



**'HEALTH CLINIC' AS A SOCIAL SPACE AND HIV/AIDS BODY SUBJECT TO IDENTITY
PRODUCTION: CRITICAL VIEW FROM FOUCAULDIAN PERSPECTIVES**

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ABSTRACT

What does the health clinic stand for? First of all health clinic is a social space to diagnose and treat the sick persons. It has also ideological imperatives to convey a way of thinking and speaking, it is a discursive practice that linked to health with medical body of knowledge and power relation. For Michel Foucault, the clinic is stand for mode of perception and enunciation, that, allow to doctor see and naming, defining and redefining about the illness and to being a authorized body to make a statements about birth to death. Foucault illustrated that by the coming of nineteenth century medicine is no longer a two-dimensional reading of symptomatic surface into disease architecture rather shift to more dimensional engles. The , clinic a disease that enables us to think about the illness when we make a statement about the sickness , also operates not only in its familiar textual domain, but in a picture of scene of sick bed , and poetry about the disease. And that way construction of patients identity is an important consideration with this framework. Along with, Health clinic produce a social space to make standard medical procedure of diagnosing the disease body, is actually part of an interpretative grid of medical perception since nineteenth century, that is contingently constituted a very specific types of configuration of concepts, objects and disease identity.

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INTRODUCTION

For us, the human body defines, by natural right, the space of origin and of distribution of disease: a space whose lines, volumes, surfaces, and routes are laid down, in accordance with a now familiar geometry, by the anatomical atlas. But this order of the solid, visible body is only one way-in all likelihood neither the first, nor the most fundamental-in which one spatializes disease. There have been, and will be, other distributions of illness. When will we be able to define the structures that determine, in the secret volume of the body, the course of allergic reactions? Has anyone ever drawn up the specific geometry of a virus diffusion in the thin layer of a segment of tissue? Is the law governing the spatialization of these phenomena to be found in a Euclidean anatomy? After all, one only has to remember that the old theory of sympathies spoke a vocabulary of correspondences, vicinities, and homologies, terms for which the perceived space of anatomy hardly offers a coherent lexicon. Every great thought in the field of pathology lays down a configuration for disease whose spatial requisites are not necessarily those of classical geometry. The exact superposition of the 'body' of the disease and the body of the sick man is no more than a historical, temporary datum.

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Their encounter is self-evident only for us, or, rather, we are only just beginning to detach ourselves from it. The space of configuration of the disease and the space of localization of the illness in the body have been superimposed, in medical experience, for only a relatively short period of time-the period that coincides with nineteenth-century medicine and the privileges accorded to pathological anatomy. This is the period that marks the suzerainty of the gaze, since in the same perceptual field, following the same continuities or the same breaks, experience reads at a glance the visible lesions of the organism and the coherence of pathological forms; the illness is articulated exactly on the body, and its logical distribution is carried out at once in terms of anatomical masses. The 'glance' has simply to exercise its right of origin over truth. But how did this supposedly natural, immemorial right come about? How was this locus, in which disease indicated its presence, able to determine in so sovereign a way the figure that groups its elements together? Paradoxically, never was the space of configuration of disease more free, more independent of its space of localization than in classificatory medicine, that is to say, in that form of medical thought that, historically, just preceded the anatomo-clinical method, and made it structurally possible. 'Never treat a disease without first being sure of its species,' said Gilibert [1]. From the Nosologie of Sauvages (1761) to the Nosographie of Pinel (1798), the classificatory rule dominates medical theory and practice: it appears as the immanent logic of morbid forms, the principle of their

decipherment, and the semantic rule of their definition: 'Pay no heed to those envious men who would cast the shadow of contempt over the writings of the celebrated Sauvages.... Remember that of all the doctors who have ever lived he is perhaps the only one to have subjected all our dogmas to the infallible rules of healthy logic. Observe with what care he defines his words, with what scrupulousness he circumscribes the definitions of each malady.' Before it is removed from the density of the body, disease is given an organization, hierarchized into families, genera, and species. Apparently, this is no more than a 'picture' that helps us to learn and to remember the proliferating domain of the diseases. But at a deeper level than this spatial 'metaphor', and in order to make it possible, classificatory medicine presupposes a certain 'configuration' of disease: it has never been formulated for itself, but one can define its essential requisites after the event. Just as the genealogical tree, at a lower level than the comparison that it involves and all its imaginary themes, presupposes a space in which kinship is formalizable, the nosological picture involves a figure of the diseases that is neither the chain of causes and effects nor the chronological series of events nor its visible trajectory in the human body. This organization treats localization in the organism as a subsidiary problem, but defines a fundamental system of relations involving envelopments, subordinations, divisions, resemblances.

This space involves: a 'vertical', in which the implications are drawn up- fever, 'a successive struggle between cold and heat', may occur in a single episode, or in several; these may follow without interruption or after an interval; this respite may not exceed twelve hours, attain a whole day, last two whole days, or have a poorly defined rhythm and a 'horizontal', in which the homologies are transferred-in the two great subdivisions of the spasms are to be found, in perfect symmetry, the 'partial tonics', the 'general tonics', the 'partial clonics', and the 'general clonics' or again, in the order of the discharges, what catarrh is to the throat, dysentery is to the intestines a deep space, anterior to all perceptions, and governing them from afar; it is on the basis of this space, the lines that it intersects, the masses that it distributes or hierarchizes, that disease, emerging beneath our gaze, becomes embodied in a living organism. What are the principles of this primary configuration of disease? 1. The doctors of the eighteenth century identified it with 'historical', as opposed to philosophical, 'knowledge'. Knowledge is historical that circumscribes pleurisy by its four phenomena: fever, difficulty in breathing, coughing, and pains in the side. Knowledge would be philosophical that called into question the origin, the principle, the causes of the disease: cold, serous discharge, inflammation of the pleura. The distinction between the historical and the philosophical is not the distinction between cause and effect: Cullen based his classificatory system on the attribution of related causes nor is the distinction between principle and consequences, since Sydenham thought he was engaged in historical research when studying 'the way in which nature produces and sustains the different forms of diseases' nor even is it exactly the difference between the visible and the hidden or conjectural, for one sometimes has to track down a 'history' that is enclosed upon itself and develops invisibly, like hectic fever in certain phthisics: 'reefs caught under water'. The historical embraces whatever, de facto or de jure, sooner or later, directly or indirectly, may be offered to

the gaze. A cause that can be seen, a symptom that is gradually discovered, a principle that can be deciphered from its root do not belong to the order of 'philosophical' knowledge, but to a 'very simple' knowledge, which 'must precede all others', and which situates the original form of medical experience. It is a question of defining a sort of fundamental area in which perspectives are levelled off, and in which shifts of level are aligned: an effect has the same status as its cause, the antecedent coincides with what follows it. In this homogeneous space series are broken and time abolished: a local inflammation is merely the ideal juxta-position of its historical elements (redness, tumour, heat, pain) without their network of reciprocal determinations or their temporal intersection being involved. Disease is perceived fundamentally in a space of projection without depth, of coincidence without development. There is only one plane and one moment. The form in which truth is originally shown is the surface in which relief is both manifested and abolished-the portrait: 'He who writes the history of diseases must... observe attentively the clear and natural phenomena of diseases, however uninteresting they may seem. In this he must imitate the painters who when they paint a portrait are careful to mark the smallest signs and natural things that are to be found on the face of the person they are painting'. The first structure provided by classificatory medicine is the flat surface of perpetual simultaneity. It is a space in which analogies define essences. The pictures resemble things, but they also resemble one another. The distance that separates one disease from another can be measured only by the degree of their resemblance, without reference to the logico-temporal divergence of genealogy. The disappearance of voluntary movements and reduced activity in the internal or external sense organs from the general outline that emerges beneath such particular forms as apoplexy, syncope, or paralysis. Within this great kinship, minor divergences are established: apoplexy robs one of the use of all the senses, and of all voluntary motility, but it spares the breathing and the functioning of the heart; paralysis affects only a locally assignable sector of the nervous system and motility; like apoplexy, syncope has a general effect, but it also interrupts respiratory movements. The perspective distribution, which enables us to see in paralysis a symptom, in syncope an episode, and in apoplexy an organic and functional attack, does not exist for the classificatory gaze, which is sensitive only to surface divisions, in which vicinity is not defined by measurable distances but by formal similarities. When they become dense enough, these similarities cross the threshold of mere kinship and accede to unity of essence. There is no fundamental difference between an apoplexy that suddenly suspends motility, and the chronic, evolutive forms that gradually invade the whole motor system: in that simultaneous space in which forms distributed by time come together and are superimposed, kinship folds back into identity. In a flat, homogeneous, non-measurable world, there is essential disease where there is a plethora of similarities. The form of the similarity uncovers the rational order of the diseases. When one perceives a resemblance, one does not simply lay down a system of convenient, relative 'mappings'; one begins to read off the intelligible ordering of the diseases. The veil is lifted from the principle of their creation; this is the general order of nature. As in the case of plants or animals, the action of disease is fundamentally specific: 'The supreme Being is not

subjected to less certain laws in producing diseases or in maturing morbid humours, than in growing plants and animals.... He who observes attentively the order, the time, the hour at which the attack of quart fever begins, the phenomena of shivering, of heat, in a word all the symptoms proper to it, will have as many reasons to believe that this disease is a species as he has to believe that a plant constitutes a species because it grows, flowers, and dies always in the same way'. This botanical model has a double importance for medical thought. First, it made it possible to turn the principle of the analogy of forms into the law of the production of essences; and, secondly, it allowed the perceptual attention of the doctor-which, here and there, discovers and relates-to communicate with the ontological order-which organizes from the inside, prior to all manifestation-the world of disease. The order of disease is simply a 'carbon copy' of the world of life; the same structures govern each, the same forms of division, the same ordering. The rationality of life is identical with the rationality of that which threatens it. Their relationship is not one of nature and counternature; but, in a natural order common to both, they fit into one another, one superimposed upon the other. In disease, one recognizes (reconnait) life because it is on the law of life that knowledge (connaissance) of the disease is also based. . We are dealing with species that are both natural and ideal Natural, because it is in them that diseases state their essential truths; ideal insofar as they are never experienced unchanged and undisturbed. The first disturbance is introduced with and by disease itself. To the pure nosological essence, which fixes and exhausts its place in the order of the species without residue, the patient adds, in the form of so many disturbances, his predispositions, his age, his way of life, and a whole series of events that, in relation to the essential nucleus, appear as accidents. In order to know the truth of the pathological fact, the doctor must abstract the patient: 'He who describes a disease must take care to distinguish the symptoms that necessarily accompany it, and which are proper to it, from those that are only accidental and fortuitous, such as those that depend on the temperament and age of the patient' . Paradoxically, in relation to that which he is suffering from, the patient is only an external fact; the medical reading must take him into account only to place him in parentheses. Of course, the doctor must know 'the internal structure of our bodies'; but only in order to subtract it, and to free to the doctor's gaze 'the nature and combination of symptoms, crises, and other circumstances that accompany diseases' . It is not the pathological that functions, in relation to life, as a counter-nature, but the patient in relation to the disease itself. And not only the patient; the doctor, too. His intervention is an act of violence if it is not subjected strictly to the ideal ordering of nosology: 'The knowledge of diseases is the doctor's compass; the success of the cure depends on an exact knowledge of the disease'; the doctor's gaze is directed initially not towards that concrete body, that visible whole, that positive plenitude that faces him-the patient-but towards intervals in nature, lacunae, distances, in which there appear, like negatives, 'the signs that differentiate one disease from another, the true from the false, the legitimate from the bastard, the malign from the benign'. It is a grid that catches the real patient and holds back any therapeutic indiscretion. If, for polemical reasons, the remedy is administered too early, it contradicts and blurs the essence of the disease; it prevents the disease from acceding to its true nature, and, by making it irregular, makes it unbeatable. In the period of invasion, the

doctor must hold his breath, for 'the beginnings of disease reveal its class, its genus, and its species'; when the symptoms increase and become more marked, it is enough 'to diminish their violence and reduce the pains'; when the disease has settled in, one must 'follow step by step the paths followed by nature', strengthening it if it is too weak, diminishing it if it strives to vigorously to destroy what resists it' . In the rational space of disease, doctors and patients do not occupy a place as of right; they are tolerated as disturbances that can hardly be avoided: the paradoxical role of medicine consists, above all, in neutralizing them, in maintaining the maximum difference between them, so that, in the void that appears between them, the ideal configuration of the disease becomes a concrete, free form, totalized at last in a motionless, simultaneous picture, lacking both density and secrecy, where recognition opens of itself onto the order of essences. Classificatory thought gives itself an essential space, which it proceeds to efface at each moment. Disease exists only in that space, since that space constitutes it as nature; and yet it always appears rather out of phase in relation to that space, because it is manifested in a real patient, beneath the observing eye of a forearmed doctor. The fine two-dimensional space of the portrait is both the origin and the final result: that which makes possible, at the outset, a rational, well-founded body of medical knowledge, and that towards which it must constantly proceed through that which conceals it. One of the tasks of medicine, therefore, is to rejoin its own condition, but by a path in which it must efface each of its steps, because it attains its aim in a gradual neutralization of itself. The condition of its truth is the necessity that blurs its outlines. Hence the strange character of the medical gaze; it is caught up in an endless reciprocity. It is directed upon that which is visible in the disease-but on the basis of the patient, who hides this visible element even as he shows it; consequently, in order to know, he must recognize, while already being in possession of the knowledge that will lend support to his recognition. And, as it moves forward, this gaze is really retreating, since it reaches the truth of the disease only by allowing it to win the struggle and to fulfill, in all its phenomena, its true nature. Disease, which can be mapped out on the picture, becomes apparent in the body. There it meets a space with a quite different configuration: the concrete space of perception. Its laws define the visible forms assumed by disease in a sick organism: the way in which disease is distributed in the organism, manifests its presence there, progresses by altering solids, movements, or functions, causes lesions that become visible under autopsy, triggers off, at one point or another, the interplay of symptoms, causes reactions, and thus moves towards a fatal, and for it favourable, outcome. We are dealing here with those complex, derived figures by means of which the essence of the disease, with its structure of a picture, is articulated upon the thick, dense volume of the organism and becomes embodied within it. How can the flat, homogeneous, homological space of classes become visible in a geographical system of masses differentiated by their volume and distance? How can a disease, defined by its place in a family, be characterized by its seat in an organism? This is the problem that might be called the secondary spatialization of the pathological. For classificatory medicine, presence in an organ is never absolutely necessary to define a disease: this disease may travel from one point of localization to another, reach other bodily surfaces, while remaining identical in nature. The space of the body and the space of the disease possess enough latitude to slide away from one another. The

same, single spasmodic malady may move from the lower part of the abdomen, where it may cause dyspepsia, visceral congestion, interruption of the menstrual or haemorrhoidal flow, towards the chest, with breathlessness, palpitations, the feeling of a lump in the throat, coughing, and finally reach the head, causing epileptic convulsions, syncopes, or sleepiness. These movements, which are accompanied by symptomatic changes, may occur in time in a single individual; they may also be found by examining a series of individuals with different link points: in its visceral form, spasm is encountered, above all, in lymphatic subjects, while in its cerebral form it is encountered more among sanguine temperaments. But in any case, the essential pathological configuration is not altered. The organs are the concrete supports of the disease; they never constitute its indispensable conditions. The system of points that defines the relation of the disease to the organism is neither constant nor necessary. They do not possess a common, previously defined space. In this corporal space in which it circulates freely, disease undergoes metastases and metamorphoses. Nothing confines it to a particular course. A nosebleed may become haemoptysis (spitting of blood) or cerebral haemorrhage; the only thing that must remain is the specific form of blood discharge. This is why the medicine of spaces has, throughout its history, been linked to the doctrine of sympathies—each notion being compelled to reinforce the other for the correct balance of the system. Sympathetic communication through the organism is sometimes carried out by a locally assignable relay (the diaphragm for spasms, the stomach for the discharge of humour); sometimes by a whole system of diffusion that radiates through the body (the nervous system for pains and convulsions, the vascular system for inflammations); in other cases, by means of a simple functional correspondence (a suppression of the excretions is communicated from the intestines to the kidneys, and from these to the skin); lastly, by means of an adjustment of the nervous system from one region to another (lumbar pains in the hydrocele). But the anatomical redistribution of the disease, whether through correspondence, diffusion, or relay, does not alter its essential structure; sympathy operates the interplay between the space of localization and the space of configuration; it defines their reciprocal freedom and the boundaries of that freedom. Or, rather, threshold, not boundary. For beyond the sympathetic transference of the structural homology that it authorizes, a relation may be set up between one disease and another that is a relation of causality, but not of kinship. By virtue of its own creative force, one pathological form may engender another that is very far removed in the nosological picture. Hence the complications; hence the mixed forms; hence certain regular, or at least frequent, successions, as that between mania and paralysis. Haslam knew of delirious patients whose 'speech is disturbed, whose mouths are twisted, whose arms and legs are deprived of voluntary movement, whose memory is weakened', and who, generally speaking, 'have no awareness of their position'. Overlapping of the symptoms or simultaneity of their extreme forms are not enough to constitute a single disease; the distance between verbal excitation and motor paralysis in the table of morbid kinships prevents a chronological proximity from deciding on a unity. Hence the idea of a causality that moves by virtue of a slight time-lag; sometimes the onset of mania appears first, sometimes the motor signs introduce the whole set of symptoms. The paralytic affections are a much

more frequent cause of madness than is thought; and they are also a very common effect of mania.' No sympathetic translation can cross this gap between the species; and the solidarity of the symptoms in the organism are not enough to constitute a unity that clashes with the essences. There is, therefore, an inter-nosological causality, whose role is the contrary of sympathy: sympathy preserves the fundamental form by ranging over time and space; causality dissociates the simultaneities and intersections in order to maintain the essential purities. In this pathology, time plays a limited role. It is admitted that a disease may last, and that its various episodes may appear in turn; ever since Hippocrates doctors have calculated the critical days of a disease, and known the significant values of the arterial pulsations: 'When the rebounding pulse appears at each thirtieth pulsation, or thereabouts, the haemorrhage occurs four days later, more or less; when it occurs at every sixteenth pulsation, the haemorrhage will occur in three days' time.... Lastly, when it recurs every fourth, third, second pulsation, or when it is continual, one must expect the haemorrhage within twenty-four hours'. But this numerically fixed duration is part of the essential structure of disease, just as chronic catarrh becomes, after a period of time, phthisic fever. There is no process of evolution in which duration introduces new events of itself and at its own insistence; time is integrated as a nosological constant, not as an organic variable. The time of the body does not affect, and still less determines, the time of the disease. What communicates the essential 'body' of the disease to the real body of the patient are not, therefore, the points of localization, nor the effects of duration, but, rather, the quality. In one of the experiments described before the Prussian Royal Academy in 1764, Meckel explains how he observed the alteration in the brain during different diseases. When he carried out an autopsy, he removed from the brain small cubes of equal volume ('6 lines in each direction') in different places in the cerebral mass: he compared these extractions with each other, and with similar cubes taken from other corpses. The instrument used for this comparison were weighing scales; in phthisis, a disease involving exhaustion, the specific weight of the brain was found to be relatively lower than in the case of apoplexy, a disease involving discharge (1 dr 3¾ gr as against 1 dr 6 or 7 gr); whereas in the case of a normal subject who had died naturally the average weight was 1 dr 5 gr. These weights may vary according to the part of the brain from which the samples have been extracted: in phthisis it is, above all, the cerebellum that is light; in apoplexy the On the contrary, their shift implies a qualitative gaze; in order to grasp the disease, one must look at those parts where there is dryness, ardour, excitation, and where there is humidity, discharge, debility. How can one distinguish, beneath the same fever, the same coughing, the same tiredness, pleurisy of the phthisis, if one does not recognize here a dry inflammation of the lungs, and there a serious discharge? How can one distinguish, if not by their quality, the convulsions of an epileptic suffering from cerebral inflammation, and those of a hypochondriac suffering from congestion of the viscera? A subtle perception of qualities, a perception of the differences between one case and another, a delicate perception of variants—a whole hermeneutics of the pathological fact, based on modulated, coloured experience, is required; one should measure variations, balances, excesses, and defects. The human body is made up of vessels and fluids;...when the

vessels and fibres have neither too much nor too little tone, when the fluids have just the right consistency, when they have neither too much nor too little movement, man is in a state of health; if the movement...is too strong, the solids harden and the fluids thicken; if it is too weak, the fibre slackens and the blood becomes thinner. And the medical gaze, open to these fine qualities, necessarily becomes attentive to all their modulations; the decipherment of disease in its specific characteristics is based on a subtle form of perception that must take account of each particular equilibrium. But in what does this particularity consist? It is not that of an organism in which pathological process and reactions are linked together in a unique way to form a 'case'. We are dealing, rather, with qualitative varieties of the illness, to which are added the varieties that may be presented by the temperaments, thus modulating the qualitative varieties in the second stage. What classificatory medicine calls 'particular histories' are the effects of multiplication caused by the qualitative variations (owing to the temperaments) of the essential qualities that characterize illnesses. The individual patient finds himself at the point at which the result of this multiplication appears. Hence his paradoxical position. If one wishes to know the illness from which he is suffering, one must subtract the individual, with his particular qualities: 'The author of nature,' said Zimmermann, 'has fixed the course of most diseases through immutable laws that one soon discovers if the course of the disease is not interrupted or disturbed by the patient'; at this level the individual was merely a negative element, the accident of the disease, which, for it and in it, is most alien to its essence. But the individual now reappears as the positive, ineffaceable support of all these qualitative phenomena, which articulate upon the organism the fundamental ordering of the disease; it is the local, sensible presence of this order-a segment of enigmatic space that unites the nosological plane of kinships to the anatomic volume of vicinities. The patient is a geometrically impossible spatial synthesis, but for that very reason unique, central, and irreplaceable: an order that has become density in a set of qualifying modulations. And the same Zimmermann, who recognized in the patient only the negative of the disease, is 'sometimes tempted', contrary to Sydenham's general descriptions, 'to admit only of particular histories. However simple nature may be as a whole, it is nevertheless varied in its parts; consequently, we must try to know it both as a whole and in its parts'. The medicine of species becomes engaged in a renewed attention to the individual-an ever-more impatient attention, ever less able to tolerate the general forms of perception and the hasty inspection of essences. Let us call tertiary spatialization all the gestures by which, in a given society, a disease is circumscribed, medically invested, isolated, divided up into closed, privileged regions, or distributed throughout cure centres, arranged in the most favorable way. Tertiary is not intended to imply a derivative, less essential structure than the preceding ones; it brings into play a system of options that reveals the way in which a group, in order to protect itself, practises exclusions, establishes the forms of assistance, and reacts to poverty and to the fear of death. But to a greater extent than the other forms of spatialization, it is the locus of various dialectics: heterogeneous figures, time lags, political struggles, demands and utopias, economic constraints, social confrontations. In it, a whole corpus of medical practices and institutions confronts the primary and secondary spatializations with forms of a social space whose genesis, structure, and laws

are of a different nature. And yet, or, rather, for this very reason, it is the point of origin of the most radical questionings. It so happened that it was on the basis of this tertiary spatialization that the whole of medical experience was overturned and defined for its most concrete perceptions, new dimensions, and a new foundation. In the medicine of species, disease has, as a birthright, forms and seasons that are alien to the space of societies. There is a 'savage' nature of disease that is both its true nature and its most obedient course: alone, free of intervention, without medical artifice, it reveals the ordered, almost vegetal nervure of its essence. But the more complex the social space in which it is situated becomes, the more denatured it becomes. Before the advent of civilization, people had only the simplest, most necessary diseases. Peasants and workers still remain close to the basic nosological table; the simplicity of their lives allows it to show through in its reasonable order: they have none of those variable, complex, intermingled nervous ills, but down-to-earth apoplexies, or uncomplicated attacks of mania. As one improves one's conditions of life, and as the social network tightens its grip around individuals, 'health seems to diminish by degrees'; diseases become diversified, and combine with one another; 'their number is already great in the superior order of the bourgeois;...it is as great as possible in people of quality'. Like civilization, the hospital is an artificial locus in which the transplanted disease runs the risk of losing its essential identity. It comes up against a form of complication that doctors call prison or hospital fever: muscular asthenia, dry or coated tongue, livid face, sticky skin, diarrhoea, pale urine, difficulty in breathing, death on the eighth or eleventh day, or on the thirteenth at the latest. More generally, contact with other diseases, in this unkempt garden where the species cross-breed, alters the proper nature of the disease and makes it more difficult to decipher; and how in this necessary proximity can one 'correct the malign effluvia that exudes from the bodies of the sick, from gangrenous limbs, decayed bones, contagious ulcers, and putrid fevers'? And, in any case, can one efface the unfortunate impression that the sight of these places, which for many are nothing more than 'temples of death', will have on a sick man or woman, removed from the familiar surroundings of his home and family? This loneliness in a crowd, this despair disturbs, with the healthy reactions of the organism, the natural course of the disease; it would require a very skilful hospital doctor 'to avoid the danger of the false experience that seems to result from the artificial diseases to which he devotes himself in the hospitals. In fact, no hospital disease is a pure disease'. The natural locus of disease is the natural locus of life-the family: gentle, spontaneous care, expressive of love and a common desire for a cure, assists nature in its struggle against the illness, and allows the illness itself to attain its own truth. The hospital doctor sees only distorted, altered diseases, a whole teratology of the pathological; the family doctor 'soon acquires true experience based on the natural phenomena of all species of disease'. This family medicine must necessarily be respectful: 'Observe the sick, assist nature without violating it, and wait, admitting in all modesty that much knowledge is still lacking'. Thus, on the subject of the pathology of species, there is a revival of the old dispute between active medicine and expectant medicine. The nosologists of necessity favoured the latter, and one of these, Vitet, in a classification containing over two thousand species, and bearing the title *Médecine expectante*, invariably prescribes quinoa to help nature follow its natural course. The

medicine of species implies, therefore, a free spatialization for the disease, with no privileged region, no constraint imposed by hospital conditions—a sort of spontaneous division in the setting of its birth and development that must function as the paradoxical and natural locus of its own abolition. At the place in which it appears, it is obliged, by the same movement, to disappear. It must not be fixed in a medically prepared domain, but be allowed, in the positive sense of the term, to 'vegetate' in its original soil: the family, a social space conceived in its most natural, most primitive, most morally secure form, both enclosed upon itself and entirely transparent, where the illness is left to itself. Now, this structure coincides exactly with the way in which, in political thought, the problem of assistance is reflected. Independently of their justifications, the thought structure of the economists and that of the classificatory doctors coincide in broad terms: the space in which disease is isolated and reaches fulfillment is an absolutely open space, without either division or a privileged, fixed figure, reduced solely to the plane of visible manifestations; a homogeneous space in which no intervention is authorized except that of a gaze which is effaced as it alights, and of assistance whose sole value is its transitory compensation—a space with no other morphology than that of the resemblances perceived from one individual to another, and of the treatment administered by private medicine to a private patient. But, by being carried to its conclusion in this way, the structure is inverted. Is a medical experience, diluted in the free space of a society reduced to the single, nodal, and necessary figure of the family, not bound up with the very structure of society? Does it not involve, because of the special attention that it pays to the individual, a generalized vigilance that by extension applies to the group as a whole? It would be necessary to conceive of a medicine sufficiently bound up with the state for it to be able, with the cooperation of the state, to carry out a constant, general, but differentiated policy of assistance; medicine becomes a task for the nation. (Menuret in the early days of the French Revolution dreamt of a system of free medical care administered by doctors who would be paid by the government out of the income from former church property. In this way a certain supervision would be exercised over the doctors themselves; abuses would be prevented and quacks forbidden to practise, and, by means of an organized, healthy rational medicine, home care would prevent the patient's becoming a victim of medicine and avoid exposure to contagion of the patient's family. Good medicine would be given status and legal protection by the state; and it would be the task of the state 'to make sure that a true art of curing does exist'. The medicine of individual perception, of family assistance, of home care can be based only on a collectively controlled structure, or on one that is integrated into the social space in its entirety. At this point, a quite new form, virtually unknown in the eighteenth century, of institutional spatialization of disease, makes its appearance. The medicine of spaces disappears.

Social constructionists posit that social reality or disease identity is constructed through dynamic socialization and that the sociology of knowledge must examine the process in which this reality construction occurs (Berger & Luckmann, 1966, p. 1). Sociology of knowledge deals not only with empirical knowledge relative to various societies but also with the processes by which bodies of knowledge become established as social realities. In essence, reality evolves

through continued socialization, yielding outcomes that result from social interactions, negotiations, and power. Where the human immunodeficiency virus (HIV) and the acquired immune deficiency syndrome (AIDS) are concerned, social construction of reality is grounded in the spatialization and politicization of the pathological. The body of knowledge associated with HIV/AIDS represents a complexity not present in any other disease. Furthermore, the epidemic has altered the model of information production and consumption and has spawned its own vernacular, one representative of a diverse population of information producers and consumers. Further compounding this complicated communication picture, the body of information surrounding HIV/AIDS continues to grow at an epidemic rate, often in tandem with the numbers of reported cases. Finally, HIV infection is not only an extremely complicated disease process, but it also transcends the boundaries of biomedicine. Various domains shape the construction of HIV/AIDS as chronic disease, including the political, social, economic, legal, philosophical, psychological, religious, and spiritual ramifications associated with the illness. The societal construct within which the body of knowledge concerning HIV/AIDS exists mirrors the complexities of the malady and the various controversies associated with it. This diseased body of knowledge—a body of knowledge that breathes life into the pathological by providing it visibility—exists because of HIV/AIDS. Disease, and the respective body of knowledge, co-exists within a social reality, a social reality that binds and circumscribes. Consequently, the organizational schema of a controlled vocabulary designed to facilitate knowledge organization relative to HIV/AIDS must be broad in coverage yet specific in terminology so that the multidisciplinary and interdisciplinary nature of the epidemic is reflected. In representing the dynamic nosological record of HIV/AIDS, the controlled vocabulary captures the societal construct circumscribing the pathological. Nature of HIV/AIDS Infection with the human immunodeficiency virus results in a complex chronic disease process, complicated by various non biomedical factors. The disease itself is characterized by a constellation of signs and symptoms that culminate in a diagnosis of acquired immune deficiency syndrome. Ultimately, most individuals infected with HIV die of AIDS-related causes. From a biomedical perspective, what differentiates HIV from other chronic disease processes is the variety of opportunistic infections and cancers commonly associated with AIDS as well as HIV-related wasting and dementia and the wide variation in the dying trajectory. Although there have been numerous therapeutic advances where HIV is concerned, drug regimens, when available and accessible, have not proven uniformly effective. Combination therapy involving anti retrovirals and protease inhibitors, while greeted with much fanfare, has proven to be a great disappointment to the many HIV-infected individuals who have failed to improve while taking the drug cocktails. Further exacerbating the medical complexities of the illness, HIV is complicated by myriad factors outside the biomedical arena—economic, legal, political, psychological, religious, social, spiritual—that compound disease chronicity. These components of an individual's psychosocial reality exist in tandem with the biophysical illness with stigma trajectory corresponding to disease course progression (AlonLo & Reynolds, 1995, p. 306). Although the spatialiation of disease has been plotted along a historical continuum that forms the foundation for

modern medicine (Foucault, 1975, pp. 3-20), the politics and stigma associated with HIV/AIDS prevents the illness from advancing to its ultimate position in the sequence (Huber, 1996, pp. 6-9). The pathological continues to exist within a socially defined set of spaces. As well as affecting the emotional, mental, and physical well-being of the HIV-infected individual, these non biomedical complications dramatically impact education and prevention efforts, treatment advances, and coping mechanisms. The repercussion of infection and disease manifestation is much more than an individual life event. In fact, given the multifarious nature of the pathological, HIV transcends the boundaries of life and death (Huber, 1993a, pp. 230-31).

In addition to HN-related information being produced and consumed at multiple levels, the epidemic has spawned its own vernacular, one representative of the diverse group of individuals infected with the virus and those working within the AIDS arena (Huber, 1993, p. vii; Huber & Gillaspay, 1996b, p. 1). The language of the pandemic embodies cultural predispositions. This vocabulary consists not only of technical, scientific, and biomedical terminology but also includes verbiage germane to the lay population directly affected by the malady as well. The lexicon also reflects the various disciplines touched by the disease. Further complicating access to HIV-related information, the body of knowledge concerning the epidemic is growing exponentially. The literature continues to increase in volume parallel to the rise in the number of documented cases of AIDS worldwide (Huber & Gillaspay, 1996a, p. 297). In addition, HIV-related information is currently produced in every conceivable format-audiovisual, electronic, print, and is present in all discipline-specific bodies of knowledge affected by the pandemic. Societal perceptions and individual perspectives fashion the pathology of the HIV/AIDS epidemic with the course of disease progression marred by politics and stigma. Complexities associated with both the pathological condition and the body of knowledge concerning HN/AIDS exist within, and because of, social constructs circumscribing the pandemic. Illness, information, and intricacies are all entwined, evolving relative to both scientific advances and social interactions.

Although numerous studies have examined the lived experience of PLWHAs (Barroso & Powell-Cope, 2000), only a few researchers have explored the incorporation process of HIV/AIDS into identity. All studies could be classified as crisis model studies, in that they spoke about observed status passages. In short, they spoke to the incorporation of a stigmatized identity into the self. Two of the four studies presented a linear model of incorporation (Dozier, 1997; Sandstrom, 1990), whereas two believed (Gurevich, 1996; Lewis, 1994) that the process could be recursive. In general, people experienced shock and disbelief on diagnosis, spent some time in denial, struggled with the stigma of the disease, and eventually embraced the HIV/AIDS identity (Dozier, 1997; Gurevich, 1996; Lewis, 1994; Sandstrom, 1990). For some the HIV/AIDS identity became primary (Sandstrom, 1990), whereas for others it became one of many identities (Gurevich, 1996). In two studies teaching others about HIV/AIDS was important for incorporation of the identity (Dozier, 1997; Gurevich, 1996). In all cases finding a community of HIV-positive people aided greatly in the incorporation process.

Although the studies on HIV/AIDS and identity incorporation have uncovered somewhat similar findings, what remains to be investigated is an examination of identity incorporation over time. None of the aforementioned studies were conducted when there was widespread use of highly antiretroviral therapy (HAART). Furthermore, no study was found that compared the incorporation of HIV/AIDS into identity as a chronic illness with other chronic illnesses. An investigation of the incorporation of HIV/AIDS into identity at three points in time would add depth to the extant literature. This study might have practical implications as well. HIV/AIDS educators, who have historically disseminated information concerning transmission and prevention (M. Swick, personal communication, October 10, 2004), might increasingly be asked to assist PLWHAs who are grappling with identity issues. This study's findings augment results found before the widespread use of HAART.

Bio-Politics Versus Bio-Power from foucauldian perspective

Within the historical development of civilization, bio-politics, or politics of the body, emerged as a result of the "proliferation of political technologies [that] ensued, investing the body, health, modes of subsistence and habitation, living conditions, the whole space of existence" (Foucault, 1978, pp. 143-44). Prior to, and in parallel with, the development of biopolitics, there was an "explosion of numerous and diverse techniques for achieving the subjugation of bodies and the control of populations, marking the beginning of an era of bio-power" (Foucault, 1978, p. 140). Both bio-politics and bio-power continue to mold reality construction today. Bio-politics relates to the empowerment of individuals, while bio-power may be thought of in terms of power over bodies by bodies-i.e., corporeal and social, individual and collective. Within the AIDS arena, politics of the body and the body politic are inextricably intertwined and often diametrically opposed. Nowhere perhaps is the strife between bio-politics and bio-power more obvious than in the debate between public health and individual rights, with regulation of individual sexual practices possibly being the best illustration (Gillaspay & Huber, in press). Societal normalization of sexuality is an instrument of power (Hewitt, 1991, p. 229). By defining what is normal, the body politic creates a tool that can be applied to control individual sexual behavior. Discourse-psychiatric, legal, moral, ethical-binds physical actions by rendering normative behavior. Social discourse is used and applied to define the rules of sexuality. The various standards, models, exclusions, limitations, and perversions of sexuality are derived from a particular discursive practice, based not on scientific discourse but on a system of values and prohibitions (Foucault, 1972, p. 193). Organized religion's stance on homosexuality, the continued existence and enforcement of sodomy laws, the legal position concerning prostitution, the lack of inclusion of homosexuality as a legitimate sexual orientation in sex education curricula, and promotion of "just say no" campaigns regarding safe sex are a few examples of the establishment's efforts of regulating or administering sexual practices. Given that gay men continue to constitute the largest affected population in the United States and a significant portion worldwide, along with the fact that engaging in unprotected sexual intercourse-heterosexual or homosexual-is the primary mode of transmission, issues involving sexuality cannot be cleaved from the complex discourse defining HIV/AIDS. In fact, where sexual practices are concerned, the struggle between politics of the body and

the body politic extends well beyond the traditional establishment and into the gay community. Even within organized sexual communities, individual sex acts and identities vary widely (Vance, 1991, p. 878). For the gay community, this variation is often a source of conflict, given the difficult nature of striking a balance between maintaining sexual liberation gained in the wake of the Stonewall riots and seeking wider social acceptance among the heterosexual population. The relationship between sexuality and the AIDS pandemic has further exacerbated this debate. Prominent gay journalists advocating reduction in promiscuity as a means of HIV prevention have come under fire by gay theorists who counter that this position engenders "gay positive but sex negative" posturing (Crain, 1997, p. 28). The contention that the struggle between politics of the body and the body politic occurs where HTV and AIDS are concerned is important because it exemplifies societal regulation-overt and covert-of the HIV affected individual and community. Social policy and processes have been, and continue to be, used to shape the politics of the HIV-affected body, both individual and collective. These politics, supplemented by medical complexities and exacerbated further by the non biomedical complications of the disease, frame the social construct within which HIV exists as a chronic disease. Within the United States, this socially constructed platform is built largely upon individual perceptions and societal perspectives involving homosexuality, drug abuse, race, and gender.

Construction of Marginalized Populations The complex nature of this chronic disease cannot be examined without considering the social construction of homosexuality given the close affinity of AIDS with the gay community in the United States. Homosexuality has been constructed socially in much of the world as a negative label, stigmatized largely because of perceived deviation from a broader societal norm. Moral entrepreneurs have toiled tirelessly in attempting to persuade society that homosexuality is abnormal and immoral. "It is beliefs that homosexuality is evil, sick, or undesirable-and the corresponding efforts to punish, cure, or prevent it-that make homosexuality deviant" (Greenberg, 1988, p. 2). This conception of deviance has resulted in discrimination against, and repression of, individuals seeking to engage in same sex unions. There has been tremendous effort from within the gay community, however, to liberate gays and lesbians from the psychosocial stigma associated with their respective sexual orientations. "It was a historic step to have homosexuality changed from a medical anomaly to a psychological impairment in the early part of the century, and an equally significant step to have homosexuality removed from DSM-3 and KD-9 in the early 1970s and later 1980s" (Patton, 1990, p. 3). The close association of HIV and AIDS with homosexuality, though, has threatened to unravel social tolerance extended toward gays and lesbians, with the stigmatization of one fueling the stigmatization of the other. While the gay community has borne the brunt of the AIDS pandemic in the United States, other socially marginalized populations have been, and increasingly are being, woven into the disease-related web of devastation. Drug injection has been determined as the mode of exposure to HIV in 26 percent of reported AIDS cases among adolescents and adults in the United States with an additional 6 percent attributed to men who have sex with men and inject drugs (Centers for Disease Control and Prevention, 1997, p. 8). Moreover, of the

adolescent and adult cases reported to the CDC from July 1996 to June 1997, 43 percent were black and 20 percent Hispanic (Centers for Disease Control and Prevention, 1997, p. 3). Further, incidence of AIDS among women in the United States now accounts for 15 percent of total reported cases (Centers for Disease Control and Prevention, 1997, p. 3). These groups live within social constructs that bind and circumscribe just as homosexuality is stigmatized by society. Although men who have sex with men continue to constitute the greatest portion of the HIV-infected population in this country, injection drug users contribute significantly to the total number of AIDS cases. Like homosexuality, substance abuse has been modeled around issues involving morality and disease. Drug abuse has been constructed as a societal taboo and criminal problem, imposing a certain degree of forced invisibility upon members of that community. Moral panics and crusades relative to illicit drug use foster the perception that this is yet another disposable population devoured by demonic deviant behavior. Perhaps one of the most visible forms of deviation, though, in a predominantly white culture, is that of race. Race is employed as a social concept to differentiate populations based on physical traits, blood types, genetic code patterns, and inherited characteristics. However, race also is applied to ascribe psychological and moral attributes, facilitating the justification of a discriminatory system exhibiting ethnocentric biases. In this way, race categories support destructive social labeling, founded in societal perspectives rather than scientific fact. "Race categories are social constructs, that is, concepts created from prevailing social perceptions without scientific evidence" (Witzig, 1996, p. 675). Unfortunately, the continued use of race taxons, despite scientific evidence repudiating the validity of racial constructs, fosters the application of race as a negative descriptive social label. This is particularly poignant where HIV infection is concerned, given that the number of documented cases of AIDS is rising disproportionately among people of color. Blacks constitute approximately 13 percent of the U.S. population and roughly 35 percent of CDC documented AIDS cases, and Hispanics account for about 11 percent of the American populace but close to 18percent of the documented AIDS cases (World Almanac and Book of Facts, 1997, p. 133; Centers for Disease Control and Prevention, 1997, pp. 9-11). Tightly woven into the social fabric defining race, gender has been constructed in many cultures to portray female submissiveness and male domination as societal norm. Building on the conflict between politics of the body and the body politic, many feminists argue that the rules of sexuality have been delineated by men (Few, 1997, p. 619). In general, universalistic feminist theory views gender as being defined in terms of binary opposition-man/woman-and assumes that women are subject to gender subordination (Dugger, 1995, p. 139). Social order revolves around patriarchy, with women occupying secondary positions. While this view does not recognize the role of race, ethnicity, and nation in gender construction, it does serve to frame loosely the social construct within which HIV-infected women and those at risk for infection live in much of the world. This construct is even more binding, however, when applied specifically to women of color. Although white women are subject to societal circumscription and HIV-related prejudices, women of color are stigmatized further by individual perceptions, social expectations, cultural norms, and socio-historical development. For Hispanic women, male dominance is often typified by

machismo attitudes. For black women, "womanhood was constructed not in terms of familial and domestic activities, but through black women's role as laborer in slave, colonial, and market economies, and through their roles as domestics and surrogate mothers to white families" (Dugger, 1995, p. 140). HIV-infected women of all races are at the same time "innocent victims" and "immoral carriers," further illuminating "prejudices which have long existed in medicine and law" (Van Vliet, 1993, p. 193). Because of the biomedical complexities, disfiguring nature of the illness, and close association with death, HIV/AIDS would most likely have been stigmatized to some degree no matter who was initially infected (Herek & Glunt, 1988, p. 887). However, the American AIDS epidemic has been defined as a disease of marginalized populations with the resulting social construct being shaped by this definition. The construct is not surprising, though, given that the construction has been based on a social response to a disease most prevalent among already stigmatized populations.

CONCLUSION

Foucault's understanding of the development of the *clinique* is primarily opposed to those histories of medicine and the body that consider the late 18th century to be the dawning of a new "supposed" empirical system, "based on the rediscovery of the absolute values of the visible".^[5] In Foucault's view, the birth of modern medicine was not a commonsensical movement towards simply seeing what was already there (and therefore a science without a philosophy), but rather a decisive shift in the structure of knowledge. That is to say, modern medicine is not a mere progression from the late 18th century wherein an understanding of the true nature of the body and disease is gradually acquired. Foucault recommends a view of the history of medicine, and clinical medicine in particular, as an epistemological rupture, rather than result of a number of great individuals discovering new ways of seeing and knowing the truth.

As an evolving narrative, the discourse surrounding the HIV/AIDS pandemic represents the dynamic nosological record of the disease. This record, as captured in an HIV/AIDS controlled vocabulary, reflects the social construct within which the pathological condition and respective body of knowledge exists. For HIV/AIDS, examining this social construct is imperative because it sheds light on the direction in which disease and socio-scientific response have developed. Although HIV is a complex chronic disease process, it has, to a large extent, been defined in the United States by the body politic. Discourse originating from the empowered elite fosters idealized conceptions, conjured through rhetoric, that are ultimately disseminated to the public. This discourse then becomes a tool central to constructing reality and building social constructs. However, social constructs, deriving from individual perceptions and societal perspectives, may be destructive in nature. Given the complexities associated with HIV/AIDS, the importance of this potentially negative effect cannot be overlooked. By representing HIV/AIDS as being reflective of particular socio-sexual categories and marginalized populations in public discourse, the body politic is provided the opportunity to promote the normalcy of "traditional" behavior and the abnormality of "deviant" conduct (Nzioka, 1996, p. 567). Discourse facilitates the shared construction of meaning, positive or negative, but only

with socialization does the discourse yield consequences. In this way, HB7, through public discourse, becomes synonymous with promiscuity, permissiveness, and moral decadence, thus facilitating stigmatization of the disease and fostering prejudice, discrimination, and blame. By politicizing and stigmatizing the pathological, the biomedical complications of HIV/AIDS are further exacerbated. The organizational schema of a controlled vocabulary intended to facilitate knowledge organization relative to HIV/AIDS must be reflective of the various biomedical and non biomedical complexities connected with the disease. Similarly, the structure needs to be flexible enough to accommodate evolution of the discourse, and the controlled vocabulary itself should be representative of the multifarious intricacies defining the body of knowledge associated with the pathological. Both disease and respective body of knowledge exist within the societal construct circumscribing HIV/AIDS, with social interactions and scientific advances delineating this construct being recorded in the controlled vocabulary. However, a lexical representation devoted to HIV/AIDS does not exist irrespective of the influence of the construct; rather, the vocabulary is affected by, just as it is reflective of, social ideologies and scientific realities framing the pandemic.

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