

SOUNDING BOARD

AIDS PREVENTION — SEXUAL ETHICS AND RESPONSIBILITY

Do people infected with the human immunodeficiency virus (HIV) have special responsibilities to their sexual partners? If so, what do these responsibilities involve? Merely raising these questions directly has tended, until recently, to disquiet many people involved in AIDS-prevention efforts.

From the onset of the AIDS epidemic in 1981, it became increasingly clear that questions of sexual ethics could not be avoided. Here was a new fatal disease, spread in the context of sexual relations that are typically consensual. The questions posed by AIDS were not fundamentally different from those raised by other sexually transmitted diseases. But the lethality of HIV infection added an urgency that made refusing to consider such matters more problematic.

The following questions had to be answered: Is there a moral obligation on the part of someone infected with HIV to use condoms when engaging in penetrative sex? If condoms are used, is there an additional obligation to inform one's partner that one is infected? Does this obligation change if the sexual acts in question are thought to involve a relatively low risk, or risks that are a matter of dispute? Does it matter whether the sexual contact occurs in the context of an ongoing relationship, one that is thought to be monogamous, a casual relationship, or an anonymous encounter? Does it matter if the infected person is a man or a woman or the sexual encounter gay or heterosexual? Is there an obligation to inform past sexual partners about one's HIV infection, and if so, partners from how long ago? Is the obligation to use condoms or to disclose infection obviated if there is a real or assumed threat of violence? Does the anticipation of rejection justify a failure to use condoms or to disclose one's HIV status? Does concern about possible secondary disclosure justify keeping silent about one's infection? What obligations do health departments and AIDS service organizations have to foster an ethic of personal responsibility? Should concern about stigmatizing people affect that obligation?

In the early years of the epidemic, the very idea of responsibility raised by these questions was viewed as alien and threatening. It was a concept more common to the moral and religious right, which had shown a profound indifference to the plight of those with AIDS. The emphasis on personal responsibility was often associated with condemnation of those whose sexual or drug-using behavior had exposed them to HIV, as well as with calls for invasions of privacy and deprivations of liberty. It seemed, finally, to echo the moralistic disapproval of sexual pleasure in general and of homosexuality more specifically.

Pragmatic, philosophical, and political objections to the concept of responsibility were raised. On a pragmatic level, it was claimed that a public health policy focusing on the responsibility of people with HIV to behave in ways that protected the uninfected — either by

using condoms or by disclosing the fact of their infection — would, paradoxically, increase the risk of HIV transmission. Misled by false expectations, people would fail to protect themselves. Some did not know they were infected. Others knew they were at high risk but sought to avoid HIV testing. Finally, it was believed that some would lie about whether they were infected. Given these prospects, it made sense to stress self-protection rather than self-disclosure. Each person had to be responsible for condom use,¹ and this obligation was shared equally by the infected and the uninfected. Because each sexual partner was responsible for his or her own health, neither was ultimately responsible for the health of the other.

Even some health departments sought to promote condom use because it was the only way of ensuring self-protection. In an AIDS-prevention advertisement produced by the New York City Health Department, in the style of pop art, a man and woman are shown embracing and thinking, "I hope he [she] doesn't have AIDS!" To this, the voice of the Health Department responds, "You can't live on hope." The text of the advertisement continues:

You hope this guy is finally the right guy.
You hope this time she just might be the right one.
And you both hope the other one is not infected with the AIDS virus.
Of course, you could ask. But your partner might not know. That's because it's possible to carry the AIDS virus for many years without showing any symptoms.
The only way to prevent getting infected is to protect yourself. Start using condoms.
Every time. Ask him to use them. If he says no, so can you.

When the question of disclosure was considered in the first decade of the epidemic, it was commonly discussed in terms of the psychological burdens associated with secrecy rather than the sexual partner's right to be informed.

From a philosophical perspective, it was asserted that since HIV was primarily transmitted in the context of consensual sex, each person bore the responsibility of self-protection. Mohr wrote, "The disease's mode of contagion argues that those at risk are those whose actions contribute to their own risk of infection."² Relying on the legal maxim "to one who consents, no harm is done,"³ Illingworth concluded that people who did not protect themselves had no claim against those who infected them.

Haunting the philosophical perspective on the dangerous concept of sexual responsibility was the specter of criminalization. If the protection of others was a moral duty and the consequence of disregarding that duty was a lethal infection, would it not be logical to impose criminal sanctions for unsafe sex? Many state legislatures enacted statutes imposing criminal penalties on those whose actions could result in HIV transmission, and they sometimes refused to distinguish between those who did use condoms and those who did not.⁴

A final, political objection was made to the claim that those with HIV infection had a special responsibility

not to transmit the virus. In the face of indifference, hostility, and stigma, it was considered crucial to articulate an ideology of solidarity, one that rejected as divisive all efforts to distinguish the infected from the uninfected. Such distinctions, it was feared, would lead to “viral apartheid.” Solidarity was endangered to the extent that the infected were held to have special duties — protecting the uninfected, even recognizing their right to choose not to have penetrative sex with them — and to the extent that the uninfected had a special need to remain uninfected. Cohesiveness could best be grounded in the concepts of universal vulnerability to HIV and the universal importance of safe sexual practices.

It is important not to overstate the extent to which the principle of self-protection rendered impossible any discussion of the responsibility of people with HIV infection. Some philosophers underscored the obligation to notify sexual partners about one’s HIV status by drawing on the doctrine of informed consent.⁵ And while virtually always rejecting the idea that there was a duty to disclose one’s HIV status, many AIDS service organizations urged universal condom use.⁶ Public health departments and the Centers for Disease Control and Prevention paid considerable attention to issues of partner notification and explicitly sought to define strategies to protect the unsuspecting sexual contacts of persons with HIV. “Privilege to disclose” legislation in many states made it possible for physicians to breach confidentiality to warn unsuspecting sexual partners.⁷

Nevertheless, self-protection was accorded a central conceptual role in AIDS-prevention efforts, especially by community-based organizations and health departments sensitive to the fears of those most at risk. In a 1995 review of preventive efforts among drug users, Des Jarlais noted that “most programs that have urged intravenous drug users to use condoms thus far have focused on the self-protective efforts of condom use. Appealing to altruistic feelings of protecting others from HIV infection may be an untapped source of motivation for increasing condom use” (Des Jarlais D: personal communication).

How deeply rooted the ideology of self-protection had become and how difficult developing programs that appealed to “altruistic feelings” might be was starkly revealed in New York City in 1993. To mark the occasion of the city’s 50,000th AIDS case, efforts were made to launch a prevention campaign that would focus on protecting others as well as oneself. Those efforts were aborted when AIDS specialists inside the health department denounced the proposal as “victim blaming.”

The emerging recognition of the limitations of self-protection reflects a growing awareness that new epidemiologic trends demand a new approach to prevention. Self-protection has little to offer the increasing number of women infected through heterosexual contact, who often cannot protect themselves. Patterns of new infections among young gay men suggest that, at least in part, they are vulnerable to infection from an

older generation in which the prevalence of HIV infection is high.

Although a growing literature in the late 1980s and early 1990s detailed the patterns of self-disclosure of HIV status to sexual partners,⁸⁻¹³ the debate about responsibility was largely inaudible. In 1995, however, *The New York Times* published a piece in which the gay journalist Michelangelo Signorile wrote, “If I am positive, I have a responsibility: not to put others at risk and to understand that not all HIV-negative people are equipped to deal with the responsibility of safer sex.”¹⁴ AIDS service organizations, he charged, had failed to address this matter. Signorile’s challenge was echoed by Gabriel Rotello, a gay columnist for *New York Newsday*: “The focus on self-protection allows some who are HIV-positive to reason that if an infected partner is willing to take risks, that’s the partner’s choice. And if that choice results in infection, it’s the partner’s fault.”¹⁵

Even more striking were the observations in 1995 by Dr. Lawrence Mass, a cofounder of Gay Men’s Health Crisis (GMHC), New York’s largest community-based organization devoted to AIDS prevention:

When I wrote the earliest version of GMHC’s Medical Answers about AIDS . . . I was maximally concerned about civil liberties. Today, I remain so, but with behavior modification looking as if it will remain the sole form of prevention for years to come, I am even more aware of and concerned about personal and moral responsibility.¹⁶

The endorsement of personal responsibility by prominent and vocal people should not be taken to mean that the world of AIDS prevention has done an about-face. Nevertheless, it represents a profoundly important challenge, one that would require fundamentally reformulating the messages conveyed in counseling and public efforts at education about AIDS.

Acknowledging that personal responsibility has a central role in AIDS prevention raises a number of complex questions. Some proponents of this concept view it primarily as an alternative strategy of motivating people to use condoms. Others underscore the concomitant obligation to disclose one’s HIV infection. After all, condoms sometimes fail. Even AIDS-prevention groups refer to sexual intercourse with the use of condoms as being “safer” rather than “safe.” Should not uninfected persons be given the opportunity to decide whether to take the risk, however small, entailed by engaging in protected sex with an infected partner?

What are the implications, if people infected with HIV are obligated both to wear condoms during penetrative sex and to disclose their status to their partners? Should those who have been told that a partner is not infected agree to intercourse without a condom? Should such arrangements between partners be thought of as “negotiated safety” or “negotiated danger”?¹⁷ Most important, should AIDS-prevention programs link the concept of candor with that of trust by suggesting that condoms may not be needed by monogamous, uninfected couples?

Alarmed at the extent to which infected people may not know that they are infected or may not be willing

to share the fact, some have recommended that intercourse always be protected, even in ongoing relationships. For them, the very concept of trust — even between husband and wife — “disempowers”¹⁸ partners by making the routine use of condoms unacceptable to those who deem their relationship completely monogamous. Sobo notes, “Unsafe sex within a so-called faithful union helps a woman to maintain her state of denial and her belief that her partnership is one of love, trust and fidelity. . . . AIDS risk denial is tied to monogamy ideals. . . .”¹⁹ From that perspective, some, not surprisingly, have argued that romantic feelings are an impediment to effective AIDS prevention.²⁰ And so, in view of the risks faced by those who follow the romantic maxim “Love conquers all,” it has been suggested that safety can be found only in the warning, “Let the buyer beware” — a warning appropriate to commercial exchanges.

Is such a perspective compatible with lasting relationships, heterosexual or gay? Can efforts to prevent AIDS subvert the expectation of trust within intimate relationships and still remain socially and psychologically credible? It may be appealing to assert that AIDS-prevention efforts should have it both ways, encouraging an ethic of responsibility as well as a posture of self-defense. But can candor be fostered when the continued need for vigilance and self-protection is underscored?

There are no simple answers that address the needs both for trust and candor in intimate relationships and for security in the era of AIDS. Systematic behavioral research is essential, as is searching inquiry into the ethical and psychological underpinnings of intimate relationships. Nonetheless, these questions make it clear that matters of sexual ethics are not moralistic diversions. They are at the heart of AIDS prevention.

This week is the 15th anniversary of the first report of AIDS by the Centers for Disease Control. All public and community-based programs of HIV prevention should mark this occasion by confronting openly the challenge of sexual responsibility, a challenge that too

many have addressed for too long in at best an oblique and morally cramped fashion.

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