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AIDS and Sex: Is Warning a Moral Obligation?

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Abstract. Common-sense holds that morality requires people who know that they are infected with the Human Immunodeficiency Virus (HIV) to disclose this fact to their sexual partners. But many gay men who are HIV-positive do not disclose, and AIDS Service Organizations (ASOs) promote public-health policies based on safer sex by all, rather than disclosure by those who know that they are infected. The paper shows that the common-sense view follows from a minimal sexual morality based on consent. ASOs' seeming rejection of the view follows from their need to take seriously widespread weakness of will in the realm of sexuality. The author argues that gay men take themselves to follow the common sense view, but hold that the possibility of a partner's HIV infection is background information that need not be disclosed for sexual consent. This suggestion is criticized. The paper concludes with a consideration of HIV disclosure and sexual ethics outside of the gay community and of legal restrictions on the sexuality of the HIV-positive.

Key words: AIDS Service Organizations, gay men, HIV disclosure, HIV/AIDS, public health ethics, sexual ethics

There might seem to be an obvious answer to the question posed in my title. Of course, warning is a moral obligation! If you know that you are infected with HIV, you should disclose this fact to your potential sexual partners so that they can decide for themselves whether to take the risks to their health that sexual activity – even safer sexual activity – with you would involve. Failure to disclose would mean that you were exploiting your partners, taking advantage of their ignorance. Indeed, the very same argument might mean that even if you do not know if you have HIV – say you have never taken the test – a duty to disclose might nonetheless apply if you recognize a real possibility of your being infected: You ought, in this case, to disclose your various risk factors to your potential sexual partners. For only when they know the likelihood of your being infected can they properly assess whether they want to take the risk that sexual activity with you would entail (Yeo, 1991).

All of this strikes many people as just common sense. But one of the most remarkable things about the moral responses to AIDS in the first twenty years of the epidemic is how this common sense has co-existed with a very different

view of what morality requires of the HIV-positive when it comes to their sex lives. On the one hand, the common sense view has been enshrined in criminal law, either by particular laws governing the behavior of people who know that they have HIV, as in many US states including South Carolina,[1] or by interpretations of already existing laws relating to assault and sexual assault, as in the 1998 *Cuerrier* decision by the Canadian Supreme Court.[2] On the other hand, many studies have shown that between 40 and 65 percent of the HIV-positive fail to disclose to all of their sexual partners.[3] Moreover, AIDS service organizations (ASOs) throughout North America, especially those organizations rooted in gay communities, have for the most part promoted an approach to sexual ethics based, not on disclosure on the part of the HIV-positive, nor on the use of information relating to their potential sexual partner's HIV status by those deliberating about their sexual activities, but rather on safer sex by all in every circumstance (Chambers, 1994; Ainslie, 1999).[4] Cindy Patton has called this the 'don't ask, don't tell' approach to sexual ethics (Patton, 1996, p. 29).

Now, it might seem that this conflict between the common-sense view and the view circulating in the gay community is not really that remarkable after all. It might simply mean that the HIV-positive have been immoral in their failures to disclose, that they have been selfishly putting their desires for sexual freedom ahead of their obligations to their partners. And the support of ASOs for non-disclosure might show only that they have been co-opted by the HIV-positive in order to give them 'cover' for their immorality.

But this dismissal of the safer sex ethics is too quick. After all, gay men who are uninfected have largely gone along with the 'don't ask, don't tell' approach, without expressing outrage that it leaves them subject to exploitation or manipulation by the HIV-positive. And those who have become infected are not rushing to court to charge their former sexual partners. Even the recent critics of the culture of sex in the gay community, such as Gabriel Rotello (1998) and Michelangelo Signorile (1998), have not condemned the HIV-positive for their failure to disclose, focusing their criticism instead on the emergence of 'barebacking' – unsafe sex undertaken for the sake of its unsafeness – and more generally on the continuing valorization of promiscuity in urban gay centers.

In what follows, I explore this conflict between the common-sense view and the safer-sex view a little more deeply. I start out by looking at the philosophical rationale for the common-sense view (§1). In §2 I turn, first, to the reasons why ASOs have departed from the common-sense view, and then (in §3) to the reasons that seemingly lead many gay men to reject it. I will argue that in fact the departure from the common-sense view is not as dramatic as

it might at first seem, but I will also argue that, where there is a departure, it is a moral mistake.

Before I start, I draw your attention to three limitations to my discussion. First, my primary interest is in the *moral* questions relating to sexual ethics in the age of AIDS, not the *legal* ones, although I briefly turn to the latter issue in the final section of my discussion (§4). The fact that sex by the HIV-positive without disclosure is currently illegal in many jurisdictions is not an argument for its immorality. Gay men and lesbians in particular have long known that one can live morally even while behaving illegally, given that 13 states – including South Carolina[5] – still have laws prohibiting sodomy, laws that the American Supreme Court upheld in the notorious *Bowers v. Hardwick* decision.[6] Second, the focus of my discussion will be sexual ethics and HIV among gay men because it is largely within that community that there has been sustained public discussion about HIV and sexual ethics. But I suggest in the final section of this paper (§4) that my conclusions have wider applicability. Third, in the course of my discussion I sometimes make generalizations about what North American gay men think about various issues, but I do not mean to deny the obvious diversity to be found within and across gay communities, nor do I mean to suggest that everyone who is gay holds the views I am describing. I am trying only to capture what I see as common or prevalent patterns of thinking among gay men at the start of the third decade of the HIV/AIDS epidemic.

The Obligation to Disclose

Moral investigations of sexuality are fraught with danger, for long traditions of moralizing about sex by clerics and other do-gooders have left many people unwilling to listen to any suggestions about what they ought or ought not to do in their sexual practices. But there is an uncontroversial starting point for this topic, namely that you are morally obliged to get your partner's consent before initiating sexual relations with her or him. Failure to do so would be rape: You would be forcing yourself on her or him; you would be treating your partner as an object to be manipulated as you see fit, independently of what she or he thinks; you would be failing to respect her or his *autonomy*, the capacity each of us has to run our lives by our own lights (Dworkin, 1988).

The consent requirement establishes a clear minimal sexual morality, in that it declares that only sex between consenting adults can be ethical sex. Thus the immorality of pedophilia stems from the fact that children, not having the relevant mental capacities to be fully autonomous nor the physical development necessary for understanding what sex involves, are not able to consent to sexual activity. Of course, most of us subscribe to much

more extensive sexual moralities than this, thinking that the consent must be accompanied by other factors for the sex to be morally worthy. Some might hold that the people in question should be in love, or married, or intending to procreate; others might think that what matters is that they integrate sex into their lives so as to transgress conventional sexual customs, or to undermine patriarchal social relations, or whatever. But the consent requirement is an obligation that all moral doctrines should recognize as a necessary condition for ethical sex.

Nonetheless, as bioethicists have often pointed out when discussing patients' consent to medical treatments, the mere fact that someone says 'yes' to some activity does not mean that she consents to it in a morally relevant way. She must also *understand* what she is getting into, which means that her partner must give her the information she needs to make her decision (and she must comprehend its relevance) (Beaucamp and Childress, 2001, pp. 77–98). If you do not tell someone that shaking your hand means that he has joined your club, he cannot be said to have joined voluntarily when he shakes your hand. The difficult question is what this means for the consent requirement as it relates to sex. What information does someone need in order to know what he or she is getting into?

This can seem to be an entirely subjective matter. Imagine someone who needs to know her partner's astrological sign before having sex (say, she refuses to be sexually involved with Virgos), or someone who takes the monetary status of his partners very seriously (say, he wants them all to make over $500,000 a year). Clearly, the only way for you to know if your prospective partner has any such esoteric requirements is if she or he asks you. Thus the consent requirement binds both partners, not only because each must consent to the activity, but because each must make sure that the other knows what he or she must disclose in order to enable her or his partner's consent. If the woman concerned about her partner's astrological hygiene fails to ask her partner the relevant questions, she can hardly claim to be exploited when he turns out to have been a dreaded Virgo. Indeed, the moral fault here would be with her, not him: She could be said to have manipulated him into doing something to her that she finds abhorrent. Of course, if she did ask, and the man in question lied to her by saying he was a Pisces, the moral fault lies with him. He elicited her consent fraudulently, and thus failed to live up to the minimal moral requirements for sex.[7]

Is this, then, the whole story – that it is incumbent on each of us to make our informational needs known and to respond truthfully to one another's queries? In the case of interest to us, this would mean that those who worry about HIV should ask their partners, and those who are HIV-positive should not deceive them when asked. True enough, but I think the consent require-

ment involves more than that, and to see why, it will be helpful to return to the case of informed consent in the health care context. For we could imagine a patient for whom the astrological sign or yearly income of his physicians matters deeply. As in the sexual case, if he did not ask them about the relevant information, he can hardly said to have been exploited by them if they turn out to fail to meet his criteria. Note, by the way, that just because a patient wants to know something about his physicians, say their yearly incomes or their sexual orientations, it does not mean that they are obliged to answer him. Though it would be immoral for them to lie, they could quite legitimately refuse to give him this information on the grounds that it is private, thus leaving the patient in a position where he must either reconsider what information he needs in order to consent to the procedure, find another physician who is less reticent, or decide to forego the procedure altogether. Where things get difficult is when the patient wants to know, say, the number of times the physician has been sued for malpractice, her success rate in a certain procedure as compared to the physician down the hall – or whether she has HIV.

Whatever we decide in these difficult cases, it is clear that the subjective informational needs of a patient do not exhaust the moral requirement of informed consent to health care. For no matter what the patient asks, we still expect the physician to inform her of such things as the nature of her condition, possible treatment options, the likelihood of various kinds of side-effects, and so on. Why is that? She might after all care little about the details of her health, and be willing to go along with whatever the physician recommends (so long as the physician has the right star sign!). Why compel her to listen to information in which she has little interest – or, minimally, why must she go to the trouble of officially waiving her right to such information? There is an easy answer to this question: A physician is a professional to whom the health of the patient is entrusted. Thus the physician has a fiduciary duty to care for the patient's health, and informing her about the facts relevant to her treatment is part of this duty.

This easy answer, however, is too easy, for it does not tell us *why* physicians' relationships with their patients is special. This is partly a matter of expertise; physicians normally know much more than their patients about the facts relevant to their condition. But why must these facts be disclosed, even to a patient, fully aware of her informational shortcomings, who does not request them? The crucial difference between the subjective informational needs of a patient and the medical information physicians are obliged to disclose is that the latter is germane to the patient's *health*, to the condition of her *body.* And even though someone might not care all that much about making her own decisions about her body, its condition remains objectively

relevant to her consent. For the whole point of the consent requirement in health care (and in sex) is to respect autonomy, the capacity we have to direct our lives for ourselves. But the status of our bodies directly impacts on that capacity, no matter what attitudes we have towards our health. After all, we are in some sense identical to our bodies: An action done to them is an action done to us; a harm to them is a harm to us. Bodily-induced pain and suffering can even threaten our autonomy itself by interfering with our thought processes, leaving us no longer able to direct our lives by our own lights. So coming to terms with the limitations our bodies put on our lives is not optional; it is something we all must confront, whether we like it or not.[8]

The special status of the body explains why health professionals are obliged to disclose medically relevant information when eliciting consent to treatment. Physicians can assume that their patients will have to take that information into account in one way or another in their medical decisions, even if they do not ask any questions about it. And the same point applies to HIV-related information in sexual consent, indeed to any STD-related information. Because HIV is a bodily condition, a life-threatening one no less, you can assume that it is relevant to your partner's sexual decision-making whether she asks about it or not. HIV infection threatens a person's body and thus also threatens her or his autonomy. So he or she should be informed of this threat and thus be enabled to make sense of it for her- or himself. One of the obvious differences between consent in the medical and sexual contexts makes this requirement even stronger. Patients are (almost always) well aware of the informational disparity between themselves and their physicians; but in the case of a sexual relationship between someone with HIV and a partner ignorant of this fact, the unknowing partner's ignorance will often extend to include an ignorance of the informational disparity structuring their relationship. The autonomy of the ignorant partner can thus be doubly threatened: not only by the possibility of HIV infection, but also by his not knowing that his partner is withholding information from him.

So a minimal sexual morality based on consent is sufficient to require the HIV-positive to disclose their condition to their partners. For the same reasons, even if you do not *know* that you have HIV, but *suspect* that it is a real possibility given your sexual history, you have a duty to disclose this fact too. Failure to disclose would mean that your partner's consent would not be genuine; he would be left not knowing information that is objectively relevant to his decision. You would be taking advantage of him by leaving him in ignorance. The common sense view that warning is a moral obligation thus seems to be vindicated.

Public Health

Why then have ASOs been unwilling fully to embrace the common-sense view? Why have they shied away from running advertising campaigns urging the HIV-positive to disclose, and for all of us to ask our partners about their HIV-related information? Why have they instead opted for the safer sex ethic, with its 'don't ask, don't tell' message? There are undoubtedly many sociological answers to these questions, pointing to how safer sex campaigns were the outcomes of competing social pressures. But I think that there are also two answers to these questions that give a *rationale* – show that there are real reasons – for the ASOs' position. Both answers have to do with the fact that the aim of these organizations is not moral behavior but public health.

First, note that the minimal consent-based sexual morality I have described leaves each of us free to make whatever decision he likes with the information provided by his potential partner. This makes room for what is sometimes called 'negotiated safety', where seroconcordant people (i.e. they both test positive or negative for the presence of HIV) in a trusting relationship opt for unsafe sex after honestly providing one another with HIV-related information. But it also allows for barebacking, unsafe sex between relative strangers, so long as all parties disclose their HIV-statuses. So unsafe sex between the HIV-positive and HIV-negative, when each knows what he is getting into, does not violate the minimal sexual morality. We might want to condemn people who have this kind of unsafe sex as imprudent or selfish or self-destructive, but this criticism takes us beyond the minimal morality and into the heavily contested grounds of a substantive moral doctrine. For some people might think sexual freedom – including unsafe sex and the concomitant risk of HIV infection – more important to their lives than having a better chance of living a longer life. They might think that the intimacy and spontaneity of unsafe sex is worth it – especially in that it gives them the chance temporarily to keep thoughts about the epidemic out of mind. Or maybe they find the thrill-seeking of unsafe sex not to be different in kind from the thrill-seeking of sky-diving or racecar-driving or mountain-climbing. Risk is a part of all our lives, and we disagree with one another about what risks are worth taking. So saying that unsafe sex entered into with full knowledge is not worth it will always be an inherently controversial position.

Thus the fact that the consent-based sexual morality is a minimal morality means that it is only contingently connected with a reduction of new infections; it all depends on what people make of the HIV-related information that their partners should be providing them with. The public health orientation of most ASOs, however, typically means that they have more than a contingent interest in limiting the epidemic. Their ultimate goal is to 'stop AIDS now', not to promote people's informed choices about risky behavior,

where those choices might put them in the path of new infections (Chambers, 1994, p. 378).[9] So when ASOs urge people to have 'safe sex, every time', they are going beyond the minimal sexual morality to endorse a particular position in sexual ethics, one which places the need to avoid infection above all else. Ironically, since this stance can easily strike people as moralizing or patronizing, it might end up ultimately undermining the goal of reducing new infections (Odets, 1994; Odets, 1995). For it aligns ASOs with those moralists who try to dictate others' sexual behavior, a group that many regard with immediate suspicion, especially gay men. Indeed, some people take pleasure in transgressing moralists' prohibitions solely for the sake of transgression.

But ASOs implicit embrace of a particular substantive sexual morality still does not fully explain their downplaying of disclosure. For the thought that you should react to HIV-specific information in a certain manner – at the very least with safer sex, perhaps even refusal of sex with someone who might infect you[10] – does not itself speak against the need for disclosure; indeed it seems to make disclosure all the more necessary. This brings me to the second reason I think that the public health perspective of ASOs leads them to embrace the safer sex ethic, along with 'don't ask, don't tell'.

The minimal consent-based sexual morality – where each of us is required to ask our prospective partners about whatever might be salient to our decisions, to answer their questions truthfully, and to disclose independently of their queries any information that might impact on their health – might seem to be an awfully cold and clinical process. It treats sex as a contract entered into by two rational individuals, each thinking clearly about her or his needs and goals, and about the importance of respecting her or his partner's autonomy. This is a highly idealized picture of sexual relations, to say the least! Even if we *ought* to behave in this way, the reality is that sex clouds our thinking and blinds us to truths and values that we would instantaneously acknowledge in different circumstances. Sex is the paradigmatic *passionate* activity in human life, and yet the minimal sexual morality requires us to be *dispassionate* in our decisions about it.[11] And if the psychic upheaval that normally accompanies sex were not enough to interfere with our adhering to our moral obligations, we should not neglect the fact that many people engage in sex when they are intoxicated or under the influence of illegal drugs, leaving neither of them in a position to consent to sex in the morally obligatory manner.

While philosophers whose concern is what we *ought* to do can downplay these empirical facts about our sexual decision-making, ASOs and other public health groups have to take how we actually *do* behave as their starting point. As I have already suggested, their concern is to reduce the spread of HIV/AIDS, regardless of whether people behave morally or not. This means

that they have had to develop a public health strategy that takes into account the following features: some people might be infected with HIV without knowing it, perhaps even without knowing that they are at risk for HIV infection; some people who know that they are HIV-positive will on occasion fail to disclose this fact to their partners unless asked; some of the HIV-positive will lie about their infection if and when they are asked. These facts show why ASOs advice always to have safer sex makes sense, in that you cannot rely on your partner's disclosure of HIV-related risk to you, either because he might not know that he is infected, or because he might be succumbing to the moral failures of non-disclosure or deceit, failures that are often not too surprising given the intense psychological stress associated with sex and with knowledge of HIV infection.

The 'don't ask, don't tell' downplaying of disclosure also, I think, follows from the realization that many people will fail to live up to the consent-based moral requirements for sex. For if ASOs were publicly to encourage the asking for and telling of HIV-related information, they might also inadvertently be encouraging those who remain uninfected to base their sexual decision-making on the information they receive from their partners. But if this information is unreliable, such a policy would leave people vulnerable to infection, since they might have unsafe sex on the basis of a partner's false or misleading statements. ASOs thus focus on safer sex rather than on disclosure because the message of 'safer sex always' circumvents the problems people have in living up to the consent-based minimal sexual morality. So I am suggesting that ASOs have made a pragmatic response to the pervasive weakness of will that we all display in matters relating to sexuality. They have calculated that the public health will be improved if the moral obligation of the HIV-positive (and those who suspect they might be infected, given their sexual history) to disclose is downplayed in favor of the need for each of us to protect our health for ourselves. Whether this calculation is correct remains an open question (Chambers, 1994, pp. 378–379).

Gay Men and 'Don't Ask, Don't Tell'

But if ASOs' public health agenda is what justifies their de-emphasizing of the disclosure requirement of the minimal sexual morality, that does not explain why gay men have largely gone along with it. Even if limiting the spread of AIDS means not publicly encouraging the HIV-positive to disclose, this does not mean that individual gay men are not morally entitled to be told by their partners if they are or are likely to be HIV-positive. Whatever the facts about the efficacy of public health campaigns, the HIV-positive wrong their partners by failing to disclose. But gay men do not seem to think so, or

at least there has not been a widespread outcry at the ‘don’t ask, don’t tell’ message promulgated by the ASOs. I suggest below three reasons why this might be the case. As in the previous section, my aim here is not to offer sociological explanations of this phenomenon, but to discern what reasons might *justify* gay men’s acceptance of ‘don’t ask, don’t tell’, even if they have not explicitly entertained these reasons for themselves.[12]

First, consider some of the more radical features of the gay sexual culture: sex clubs, bathhouses, cruising in public parks and bathrooms, and so on, all of which promote ease of sexual contact with a minimum of fuss. Encounters are usually anonymous, and communication between the parties is primarily non-verbal.[13] How does the minimal sexual morality come into play in these domains? Let us suppose that the participants do not force themselves on one another, so a narrow form of consent obtains. Neither partner speaks to the other, so each presumably knows all of the subjective factors relevant to his consent: mutual attraction. But what if one of them knows that he has HIV: Must he disclose this fact in this context?

I argued above that since HIV is a bodily condition, it is objectively relevant to any person’s consent to sex. So normally, HIV-related information must be disclosed. Note, however, that some people might choose to *waive* their right to such information by declaring “I don’t want to know.” They are entitled to do this, for choosing to remain ignorant is one way autonomous people might undertake to shape their lives. But, if they do so, it means that they have taken upon themselves the responsibility for the outcome. They cannot blame someone else for whatever eventuates as a result of their voluntary ignorance of the ramifications of their activities.

I suggest that those who choose to engage in anonymous sex thereby choose also to waive their right to HIV-related information. It is true that they do not make a public declaration of such a waiver, but the whole point of anonymous sex is to do away with public declarations of all kinds, to reduce the interaction to the mere physical act. The participants do not want to know if their partners think of themselves as homosexual or heterosexual, if they are married or single, if they are Virgos or make over $500,000 a year. It does not seem to me that someone who is not interested in knowing *anything* substantive about his sexual partners retains the right to be informed by them of their HIV-related information. If he wanted to have sex with people who would disclose to him, he should not be having anonymous sex.

If I am right that participants in such settings waive their right to HIV-related information then, despite appearances, they conform to the minimal sexual morality, which would explain why they do not take their behavior to violate the common sense it encodes. While many of us might think that engaging in such activities is imprudent or morally suspect in one way or

another, the participants in it would be respecting one another's autonomy. But what of those gay men who do not opt for these radical sexual practices? They too seem not to be offended by the 'don't ask, don't tell' aspect of the safer sex ethic. It is clear that they have not waived the right to be informed of HIV-related information from their sexual partners, for normally such a waiver must be done publicly and officially; the only reason those engaging in anonymous sex were taken to have waived their right to information despite the lack of any such announcement was because their activities were so designed as to avoid having to make *any* public and official declarations, of HIV status or of a waiver (or of anything else). In any less anonymous context, even a one-night stand, the interactions of the people in question can be judged according to the minimal consent-based morality, including its demand for the sharing of health-related information. So why have gay men not pressed their right to this information? Why have they acquiesced to 'don't ask, don't tell'?

I think that part of an answer to this question can be found by thinking a little more about what information must be disclosed in consent situations in the health care setting. I have already said that physicians must inform their patients about treatments options and the like; but note that (barring unusual circumstances) they do not have to inform them about facts that any person should be expected to know: that surgery without anesthesia is extremely painful, that healthy humans typically have a lifespan of 80-odd years, and so on. Of course, if patients *ask* for this information (or otherwise make clear their need for it), physicians would surely have to provide it, just as they would have to respond to their other subjective informational needs. But it is pragmatically impossible to convey *all* the information that relates to the body when eliciting a patient's consent to treatment. So physicians need only provide that information salient to the patient's condition that their special expertise makes available to them – that information that the patient is not expected to know for her- or himself. My point is that the informed consent procedure in health care only makes sense in the context of a background of information that is taken for granted.

The same is true of other consent situations as well, even if neither partner has the kind of professional expertise that creates an asymmetry between physician and patient. It is always pragmatically impossible to convey *all* the information relating to that to which the consent is being made. Thus the person shaking hands in order to join the club need not be told that the members of the club all have two eyes or that they breathe oxygen, though she or he should be told the responsibilities and benefits of membership. And, similarly, consent to sex presupposes some background information as taken for granted – say, that unprotected heterosexual intercourse can lead

to a woman's becoming pregnant, that condoms can break, that birth control methods in general are not failsafe, and so on. So this information need not be disclosed in eliciting someone's consent to sex.

My suggestion is that many gay men do not take their prospective sexual partners to be obliged to disclose their HIV-related information because they treat it as background information, akin to the possibility heterosexual women face with pregnancy. Many gay men take for granted that their partners might be HIV-positive and deliberate about sex accordingly. Or they figure that if this possibility really makes a difference to them, they could ask. It is up to them, not the person who knows that he has HIV. The fact that ASOs promote the idea that each person is responsible for his own sexual health as part and parcel of the safer sex ethic only reinforces this sense that the possibility of a sexual partner's HIV infection is background information, not something that needs to be made explicit. If I am right, this would mean that many of those gay men who endorse 'don't ask, don't tell' take themselves to share the common-sense moral view of sexual ethics, even while they do not treat HIV-related information as worthy of being disclosed in the context of consent to sex; for they treat the threat of HIV as something everyone should know, as a possibility that should be taken for granted by anyone who is sexually active.

But if this interpretation of why gay men have not been critical of the 'don't ask, don't tell' aspect of the safer sex ethic is correct, I think that they have been making a deep mistake. For I think that it enables a kind of double-think amongst gay men, where people can interpret someone's not disclosing his HIV infection to mean that he does not have HIV, leading them to engage in riskier behavior than would have been undertaken with someone known to be HIV-positive.[14] Indeed, it might be the case that gay men have gone along so readily with 'don't ask, don't tell' exactly because it allows them to postpone dealing with the reality of sexual activity with someone with HIV. It allows them to postpone dealing with the grim reality of the epidemic until it might be too late to make a difference.[15]

Moreover, pushing HIV-related information into the background of sexual consent presupposes that both partners share this attitude towards it. While ASOs have promoted this way of thinking about the epidemic, it cannot be established that both parties have accepted it – or even that they have both heard of the safer sex ethic – unless they discuss the issue. And such a discussion should yield either a waiver of the right to know, or the disclosure of the relevant information.

The third reason that gay men seem not to accept the disclosure requirement of the minimal sexual morality is even more problematic. It starts from the recognition that people who are publicly known to have HIV are at risk for many sorts of injustices, from discrimination at work or in accommo-

dations, to social isolation and even physical attack. In the twenty years of the epidemic, gay men have made tremendous strides in combating these injustices, but they nonetheless remain a real possibility. The safer sex ethic, with its downplaying of disclosure, allows those who know that they have HIV to protect themselves from this possibility by keeping this information private. Indeed, some gay men have suggested that the fight against these injustices should even be extended into the sexual realm; they hold that you should not let HIV-related information about your potential partner influence your sexual decision-making, for refusing someone sexually solely for the reason that he has or might have HIV is discriminatory, a form of "AIDS apartheid."[16] 'Don't ask, don't tell' thus might be taken to be the expression of a mutual commitment by gay men not to engage in such discrimination among themselves when it comes to sex. It might seem, then, that the safer sex ethic is an ethic of *solidarity*, in that it both allows the HIV-positive to maintain their privacy and lessens the likelihood of their becoming sexual outcasts (Chalmers, 1994, pp. 362, 382–383; Ainslie 1999, pp. 28–29).

This might be an admirable moral goal, but I doubt that 'don't ask, don't tell' is the appropriate means for reaching it. A truer expression of solidarity would involve gay men making a specific waiver of their right to know in the case at hand, an autonomous commitment to protecting the privacy of the HIV-positive. Or, if they do not make such a waiver, they could show their rejection of the sexual isolation of the HIV-positive by being willing to continue with the planned sexual encounter even after the disclosure of the relevant HIV-related information. Otherwise the people in question are left in a position where they have no choice over whether to express solidarity with the HIV-infected. That is to say that a practitioner of 'don't ask, don't tell', by leaving people in ignorance of his HIV-related information, infringes on his partners' autonomy; it does not allow them to direct their lives by their own lights. And this means that the safer sex ethic is in violation of the minimal sexual morality, for it leaves people in a position where their consent to sex would be made without full knowledge of what they are getting into.

So I think that gay men should not accept the 'don't ask, don't tell' aspect of the safer sex ethic; unless they waive their right to know, they should demand that their sexual partners respect them by disclosing to them the HIV-related information they need to consent to sex. This may put enormous pressure on those who are HIV-positive, for they might not *want* to disclose given the increased likelihood of rejection and susceptibility to injustice that public knowledge of their status could entail. They might also be wrestling with feelings of shame, sexual inadequacy, or depression over their condition. Psychological and social factors such as these make what morality demands of the HIV-positive truly difficult, perhaps even leaving them in a position

where they must give up on sex altogether if they do not want to disclose. The weakness of will that looms so large in the public-health endorsement of 'don't ask, don't tell' is surely understandable here. Thus gay men might choose to *forgive* those who fail to live up to their moral obligation to disclose HIV-related information to their sexual partners. After all, many gay men know all too well from their own experiences with discrimination and homophobia both the burdens of living with a stigmatizing condition, and the difficulties of having to disclose to others information about themselves that might lead to their rejection or isolation. But this willingness to forgive, to understand the challenges that come with living with HIV, is not sufficient to negate the duty to disclose. After all, we can only forgive something if we think it is wrong, and I have argued that sexual activity without disclosure of HIV-related information is a moral failing.

Conclusions

I have two concluding points. First, although I have here focused on sexual ethics in the gay community, the conclusions I have reached actually apply much more widely. For the minimal sexual morality that stands behind the duty to disclose HIV-related information is not community-specific. It is true that my consent-based analysis presupposes that the parties considering sexual activity are equals, each able to put forward her or his own needs and desires. And, while surely this *ought* to be the case, in many situations the marked disparities in power among the sexual actors leaves one of them unable to articulate her needs or to have them respected – and I use the feminine pronoun here on purpose to mark the fact that many women, especially those in patriarchal cultures, are unable to demand much of their partners. The men in question might even reject the minimal morality that makes consent relevant, let alone the informational considerations I have been suggesting are necessary to make the consent fully morally significant. In a longer discussion, I would argue that, even if their behavior is sanctioned by their cultural tradition, these men are morally mistaken: They have failed to recognize the humanity of their female partners. Nonetheless, such cultural traditions must be taken quite seriously when crafting a public health response to the AIDS epidemic.

My second concluding comment has to do with how my *moral* argument relates to the *legal* restrictions on the sexual activity of those with HIV that I noted at the start of this essay. The question of how law relates to morality is notoriously complex, and I can only gesture at how I would approach the issue in the case at hand. Note that my discussion treats the capacity we have to direct our own lives – autonomy – as fundamentally valuable. This is an

inappropriate starting point for a legal argument, in that a liberal state should not require its citizens to subscribe to a particular set of substantive values. But this very thought, that citizens should be left to themselves to craft their own ethical vision, embodies a certain kind of commitment to the value of autonomy – not to its *moral* value, but to its *political* value. That is to say that, here, autonomy is not put forth as something we should all value in our attempts to live morally, but rather as something that must be respected in the structure of our political institutions (Rawls, 1993). If this is right, then the *moral* argument, above, can easily be recast as a *political* argument in favor of a prohibition on sex without appropriate disclosure. It is true that such a prohibition might interfere with public health measures aimed at decreasing the spread of the epidemic, say, by driving the HIV-positive underground. And a law aimed at the sexual practices of those with HIV might involve too much of an infringement of citizens' privacy. So before the political argument for the obligation to disclose could be used to justify a law focusing on the sexual behavior of those with HIV, it would have to balanced against these other legitimate interests of the state.

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Notes

[1] For overviews of the American legal situation, see Gostin (1990) and Chambers (1994, pp. 380–384). The South Carolina statute says: "It is unlawful for a person who knows that he is infected with Human Immunodeficiency Virus (HIV) to: (1) knowingly engage in sexual intercourse, vaginal, anal, or oral, with another person without first informing that person of his HIV infection. ... A person who violates this section is guilty of a felony and, upon conviction, must be fined not more than five thousand dollars or imprisoned for not more than ten years" (*South Carolina Code of Laws*, Section 44-29-145).

[2] *R. v. Cuerrier*, 1998, 2 SCR 371.

[3] Wolitski et al. (1998) found that 66% of men who recently tested positive had sex without disclosure; Prestage et al. (2001) found similar rates of disclosure, while Kalichman et al.

(1999) found that 41% of positive men did not disclose their status to all of their partners. Other empirical studies of the sexual behavior of people with HIV and the frequency of disclosure of HIV status, are: Kegeles et al. (1988), Wiktor et al. (1990), Marks et al. (1991), Schnell et al. (1992), Wenger et al. (1994), and Stein et al. (1998).

[4] In the past few years, ASOs have sometimes moved towards recommending disclosure, not as a moral requirement, but as an aspect of a *psychologically healthy* approach to sex. Consider, for example, this advice found on the San Francisco AIDS Foundation's website, *<http://www.gaylife.org/>* [September 20, 2001]: "Some guys *feel better* when they talk about their HIV status first, and then decide how to fuck, depending on the other guy's HIV status" (emphasis added). New York City's Gay Men's Health Crisis issues similar advice, though with a more directive edge: "If your know you're HIV positive. . . . You definitely need to be more cautious when you're having sex, to make sure you don't infect someone. Even when things are 'clearly' safe – masturbation or kissing, for example – *you may want to talk about your HIV status and his*. In gray areas, such as ejaculating in someone's mouth or with a condom in someone's ass, staying silent may amount to making decisions for both of you, whether or not it was your responsibility to bring it up. You may be okay with a gray area, and he may seem okay, but what he actually knows about your HIV status might make him act differently. If you don't feel ready for that fact, or a discussion about HIV, then definitely don't come in his mouth or up his ass, even with a condom. Even putting your dick in his mouth may cause him to get worried later" (*<http://www.gmhc.org/basics/men.html>* [September 20, 2001], emphasis added).

[5] *South Carolina Code of Laws*, Section 16-15-120.

[6] *Bowers v. Hardwick*, 1986, 478 U.S. 186.

[7] I make this sound more straightforward than it is in reality. Consider a woman who approaches a man at a bar and says to him, "You look like a Pisces." Though he is actually a Virgo, he replies to her that he is indeed a Pisces, primarily because he wants to encourage her to enter into conversation with him. Eventually, she proposes a sexual encounter, basing her suggestion on his assurance that he was not a Virgo. He does not know that what he thought was a harmless 'white lie' was to her a piece of highly significant information. Has he fraudulently elicited her consent to sex? Probably not; she would need to underline for him the significance of astrological hygiene to her before his lie would count as a form of exploitation.

[8] See Dworkin (1988, 113–114). Note that, just as information about our bodily condition is objectively relevant to our consent to health care, so also is information about our *mental* condition. For just as the status of our bodies directly impacts on our autonomy, so also does the status of our minds. We are in some sense identical to our minds, just as much as we are in some sense identical to our bodies. And thus coming to terms with the limitations our minds put on our lives is not optional, and must be confronted by all of us, whether we like it or not. (I owe thanks to Wayne Sumner for discussion of this point.)

[9] Some ASOs have recently adopted a non-directive 'harm-reduction' approach, the aim of which is to give people the information about the risk of various activities so that they can know the ramifications of their activities (see GMHC, *<http://www.gmhc.org/basics/men.html>* [September 20, 2001]). This approach is more in keeping with the autonomy-based analysis I give here.

[10] Then-Surgeon-General C. Everett Koop, for example, advised in 1987 that physicians should tell their patients to "[a]bstain from sex with individuals other than seronegative partners . . ." (Koop, 1987).

[11] The fact that sex involves our temporarily losing control, our no longer being to run our lives by our own lights, might mean that an autonomy-based analysis of sexual ethics is inappropriate (Warner, 1999). But the decision-making I have focused on occurs *before* we are

fully in the grip of sexual passion; it concerns the choices we make about *how* the unruliness of sex should be integrated into our lives. And this is a matter that involves our autonomy.

[12] John Rawls would call this a case of "reasoning from conjecture," in that I aim to find reasons animating a particular moral stance (Rawls, 1997, pp. 783, 786–787).

[13] See Laud Humphrey's classic *Tea-Room Trade* (Humphrey, 1975).

[14] Consider the San Francisco AIDS Foundation's poster, which shows two men sexually involved with one another, one thinking "He'd tell me if he's negative," the other thinking "He'd tell me if he's positive" (<*www.gaylife.org*> [September 20, 2001]).

[15] See Patton (1996, 161n22): "Men both fail to practice safe sex out of assuming a partner who doesn't say anything is *not* placing them at risk and do practice safe sex (by simply never practicing intercourse) without realizing that they have done so without needing to know another's serostatus. The problem of not disclosing one's serostatus comes about because a specific meaning is attached to saying nothing, and a decision-making process is set into motion based on that meaning. The idea that you can tell if someone is seropositive by looking (still, I believe, a prevalent belief – many gay men simply believe they have a larger pool on which to base such 'educated' guesses) is partially replaced by the idea that you can tell their status by whether they disclose it or by what they will agree to do. In this logic, those who don't tell you they are seronegative are suspicious (but really, wouldn't that be the more dangerous lie to believe?) while those who refuse to disclose and instead practice safe sex are assumed to be positive (but really, aren't they avoiding the possibility of everyone's lies)?"

[16] See Charles Barber's discussion of Phil Zwickler's and David Wojnarowicz's short film, "Fear of Disclosure" (Barber, 1991).

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