of social construction advanced by Herek and Glunt (1988) was not one in which social constructionism constitutes a form of epistemological relativism in which

all truths are equally valid (see also Hacking 1999). Rather, it was an understanding which described how AIDS stigma was assembled by reworking existing stigmatisation of gay and bisexual men, drug users and ethnic minorities, through both erasure and spectacle. Early lack of coverage of AIDS in US newspapers was one part of this process of social construction, Naming AIDS the ‘gay plague’ in the mass media and constructing ‘risk groups’ that eased the existential threat to the ‘general public’ was another.

Herek and Glunt (1988) developed their analysis in a context where behavioural science responses to HIV were newly recognised at national levels creating opportunities for US psychologists of diverse kinds to develop funded lines of research relevant to HIV which were conducive to mainstreaming gay-affirmative perspectives in US psychology thereafter (Hegarty 2018). Herek and Glunt prioritised homophobia among the several different forms of stigma that they recognised in their analysis of AIDS stigma. National responses that abstracted some gay men’s responses to the epidemic – such as safer sex – as a ‘new normal’, received criticism from some psychologists for their lack of value to other marginalised groups such as women of colour (Mays and Cochran 1988). A major weakness of thinking about stigma in the 1980s was that it rarely addressed the particularly deep effects of the pandemic on African-Americans which created the conditions for the current HIV-COVID syndemic (Cohen 1999).

Treichler’s (1987) recognition that HIV is an epidemic of signification also included an analysis of how the social construction of ‘others’ and of ‘normality’ influenced the drawing up of categories of individuals in public health and political imagination. She pointed to the now forgotten, but then circulating theory that HIV had differentially affected gay and bisexual men because viral entry occurred through the ‘vulnerable rectum’ rather than the more ‘rugged vagina’. As late as 1988, *Cosmopolitan* magazine published an article assuring women that there was ‘almost no danger of women ... contracting AIDS through ordinary sexual intercourse’, by which the author meant well-lubricated, penile/vaginal penetration (Treichler 1999, 236). Biological causal theories linking groups to risk are chronically available ways of re-narrating stigmatising narratives in viral times. However, locating risk *within* some people rather than *between* all of us does not create deliver immunity or certain relief from disease-based stigma even for those not categorised as being ‘at risk’. In AIDS-related litigation cases from 1983–1995, HIV + litigants were sometimes healthcare workers, and were almost always assumed to be heterosexual. Yet, those litigants were statistically less likely to win their cases when the judges who ruled in their cases used rhetoric that constructed HIV as a gay disease in making those rulings (Rollins 2002). Like the viruses themselves, epidemics of stigma and signification are not bounded by social constructions of groups defined as others, strangers or ‘at risk’ in viral times.

Viral forgetting

These writings on the lessons to be learned from HIV for COVID prompt us to conceptualise the category of *viral forgetting* to describe the kinds of slippages that involve denial and anxious distancing from the particularities of risk, illness and death and the responsibility to participate in a change in social norms in the face of them. Once the

pandemic can no longer be denied, narrating how its risk is limited to certain groups can be the next ideological response to it. President Trump insisted on first denying the existence of a pandemic before he later assigned blame for COVID-19 to particular groups by naming it as the 'Kung Flu' or the 'Chinese Virus', assigning blame to an identifiable 'other' in a manner reminiscent of the othering narratives associated with 'African AIDS' (Treichler 1999). Then, following the collapse of outright denial and the recognition of high risk groups, viral forgetting can take the form of wishing those groups who are at risk to be so small in number, or so disposable in their entirety that their vulnerability can be easily borne. A chilling documentary entitled *When AIDS Was Funny* (Calonico dir. 2016) shows the dismissive, demeaning attitude toward HIV that emanated from the White House during Reagan's first term in office. In that short feature, journalists and White House staff are filmed talking about HIV. What the film makes clear is the ignorance and discomfort of the staff at the prospect of taking that pandemic seriously; their childish tittering reading to our eyes today as callous disregard. By bringing the attention of the politically powerful to marginalised groups in new ways, epidemics risk exposing systems of inequality to closer scrutiny. In viral times, we forget that it is only an illusion that the groups focused upon are – socially and ontologically – discretely bounded. What else are we keen to remain ignorant of in order to protect ourselves from the real or imagined threat that epidemics pose? As Bowleg (2020) emphasised, COVID-19, like HIV, risks putting on display the effects of racism, poverty, affluence, frayed social networks, and weakened health care systems. Viral forgetting can be motivated not only by the desire to believe in the illusion that one's health is not at risk, but also to sustain ignorance that the system does not work for all (Alcoff 2007).

Accepting that everyday careful acts of prophylaxis are needed is one response to such forgetting. Logie and Turan (2020) highlighted gay and bisexual men's responses to AIDS stigma by describing the 1983 publication 'How to have Sex in an Epidemic' (Callen and Berkowitz 1983/1997) which 'explored care, love, and intimacy as reasons for safer sex motivation'. If they have nothing else in common, then the acts of putting on a condom or a face mask share the characteristic of protecting the other from what may lie within oneself, not only bounding the self from the outside. Prophylaxis is not (only) about rationally choosing to protect one's own (presumed) health but can express a shared understanding of ourselves as the preferred host organism of a virus that we are learning to live with at a novel moment in time. One insight from HIV for COVID times is to think of our human condition primarily as one that is not 'individual' at all (Griffiths 2015).

In an editorial in the *African Journal of AIDS Research*, Whiteside, Parker, and Schramm (2020, 3) described gay men's social and political mobilisation in that context as 'a unifying front that employed sharing of knowledge, comradeship, love, art, theatre, and care and support for the ill and dying'. Along with the response to HIV in Uganda, Whiteside, Parker, and Schramm (2020, 3) positioned gay men's response as teaching us such historical lessons as 'don't overlook what works; don't allow political imperatives to undermine rational action; and be open to the possibility that directives from esteemed bodies may not be entirely adequate'. Community, and the shelter of others upon which a people live, is clearly subject to viral forgetting.

Against this impulse, it is salutary to recall Jan Zita Grover's (1987) thinking about the historical specificity of the concept of 'community' that was being forgotten in the context of the first decade of HIV. Grover identified several 'keywords' of HIV times, seeking to historicise the meanings of terms that are both familiar and confusing. Among Grover's keywords were 'gay/homosexual community' and 'heterosexual community'. The former term, she noted, tended to reduce considerable diversity to a single stereotype. The latter term had recently been crafted by conservatives to portray a supposedly victimised minority. Gay communities were being displaced, the concept of community no longer signified alterity and experimentation, and its equation with 'population' has continued apace; men, Whites, business leaders, and consumers of particular products were all described as 'communities' by the time COVID arrived.

In her political memoir, Sarah Schulman (2013) describes how AIDS not only made gay individuals sick but undermined communities in part because gay communities had such a precarious hold on the homes in which they lived. Lovers and friends rarely held joint leases, so that the illness of one displaced the other(s), made rental property newly available, and facilitated the gentrification of areas such as Manhattan's East Village. For Schulman, gentrification also provides a metaphor for the forgetting of those earlier urban communities and their displacement by suburban ideals in the minds of some gay people. She is particularly critical of Andrew Sullivan's specific arguments from the mid-1990s that the historical reality of AIDS was over, and of the more general emergence of a politics of 'homonormativity' that forgot how sexuality was recognised as an axis of power in intersection with others (e.g. Sullivan 1996; see also Duggan 2003). Indeed, against that assumption that homophobia was over, same-sex couples have faced persistent discrimination from mortgage brokers and paid lifelong financial penalties in higher mortgage interest rates in the USA from the first phase of the HIV epidemic onward. As in other areas, the cost of stigma is not limited to same-sex couples as a group; *anyone* trying to raise a loan to purchase a house in an area of the USA with a high proportion of same-sex couples pays a penalty when they take on a mortgage (Sun and Gao 2019).

Callen and Berkowitz's pamphlet on *How to have Sex in an Epidemic*, exemplifies Logie and Turan (2020) claim that strategies for countering stigma should ideally be led by those communities most affected by it. Importantly, AIDS researchers and community leaders such as Larry Kramer, Peter Staley and Mark Harrington successfully pressured the US federal government to include people with HIV in scientific, scholarly work. As Anthony Fauci put in an interview with the Washington Post in COVID times, 'I felt very strongly that we needed to get them into the planning process because they weren't always right, but they had very, very good input' (Bernard 2020). Fauci was America's pre-eminent medical expert in the time of COVID-19 and was later appointed as President Biden's chief medical advisor. On 19 October 2020, Trump referred to Fauci as a 'disaster' who has been around for '500 years', while also referring to his colleagues as 'idiots' (Collins and Liptak 2020). Yet, a historical consequence of activism which shapes responses to COVID is that it is now unthinkable to consider a public health response or a research strategy in the USA that does not include diverse samples to represent populations or community participation in research (Epstein 1996).

Willful ignorance

Our concept of viral forgetting is indebted to Sedgwick's (1990) insight that the maintenance of power in an epidemic is premised on wilful ignorance. When AIDS first appeared in the USA, President Ronald Reagan did not conveniently or accidentally forget that it existed; he did so wilfully. The president broke his silence four years into the pandemic not because the administration was gathering resources and planning to address the problem, but because of the announcement that his friend Rock Hudson had AIDS (Shilts 1987, 575–580).

COVID-19 risk is also subject to a desire to not know that has found powerful political expression. This wilful ignorance includes the circling of wagons in the UK Conservative party after political advisor Dominic Cummings broke lockdown rules in May 2020 to visit his family, occasioning a large drop in public confidence in the Westminster government's ability to handle the pandemic effectively (Fancourt, Steptoe, and Wright 2020). On September 26 of the same year, Trump held what has now been dubbed a 'superspreader' event at the White House to announce his newest nominee to the US Supreme Court (Buchanan et al. 2020). Trump, Melania and their son Barron all tested positive for the virus the following Friday. After three days of round-the-clock medical care by a team of experts, Trump returned to the White House and staged an elaborate mask removal performance on the balcony. Motivated by his desire to see a strong US economy buoy his prospects for re-election, Trump insisted that businesses remain open, that life continue as normal, and that social distancing and mask wearing threatened the image of strength that he imagined his leadership presented. Only after electoral defeat and departure from the White House did the news arrive that Trump had been so dangerously ill when admitted to the hospital and that doctors had considered putting him on a ventilator (Weiland et al. 2021). Trump's wilful ignorance extended to the desire to not know about the pandemic at all. He repeatedly insisted that the reason case numbers were so high in the USA lay in the exceptional testing efforts of American doctors. Fewer tests, he claimed, would result in fewer positive results; in other words, the best response would be to remain in a state of ignorance about the extent of the pandemic.

These displays of wilful ignorance are also acts of subversive political leadership. Trump not only refused to wear a mask, but also derided his opponent Joe Biden for doing so, telling the press that he did not intend to start wearing one. His actions put Anthony Fauci in the awkward position of having to massage the facts of the situation. In mid-June when asked why face masks had not been part of the government's response to COVID-19, Fauci claimed that due to shortages of personal protective equipment (PPE), masks and other protective gear should be reserved for doctors, nurses and others on the front lines of saving lives.

Conclusion

As the viral trauma of COVID continues to move through the global population with devastating efficiency, its operations in public discourse remain as a spectacle of memory and amnesia (Sturken 1997), simultaneously realigning multiple dynamics of power. It is spectacular to experience how different communities and political systems

have responded to the pandemic: long lines at testing sites and food banks; massive losses of jobs and economic security; daily press briefings wherein politicians and public health officials bring updates and information to a worried (or sceptical) public with varying levels of recognition of the inevitability of uncertainty; sentimental shows of support for front-line workers (in the form of the evening applause rituals that spontaneously erupted in cities across the globe). Perhaps more spectacular in both the USA and UK have been the images of health-care professionals sharing their most intimate and horrifying experiences of the pandemic, taking cameras into ICU units at hospitals and pleading with the public to take COVID seriously.

What matters more, perhaps, are the spectacles of amnesia and those aspects of the pandemic that have been or will be forgotten quickly when it becomes possible and convenient to do so. Eager to travel, dine out, attend the theatre or sporting events, go to school or to the office, many people confined by 'lock-downs' and quarantine are impatient to return to the old normal, the time before COVID that is now lost, when protecting oneself was a solipsistic, narcissistic act of self-regulation like wearing a seat belt or losing weight. As time passes, we will forget the people working in fields to keep the food supply chain intact; we will ignore the health professionals who kept patients alive; we will again take no notice of the cashier at the check-out stand in our grocery stores. All the communities that have been hit hardest by COVID-19 will again slip into narratives of immigration, poverty and dependency; their time of heroic effort being lost once more to the demands of neo-liberal capitalism, as we become more bounded individuals again.

As we conclude, we are aware that much of the forgoing discussion has situated HIV in the past and our ruminations here have been, in part, an act of memory as our offices, libraries, and archives are inaccessible in this time of COVID. But before we conclude, we must also recall that HIV in 2021 is not the same pandemic that it was in 1981. Pharmaceutical advance has made HIV a manageable, chronic condition (for those who can access medication). HIV has also become pharmaceutically preventable, making the use of condoms unnecessary (at least for that reason). In New York City, Pre-Exposure Prophylaxis for HIV is advertised on all modes of public transport and the traveling public is encouraged to 'play safely', to 'step up and PrEP Up!' Sex, and its attendant risks for gay men, has been publicly presented as play again, in a manner that has long alienated many (Mays and Cochran 1988). Television commercials hawk various anti-retroviral treatments and forms of prophylaxis, assuring us that we should continue to love who we are and fulfil our individualistic aspirations free from worry about HIV. Perhaps foolish or careless, such messages allow us to forget the time when AIDS was unmanageable. Marlon Riggs's (1989) powerful phrase, 'now we think, as we fuck, this nut might kill us', no longer echoes in our minds or in the minds of those born after it was voiced. In time, amnesia will govern our memories of COVID in the same way that amnesia – generational and otherwise – has allowed us to become comfortable with the new normal of HIV. We 'all' may comfort ourselves by forgetting the lessons and traumas of COVID as so often has happened with HIV: it's a problem of representation, elsewhere and for other people, in another time, and we can forget about it. Will we rush recklessly into a new future allowing viral forgetting to become viral trauma, or will 'the lessons of the past' school us to remember that caring for vulnerable others and selves is all there is?

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