Gay Men, AIDS, and the Code of the Condom

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It's not who you are but what you do.

Twelve years into the epidemic of AIDS, there is no vaccine and no cure. For sexually active people, and for gay men in particular, the answer to the epidemic, our "magic bullet," is the condom, a thin layer of latex to shield us from infection and death. AIDS organizations run largely by gay men announce a message that sex is fine, and that anal sex is fine—so long as a condom is used. These organizations imbue the directive about condoms with the force of a moral code. Not wearing a condom is not simply unwise; it is wrong. Not wearing a condom violates obligations to other gay men and, in the views of some, obligations to a larger gay community. Moreover, this directive sweeps beyond the sexual act itself to a range of other conduct critical to the lives of gay men. The person who assiduously uses condoms has no obligation under the rule to be tested for antibodies to the Human Immunodeficiency Virus (HIV) or to inform his prospective sexual partners of his HIV status, even when he knows himself to be infected.

Condoms are not for gay men alone. Public health officials have recommended condoms for vaginal intercourse between women and men who are not confident that both are HIV-negative and for all anal intercourse between women and men. Although current evidence suggests that heterosexuals use condoms less frequently than gay men, this Article

* Wade H. McCree, Jr., Collegiate Professor of Law, University of Michigan. A.B., Princeton University, 1962; LL.B., Harvard Law School, 1965. This Article is dedicated to the memory of Martin Levine, distinguished sociologist, excellent friend.

1 I am a gay man, though I was deeply in the closet when this epidemic began. In silent admiration, I watched as gay men, joined by lesbians, organized to provide care for each other and advocacy for our community. From place to place in the Article that follows, I use "we" and "our" to refer to gay men in general or to a community of gay men and lesbians, even though I was barely a member of that community during much of the relevant period.

2 I refer to the "gay community" throughout this Article, although it is an imprecise and problematic term. Most persons who have sex with others of the same sex probably do not see themselves as part of a "community." There are, at most, multiple communities—organized not only by gender, but also by race, geography, class, and political beliefs. I nonetheless believe that, in the context of AIDS, it is defensible to refer to a "community" of gay men and lesbians that has responded to this epidemic and claimed it as its own.

3 For example, as to anal intercourse, a nationwide survey of 10,600 persons conducted by phone found that among heterosexuals with a "risk factor" (most commonly multiple sexual partners) only 19% who said they practiced anal intercourse claimed always to use condoms; 71% claimed never to have used them. Joseph Catania et al., Prevalence of AIDS-Related Risk Factors and Condom Use in the United States, 258 SCIENCE 1101, 1104 (1992). The proportion of gay men who say they always use condoms varies across studies,
focuses almost entirely on gay men. It does so because the code of conduct I discuss has developed within the largely separate culture of gay men within our society.  

Whatever its form and reach, the central message that anal sex is fine so long as a condom is worn is under siege. From the earliest days of the epidemic, it has been under siege from states and the federal government. For gay men, many public officials have been unwilling to endorse sexual lives of any sort. They do not want safe sex. They want no sex. The more worrisome challenge, however, is from the HIV itself. In response to the epidemic, American men who have sex with other men have, as a group, made huge changes in their sexual behavior, changes that researchers in public health regard as among the most profound they have ever observed. Yet large numbers of men who have anal intercourse either never use a condom or plan to use one but often fail to do so. New infection continues at substantial levels, especially among young gay men and gay men of color. One recent, cautious study makes the horrifying prediction that about a third of sexually active gay men in this country will be HIV-positive or dead by the time they reach 30.

The principal purpose of this Article is to explore the origins and moral content of the code of behavior among gay men that has developed around the condom. A second purpose is to consider whether this code is wise and defensible under current circumstances. A final purpose is to compare the condom rules to the code of sexual behavior that state governments have created in response to AIDS under their criminal laws.

I. The “Code of the Condom”

A. The Formation of the Central Message

It is hard to remember how little we knew such a short time ago. Think back ten years. By the beginning of 1984, nearly two thousand but most studies find that the proportion has risen from almost none prior to the epidemic to at least 60% in recent years. E.g., Marshall Becker & Jill Joseph, AIDS and Behavioral Change to Reduce Risk: A Review, 78 AM. J. PUB. HEALTH 394 (1988).

The day may come when the messages transmitted and received by heterosexual men and women regarding condom use will seem as insistent as the messages for gay men. But when that day arrives, the messages will have different social meanings because of the gender differences within heterosexual couples, see Dooley Worth, Sexual Decision-Making and AIDS: Why Condom Promotion Among Vulnerable Women is Likely to Fail, 20 STUD. FAM. PLAN. 297 (1989), and the stigma attached to homosexual behavior.

5 See, e.g., Maria Ekstrand & Thomas Coates, Maintenance of Safer Sex Behaviors and Predictors of Risky Sex: The San Francisco Men’s Health Study, 80 AM. J. PUB. HEALTH 973, 975 (1990) (“Overall these changes may represent the most profound changes ever observed in the literature on health change behavior.”) [hereinafter Ekstrand & Coates, Maintenance of Safer Sex Behaviors].

Americans, the great majority of them gay men, had already died of AIDS, and thousands more were ill. Gay newspapers had printed scores of articles about the disease as well as growing numbers of obituaries of men who had died from it. Most gay men knew something terrible was upon them but widely disagreed about what they should do to protect themselves.

In June 1984, the Advocate, the most widely circulated magazine for a lesbian and gay audience in the United States, reprinted a short pamphlet that had been prepared by gay health organizations. The Advocate stated that the cause of AIDS was not yet clear but that there was increasing agreement that some sort of "germ . . . inhabits the body's fluids." The article then quoted the pamphlet's advice on ways to avoid AIDS and other sexually transmitted diseases. Its tone was hortatory. The first of eleven suggestions was to know your sexual partners and reduce their number: "[t]he fewer different partners the less your risk of acquiring a disease." The third suggested couples shower together as a part of foreplay to check "for sores, lymph glands, etc., which might not have been noticed by the partner," a piece of advice that implied that if the couple could see nothing amiss, they were probably safe. The next paragraphs urged caution in rimming (oral contact with the anus) and in swallowing semen. Seventh on the list was advice about anal intercourse. Intercourse, the pamphlet warned, caused tiny tears in the anus through which "germs" could enter the body, but "wearing a condom may reduce the risk of transmitting diseases between partners."

The Advocate was timorous about publishing the advice that today seems mild. The publishers explained, defensively, that they were "not necessarily endorsing" the guidelines, but simply wanted to contribute to "enlightened discussion." The Advocate justly feared that their readers would resent being lectured about sex. They may also have feared that their readers would worry that conservatives would use information about disease transmission as a pretext for additional restrictions on gay men's sexual lives.

By 1984, HIV had already been identified in the laboratory and soon became widely accepted as the cause of AIDS. Less than a year later, after a test for HIV antibodies had become available, researchers estimated that over a million Americans, most of them gay men, had already been infected with HIV. Even then, we hoped that few of those who were HIV-positive would ever become ill or die, but such hopes quickly faded as more and more became ill. Hopes similarly faded for the rapid devel-

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7 Nathan Fain, More on Safe Sex, ADVOCATE, Apr. 17, 1984, at 20, 20-21. The original pamphlet was written by the New York Physicians for Human Rights and distributed by the Gay Men's Health Crisis.

opment of a vaccine or a cure. We soon realized that preventing new infections was the only way to save lives. 9

The principal mode of transmission among gay men also became clear. Epidemiological studies, coupled with the identification of the virus in blood and semen, demonstrated that for gay men the conduct most likely to transmit HIV was what we now call "unprotected" anal intercourse. 10 Some risk, of a much lower level, was also associated with unprotected oral sex. 11 Since the risk involved for either partner in any single act of unprotected intercourse is impossible to calculate, no person can know whether the next unprotected act will lead to transmission.

Before the AIDS epidemic, a few gay-run health clinics, like the Whitman-Walker Clinic in Washington, D.C., had already formed to meet the health needs of gay men and lesbians. In the first years of the epidemic, new gay-run health organizations 12 like the Gay Men's Health Crisis in New York (GMHC) and the San Francisco AIDS Foundation formed in several cities specifically to respond to AIDS. These organiza-

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9 In 1986, two officials at the Centers for Disease Control observed that "'HLTVIII/LAV [the term then used for HIV] infection is the first modern transmissible disease causing significant morbidity and mortality for which health education and risk reduction are the main instruments available to carry out a public health control effort.'" RONALD BAYER, PRIVATE ACTS, SOCIAL CONSEQUENCES: AIDS AND THE POLITICS OF PUBLIC HEALTH 208 (1989) (quoting G. Russel Havlak & Stephen Margolis, Potential Strategies for the Control and Prevention of AIDS, Mimeograph Prepared for the Public Health Service Conference: Prevention and Control of AIDS: Planning for 1991) [hereinafter BAYER, PRIVATE ACTS, SOCIAL CONSEQUENCES].

10 Both insertive and receptive intercourse without a condom carry significant risks, but receptive intercourse is considerably more risky. See, e.g., Roger Detels et al., Sexual Activity, Condom Use, and HIV-1 Seroconversion, in AIDS AND SEX: AN INTEGRATED BIOMEDICAL AND BIOBEHAVIORAL APPROACH 13, 15-17 (Bruce Voeller et al. eds., 1990).

11 Throughout the 1980s, the dangers of oral sex remained unclear and debated. By the 1990s, all that could confidently be said about oral sex was that while a single act with an infected person carried a much lower probability of transmission than a single act of anal intercourse, taking semen into the mouth was not completely risk-free. See Kenneth Mayer & Victor DeGruttola, Human Immunodeficiency Virus and Oral Intercourse, 107 ANNALS INTERNAL MED. 428 (1987) (reporting one case of transmission through oral intercourse); see also Detels et al., supra note 10, at 17-18 (same). Determining the risks of oral sex is made difficult by the fact that the great majority of gay men who have anal sex also engage in oral sex. For epidemiological purposes, however, every HIV-positive person who reports engaging in anal sex is recorded as having been infected through anal sex, even though an act of oral sex may have led to their infection. The principal reason that so many gay men (and many epidemiologists) believe that oral sex carries a very low risk is that large numbers of gay men who say that they frequently engage in unprotected receptive oral sex but never engage in unprotected anal sex continue thereafter to test negative for HIV. See Nicholas Mulcahy, The Truth About Oral Sex: What You Don't Know May Surprise You, QW, Nov. 29, 1992, at 37.

tions filled a vacuum left by local governments and the federal government, which generally refused to expend funds for safe-sex education for gay men. Rather, these private organizations developed hotline telephone services, printed materials, and one-on-one counseling to inform gay men how to protect themselves.

The advice organizations gave was wide-ranging and evolved over time—reduce the numbers of sexual partners, develop a varied repertoire of sexual activities other than anal sex, be cautious about oral sex. Within a few years, as the epidemiological evidence became clearer, the most pointed advice focused in on anal intercourse. Soon, the most insistent message was that men engaging in anal intercourse must always use a condom. Creators of materials for gay men ceased to worry about seeming preachy about sex and safety. They told men to use condoms, and to use them properly: use only condoms made of latex; do not store the condom in a heated place; always roll the condom all the way down the shaft of the penis; always use a water-based lubricant; take care when removing the condom after ejaculating; never reuse a condom; and so on. By the 1990s, the great majority of posters directed at gay men about being safe explicitly mention "condoms" or "rubbers" or allude to their use. Many now show a condom or a condom packet. The condom has become a generic symbol of sexual health and safety, as well as an allusion to and a directive about a particular sexual act. In fact, posters and other advice commonly reduce safety to a single notion: always use a condom for anal intercourse.

This central directive about condoms was not inevitable, although it may seem so today. At least two other messages about anal intercourse were plausible. One message would simply have provided accurate information about the risks of anal sex without a condom and about the protection condoms offer, conveying in a neutral manner that the decision to have unprotected anal intercourse is the individual's. In the 1970s, gay doctors had adopted this position with respect to activities that posed the risk of transmitting curable diseases like gonorrhea or genital warts. Some leaders of the Gay Men's Health Crisis took the same position early in the epidemic regarding all sexual acts that might transmit HIV. Today this view is still advocated by GMHC and others about some activities, such as

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15 In debates within GMHC, Larry Kramer wanted to tell men bluntly to stop engaging in behaviors that might transmit the virus. Paul Popham, GMHC's president, thought that the organization's only appropriate role was to tell people the facts, allowing them to make their own choices. Shilts, supra note 12, at 310.
as oral sex without taking semen into the mouth, which they perceive as low risk for HIV but not entirely risk-free.¹⁶

At the opposite extreme, a second possible message would have urged men to refrain from anal intercourse altogether. Some early materials issued by gay groups actually took this view. For example, one GMHC leaflet simply said, "Try to avoid anal sex."¹⁷ A few pamphlets still in distribution suggest thinking twice about anal intercourse: "If you do not have anal sex, you will greatly decrease your chances of ever being infected with HIV."¹⁸

Either of these messages was possible. Today, however, it is rare for printed materials directed by gay men to other gay men to advise giving up anal intercourse. Instead, they typically endorse anal intercourse so long as the partners always use a condom. In fact, many posters portray anal intercourse as especially sexy and alluring.¹⁹ Some posters for gay men even lightly mock other forms of sex, such as a GMHC poster that reads "Condoms. Wear one or beat it."

The measures of safe behavior now most commonly emphasized by AIDS researchers also reflect the hegemony of anal intercourse. Early in the epidemic most research on safer behavior among gay men stressed as one measure of safety the number of persons who were refraining from anal intercourse altogether.²⁰ Today, to a surprising extent, many research articles about safer sex accept the priorities of gay AIDS organizations and report almost solely the incidence of condom use among the men who practice anal sex.²¹

The condom rule thus charts a middle course between giving permission to take serious risks and demanding the avoidance of any risks at all.

¹⁶ Discussing oral sex without a condom and without taking semen into the mouth, AIDS materials say, variously, that "it's up to you to decide what your limits are and what's safe enough for you" (pamphlet issued by California AIDS Clearinghouse) or that "you're the only one who can decide how risky you want to get" (pamphlet issued by GMHC).


¹⁸ WHITMAN-WALKER CLINIC, GOOD SEX IS SAFER SEX (n.d.).

¹⁹ For example, one poster from the Gay Men's Health Crisis shows an attractive unclothed young man, viewed from behind. He is holding a condom. The caption reads "Take it Safely." Another poster, created by the AIDS Committee of Toronto, shows the midsections of two young men, standing back to front, with one pulling the jockstrap off the other and with the caption "Take it off . . . . Put it on." A condom is placed next to the second "it" to underscore the message.

²⁰ See, e.g., Becker & Joseph, supra note 3, at 395 (reviewing studies conducted prior to mid-1987 and using as the first measure of safer behavior "frequency of anal intercourse").

²¹ See, e.g., Ekstrand & Coates, Maintenance of Safer Sex Behaviors, supra note 5 (men asked about 22 sexual behaviors including whether they had anal sex at all, but article focuses on protected anal intercourse as principal measure of safe behavior).
It is not a course that itself rejects all risk, since it tolerates (even celebr- 
ates) anal sex with condoms in the face of condom breakage and misuse. AIDS 
organizations acknowledge the risks by referring to sex with condoms as "safer 
sex," not "safe sex." In addition, AIDS organizations know that, while condom use has 
greatly curtailed new transmissions of HIV, many gay men do not obey the condom rule. Many men know the rule but ignore it, while many others accept the rule and intend to use 
condoms whenever they have intercourse but often fail to do so. Much new infection from anal intercourse continues to occur.

As the condom strategy emerged, it was not fully clear whether those 
who came to promote it believed that nearly all men would be able to 
follow it. Many gay men, including many who worked as AIDS educators, 
were confident that they themselves could use condoms consistently and 
properly, thereby reducing nearly to zero their own probability of infection. They may have believed that everyone else could do likewise, even though there was abundant evidence from another context that people who plan to use condoms do not always do so or do not always use them correctly: women who depend upon condoms as their method of birth control often become pregnant. For many AIDS educators, however, I suspect that recommending the use of condoms rather than advising restraint from anal intercourse in part derived from sources other than a belief in the infallibility of condoms or the inevitability of anal intercourse. Advocating condom use may have been the strongest message that the gay community—and they themselves—could tolerate politically and psychologically.

Many gay men do not engage in anal intercourse, but for many others, anal intercourse ranks highest in a hierarchy of sexual activities. Everything else is merely foreplay. It holds the place in their lives that vaginal intercourse holds for most heterosexual men. And for many gay men, anal intercourse is more. It is a symbol of the most powerful emotional union between men and a symbol of gay men’s hard-fought battle for sexual freedom. People who hold these views understandably regard with great suspicion any suggestion to abstain from anal sex.

I had a conversation recently with the associate director of education of a large AIDS service organization that conveyed gay men’s intense feelings about sex and sexual freedom. I asked whether, given the high

\[^{22}\text{See infra text accompanying notes 55–61.}\]
\[^{23}\text{E.g., James Trussell et al., } \text{Contraceptive Failure in the United States: A Critical Review of the Literature, } 18 \text{ STUD. FAMILY PLAN.} 237, 238 (1987).\]
\[^{24}\text{See, e.g., Frank Browning, } \text{The Culture of Desire: Paradoxes and Perversity in Gay Lives Today} 86 (1993) \text{(quoting gay AIDS researcher Dr. Joseph Sonnabend: "The rectum is a sexual organ, and it deserves the respect that a penis gets and a vagina gets. Anal intercourse is a central sexual activity, and it should be supported, it should be celebrated.")}.\]
rates of unprotected sex occurring even among men who intend to use a condom on all occasions, he thought that the best advice to a young person just coming out might be to try to develop a lively sexual life that did not include anal intercourse. His response was abrupt and unequivocal. His organization, he said, would never recommend avoiding anal intercourse. To him, a gay man who told another gay man to avoid anal intercourse had probably absorbed the larger society’s hatred of gay sexuality or was himself ashamed of the allure of anal sex. At a minimum, he said, advice of this sort would be ineffective because it would be seen as coming from such a person. I suddenly felt that in raising the subject, I became the chaperone at the prom. I became Nancy Reagan, urging, “Just say no.”

My conversation with him reminded me that, during the 1970s, gay men and lesbians asserted with passion their right to have sex in the ways that pleased them. In the 1980s, as their friends began to die, many men felt a pall cast over all sexual acts and particularly anal intercourse, even though gay organization remained consistent advocates for safe but full sexual lives. Some men, for rational or irrational reasons, chose celibacy. A mild counter-revolution began in the late 1980s. Queer Nation urged gay men to rejoice in their sexual lives, distributing stickers proclaiming “Buttfucking is Fun.” ACT-UP printed T-shirts and posters with the intertwined thighs of two muscular men obviously having intercourse to show us that “Safe Sex is Hot Sex.” In this celebration of sex and the condom, gay men were responding to our frustration with the saltpeter in our brains after more than a decade of an epidemic. We wanted a life.

Through the condom strategy, we are asserting a belief in our capacity to gain some control over this terrible disease by our repeated act of putting on a condom. The question for us is whether we can hold onto these beliefs in our capacities and hold onto our lives at the same time.

B. The Moral Content of the Central Message

1. The Uses of Moral Language

Every advertisement, poster or pamphlet advising men to use a condom carries two implicit value-laden messages. One is that anal sex is a socially acceptable pleasure. The other is that using a condom is the right thing to do. Even messages that seem primarily informational are read by men who already know how HIV is transmitted, already know that condoms can reduce the likelihood of transmission and, in most cases, believe that others expect them to use a condom. In this sense, these messages remind us of an obligation.

To a greater degree than is widely recognized, however, many materials now aimed at gay men include overt moral content that reveals a
change in the moral posture of gay men toward each other. When discussing conduct other than anal sex, materials on safer sex typically strike an advisory tone—"you would be wise" or "you should for your own sake." But when discussing anal sex, the tone shifts. "You must use a condom," the materials direct, conveying a moral imperative. You must use a condom. And the reasons why one "must" extend beyond self-protection. Examining a few posters and pamphlets distills the messages currently transmitted to gay men.

Consider first an ad prepared by the American Foundation for AIDS Research (AmFAR) that has been widely published in media reaching gay men. Its central image is a king-sized condom. Above the condom is a headline—"What the Smart Set is Wearing this Winter"—that appeals to both self-interest and self-esteem. Below the condom is a direct plea for altruism: "Help stop the spread of AIDS." Using a condom is important for saving the lives of others.

A recent poster from the Boston AIDS Action Committee goes further. The poster appeared in local newspapers, in buses and in subway stations throughout Boston during the summer of 1993. It shows six smiling young men standing together, some with their arms on the shoulders of others, each holding a condom packet. Above the men is the slogan "There's safety in rubbers." And below: "Safer sex demonstrates the creativity, strength and love of the gay community. Take pride. Take care. Always use condoms." The poster conveys several moral lessons. Given the public setting in which the poster appears, it broadcasts that sex between men is wholesome and can be discussed openly. This is a notion that both heterosexuals and self-battering gay men need to absorb. The specific message to gay men goes beyond responsibility to self and to one's partner. Always using condoms, the poster suggests, is something we do for the gay community. Using a condom is a matter of group pride. The converse suggestion, a bit brutal, is that gay men who do not "always use condoms" lack pride and fail to support the community.

The same homily is delivered with more detail in a small pamphlet distributed by the San Francisco AIDS Foundation that appropriates slogans from the political right. One photograph depicts a multi-racial group of smiling gay men, labelling them "The moral majority." Another shows

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25 An ad that is even more blunt about what it means to be smart recently appeared in the newsletter of the Michigan Organization for Human Rights, a statewide gay political organization. Sponsored by the Michigan Department of Public Health, the ad displays a tic-tac-toe board. The Os, three in a diagonal row, are condoms. There are also three scattered Xs. The caption beneath reads "Winners Always Use Condoms." The clear implication is that people who do not use condoms are losers.

26 Consider another poster, distributed by the Los Angeles chapter of Black & White Men Together. It depicts two men, one black, one white, sitting face to face, hugging with legs entwined. The caption reads: "If you really love him . . .," followed by a condom.
an embracing male couple with the caption "Family values." The core of
the pamphlet's text reads:

Gay men are part of the solution to the HIV epidemic. We
can be proud of our success in fighting this disease . . . .

Some groups have tried to condemn and exclude us by the
way they use certain words and phrases. Now, we're taking back
those phrases. We are defining our own morality, our own
families, and our own rights.

Safe sex is the norm for gay men today. This Moral Majority
is made up of HIV-negative and HIV-positive men who express
their sexuality in a healthy way.

By maintaining safe sex, we are showing the world how to
successfully stop the spread of HIV.

By strengthening your commitment to safe sex you continue
to be part of the solution.

The pamphlet ends with the slogan "Right to life" superimposed over an
image of a larger-than-life-size condom. While information in other parts
of the pamphlet alludes to self-interest, the pamphlet as a whole appeals
to solidarity within the gay community. It declares that we need each
other and expect good things of each other: HIV-positive and HIV-nega-
tive men are mutually responsible for safer behavior.

The obligation to use a condom is proclaimed in more than the public
health announcements of AIDS organizations. Charles Kaiser, writing in
QW, a now defunct gay current affairs magazine, depicts openly gay men
as revolutionaries whose first obligation is to stay alive.27 Kaiser implies
that dying is unpatriotic and spreading the disease, treason. Quite different
in tone from QW, but with the same message, Steam is "a quarterly
journal for men with an interest in public and semi-public sex." Its initial
issue, in the spring of 1993, contains reviews of the best gay bathhouses
in Italy and of public restrooms in the United States where readers can
find anonymous sex. The editors end an introductory article on safer,
anonymous sex with the injunction, "Basically what I’m trying to com-
municate, guys, is that there is simply no excuse for fucking without
condoms."

Many posters and other instructions about condoms can be read as
applying to both anal and oral sex, since educational materials often
suggest using a condom for oral sex as well. Yet most gay men who see
a condom poster probably do not understand it to mean oral sex. Only a
small minority of gay men regularly use a condom for oral sex,28 and most

28 See, e.g., John L. Martin, The Impact of AIDS on Gay Male Sexual Behavior
AIDS educators now believe that oral sex carries very low risk. Still, there is a widely acknowledged (if widely violated) rule about oral sex: one should neither swallow semen nor allow one's partner to do so. The message about oral sex is, however, a directive of a lesser order than the rule of anal sex: pamphlets say "never" but they almost never say "never."

2. Some Reasons for the Moral Content of the Code

The particular language that announces the code of the condom—the language of obligation to self, to others, and to the gay community—derives in part from an appropriate sense of urgency about the need to save lives and the difficulties of inducing men to protect themselves and others. Getting men to use condoms regularly has proven to be no easy feat. The huge majority of gay men know how HIV is transmitted and understand the value of condoms, yet despite the prospect of a fatal disease, large numbers of them do not use condoms on all occasions.

It is easy to understand why they do not. For an individual, the commitment to using condoms requires much more than a single decision, such as a decision to undergo a vasectomy. It requires making the choice every time he approaches anal sex. At that moment, stopping to put on a condom interferes with spontaneity. Using one typically reduces the physical pleasure of one or both parties. Even thinking about condoms at all brings to mind the specter of disease and death, and so denial may lead to not "remembering" to think. All these impediments to invariable safety come to bear at moments of passion when thinking for most men and women, gay and heterosexual, lacks cool rationality. That's part of the pleasure of sex. Thus the insistent, repetitive, socially charged tone of the condom message is in part strategic. The goal is to make the use of a condom an automatic reflex, like getting drivers to buckle up without calculating each time the risk of going without a seat belt.

The choice of AIDS organizations to invoke altruism and communal responsibility has a more specific strategic base. First, although ads are typically directed at both partners having anal sex (most say, "use a condom," not "wear a condom"), bringing the message home to the person who expects to perform the inserting role (the "top") poses a special challenge. Many such men believe that they are unlikely to be-

Patterns in New York City, 77 AM. J. PUB. HEALTH 578 (1987) (only about five percent of men in sample reporting regular condom use for oral sex).

29 Gay Men's Health Crisis now treats oral sex as "low-risk" in its educational materials. See supra note 11 and accompanying text.

30 See infra text accompanying notes 55-61.

31 One counselor of young gay men recently lamented the thinking processes of teenagers: "'If the choice is between protecting yourself from a virus that may kill you in ten or fifteen years and destroying the mood of the moment, you know which is going to win out.'" Kaiser, supra note 27, at 48.
come infected through unprotected intercourse. Since these men believe that they do not need to wear a condom to protect themselves, educators hope to reach them through appeals to their sense of altruism and sense of loyalty to the gay community. Second, research suggests that gay men are most likely to engage in protective behavior when they feel good about themselves and believe that their peers expect such behavior from them. The creators of the Boston poster with the six men in a group, praising the creativity, love, and strength of the gay community, want the viewer to see himself as the seventh man in the group, a group that feels good about itself and cares about him.

At the same time that AIDS educators want gay men to have a sense of peer support, they are also well aware of the dangers of lecturing gay men about sex. The fears of the editors of the Advocate in 1984 have not disappeared completely. But to a surprising extent, at least on the subject of anal sex, those who create educational materials assume they are speaking to an audience who will not resent being told to wear a condom. This wide internalization of the standards of safer sex is apparent in interview studies of men who have engaged in intercourse without a condom. Only rarely do men assert that they have intercourse without a condom because it is their right or desire to do so. They offer either rationalizations (“I believed that my partner’s HIV status was the same as mine”) or confessions (“I was drunk and I didn’t have a condom”). Nearly all accept the premise that protected sex is the norm.

If the audience accepts protected sex as the norm, so clearly do their educators. Many gay educators feel a proprietary interest in the responses to the epidemic. Groups founded within gay communities have acknowledged AIDS as their problem from the beginning—they “own” it. They have successfully demanded a role in every aspect of the response to it. The folder distributed by the San Francisco AIDS Foundation discussed

32 See Martin P. Levine & Karolyyn Siegel, Unprotected Sex: Understanding Gay Men’s Participation, in THE SOCIAL CONTEXT OF AIDS 47, 67 (Joan Huber & Beth Schneider eds., 1992) [hereinafter Levine & Siegel, Unprotected Sex]. In fact, unprotected anal intercourse may well carry more risks to the top than most men believe, although the risks are still substantially lower than for receptive anal intercourse. See Detels et al., supra note 10, at 16.


34 See Maria L. Ekstrand et al., Frequent and Infrequent Relapsers Need Different AIDS Prevention Programs, Poster Presented at VIII International Conference on AIDS (Amsterdam) (July 19–24, 1992) (abstracted in VIII INTERNATIONAL CONFERENCE ON AIDS/III STD WORLD CONGRESS, POSTER ABSTRACTS D408 (1992)) [hereinafter Ekstrand et al., Frequent & Infrequent Relapsers]. See also Levine & Siegel, Unprotected Sex, supra note 32, at 68.
earlier refers to gay men's right to feel proud of their success in fighting this disease. Those who have given so much effort to the saving of lives feel a stake in these successes. Every new infection lets them down.

It is here that the moral content of the condom code is more than simply instrumental. Many of the educators speak from the heart. Gay men and lesbians, often alienated from the majority culture, have long taken responsibility for each others' well-being, but we now do it more visibly and self-consciously. We have moved in our political language and sensibilities from individualism and liberalism to communitarianism and republicanism. The loss of so many friends and lovers has made us realize how much others count and how much the loss of more will mean.

C. The Rest of the Code

The principal rule of the code is always use a condom for anal sex and use it properly. The second rule, in smaller print, is do not swallow semen or get semen into your partner's mouth. There are no other major imperatives. Yet the rules surrounding the condom have implications beyond the sexual act. A critical consequence of the core condom rule is that if you abide by it, you have also, in the views of its guardians, resolved whatever obligations you may have had with regard to two other major issues of conduct gay men face: whether to be tested for HIV antibodies and whether to tell your sexual partners of your HIV status if you know you are infected.

1. Antibody Testing

Does a person who has engaged in unprotected sex in the past and intends to continue to have anal sex in the future have a moral obligation to learn whether he is infected by being tested for HIV antibodies? The claim for such testing is that a person who learns that he is HIV-positive not only will make better decisions about his own health care but also will be more prudent in protecting and warning others.

Gay AIDS organizations have nonetheless refused to announce an obligation to be tested. When the antibody test first became available, many advised gay men not to be tested at all, fearing misuse of test results by those with access to them. Some years later, the same organizations changed their position and encouraged testing, when they concluded that those who are HIV-positive could benefit from early medical care. At all points, AIDS groups have been clear that the individual who is deciding

35 SHILTS, supra note 12, at 469-70, 539-43.
whether or not to be tested has no obligation to take into account interests other than his own. No poster has ever declared that we prove our love for each other by being tested. On the contrary, the condom rule fully answers the obligations to others. So far as others are concerned, if we use condoms, then it does not matter whether we have the virus.

2. The Obligation to Inform Prospective Sexual Partners of One’s HIV Status

The condom rule also resolves the question of the obligation of a person who knows he is HIV-positive to inform sexual partners of his status. The case for a moral obligation to inform the partner is even easier to state than the case for testing: providing information gives the partner a chance to make more fully informed decisions about sex. Many men who would willingly have intercourse with a condom with a man of unknown serostatus would not do so with the same man, even with a condom, if they knew that he had HIV. They might well refrain from sex altogether.

In the view of most AIDS organizations, however, following the condom rule fulfills the obligations of the HIV-positive person to his partner. Disclosure to the partner, especially a new partner, might be important for building a long-term relationship, but it is not obligatory and might not even be wise since the partner might reveal the information to third persons who have no legitimate need to know. GMHC currently distributes a pamphlet for gay men containing a page on “Safer Sex for HIV Positives” that reads in part:

If you follow these safer sex guidelines, you don’t need to worry about whether your partners know that you’re positive. You’ve already protected them from infection and yourself from reinfection.

Some guys need to get their HIV status out on the table up front, especially if it’s a possible relationship situation. Just use your judgment about who you tell—there’s still discrimination out there.

We need to support and protect each other, no matter what our HIV status, and safer sex accomplishes both.

Similarly, a recent issue of Positive News, a newsletter of the San Francisco AIDS Foundation for its HIV-positive clients, includes a section on “Discussing HIV With Your Sex Partners.” Earlier sections offer clear

guidelines, particularly about safer sex, but this section simply says there are “so many questions.” The first of the many questions is whether “you have a responsibility to tell all your sex partners that you are HIV positive.” The section makes clear that using condoms is mandatory but that questions about disclosure are up to the individual, viewing them as a matter of personal preference short of a moral claim.38

The same page of Positive News contains a side-bar interview with “Dave,” who is HIV-negative. Dave reflects on the obligation to inform:

I did not learn that my partner was HIV-positive until after we had been together several months. It was not easy for him to tell me. I did not feel worried about my own health since we had always practiced safe sex. After I learned he was positive, we continued to do the same things that we always had, safely.

Some argue that it is morally wrong not to say that you are HIV-positive before having sex. I disagree. My feeling is that people should practice safe sex with any new partner. That way, you are protected no matter what their HIV status might be.39

Even though the newsletter’s editors imply that their HIV-positive readers should feel comfortable about not revealing their status, they nonetheless intimate that they are in an ethically queasy position. The newsletter selected Dave, the HIV-negative partner, to speak. It is more palatable for Dave to explain his partner’s silence than for his HIV-positive partner to speak for himself and seek to justify it. The partner’s reason for failing to disclose well into the relationship—perhaps shame or a fear of abandonment—is understandable but not commendable within the terms of most relationships. It is Dave’s position to understand and to forgive. Still, AIDS groups’ position would remain that, whatever men owe each other as friends and confidants, the HIV-infected person fulfills his obligations to protect the health of his partner by rigorously adhering to the rules of safer sex.40

38 "No matter how you deal with these questions, two facts are completely clear. You should only have safe sex with all your partners. And having HIV does not mean you cannot have great sex." Id. at 10.

39 Id.

40 Consider in the same light the story of Michael Boyle, an aide to Senator Strom Thurmond. Boyle died of AIDS in the summer of 1993. An Associated Press account of Boyle's death includes the following:

Boyle kept his disease secret for four years, even from David, his companion whom he met on Christmas Day in 1988 at a gay bar in Columbia[, South Carolina]. It took Boyle nearly two years to tell David the truth: that he had known that he was HIV-positive when the two first met.
II. Perspectives on the Code

A. The Costs of a Moral Message

AIDS organizations believe that their morally charged directives will make men more attentive to being safe. Whether or not they are right, the moral content of their messages has some costs and drawbacks. An initial drawback of which gay health educators are acutely aware is that many gay men remain deeply hostile to being lectured about sex and do not draw fine distinctions among lecturers. AIDS organizations hope that men will hear their condom directives as coming from a loving friend or mentor. But for some listeners, and particularly for some young men, any instructions about sexual conduct will be experienced as coming from the emotional equivalent of a parent or preacher, the disapproving figures from their childhood whose advice they now most resent and resist.

The moral tone of the messages may have a different, unintended impact on men who listen to the message and accept it but nonetheless fail to use condoms all the time. Research suggests that most men who engage in unprotected sex plan to use a condom but fail from time to time. Almost none of these men say they wanted to harm another person. Rather, they explain that they generally use a condom but occasionally fail when they have drunk too much, are high on drugs, or are particularly attracted to the man they are with and just do not happen to have a condom around. Afterwards they often report feeling guilty and blame themselves. The good side of guilt and self-blame is that they sometimes lead to a resolve not to have unprotected sex in the future—and, in fact, in one study that reports feelings of guilt, over half the men who had lapsed from safer sex said that they had, in the wake of the event, vowed never to lapse again. On the other hand, the same study also found that some men viewed their slip as evidence of their worthlessness.

If research about stigma and self-labeling in other contexts applies here, some of these men, already struggling with heterosexual society’s judgment that they are immoral because of who they are, may well redefine (or reconfirm) themselves as the sort of person who does bad or

“..."I loved him. Whatever he was going to tell me didn’t change things," said David, who asked that his full identity be kept secret. David still tests negative for HIV, a fact that he attributes to their caution during sex.

41 See Ekstrand et al., Frequent & Infrequent Relapsers, supra note 34. See also Levine & Siegel, Unprotected Sex, supra note 32, at 68.
42 See Ekstrand et al., Frequent & Infrequent Relapsers, supra note 34. See also Levine & Siegel, Unprotected Sex, supra note 32, at 68. ("The men frequently expressed regret, guilt or remorse from participating in unprotected sex, which they often regarded as 'irresponsible,' 'stupid,' or 'wrong,' behavior.").
43 See Ekstrand et al., Frequent & Infrequent Relapsers, supra note 34.
These men become more likely to engage in unprotected sex in the future. Moreover, their feelings of shame may keep them silent about the risks they take, when they should talk to others for counseling and renewed resolve.45

Casting unprotected sex in moral terms may most harm those who not only engage in unprotected sex but also learn later that they have become infected.46 At all times during the epidemic, many gay men have considered themselves morally blameworthy for becoming infected. In the early years of the epidemic, most infected men received assurance from other gay men that no one could have foreseen that infection with a fatal virus was the probable consequence of anal sex. Today, everyone is expected to recognize the risks of unprotected sex and newly infected men feel less support.47 Some safer sex counselors worry that men who once test negative and later engage in unprotected sex put off being retested in part because they seek to avoid confirmation of mistakes they considered foolish. They also fear that feelings of self-blame, similar to those reported for heavy smokers diagnosed with lung cancer, will lead to an even greater depression and a greater sense of isolation than is generally associated with persons who know they have a fatal illness.

The guilty feelings of those who engage in unprotected sex arise in part from a projection onto others, an expectation that others will condemn them. The content of condom propaganda seems to justify that fear. Projection or not, the changed moral view of unprotected sex has worrisome implications for gay men’s responses to newly infected men in the future. AIDS service organizations provide extensive counseling and services to the newly infected, helping them with their feelings of fault and guilt.48 Perhaps most other uninfected gay men will continue to care. After all, unprotected sex is common and the reasons men give when they do engage in it are so mundane. The uninfected may appropriately say to themselves, "There but for the grace of God go I."

I worry, however, that at its worst, the relationship between newly infected gay men and other gay men increasingly resembles the relationship between all gay men and the Roman Catholic Church. Gay men

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45 See id. at 6.
46 On the general issue of reactions to fault in illness, see Frederick Reamer, AIDS: The Relevance of Ethics, in AIDS & ETHICS 1, 18–19 (Frederick Reamer ed., 1991).
47 A clinical psychologist who works with gay men has written, "One is encouraged and expected to feel guilty about contracting HIV now that it [the virus] has been discovered." Walt Odets, The Psychological Epidemic: The Impact of AIDS on Uninfected Gay and Bisexual Men 50 (1990) (unpublished manuscript, on file with author) [hereinafter Odets, The Psychological Epidemic]. See also Charles Flowers, Living and Loving with HIV and AIDS, VOLUNTEER (New York [GMHC]), Mar.-Apr. 1993, at 4.
48 "People have real feelings of guilt and shame about being infected and how they became infected. These feelings need to be brought out and worked through." Flowers, supra note 47, at 4 (quoting a facilitator of workshops for HIV-positive men).
deplore unsafe sex, but claim to cherish their newly fallen brethren: they hate the “sin” but love the “sinner.” And just as many Catholic (or once-Catholic) gay men doubt whether the Church really does love its sinners, so newly infected gay men may doubt whether their gay brothers truly care for them. Those who were infected before the modes of transmission were known may regard the newly infected, indeed all those who continue to engage in unprotected sex, “as ignorant, offensive, and an insult to the battle they are fighting against HIV itself.”49 Similarly, in large numbers, those who are not infected fear men who are infected and will not date them.50 And some uninfected gay men who have worked hard to maintain safer sex practices feel a strong psychological need to condemn or avoid those who engage in unprotected intercourse, in part because they can so easily imagine doing the same.

The guilt felt by gay men who “lapse” and the blaming of them by others would almost certainly occur even if the current educational messages did not have a moral cast. Gay men who engage in unprotected sex or reach judgments about others who do, do not need AIDS organizations to draw simple ethical lessons from the conduct. Yet whether gay groups play a role in encouraging negative moral judgments may in the end be unimportant.

What is significant is that within the last few years a change in attitudes toward safer sex has occurred within the gay community in many cities, a change that is comparable to the change in the last decade in attitudes toward drinking and driving and toward smoking cigarettes. Unprotected sex, much like these other activities, has shifted in the eyes of large numbers of gay men from being merely imprudent to being wrong. Whatever the role gay organizations have played in this shift, it has consequences for gay men’s views of themselves and for their relationships with each other. What is not answerable today is whether the increase in safe behavior due to this moral shift will outweigh the harms to infected gay men and to the sense of community among gay men that developed during the early stages of the AIDS epidemic.

B. The Justifiability of the Code of the Condom

1. The Core Rule: Anal Sex Is Fine, but Always Use a Condom.

We know much more today than we did a decade ago about the impact of the condom strategy. The Centers for Disease Control has recently affirmed its belief that, if used “consistently and correctly,” latex condoms are a “highly effective” barrier against infection.51 What we now

49 Odets, The Psychological Epidemic, supra note 47, at 48.
51 See Centers for Disease Control, U.S. Dep’t of Health & Human Servs., Update:
know, however, is that while large numbers of gay men are committed to using condoms and many use them all the time,\textsuperscript{52} many men do not always use them correctly and many, at least on occasion, do not use them at all. The question thus posed is whether the current position of AIDS groups, supporting anal intercourse so long as a condom is used, remains defensible.

Some condoms fail because they are used with a non-water-based lubricant (such as Vaseline)\textsuperscript{53} or because they slip off or break.\textsuperscript{54} In addition, and more significantly, between a quarter and a half of men who engage in anal intercourse have failed in the recent past to use a condom on at least one occasion.\textsuperscript{55} The rates of nonuse are particularly high among young men,\textsuperscript{56} men of color,\textsuperscript{57} men in small and mid-sized cities,\textsuperscript{58} and men

\textit{Barrier Protection Against HIV Infection and Other Sexually Transmitted Diseases, 42 Morbidity \& Mortality Wkly. Rep., 589, 591 (1993).} The CDC reported two studies of heterosexual couples one of whose members, at the outset, was seropositive and the other seronegative. In the first study, none of a group of 123 seronegative partners who reported consistent and correct use of condoms seroconverted, while 12 of 122 (10\%) of another group who used condoms inconsistently seroconverted. In the second study, in which females were seronegative partners of seropositive men, 3 out of a group of 171 consistent condom users (2\%) and 8 out of another group of 55 (15\%) of inconsistent condom users seroconverted. \textit{Id.} at 589.

\textsuperscript{52} See, \textit{e.g.}, \textsc{Charles Turner et al.}, \textit{AIDS: Sexual Behavior and Intravenous Drug Use} 133 (1989) (reporting study finding increase in men who reported always using condom for anal intercourse from 2\% in 1981 to 62\% in 1987). \textsuperscript{53} See \textsc{David J. Martin}, \textit{Inappropriate Lubricant Use with Condoms by Homosexual Men}, 107 Pub. Health Rep. 468, 471 (1992) (finding, in two samples of gay men, that 60\% of those who reported having anal intercourse within the preceding year reported using a non-water-based lubricant on at least one occasion); \textsc{Bruce Voeller et al.}, \textit{Mineral Oil Lubricants Cause Rapid Deterioration of Latex Condoms}, 39 Contraception 95, 99 (1989).

\textsuperscript{54} See \textsc{John L. Thompson et al.}, \textit{Estimated Condom Failure and Frequency of Condom Use Among Gay Men}, 83 Am. J. Pub. Health 1409 (1993) (estimating on the basis of interviews about a 3\% risk of condom breakage or premature slipping off during any single act of anal intercourse; not every breakage or slipping off leads to a transmission of fluids).

\textsuperscript{55} For a recent study that refers to most earlier studies, see \textsc{Jeffrey A. Kelly et al.}, \textit{Acquired Immunodeficiency Syndrome/Human Immunodeficiency Virus Risk Behavior Among Gay Men in Small Cities: Findings of a 16-City National Sample}, 152 Archives Internal Med. 2293 (1992) [hereinafter Kelly et al., \textit{Findings of a 16-City National Sample}].


\textsuperscript{57} As of 1988, the incidence of AIDS per 100,000 was 3.5 times as high for black men as it was for non-Hispanic white men and 2.5 times as high for Hispanic men as it was for non-Hispanic white men. Black and Hispanic men are over-represented (as a proportion of the total population) not only among IV-drug users with AIDS but also among men with AIDS who report having sex with other men. Of all men with AIDS who report having sex with men, 32\% are black or Hispanic. \textsc{Centers for Disease Control, U.S. Dep't of Health \& Human Servs.}, \textit{HIV/AIDS Surveillance Report} 7 (Oct. 1993).

\textsuperscript{58} Kelly et al., \textit{Findings of a 16-City National Sample}, supra note 55, at 2293.
in long-term relationships. Even many men who know they are seropositive admit to failing to use condoms with all their HIV-negative partners.

The consequence of the unprotected sex is, not surprisingly, significant levels of new infection, although gauging how much new infection is actually occurring among gay men is impossible. One group of researchers, drawing on data from an ongoing study of a large sample of gay men in Chicago, Los Angeles, Baltimore, and Pittsburgh, has recently made an extremely depressing forecast. Using the actual annual rates of seroconversion among the men in their sample, they estimate that, in communities like those they studied, approximately thirty percent of sexually active gay men who are seronegative at the age of twenty will be seropositive (or dead) by the age of thirty. If young men who are already infected by age twenty are added, it then appears likely that over a third of young gay men in these cities will be dead or dying by their thirties.

These calculations, though somewhat speculative, rest on a horrifying truth: that even if a small proportion of a group is infected each year (for

59 See, e.g., Leon McKusick et al., Longitudinal Predictors of Reductions in Unprotected Anal Intercourse Among Gay Men in San Francisco: The AIDS Behavioral Research Project, 80 AM. J. PUB. HEALTH 978, 980 (1990). Many men in long-term relationships have good reason to believe that they are taking almost no risk in having unprotected intercourse. They know that each of them has tested negative for antibodies and they are committed to a monogamous relationship. But many men in relationships engage in unprotected sex even though one or both have never been tested.

60 See Gary Marks et al., Self-disclosure of HIV Infection to Sexual Partners, 81 AM. J. PUB. HEALTH 1321 (1991). Out of 138 HIV-positive men at an HIV clinic, only 62 men (45%) reported being sexually active (besides kissing) after testing positive. Id. at 1321. But of the sexually active group, 10 men reported insertive anal intercourse without a condom with partners whom they believed to be HIV-negative, and 13 reported receptive anal intercourse without a condom with partners they believed to be HIV-negative. Id. at 1322.

61 The principal obstacle to measuring the incidence of new infection among gay men is the practical impossibility of obtaining a random sample of men who are having sex with other men for interviewing and testing.

62 Hoover et al., supra note 6. Similarly discouraging conclusions have been reached as to vaginal intercourse for heterosexual couples in which one of the partners is HIV-positive. In a recent review of studies of heterosexual couples in which one partner was infected, the author looked at the incidence of seroconversion of the uninfected partner and found that the seroconversion rate was very high even when the couple claimed to use condoms: overall the studies suggested that, over a several-year period, condoms were only 69% effective in preventing transmission of HIV. See S. Weller, A Meta-Analysis of Condom Effectiveness in Reducing Sexually Transmitted HIV, 36 SOC. SCI. & MED. 1635 (1993).

63 The authors believe that their projections would be even higher if their sample had included a broader population of gay men. The study tracked the actual rate of seroconversion of men who were tested and counselled about safer sex twice a year. Seroconversion might well be higher among men who do not receive such regular counseling. See Hoover et al., supra note 6, at 1203. The sample also had a substantial drop-out rate over the years, and the actual rate of seroconversion of the dropouts might well have been higher than that of the men who remained in the study (for reasons apart from the missed occasions for additional counseling). Id. at 1202.
example, one or two percent), the cumulative effect over a few decades will be devastating.\textsuperscript{64} It is deeply alarming to confront the possibility that the most successful public health campaign in history may not be good enough.\textsuperscript{65}

AIDS educators have at least two approaches for the future. One is to continue delivering the current approving messages about anal sex and condoms but to do so more effectively. The other approach is to deliver a double message—a message that is more cautious about anal intercourse even with a condom but also more effective at getting those who do engage in anal intercourse to use a condom every time.

Many believe that the current message about condoms is the correct message and that the appropriate approach for the future is to find and support ways to get the message across more effectively. Many men who have anal intercourse believe that they do not need to use a condom if they are always the inserter or if they have sex only with men who are young or with men who come from places where few persons have AIDS.\textsuperscript{66} They need both accurate information as well as help in breaking patterns of denial. Other men know exactly the risks they are taking and either do not care or have insufficient resolve under certain conditions. For these men, new strategies emphasize culturally specific interventions and interventions that enlist groups of peers to support each other. Small-scale studies show that some of these interventions have valuable effects.\textsuperscript{67}

One challenge for prevention programs is the likelihood that techniques that have made a difference up to this point will no longer work as well in the future. In many cities, gay men have been so inundated with public health messages about safer sex that they no longer read them.

\textsuperscript{64} Another recent study has found an annual rate of seroconversion of about four percent among gay men under 25 in San Francisco. See Jane Gross, Second Wave of AIDS Feared by Officials in San Francisco, N.Y. TIMES, Dec. 11, 1993, at A1. See also Detels et al., \textit{supra} note 10, at 13. In a study of 2915 gay and bisexual men who had no evidence of HIV antibodies at the initial testing in 1984 and 1985, 232 men (8%) seroconverted within the subsequent 24 months, with the highest numbers occurring in the six-month period immediately after the negative test. \textit{Id.} at 15. Seven of the men who seroconverted said that they used condoms with all of their partners; 111 of the men who seroconverted said that they used condoms with some of their partners. \textit{Id.} at 17.

\textsuperscript{65} In July 1994, the American Association of Physicians for Human Rights, an organization of lesbian and gay male physicians, will hold an HIV Prevention Summit in Dallas, Texas. The alarm over apparent high levels of new infection is the reason for the meeting, which has received substantial funding from, among others, the Centers for Disease Control.

\textsuperscript{66} Levine & Siegel, \textit{Unprotected Sex}, \textit{supra} note 32, at 53–54. In one study, 77\% of men who had engaged in unprotected anal intercourse within the preceding two months estimated their personal level of risk "inaccurately." Kelly et al., \textit{Findings of a 16-City National Sample}, \textit{supra} note 55, at 2296.

Some gay men have endured the illness and death of so many of their friends that they care less about living, or fatalistically conclude that infection is simply inevitable. More fundamentally, at the beginning of the epidemic, many of us believed that condoms were a stopgap device we would have to put up with only for a few years until science provided a vaccine. Now educators face the task of convincing gay men that it is possible to use condoms forever.

Even if substantial new funds and new ideas are invested in delivering the current messages more effectively, a significant possibility remains that a high rate of new infection will continue. Given all the enduring obstacles to invariable safety, gay organizations may be wise to consider altering the core messages about anal sex.

One alternative to the current message, politically difficult even to suggest within the gay community, would be to advise men to stop having anal intercourse altogether; use a finger or a dildo but avoid penile penetration even with a condom. Gay organizations would not hesitate to send this message if condoms had no capacity to contain the virus and if nearly every act of anal intercourse between an infected and an uninfected person led to a new infection. Even though condoms provide a high level of protection if properly used, gay organizations may need to adopt this unpalatable message in the future if, irrespective of educational efforts, a high proportion of gay men (a quarter or a third, for example) become infected through unprotected intercourse by the time they are thirty or forty.

A message to desist from anal sex altogether is not, however, the only alternative to the current message. Another possibility is to provide men with more information that permits them to perceive the problems they may personally have with the condom strategy, so that they can make more informed decisions for themselves. Only a few gay organizations are broadcasting widely that gay men who have anal intercourse and plan to use a condom are still running substantial risks of infection. To be sure, most organizations describe condom use as “safer” sex, not “safe” sex, but many men believe that a commitment to condoms will make them “safe.” A revised position might take the following shape, stated in terms largely borrowed from existing materials produced by gay-run AIDS organizations but taken out of context to give them a new emphasis:

Whenever you have anal intercourse, you should use a condom to protect yourself and your partner. You need to know, however, that always using a condom takes great perseverance. Lots of men find that they do not always get themselves to use one and

only you can decide whether you will. If you're not sure you will, you may want to build a rich sexual life that doesn't include anal intercourse. Remember: If you do not have anal sex, you will greatly decrease your chances of ever being infected with HIV.69

Many gay men would find this revised message repugnant since it raises doubts about anal sex and "problematizes" it in a world in which straight people (and we ourselves) have problematized our sex lives for too long.70 They would say that we have fought too hard for the right to make love as we please71 to turn around suddenly and attack it as a problem. Yet advising men to think twice need not be the same as telling them to stop. In fact, urging gay men to think carefully about their capacity to adhere to the condom rule conforms to gay organizations' ostensible commitment to help men make informed choices about their sexual lives and their health. It would simply treat anal intercourse much like alcohol consumption: an activity the state has no business prohibiting but one that some people find they are better off avoiding.

Whether or not a hesitant message would save more lives than a reinvigorated version of the current upbeat message is a different question. The strategy might not work. It may be the wrong message for young men who are either overconfident in their capacities to insist on condoms or oblivious to the possibility of death ten years in the future. There is even a risk that a more cautious approach could backfire in any of several ways and lead to more, not less, unprotected sex. For example, it could backfire if the warning to think twice about anal sex were unconsciously heard as permission to fail: "lots of men are not 'remembering' to use condoms all the time so it's not such a big deal if I fail too, from time to time." It could also backfire if many men, deciding that they were among those who should avoid anal intercourse, plan not to and then have

69 The last sentence is from Good Sex is Safer Sex, a pamphlet from the Whitman-Walker Clinic. Cf. id., supra note 18.
70 Consider this view from Michael Callen in a piece written in the mid-1980s when some AIDS groups were advising gay men to avoid anal sex:

I am appalled by the sentiment that all one has to do to wipe out AIDS is eliminate anal intercourse. (Childbirth has often been fatal to women, but no one has seriously suggested that the way to reduce or eliminate maternal mortality is to eliminate vaginal intercourse . . . .) Simply put, those who enjoy getting fucked should not be made to feel stupid or irresponsible. Instead they should be provided with the information necessary to make what they enjoy safe(r)!

Callen, supra note 17, at 151.
71 It is a fight that has yet to be won. See, e.g., Bowers v. Hardwick, 478 U.S. 186 (1986) (upholding constitutionality of laws criminalizing same-sex sodomy.)
no condom when they find themselves in a situation in which they have intercourse anyway.72

The strategy might have some success, however, if a greater number of men came to recognize their own human limitations and gave up anal intercourse. In the years before the epidemic, anal intercourse was an activity in which a significant minority of sexually active gay men did not engage.73 After the modes of transmission of HIV became known, many gay men who had previously engaged in anal intercourse gave it up,74 some of them never returning to it. This pattern of choice and change suggests that, at least for large numbers of gay men, anal intercourse is not indispensable to sexual fulfillment.


Large numbers of men who have had sex with other men have never been tested for HIV antibodies. One recent study found that only sixty percent of men acknowledging having sex with other men had ever been tested.75 In an influential article on antibody testing published in 1986, Ronald Bayer, Carole Levine, and Susan Wolf argued that persons at high risk for acquiring HIV "have a moral obligation to take all possible steps to prevent harms to others, including taking the antibody test."76 They believed that the governments should rarely impose antibody testing, but that individuals should impose it on themselves because learning their status will encourage them to make radical alterations in sexual conduct. The communitarian Amitai Etzioni has recently taken a similar position.77

72 Compare the position of a teenage girl who wants neither herself nor others to see her as "loose" and thus does not carry condoms, a diaphragm, or take the pill. Consequently, when the occasion arises that she and her boyfriend are moving toward intercourse, she has no contraceptive protection at hand. See Nat'l Research Council, Panel on Adolescent Childbearing and Pregnancy, Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing (Cheryl D. Hayes ed., 1987).

73 For example, in one study in four cities early in the epidemic, 26% of gay men said that they never engaged in receptive anal intercourse. Ronald Fox, Changes in Sexual Activities Among Participants in the Multicenter AIDS Cohort Study, in Abstracts: Third Int'l Conference on AIDS (1987).

74 Two years after the extent of infection in the epidemic became clear, 49% of the men interviewed said they did not engage in anal intercourse at all. Id. Other studies conducted in large cities report even greater levels of abstaining from anal intercourse. See Turner et al., supra note 52, at 132 (reviewing literature).

75 Daniel C. Berrios et al., HIV Antibody Testing Among Those at Risk for Infection, 270 JAMA 1576, 1578-79 (1993). While some number of the 40% who have never been tested have never engaged in anal intercourse, some number of those who have been tested and tested negative have engaged in unprotected intercourse since their last test.

76 Ronald Bayer et al., HIV Antibody Screening: An Ethical Framework for Evaluating Proposed Programs, 256 JAMA 1768, 1773 (1986) [hereinafter Bayer, HIV Antibody Screening]. The discussion in the article is brief on this point. The authors suggest that a person who knows he is HIV-positive has an obligation to inform both past and current sexual partners. Id.

77 Amitai Etzioni, HIV Sufferers Have a Responsibility, Time, Dec. 13, 1993, at 100
As discussed earlier, many AIDS organizations have rejected this position. Their view has been that gay men should not feel obliged to learn their HIV status. So long as they follow the rule of using a condom every time they have anal intercourse, they fulfill their obligations to others.

Research in the eight years since Bayer, Levine, and Wolf's article was published provides little support for their expectations about changes in behavior of persons who have been tested. The great majority of persons who are tested, whether they test positive or negative, have already altered their sexual activities and make few additional changes after testing. A few studies do find that persons who test HIV-positive are more likely to refrain from anal sex altogether, but other studies have found almost no effect on the positive testers and none on those who test negative. In fact, a few studies offer disturbing evidence that some people who test negative engage more frequently in dangerous behavior thereafter.


What moral obligations does a person who knows himself to be HIV-positive have to his prospective sexual partners? As stated earlier, the case for requiring notice is easy to make: if the person with HIV informed his partner, the partner could make a more informed choice. Amitai Etz-
ioni has recently argued that upon testing positive, persons “should inform their previous sexual contacts and warn all new ones. The principle is elementary, albeit openly put: the more responsibly AIDS sufferers act, the fewer dead they will leave in their trail.”

AIDS organizations serving gay men disagree. Generally these organizations support the choice of infected individuals who do inform their prospective partners but announce that there is no moral obligation to do so. In their view, the infected and the uninfected are absolutely obliged to practice safer sex, and disclosure is merely optional. Is this position justifiable either as a position for individuals or for organizations to recommend to individuals?

As a starting point, Etzioni’s position seems compelling: if an individual is contemplating an activity that could seriously harm another person, he should either refrain altogether from the activity or inform the other so that that person has the opportunity to make an informed choice about the risks. After all, condoms break and are sometimes not put on or taken off properly.

The question facing AIDS organizations in framing a position on informing partners is not, however, precisely the same as the question facing an individual trying to act responsibly. AIDS organizations, seeking to preserve the lives of large numbers of fallible human beings, may fear that broadcasting a message about informing partners will reduce the impact of their central message that partners must always use a condom. That is, they do not want to be perceived as condoning high-risk sex even when a partner has been informed and appears fully willing to assume the risks of sex without a condom. AIDS organizations also do not want uninfected persons to infer that the sexual partner who does not volunteer that he is infected is probably uninfected.

For these reasons, not announcing an obligation to inform may, paradoxically, save more lives in the aggregate than announcing such an obligation. If so, AIDS organizations, concerned with saving lives, are probably justified in maintaining their position. Unfortunately, of course, they cannot know whether this position saves lives. Like many asserted paradoxes, this one may be specious.

In my view, what constitutes acceptable behavior under these circumstances, even for the individual making a choice about his own conduct, is more complicated than Etzioni recognizes. The defense of an HIV-posi-

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81 Etzioni, supra note 77, at 100.
82 The fear that some uninfected men will choose to risk condomless sex with a person they know is HIV-positive has a realistic foundation. For example, one study of 58 HIV-infected men who were sexually active after learning that they had been infected reported that five infected men had insertive anal intercourse without a condom with a partner believed to be HIV-negative even after informing the partner of their HIV status. Marks et al., supra note 60, at 1322 table 1.
tive person who does not inform is that if he insists on using a condom (and he is absolutely obliged to do so), then the risks of transmission are very low, while the costs of candor may be very high. An initial cost is that the partner informed of the HIV status may misuse the information to the detriment of the infected person. A second possible cost is that the informed partner may overreact to the information by refraining from any physical contact whatever. This overreaction may have nothing to do with the fear of infection; many gay men cannot stand the thought of the future loss of yet another friend or lover. Still, for those suffering with the knowledge that they will probably die an early death, the continual loss of incipient relationships is a heavy burden to bear. To these possible costs, the ethicist Ronald Bayer responds that persons who know that they are infected "will have to warn their sexual partners about their HIV status, even at the risk of rejection." Etzioni is equally blunt: "It may be harsh to say, but the fact that an individual may suffer as a result of doing what is right does not make doing so less of an imperative.”

Etzioni’s response is either tautological or wrong—tautological if he means that because on balance disclosure is the right thing to do, it becomes an imperative to do it, and wrong if he is suggesting that if some action is generally required it is required regardless of the consequences.

I believe that it is justifiable for an infected gay man to remain silent with a person he has sex with on a single occasion if, but only if, he insists on a condom and takes the further precaution of securing from his partner in advance a commitment to safer sex. On that occasion, with the use of a condom, he has so reduced the probability of transmission that the partner has no legitimate claim to know more. When two gay men have sex, they commonly engage in a delicate minuet with regard to each other’s HIV status. The person with HIV does not reveal it for the reasons I have discussed previously. The uninfected partner, in return, knows that there is a risk that the person he is about to have sex with is infected, but he does not ask, in part because he does not want to disturb the passion of the moment and in part because he does not want to know the truth (believing that he himself will freeze if he learns his partner is infected). The condom permits sex to proceed, which each of them wants, while providing a high level of protection.

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83 Bayer, Private Acts, Social Consequences, supra note 9, at 230.
84 Etzioni, supra note 77, at 100.
85 This position on nondisclosure is most defensible when the infected person who does not reveal his status is the receiver (the “bottom”) in anal intercourse. In that case, the uninfected inserter, if he is wearing a condom, is highly protected even if the condom tears during use or comes off in the process of removal. The position becomes more questionable, however, in the case where it is the inserter who knows that he is infected, since the cumulative probability of breakage across multiple events is substantial and the risks of transmission to the other person are greater.
The obligations of an infected person present more difficulties as the first encounter grows into a longer-term relationship. Fear of the misuse of information will usually decline, and affection will typically increase the concern of each partner for the safety and welfare of the other. These changes over time suggest that the HIV-positive person should feel obliged, out of a duty not to harm the other, to inform the partner of his status. Still, the moral question is a close one, at least in the context of those gay men who have a sophisticated understanding of their risks. In the example mentioned above, Dave’s partner did not inform him of his HIV-positive status until they had been together for “several months.” What did Dave and his partner talk about during all that time? Assuming that his partner did not lie about his HIV status, Dave apparently did not ask. For Dave and his partner, and for others, the faithful use of the condom permits the relationship to develop to a point at which the partner finds it possible to tell.

Nonetheless, the evidence of high levels of unprotected intercourse among men who intended to use condoms regularly, as well as the evidence of condom breakage and misuse, strongly suggests that infected men, even men who insist on condom use on all occasions, ought to feel obligated to reveal their HIV status to the partners with whom they begin to have anal sex on a continuing basis so that their partners may protect themselves. While this may come at a heavy price of the loss of relationships, it may spare them the early deaths of the men they love.

C. State Codes and the Code of the Condom

Western societies announce their norms of minimally acceptable social conduct most forcefully through their criminal codes. When the AIDS epidemic began, many states, through law intended to punish gay persons for having sexual lives of any sort, already prohibited sexual behaviors that might transmit HIV. About half the states still had sodomy laws that rejected the sex-positive starting premise of the condom code we have been discussing. Many state codes had also long imposed criminal sanctions on persons who, knowing that they were infected with a sexually transmitted disease, engaged in sexual intercourse. Especially instructive for our purposes, however, are new criminal laws that were enacted

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86 See supra text accompanying note 39.
87 See supra note 40.
after the AIDS epidemic began and that rest on conceptions of social responsibility quite different from those announced by the condom code.

States have enacted two different sorts of criminal legislation to compel or induce safer sexual conduct. Twelve states have adopted statutes making it a felony for a person who knows he is HIV-positive to have intercourse with another person without first warning the other person that he is infected. Some of the statutes require that the informed person understand what they are told and expressly consent to sex. Several carry maximum sentences of five or even ten years' imprisonment. Thirteen states, including California, have created a second sort of offense aimed primarily at prostitutes. Under these laws, persons convicted of prostitution and other sexual offenses are subjected to testing for HIV antibodies. A person found to be HIV-positive commits a felony or high misdemeanor under these laws if she or he is later caught engaging in prostitution, whether or not a condom is worn on the later occasion.

These new laws share with the code of the condom one obvious central attribute: they ostensibly seek to reduce the spread of infection. While it is unlikely that the new statutes will exert significant deterrent effects on unsafe behavior, it is certainly true that if everyone followed their precepts—warning their sexual partners, desisting from prostitution when HIV-infected—some additional lives would be saved. These criminal laws are also easy to defend on traditional grounds for making conduct criminal: many of the persons these laws reach have engaged in behavior that they know or ought to know poses substantial and unjustified risks to others. The new statutes nonetheless differ from the condom code in

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92 See, e.g., MODEL PENAL CODE § 211.2 (defining reckless endangerment of another person as a misdemeanor when "[a] person . . . recklessly engages in conduct which places or may place another person in danger of death or serious bodily injury.").
two significant and revealing ways. First and most obviously, they do not exculpate persons who use a condom during the sexual act. If Recall Dave, whose partner faithfully followed the rules of safer sex but did not tell Dave for many months that he (the partner) was HIV-positive. If Dave and his partner had lived in Nevada, the partner would have committed a felony carrying a maximum possible sanction of 20 years' imprisonment. Under the condom rule, if Dave and his partner always used a condom, the partner would have committed no offense at all.

Second, the new statutes place all responsibility for safe behavior on the infected person. Some require that infected persons warn their partners and obtain their consent; others require the infected person to desist from certain sexual conduct altogether. Thus the code of the condom and these criminal statutes conceive of the human actors they regulate in deeply different ways. Under the condom code, safety is a mutual responsibility. Each person is responsible for making certain that he protects himself and his partner by insisting on the use of a condom. Whether HIV-positive or -negative, a party commits an offense under the rule if he fails to take the precaution that protects them both. In contrast, the criminal statutes demonize HIV-positive persons. They alone are responsible for preventing new infection. HIV-infected persons become the "they" who are a danger to "us." "They" are felons and "we" are victims.

This difference between the criminal codes and the condom code reveals their origins. The new criminal laws were promulgated by legislatures dominated by heterosexuals worried about the spread of the virus to them—to what some of them unself-consciously refer to as "the general population." The statutes were not enacted to protect gay men and IV-drug users but to protect others from them.

In some circumstances, the legislatures may be correct to view uninfected heterosexual persons as especially needing protection from the infected: gay men are typically much more alert to the possibility that their partners may be infected than are, for example, spouses in long-term heterosexual marriages. At least for the American gay community today,

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93 One state with a warning law does refer to condoms, but makes it a crime for a person who knows he has HIV to engage in intercourse unless he has both warned the partner and used an effective barrier protection. North Dakota makes it a felony for a person who knows he has HIV to transfer any of his semen to another person. The statute creates an affirmative defense in cases in which "the sexual activity took place between consenting adults after full disclosure of the risk of such activity and with the use of an appropriate prophylactic device." N.D. CENT. CODE § 12.1-20-17 (1993). The President's AIDS Commission endorsed this sort of legislation in its final report to President Reagan in 1988. See REPORT OF THE PRESIDENTIAL COMM'N ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC 130-31 (1988) (favoring criminal sanctions for HIV-positive persons who, knowing their status, do not both disclose their status to their partner and "use precautions").

94 See supra text accompanying note 39.
however, the ethos behind the condom code has much to be said for it. It begins with the premise that sex is good. That is a life-affirming place to start. It goes on to declare that all of us are in this together—the HIV-positive and the HIV-negative, the tested and the untested, those who fail to inform and those who are not informed. It asserts that none of us is innocent and each of us is responsible for our collective well-being. That is an especially important message in a world where the infected and the uninfected fear and mistrust each other but need to work together for their common salvation. It is nonetheless a rule that countenances the possibility that some additional lives will be lost (from failure to warn) as the price of announcing rules that refuse to divide the community against itself.

If we in the gay community truly believe that safer sex is a mutual responsibility, should we encourage states to consider a form of criminal law different from those they have enacted thus far? Should they impose the code of the condom through the criminal law? Suspend disbelief for a moment and consider a statute that imposes mild sanctions, comparable to sanctions that some states have created for failing to wear a seatbelt, on any person who fails to use a condom during anal intercourse. The sanction would apply without regard to HIV status and each party in any unprotected act would be guilty (unless, perhaps, each knew that the other was seropositive or each had been recently tested and knew the other to be seronegative). The virtue of such a statute would be to place the imprimatur of the state on a standard of mutual responsibility.

The endorsement by the gay community of such legislation would mark a willingness to claim as ours a form of law, the criminal law, that, with the exception of recent hate-crimes legislation, we have commonly regarded as our enemy. In endorsing it, we would be demanding that the state honor and enforce a set of moral norms within our community, much as, for example, women have demanded more adequate protection from date rape or from domestic violence. But, of course, it is inconceivable today that gay organizations would endorse such a statute. Every gay man or lesbian to whom I’ve so much as suggested the possibility has been appalled. As a single objection among many, we know who would enforce such laws if any were enacted. We would fear that they would be enforced by police and prosecutors not primarily in the hopes of promoting safe behavior but rather as a tool for harassing gay men and for stirring antigay sentiment. To discuss the possibility of such a law at all reminds us of how far we are from feeling secure in the embrace of the state.

What the gay community needs now to encourage safe behavior among gay men is not criminal legislation but more adequate support for the community’s own educational efforts. Although we are wary of the loss of independence, we need, and routinely seek, government money for research on prevention and for new educational programs. At the federal
level, we need a dramatic shift from the disgraceful behavior of the federal government toward safer sex education for gay men during the Reagan and Bush administrations.\textsuperscript{95} Regarding condoms and gay men, for example, one discouraged senior administrator in the Centers for Disease Control recently summarized a decade of governmental indifference and hostility. "How," he lamented, "can CDC . . . prevent HIV infection when upper levels of Government take a whole year in deciding what can be said to gay men regarding preventing HIV? How can the CDC promote public health when the promotion of condoms, a very effective approach, . . . is stifled because we cannot use the C word?\textsuperscript{96} What held the CDC back was not uncertainty as to the effectiveness of condoms,\textsuperscript{97} but unwillingness to face the political costs ofcondoning "sin."\textsuperscript{98}

We now have a new Administration with officials who are apparently committed to working more closely with gay organizations.\textsuperscript{99} Federal expenditures for AIDS prevention, after a few years of shrinking, has been expanded in the 1994 budget,\textsuperscript{100} but it remains uncertain how much of the new efforts will be directed toward gay men.

Conclusions

Over the course of a decade, gay-run organizations have broadcast a reasonably straightforward rule of behavior as the principal line of defense for gay men against the epidemic of AIDS: always use a condom for anal sex. If you use a condom, you will save your own life, protect the lives of others, and serve the interests of the gay community. Do so and you will also have no obligation to be tested for HIV antibodies or


\textsuperscript{97} See, e.g., William L. Roper et al., Commentary: Condoms and HIV/STD Prevention: Clarifying the Message, 83 AM. J. PUB. HEALTH 498 (1993) (strong endorsement of the condom strategy by Roper, Director of the CDC under the Bush Administration).

\textsuperscript{98} To the extent that the federal government has underwritten supportive education for gay men, it has largely done so through funds for antibody testing clinics where one-on-one counselling takes place behind closed doors, out of the earshot of public officials. See Scott Burris, Education to Reduce the Spread of HIV, in AIDS LAW TODAY, supra note 90, at 82, 89.


\textsuperscript{100} For example, the CDC's total budget for AIDS prevention went from $498 million under the 1993 budget to $543 million under the 1994 budget. John Gallagher, At Last, A Promise Kept?, ADVOCATE, Nov. 16, 1993, at 24, 24–25.
to tell your sexual partners what you know about your HIV status. The code of the condom has become charged with moral significance. Its great virtue is that it has almost certainly led to the saving of many lives. It has also had costs and limits. Most significantly, although many men protect themselves on all occasions, many others ignore the code or intend to follow it but often do not. Many men are becoming newly infected each year.

We need to find ways to deliver our current messages more effectively. We need to consider afresh exactly what our messages should be. And, while we feel some trepidation, we need more substantial and cooperative support on the part of states and the federal government to find ways to do it.