

THE AFTERLIFE OF HOMOPHOBIA

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Over the past 15 years, the LGBTQ movement in the United States has vanquished sodomy laws, the military's Don't Ask, Don't Tell policy, and laws banning same-sex marriage. Despite these formal legal advances, there remains a disparity between social acceptance of same-sex marriage and persistent aversion to sex between men. Even as the U.S. Supreme Court gradually came to embrace same-sex marriage, it was closeting sex between men. This Article is the first to identify a similar fear of sex between men in several long-standing public-health policies, including those of the avowedly pro-LGBTQ Obama Administration. The fusion of sex between men and HIV risk undergirds long-standing policies that ban many men who have sex with men ("MSM") from donating blood and sperm, and more recent guidelines that encourage even gay men at low risk of HIV infection to take preventative anti-retroviral drugs that had been typically reserved for people who are HIV positive. These policies presume that sexual-minority men have risky sex—and lots of it. The original blood ban imposed what we might call a "one drop" rule: all men who had "sex" with a man "even one time" since 1977 were treated as if

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their blood was infected with HIV. The Obama Administration revised the policy to allow such men—even those who married under Obergefell v. Hodges—to donate blood only if they have abstained from sex with men for one year. These policies effectively reinstate the long-standing belief that gay and bisexual men are pathological and need medical intervention. Indeed, they serve as government-endorsed “lessons in being gay,” teaching gay, bisexual, and questioning youth what it means to be a sexual minority in the post-marriage equality landscape.

We explain this contradiction by illuminating the law’s bifurcated vision of sex between men as either inherently dangerous—i.e., public-health policies—or as identical to heterosexuality—i.e., Obergefell. While federal public-health authorities have consistently endorsed the stereotype that sex between men is dangerous, various state and federal courts have increasingly rejected government arguments that sought to fuse such sex and HIV. These undersung precedents, rather than the high-profile marriage-equality victories, provide tools for critiquing laws based on a conception of sex between men as pathological. Moreover, our call for attention to policy-level sexual stereotyping has implications beyond the HIV context. It speaks to the current debate about transgender bathroom policies. Drawing on Kimberlé Crenshaw’s scholarship on intersectionality and Angela Harris’s work on gender essentialism, we show that opposition to policies that would guarantee transgender people access to bathrooms of their choice relies on related gender/sexuality stereotypes.

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INTRODUCTION

The stunning success of the marriage-equality movement in the United States—which within a mere 15 years achieved the previously unthinkable goal of a nationwide fundamental right to marry—has been widely applauded as a turning point in our nation’s history. Mainstream media outlets and several prominent LGBTQ commentators breathlessly described marriage equality as the final great

civil-rights movement.¹ Because the marriage-equality breakthrough was fueled by an unprecedented surge in public support for same-sex marriage, particularly among younger Americans, some may think that marriage equality signals that homophobia is disappearing. A more modest claim would be that *legalized* homophobia under federal law is virtually extinct now that the LGBTQ movement has vanquished sodomy laws; the military's Don't Ask, Don't Tell policy as it pertains to gay, lesbian, and bisexual people; and discriminatory marriage laws.² However, we show that federal public-health policies contain several explicit legal distinctions that single out sex between men and treat it as especially dangerous. These policies have endured for decades but have been insufficiently publicized and critiqued by the LGBTQ community.³ Our investigation illustrates that homophobia and gendered

1. See, e.g., Errin Haines & Jesse Washington, *Changes in Barack Obama's Gay Marriage Stand Are Shrugged Off By Many Black People*, NOLA.COM: POLITICS (May 12, 2012, 10:00 AM), http://www.nola.com/politics/index.ssf/2012/05/changes_in_barack_obamas_gay_m.html (describing marriage equality as the "last frontier" of civil rights); Adam Nagourney, *A Watershed Move, Both Risky and Inevitable*, N.Y. TIMES (May 9, 2012), <http://www.nytimes.com/2012/05/10/us/politics/obamas-watershed-move-on-gay-marriage.html> (stating that many people consider marriage equality to be "the last civil rights movement"). Gay commentator Dan Savage has described the "entire gay rights agenda" as consisting of the right to marry, bans on discrimination in employment and education, and immigration rights for transnational same-sex couples. Dan Savage, *A Gay Agenda for Everyone*, N.Y. TIMES: OPINION (Jan. 22, 2011), <http://www.nytimes.com/2011/01/23/opinion/23savage.html>. This is reminiscent of the claim by Andrew Sullivan over 20 years ago that "[i]f nothing else were done at all, and gay marriage were legalized, ninety percent of the political work necessary to achieve gay and lesbian equality would have been achieved. *It is ultimately the only reform that truly matters.*" ANDREW SULLIVAN, VIRTUALLY NORMAL 185 (1995) (emphasis added).

2. For example, Cary Franklin's recent article interprets the marriage-equality cases as installing a broad anti-stereotyping principle. Cary Franklin, *Marrying Liberty and Equality: The New Jurisprudence of Gay Rights*, 100 VA. L. REV. 817, 880, 889 (2014) (reading marriage cases to "suggest that discrimination against gays and lesbians is an equality problem across the board"). As we explain more fully below, the most prominent cases, unfortunately, are susceptible to a rather narrow reading premised on respectability and the avoidance of sexuality. Moreover, Franklin overlooks the sexual orientation-based distinctions in other areas of the law that we discuss below. See generally *id.* As this Article goes to press, the status of transgender people in the military remains in question after President Trump's tweet, ensuing policy developments, and court challenges to the policy. Steve Benen, *Defense Chief Hedges on Implementing Trump's Transgender Ban*, MSNBC: MADDOWBLOG (Aug. 15, 2017, 10:41 AM), <http://www.msnbc.com/rachel-maddow-show/defense-chief-hedges-implementing-trumps-transgender-ban>; *Jane Doe 1 v. Donald J. Trump*, No. 17-1597, <https://assets.documentcloud.org/documents/4163525/10-30-17-Doe-v-Trump-Opinion.pdf>; Lawrence Hurley & Idrees Ali, *U.S. Military to Accept Transgender Recruits on Monday: Pentagon*, REUTERS (Dec. 29, 2017, 12:18 PM), <https://www.reuters.com/article/us-usa-military-transgender/u-s-military-to-accept-transgender-recruits-on-monday-pentagon-idUSKBN1EN1LV?il=0>.

3. Despite President Obama's pro-gay reputation, see, for example, Andrew Sullivan, *Andrew Sullivan on Barack Obama's Gay Marriage Evolution*, NEWSWEEK (May 13, 2012, 12:00 AM), <http://www.newsweek.com/andrew-sullivan-barack-obamas-gay-marriage-evolution-65067> (lauding Obama in a *Newsweek* cover story titled "The First Gay President" and illustrated by a portrait of Obama crowned with a rainbow halo); Aaron

assumptions can burrow into scientific research and “common sense” understandings of health risk—even in LGBTQ communities. Thus, these assumptions have not been exposed to constitutional scrutiny and have persisted long after conscious animus toward gay and bisexual men has declined. This is the afterlife of homophobia.

Our analysis reveals the shift from a Republican to a Democratic administration and back again to be less consequential than many have assumed. Although the Trump Administration has jettisoned many of the LGBTQ protections secured during the Obama Administration and appears most hostile to transgender rights,⁴ we see Trump *and* Obama as initially resisting and then acquiescing to same-sex marriage.⁵ We see a broader legal regime that alternates between suggesting that gays and lesbians are just like other Americans and elsewhere declaring that sex between men poses a serious threat to public health. We see the tendency of right- and left-leaning justices to affirm the humanity of gays and lesbians by erasing sex between men and sex between women, and we juxtapose this bipartisan trend with policies that obsess on sex between men as inherently risky. We show the limitations and contradictions in *Obergefell v. Hodges*,⁶ which many consider to be the capstone of the LGBTQ movement. For example, the United States’s brief supported marriage equality and condemned the long history of federal and state laws that

Hicklin, *Out100: President Barack Obama, Ally of the Year*, OUT.COM (Nov. 24, 2015, 8:15 AM), <http://www.out.com/out100-2015/2015/11/10/out100-president-barack-obama-ally-year>, his Administration merely tinkered with these distinctions, refining some and creating others.

4. See, e.g., Beth Reinhard, *Trump’s Mixed Messages on Gay Rights Frustrate Activists*, WALL STREET J. (June 28, 2017, 10:40 AM), <https://www.wsj.com/articles/trumps-mixed-messages-on-gay-rights-frustrate-activists-1498660803>; Michael D. Shear & Charlie Savage, *In One Day, Trump Administration Lands 3 Punches Against Gay Rights*, N.Y. TIMES (July 28, 2017), https://www.nytimes.com/2017/07/27/us/politics/white-house-LGBTQ-rights-military-civil-rights-act.html?_r=0.

5. See Russell K. Robinson, *Marriage Equality and Postracialism*, 61 UCLA L. REV. 1010, 1013 (2014). Lest we forget, it took President Obama several years to “evolve” to an acceptance of same-sex marriage. And even then, he initially claimed that it was a states’ rights issue and ought not to be resolved by the Supreme Court. See, e.g., Josh Gerstein, *Obama Evolves Again on Same-Sex Marriage*, POLITICO (Oct. 20, 2014), www.politico.com/blogs/under-the-radar/2014/10/obama-evolves-again-on-same-sex-marriage-197348. During his campaign, President Trump said that he opposed same-sex marriage, but almost as soon as he was elected, he declared the issue “settled” by the Supreme Court and stated, “I’m fine with that.” See Emily Schultheis, *Trump Talks to “60 Minutes” About Same-Sex Marriage, Abortion and the Supreme Court*, CBS NEWS (Nov. 13, 2016, 6:58 PM), <http://www.cbsnews.com/news/trump-promises-pro-life-justices-supreme-court-same-sex-marriage/>; Kayla Epstein, *Trump’s Stance on LGBT Rights Has Always Been Confusing*, WASH. POST (July 26, 2017), www.washingtonpost.com/news/the-fix/wp/2017/07/26/trumps-stance-on-lgbt-rights-has-always-been-confusing/?utm_term=.25821f7f25e.

6. 135 S. Ct. 2584 (2015).

stereotyped gays and lesbians as “moral degenerates or sexual perverts.”⁷ Yet as we document below, the Obama Administration was quietly writing that very stereotype into federal public-health policy.

Specifically, the federal government assumes that men who have sex with men (“MSM”) are generally at high risk for HIV and should take a daily regimen of HIV medication called Pre-Exposure Prophylaxis (“PrEP”) to prevent HIV infection.⁸ This medication, which was designed for people who are actually HIV positive, has been likened by some long-time LGBTQ-rights advocates to a form of chemotherapy.⁹ The government also restricts the ability of MSM to give blood and donate sperm. For example, in June 2016, Omar Mateen killed 49 people at a gay Latino nightclub in Orlando, Florida, in one of the worst mass shootings in recent U.S. history.¹⁰ Many gay and bisexual men were surprised to learn that because of their sexuality they could not give blood to help the victims.¹¹ This incident exposed the blood ban to an unprecedented level of publicity and pressure.¹² This Article demonstrates that the core logic of the blood ban undergirds several policies that fixate on sex between men while downplaying similar risks undertaken by heterosexuals. We name this form of homophobia *gay/bisexual distinctiveness*, in

7. Brief for United States as Amicus Curiae Supporting Petitioners at 4–5, *Obergefell v. Hodges*, 135 S. Ct. 2584 (2015) (Nos. 14-556, 14-562, 14-571, 14-574), 2015 WL 1004710, at *4–5 [hereinafter U.S. Amicus Brief, *Obergefell*].

8. See U.S. PUB. HEALTH SERV., PREEXPOSURE PROPHYLAXIS FOR THE PREVENTION OF HIV INFECTION IN THE UNITED STATES—2014 CLINICAL PRACTICE GUIDELINE 26–29 (2014), <http://www.cdc.gov/hiv/pdf/prepguidelines2014.pdf> [hereinafter PREP GUIDELINES].

9. Larry Kramer, *We Don't Know the Full Effects of Truvada Yet*, N.Y. TIMES: ROOM FOR DEBATE (June 18, 2014, 12:07 PM), <https://www.nytimes.com/roomfordebate/2014/06/17/is-prep-a-good-way-to-fight-hiv-infections/we-dont-know-the-full-effects-of-truvada-yet>. A key difference between chemotherapy and PrEP, of course, is that the person taking PrEP is most likely healthy—there is no cancer or virus to kill.

10. Initial reports indicated that Mateen was associated with Islamic terrorism; subsequent reports suggested that Mateen may have been a gay man struggling with internalized homophobia, although the FBI claims to have found no evidence of this. See Frances Robles & Julie Turkewitz, *Was the Orlando Gunman Gay? The Answer Continues to Elude the F.B.I.*, N.Y. TIMES (June 25, 2016), http://www.nytimes.com/2016/06/26/us/was-the-orlando-gunman-gay-the-answer-continues-to-elude-the-fbi.html?_r=0.

11. See John Paul Brammer, *Gay Men Can't Donate Blood to Victims of the Orlando Shooting. That's Absurd*, GUARDIAN (June 12, 2016), <https://www.theguardian.com/commentisfree/2016/jun/12/gay-men-blood-donation-orlando-shooting-victims-florida> (“It is an outrage that our blood can be spilled but not donated.”); Cassie Spodack, *Gay Congressman Calls for FDA to Overturn Blood Donation Ban for Gay Men*, CNN: POLITICS (June 17, 2016), <http://edition.cnn.com/2016/06/17/politics/jared-polis-fda-overtun-blood-donation-ban-for-gay-men/>.

12. See, e.g., FOOD & DRUG ADMIN., BLOOD DONOR DEFERRAL POLICY FOR REDUCING THE RISK OF HUMAN IMMUNODEFICIENCY VIRUS TRANSMISSION BY BLOOD AND BLOOD PRODUCTS; ESTABLISHMENT OF A PUBLIC DOCKET; REQUEST FOR COMMENTS (July 28, 2016), <https://www.gpo.gov/fdsys/pkg/FR-2016-07-28/pdf/2016-17804.pdf> (expressing a willingness to reconsider the blood ban after the Orlando attack).

that it assumes that gay and bisexual male sexuality is intrinsically different not just from that of heterosexuals but also from that of *sexual-minority*¹³ women.

Contemporary homophobia turns on a bifurcated conception of sex between men and the public identities associated with men who engage in that sexual behavior, including gay, bisexual, and queer. Marriage-equality discourse, notably in the *Obergefell* and *Windsor* majority opinions, exemplifies *sexual erasure*: the tendency to affirm LGBTQ rights by stripping sexual orientation of its sexual dimension. These opinions affirmed same-sex marriage while closeting same-sex sexuality.¹⁴ But competing with sexual erasure is a persistent commitment to perceiving and presenting sex between men as dangerous and “deviant”—and certain gay men are among the most vociferous proponents of this view.¹⁵ Yet these arguments unwittingly reinforce long-standing attempts to convince sexual-minority men that their sexuality manifests that they are fundamentally flawed. In the future, we expect to see law, society, and the LGBTQ community wrestle with these dueling

13. This Article uses different terms for the relevant population(s), depending on the context. Where we speak for ourselves, we use *sexual minority* to be as inclusive as possible of nonheterosexual people, including those who prefer terms such as *same gender loving* or *queer* to *gay* and those who decline sexual labels altogether. Unlike some of the public-health scholars who argued for the use of the term *men who have sex with men*, see *infra* Section III.A, we do not use *sexual minority* to avoid or minimize identity. We attempt to address the behavioral aspects of sexuality as well as the identities that are often associated with them. Where we describe people or institutions that adopted less inclusive conceptions of the relevant population, we follow their usage, such as *gays and lesbians* in discussing Supreme Court opinions, and *gay men* when discussing prominent proponents of PrEP.

14. The sexual-erasure school of thought has become so powerful in society that even dogged opponents of LGBTQ rights, such as the late Justice Scalia and Chief Justice Roberts, refrained from making arguments about gay and lesbian sexual difference in their *Obergefell* dissents. They seemingly knew that attacking sex between men and sex between women would expose them to condemnation as homophobic. For example, Justice Scalia’s *Lawrence* dissent compared homosexuality to bestiality and incest, but by the time the Court ruled on same-sex marriage, he refrained from reasserting such arguments and struck a more neutral tone. *Lawrence v. Texas*, 539 U.S. 558, 599 (2003) (Scalia, J., dissenting).

15. See *infra* Section III.D.

concepts.¹⁶ These paradigms are deeply interrelated: the belief in sexual distinctiveness drives the forces of sexual erasure.¹⁷

Both concepts should worry us because they would enshrine an *essential gay and bisexual man* and, as such, misrepresent sexual-minority men's actual identities and sexual practices. Some gay men and government policies seek to *fuse* gay and bisexual identities, promiscuity,¹⁸ and HIV risk, extending beyond descriptions of sexual behavior between men to prescriptions for how such men and youth should live and understand themselves. Meanwhile, other gay men and some courts, acting as guardians of respectability, deny ways in which sexual-minority male sexual patterns may differ—in the aggregate—from heterosexuals precisely

16. While some earlier scholarship has depicted a division within the gay community between “queers” and “normals,” *see, e.g.,* Kenji Yoshino, *Covering*, 111 *YALE L.J.* 769, 839–41 (2002), we think this framework does not fully reflect the complexity and contradiction within the community and individuals. For example, while Andrew Sullivan has publicly argued that gay men are “virtually normal,” he has simultaneously propagated the view that gay men are naturally promiscuous. *See infra* Section III.D. Sullivan, who is HIV positive, has also faced criticism for posting an ad featuring headless naked photos and seeking “orgies,” “gang bangs,” and unprotected sex. *See, e.g.,* Richard Goldstein, *The Real Andrew Sullivan Scandal*, *VILLAGE VOICE* (June 19, 2001), <https://www.villagevoice.com/2001/06/19/the-real-andrew-sullivan-scandal/>. We think the framework of bifurcation helps explain how men like Sullivan can pursue respectability in public, while seeking to wall off their sexual practices as “none of your business” and irrelevant to policymaking. *Id.*

17. We are grateful to Melissa Murray for this incisive point.

18. We want to be clear that this Article is not an argument against or for promiscuity, but rather against sexual-minority men being *stereotyped* as promiscuous. We recognize that “promiscuity” is a term that is loaded with social meanings, and the concept has been used to police the sexuality of women and others. We have opted not to use a clinical term such as *concurrent sexual partnerships*, *see, e.g.,* Sabrina Hirschfield et al., *Drug Use, Sexual Risk, and Syndemic Production Among Men Who Have Sex With Men Who Engage in Group Sex Encounters*, 105 *AM. J. PUB. HEALTH* 1849, 1849 (2015), or invent some new term because of the following: (1) existing scientific terms do not capture the full range of cultural meanings associated with the words *promiscuous* and *hypersexual* (which we understand to mean not simply that one has overlapping relationships with two or more sex partners, but also that one has an excessive interest in sex and is indiscriminate and irresponsible in pursuing sexual gratification); and (2) deploying a word that dilutes or diverts from the full range of derogatory assumptions made about sexual-minority men would undermine our ability to make those stereotypes visible (including the stereotypical association of sexual-minority men with women). We recognize the body of queer scholarship that celebrates non-normative sexuality as transgressive. *See, e.g.,* MICHAEL WARNER, *THE TROUBLE WITH NORMAL: SEX, POLITICS, AND THE ETHICS OF QUEER LIFE* (1999). However, directly engaging that work is not our focus here.

because of structural¹⁹ and internalized homophobia.²⁰ While the former distortion perpetuates stereotypes and alienates independent-minded sexual-minority men, the sexual-erasure model harms the community in nurturing the idea that same-sex behavior is shameful and foreclosing a thorough investigation of homophobia and its enduring marks on community sexual norms and values. Unlike those who assert an essential gay-male identity, we draw on Kimberlé Crenshaw's scholarship on intersectionality and Angela Harris's work on gender essentialism²¹ to argue that policies that attend to distinctions among sexual-minority men may signify progress. Some lower courts, we show, have rejected efforts by government lawyers to fuse sex between men and HIV risk. The reasoning in these undersung opinions developed tools that legal advocates and activists should use for attacking various laws and policies that rest on sexual/gender stereotypes.

This Article also demonstrates the necessity of understanding how sexual stereotypes and gender essentialism continue to be woven together to oppress various groups. Coursing through the conflation of sex between men and HIV risk is an essential claim that gay men are aggressive and sexually voracious. By extension, we see related gendered claims in the resistance to protecting transgender people's right to use bathrooms that match their gender identity. We show that a central tactic deployed by anti-LGBTQ forces is reimagining transgender women as

19. This term refers to homophobia's role in shaping the infrastructure that facilitates MSM meeting other MSM. For example, we can see the influence of the closet in the norm of concealing one's identity on hookup websites and smartphone apps and in mainstream gay community norms that maximize transactional sexual opportunity instead of dating. See *infra* text accompanying notes 96–99.

20. Internalized homophobia consists of negative attitudes from the broader society that a gay person directs toward the self. This negative state stems not from any inherent personal pathology, but rather from the external denigration of gay identity. See David M. Frost & Ilan H. Meyer, *Internalized Homophobia and Relationship Quality Among Lesbians, Gay Men, and Bisexuals*, 56 J. COUNSELING PSYCHOL. 97, 97–98 (2009).

21. Kimberlé Crenshaw's and Angela Harris's foundational articles have demonstrated, in different but complementary ways, how society, feminist movements, and the law anoint white women as universal representatives of all women, while denying that role to women of color. See Kimberlé Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*, 1989 U. CHI. LEGAL F. 139, 154 [hereinafter Crenshaw, *Demarginalizing*]; Kimberlé Crenshaw, *Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color*, 43 STAN. L. REV. 1241, 1277 (1991); Angela P. Harris, *Race and Essentialism in Feminist Legal Theory*, 42 STAN. L. REV. 581, 595–601 (1990); cf. Janet E. Halley, "Like Race" Arguments, in WHAT'S LEFT OF THEORY?: NEW WORK ON THE POLITICS OF LITERARY THEORY 40, 45, 52 (Judith Butler et al. eds., 2000) (describing representational choices of LGB movement decision-makers as exercises of power). Crenshaw also performs a related intervention in the black anti-racist movement, which continues to make black men the focus of anti-racist politics. Our Article extends this body of scholarship to questions of competing values among sexual-minority men and efforts to impose a singular popular image of the community as well as to competitions between cisgender and transgender women to represent true womanhood.

“biological males” who, as men, are constructed as a threat to cisgender women.²² Moreover, this misgendering²³ holds identity implications for cisgender people as well. This frame stereotypes cisgender women as fragile and uniquely in need of governmental protection from transgender women, and it also reinforces the stereotype that male sex necessarily entails sexual violence. Therefore, cisgender and transgender people can find common ground in opposing legal efforts to restrict transgender people’s bathroom access.²⁴

I. DESEXUALIZING GAY IDENTITY

The marriage-equality movement made extraordinary efforts to offer an airbrushed, desexualized version of gay and lesbian identity to the courts and the public. While the success of marriage equality is a signal achievement in our march toward a more inclusive society, the movement’s distorted, non-representative images of LGBTQ people create the risk that only LGBTQ people who can maintain such an image will enjoy full acceptance. Various scholars have criticized the LGBTQ movement for adopting respectability politics and excluding people because they are bisexual, transgender, people of color, poor or working class, or engage in controversial sexual practices.²⁵ Our brief discussion of respectability

22. *Cisgender* refers to “someone who exclusively identifies as their sex assigned at birth.” *LGBTQ+ Definitions*, TRANS STUDENT EDUC. RESOURCES <http://www.transstudent.org/definitions> (last visited Feb. 4, 2018). By contrast, *transgender* is an “umbrella term for people whose gender identity differs from the sex they were assigned at birth. The term *transgender* is not indicative of gender expression, sexual orientation, hormonal makeup, physical anatomy, or how one is perceived in daily life.” *Id.*

23. *Misgender* means “[t]o refer to a person using terms (pronouns, nouns, adjectives . . .) that express the wrong gender, either accidentally or deliberately; for example by calling a woman ‘son,’ a boy ‘she,’ or an agender individual ‘he’ or ‘she.’” *What is “Misgender”*, WORD FINDER, <http://findwords.info/term/misgender> (last visited Feb. 2, 2018).

24. This Article’s focus on men responds to the federal government’s concentration on MSM in public-health policies that implicate HIV/AIDS. The government does not similarly treat “women who have sex with women.” As we have argued elsewhere, corollaries to perceptions that gay men are oversexed may be harmful stereotypes that lesbians are undersexed or not even sexual beings. See Russell K. Robinson, *Diverging Identities: Gender Differences and LGBT Rights*, in *AFTER MARRIAGE EQUALITY: THE FUTURE OF LGBT RIGHTS* 212, 224 (Carlos A. Ball ed., 2016); David M. Frost & Michele J. Eliason, *Challenging the Assumption of Fusion in Female Same-Sex Relationships*, 38 *PSYCHOL. WOMEN Q.* 65, 73 (2014). This Article recognizes the need for greater attention to the role of gender in homophobia by digging deeply into the relationship between being male, having sex with men, and HIV risk. The hypersexualized/desexualized binary understanding of gender/sexuality might problematically reflect a perceived male/female binary, which helps explain why anti-LGBTQ forces are attempting to depict transgender women as “biological males.”

25. See, e.g., Devon W. Carbado, *Black Rights, Gay Rights, Civil Rights*, 47 *UCLA L. REV.* 1467, 1506 (2000) [hereinafter Carbado, *Black Rights*] (race); Devon W. Carbado, *Colorblind Intersectionality*, 38 *SIGNS* 811, 812 (2013) (race and sexual orientation); Katherine M. Franke, *Commentary, The Domesticated Liberty of Lawrence v. Texas*, 104 *COLUM. L. REV.* 1399, 1414 (2004) (sexual practices); Melissa Murray, *What’s So New About the New Illegitimacy?*, 20 *AM. U. J. GENDER SOC. POL’Y & L.* 387, 435 (2012)

politics focuses on the erasure of sexuality from the recent marriage cases to draw a contrast with the obsession with sex between men that pervades federal public-health law and policy.

The Supreme Court's decision in *Lawrence v. Texas* created a pathway to same-sex marriage by holding that gays and lesbians possess a liberty interest in engaging in intimate conduct. Justice Kennedy's majority opinion relayed the facts in a single terse paragraph. He wrote:

In Houston, Texas, officers of the Harris County Police Department were dispatched to a private residence in response to a reported weapons disturbance. They entered an apartment where one of the petitioners, John Geddes Lawrence, resided. The right of the police to enter does not seem to have been questioned. The officers observed Lawrence and another man, Tyron Garner, engaging in a sexual act. The two petitioners were arrested, held in custody overnight, and charged and convicted before a Justice of the Peace.²⁶

This version of the facts leaves open the precise nature of the relationship between Garner and Lawrence. That ambiguity seemingly evaporates once Justice Kennedy delves into the legal analysis. There, as Katherine Franke and others have argued,²⁷ Justice Kennedy's legal analysis treats Lawrence and Garner as if they were a long-term, committed, monogamous couple without precisely stating that as fact. Aligning the right to engage in homosexual conduct with a series of cases protecting marriage, procreation, and parenting by heterosexuals, Justice Kennedy cited *Planned Parenthood of Southeastern Pennsylvania v. Casey's* statement that such "matters involv[e] the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life."²⁸

This lofty rhetoric studiously ignored the actual facts of the case. As Dale Carpenter has shown,²⁹ the situation was far from a picture of domesticated bliss. John Lawrence was a 51-year old white man who was a medical technician; Tyron Garner was two decades younger, black, and had a criminal record.³⁰ Often unemployed, Garner at times worked for Lawrence, cleaning his house.³¹ Garner was in an ongoing relationship—*not* with Lawrence—with another older, white

(race and gender); Robinson, *supra* note 5, at 1060–61 (race and bisexual and transgender identity).

26. *Lawrence v. Texas*, 539 U.S. 558, 562–63 (2003).

27. *See, e.g.*, Franke, *supra* note 25, at 1411–14.

28. *Lawrence*, 539 U.S. at 574 (citing *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 851 (1992)).

29. Dale Carpenter, *The Unknown Past of Lawrence v. Texas*, 102 MICH. L. REV. 1464, 1478 (2004).

30. *Id.* at 1477–78.

31. Marc Spindelman, *Tyrone Garner's Lawrence v. Texas*, 111 MICH. L. REV. 1111, 1124 (2013).

man, Robert Eubanks.³² Lawrence hired Eubanks and Garner to clean Lawrence's house once a month and run errands for him.³³ Garner was described as passive and effeminate.³⁴ Thus, Garner and Lawrence were separated by race, age, socioeconomic status, and gender expression, as well as different relationships to the law. The *Lawrence* opinion provides no glimpse of these power differences.³⁵

On the evening of the arrest, all three men were hanging out and drinking at Lawrence's apartment.³⁶ Eubanks got drunk and became jealous at the sexual interest between Lawrence and Garner. He threw a tantrum and stormed out. Lawrence and Garner retired to the bedroom and apparently began having sex. Knowing that Garner had had trouble with the law, the dejected Eubanks decided to punish him by calling the police.³⁷ He alerted the police that "a black man" was going crazy in Lawrence's apartment and they should come quickly. According to some accounts, Eubanks, whom Carpenter describes as a "gun-totin," "beer-swillin'" "bubba," described his boyfriend as a "nigger" in his call to the police.³⁸ And Eubanks left Lawrence's door ajar. The police entered the apartment, claimed to catch Lawrence and Garner in the act,³⁹ and arrested them. Garner may have been no passive victim. Eubanks accused him of physical and sexual assault, although most of these accusations did not result in convictions.⁴⁰ If Justice Kennedy had candidly acknowledged these facts, it would have been harder for him to describe gay relationships in uniformly transcendent terms.⁴¹ Dale Carpenter's investigation of the case suggests that Lawrence and Garner's lawyers were eager for a case that would permit them to challenge sodomy laws, which were rarely enforced.⁴² That may have meant they worked to conceal the messy facts, since they had no assurance that a better case would come along. By contrast, marriage-equality lawyers, who

32. *Id.* at 1125.

33. *Id.* at 1124.

34. *Id.* (citing DALE CARPENTER, FLAGRANT CONDUCT: THE STORY OF *LAWRENCE V. TEXAS* 45 (2012)). One of the officers who arrested Garner called him a "naggy bitch." *Id.* at 1127. Spindelman suggests that the officers may have perceived Garner, a black man, as the "bottom" in his sexual relationship with Lawrence, and they may have found that offensive. *See id.* at 1127–28, 1133.

35. The Court's attempt to differentiate sodomy prosecutions of sex "between adults implicating disparity in status" shows how oblivious the Court was to the underlying facts. *Lawrence v. Texas*, 539 U.S. 558, 559 (2003).

36. *See* Carpenter, *supra* note 29, at 1490, 1508–09.

37. *See id.* at 1509.

38. *Id.* at 1479. According to Carpenter's research, Eubanks was prone to calling Garner a "nigger" when Eubanks was drunk or angry. Spindelman, *supra* note 31, at 1125 (citing CARPENTER, *supra* note 34, at 45).

39. In recent years, some have raised doubts about whether Lawrence and Garner were having sex at that moment. *See, e.g., The Imperfect Plaintiffs*, WNYC STUDIOS (June 27, 2016), <http://www.wnyc.org/story/imperfect-plaintiff>.

40. *See* Spindelman, *supra* note 31, at 1125.

41. *See, e.g., Lawrence v. Texas*, 539 U.S. 558, 562 (2003) ("Liberty presumes an autonomy of self that includes freedom of thought, belief, expression, and certain intimate conduct. The instant case involves liberty of the person both in its spatial and in its more transcendent dimensions.").

42. *See* Carpenter, *supra* note 29, at 1496.

built on *Lawrence*'s foundation, made a concerted effort to build their cases around "perfect plaintiffs."⁴³

LGBTQ-rights lawyers vetted thousands of potential plaintiffs before settling on the handful that ended up representing the gay and lesbian community at the Supreme Court.⁴⁴ The first marriage victory at the Supreme Court was *United States v. Windsor*,⁴⁵ which focused on the federal government's refusal to recognize Edith Windsor's marriage to Thea Spyer after Spyer passed away and Windsor inherited Spyer's estate.⁴⁶ The Defense of Marriage Act ("DOMA") recognized only a marriage between a man and a woman, which meant that the government treated Windsor and Spyer as strangers and required Windsor to pay over \$300,000 in estate taxes.⁴⁷

Windsor's case did not accidentally end up at the Supreme Court. In steering Edith Windsor's case toward Supreme Court review, her lawyer Roberta Kaplan argued within the marriage-equality movement that Windsor was a superior client for a Supreme Court challenge to DOMA for several reasons. Namely, she argued, Windsor was the following: (1) a widow, which meant she could not be caught in an affair, nor could her partner leave her during the litigation; (2) a woman, which made her less likely to trigger stereotypes of gay promiscuity; and (3) in her 80s. Thus, "Windsor could be remade as a non-threatening little old lady."⁴⁸ In truth, Windsor's relationship with Spyer was very sexual, and Windsor remained a sexually vital presence when *The New Yorker* profiled her after she won her case.⁴⁹ But during the litigation, Windsor complied with her lawyer's request that she not discuss her sexuality.⁵⁰ An article in *The Atlantic* found that marriage-equality advocates who were fighting ballot initiatives that would have banned same-sex marriage similarly concluded that when their advertisements featured gay people

43. See Cynthia Godsoe, *Perfect Plaintiffs*, 125 YALE L.J.F. 136, 136 (2015).

44. Cynthia Godsoe notes that roughly 1,200 people responded to a call for plaintiffs in Florida. *Id.* at 151 n.90.

45. *United States v. Windsor*, 133 S. Ct. 2675 (2013).

46. *Id.* at 2679, 2682.

47. See *id.* at 2683.

48. Ariel Levy, *The Perfect Wife*, NEW YORKER (Sept. 30, 2013), <http://www.newyorker.com/magazine/2013/09/30/the-perfect-wife>.

49. *Id.* In the *New Yorker* profile, Windsor stated, "I never wanted anybody inside me till Thea. And then I wanted her inside me all the time." *Id.* Elsewhere in the article, a friend "said that she wanted to set Windsor up with a friend in town, a ninety-four-year-old redhead. 'Is she still sexual?' Windsor asked. 'Very,' Pomponio promised." *Id.* As one commentator noted, "What's truly remarkable about the [*New Yorker*] story is that it treats lesbians as sexual creatures." June Thomas, *The Dirtiest, Sexiest Profile The New Yorker Has Ever Run*, SLATE (Sept. 23, 2013, 2:48 PM), http://www.slate.com/blogs/outward/2013/09/23/_edie_windsor_profile_in_the_new_yorker_the_dirtiest_in_the_magazine_s_history.html.

50. Levy, *supra* note 48.

(which was not often),⁵¹ “it was old-lady lesbians who . . . were the best messengers . . . Nobody thought about sex when they saw them.”⁵²

The *Obergefell* case adhered to this strategy of closeting LGBTQ sexuality and portrayed the entire community as “perfectly mainstream.”⁵³ In June 2015, the Supreme Court ruled that same-sex couples enjoy a fundamental right to marry just like male–female couples.⁵⁴ The Court consolidated several cases arising from states in the Midwest that refused to grant or recognize same-sex marriage. Once again the named plaintiff, Jim Obergefell, was a widower, which meant that the Justices did not have to think about an ongoing sexual relationship between Jim and his partner. Cynthia Godsoe’s empirical analysis of the 30 plaintiffs in *Obergefell* suggests various ways in which they were unlike the broader LGBTQ community and how these differences, on balance,⁵⁵ helped to desexualize the group.⁵⁶ The group is whiter and more affluent than the broader community.⁵⁷ By excluding bisexual plaintiffs and including few people of color, the group’s composition may have helped the lawyers avoid stereotypes of sexual promiscuity or irresponsibility that unfairly attach to bisexuals and people of color.⁵⁸ Perhaps most importantly, the group was immersed in parenting—a striking 100% of the female plaintiffs had children, compared to about one-third of lesbian and bisexual women in general; half of the male plaintiffs were raising children, compared to just 16% of gay and bisexual men.⁵⁹ Studies suggest that because of their role as parents, these plaintiffs

51. There is something deeply offensive about the fact that many marriage-equality advertisements avoided depicting LGBTQ people and especially same-sex couples, preferring to showcase their heterosexual relatives.

52. Molly Ball, *How Gay Marriage Became a Constitutional Right*, ATLANTIC (July 1, 2015), <http://www.theatlantic.com/politics/archive/2015/07/gay-marriage-supreme-court-politics-activism/397052/>.

53. Cf. Carbado, *Black Rights*, *supra* note 25 (using this term to describe the campaign against the military’s Don’t Ask, Don’t Tell policy).

54. *Obergefell v. Hodges*, 135 S. Ct. 2584, 2604–05 (2015).

55. The group was more male than female, even though lesbians appear less likely to trigger the promiscuity stereotype. That said, some research suggests that white gay men are seen as the essential face of the LGBTQ community, and they make the most compelling plaintiffs. See Jennifer Richeson & Alexa Van Brunt, *Same-Sex Marriage and the Case of Race*, HILL (Apr. 29, 2015, 1:30 PM), <http://thehill.com/blogs/congress-blog/judicial/240417-same-sex-marriage-and-the-case-of-race>; see also Robinson, *supra* note 5, at 1069–70 (criticizing assumption that gay white men must be at the center of the LGBTQ rights movement). Scholars are still working to unpack the various factors that confer this privilege upon white gay men.

56. See Godsoe, *supra* note 43, at 137–38.

57. *Id.* at 145. Eighty-three percent of the plaintiffs are white, compared to 67% of the LGBTQ community. *Id.* at 139. While 35% of the LGBTQ community makes less than \$24,000 in income, none of the *Obergefell* plaintiffs fell into this category. *Id.* at 139 fig.1.

58. See, e.g., Michael Boucai, *Sexual Liberty and Same-Sex Marriage: An Argument from Bisexuality*, 49 SAN DIEGO L. REV. 415, 458 (2012); Kenji Yoshino, *The Epistemic Contract of Bisexual Erasure*, 52 STAN. L. REV. 353, 400 (2000).

59. See Godsoe, *supra* note 43, at 139 fig.1.

may have had less time for sex,⁶⁰ or at least the Justices might have regarded them as “sexless caretakers.”⁶¹ Katherine Franke sums up the monolithic “all-American” image produced by marriage-equality lawyers:

The homosexual portrayed in these filings is the soccer mom, the partner who is a good provider, the loving father, the de-facto daughter-in-law, and the fellow who attends stamp-collecting conventions. The legitimate homosexual is he or she who is willing to keep quiet about the sex part of homosexual.⁶²

Cynthia Godsoe reviewed the media coverage of the *Obergefell* plaintiffs, including material posted by their lawyers and found that “[n]ot one of the many photographs and videos available online depict a plaintiff kissing his or her partner. Sex is never mentioned”⁶³ Remarkably, these lawyers seemed to think that winning a case about marriage required stripping the case of references to sexuality.⁶⁴

Although the Court has handed the LGBTQ movement a string of victories in the last 20 years,⁶⁵ it has not only avoided mentioning LGBTQ sexuality, it also has said remarkably little about the broader issue of sexual orientation stereotyping. The most recent example of this was *Obergefell*, in which the Court recognized that same-sex couples have a fundamental right to marry, but said absolutely nothing about the sexual stereotypes that states have used to deny LGBTQ people access to marriage. Like the LGBTQ advocates, Justice Kennedy’s majority opinion skates over anti-gay stereotypes, aligning same-sex couples with married heterosexual couples to paint a picture of domestic bliss. But this Article explores public-health law and policy and shows that such stereotypes have not vanished. Our discussion below and complementary work showing similar stereotypes in sexual-harassment doctrine⁶⁶ suggest that the new work of LGBTQ movements should be a direct

60. See David M. Huebner et al., *The Impact of Parenting on Gay Male Couples’ Relationships, Sexuality, and HIV Risk*, 1 COUPLE & FAM. PSYCHOL. 106, 108 (2012) (finding that male couples who were raising children had sex less frequently than those without children).

61. Robinson, *supra* note 24, at 224; Godsoe, *supra* note 43, at 147 (“It is no coincidence that most of the plaintiffs are either parents or widowers, so the focus is not on the couple alone.”); see also Godsoe, *supra* note 43, at 149 n.73 (“Although lesbians of color are by far the most common LGB parents, they are underrepresented in this group.”).

62. See Katherine Franke, *Public Sex, Same-Sex Marriage, and the Afterlife of Homophobia*, in PETITE MORT: RECOLLECTIONS OF A QUEER PUBLIC 157, 157 (Carlos Motta & Joshua Lubin-Levy eds., 2011).

63. Godsoe, *supra* note 43, at 148.

64. *Id.* at 153. This intuition may have stemmed not only from the lawyers’ fear that the Justices would be averse to thinking about gay and lesbian sexuality, but also from the Court’s general tendency to protect sex only when it advances some larger purpose. See, e.g., Margo Kaplan, *Sex-Positive Law*, 89 N.Y.U. L. REV. 89, 142 (2014) (“[M]any of [the key cases] seem to go out of their way to avoid a positive discussion of sexual pleasure.”).

65. See generally Russell K. Robinson, *Unequal Protection*, 68 STAN. L. REV. 151, 153–54 (2016).

66. See Jessica A. Clarke, *Inferring Desire*, 63 DUKE L.J. 525, 531 (2013). Jessica Clarke’s insightful article demonstrates the influence of marriage-equality discourse in sexual-harassment cases, and that it is interwoven with a homophobic standard that makes

engagement with sexuality/gender stereotypes.⁶⁷ This review of marriage-equality advocacy has shown that advocates leveraged gendered assumptions to cover the sexual nature of same-sex relationships. Advocates favored “old-lady lesbians” over gay men because they assumed that older lesbians would be perceived as the least sexual members of the LGBTQ community. When forced to litigate a case involving sex between men, the movement helped to remake Lawrence and Garner as a long-term, committed couple—thus successfully distancing these men from the core stereotype of freewheeling, single gay men. Part II of this Article calls for a concerted engagement with equal-protection principles on gender stereotyping to dismantle anti-LGBTQ discrimination.

II. LOOKING TO GENDER

This Part lays the foundation for our critique of federal public-health policy by extracting instructions from the Supreme Court’s gender cases. The laws at issue in *Obergefell* and *Windsor* used a person’s gender to determine that person’s marital opportunities. For example, Bob could marry Ann, but not Tim.⁶⁸ Similarly, the public-health policies that we critique below single out *men* who have sex with *men* and thus clearly contain gender classifications on their face. In the marriage cases, advocates assailed the sex-based distinctions in marriage laws as a form of gender discrimination, yet the Court chose to treat these laws as only a form of sexual-orientation discrimination and made little effort to show how sexual orientation and

LGBTQ employees uniquely vulnerable to claims of harassment. Clarke shows that many courts apply assumptions about same-sex sexuality that seem consonant with those in the marriage-equality context: same-sex desire must be expressed openly and sincerely and be romantic in nature for a court to treat a heterosexual-identified defendant as desiring a person of the same sex. *Id.* at 562–63. Courts are likely not to recognize expressions of desire that involve aggression, humor, or ambivalence, even though same-sex desire (like heterosexual desire) often reflects those elements. *Id.* at 562–63, 566–67. Even more disturbingly, courts tend to apply a double standard that hinges on self-identified sexual orientation. *Id.* at 585–86. Professor Clarke argues that courts stereotype openly gay employees as oversexed, making them particularly vulnerable to charges of harassment, unlike heterosexual-identified employees who harass people of the same sex. *Id.* at 587–88. The law generally permits people who identify as heterosexual to touch, grope, and harangue people of the same sex, and then invoke their heterosexual identification, their marriages, and their children to rebuff the claim that the harassment was based on desire. *See id.* at 574. A complementary book by Jane Ward charts cultural narratives and institutions—i.e., the military, fraternities—that allow straight white men to engage in sexual contact with other men without imperiling their reputations as heterosexual. *See generally* JANE WARD, NOT GAY: SEX BETWEEN STRAIGHT WHITE MEN (2015).

67. Cary Franklin argues that the marriage-equality cases stand for a general anti-stereotyping principle that sweeps beyond the marriage context. Franklin, *supra* note 2, at 829. However, the empirical foundation for this claim is thin, relying on snippets from cases decided under state law and finding little support in the Supreme Court’s sexual-orientation cases. Further, Franklin wrote this article before the Court decided *Obergefell*, which focuses myopically on marriage and refrains from discussing stereotyping.

68. *See Latta v. Otter*, 771 F.3d 456, 479–85 (9th Cir. 2014) (Berzon, J., concurring).

sex/gender discrimination are linked.⁶⁹ Another flaw in the marriage cases is that the Court left it unclear what level of scrutiny applies generally when laws outside the marriage context burden people based on sexual orientation. As a result, the Supreme Court sexual-orientation precedents do not incorporate long-standing doctrinal rules that order the analysis in gender cases. In this Part, we argue that, going forward, courts adjudicating cases styled as sexual-orientation claims should look to the Supreme Court's equal-protection gender jurisprudence, which represents the Court's most extended analysis of stereotyping. Beginning in the early 1970s, the Court interpreted the Equal Protection Clause to forbid government from "rely[ing] on overbroad generalizations about the different talents, capacities, or preferences of males and females."⁷⁰ Four hallmarks of this body of law could guide LGBTQ movements and the courts. The discussion below describes these principles and applies them to the HIV/MSM context.

First, in the gender cases, the Court applies heightened scrutiny to take a hard look at gender-based policies that the government says are based on empirical realities. This "careful[] inspect[ion]"⁷¹ has revealed the limitations of empirical claims that supposedly justify treating men and women differently.⁷² *Craig v. Boren*, the first case to announce that heightened scrutiny applies to gender-based classifications, illustrates this analysis.⁷³ In that case, an Oklahoma statute set different ages for men and women to purchase "non-intoxicating" 3.2% beer. Men had to be 21 years old to buy this beer, whereas women could buy it at age 18.⁷⁴ Oklahoma argued that it was concerned about public health and safety, and the Court accepted these as important governmental interests.⁷⁵ The state argued, for instance,

69. Robinson, *supra* note 65, at 176–77. The Court has declined several invitations to address the question of whether laws that harm gays and lesbians are a form of gender discrimination. *See id.* at 176. For leading scholarly explanations of the argument that sexual-orientation discrimination is a form of sex discrimination, see, for example, Mary Anne Case, *What Feminists Have to Lose in Same-Sex Marriage Litigation*, 57 UCLA L. REV. 1199 (2010); and Andrew Koppelman, *Why Discrimination Against Lesbians and Gay Men is Sex Discrimination*, 69 N.Y.U. L. REV. 197 (1994). For a competing view, which seems to turn less on the doctrinal persuasiveness of the sex argument than the social meaning of relying on the sex argument instead of a sexual-orientation argument, see Edward Stein, *Evaluating the Sex Discrimination Argument for Lesbian and Gay Rights*, 49 UCLA L. REV. 471 (2001). Two recent Court of Appeals decisions held that Title VII's ban on "sex" discrimination includes a ban on sexual orientation discrimination. *See Zarda v. Altitude Express, Inc.*, 2018 WL 1040820, at *11 (2d Cir. 2018); *Hively v. Ivy Tech Cmty. Coll.*, 853 F.3d 339, 342 (7th Cir. 2017).

70. *United States v. Virginia*, 518 U.S. 515, 532 (1996); *id.* at 541 (requiring courts to take a "hard look" at generalizations or "tendencies" asserted by the state) (citation omitted).

71. *Id.* at 532.

72. *See, e.g., Frontiero v. Richardson*, 411 U.S. 677, 688–89 (1973) (plurality opinion) ("[T]he government maintains that, as an empirical matter, wives in our society frequently are dependent upon their husbands, while husbands rarely are dependent upon their wives.").

73. 429 U.S. 190, 198, 200 (1976).

74. *Id.* at 197.

75. *Id.* at 199–200.

“18–20-year-old male arrests for ‘driving under the influence’ and ‘drunkenness’ substantially exceeded female arrests for that same age period.”⁷⁶ The Court concluded that even assuming the accuracy of the state’s various studies, it offered “only a weak answer to the equal protection question presented here.”⁷⁷ The most relevant study established that 0.18% of females and 2% of males 18–20 years old were arrested for driving under the influence of alcohol.⁷⁸ The Court conceded that the gender disparity may have been significant, but went on to conclude that the government could not use maleness as a proxy for engaging in DUI because there was a tenuous fit between maleness and the offense.⁷⁹ “Indeed, prior cases have consistently rejected the use of sex as a decision-making factor even though the statutes in question certainly rested on far more predictive empirical relationships than this.”⁸⁰ The fit between maleness and DUI was very strong when compared to the fit between femaleness and DUI—perhaps ten times as high, which would certainly be significant from a scientific perspective. But it is fairly low in absolute terms—being male is not very predictive of having a DUI conviction. In the HIV context, identity as an MSM is also a weak proxy for being HIV positive. The vast majority of MSM, nearly 90% of those who had sex in the last year, are HIV negative.⁸¹

Second, the Supreme Court has corroborated this skeptical parsing of statistical claims with an understanding of the social and historical context that *creates* gender-based statistical disparities.⁸² This historical lens helps to explain why the Court refuses to take empirical disparities at face value when it applies heightened scrutiny. Similarly, claims of “administrative ease and convenience” do not justify using a suspect trait to address a problem.⁸³ In short, the Court has recognized that, although there are “enduring” biological differences between the

76. *Id.* at 200.

77. *Id.* at 201.

78. *Id.*

79. *Id.* at 201–02.

80. *Id.* at 202; *see also* *J.E.B. v. Alabama*, 511 U.S. 127, 139 n.11 (1994) (“Even if a measure of truth can be found in some of the gender stereotypes used to justify gender-based peremptory challenges, that fact alone cannot support discrimination on the basis of gender . . .”).

81. The precise percentage of HIV-positive MSM is 11.8% among MSM who reported sex in the past year. Fujie Xu et al., *Men Who Have Sex with Men in the United States: Demographic and Behavioral Characteristics and Prevalence of HIV and HSV 2 Infection, Results from National Health and Nutrition Examination Survey 2001–2006*, 37 *SEXUALLY TRANSMITTED DISEASES* 399, 401 tbl.1 (2010) (finding that HIV prevalence was 9.1% among MSM who reported sex ever in their lifetime, and 11.8% among MSM who had sex in the past year).

82. *See Craig*, 429 U.S. at 202 n.14 (“The very social stereotypes that find reflection in age-differential laws . . . are likely substantially to distort the accuracy of these comparative statistics. Hence ‘reckless’ young men who drink and drive are transformed into arrest statistics, whereas their female counterparts are chivalrously escorted home.”); *United States v. Virginia*, 518 U.S. 515, 531 (1996) (“Today’s skeptical scrutiny of official action denying rights or opportunities based on sex responds to volumes of history.”).

83. *See, e.g., Craig*, 429 U.S. at 198.

sexes,⁸⁴ most gender-based differences are socially constructed and serve to subordinate women.⁸⁵ As in the gender context, disparities between MSM and heterosexual men and women are driven by a mix of biological difference and social pressure to perform particular identities. Heterosexual men are the least likely to contract HIV because they do not engage in receptive anal sex,⁸⁶ which is the riskiest sexual activity if engaged in without a condom.⁸⁷ Heterosexual and bisexual women face greater risk because they may engage in receptive anal sex and receptive vaginal sex.⁸⁸ Gay men are particularly vulnerable to HIV because many engage in anal sex, and it may play a greater role in their sex lives since vaginal sex is not an option. Justifications for federal policies that single out MSM almost always emphasize stark statistical disparities between MSM and heterosexuals. For example, the 2015 blood memo proclaimed: “In 2010, the majority of new HIV infections were attributed to male-to-male sexual contact: 63% among all adults and 78% among men, indicating that male-to-male sexual contact remains associated with high risk of HIV exposure.”⁸⁹ Such statistics may seem undeniable, but the Court’s gender jurisprudence directs us to ask whether society is at least partly to blame for these disparities.

Our argument assumes that physical differences alone do not explain these disparities and that, on average, MSM have more sexual partners than heterosexuals. It is very difficult to find reliable data on the question of sexual partners because it is so politically fraught and few scholars want to address it. In addition, national health surveys that use representative samples contain very small numbers of MSM, making it difficult to draw reliable comparisons. The important point is that if MSM, on average, have more sexual partners than heterosexuals over the course of their lifetimes, homophobia and masculinist conceptions of sexuality provide a major explanation for the disparity.

84. *Virginia*, 518 U.S. at 533.

85. *See id.* at 531, 534.

86. For purposes of this discussion, we accept the CDC’s definitions of sexual identity instead of self-identification. Under this measure, a man who engages in anal sex with another man is MSM, i.e., not heterosexual. In fact, as discussed further below, there are plenty of men who have engaged in anal sex with a man at least once, but do not publicly or personally identify as MSM, gay, or bisexual. *See, e.g.*, WARD, *supra* note 66, at 64. We also do not count receptive anal sex involving objects, such as a dildo, because it does not create significant HIV risk.

87. *See* Pragna Patel et al., *Estimating Per-Act HIV Transmission Risk: A Systematic Review*, 28 AIDS 1509, 1513 tbl.1 (2014).

88. Transgender people may also engage in receptive vaginal and anal sex. Healthcare providers ought not to assume that a person’s transgender identity dictates their sexual orientation and what sexual acts they perform.

89. U.S. DEP’T HEALTH & HUM. SERVS. FOOD & DRUG ADMIN., REVISED RECOMMENDATIONS FOR REDUCING THE RISK OF HUMAN IMMUNODEFICIENCY VIRUS TRANSMISSION BY BLOOD AND BLOOD PRODUCTS: GUIDANCE FOR INDUSTRY 4 (2015), <https://www.fda.gov/downloads/BiologicsBloodVaccines/GuidanceComplianceRegulatoryInformation/Guidelines/Blood/UCM446850.pdf> [hereinafter 2015 REVISED BLOOD GUIDANCE].

Federal and state policies have long stigmatized sex between men and have subjected MSM to intense pressure to remain closeted and pursue sexual gratification in furtive and isolated ways. The law has treated “gay people as criminals and deviants, unfit parents, targets for hate crimes, and undesirable employees.”⁹⁰ Until the Court’s recent *Lawrence* decision in 2003, states were free to criminalize oral and anal sex between men. As the *Lawrence* Court observed, even though such statutes were rarely enforced, they signaled to the community that the defining trait of the class of homosexuals—their sexuality—was morally reprehensible.⁹¹ Even after *Lawrence*, several states have chosen to keep such laws on the books to express that message.⁹² For decades, the American Psychiatric Association endorsed the idea that homosexuality was a mental illness.⁹³ Gay and bisexual men could be castrated, subjected to electroshock therapy, and institutionalized simply because of their sexual orientation.⁹⁴ Until 1991, federal law excluded gay and bisexual people seeking to migrate to the United States and deemed them “persons of constitutional psychopathic inferiority.”⁹⁵ For most of our nation’s history, openly expressing homosexual desire or identity has triggered the palpable threat of losing one’s liberty, job, housing, children, and other familial connections.⁹⁶ We emphasize that gay and bisexual men’s sexual decision-making must be understood in this context. In some regions, despite the progress of the last

90. U.S. Amicus Brief, *Obergefell*, *supra* note 7, at 17. Martha Nussbaum’s analysis of the politics of disgust examines several examples of how anti-gay forces depict gay sex as threatening to the public. For example, she describes the work of Paul Cameron, who has filed amicus briefs in several gay-rights cases, as follows: “When Cameron and his associates look at male homosexuality, they are virtually obsessed with the disgusting. Feces, saliva, urine, semen, blood—all these bodily products are harped on again and again in his writings, together with frequent references to dangerous disease-bearing germs.” MARTHA NUSSBAUM, *FROM DISGUST TO HUMANITY: SEXUAL ORIENTATION AND CONSTITUTIONAL LAW* 3 (2010).

91. *Lawrence v. Texas*, 539 U.S. 558, 573–75 (2003).

92. U.S. Amicus Brief, *Obergefell*, *supra* note 7, at 3–4.

93. Brief of the American Psychological Association et al. as Amici Curiae in Support of Petitioners at 7–8, *Obergefell v. Hodges*, 135 S. Ct. 2584 (2015) (Nos. 14-556, 14-562, 14-571, 14-574), 2015 WL 1004713, at *7–8. For an insightful and nuanced history of gay men’s contestation of psychiatry’s role in perpetuating anti-gay stigma, see generally RONALD BAYER, *HOMOSEXUALITY AND AMERICAN PSYCHIATRY: THE POLITICS OF DISGUST* (1987). Bayer warned that the AIDS crisis beginning in the early 1980s threatened to reverse the trajectory promised by the American Psychiatric Association’s (“APA”) decision to declassify homosexuality as an illness in 1973. *See id.* at 202–04. Whereas psychiatrists had identified homosexuality as a mental illness, public-health scholars—just ten years after the APA declassified homosexuality—began characterizing sex between men as a vector of AIDS and a threat to the general public.

94. Dale Carpenter, *Windsor Products: Equal Protection from Animus*, 2013 SUP. CT. REV. 183, 253–54.

95. U.S. Amicus Brief, *Obergefell*, *supra* note 7, at 4.

96. *See* William N. Eskridge, Jr., *Law and the Construction of the Closet: American Regulation of Same-Sex Intimacy, 1880–1946*, 82 IOWA L. REV. 1007, 1019, 1034, 1054, 1082 (1997).

few decades, many MSM continue to live closeted lives.⁹⁷ And of course until very recently, marriage was not a possibility for gay and bisexual men, and this prohibition structured gay and bisexual men's sexual decision-making. As Adam I. Green stated:

Like the opposite poles of a compass, inclusion in and exclusion from marriage provide contrasting navigational reference points, propelling heterosexual men into career trajectories characterized by decreasing sexual exploration and growing investment in monogamous dyadic forms, and homosexual men into career trajectories characterized by increasing sexual exploration, dyadic innovation, and reevaluation of the value of monogamy.⁹⁸

Even as marriage has become an option for gay and bisexual men, they continue to meet through an infrastructure of sexual opportunity developed during a virulently homophobic era. The pervasive stigma surrounding gay sexuality produced multiple ways for MSM to meet for anonymous sex—the secrecy being key to preserving their public, heterosexual-identified life. Many MSM still have their formative sexual experiences in public bathrooms, parks, and bathhouses.⁹⁹ These sex-focused outlets now compete with copious online versions: websites, and location-based smartphone apps directed at MSM. People who survey a site such as adam4adam.com will find that many—perhaps most—men do not post their face as their primary photograph. Such men are more likely to post their naked torso, their penis or buttocks, or no photo at all. Those who do post face photos tend to keep them “locked,” permitting only a select few to view their face. Notably, many of these men are actually out of the closet—as their profiles indicate. Yet the norm that gay sexuality is something that should be secret and separated from one's daily life remains strong. We might understand these dual identities as tracking the bifurcated federal law and policy on gay and bisexual men. The public identity is the respectable, desexualized one—for example, the profile a man might post on Facebook. The sexual profile is hidden from public view and often emphasizes one's body, rather than his face, his mind, his values, and his emotions.¹⁰⁰ The public profile is *Obergefell*-worthy; the anonymous hook-up profile on Grindr is NSFW.¹⁰¹ Although this discussion has examined how societal, structural, and internalized homophobia combine to shape the sexual decision-making of MSM, we do not deny

97. See Seth Stephens-Davidowitz, *How Many American Men Are Gay?*, N.Y. TIMES (Dec. 7, 2013), <http://www.nytimes.com/2013/12/08/opinion/sunday/how-many-american-men-are-gay.html> (describing studies that found that Craigslist ads for MSM “casual encounters” are more common in the least tolerant regions of the United States and a related “large number of missing gay men” on dating-oriented sites like Match.com). A study of dating scripts described by gay and lesbian subjects found that gay men's scripts were more sexually oriented and more likely to involve drinking alcohol than those by lesbians. See Dean Klinkenberg & Suzanna Rose, *Dating Scripts of Gay Men and Lesbians*, 26 J. HOMOSEXUALITY 23, 31(1994).

98. Adam Isaiah Green, *Until Death Do Us Part?: The Impact of Differential Access to Marriage on a Sample of Urban Men*, 49 SOC. PERSP. 163, 163 (2006).

99. See, e.g., Eskridge, Jr., *supra* note 96, at 1080.

100. By contrast, the norm among smartphone apps that heterosexuals use to hook up, such as Tinder, is to post a face picture.

101. This term means “not suitable for work.”

individual agency to make sexual decisions even in the face of this pressure.¹⁰² To the contrary, our critique of the federal public-health policies below laments the government's failure to respect the differences among MSM in terms of how we navigate and respond to such oppressive forces.

The third and related principle that we draw from the Court's gender precedents is respect for the exceptional person: for example, the woman who applies for admission to the Virginia Military Institute in defiance of the school's history of excluding women and the dominant social concept of the citizen-soldier as inherently male.¹⁰³ In the HIV context, the government repeatedly cites the disproportionate representation of MSM among people with HIV as grounds for treating MSM differently. But cases such as *United States v. Virginia* suggest that the fact that most men with HIV are MSM is irrelevant.¹⁰⁴ The gender precedents create space for women and MSM to reject conventional expectations and slowly begin to unravel discriminatory patterns.

Fourth, the Court has chosen to look closely at gender stereotypes that burden men and women because it recognizes that those concepts are often interlinked. For example, it was important for the Court to protect the right of a man who applied to an all-female nursing school because not only did the school's policy punish him for violating the gender stereotype that men should not be nurses, but also the all-female preference served to nudge women into the subordinate role of nurses, instead of the higher-status role of physician.¹⁰⁵ In the spirit of these gender precedents, this Article seeks to show how the federal public-health policies do not merely stereotype gay and bisexual men; they also inflict harms on heterosexual men and women and bisexual women. In projecting sexual risk onto gay and bisexual men, the policies simultaneously mislead others into believing they are "safe" simply because they are not having sex with gay or bisexual men. Ultimately, the federal public-health policies rely on "overbroad generalizations to make judgments about people that are likely to . . . perpetuate historical patterns of discrimination."¹⁰⁶

102. Kathy Abrams's *Sex Wars Redux* article provides a cogent and carefully argued exploration of how "dominance" feminism could be read to depict women as passive victims of patriarchy and preclude full exploration of women's sexual pleasure and "partial agency" under oppressive conditions. See Kathryn Abrams, *Sex Wars Redux: Agency and Coercion in Feminist Legal Theory*, 95 COLUM. L. REV. 304, 305–06, 343 (1995). Abrams's exploration of bounded autonomy has much relevance to gay and bisexual men's sexual decision making.

103. *United States v. Virginia*, 518 U.S. 515, 541 (1996) ("[T]he Commonwealth [cannot] constitutionally deny to women who have the will and capacity, the training and attendant opportunities that VMI uniquely affords."); *id.* at 532 (emphasizing the "equal opportunity to aspire, achieve, participate in and contribute to society based on their individual talents and capacities") (emphasis added).

104. *Id.* at 542 (dismissing fact that "most women would not choose VMI's adversative method").

105. *Miss. Univ. for Women v. Hogan*, 458 U.S. 718 (1982).

106. *Virginia*, 518 U.S. at 542.

III. FUSING HIV AND GAY/BISEXUAL IDENTITY

The average homosexual, if there be such, is promiscuous. He is not interested in nor capable of a lasting relationship like that of a heterosexual marriage. His sex life, his love life, consists of a series of chance encounters at the clubs and bars he inhabits. And even on the streets of the city—the pick-up, the one night stand, these are characteristic of the homosexual relationship.¹⁰⁷

—*The Homosexuals*, CBS, 1967

This Part counters the view that the advent of marriage equality marked the end of homophobia by examining an area of federal law and policy that is often neglected—public health. The social consensus that marriage equality is the central issue for LGBTQ people partially explains the failure to prioritize opposing discriminatory public-health laws and policies. But it is not simply a question of LGBTQ movement or broader social priorities that rank marriage as more important than public health. A more troubling reason is that many people—including many in the LGBTQ community—do not even regard these policies as discriminatory. This development reveals the extent to which sex between men, gay identity, and HIV risk have become fused in the public imagination and gay culture.¹⁰⁸ Policies that are said to address HIV risk and single out gay and bisexual men to promote health are often seen as the “natural” outcome of gay/bisexual sexual distinctiveness and as dictated by scientific realities rather than stereotypes. This Part seeks to make visible the stereotypical dimensions of these policies and to show that they promote stigma in ways that are not required by science. We aim to unpack the “common sense” that has protected them from constitutional scrutiny.¹⁰⁹ These policies matter because they instantiate government-influenced “lessons in being gay,”¹¹⁰ which confine the ways in which some men see themselves, their sexuality, and their life possibilities. The core stereotypes that these policies perpetuate, partially reflected in the above quote from a 50-year-old CBS documentary, are as follows: gay and bisexual men are incapable of maintaining enduring, healthy relationships because

107. CBS, *The Homosexuals* (CBS television broadcast Mar. 7, 1967), <https://www.youtube.com/watch?v=zWNEdoXo0Yg>.

108. Judge Myron H. Thompson eloquently described this phenomenon as follows: “Prejudice against homosexuals intensifies prejudice against HIV, and prejudice against HIV becomes a proxy for prejudice against members of the gay community. Because HIV is also more common among minorities and the poor, the stigma attached to HIV deeply implicates race and class prejudice, as well as homophobia.” *Henderson v. Thomas*, 913 F. Supp. 2d 1267, 1278 (M.D. Ala. 2012).

109. Cf. IAN HANEY-LOPEZ, *RACISM ON TRIAL: THE CHICANO FIGHT FOR JUSTICE* (2003) (discussing and critiquing “racial common sense”). At least for people who came of age during the AIDS crisis of the 1980s and 1990s, sex between men and HIV risk have been fused in the popular imagination. Thus, treating sexual-minority men differently than other people who may engage in risky sexual behavior has been understood as a matter of “common sense” rather than sexual-orientation discrimination.

110. Regina Kunzel, *Lessons in Being Gay: Queer Encounters in Gay and Lesbian Prison Activism*, 100 *RADICAL HIST. REV.* 11 (2008); Russell K. Robinson, *Masculinity as Prison: Sexual Identity, Race, and Incarceration*, 99 *CALIF. L. REV.* 1309, 1314 (2011).

they are less sexually responsible, more sex-focused, and indiscriminate in selecting sex partners, as compared to straight people; because of their sexuality, gay and bisexual men are inherent vectors of disease.

We end the introduction to this Part by addressing a potential counterargument that might distract some readers. Some may share our concern about the stigma inflicted by the policies discussed herein, but nonetheless might believe that the stigma is worth bearing if these policies save lives. Indeed, some in the hardest-hit and most-stigmatized communities, such as black MSM, might feel that the only thing that matters is preventing HIV infection.¹¹¹ At the peak of the AIDS crisis, the gay activists who rallied around HIV and demanded that the government address their needs may have felt that fusing HIV with sex between men and gay identity was a small price to pay if it saved their lives and those of their lovers and friends.¹¹² However, much has changed since the 1980s, including the constitutional status of LGBTQ people.¹¹³ Importantly, HIV is no longer fatal for most people with access to state-of-the-art treatments. As courts have recognized in recent years, HIV-positive people who know their status and are receiving proper healthcare can expect to live a normal lifespan or one slightly shorter than that of the average HIV-negative person.¹¹⁴ These shifts change the stakes and should make it easier for us to see and discuss the price of policies that broadly stigmatize MSM.

111. Cf. CDC, FACT SHEET, LIFETIME RISK OF HIV DIAGNOSIS IN THE UNITED STATES, CTRS. FOR DISEASE CONTROL & PREVENTION (Feb. 2016), <http://www.cdc.gov/nchstp/newsroom/docs/factsheets/lifetime-risk-hiv-dx-us.pdf> (asserting, without providing significant supporting evidence, that half of black MSM will become HIV positive at some point in their lifetimes, compared to 9% of white men).

112. We can understand the current policies' focus on sexual orientation rather than race as reflecting the history of political movements. As Cathy Cohen's incisive history explains, the gay white community embraced HIV as a "gay disease" and ultimately won considerable federal funding for HIV/AIDS care, treatment, and prevention, often housed in gay neighborhoods. Black leaders, meanwhile, largely denied the devastating impact that AIDS inflicted on black communities, which may have avoided an additional form of stigma, but also allowed the disease to flourish. See CATHY J. COHEN, *THE BOUNDARIES OF BLACKNESS: AIDS AND THE BREAKDOWN OF BLACK POLITICS* 313 (1999); see also Russell K. Robinson, *Racing the Closet*, 61 STAN. L. REV. 1483 (2008).

113. See generally Robinson, *supra* note 65.

114. Henderson v. Thomas, 913 F. Supp. 2d 1267, 1277 (M.D. Ala. 2012) ("[A]lthough people with HIV will require treatment for their entire lives, HIV is no longer invariably fatal. People who receive treatment for HIV can expect to enjoy near-normal lifespans."); *In re Adoption of Doe*, 2008 WL 5006172, at *13 (Nov. 25, 2008) ("[M]ost HIV patients taking medication as prescribed now have a normal lifespan and will likely die of something other than AIDS."); *HIV Care Saves Lives Infographic*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/vitalsigns/hiv-aids-medical-care/infographic.html> (last updated Nov. 25, 2014) (noting that the estimated lifespan of a person diagnosed with HIV at 20 and taking current HIV medication is 71 years, compared to 79 for the general population). Unfortunately, far too many HIV-positive people, especially people of color and poor people, do not know their HIV status and are not receiving treatment. This persistent reality is masked by the efforts of some affluent white gay men to celebrate PrEP as a drug that enhances sexual pleasure and "partying." See *infra* text accompanying notes 252–57.

Those who would use the continuing crisis to inscribe PrEP use as a normal part of gay identity would paradoxically treat all gay and bisexual men as if they are already infected—providing them with a prescription for the rest of their sexually active lives, taking the same drugs as an HIV-positive person, and accepting the risk of known side effects (which can include kidney failure, severe liver problems, and bone pain, softening, or thinning) and unknown long-term side effects¹¹⁵—all to “save” them from HIV.

Before analyzing three specific public-health policies in detail, we address another counterargument that might concern those who are steeped in public health. We identify tension between equality and autonomy principles in the Constitution, which collectively discourage government from using identity to regulate people and a public-health model that often uses identity as a proxy for certain health risks.

A. Conflicting Paradigms: Equality v. “Community”

The tension between marriage-equality discourse and public-health policy stems from divergent assumptions about the permissibility of lawmakers relying on identity to regulate individuals and the importance of lawmakers respecting individual autonomy. Supreme Court jurisprudence often invokes individual autonomy and conceives of equal protection as freeing the individual from stereotypes ascribed to his or her group.¹¹⁶ By contrast, the public-health discipline

115. Side effects include kidney problems, including kidney failure; lactic acidosis, which can be fatal; severe liver problems; bone pain, softening, or thinning; worsening of Hepatitis B infection; stomach pain; headaches; and weight loss. *Understanding Truvada for PrEP*, TRUVADA.COM, <https://start.truvada.com/side-effects> (last visited Feb. 23, 2018). The manufacturer’s website warns that “[t]hese are not all the possible side effects of TRUVADA.” *Id.*

116. See, e.g., *J.E.B. v. Alabama*, 511 U.S. 127, 141 (1994) (forbidding striking a juror based on gender stereotypes “[b]ecause these stereotypes have wreaked injustice in so many spheres of our country’s public life”); *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 851 (1992) (“These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment . . . Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.”); *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) (“If the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.”); *Lawrence v. Texas*, 539 U.S. 558, 574 (2003) (extending principles from reproductive-rights cases to enter into a gay sexual relationship); *Obergefell v. Hodges*, 135 S. Ct. 2584 (2015) (holding that fundamental right to marry extends to same-sex couples). Notably, the Court has addressed reproductive rights under the rubric of individual liberty and often ignored the link between gender and pregnancy/abortion. See *Geduldig v. Aiello*, 417 U.S. 484 (1974); *Bray v. Alexandria Women’s Health Clinic*, 506 U.S. 263 (1992). While this refusal to fully consider the gender implications of pregnancy is problematic, see, e.g., Robinson, *supra* note 65, at 176–77 (criticizing *Geduldig*), it does help explain how the Court’s approach to reproductive and sexual-liberty claims prioritizes an individual frame over a group frame. Luke Boso offers an intriguing argument that anti-stereotyping principles reflect autonomy and anti-subordination concerns. Luke A. Boso, *Dignity, Inequality, and Stereotypes*, 92 WASH. L. REV. 1119 (2017).

tends to adopt a *community-wide approach*. That is, federal, state, and local governmental authorities, as well as public health scholars, tend to frame health problems at a broad level and seek to stamp out problems throughout the entire community or population.¹¹⁷ This model often imagines the *community* or *population* as a cohesive entity of clinically distinct individuals that share the same risk profile or medical need by virtue of community membership, which minimizes differences among people within the community.

This model has implications for gender and sexual orientation. For example, in early 2016, the Center for Disease Control (“CDC”) set off a firestorm by providing guidelines that, due to the risk of fetal alcohol syndrome, advised all sexually active women not to consume alcohol if there is “any chance that they could be pregnant.”¹¹⁸ The guidance treated women of childbearing age who are not on birth control as a singular community of potentially pregnant women and offered them just one solution—stop drinking altogether. These unbending guidelines collided with equality and autonomy norms, and various media outlets and bloggers took the CDC to task.¹¹⁹ Alexandra Petri castigated the guidance as “incredibly condescending” and suggested that it effectively announced the following: “The most important fact about [women of childbearing age] is not that you are people but that you might potentially contain people one day.”¹²⁰ Ignoring the Supreme

117. Some sources refer to this model as the “public health approach,” “community health approach,” and “population health approach.” See, e.g., Michael A. Ibrahim et al., *Population-Based Health Principles in Medical and Public Health Practice*, 7 J. PUB. HEALTH MGMT. & PRAC. 75, 75–77 (2001); Merwyn R. Greenlick, *Educating Physicians for Population-Based Clinical Practice*, 267 JAMA 1645, 1645–48 (1992); Cheryl Merzel & Joanna D’Afflitti, *Reconsidering Community-Based Health Promotion: Promise, Performance, and Potential*, 93 AM. J. PUB. HEALTH 557, 557–74 (2003). Legal scholars in the public-health arena echo the public-health community’s approach. See, e.g., Lawrence O. Gostin & Lindsay F. Wiley, *Public Health Law: Power, Duty, Restraint* 4, 12–13 (3d ed. 2016) (defining public-health law as the study of the state’s powers to ensure community health); Wendy E. Parmet & Jason A. Smith, *Free Speech and Public Health: A Population-Based Approach to the First Amendment*, 39 LOY. L.A. L. REV. 363, 430–43 (advocating for courts to employ a population-based perspective in public health cases); Elizabeth B. Cooper, *Social Risk and the Transformation of Public Health Law: Lessons from the Plague Years*, 86 IOWA L. REV. 869, 929–43 (2001).

118. The CDC urged healthcare providers to “[a]dvise women not to drink at all if there is any chance they could be pregnant.” CTRS. FOR DISEASE CONTROL & PREVENTION, *Alcohol and Pregnancy*, <http://www.cdc.gov/vitalsigns/fasd/> (last visited Feb. 9, 2018) (emphasis added); see also *id.* (directing women to “[s]top drinking alcohol if they are trying to get pregnant or could get pregnant.”) (emphasis added). According to the CDC, “fetal alcohol spectrum disorders (FASDs) . . . are physical, behavioral, and intellectual disabilities that last a lifetime.” *Id.*

119. See, e.g., Allison Aubrey, *Women Blast CDC’s Advice To Use Birth Control If Drinking Alcohol*, NPR (Feb. 4, 2016, 4:20 PM), <http://www.npr.org/sections/health-shots/2016/02/04/465607147/women-blast-cdcs-advice-to-use-birth-control-if-drinking-alcohol>.

120. Alexandra Petri, *The CDC’s Incredibly Condescending Warning to Young Women*, WASH. POST (Feb. 3, 2016), <https://www.washingtonpost.com/blogs/compost/wp/2016/02/03/the-cdcs-incredibly-condescending-warning-to-young-women/>. Using language

Court's emphasis on women's personhood and decisional autonomy,¹²¹ the CDC disrespected every woman's individual judgment to evaluate the likelihood of pregnancy at any given moment, possibility of injury to a fetus, and extent to which she would terminate an unwanted pregnancy.¹²² Relatedly, some scholars critiqued the CDC for conflating various subcategories of women, because it included women who want to get pregnant with those who don't, and women who drink heavily with those who drink occasionally and lightly.¹²³ While the CDC claimed to be motivated by only health risk, its concern was laced with identity-based assumptions.¹²⁴ The

reminiscent of that in the Supreme Court's reproductive-rights cases, Darlena Cunha castigated the CDC for "talking down to women who have the right to privacy [and] the right to monitor their own health like adults . . ." Darlena Cunha, *The CDC's Alcohol Warning Shames and Discriminates Against Women*, TIME (Feb. 5, 2016), <http://time.com/4209491/cdc-alcohol-pregnancy/>.

121. See, e.g., *Casey*, 505 U.S. at 833.

122. Olga Khazan & Julie Beck, *Protect Your Womb from the Devil Drink*, ATLANTIC (Feb. 3, 2016), <http://www.theatlantic.com/health/archive/2016/02/protect-your-womb-from-the-devil-drink/459813/> (statement of Olga Khazan objecting to the CDC's decision to "privilege a risk-free, hypothetical, future motherhood—especially if you don't desire said motherhood—over one of life's greatest pleasures"). The CDC's cramped assumptions about women are evident from the following statement by Dr. Anne Schuchat, the Principal Deputy Director of the CDC: "It is important to recognize that women do not drink during pregnancy to intentionally hurt their baby. They are either not aware of the risks, not aware they are pregnant or they need help to stop drinking." *Transcript for CDC Telebriefing: New Vital Signs Report - Why Are Millions of US Women at Risk of Alcohol-exposed Pregnancies?*, CTRS. FOR DISEASE CONTROL & PREVENTION (Feb. 2, 2016) [hereinafter *CDC Transcript*], <http://www.cdc.gov/media/releases/2016/t0202-alcohol-exposed-pregnancies.html> (emphasis added). Nowhere does Dr. Schuchat acknowledge the possibility that a woman might know the risks, accept them, and decide to drink anyway. Nor can Dr. Schuchat envision a woman deciding to drink because she does not want to be a mother and knows she would exercise her constitutional right to terminate an unplanned pregnancy.

123. See, e.g., Emily Oster, *'No Alcohol' During Pregnancy Is Just Another Shame Battle in the Mommy Wars*, TIME (Oct. 21, 2015), <http://time.com/4081343/no-alcohol-during-pregnancy/> (drawing on European studies that suggest light drinking during pregnancy is low risk). During Dr. Schuchat's conference call with the media, one reporter asked the following question: "I'm wondering how serious the risk is for a woman who is drinking very mildly or moderately during that month when she hasn't yet found out that she is pregnant." Dr. Schuchat responded, "You know, we can't put a number on that for any individual woman. What we can say is that fetal alcohol spectrum disorders are 100% preventable if there is no alcohol exposure at all." *CDC Transcript*, *supra* note 122.

124. See Cunha, *supra* note 120 ("Suddenly, it's no longer a political question whether a mother's right to her body outweighs the right of an unborn fetus inside of her. Instead it is a medical guideline that a woman's right to her body vanishes if there is a mere possibility that a fetus might reside there someday."). After the public backlash, a CDC official tried to walk back its recommendation by claiming that its guidance was directed only at women who are trying to get pregnant. See Erin Shumacker, *No, The CDC Did Not Tell Women To Stop Drinking: It Could Use Some Help on Press Releases, Though*, HUFFINGTON POST (Feb. 3, 2016, 9:51 PM), http://www.huffingtonpost.com/entry/cdc-alcohol-young-women-pregnancy-warning_us_56b22f03e4b04f9b57d805bc ("We definitely didn't make any recommendations for women who are pre-pregnant," said Lela McKnight-Eily, an

unique burdens it placed on women outstrip actual risk in many cases. As elaborated below, we see similar identity-based dynamics at work in public-health policies that impute excessive sexual risk to gay and bisexual men and encourage PrEP as a “community-wide” method of managing such risk.¹²⁵

Some readers, particularly those steeped in public health, might resist our claim that HIV-related public-health policies regulate and stigmatize gay and bisexual identity because public-health policymakers and scholars have moved away from terms such as *gay* and *bisexual* and coalesced around the label *MSM* to underscore the importance of behavior, not identity. This development marks another cleavage between public health and constitutional law because the Supreme Court has generally treated regulation of same-sex behavior as tantamount to discrimination based on gay identity.¹²⁶ As an influential article by Rebecca Young and Ilan Meyer explained, public-health scholars introduced *MSM* in the early 1990s to shed the identitarian aspects of *gay* and *bisexual*.¹²⁷ Some of these scholars believed that “behaviors, not identities, place individuals at risk for HIV infection, a particularly important distinction given that scientific and medical experts had initially identified gay identity as a risk for HIV/AIDS.”¹²⁸ For example, government

epidemiologist and clinical psychologist on the Fetal Alcohol Syndrome Prevention Team at the CDC.”). However, this is hard to square with the above-mentioned statements referring to the risk of unplanned pregnancies, which remain on the CDC’s website. *See supra* note 118.

125. Just as the CDC’s guidance and associated discourse increase the surveillance and stigma on women’s sexual and reproductive decision-making (while typically ignoring the behavior of their heterosexual male partners), we worry that public-health policy and discourse regarding *MSM* and HIV justifies and magnifies the fear and anxiety that many *MSM* experience with respect to sex with men. *Cf. Cunha, supra* note 120 (“[W]omen are thinking, feeling, sentient beings who probably care very much about the wellbeing of their future children. We’re already scared we’re going to mess something up. We worry constantly about the welfare of our kids. We don’t need the extra, condescending guilt from our professional health services.”).

126. *See Lawrence v. Texas*, 539 U.S. 558, 583 (2003) (O’Connor, J., concurring) (“While it is true that the [sodomy] law applies only to conduct, the conduct targeted by this law is conduct that is closely correlated with being homosexual. Under such circumstances, Texas’s sodomy law is targeted at more than conduct. It is instead directed toward gay persons as a class.”); *Christian Legal Soc’y v. Martinez*, 561 U.S. 661, 689 (2010) (“Our decisions have declined to distinguish between status and conduct in this context.”); *see also* Robinson, *supra* note 65, at 174 (arguing that the Court has ignored the distinction between identity and conduct in sexual orientation cases, but not in race and gender cases); JANET E. HALLEY, DON’T: A READER’S GUIDE TO THE MILITARY’S ANTI-GAY POLICY 27, 47 (1999) (discussing the fraught relationship between identity and conduct in the context of the military’s Don’t Ask, Don’t Tell policy).

127. Rebecca Young & Ilan Meyer, *The Trouble with “MSM” and “WSW”*: *Erasure of the Sexual-Minority Person in Public Health Discourse*, 95 AM. J. PUB. HEALTH 1144 (2005).

128. *See id.* at 1144 (stating that *MSM* was “introduced to reflect the idea that behaviors, not identities, place individuals at risk for HIV infection.”). In addition to this “epidemiological perspective,” Young and Meyer link the emergence of *MSM* to queer

researchers initially described the disease now known as AIDS as “gay-related immune deficiency,” failing to understand that the disease was also impacting many heterosexual people.¹²⁹ Others were troubled by the culturally contingent nature of sexual-identity labels and saw them as conflicting with how many men of color in the United States and abroad conceived of themselves.¹³⁰ Both camps were motivated by the desire to reach men who did not embrace gay or bisexual labels but engaged in risky sexual behavior. As important as these concerns are, close analysis of how *MSM* has been deployed in public-health circles shows that *MSM* is often used both as a proxy for as well as a new form of identity, rather than a truly “identity-free” behavioral concept.¹³¹

In practice, Young and Meyer and others argue, *MSM* has tended to hide—rather than transcend—social aspects of sexuality.¹³² First, researchers and policymakers often simply substitute *MSM* for *gay* and *bisexual*, speaking of an *MSM community*, *MSM risk group*, and yes, even *MSM identity*, rather than seeing *MSM* as individuals who just happen to engage in a particular sexual act.¹³³ Second, although researchers often use *MSM* as an umbrella term referring to all men who engage in particular sexual behavior, they simultaneously tend to foreground *MSM who do not identify as gay or bisexual*.¹³⁴ Moreover, this focus on men who reject sexual-identity labels or identify as heterosexual intersects with race, as researchers increasingly have identified black and Latino *MSM* as the most vulnerable to HIV and the principal subjects of HIV-related research.¹³⁵ *MSM* has come to “implicitly refer to people of color, poor people, or racially and ethnically diverse groups” outside the perceived gay mainstream.¹³⁶ This alignment of marginalized communities with those who reject gay/bisexual identities tends to erase racially and socioeconomically marginalized people who also embrace an identity as gay,

theory’s pursuit of “more textured understandings of sexuality that do not assume alignments between identity, behavior, and desire.” *Id.*

129. Cathy Cohen has insightfully documented how the CDC’s fixation on (white) gay identity led it to miss the burgeoning AIDS crisis among black communities, including black gay and bisexual men and black IV drug users. COHEN, *supra* note 112, at 124–25, 166; see also Young & Meyer, *supra* note 127, at 1145 (“[G]ay and lesbian are often coded as ‘White.’”).

130. Young & Meyer, *supra* note 127, at 1144.

131. *Id.*

132. *Id.* at 1144–45; Tom Boellstorff, *But Do Not Identify as Gay: A Proleptic Genealogy of the MSM Category*, 26 CULTURAL ANTHROPOLOGY 287, 288 (2011) (“The *MSM* category may be on its way to becoming a globally dominant identity category . . .”).

133. Boellstorff, *supra* note 132, at 298–99 (recounting various examples).

134. Initial articulations of this term made this caveat explicit, but over time, the condition became implicit. *Id.* at 291.

135. See, e.g., *id.* at 293 (arguing that “the *MSM* category, tightly linked to HIV/AIDS and nonwhite and non-Western men, allowed for new forms of racialized pathologization linked to the figure of the diseased body of color”); cf. Robinson, *supra* note 112 (discussing public health’s fixation on black men who have sex with women and men on the “down low” as an ostensible vector of disease in black communities).

136. Young & Meyer, *supra* note 127, at 1145.

bisexual, or queer, as well as white MSM who shun sexual-identity labels.¹³⁷ *MSM* thus has become a way for people to talk about identity without talking about identity. Some scholars and policymakers may genuinely have thought that they had constructed an identity-less behavioral risk profile, but many have applied *MSM* in a way that reflects the stereotypical view that all sex between men is similarly risky.

Third, even if *MSM* had succeeded in stripping identity from sexuality discourse, that would be a mistake because “social dimensions of sexuality . . . are critical in understanding sexual health.”¹³⁸ For example, identities such as *top* and *bottom*, which describe gay men’s sex roles, and the term *bareback*, which refers to a preference for condom-less sex, “are part of a sex culture and connote meanings as well as behaviors that are associated with HIV risk and are relevant to HIV prevention.”¹³⁹ “Thinking in flat behavioral terms may lead us to ignore affiliation networks and communities that are important sources of information, norms, and values.”¹⁴⁰ Such social connections can be pathways for risky or protective behaviors and healthcare interventions.

Young and Meyer ultimately do not call for abandoning the terms *MSM* and *women who sleep with women* (“WSW”), but describe them as “lowest common denominator terms that tell us little about risks for HIV/AIDS or any other disease.”¹⁴¹ In line with Young and Meyer, we conclude that public health should investigate sexual risk in an identity-sensitive—not identity-free—manner.¹⁴² And

137. *Id.* at 1146 (arguing that with respect to both whites and people of color, “[t]o label as MSM and WSW people who describe themselves as gay or lesbian or use another identity term is to deny their self-labeling and, by extension, their self-determination.”); *see also* WARD, *supra* note 66.

138. Young & Meyer, *supra* note 127, at 1147; Karen Glanz & Donald B. Bishop, *The Role of Behavioral Science Theory in Development and Implementation of Public Health Methods*, 31 ANN. REV. PUB. HEALTH 399, 399–418 (2010).

139. Young & Meyer, *supra* note 127, at 1147; Troy Suarez & Jeffrey Miller, *Negotiating Risks in Context: A Perspective on Unprotected Anal Intercourse and Barebacking Among Men Who Have Sex with Men—Where Do We Go from Here?*, 30 ARCHIVES SEX. BEHAV. 287, 287–300 (2001); *see also* Trevor Hoppe, *Circuits of Power, Circuits of Pleasure: Sexual Scripting in Gay Men’s Bottom Narratives*, 14 SEXUALITIES 193, 213 (2011) (“Public health scholars and practitioners should take seriously the socio-sexual scripts and systems of meaning operating within the communities in which they work, and aim to develop intervention strategies that are attuned—and conceptualized as working with—these constructions of sexuality.”).

140. Young & Meyer, *supra* note 127, at 1146; *see also* Bianca Wilson et al., *Sexual and Gender Diversity Within the Black Men Who Have Sex with Men HIV Epidemiological Category*, 13 SEX RES. SOC. POL’Y 202, 203 (2016) (arguing that a narrow focus on “sex” ignores “emotional and relational attraction to men and the meaningfulness of social, political, and sexual communities” to determining HIV risk).

141. Young & Meyer, *supra* note 127, at 1147 (calling for a “more critical and reflective stance” in selecting and using terms).

142. A central theme in critical race theory is that colorblind policies may conceal racial discrimination and thus be perilous for people of color. *See, e.g.*, Neil Gotanda, *A Critique of “Our Constitution is Color-Blind”*, in CRITICAL RACE THEORY: THE CUTTING EDGE 35 (Richard Delgado & Jean Stefancic eds., 2000); Russell K. Robinson, *Perceptual Segregation*, 108 COLUM. L. REV. 1093, 1126–27 (2008) (noting that many people of color

that sensitivity must entail paying close attention to differences within any community. Taking into account interactions between behavior and identity is likely to “reveal more nuanced information” about HIV risk and lead to more effective public-health interventions.¹⁴³

The term *MSM* may strike readers as more clinical and objective than terms such as *gay* or *bisexual* because it does not seem to map onto broader meanings outside public health. Yet *MSM* too is a social construction, and it reflects various debatable choices. First, critical scholarship teaches us that the definition of a *man* (which is both a subject and object in the *MSM* construction)¹⁴⁴ and *sex*¹⁴⁵ are not self-evident. Policymakers have often deployed the *MSM* concept to shunt transgender women into the classification, despite such women’s self-defined gender.¹⁴⁶ At the same time, policymakers have wrongly excluded transgender men from the *MSM* category, assuming that transgender men have sex with only cisgender women.¹⁴⁷ Instead of focusing on *MSM*, we might reconstruct the high-risk category as a more gender-inclusive group of *people who have sex with men* or

regard race-consciousness as necessary for their survival in predominantly white spaces); Devon W. Carbado & Cheryl I. Harris, *The New Racial Preferences*, 96 CALIF. L. REV. 1139 (2008) (illustrating how Prop. 209’s ban on racial “preference” in governmental decision-making in California may impose burdens on college applicants whose life stories have been deeply influenced by racial discrimination).

143. Young & Meyer, *supra* note 127, at 1148; see Bethany G. Everett, *Sexual Orientation Disparities in Sexually Transmitted Infections: Examining the Intersections Between Sexual Identity and Sexual Behavior*, 42 ARCH. SEX BEHAV. 225, 233 (2013) (finding that gay-identified men who had sex with men and women were more likely to report a sexually transmitted infection than heterosexual-identified men who had sex with women, but finding no difference between the latter group and gay-identified MSM); Derrick D. Matthews et al., *Operational Definitions of Sexual Orientation and Estimates of Adolescent Health Risk Behaviors*, 1 LGBT HEALTH 42, 45 (2014) (finding that whether sexual orientation was associated with greater health-risk behaviors among a sample of teenagers depended, in some cases, on whether the measure of orientation included sexual behavior and self-identity); see also Hector Carillo & Amanda Hoffman, *From MSM to Heteroflexibilities: Non-exclusive Straight Male Identifies and Their Implications for HIV Prevention and Health Promotion*, 11 GLOBAL PUB. HEALTH 923, 933 (2016) (arguing for a focus on the role of identity in shaping the sex practices of “heteroflexible” men).

144. Wilson et al., *supra* note 140, at 203; Rachel L. Kaplan et al., *In the Name of Brevity: The Problem with Binary HIV Risk Categories*, 11 GLOBAL PUB. HEALTH 824, 825 (2016) (pointing out that proponents of *MSM* assume that the term *man* is not an identity and that “the ‘male body’ is something homogenous, stable, and easily identifiable”).

145. As we detail later, the government’s policies typically refuse to define precisely which bodily acts count as sex. See *infra* text accompanying notes 191–98; Wilson et al., *supra* note 140, at 203 (“Does a penis have to be involved in the sexual act?”); see also JUDITH BUTLER, *BODIES THAT MATTER* 57–91 (1993); Marilyn Frye, *Lesbian ‘Sex’*, in *LESBIAN PHILOSOPHIES AND CULTURES* 305 (Jeffner Allen ed., 1990) (critiquing heteronormative definitions of sex that imagine male ejaculation as the culmination of “real sex”).

146. See Kaplan et al., *supra* note 144, at 826.

147. See Wilson et al., *supra* note 140, at 203.

(more specifically) *people who engage in receptive anal or vaginal sex with men*.¹⁴⁸ Second, the CDC's reports show dramatic geographic variation in HIV prevalence depending on region and whether one lives in a major city, a suburb, or a rural area.¹⁴⁹ Thus, even if the essential MSM practices indiscriminate and unprotected receptive anal sex,¹⁵⁰ a man's sexual risk is determined by the market of potential sexual partners (for example, the number of men on Grindr) and the HIV rate in that particular subgroup of MSM. To assume that MSM in, say, Wyoming, which has an HIV rate of 2.9 persons per 100,000, is as vulnerable to HIV as MSM in Washington, D.C., which has an HIV rate of 74.3 persons per 100,000, is fanciful.¹⁵¹ Third, CDC data also demonstrate that black and Latino MSM are significantly more likely to contract HIV than white MSM,¹⁵² but none of the federal health policies distinguish *among* MSM based on race. These examples reveal the government's focus on MSM to be a rather crude lowest common denominator in that the CDC disregards more finely grained questions that would yield better estimates of risk. The notion of a "community" of MSM who share a uniform level of HIV risk is ultimately a fabrication that reflects political choices and, we argue below, entrenches negative stereotypes of sex between men and gay and bisexual identity.

The following discussion describes three federal public-health policies that single out MSM for special treatment. The next Part first describes the Food and Drug Administration ("FDA") restrictions on MSM giving blood and donating sperm. Because these policies share a similar structure, we critique them jointly. The

148. See Kaplan et al., *supra* note 144, at 827 (noting that World Health Organization guidelines specifically include "transgender women or transgender men who have receptive anal sex with men").

149. See, e.g., U.S. DEP'T OF HEALTH AND HUMAN SERV., CTRS. FOR DISEASE CONTROL, HIV SURVEILLANCE REPORT: DIAGNOSES OF HIV INFECTION IN THE UNITED STATES AND DEPENDENT AREAS 7 (2015), <https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-2015-vol-27.pdf> [hereinafter 2015 HIV SURVEILLANCE REPORT] (finding that rates of AIDS deaths in the Northeast and South were roughly double the rates in the West and Midwest).

150. It seems that in the popular imagination gay men are typically perceived as bottoms, regardless of how they define themselves and their sexual practices.

151. 2015 HIV SURVEILLANCE REPORT, *supra* note 149, at 99 (listing HIV rates by state).

152. *HIV Among African American Gay and Bisexual Men*, CDC, <https://www.cdc.gov/hiv/group/msm/bmsm.html> (last visited Feb. 23, 2018) ("Among all gay and bisexual men who received an HIV diagnosis in the United States in 2015, African Americans accounted for the highest number (10,315; 39%), followed by whites (7,570; 29%) and Hispanics/Latinos (7,013; 27%)."). To be clear, a race-based policy would raise some of the same stigmatic concerns as the MSM-centered policies, and we do not endorse such a policy. Our point is simply that the government's guidelines focus on MSM status, while choosing to ignore racial disparities among MSM and among women, likely because of the different political implications of taking race and sexual orientation into account. Although the Obama Administration generally exercised restraint in linking HIV to race, the Trump Administration recently released a report suggesting that people of color have a special need for PrEP. *HIV Prevention Pill Not Reaching Most Americans Who Could Benefit – Especially People of Color*, AIDSINFO (Mar. 6, 2018), <https://aidsinfo.nih.gov/news/2026/hiv-prevention-pill-not-reaching-most-americans-who-could-benefit-especially-people-of-color>.

following Part shifts to examine a more recent and nuanced policy, which concerns recommending HIV medication as prevention for certain “high risk” populations. The chart below provides a concise overview of the policies before we delve into each.

FIGURE 1: Differential Treatment of MSM in Public-Health Regulations¹⁵³

HETEROSEXUAL MEN	WOMEN	MEN WHO HAVE SEX WITH MEN
BLOOD DONATION GUIDANCE ¹⁵⁴ — <i>FDA recommends refusing blood donations if donor:</i>		
has had sex in the past year with a woman who (a) has exchanged sex for money/drugs, (b) is HIV positive, or (c) has injected non-prescription drugs	(1) has had sex in the past year with a man who (a) has exchanged sex for money/drugs, (b) is HIV positive, or (c) has injected non-prescription drugs; <i>or</i> (2) has had sex in the past year with a bisexual man	has had sex in the past year with a man
SPERM DONATION GUIDANCE ¹⁵⁵ — <i>FDA recommends banning anonymous donations if donor:</i>		
has had sex in the past year with a woman who either (a) is infected with HIV, or (b) has injected non-prescription drugs in past five years	N/A	has had sex in the past five years with a man

153. The guidelines contain additional exclusions that are not represented in this figure.

154. 2015 REVISED BLOOD GUIDANCE, *supra* note 89.

155. U.S. DEP'T OF HEALTH AND HUMAN SERV., FOOD & DRUG ADMIN., GUIDANCE FOR INDUSTRY: ELIGIBILITY DETERMINATION FOR DONORS OF HUMAN CELLS, TISSUES, AND CELLULAR AND TISSUE-BASED PRODUCTS (HCT/PS) 14–21 (Aug. 2007), <http://www.fda.gov/downloads/BiologicsBloodVaccines/GuidanceComplianceRegulatoryInformation/Guidances/Tissue/UCM091345.pdf> [hereinafter SPERM DONATION GUIDANCE].

HETEROSEXUAL MEN	WOMEN	MEN WHO HAVE SEX WITH MEN
TRUVADA AS PrEP PRESCRIBING GUIDELINES ¹⁵⁶ — <i>U.S. Public Health Service recommends prescribing PrEP to any patient who:</i>		
(1) is not in a monogamous relationship with a recently tested HIV negative partner; <i>and</i> (2) uses condoms infrequently in sex with <i>either</i> (a) a person known to be HIV positive, <i>or</i> (b) an injecting drug user not known to be HIV negative	(1) is not in a monogamous relationship with a recently tested HIV negative partner; <i>and</i> (2) uses condoms infrequently in sex with <i>either</i> (a) a person known to be HIV positive, (b) an injecting drug user not known to be HIV negative, <i>or</i> (c) a bisexual man not known to be HIV negative	(1) is not in a monogamous relationship with a recently tested HIV negative partner; <i>and</i> (2) <i>either</i> (a) has had sex in the past six months with a woman, (b) is in an ongoing sexual relationship with an HIV-positive male partner, (c) has had unprotected anal sex with another man once in the past six months, <i>or</i> (d) has been diagnosed with an STI in the past six months

B. Blood and Sperm Donation Guidance

Following guidance provided by the FDA, blood banks generally require potential donors to answer a series of questions about risky behavior during an interview.¹⁵⁷ These questions are designed to identify blood that may pose a risk to public health. Those whose answers suggest high risk are deferred, meaning they are barred from donating blood.¹⁵⁸ Even when the potential donor's answers indicate that he is eligible, blood banks test a sample of his blood for HIV and several other diseases.¹⁵⁹ Current tests can identify an HIV infection within 9 to 11 days after exposure to the virus.¹⁶⁰ Much of the FDA's current concern appears to stem from

156. PREP GUIDELINES, *supra* note 8, at 26–29.

157. See *Donation FAQ*, AM. RED CROSS, <http://www.redcrossblood.org/donating-blood/donation-faqs> (last visited Feb. 19, 2016).

158. See *If You're Not Eligible to Give Blood*, AM. RED CROSS, <http://www.redcrossblood.org/donating-blood/eligibility-requirements/if-you-are-not-eligible> (last visited Feb. 19, 2016).

159. See *Keeping Blood Transfusions Safe: FDA's Multi-layered Protections for Donated Blood*, FDA, <http://www.fda.gov/BiologicsBloodVaccines/SafetyAvailability/BloodSafety/ucm095522.htm> (last visited Feb. 19, 2016).

160. Sabrina Tavernese, *F.D.A. Easing Ban on Gays, to Let Some Give Blood*, N.Y. TIMES (Dec. 13, 2014), http://www.nytimes.com/2014/12/24/health/fda-lifting-ban-on-gay-blood-donors.html?_r=0.

this so-called window period, during which its tests may miss HIV-infected blood. It relies on the risk questions to backstop this screening.

The historical origins of the policy are important. In 1985, during the early days of the AIDS epidemic, the FDA adopted guidelines permanently deferring blood donated by MSM.¹⁶¹ At that time, the FDA lacked the technology to screen blood for HIV. This was also a time of intense social panic and pervasive homophobia.¹⁶² Just one year later, in *Bowers v. Hardwick*, the Supreme Court would blithely reject a gay man's claim that Georgia's criminal law banning sodomy violated his right of privacy.¹⁶³ (The Court overturned *Bowers* in 2003, declaring it wrong when it was decided.¹⁶⁴) In 1983, the FDA announced an "interim measure" precluding "sexually active homosexual or bisexual men with multiple partners" and others from donating blood.¹⁶⁵ This policy was flawed in that it did not define "multiple partners"—for instance, 2 or 20?—or specify the relevant time period. Nor did it consider protective measures such as condom use. Late the next year, the FDA changed the MSM blood ban to apply to "[m]ales who have had sex with more than one male since 1979 and males whose male partner has had sex with more than one male since 1979."¹⁶⁶ In 1992, the FDA revised some aspects of its guidance, but imposed a lifetime exclusion of "men who have had sex with another man even one time since 1977."¹⁶⁷ Other groups subject to a lifetime ban included "past or present intravenous drug users" and "men and women who have engaged in sex for money or drugs since 1977."¹⁶⁸ The 1992 memo also imposed a 12-month exclusion for people who engaged in sex with a person subject to a lifetime ban—e.g., MSM, IV

161. 2015 REVISED BLOOD GUIDANCE, *supra* note 89, at 2.

162. *Henderson v. Thomas*, 913 F. Supp. 2d 1267, 1277 (M.D. Ala. 2012) ("The profound consequences of the disease, combined with lack of knowledge about how it could spread, created an era of hysteria in the epidemic's early days.").

163. 478 U.S. 186 (1986).

164. *Lawrence v. Texas*, 539 U.S. 558, 577 (2003) ("*Bowers* was not correct when it was decided, and it is not correct today. It ought not to remain binding precedent. *Bowers v. Hardwick* should be and now is overruled.>").

165. U.S. DEP'T OF HEALTH AND HUMAN SERVS., MEMORANDUM FROM THE DIRECTOR, OFFICE OF BIOLOGICS, NAT'L CTR. FOR DRUGS AND BIOLOGICS, RECOMMENDATIONS TO DECREASE THE RISK OF TRANSMITTING ACQUIRED IMMUNE DEFICIENCY SYNDROME FROM PLASMA DONORS (Mar. 24, 1983). The others were "Haitian entrants to the United States, present and past abusers of intravenous drugs, and sexual partners of individuals at increased risk of AIDS." *Id.*

166. U.S. DEP'T OF HEALTH AND HUMAN SERVS., MEMORANDUM FROM THE ACTING DIRECTOR, OFFICE OF BIOLOGICS, NAT'L CTR. FOR DRUGS AND BIOLOGICS, REVISED RECOMMENDATIONS TO DECREASE THE RISK OF TRANSMITTING ACQUIRED IMMUNE DEFICIENCY SYNDROME FROM PLASMA DONORS (Dec. 14, 1984).

167. U.S. DEP'T OF HEALTH AND HUMAN SERVS., FOOD & DRUG ADMIN., MEMORANDUM TO ALL REGISTERED BLOOD ESTABLISHMENTS: REVISED RECOMMENDATIONS FOR THE PREVENTION OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) TRANSMISSION BY BLOOD AND BLOOD PRODUCTS 3 (Apr. 23, 1992), <https://www.fda.gov/downloads/BiologicsBloodVaccines/GuidanceComplianceRegulatoryInformation/otherRecommendationsforManufacturers/MemorandumtoBloodEstablishments/UCM062832.pdf>.

168. *Id.*

drug users, and sex workers. Although this policy repeatedly referred to *sex*, it never expressly defined that key term.

Times have changed, but the policy continues to exclude many gay and bisexual men. In December 2014, the FDA announced plans to revise its guidance to blood banks regarding the exclusion of blood from MSM.¹⁶⁹ The new guidelines were finalized one year later.¹⁷⁰ Some media outlets hailed this development as the government “lifting the lifetime ban” or “ending it.”¹⁷¹ Despite this fanfare, the only real change is that the new policy allows MSM who have been celibate for one entire year to donate.¹⁷² The revised guidance provides that “[f]or male donors: a history in the past 12 months of sex with another man” will result in exclusion.¹⁷³ The FDA explained that it planned to conduct a pilot study to examine the risk of eliminating the ban on MSM donors. Ultimately, a government working group decided that “resources at HHS could be used in more efficient ways” by relying on studies from other countries.¹⁷⁴ The new policy tracks a revised Australian policy; studies show that the Australian policy did not increase the risk of HIV infection. But the new U.S. policy also disregards Italy’s policy, which contains no broad-based ban on MSM donors and is more focused on individual behavior.¹⁷⁵ The shifting nature of the ban—from applying only to men who have “multiple partners” to permitting sex

169. Tavernese, *supra* note 160. The old policy was forcefully opposed by scholars such as I. Glenn Cohen, organizations including the American Red Cross, America’s Blood Centers, American Association of Blood Banks, LGBTQ groups such as Lambda Legal, and a bipartisan group of Senators and Congressional Representatives. *See, e.g.*, I. Glenn Cohen & Jeremy Feigenbaum, *Reconsideration of the Lifetime Ban on Blood Donation by Men Who Have Sex with Men*, 312 JAMA 337 (2014).

170. 2015 REVISED BLOOD GUIDANCE, *supra* note 89. The guidance states that it does not “establish legally enforceable responsibilities.” *Id.* at 1.

171. Maggie Fox, *As Promised, FDA to Lift Ban on Gay Blood Donation*, NBC NEWS (May 12, 2015, 3:07 PM), <http://www.nbcnews.com/health/health-news/promised-fda-lift-ban-gay-blood-donation-n357816>.

172. Some other media outlets, such as CNN, framed the change in policy more accurately. *See, e.g.*, *FDA Plan: Gay Men Who Abstain from Sex May Be Allowed to Give Blood*, CNN (Dec. 23, 2014, 6:45 PM), <http://www.cnn.com/2014/12/23/health/fda-blood-donation-proposal-gay-men/> (“Gay men who’ve abstained from sex for one year would be able to donate blood in 2015, ending a lifetime ban for the gay community, under a proposed FDA policy change unveiled Tuesday.”).

173. 2015 REVISED BLOOD GUIDANCE, *supra* note 89.

174. *Id.* at 3.

175. Clive R. Seed et al., *No Evidence of a Significantly Increased Risk of Transfusion-Transmitted HIV Infection in Australia Subsequent to Implementing a 12 Month Deferral for Men Who Have Had Sex with Men*, 50 TRANSFUSION 2722, 2726 (2014); Cohen & Feigenbaum, *supra* note 169, at 337; Glenn Cohen, *FDA’s Non-Response Response to My New York Times Op-Ed on Gay Blood Ban*, BILL OF HEALTH, PETRIE-FLOM CTR., BLOG (June 5, 2015), <http://blogs.harvard.edu/billofhealth/2015/06/05/fdas-non-response-response-to-my-new-york-times-op-ed-on-gay-blood-ban/> (pointing out FDA’s failure to address Italy’s policy, as well as that of South Africa); I. Glenn Cohen & Eli Y. Adashi, *New Blood-Donor Policy, Same Gay Stigma*, N.Y. TIMES (May 21, 2015), <http://www.nytimes.com/2015/05/21/opinion/new-blood-donor-policy-same-gay-stigma.html>.

between two men so long as neither had a prior male partner to banning all men who have had a single male partner to banning all men who have had a single male partner in the last 12 months—suggests how mutable and subject to shifting political winds such policies may be. Notably, these policies often fail to explain how science has motivated the change in policy. Finally, it is striking that some early policies were more generous to MSM than more recent policies, despite the availability of better technology for screening blood for potential infections and better treatment options for people with HIV.

The federal government's ban on MSM sperm donation follows a structure like that of the blood ban. For more than ten years, the FDA has recommended banning anonymous sperm donation by men who have had sex with men in the past five years.¹⁷⁶ The guidance notes at the outset that it does “not establish legally enforceable responsibilities” and “the use of the word ‘should’ . . . means that something is suggested or recommended, but not required.”¹⁷⁷ The guidance suggests that establishments that determine donor eligibility screen cells and tissues for several diseases, including HIV, and question donors about whether they fall into risk groups.¹⁷⁸ The first group is “men who have had sex with another man in the preceding 5 years,”¹⁷⁹ which is said to be at risk for HIV and Hepatitis B.¹⁸⁰ The FDA also tells establishments to consider “physical evidence of anal intercourse” for male donors only.¹⁸¹

As a formal matter, the FDA's designation of MSM as a risk group applies only to anonymous donations. This exclusion may impact lesbian couples that prefer to use sperm from a gay or bisexual man.¹⁸² However, the policy permits “directed donations,” which are made by a man who knows the woman who plans to use his sperm.¹⁸³ Further, the policy does not apply to sperm donated by a man who is in a sexual relationship with his female partner. The policy apparently would not exclude

176. SPERM DONATION GUIDANCE, *supra* note 155; see also *FDA Set to Ban Gay Men as Sperm Donors*, NBC NEWS (May 5, 2005), http://www.nbcnews.com/id/7749977/ns/health-mens_health/t/fda-set-ban-gay-men-sperm-donors/#.VrUQDHvApzk (reporting FDA's plan to issue guidance).

177. SPERM DONATION GUIDANCE, *supra* note 155, at 1.

178. *Id.* at 3.

179. *Id.* at 14.

180. *Id.*

181. *Id.* at 24. Other risk groups that are subject to a five-year window include “persons who have injected drugs for a non-medical reason” and “persons who have had sex in exchange for money or drugs.” *Id.* at 15. Some other restrictions apply to behavior during the last 12 months. These risk factors include persons who have had sex with someone who has tested HIV positive, persons who have had sex with MSM or an IV drug user, and “persons who have been in juvenile detention, lock up, jail or prison for more than 72 hours in the preceding 12 months.” We are not aware of any other HIV-related federal policy that treats incarceration as a risk factor. The racial implications of this policy are troubling, particularly in light of the limited evidence of HIV transmission in prisons and jails.

182. Camille Beredjick, *The FDA's Lesser-Known Insult: A Ban on Gay Sperm Donors*, ADVOCATE (Nov. 21, 2012, 2:32 PM), <http://www.advocate.com/health/2012/11/21/fdas-lesser-known-insult-ban-gay-sperm-donors>.

183. SPERM DONATION GUIDANCE, *supra* note 155, at 40.

donations by a bisexual MSM who wishes to conceive a child with his female partner.¹⁸⁴ Further, the guidance is on its face optional, and it appears that, in practice, establishments have been more willing to reject this policy than other policies, such as the blood ban.¹⁸⁵ For example, some sperm banks in the San Francisco Bay Area that cater to LGBTQ clients argue that their practice of screening all sperm twice (which is recommended by the FDA¹⁸⁶) suffices to address HIV risk. The variance in compliance may explain why the sperm policy has received less media attention than the blood ban.¹⁸⁷

These policies share several discriminatory aspects. First, the policies portray sex between men as uniformly risky, ignoring salient differences among MSM in terms of sexual behavior and HIV risk. The original blood ban was more extreme than the current policies for blood and sperm donation, in that it embraced what we might call a “one drop” rule¹⁸⁸—all men who had “sex” “even one time” since 1977 were treated as if their blood was infected. For example, the policy equated a middle-aged man married to a woman who had a single episode of oral sex with a man when he was a teenager with another man who regularly had receptive anal sex during group sex with anonymous male partners. Recent studies suggest that about 7% of men report sexual activity with men at some point in their lifetime, whereas around 4% report such activity within the last five years, and 3% report it within the last year.¹⁸⁹ On the one hand, the revised blood ban reflects progress in that it sorts MSM into high- and low-risk subgroups and may free many MSM to donate blood. On the other hand, it sorts MSM in a very crude manner—those who have had *no* sex with men in the last year versus those who have had *any* sex with men. And because gay- and bisexual-identified men are the most likely to have had any sex with men in the last year, the revised policy is *more* identity-based than its predecessor.

Second, the current sperm policy, as well as the original blood policy and its 1992 revision, makes no effort to define what contact between men counts as *sex*, combining sexual acts that pose very different levels of HIV risk. Considering this vagueness, some men might understand *sex* to refer to the full range of sexual

184. *Id.* at 39.

185. Some such establishments have complained about receiving threatening letters from the FDA, even though the guidance is not legally enforceable. Beredjick, *supra* note 182 (quoting Leland Traiman, executive director of Rainbow Flag Health Services and Sperm Bank, Alameda, California).

186. SPERM DONATION GUIDANCE, *supra* note 155, at 37.

187. Beredjick, *supra* note 182 (“In comparison [to the blood ban], the ban on gay sperm donors is relatively unknown.”).

188. *Cf.* Cheryl I. Harris, *Whiteness as Property*, 106 HARV. L. REV. 1709, 1737 (1993) (“In the commonly held popular view, the presence of Black ‘blood’—including the infamous ‘one-drop’—consigned a person to being ‘Black’ and evoked the ‘metaphor . . . of purity and contamination’ in which Black blood is a contaminant and white racial identity is pure.”).

189. *See* David W. Purcell et al., *Estimating the Population Size of Men Who Have Sex with Men in the United States to Obtain HIV and Syphilis Rates*, 6 OPEN AIDS J. 98, 99 (2012) (making this estimate based only on national, probability-based surveys).

contact. But the policies overlook public-health studies that demonstrate that the riskiest sexual behavior for a man or a woman is unprotected receptive anal sex, which is often called *bottoming* in the gay community.¹⁹⁰ According to the CDC, the odds of HIV transmission from unprotected bottoming are 138 per 10,000 exposures (1.38%).¹⁹¹ Unprotected insertive anal sex (or *topping*) is much less risky: 11 per 10,000 exposures (0.11%).¹⁹² The risk of transmission for a man having unprotected insertive vaginal sex is 4 in 10,000 exposures (0.04%), while the woman's risk from receptive vaginal sex is double that figure (0.08%).¹⁹³ By contrast, most public-health scholars regard oral sex as minimally risky, particularly if it does not involve ejaculation.¹⁹⁴ The CDC describes the risk of oral sex simply as low—meaning lower than the estimates for anal and vaginal sex.¹⁹⁵ There remains another category of sexual behavior that is widely regarded as carrying no HIV risk, including touching, fondling, kissing, and mutual masturbation.¹⁹⁶ These behaviors are generally considered safe because they do not involve the exchange of blood or semen.¹⁹⁷

The sperm-donation policy's failure to define what counts as sex is particularly problematic given that sexual encounters between MSM often do not involve anal sex. One of the few studies to ask gay and bisexual men broadly about their sexual behavior during their most recent sexual event found that “gay and bisexually identified men have a diverse sexual repertoire” and “anal intercourse was among the least common behavior[s] that occurred during participant's most recent sexual event with another male.”¹⁹⁸ Approximately one-third of subjects reported engaging in insertive or receptive anal intercourse during their most recent sexual event. Far more common were oral sex and kissing one's partner on the mouth; approximately 75% of subjects reported these activities.¹⁹⁹ Masturbation of

190. See Patel et al., *supra* note 87, at 1513.

191. *HIV Risk Behaviors*, CDC, <http://www.cdc.gov/hiv/policies/law/risk.html> (last visited Feb. 27, 2016) (citing Patel et al., *supra* note 87).

192. Patel et al., *supra* note 87, at 1513.

193. See *id.*

194. See *id.* at 1512, 1514 (describing risk as “quite low” and noting few documented cases of transmission through oral sex).

195. *HIV Risk Behaviors*, *supra* note 191; see also Patel et al., *supra* note 87, at 1512, 1514.

196. See generally Carol L. Galletly & Steven D. Pinkerton, *Toward Rational Criminal HIV Exposure Laws*, 32 J.L. MED. & ETHICS 327 (2004).

197. *Id.*

198. Joshua G. Rosenberger et al., *Sexual Behaviors and Situational Characteristics of Most Recent Male-Partnered Sexual Event Among Gay and Bisexually Identified Men in the United States*, 8 J. SEXUAL MED. 3040, 3045 (2011). Like much sexuality research, this study did not obtain a nationally representative sample. Nationally representative sexuality surveys tend to produce a small sample of MSM because such men are sexual minorities. This study recruited nearly 25,000 gay and bisexual men by emailing members of a popular internet website targeting MSM. *Id.* at 3041.

199. *Id.* at 3042.

self, one's partner, or both was also much more common than anal sex; approximately two-thirds of subjects engaged in this activity.²⁰⁰

The 2015 blood-donation policy does define sex, apparently for the first time in the history of the MSM blood ban. It states: "the term 'sex' refers to having anal, oral, or vaginal sex, regardless of whether or not a condom or other protection is used."²⁰¹ This is an important improvement on the 1992 policy in that it excludes fondling and masturbation. However, it continues to conflate anal sex with oral sex, which the CDC itself describes as low risk.²⁰² The discrepancies between the sperm and blood policies' definitions of sex reveal that risk estimates are contingent on the selection of the "reference class." For example, the reference class could be men who have had *any* kind of sex with men: men who have had anal sex with men, or who have receptive anal sex with men in a non-monogamous relationship. The choice of a reference class is not a pre-political, "objective" scientific decision; rather, it is a value-based decision that carries political consequences. The HIV rate will change with the reference class, and even the claim that "10% of MSM have HIV" may conceal the government's choice of a very broad reference class, which includes a lot of low-risk men.

Third, none of these policies, including the revised blood ban, considers HIV testing or condom usage. According to the best estimates, approximately 90% of gay men are HIV negative,²⁰³ and condoms reduce the risk of HIV transmission by approximately 90%.²⁰⁴ Finally, the policy does not consider the number of sexual partners that a man has experienced. A monogamous gay man or one who has sex rarely is treated the same as the man who has casual sex with a new partner every weekend. The Obama Administration's revision of the blood ban does not fix these problems. Thus, a gay man who can marry his partner after *Obergefell* cannot donate blood—unless he and his husband are willing to be celibate for an entire year. By overlooking salient differences among gay and bisexual men, these policies magnify the risk of sex between men, depicting it as uniformly dangerous. This discussion has shown that the federal government, rather than being guided by empirical differences in HIV risk, has chosen to ignore scientific findings in favor of broadly characterizing all sexually active MSM as high risk.

In addition to critiquing federal policies as overbroad in identifying HIV risk, this Article seeks to make manifest and to dismantle what we might call "lessons in being gay."²⁰⁵ This frame helps us understand that the federal government is not simply *assessing* HIV risk as it collects blood from the public. It is also *teaching* us what counts as "risky sex" and what it means to be a gay,

200. *Id.* at 3044.

201. 2015 REVISED BLOOD GUIDANCE, *supra* note 89, at 13 n.6.

202. *HIV Risk Behaviors*, *supra* note 191.

203. Xu et al., *supra* note 81, at 399 (2010) (finding that HIV prevalence was 9.1% among MSM who reported sex ever in their lifetime, and 11.8% among MSM who had sex in the last year).

204. S.D. Pinkerton & P.R. Abramson, *Effectiveness of Condoms in Preventing HIV Transmission*, 44 SOC. SCI. MED. 1303 (1997).

205. Kunzel, *supra* note 110; *see* Robinson, *supra* note 110, at 1314.

bisexual, or other sexual-minority man.²⁰⁶ The policies fuse sex between men and gay and bisexual identity with HIV risk, implying that a gay or bisexual man's sexual decision-making barely matters. For example, the blood-ban policy asks flatly whether a man is having sex with men (high risk) or not (low risk). This simple distinction is in tension with other government strategies encouraging gay and bisexual men to use condoms consistently and take HIV tests regularly.²⁰⁷ Some gay and bisexual men may absorb this fatalistic message and figure that "anything goes" when it comes to sex, because HIV infection is inevitable.²⁰⁸

The policies also hold lessons for heterosexual and bisexual women. They teach heterosexual women that sex with a man who has ever had sex with a man is very risky, and that a responsible woman would avoid this risk. A woman who has a bisexual boyfriend or lover cannot donate blood until 12 months after her latest sexual episode with him. The policies suggest that the principal sources of HIV infection among heterosexual women are sex with MSM or IV drug users. They do not identify other categories of heterosexual men, such as men who have multiple partners, as high risk and refuse to let such men donate sperm and blood. The

206. These policies interact with a cultural backdrop that has long depicted LGBT lives as tragic. Hollywood's predilection for LGBT despair extends from *Brokeback Mountain* to *Milk* to *Monster* to *Boys Don't Cry*, stories about LGBT people suffering and dying. These Oscar-winning films "remind[] viewers that any deviancy from heterosexuality will ultimately result in death by suicide, murder or AIDS." James Rawson, *Why Are Gay Characters at the Top of Hollywood's Kill List?*, *GUARDIAN* (June 11, 2013), <https://www.theguardian.com/film/filmblog/2013/jun/11/gay-characters-hollywood-films>; see also *All 195 Dead Lesbian and Bisexual Characters on TV and How They Died*, *AUTOSTRADDE* (Mar. 11, 2016, 9:29 AM), <https://www.autostraddle.com/all-65-dead-lesbian-and-bisexual-characters-on-tv-and-how-they-died-312315/> (compiling a list of lesbian and bisexual female TV characters who were killed). This narrative seems so deeply embedded in many gay male viewers that they found the recent *Call Me By Your Name* groundbreaking simply because no one died at the end. Yet this film and many others engage in sexual erasure. They "limit the visibility of gay male sex" to "elicit sympathy for gay male love in its struggle to affirm itself under the barbaric repressions of the closet." "Only by averting our eyes from the distinctive gay male sex act can we defend a man's freedom to perform it." D.A. Miller, *Elio's Education*, *L.A. REV. BOOKS* (Feb. 19, 2008), <https://lareviewofbooks.org/article/elios-education/#!>.

207. See *HIV Among Gay and Bisexual Men*, CDC (Sept. 27, 2017), <https://www.cdc.gov/hiv/group/msm/index.html>.

208. Some research finds a correlation between practicing unprotected anal sex outside of an exclusive relationship and expecting a shorter lifespan. See, e.g., Seth C. Kalichman et al., *Fatalism, Current Life Satisfaction, and Risk for HIV Infection Among Gay and Bisexual Men*, 65 *J. COUNSELING & CLINICAL PSYCHOL.* 542, 545 (1997) ("[G]ay men may engage in high-risk sexual behavior because they do not perceive their future as promising or certain."). This possibility seems particularly acute for black MSM, given the constant stream of studies portraying the existence of black MSM as precarious. See, e.g., CDC, *FACT SHEET*, *supra* note 111 (asserting that half of black MSM will acquire HIV over their lifetimes, compared to 9% of white men). Although the authors of these studies may mean well in urging government and public health scholars and workers to attend to the needs of a very vulnerable population, they may simultaneously persuade black MSM that HIV infection is a normal outcome for black gay and bisexual men, and that resistance is futile.

policies thus place the onus on women and direct them to focus on detecting and avoiding bisexual men and IV drug users. This obscures the risks posed by non-drug-using heterosexual men who may be having unprotected sex with multiple female partners.²⁰⁹

In drawing connections between the lessons that the policies teach gay, bisexual, and other sexual-minority men, and heterosexual and bisexual women, among others, we want to note that the harms are interwoven—but different.²¹⁰ Put in terms of equal-protection jurisprudence, we might say that the policy is over-inclusive in its treatment of MSM and under-inclusive regarding heterosexual risk. Further, the policies impose stigma. They broadly treat sex between men as dangerous, aligning gay and bisexual identities with pathology and encouraging questioning men to resist their attraction to men. Meanwhile, the policies discipline a woman's sexual choices, placing the blame for her HIV infection on her willingness to have sex with MSM.

C. Medicalizing Sex Between Men

Truvada is a drug that doctors commonly prescribe for HIV-positive individuals to treat HIV infection and forestall AIDS.²¹¹ If properly treated with a regimen of drugs (of which Truvada is one), HIV can be a chronic disease that does not substantially reduce one's lifespan.²¹² In 2012, the FDA approved Truvada for the prevention of HIV.²¹³ This use of the drug has become known as Pre-Exposure Prophylaxis or "PrEP."²¹⁴ In 2014, the U.S. Public Health Service issued guidelines for prescribing Truvada as PrEP, wherein HIV-negative people take a daily regimen of Truvada to substantially reduce the likelihood that they will become infected with HIV.²¹⁵ The use of Truvada as PrEP is an important medical advancement that stands to improve the lives of many individuals who are at high risk of HIV infection, most notably couples in which one person is HIV positive and the other is HIV negative, sex workers, and IV drug users. Our focus here is the government's decision to direct Truvada as PrEP at HIV-negative gay and bisexual men broadly, as if their identities alone constitute risk of infection.

209. See Robinson, *supra* note 112, at 1475 (discussing how popular media similarly encourage women to identify and avoid bisexual men); Carlos Ulises Decena, *Profiles, Compulsory Disclosure and Ethical Sexual Citizenship in the Contemporary USA*, 11 *SEXUALITIES* 397, 401 (2008).

210. See Robinson, *supra* note 112, at 1500–15 (recounting the structural forces that connect black MSM and black women); Kendall Thomas, *The Eclipse of Reason: A Rhetorical Reading of Bowers v. Hardwick*, 79 *VA. L. REV.* 1805, 1822–23 (1993).

211. *HIV Basics: PrEP*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/hiv/basics/prep.html> (last visited Feb. 9, 2016).

212. See *HIV Care Saves Lives Infographic*, *supra* note 114.

213. *FDA Approves First Drug for Reducing the Risk of Sexually Acquired HIV Infection*, FOOD & DRUG ADMIN. (July 16, 2012), <https://aidsinfo.nih.gov/news/1254/fda-approves-first-drug-for-reducing-the-risk-of-sexually-acquired-hiv-infection>.

214. *Id.*

215. PrEP GUIDELINES, *supra* note 8.

This Section critiques both the federal government's PrEP guidelines and a subsequent CDC analysis that estimated the percentages of MSM and heterosexuals who should be taking PrEP. The following Section turns to gay discourse on PrEP, which has offered justifications that expand on the federal government's and seek to regulate gay/bisexual identity in troubling ways. This analysis shows that some leading gay figures have outflanked the Obama Administration in perpetuating homophobic²¹⁶ and masculinist²¹⁷ conceptions of gay and bisexual men.

The guidelines are directed at healthcare providers, who tend not to ask patients about HIV risk as regularly as the government thinks is necessary.²¹⁸ The guidelines function as a flow chart, using sexual identity to direct the provider to ask a set of questions. The basic structure of the guidelines reveals the double standard that directs the government's recommendations. That is, the guidelines establish one rule for MSM and another for everyone else.

We have highlighted the key language from the guidelines that marks the differential treatment of MSM and heterosexuals. Box B1, "Recommended Indications for PrEP Use by MSM," provides the following:

- Adult man
- Without acute or established HIV infection
- Any male sex partners in past 6 months (if also has sex with women, see Box B2)
- Not in a monogamous partnership with a recently tested, HIV-negative man

and at least one of the following:

216. Scholars of internalized homophobia understand that merely being a member of a sexual-minority group does not free one from homophobia. Internalized homophobia consists of negative attitudes from the broader society that a gay person directs toward the self. This negative state stems not from any inherent personal pathology but rather from the external denigration of gay identity. *See, e.g.,* Frost & Meyer, *supra* note 20, at 97–98. Internalized homophobia is just one form of internalized oppression. Social-science studies indicate that people on the bottom of social hierarchies, including people of color and women, often endorse the very systems that oppress them. *See* Gary Blasi & John T. Jost, *System Justification Theory and Research: Implications for Law, Legal Advocacy, and Social Justice*, 94 CALIF. L. REV. 1119, 1119 (2006). System-justification theory reveals that stigmatized groups have powerful incentives to deny or minimize the existence of discrimination, to avoid the view that the social world is structurally stacked against them. *See generally id.*

217. Masculinist conceptions promote male superiority and dominance, often by portraying men as virile and sexually powerful. (Think Don Draper in *Mad Men* before the series' redemptive finale or a real-world Donald—President Trump's boasting about grabbing women by their genitalia.)

218. Dawn K. Smith et al., *Vital Signs: Estimated Percentages and Numbers of Adults with Indications for Pre-Exposure Prophylaxis to Prevent HIV Acquisition—United States, 2015*, 64 MORBIDITY & MORTALITY WKLY. REP. 1291–95 (2015), http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6446a4.htm?s_cid=mm6446a4_w.

- *Any anal sex without condoms* (receptive or insertive) in past 6 months
- *Any STI* [sexually transmitted infection] diagnosed or reported in past 6 months
- Is in an ongoing sexual relationship with an HIV-positive male partner²¹⁹

Box B2, “Recommended Indications for PrEP Use by Heterosexually Active Men and Women,” provides the following:

- Adult person
- Without acute or established HIV infection
- Any sex with opposite sex partners in past 6 months
- Not in a monogamous partnership with a recently tested HIV-negative partner

and at least one of the following:

- *Is a man who has sex with both women and men* (behaviorally bisexual) [also evaluate indications for PrEP use by Box B1 criteria]
- *Infrequently uses condoms* during sex with 1 or more partners of *unknown HIV status who are known to be at substantial risk of HIV infection* (IDU [IV drug user] or *bisexual male partner*)
- Is in an ongoing sexual relationship with an HIV-positive partner²²⁰

The guidelines are riddled with double standards based on sexual identity. First, the guidelines use STDs other than HIV as a proxy for HIV risk for MSM, but they do not ask heterosexuals about STDs other than HIV. This distinction ignores studies, cited elsewhere in the government’s guidelines,²²¹ that find that having an STD correlates with HIV risk for heterosexuals *and* MSM.²²²

Second, the guidelines identify single, bisexual men as inherently risky. They treat the mere status of “being a man who has sex with both men and women” as high risk.²²³ Unlike gay men, such men need not engage in *any* additional behavior, such as having unprotected sex at least once. This differential treatment afforded to bisexual men perpetuates prejudice against bisexuals in the medical community as inherently promiscuous and representing an “infection bridge” between heterosexual women and MSM, rather than an identity deserving of its own

219. PrEP GUIDELINES, *supra* note 8, at 28.

220. *Id.* at 29.

221. *Id.* at 27, 28 n.48.

222. The assumed connection between having any STD and HIV risk is over-inclusive in that simple genital contact (such as mutual masturbation) can result in HPV and herpes transmission but not HIV transmission.

223. *Id.* at 29.

nanced considerations.²²⁴ Further, despite the Obama Administration's acknowledgment that "transgender women have among the highest rates of HIV in the country,"²²⁵ its PrEP guidelines make no mention of transgender people or how the guidelines' gendered categories (such as MSM) should apply to transgender populations.

Third, the guidelines explicitly permit heterosexuals to engage in more unprotected sex than MSM before they are labeled as being at a "substantial risk" of contracting HIV. MSM who have engaged in unprotected sex—insertive or receptive—just once in the past six months are deemed risky, even though the risk of MSM being infected based on an isolated incident of unprotected sex is vanishingly small. The guidelines collapse the distinction between insertive anal sex (relatively low risk—11 infections per 10,000 exposures) and receptive anal sex (relatively high risk—138 per 10,000 exposures), even though other commentary in the guidelines treats this difference as important.²²⁶ While "any" unprotected intercourse between MSM raises a red flag—a zero-tolerance policy for such men—non-MSM are permitted to use condoms inconsistently, so long as their use is not *infrequent*. This key term is—oddly—not defined. What is a healthcare provider to do? If a patient says that she uses condoms half of the time, is that infrequent? One could easily imagine a physician viewing that as frequent enough not to need PrEP.

Fourth, the guidelines effectively treat all MSM sex partners as presumptively HIV positive, while they inquire about HIV status when women have sex with bisexual men or men who use drugs. Unprotected anal sex between men is not risky if both partners are known HIV negative. Yet the guidelines never ask about MSM's HIV status when the issue is sex between men. By contrast, when *women* have sex with MSM, they may have unlimited unprotected sex if they believe their male partners to be HIV negative. If a woman does not know her partner's HIV status but knows him to be at high risk, she can have unprotected sex until her condom usage would be understood as "infrequent" (unlike MSM). The guidelines' permissiveness toward heterosexuals is sweeping. Even "infrequent" use of condoms during sex with multiple partners does not count as substantial risk if a woman believes her partners to be heterosexual. If a woman—let's call her Susan—knows (or more likely thinks she knows²²⁷) her partner's HIV status, she may freely engage in unprotected sex, even though the relationship is not monogamous—a privilege that is not extended to MSM. For example, consider Joe, a MSM who says that he has had unprotected insertive sex just once and reports that he knows his

224. Christine E. Kaestle & Adrienne H. Ivory, *A Forgotten Sexuality: Content Analysis of Bisexuality in the Medical Literature over Two Decades*, 12 J. BISEXUALITY 35 (2012).

225. NATIONAL HIV/AIDS STRATEGY AND THE TRANSGENDER COMMUNITY, https://obamawhitehouse.archives.gov/sites/default/files/docs/nhas_transgender_community.pdf (last visited Feb. 24, 2018).

226. Another part of the guidelines proposes more specific behavioral questions, such as "How many men have you had sex with?" PrEP GUIDELINES, *supra* note 8, at 27 (setting forth "Box A" risk behavior assessment for MSM and a separate assessment for heterosexuals). But this part strangely provides no answers to the set of questions.

227. To the extent that they ask about STDs, most people rely on their partners' representations as to their health status, as opposed to requiring documentation of test results.

partner is HIV negative because he has seen his test results. The policy would deem Joe high risk notwithstanding these protective factors. And there is more: Susan can abandon using condoms entirely with partners even of *unknown* HIV status, so long as she does not *know* that they are at high risk of contracting HIV. (It may be worth reading that sentence twice to let it sink in.) And how do we know whether Susan's partners are risky? They are either MSM or IV drug users. In other words, all non-drug-using, heterosexual-identified men are deemed categorically safe, while bisexual men are labeled as presumptively risky.

When we put all this together, we see that Susan could have had 20 partners in the past six months, never used condoms for either vaginal or anal sex, and never once asked her partners about their HIV status. She might have multiple STDs other than HIV—say, chlamydia, herpes, and gonorrhea. The guidelines can be read to characterize Susan as not risky and suggest that she does not stand to benefit from PrEP, unless Susan happens to know that at least one of her partners is bisexual, an IV drug user, or both.

By contrasting Susan's sexual practices with Joe's, we can see the heavy lifting that the intersection of gender and sexual identity is doing. In Susan's case, some risk is deemed irrelevant to the inquiry, simply because of her gender and perceptions of her partners' sexual orientations. In Joe's case, protective measures, such as obtaining confirmation of his partner's HIV-negative status, are viewed as extraneous simply because Joe identifies as MSM. This highlights the double-edged nature of the guidelines. They simultaneously stigmatize MSM through over-protection (converting relatively low-risk behavior into "substantial risk" when MSM engage in it) and under-protect heterosexuals—especially women who engage in receptive sex, vaginal and anal, which is relatively high risk.²²⁸ While the guidelines do not characterize women like Susan as "risky" or "promiscuous," they leave such women vulnerable to HIV infection by focusing too narrowly on whether they are having sex with MSM or IV drug users.²²⁹

A supplementary document ("PrEP Supplement") in some respects refines this inquiry, but it also conflicts with some aspects of the guidelines and raises as

228. For the CDC's compilation of statistics concerning women and HIV, see *HIV Among Women*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/hiv/group/gender/women/> (last updated Nov. 9, 2015). In recent federal sex surveys, between 30%–40% of heterosexual men and women have reported that they engaged in anal sex at some point in their lifetime. National Survey of Family Growth, *Anal Sex—Males and Females*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/nchs/nsfg/key_statistics/s.htm# analsex (last visited Feb. 24, 2018).

229. Black and Latina women are the most likely to suffer from this under-protection of heterosexuals. Even though black women are no more likely to engage in unprotected sex than white women, the HIV incidence rate for black women was 20 times the rate for white women. The rate for Latinas was four times the rate for white women. *Women and HIV/AIDS in the United States*, KAISER FAMILY FOUND., <http://kff.org/hivaids/fact-sheet/women-and-hivaids-in-the-united-states/> (last visited Feb. 19, 2016); *HIV Among African Americans*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/hiv/group/raciaethnic/africanamericans/index.html> (last updated Feb. 4, 2016).

many questions as it answers.²³⁰ The supplement's treatment of MSM is more nuanced than the guidelines. Most importantly, the supplement contains a "MSM Risk Index," which distinguishes between unprotected insertive and receptive anal sex and assigns risk points based on the number of times that a man engaged in each act during the last six months.²³¹ However, there is considerable conflict between the PrEP Supplement and the actual guidelines, and it is unclear whether most providers would follow the PrEP Supplement instead of the actual guidelines. For example, the PrEP Supplement considers MSM age—which the guidelines never mention. Box B of the guidelines instructs providers to consider whether MSM have had STDs other than HIV—but this factor is missing from the PrEP Supplement.²³² And the PrEP Supplement adds a question for MSM about crystal meth and speed use—which is never asked of MSM or heterosexuals in Box B of the guidelines.²³³ A major problem is that the guidelines and the PrEP Supplement do not adequately cross-reference each other and explain how one is to resolve the several discrepancies between the two documents. Finally, the PrEP Supplement carries forward the double standard that pervades the guidelines in that it offers no risk index for heterosexuals (accounting for factors such as STDs and crystal meth use) or any group other than MSM, which reinforces the fusion of HIV risk and sex between men.²³⁴

Taken together, the guidelines, and the related PrEP Supplement, potentially encourage medical providers to overprescribe PrEP to MSM and underprescribe it to heterosexual and bisexual women. Relying on federal guidelines would also put medical providers out of sync with the Gay and Lesbian Medical Association guidelines for LGBTQ-affirmative care, which caution against making assumptions of risk and medical need based on identity alone.²³⁵

A recent CDC study that estimated the percentages of people in particular populations who would benefit from taking PrEP provides another example of how the government has fostered misperceptions about HIV risk and MSM. The guidelines for prescribing PrEP do not speak to how many people in each identity group should use PrEP. In late 2015, the CDC released a study that estimated

230. See U.S. DEP'T OF HEALTH & HUMAN SERVC'S., CTRS. FOR DISEASE CONTROL, U.S. PUB. HEALTH SERV., PREEXPOSURE PROPHYLAXIS FOR THE PREVENTION OF HIV INFECTION IN THE UNITED STATES—2014 CLINICAL PROVIDERS' SUPPLEMENT (2014), <https://www.cdc.gov/hiv/pdf/preprovidersupplement2014.pdf> [hereinafter PREP SUPPLEMENT].

231. *Id.* at 21.

232. See PREP GUIDELINES, *supra* note 8, at 28.

233. See PREP SUPPLEMENT, *supra* note 230, at 21.

234. See *id.* at 21.

235. GAY & LESBIAN MEDICAL ASS'N, GUIDELINES FOR CARE OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDER PATIENTS 42 (2006), http://www.gлма.org/_data/n_0001/resources/live/Welcoming%20Environment.pdf ("Begin with a statement that taking a sexual history is routine for your practice. Focus on sexual behavior rather than sexual orientation/identity. . . . Some well-informed gay and bisexual men may resent a discussion of HIV risk; for example, assuming a clinician is equating homosexuality with HIV.").

percentages of populations that have “indications” for PrEP.²³⁶ The study uses existing surveys on sexual-risk practices²³⁷ to determine the optimal prevalence of PrEP in particular communities. The study’s ultimate claim is that about one quarter of MSM should be on PrEP, compared with 18.5% of people who inject drugs, and 0.4% of heterosexuals.²³⁸ At first glance, this study suggests that a relatively low number of MSM should be on PrEP. At the same time, the study depicts a vast disparity between MSM and heterosexuals, suggesting that PrEP is relevant to a minuscule sliver of the latter (less than half of 1%). A casual observer might infer from this estimate that differences in risk behavior account for the disparity. However, a close reading of the CDC’s analysis reveals that the authors manipulated risk to magnify differences between MSM and heterosexuals. Specifically, the authors considered whether MSM engaged in any unprotected sex in the *past 12 months*, while they determined whether heterosexuals had engaged in any unprotected sex in the *past four weeks*.²³⁹ In other words, the window for assessing sexual risk for MSM was 12 times larger than the window for heterosexuals. Also, consistent with the guidelines’ approach, the authors used STD rates as a risk factor for MSM, but not for heterosexuals. The study thus reinforces the public impression that HIV is a “gay” disease and that PrEP is primarily for gay and bisexual men, while concealing the double standard it deploys.

This discussion makes visible the discrimination implicit in the government’s special treatment of MSM in public-health law and policy. The government uses different risk thresholds in the contexts of blood, sperm, and PrEP for no apparent reason. For example, it says that monogamous male couples who have tested HIV negative need not be on PrEP, but they cannot donate blood or sperm. The sperm ban considers sex with men during the last five years, while the blood ban focuses only on the last year. As we discuss at greater length below, the government should refrain from using gay and bisexual identity as an inaccurate and stigmatizing proxy for sexual risk and instead ask all people about potential risky behavior.

236. See Smith et al., *supra* note 218.

237. Specifically, the study used National Health and Nutrition Examination Survey (NHANES) data from 2007–2008, 2009–2010, and 2011–2012, and National Survey of Family Growth (NSFG) data from 2011–2013. *Id.*

238. *Id.*

239. *Id.* Both periods (12 months and 4 weeks) differ from the six-month window used in the guidelines. The study used criteria for high risk that depart in several respects from the guidelines, and it failed to fully explain these differences. For example, while the Box B inquiries in the guidelines do not consider numbers of sexual partners, to be deemed risky for purposes of the CDC study, a person had to report having had two or more partners. Also, the study did not consider monogamy for either MSM or heterosexuals. That is, a person who reported just one sexual partner would not be treated as risky even if his partner was not monogamous and they never used condoms. Further, the study’s standard for heterosexuals treated any sex with an HIV-positive partner as risky (unlike the guidelines, which ask simply whether a woman was in an “ongoing sexual relationship” with an HIV-positive man) but did not consider the HIV status of MSM sexual partners. The study treated “[a]ny condomless sex” by MSM as risky so long as they had had two or more partners in the past year. *Id.*

D. Policing Gay Identity

PrEP, also known as Truvada, has unleashed furious debate within the gay community.²⁴⁰ But this analysis is not just about a new drug. Rather, it serves as a window into polarizing topics such as the value of sexual pleasure, monogamy, and what it means to be a gay man today. Although the CDC ultimately suggested that a mere *quarter* of MSM should be on Truvada, gay pundits and bloggers have issued broader calls for *all* or *most* MSM to embrace Truvada. And these arguments often hinge on narrow, stereotypical conceptions of who gay men are and what they do sexually. The headline of a Slate piece bluntly announces: “There Is a Daily Pill That Prevents HIV. Gay Men Should Take It.”²⁴¹ Another piece is entitled “Why All Men Who Sleep With Men Should Take Truvada.”²⁴² Yet another commands, “It’s Time to Take the Fucking Pill.”²⁴³

Such arguments tend to impose a monolithic and masculinist conception of gay male identity and ignore differences in values and experiences of non-gay sexual-minority men. Andrew Sullivan, the aforementioned pundit and blogger, has suggested that most gay men have “lots of sex” with “lots of partners” “because, well, men are men.”²⁴⁴ Moreover, he describes male promiscuity as a biologically driven phenomenon—the natural result of a sexual community that excludes women: “Betting against [gay men’s] testosterone in a sub-population without women is a mug’s game.”²⁴⁵ Since indiscriminate sex is an inherent part of male identity, he claims, taking PrEP is a “complete no-brainer.”²⁴⁶ This construction of

240. See, e.g., Rich Juzwiak, *Truvada: It’s Time to Take the Fucking Pill*, GAWKER (July 30, 2014, 12:53 PM), <http://gawker.com/truvada-its-time-to-take-the-fucking-pill-1612386701> (“[I]f you cannot deal with taking a single pill every day, you need to get a grip and reevaluate your life. After you do that, *then* just take the fucking pill.”).

241. Mark Joseph Stern, *There Is a Daily Pill That Prevents HIV, Gay Men Should Take It*, SLATE (Jan. 6, 2014, 12:00 PM), http://www.slate.com/blogs/outward/2014/01/06/truvada_prep_hiv_gay_men_should_take_pre_exposure_prophylaxis.html. Stern seems to walk back this claim at the end of the piece: “Every gay man with multiple sex partners should take Truvada.” *Id.*

242. Lavi Adler, *Why All Men Who Sleep with Men Should Take Truvada*, PUCKERMOB, <http://www.puckermob.com/relationships/7-reasons-why-all-men-who-sleep-with-men-should-to-take-truvada> (last visited Feb. 19, 2016).

243. Juzwiak, *supra* note 240.

244. Andrew Sullivan, *Why Aren’t Gay Men on the Pill?*, DISH (Apr. 9, 2014, 12:31 PM), <http://dish.andrewsullivan.com/threads/why-arent-gay-men-on-the-pill/>.

245. *Id.*

246. *Id.* Sullivan extended this point in a recent piece in which he opined on the “the sheer and immense natural difference between being a man and being a woman.” *Id.* He seeks to prove his essentialist understanding of gender by citing the gay community:

I live in a sexual and romantic world without women, where no patriarchy could definitionally exist, a subculture with hookups and relationships and marriages and every conceivable form of sexual desire that straight men and women experience as well. And you know what you find? That men behave no differently in sexual matters when there are no women involved at all. In fact, remove women, and you see male sexuality unleashed more fully, as men would naturally express it, if they could get away with it. It’s full of handsiness and groping and objectification and lust and

gay identity might be particularly alienating to men who are just starting to explore their attraction to men and considering whether and how they want to identify publicly with the gay community.

Other proponents of PrEP as a universal prescription for sexual-minority men argue that Truvada is a means of healing the rift between HIV-positive and HIV-negative MSM by blanketing the community with HIV drugs. At least prior to the push to make PrEP widely available, many sexual-minority men preferred to partner with other men with the same HIV-status—i.e., serosorting—for romantic relationships and for casual sex.²⁴⁷ These reasons include a greater sense of intimacy (physical, emotional, and communicative), safety, and similarity when two men share the same HIV status.²⁴⁸ Historically, differences in status and stigma associated with being HIV positive have created a schism in the gay/bisexual community and made conversations about HIV status and partner status preferences a contentious topic. Some men within the gay/bisexual community see PrEP as a means of mending this rift by effectively reducing the potential of transmission by putting all sexual-minority men on Truvada (either as treatment or PrEP), thus leveling the playing field. According to one blogger, “[gay, bisexual, and trans] men of the 1980s fought and died for increased government support and AIDs [sic] education. It’s an affront to their memory and hard work to let HIV flare up again. As a community, we need to come together and push for wide usage of [Truvada]”²⁴⁹ Sullivan similarly asserts: “We have a chance our predecessors long dreamed of: to have great and enjoyable sex lives without this paralyzing fear and this dehumanizing stigma. We owe it to them and to ourselves to do all we can to make this scenario possible.”²⁵⁰

Rich Juzwiak, a blogger for the former Gawker, states that Truvada diminishes the stigma that HIV-positive men experience

aggression and passion and the ruthless pursuit of yet another conquest.

And yes, I mean conquest. That’s what testosterone does.

Andrew Sullivan, *#Me Too and The Taboo Topic of Nature*, N.Y. MAG. (Jan. 19, 2018, 10:59 AM), <http://nymag.com/daily/intelligencer/2018/01/sullivan-metoo-must-choose-between-reality-and-ideology.html>. Sullivan would benefit from reading Marilyn Frye’s incisive critique of masculinist conceptions of gay male identity. See Marilyn Frye, *Lesbian Feminism and the Gay Rights Movement: Another View of Male Supremacy, Another Separatism*, in *THE POLITICS OF REALITY: ESSAYS IN FEMINIST THEORY* 128–51 (1983).

247. See, e.g., David M. Frost et al., *Understanding Why Gay Men Seek HIV-Seroconcordant Partners: Intimacy and Risk Reduction Motivations*, 10 *CULTURE HEALTH & SEXUALITY* 513, 515 (2008) (“Research has long indicated that gay men often hold preferences regarding the HIV serostatus of their sexual and relationship partners.”).

248. See *id.* (discussing “agentic attempts on the part of gay men to reduce HIV transmission risks without adhering to the predominant public health message of universal condom use”); see also *id.* at 516, 519 (stating that some HIV-positive men seek HIV-positive partners to “eliminate the stress and fear associated with the possibility of infecting a HIV-negative partner” and to experience various aspects of intimacy).

249. Adler, *supra* note 242; see also Sullivan, *supra* note 244.

250. Sullivan, *supra* note 244.

by giving negative men a taste of the HIV experience without the HIV. If you are on Truvada, you're medicating yourself (hopefully) every day, like someone with HIV. You're being closely monitored by your doctor with tests every three months to make sure you're negative and that your body is functioning properly, like someone with HIV. The cultural divide between the positive and the negative erodes, as it should. HIV is everyone's issue, but this is especially so for members of groups that are particularly at-risk.²⁵¹

In short, the solution to HIV stigma is to treat all MSM as if they were already HIV positive, prescribing HIV medicine for them and placing them under close and life-long medical surveillance. This approach does not make HIV "everyone's issue;" it makes it *every gay and bisexual man's issue*. In disregarding the divide between MSM and heterosexuals, it would nurture and intensify the perception that HIV is a "gay disease," and all gay and bisexual men are "sick."

Instead of making solemn claims about duty to the "community," some gay PrEP proponents underscore pleasure. These writers position condomless sex as the most "natural" and something that men are biologically attracted to. Juzwiak, the Gawker blogger, writes: "Condomless sex is just better. The best sex I've had, sex that has made me understand gay culture in new ways, has been raw. I generally don't have problems with condoms, but on a sensory level, I'd always rather not be wearing one."²⁵² It's not just that unprotected sex brings one physical pleasure, but it supposedly reveals new dimensions of "gay culture." Mark S. King, echoing Sullivan's claim that testosterone makes gay men engage in rampant sex, claims that unprotected sex is "natural."²⁵³ This blogger makes a heteronormative claim in a piece entitled *Your Mother Liked It Bareback*.²⁵⁴ In essence, he argues, if "bareback" sex was good enough for your mother, it is good enough for you. Indeed, he depicts denying gay men this experience as a cruel affront to Mother Nature.²⁵⁵ Unprotected sex is praised as a "natural and precious act that has been going on, quite literally, since the beginning of mankind."²⁵⁶ King goes on to describe men having unprotected sex, even during the height of the AIDS crisis, as a "life affirming gesture."²⁵⁷

But are STDs also natural? If gay men embraced "barebacking" as natural and normative, they would also have to accept increased rates of STDs other than HIV. Truvada protects against HIV but leaves people vulnerable to many other

251. Juzwiak, *supra* note 240. Gawker shut down in 2016.

252. Rich Juzwiak, *What Is Safe Sex? The Raw and Uncomfortable Truth about Truvada*, GAWKER (Mar. 4, 2014, 10:52 AM), <http://gawker.com/what-is-safe-sex-the-raw-and-uncomfortable-truth-about-1535583252>.

253. Mark S. King, *Your Mother Liked It Bareback*, MY FABULOUS DISEASE (Jan. 28, 2013), <http://marksking.com/my-fabulous-disease/your-mother-liked-it-bareback/>.

254. *Id.*

255. King makes clear that he is not talking about gay men who have unprotected sex in mutually monogamous relationships, which he claims is a "tiny" portion of the community. *Id.*

256. *Id.*

257. *Id.*

STDs, including some that are incurable, such as Hepatitis B. Thus, if we follow King's suggestion to throw out our condoms in favor of Truvada and "life affirming sex," we should expect hepatitis, gonorrhea, syphilis, and chlamydia to be normative among MSM along with a Truvada prescription. The first PrEP study based on a clinical practice sample reported no new HIV infections but a major increase in condomless sex and a 50% spike in STDs other than HIV.²⁵⁸ Further, those advocating for use of PrEP without condoms would be violating the CDC and World Health Organization guidelines that PrEP is a prevention tool meant to be used in conjunction with, not instead of, condoms.²⁵⁹

And then there is the claim that Truvada can eliminate fear. A *New York Magazine* writer asserts that Truvada "has the potential to dramatically alter the sexual behavior—and psychology—of a generation."²⁶⁰ Gabriel, one man profiled in the story,

says it's allowed him to be bolder and more unapologetic in his desires, to have the kind of joyfully promiscuous, liberated sex that men enjoyed with one another in the decade or so after the Stonewall riots brought gay life out from the shadows and before the AIDS crisis shrouded it in new, darker ones.²⁶¹

Damon L. Jacobs, a therapist who advocates PrEP use on Facebook, stated in the article: "I'm not scared of sex for the first time in my life, ever. That's been an adrenaline rush."²⁶² Juzwiak, the Gawker blogger, claims that PrEP allowed him to feel certain about his health status in a singular way: "To understand the extent of the relief that Truvada affords, consider this: For the first time since the dawn of AIDS, a sexually active guy can say, 'I'm negative,' with a great deal of certainty."²⁶³ Juzwiak's claim is puzzling. Both condoms and PrEP are understood to be effective about 90% of the time.²⁶⁴ Neither provides complete certainty, but

258. Jonathan E. Volk et al., *No New HIV Infections with Increasing Use of HIV Pre-Exposure Prophylaxis in a Clinical Practice Setting*, 61 *CLINICAL INFECTIOUS DISEASES* 1601 (2015); Nigel Campbell, *2.5 Years Later, Zero Cases of HIV in Large San Francisco PrEP Group*, *INSTINCT MAG.* (Sept. 2, 2015), <http://instinctmagazine.com/post/25-years-later-zero-cases-hiv-large-san-francisco-prep-group>. The recent disclosure of the first known case of a man who regularly took PrEP but became infected with a drug-resistant strain of HIV has raised questions about the future efficacy of PrEP. Azeen Ghorayshi, *First Case of Someone on Daily PrEP Getting HIV*, *BUZZFEED* (Feb. 25, 2016, 4:16 PM), <http://www.buzzfeed.com/azeenghorayshi/man-on-prep-gets-hiv>.

259. See, e.g., *Questions and Answers on Pre-exposure Prophylaxis for Men who Have Sex with Men*, *WORLD HEALTH ORG.* (Dec. 2, 2014), <http://www.who.int/hiv/pub/guidelines/qa-prep-msm/en/>.

260. Tim Murphy, *Sex Without Fear: The New Pill that Could Revolutionize Gay Life is Reawakening Old Arguments*, *NEW YORK MAG.* (July 13, 2014), <http://nymag.com/news/features/truvada-hiv-2014-7/>.

261. *Id.*

262. *Id.*

263. Juzwiak, *supra* note 240.

264. *HIV Basics: PrEP*, *supra* note 211 ("Studies have shown that PrEP reduces the risk of getting HIV from sex by more than 90% when used consistently.").

both can confer a “great deal of certainty.”²⁶⁵ Each requires responsible conduct—either properly using the condom or taking the Truvada pill consistently. Juzwiak’s argument also seems to rest on some unflattering assumptions about gay men and our ability to trust our partners. According to his argument, a sexually active gay man who is in a committed relationship with a recently tested partner and using condoms cannot rest assured that he is HIV negative. This must be because of the following assumptions: (1) gay men cannot be faithful or cannot be trusted to disclose their HIV status;²⁶⁶ and (2) condoms, unlike PrEP, sometimes fail. Once again, masculinist assumptions about sex between men drive the analysis.

This analysis shows that some prominent gay commentators have embraced the homophobic assumption at the core of the federal guidelines: that gay men are inherently sexually risky. These speakers’ masculinist understanding of sexuality might be summed up as “I do what I want, when I want, with no consequences.”²⁶⁷ But this view does carry consequences for others. Some of these men have claimed that men who resist PrEP are shirking their duty to eliminate HIV transmission and standing as obstacles to expanded sexual opportunities.²⁶⁸ Even as these men rail against stigma, they seek to stigmatize gay and bisexual men who *decline* to take Truvada as PrEP. These speakers would erase the variance among gay and bisexual men in terms of their sexual practices and sexual risk, as well as the fact that using condoms remains an effective risk-reduction strategy for many men. In short, the PrEP discourse reveals nothing less than a battle among MSM over the nature of gay identity. The most vocal proponents of PrEP seek to embed

265. The broader culture’s exaggeration of HIV risk, which is evident not only in federal policies but also in state criminal laws that treat failure to disclose HIV-positive status as a felony even when the sex is protected, *see* Robinson, *supra* note 112, at 1511–13, may explain why some gay men experience an irrational fear of HIV. For example, one qualitative study of gay men’s efforts to manage HIV risk noted that “men in this sample commonly regarded sexual contact with an HIV serodiscordant partner to be inherently risky, regardless of sexual practice or condom use.” Frost et al., *supra* note 247, at 518. The psychology of HIV risk is an important issue for further study, but it need not turn on whether one relies on condoms or PrEP to manage risk.

266. *But see* Robinson, *supra* note 112, at 1524 (“Studies indicate that most positive men feel a moral obligation to tell their primary partners, although some believe that using condoms reduces this obligation.”).

267. We thank Mari Matsuda for offering this apt formulation after reading an earlier draft. “Performance of normative masculinity emphasizes the need for a man to ‘take charge’ and assume positions of power, to use intimidation to ‘get the job done,’ to sacrifice relationships in place of monetary and career success, and to easily separate sex from emotional attachments.” Christopher W. Wheldon & Elizabeth B. Pathak, *Masculinity and Relationship Agreements Among Male Same-Sex Couples*, 47 J. SEX RES. 460, 461 (2009). Wheldon and Pathak’s study of MSM found that “men who expressed high endorsement of normative masculinity were more than twice as likely to be in non-monogamous relationships compared to men with low endorsement.” *Id.* at 464.

268. *See supra* text accompanying note 249–51.

Truvada into gay identity just as condoms were at the height of the AIDS crisis.²⁶⁹ And the federal government has, in important respects, sided with this cohort.²⁷⁰

IV. REJECTING FUSION

This Part argues that if courts widely embraced the core stereotypes of sexual-minority men embedded in federal public-health policies, they would authorize discrimination against such men in many contexts. In fact, in surveying where and how HIV surfaces in various legal contexts beyond public health, we show that defendants have relied on the fusion of gay identity and HIV risk to justify discrimination in contexts including employment, adoption, public accommodations, the military, and prison.²⁷¹

We generally understand the Obama Administration to have been the most LGBTQ-friendly administration in our country's history. In many respects, this is true. Under President Obama's leadership, LGBTQ people achieved rights and recognition that were unimaginable just a few decades before. However, if we dig deeper into the case law on gay identity and HIV status, it becomes clear that in some respects yesterday was not as backwards and the Obama years were not as forward-thinking as the conventional narrative of LGBTQ progress would have us believe. Through its public-health policies, the Obama Administration supported ideas about gay and bisexual men and disease that some courts—even back in the dark ages of LGBTQ rights—dismissed as ridiculous and discriminatory.

In the mid-1980s, at the inception of the AIDS crisis and accompanying moral panic, the federal government installed an across-the-board ban on MSM donating blood. By contrast, courts required to decide whether HIV risk justified restricting the rights of gay and bisexual men reached divergent outcomes. Some courts mimicked the “common sense” view of the FDA: that MSM are inherently high risk.²⁷² Indeed, such courts often cited studies by the CDC and FDA to justify upholding discriminatory policies.²⁷³ But other judges bucked this trend, firmly rebuking the attempt to fuse sex between men, gay identity, and HIV risk.²⁷⁴ This

269. See Frost et al., *supra* note 247, at 515 (noting the “predominant public health message of universal condom use” before PrEP emerged).

270. Although the federal guidelines fuse gay and bisexual identity with PrEP, the government has encouraged condoms *and* PrEP, unlike some prominent gay advocates of PrEP who dismiss condoms.

271. See, e.g., *In re Adoption of Doe*, 2008 WL 5006172, at *1 (Fla. Cir. Ct. Nov. 25, 2008) (adoption); *Leckelt v. Bd. of Comm'rs of Hosp. Dist. No. 1*, 909 F.2d 820 (5th Cir. 1990) (employment); *State v. Limon*, 122 P.3d 22, 24 (Kan. 2005) (criminal law); *Steffan v. Perry*, 41 F.3d 677 (D.C. Cir. 1994) (military); *cf. Henderson v. Thomas*, 913 F. Supp. 2d 1267, 1294, 1296, 1307 (M.D. Ala. 2012) (ruling unconstitutional the automatic segregation of HIV-positive prisoners, requiring individualized assessments as to whether any particular prisoner was likely to transmit the virus, and noting that transmission among female inmates was exceedingly unlikely).

272. See, e.g., *Steffan v. Cheney*, 780 F. Supp. 1, 2 (D.D.C. 1991) (citing HIV risk to justify excluding gays from the military), *rev'd*, *Steffan v. Aspin*, 8 F.3d 57, 59 (D.C. Cir. 1993).

273. See, e.g., *id.*

274. *Perry*, 41 F.3d at 721 (Wald, J., dissenting).

defiance of mainstream sentiment is particularly laudable because many of these courts rendered their decisions years before the U.S. Supreme Court began to protect the rights of LGBTQ people in *Romer v. Evans*.²⁷⁵ Around the year 2000, courts became more vigilant about questioning popular conceptions of HIV risk.²⁷⁶ In recent years, most courts that have addressed this issue have sought to decouple HIV risk and gay identity.

We can observe the early cases' tortured efforts to understand the relationship between gay identity and HIV simply by tracing judicial opinions arising from one challenge to the military's ban on homosexuality. Shortly before graduation from the U.S. Naval Academy, Joseph Steffan resigned his position as a midshipman.²⁷⁷ Steffan had earlier disclosed his homosexuality to a few peers, who then reported it to the authorities. The Academy thus determined that Steffan possessed "insufficient aptitude to become a commissioned officer in the naval service," notwithstanding an exemplary record.²⁷⁸ Steffan ultimately sued to challenge the constitutionality of the military's ban on homosexuality. The resulting 1991 opinion, *Steffan v. Cheney*, is a classic fusion opinion. Even though the government did not rely on HIV risk to justify its ban, the district court reached out to take judicial notice that "far and away the highest risk category for those who are HIV positive, a population who will with a high degree of medical certainty one day contract AIDS, is homosexual men."²⁷⁹ Citing a CDC report on HIV prevalence among MSM, the court opined:

Given that at least 59% of all those who have contracted HIV have done so due to homosexual or bisexual activity, surely it does not require extended discussion . . . to show that the exclusion of homosexuals from the Armed Forces constitutes a reasonable step towards the protection of those forces' health.²⁸⁰

Although the court conceded that "there is no evidence in this case about the plaintiff having had sex with anybody, male or female," Steffan's actual behavior was beside the point. "The fact remains," the court concluded, "that 59% is a much larger risk category for men who engage in homosexual activity than the 10% or so of all persons, male or female, who have the HIV from heterosexual activity."²⁸¹ Here, the court apparently misread the CDC report. While the CDC stated that 59% of people with HIV are MSM, the court seemed to think that 59%

275. *Romer v. Evans*, 517 U.S. 620 (1996).

276. *Limon*, 122 P.3d at 37.

277. *Cheney*, 780 F. Supp. at 2, *rev'd*, *Aspin*, 8 F.3d at 59.

278. *Id.* at 3; *Aspin*, 8 F.3d at 59 (describing Steffan as "one of the ten highest ranking midshipmen at the Academy" and noting that he had "direct command over one-sixth of the Academy's 4,500 midshipmen").

279. *Cheney*, 780 F. Supp. at 13 (quoting CDC Report at 9–11) (emphasis added).

280. *Id.* at 16.

281. *Id.* at 16 n.28 (quoting CDC Report at 9 tbl.4, 11 tbl.6).

of MSM have HIV. The actual prevalence of “the HIV” among MSM is much lower—less than 10%, according to recent CDC reports.²⁸²

On appeal, the D.C. Circuit’s decidedly liberal panel held that the military regulation lacked a rational basis and was unconstitutional on its face.²⁸³ Relying on First Amendment precedent, the court drew a distinction between thoughts/desire/sexual orientation and sexual conduct, holding that the government could prohibit only the latter.²⁸⁴ As the court explained:

Homosexual *orientation* cannot spread the AIDS virus. Homosexual, or heterosexual, *conduct* can—and then only if one of the participants carries the virus. Even if AIDS happens to be more prevalent today among homosexuals than among heterosexuals, justifying the Directives on this basis requires the illegitimate assumption that persons of homosexual orientation will break the rules by engaging in homosexual conduct as members of the armed forces.²⁸⁵

While the district court saw homosexual orientation as ineluctably leading gay men into risky sexual practices,²⁸⁶ the D.C. Circuit panel recognized a gay person’s agency to decide whether to engage in sexual behavior (and presumably to use condoms to prevent the spread of disease if they did decide to have sex).

But the D.C. Circuit reviewed the case en banc and reversed the panel decision. The majority held that the government could reasonably assume that a gay man who declares himself homosexual is likely ultimately to engage in prohibited sex.²⁸⁷ A dissent by Judge Wald, who had been on the original panel that struck down the policy, accused the majority of relying on a “stereotypical assessment” that gay service members “must be presumed incapable of controlling their sexual

282. See Xu et al., *supra* note 81. The court thus committed the “fallacy of the transposed conditional,” which means mistaking one “conditional probability” for another. Andrea Roth, *Safety in Numbers? Deciding When DNA Alone Is Enough to Convict*, 85 N.Y.U. L. REV. 1130, 1150–52 (2010) (documenting this error in criminal cases that turn on DNA evidence). The court went on to suggest that gay men inherently undermine morality and discipline. See *Cheney*, 780 F. Supp. at 12 (“[A]llowing admitted homosexuals to serve alongside heterosexual members and officers in the Armed Forces would jeopardize morale, discipline and the system of rank and command. Under the deferential standard of rational basis review, we cannot say that these are not in fact legitimate interests, or that the regulations in question do not promote them.”). It also treated all legislation addressing HIV as evidence of gay men’s political power—as if HIV/AIDS concerns only gay men. *Id.* at 9.

283. *Aspin*, 8 F.3d at 59, *rev’d*, *Steffan v. Perry*, 41 F.3d 677 (D.C. Cir. 1994).

284. *Id.* at 65–67.

285. *Id.* at 69.

286. *Cheney*, 780 F. Supp. at 12 (“[I]t has not been shown in this case that lifelong, or even career-long celibacy among those with a homosexual orientation is the rule rather than the exception.”). The court accorded no significance to gay men who depart from the norm, quite unlike the rule in the gender jurisprudence, which explicitly protects the exceptional woman or man. See *supra* text accompanying notes 103, 104.

287. *Perry*, 41 F.3d at 685–86, 688. At the time, *Bowers v. Hardwick* established that government could criminalize homosexual sodomy, and *Steffan* did not challenge *Bowers*. Echoing the district court’s conclusion, the D.C. Circuit deemed irrelevant the possibility of a so-called celibate homosexual. *Perry*, 41 F.3d. at 686, 689 n.10.

‘desires’ in conformity with the law.”²⁸⁸ She also argued that the district court’s invocation of HIV risk “relies on the illegitimate assumption that homosexual servicemembers will break the rules and engage in prohibited homosexual conduct that may spread the disease, but heterosexuals—to whom sexual conduct is not forbidden—will not pose any such danger.”²⁸⁹ While the district court saw HIV as implicating only gay servicemembers, Judge Wald made clear the military’s tolerance of risky heterosexual behavior. This argument tracks our critique of the PrEP guidelines.

A contemporaneous and more complex case, *Leckelt v. Board of Commissioners of Hospital District Number 1*, involved HIV suspicion based not only on a gay man’s orientation but also his sexual conduct. Hospital administrators demanded that a male nurse reveal his HIV status because he was “known to be homosexual and . . . the roommate of a [hospital] patient believed to have AIDS.”²⁹⁰ After demanding an HIV test, hospital administrators learned that Leckelt had Hepatitis B and a history of syphilis.²⁹¹ The hospital argued that it needed to know Leckelt’s HIV status “to comply with the CDC guidelines.”²⁹² Leckelt had taken an HIV test in another city before the hospital’s demand, but after consulting with a lawyer, he declined to obtain the results or share them with his employer for fear that the hospital would fire him if he were HIV positive.²⁹³ The Fifth Circuit rejected Leckelt’s claim under § 504 of the Rehabilitation Act of 1973²⁹⁴: “It is undisputed, and indeed virtually common knowledge, that homosexuals are a high risk group for contracting HIV and AIDS.”²⁹⁵ Yet the court also relied on its understanding that Leckelt was involved in an eight-year romantic relationship with his roommate, who later died of AIDS, and that Leckelt had a history of syphilis, Hepatitis B, and another condition consistent with HIV infection.²⁹⁶ The court conflated Leckelt’s reputation as a gay man with the other, more-specific evidence of sexual risk in

288. *Id.* at 712 (Wald, J., dissenting).

289. *Id.* at 720.

290. *Leckelt v. Bd. of Comm’rs of Hosp. Dist. No. 1*, 909 F.2d 820, 822 (5th Cir. 1990).

291. *Id.* at 823.

292. *Id.* at 822. The CDC guidelines addressed only the question of how to treat healthcare workers who were exposed to HIV on the job, and they recommended accommodating HIV-positive employees, not firing them. However, the Fifth Circuit effectively broadened this guidance in applying it to HIV risk that occurred outside of work, including the presumed sexual relationship between Leckelt and his roommate. *Id.* at 828–29 nn.15–17; *id.* at 830 (“[T]here is no logical reason that this guideline should be restricted to HIV exposure in the hospital setting.”).

293. *Id.* at 823–24.

294. 29 U.S.C. § 794 (2012). The court assumed that Leckelt had a “handicap” under the Act (being HIV positive) and that his employer treated him differently on the basis of that handicap. *Leckelt*, 909 F.2d at 824–25.

295. *Id.* at 823–24, 826.

296. *Id.* at 833 (“Leckelt was treated in 1984 for lymphadenopathy, a condition that is symptomatic of recent HIV infection and that his treating physician advised him might be related to AIDS.”). It appears that Leckelt did not deny in court that he had a sexual relationship with his roommate.

deciding whether the hospital's demand for an HIV test was justified, and considered him categorically different from a female nurse who was exposed to HIV through a needle stick.²⁹⁷ A proper analysis would distinguish Leckelt's behavior from his identity as a gay man and rely only on evidence of behavior: particularly a long-standing sexual relationship with an HIV-positive man.

More consistent with our approach is a recent wave of cases in which courts rejected arguments that sought to fuse sex between men, gay identity, and HIV. As such, this body of law calls into question the reasoning undergirding federal public-health policies. This brief discussion highlights two notable examples. *State v. Limon*, a 2003 case, involved consensual oral sex between two students at a school for developmentally disabled children. Limon, who had recently turned 18, performed consensual oral sex on a boy who was almost 15.²⁹⁸ The state charged Limon with criminal sodomy. Because the incident did not involve people of the "opposite sex," Kansas law deemed Limon ineligible for a "Romeo and Juliet" exception, which treats sex between people who are close in age more leniently than sex between an older adult and a minor.²⁹⁹ Consequently, the court sentenced Limon to roughly 17 years in prison, whereas if Limon had had sex with a young woman, the court would have sentenced him to little more than a year.³⁰⁰ On appeal, Limon argued that the sentence violated substantive due process and equal protection. One day after the Supreme Court struck down a sodomy law in *Lawrence v. Texas*, it granted Limon's petition, vacated the judgment, and remanded the case to the Kansas Court of Appeals for further consideration in light of *Lawrence*.³⁰¹ The divided Kansas appellate court distinguished *Lawrence* and denied Limon relief.³⁰²

297. See, e.g., *id.* at 827 (stating that "Leckelt, unlike [a female RN who was exposed to HIV through a needle stick], was known to be a homosexual," but then going on to rely on several distinctions between Leckelt's conduct and that of the female RN); *id.* at 833 ("Under all the circumstances respecting Leckelt, including his apparent homosexuality, medical condition, and long-term relationship with a man who was hospitalized with and ultimately died from AIDS-related complications, Smith was justified in demanding the results of Leckelt's HIV antibody test."). The court also elided the question whether the evidence of medical conditions associated with HIV predated and motivated the hospital's requirement that Leckelt turn over his test results. A similar case involved a gay man who attempted suicide and was denied access to the psychiatric ward until the hospital obtained the results of an HIV test. *Doe v. D.C. Comm'n on Human Rights*, 624 A.2d 440, 442 (D.C. App. 1993). The hospital took into account the man's "hepatitis, gonorrhea and syphilis, homosexual history . . . and a negative HIV antibody test result two years prior to his hospital admission." *Id.* Without distinguishing among these various factors, the court ruled: "We hold that the Commission could reasonably conclude that the Hospital considered petitioner's sexual orientation merely as a medical risk factor, not as a discriminatory basis for the actions taken with respect to him . . ." *Id.* at 445-46 (citing CDC guidelines). *But cf. id.* at 448 (Ferren, J., concurring) ("I want to emphasize that nothing in the majority opinion should be understood to support an argument that sexual orientation, without a medical history of sexually transmitted diseases, can serve as a proper basis for any discriminatory treatment.").

298. *State v. Limon*, 122 P.3d 22, 24 (Kan. 2005).

299. *Id.*

300. *Id.* at 25.

301. *Limon v. Kansas*, 539 U.S. 955 (2003).

302. *State v. Limon*, 83 P.3d 229 (Kan. App. 2004).

Judge Green, writing for the majority, concluded that the harsher punishment of same-sex conduct was justified by the need to prevent STDs because “certain health risks are more generally associated with homosexual activity than with heterosexual activity.”³⁰³

The Kansas Supreme Court rejected this attempt to portray sex between men as uniformly riskier than heterosexual sexual conduct. It explained:

There is a near-zero chance of acquiring the HIV infection through the conduct which gave rise to this case, oral sex between males, or through cunnilingus. And, although the statute grants a lesser penalty for heterosexual anal sex, the risk of HIV transmission during anal sex with an infected partner is the same for heterosexuals and homosexuals.³⁰⁴

Thus, the court indicated that if lawmakers are to rely on public health, they must hone in on the specific risks posed by particular sexual acts instead of depicting certain sexual identities as inherently dangerous. The statute failed equal-protection review because it “burdens a wider range of individuals than necessary for public health purposes. Simultaneously, the provision is under-inclusive because it lowers the penalty for heterosexuals engaging in high-risk activities.”³⁰⁵ In the absence of a plausible public-health justification, the court concluded that the law was “inexplicable by anything but animus”³⁰⁶

While courts have become more skeptical about the link between HIV, sex between men, and gay identity, some have imagined the airbrushed version of gay identity familiar from the marriage-equality cases. Consider *In re Adoption of Doe*,³⁰⁷ which involved a gay man who served as a foster parent to two young boys and sought to adopt them despite Florida’s ban on such adoptions. Florida argued that its ban was based on research showing that gay and lesbian parents are susceptible to various mental- and physical-health disparities, including HIV.³⁰⁸ The court was not persuaded: “As a general premise, elevated occurrences of psychiatric disorders and rates of depression and suicidality are associated with demographic characteristics, such as race, gender, age, socioeconomic status and sexual

303. *Limon*, 122 P.3d at 26–27, 30 (quoting opinion of Judge Green).

304. *Id.* at 37. The court relied on an “*amici curiae* brief of a number of public health organizations which provided scientific and statistical information.” *Id.*

305. *Id.*

306. *Id.* (quoting *Romer v. Evans*, 517 U.S. 620, 632 (1996)).

307. 2008 WL 5006172 (Fla. Cir. Ct. Nov. 25, 2008).

308. *Id.* at *27. The state relied on, among other things, testimony by Dr. George Rekers, a clinical psychiatrist, who claimed that

Petitioner is in a high risk group; the majority of individuals sharing Petitioner’s demographic characteristic of homosexuality suffer from a disorder or have the propensity to suffer from a disorder; therefore, even if Petitioner is studied to determine his individual risk factor, the prediction for his propensity to succumb to a lifetime prevalence of risk cannot be overcome.

Id. at *11 (emphasis added).

orientation.”³⁰⁹ The court warned of the slippery slope courts would confront if they began discounting the right to adopt based on studies showing that certain parents are more likely to divorce or to deal with particular health problems. This reasoning is sound and reminds us of the Obama Administration’s (unexplained) decision to use MSM identity but *not* black or Latino/a identity as a proxy for HIV risk in blood donation, despite studies showing elevated rates in racial minority communities.³¹⁰ However, the court went on to gloss a substantial body of literature demonstrating that “minority stress” sometimes leads to greater health problems in sexual minority communities³¹¹: “The research shows that sexual orientation alone is not a proxy for psychiatric disorders, mental health conditions, substance abuse or smoking; members of every demographic group suffer from these conditions at rates not significantly higher than for homosexuals.”³¹² Later in the opinion, the court similarly dismissed the impact of HIV. It distorted CDC statistics to suggest that HIV is mostly an issue for heterosexuals.³¹³ In short, the court implied, LGBTQ people are just like heterosexuals, despite ample research showing that discrimination leaves a mark on sexual minorities. Rather than acknowledge HIV and other health disparities and seek to understand how discrimination fuels them, the court chose to deny that disparities exist.³¹⁴ In so doing, the court minimized ongoing homophobia, even as it reached a correct result.

We sum up our discussion of HIV with some concrete policy recommendations. Ultimately, the government should focus on actual behavioral risk associated with unprotected sexual acts rather than imputing risk from identity categories alone. MSM should be understood as a lowest common denominator that confers little meaningful information. Healthcare providers must go beyond sorting people into MSM or non-MSM camps and shift focus to more probative questions

309. *Id.* at *7, *20. For example, the court cited studies showing that over a ten-year span, blacks are 47% likely to divorce and interracial couples 41% likely to divorce, whereas the likelihood for whites is 32%. *Id.* at *7. Couples without a religious affiliation are 46% likely to divorce compared to 32% of couples with some religious affiliation. *Id.* at *7 n.7.

310. *See id.* at *13 (“[F]or African American women, the risk [of HIV] is 50 to 60 percent more than that of white women.”).

311. *See, e.g.,* Ilan H. Meyer, *Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence*, 129 PSYCHOL. BULL. 674 (2003) (providing meta-analyses of studies); Frost & Meyer, *supra* note 20.

312. *In re Adoption of Doe*, 2008 WL 5006172, at *7.

313. *Id.* at *13 (relying on expert testimony to find that “the majority of cases of HIV are transmitted by heterosexual transmission,” but also inexplicably characterizing half of transmissions as occurring “among homosexual men”); *see also id.* (“Overall, women generally contract HIV heterosexually.”). The court failed to acknowledge that even if most transmissions occurred among heterosexuals, HIV prevalence among MSM would still be very disproportionate given the small size of the MSM community (around 5%–8%, depending on the study).

314. *Id.* at *28 (“[H]omosexuals are no more susceptible to mental health or psychological disorders, substance or alcohol abuse or relationship instability than their heterosexual counterparts. Accordingly, such governmental interest does not justify the legislation.”).

that distinguish low-risk from high-risk sexual behavior. This does not mean that identity and culture should always be irrelevant. Particular sub-identities within gay or straight culture might be relevant to one's sexual risk. But these sub-identities should come into play when the patient associates with a particular cultural construct that correlates with sexual risk. For example, imagine that a patient tells his doctor that he had unprotected sex at a "circuit party," a multi-day dance party for gay men that typically involves uninhibited sex and drug use. The doctor should know that there is a public-health literature linking circuit parties to high-risk sex.³¹⁵ Accordingly, the doctor should ask the patient follow-up questions and might reasonably recommend PrEP. In this way, healthcare would be identity-sensitive, but not identity-free. And that sensitivity must entail paying close attention to differences within any "community," distinguishing the circuit-party regular from a man who does not mix drugs and sex and consistently uses condoms.

Additionally, guidelines should focus on behavioral risk for heterosexual men and women. Healthcare providers should be vigilant for heterosexual cultural spaces and norms that correlate with high risk, such as a married woman's reluctance to ask her husband to use a condom even if she suspects that he is sleeping with other people.³¹⁶ Additionally, research has found that rates of anal sex among heterosexuals range from one quarter to one third of the population and condom use in heterosexual anal sex is even lower than for vaginal sex.³¹⁷ That said, we acknowledge that attending to interactions between culture and behavior will not always be easy. For instance, a doctor should more carefully consider recommending PrEP if her patient identifies as a "bottom" and reports unprotected sex, because receptive anal sex carries the greatest risk. By adopting the label of *bottom*, the patient suggests that practicing receptive anal sex is the norm for him and perhaps an important part of his identity. Some literature indicates that bottoms may struggle to reconcile their investment in a script of sexual submission to their top with the agency required to insist that the top use a condom.³¹⁸ At the same time, a counter narrative expressed by some bottoms describes the bottom as a gatekeeper to the top's pleasure; as such, the bottom can use this leverage to insist on a condom or divert sexual activity away from anal sex.³¹⁹ Given these competing definitions of bottom identity, a healthcare provider would be well advised to ask questions

315. See, e.g., Amin Ghaziani & Thomas D. Cook, *Reducing HIV Infections at Circuit Parties: From Description to Explanation and Principles of Intervention Design*, 4 J. INT'L ASS'N AIDS CARE 2 (2005).

316. See, e.g., Hortensia Amaro, *Love, Sex, and Power: Considering Women's Realities in HIV Prevention*, 50 AM. PSYCHOLOGIST 437 (1995).

317. K.R. McBride & J.D. Fortenberry, *Heterosexual Anal Sexuality and Anal Sex Behaviors: A Review*, 47 J. SEX RES. 123, 125–26 (2010).

318. Hoppe, *supra* note 139, at 199 (reporting, based on qualitative interviews with bottom-identified men, that many claimed that their sexual pleasure "originates in their top-identified partners and is only experienced by bottoms when they perceive their partners' pleasure"); *id.* at 204, 212 (describing an extreme version of this concept in which the top "uses" the bottom as a "cumdump" because "only the top's pleasure . . . matters").

319. *Id.* at 211.

about how her patient understands the role of bottom instead of assuming that there is only one way to be a bottom.

This approach would caution against making assumptions about behavior based on identity and instead encourage healthcare providers to consider the patient's intersecting sexual identities and behavioral histories and intentions in making sexual healthcare decisions. LGBTQ-affirming guidelines by the Gay and Lesbian Medical Association provide a helpful starting point.³²⁰ The key is that when culture enters the conversation, the patient initiates it and the healthcare provider does as much listening as instructing. This listening may help the provider be more informed and respectful when engaging future sexual-minority patients. The government would likely need to work with and learn from medical schools and healthcare associations, helping healthcare providers to become more comfortable talking about sex in general, consider potential interactions between sex and minority stress, and avoid shaming any patient about risky behavior.³²¹ With respect to blood and sperm donation, the questions that government should require should similarly focus on behavior, including the following³²²: (1) whether and when the person has obtained an HIV test; (2) whether he knows the HIV status of his sexual partners; (3) the extent to which he used condoms when engaging in anal or vaginal sex; and (4) the number of unprotected anal sex partners. This more precise focus, as applied to MSM, would hone in on unprotected anal sex instead of conflating it with protected anal sex and oral sex, as federal policy has often done.

V. LOOKING FOR SELF-DEFINITION

This Part illustrates common ground among gay men, bisexual men, other MSM, transgender women, and cisgender women. Although there are important differences between and within such groups, they share an interest in asserting a right of self-definition against governmental and cultural efforts to stereotype their gender identities. More specifically, our juxtaposition of the HIV context with the current controversy over protecting transgender people's right to use restrooms that

320. See generally GAY & LESBIAN MEDICAL ASS'N, *supra* note 235.

321. One concern with the public-health community's reliance on PrEP is that it seems to treat HIV risk as a purely medical issue that can be solved by blanketing the community with pills. Indeed, some are exploring proposals to make PrEP available to patients without even the patient having to see a healthcare provider. See, e.g., Matthew E. Levy, *Acceptability of a Smartphone Application Intervention to Improve Access to HIV Prevention and Care Services for Black Men who Have Sex with Men in the District of Columbia*, 7 DIGITAL CULTURE & EDUC. 169 (2015). This approach strikes us as a major lost opportunity in that it does not engage the full person or address how one's psychology and social context, including problems with alcohol or drugs, may produce vulnerability and influences one's ability to adhere to PrEP. We encourage public-health researchers to think beyond mere sexual acts and see the whole-person context, which may help explain risky behavior. See Frost et al., *supra* note 247, at 525 ("If HIV risk and prevention campaigns and programmes targeted at gay men favour a limited focus on sexual risk reduction and fail to incorporate a larger understanding of how men conduct and negotiate their sexual and romantic lives, then their relevance and efficacy will be compromised.").

322. Given that this screening is not typically done in the context of a regular doctor-patient relationship and is less likely to involve an open-ended dialogue, the questions should more narrowly focus on behavior.

match their self-defined gender reveals that government tends to use stereotypes of a group's—in this case transwomen's—sexuality as a tool of gender-based subordination. Thus, to achieve liberation from structural oppression, stigmatized groups must contest and reconstruct misrepresentations of their sexual practices. We manifest this common ground in the discussion below.

First, in both the HIV and bathroom contexts, we see the majority projecting sexual deviance onto a stigmatized minority—promiscuity in the case of gay and bisexual men, and sexual predation in the case of transgender people. Second, we see a related denial of the right to self-define one's gender and sexuality. Instead of reflecting the diverse, and at times competing, understandings of sexuality and gender in gay, bisexual, MSM, transgender, and female communities, we see governmental efforts to construct a prototype for each group: gay, bisexual, and other MSM as sexually voracious, sick, and less masculine than heterosexual men; ciswomen as utterly feminine, i.e., intrinsically vulnerable and in need of governmental protection from bisexual men (in the HIV context) and transgender people (in the bathroom context); transgender women as essentially male and sexually predatory; and people who most directly question the gender binary (including bisexual and transgender people) as the most dangerous and disruptive.

A. Masculinity and Self-Definition

In the HIV context, the stereotyping of gay, bisexual, and other sexual-minority men lies at the core of “hegemonic masculinity.”³²³ This pervasive gender tenet posits that “real men” are only those who perfectly embody masculine traits and eschew feminine traits.³²⁴ And sex between men is understood as the ultimate relinquishment of masculinity.³²⁵ Consider, for example, Stephen Colbert's decision to conclude a diatribe against President Donald Trump with the claim that “[t]he only thing your mouth is good for is being Vladimir Putin's cock holster.”³²⁶ Providing oral sex to Putin, in Colbert's view, would eviscerate Trump's masculinity. Gay, bisexual, and other sexual-minority men have a common interest

323. *Hegemonic masculinity* describes “the most legitimate and respected conception of masculinity in a given culture.” Robb Willer et al., *Overdoing Gender: A Test of the Masculine Overcompensation Thesis*, 118 AM. J. SOC. 980, 982 (2013); *id.* at 983 (describing core traits of masculinity as “competitiveness, assertiveness, physical strength, aggression, risk-taking, courage, heterosexuality, and lack of feminine traits”).

324. *See, e.g.*, Robinson, *supra* note 110, at 1331 (“Masculinity is a complex set of social regulations that determine what ‘real men’ can and cannot do. Although masculinity often is a site of privilege, it simultaneously serves as a system of constraint.”).

325. Two prominent Court of Appeals decisions have recently made this claim in holding that sexual orientation discrimination is sex discrimination under Title VII. *See Zarda v. Altitude Express, Inc.*, 2018 WL 1040820, at *11 (2d Cir. 2018); *Hively v. Ivy Tech Cmty. Coll.*, 853 F.3d 339, 342 (7th Cir. 2017). They stated that men who date men are perceived as diverging from the gender stereotype that real men desire only women.

326. Tim Kenneally, *Read Stephen Colbert's Complete Comments on Trump 'Cock Holster' Joke*, WRAP (May 8, 2017, 7:59 AM), <http://www.thewrap.com/read-stephen-colberts-complete-comments-trump-cock-holster-joke/>. Criticism of Colbert's comment as homophobic was rather muted, which may reflect not only liberals' outrage at Trump but also the “common sense” logic that sex between men constitutes emasculation. *Id.*

in disrupting the ostensible relationship between sex between men and masculinity. Men should not have to choose between honoring their sexual interest in men and affirming their self-identities as men. Bisexual men have an additional challenge in that many people perceive one experience of sex between men as marking a man as essentially gay—e.g., the “one drop” rule of the original blood ban. This view denies that bisexuality is a real, stable, and healthy identity; and claims that bisexual identity is simply a sham that some gay men use to hide their true gay selves. Moreover, in this view, bisexual men’s involvement with women poses special risks to “innocent” women.³²⁷

Public aversion to sex between men rests on a cramped understanding of gender. For most of its history, mainstream psychology has perpetuated the view of homosexuality as pathological gender “inversion.”³²⁸ Even today, over 40 years after the discipline repudiated the notion that homosexuality is pathological, prominent scholars continue to promote the notion that gay men are like women and lesbians are like men, embedding popular (mis)conceptions of sexual minorities in “objective” science.³²⁹

Heterosexual men and women tend to endorse such stereotypes, but heterosexual men hold more negative attitudes toward gay men than heterosexual women do.³³⁰ Indeed, many heterosexual-identified men understand gay and

327. See COHEN, *supra* note 112, at 313 (discussing media’s sorting of HIV cases into “deserving” victims, such as women and children, and “undeserving” victims, including gay men).

328. Aaron J. Blashill & Kimberly K. Powlishta, *Gay Stereotypes: The Use of Sexual Orientation as a Cue for Gender-Related Attributes*, 61 *SEX ROLES* 783, 784 (2009) (discussing Freud’s “gender inversion theory”); Phillip L. Hammack et al., *Narrative, Psychology, and the Politics of Sexual Identity in the United States: from ‘Sickness’ to ‘Species’ to ‘Subject,’* 4 *PSYCHOL. & SEXUALITY* 219, 221–23 (2013).

329. See generally Amy M. Rees-Turyn et al., *Sexism and Sexual Prejudice (Homophobia): The Impact of the Gender Belief System and Inversion Theory on Sexual Orientation Research and Attitudes Toward Sexual Minorities*, 2 *J. LGBT ISSUES COUNSELING* 2 (2008); Ritch Savin-Williams et al., *Depressive Symptoms Among Same-Sex Oriented Young Men: Importance of Reference Group*, 39 *ARCHIVES SEXUAL BEHAV.* 1213, 1215 (2010); Robinson, *supra* note 110, at 1339–40 (critiquing psychology scholarship by Nalini Ambady and Kerry L. Johnson).

330. Blashill & Powlishta, *supra* note 328, at 786; Juan Manuel Falomir-Pichastor & Gabriel Mugny, “*I’m not gay . . . I’m a real man!*”: *Heterosexual Men’s Gender Self-Esteem and Sexual Prejudice*, 35 *PERSONALITY & SOC. PSYCHOL. BULL.* 1233, 1234, 1241 (2009). Public attitudes toward gays and lesbians differ in some respects. For example, people appear more likely to perceive a same-sex male relationship as purely sexual and lacking in intimacy and commitment than a same-sex female relationship. See Long Doan et al., *The Power of Love: The Role of Emotional Attributions and Standards in Heterosexuals’ Attitudes Toward Gay and Lesbian Couples*, 94 *SOC. FORCES* 401, 412–13 (2015) (finding significant differences in how heterosexual subjects evaluated vignettes that were identical but for the sex of the partners; they perceived the gay couple as less loving than the heterosexual and the lesbian couple).

bisexual men's very existence as uniquely threatening to their identities.³³¹ A considerable body of psychological research demonstrates that effeminate men are perceived as gay, and men who identify as gay are assumed to be effeminate.³³² One study asked college students to describe the traits of gay men, lesbians, heterosexual men, and heterosexual women. The study found that gay men were considered to be just as low in masculinity as heterosexual women and to be more feminine than lesbians.³³³ In another recent study, subjects watched video of two "relatively gender-typical white men" playing a game.³³⁴ Both were gay, and pre-testing in which their sexual orientation was not revealed showed that one was regarded as "very masculine" while the other was deemed to be of "average masculinity."³³⁵ In some study conditions, one man was identified as gay, while in other conditions he was described only as adopted. Male and female subjects rated both men less masculine and more feminine when he was identified as gay—but not when he was labeled as adopted.³³⁶ This effect was most pronounced with respect to the more masculine of the two gay men.³³⁷ When the very masculine man was identified as gay, but the average masculine man was not identified as gay, subjects rated the former more feminine than the latter.³³⁸ The authors concluded that "the stereotype of gay men as less masculine and more feminine than other men appears to have remained steadfast for the past three decades . . ."³³⁹ It appears that the success of the marriage-equality movement did little to dislodge the idea that engaging in sex with a man feminizes a man's gender identity.

Because of the widespread belief that gay men are the antithesis of "real men,"³⁴⁰ and the reality that a man can never definitely prove that he is not a closeted gay man,³⁴¹ heterosexual-identified men have strong incentives to distance

331. Such men are likely to erase or trivialize lesbians, queer women, and bisexual women, treating their sexuality as a fetish for men's pleasure instead of a real and stable identity.

332. See, e.g., Blashill & Powlishta, *supra* note 328, at 788–89; Theodore Weissbach & Gary Zagon, *The Effect of Deviant Group Membership upon Impressions of Personality*, 95 J. SOC. PSYCHOL. 263, 264–65 (1975).

333. Blashill & Powlishta, *supra* note 328, at 788–89.

334. See Robert W. Mitchell & Alan L. Ellis, *In the Eye of the Beholder: Knowledge that a Man Is Gay Promotes American College Students' Attributions of Cross-Gender Characteristics*, 15 SEXUALITY & CULTURE 81 (2011).

335. See *id.* at 84.

336. See *id.* at 89–90.

337. See *id.* at 89–90, 92.

338. See *id.* at 90, 92.

339. *Id.* at 91. At least one study suggests that, at least in certain contexts, traditionally masculine gay men may not trigger masculinity threat in heterosexual-identified men. See Peter Glick et al., *Defensive Reactions to Masculinity Threat: More Negative Affect Toward Effeminate (But Not Masculine) Gay Men*, 57 SEX ROLES 55, 57 (2007) (finding that heterosexual men who were told that a personality test revealed them to have a "feminine" score expressed greater fear, hostility, and discomfort toward an effeminate gay man, but not a traditionally masculine gay man).

340. See *id.*

341. Robinson, *supra* note 110, at 1333–34.

themselves from gay men and any traits that are perceived as feminine.³⁴² Studies show that simple interactions with gay-identified men or exposure to gay sex may provoke anxiety and aggression in many, but not all, straight men. For example, one study found that requiring a straight man to watch a brief video clip of men having sex before he interacted with a gay peer increased the odds that heterosexual men who were highly homophobic would act punitively toward the gay peer.³⁴³ One scholar concluded that “[m]en may be lashing out against a gay man not for [the gay man’s] perceived violations of the gender system and ‘betraying masculinity’ but for the perpetrator’s perceptions of their own [masculinity] failure.”³⁴⁴ In the words of another scholar, “[m]en’s pursuit of masculinity in the face of threats is driven by desires to recover masculine status both in their own and others’ eyes.”³⁴⁵ Moreover, some heterosexual men’s aversion to gay men is also driven by disgust arising from the fusion of gay identity and HIV.³⁴⁶

This dynamic of heterosexual-identified men’s insecurity in the presence of gay men or sex between men has important policy implications. Robb Willer’s study involved giving men and women a gender-identity survey and then giving them false feedback as to whether their personalities were masculine or feminine.³⁴⁷ Men who were told that their personality was in the feminine range were more likely to support amending the Constitution to ban same-sex marriage and to deem homosexuality morally wrong than those who were told that they were masculine.³⁴⁸ The men labeled *feminine* reported “feeling more guilty, ashamed, upset, and hostile” than the unthreatened group of men.³⁴⁹ There was no comparable effect for women.³⁵⁰ This discussion has sought to show that hegemonic conceptions of masculinity imagine sex between men as contaminating a man’s masculine identity, the threat of being misclassified as gay causes anxiety and aggression in many men,

342. See Jennifer K. Bosson & Kenneth S. Michniewicz, *Gender Dichotomization at the Level of Ingroup Identity: What It Is, and Why Men Use It More Than Women*, 105 J. PERSONALITY & SOC. PSYCHOL. 425 (2013) (describing the “relatively precarious, easy-to-lose” status of masculinity).

343. Jeffrey A. Bernat et al., *Homophobia and Physical Aggression Toward Homosexual and Heterosexual Individuals*, 110 J. ABNORMAL PSYCHOL. 179, 181 (2001). In the exercise, the straight subject and gay man were engaged in a game, and the winner was told that he could subject the loser to electric shocks. In truth, there was no gay opponent (just a person on a video screen), and no one received shocks. *Id.*

344. *Id.* at 141.

345. Willer et al., *supra* note 323, at 981.

346. See Marlon Mooijman & Chadly Stern, *When Perspective Taking Creates a Motivational Threat: The Case of Conservatism, Same-Sex Sexual Behavior, and Anti-Gay Attitudes*, 42 PERSONALITY & SOC. PSYCHOL. BULL. 738 (2016); Nilanjana Dasgupta et al., *Fanning the Flames of Prejudice: The Influence of Specific Incidental Emotions on Implicit Prejudice*, 9 EMOTION 585 (2009).

347. Willer et al., *supra* note 323, at 980.

348. *Id.* at 990–91.

349. *Id.* at 991.

350. *Id.* at 992. Willer and his co-authors found that, based on measures conducted before the gender-identity feedback, the men in the masculinity-threat condition and the control condition did not differ significantly in their gender identities or their political views. *Id.*

and these gender/sexuality dynamics can drive policy outcomes. Gay, bisexual, other sexual-minority men, and their allies should work to disrupt the assumed correlation between gender identity and sex between men to foster greater autonomy for men of all orientations to make sexual decisions without the threat of the loss of masculine identity.

The gay proponents of PrEP focus on trying to level the playing field within the gay community by medicating all sexually active gay men. But this focus does nothing to challenge the fraught relationship between gay men and heterosexual men, and the many whose attraction, behavior, and identities are somewhere on the spectrum between these poles. This relationship is so fraught that we continue to see instances of heterosexual-identified men perpetrating violence against gay men and transgender people simply for expressing a sexual or romantic interest, and some courts have justified the “panicked,” violent responses of such straight men.³⁵¹ We think that a better goal would be to destigmatize sex between men so that men can explore their interest in sexual and romantic relationships with men without anxiety about potentially sacrificing their life-long identification as heterosexual men. This might strike some as an unrealistic goal. However, as George Chauncey has documented, the belief that sex between men necessarily taints a man’s masculinity emerged in the middle of the twentieth century and as such is a “stunningly recent creation.”³⁵² Gender and sexuality norms are social constructions, and each of us bears responsibility for deciding whether to maintain or seek to dismantle particular norms in our daily interactions.

As we detail below, transgender women face a related denial of their identity. Just as the HIV context implicates a cultural contest over who can qualify as a “real man” and the stigmatization of sexual-minority men as sexually dangerous, the transgender bathroom debate reflects a hierarchy among people who identify as women—and disagreement about which women deserve protection. Opponents of protecting transgender people’s right to use a bathroom that matches their gender identity redefine transgender women as “biological males” who have a predatory nature. They simultaneously deny transwomen’s self-identity as female and align male identity with sexual aggression.³⁵³ The flip side of this gender stereotype is that “real women” are seen as vulnerable to sexual predation and have the most compelling claim to governmental protection. Black feminist scholarship on intersectionality and gender essentialism warns us that white women are typically held up as the true exemplars of womanhood and lived experiences that diverge from theirs, including racial discrimination, tend to be ignored or relegated to the

351. See, e.g., Kavita Ramakrishnan, *Inconsistent Legal Treatment of Unwanted Sexual Advances: A Study of the Homosexual Advance Defense, Street Harassment, and Sexual Harassment in the Workplace*, 26 BERKELEY J. GENDER L. & JUST. 291, 321 (2011).

352. See GEORGE CHAUNCEY, *GAY NEW YORK: GENDER, URBAN CULTURE, AND THE MAKINGS OF THE GAY MALE WORLD, 1890–1940*, at 13 (1994). Before the mid-twentieth century, men who behaved effeminately in public were labeled as “fairies,” a precursor to the term *gay*, but men who acted masculine in public were not seen as sexual others simply because they had sex with men. *Id.*

353. See *infra* text accompanying notes 377–80.

footnotes.³⁵⁴ For that reason, transwomen, women of color, and especially transwomen of color are unlikely to qualify as “real women.”³⁵⁵ Moreover, inclusion in the category of “real women” may be perilous even for cisgender white women in that it reinforces long-standing stereotypes of such women as passive and fragile.³⁵⁶

B. Bathroom Access and Defining Womanhood

This Section describes the history of a controversial North Carolina law that regulated bathroom access and the light it sheds on gender and sexuality stereotypes. In February 2016, the Charlotte City Council amended the city’s anti-discrimination provisions to prohibit businesses and places of public accommodation from discriminating based on sexual orientation, gender identity, or gender expression. The amended ordinance was understood to ensure transgender people “full and equal enjoyment of . . . facilities.”³⁵⁷ Claiming that this law was a radical intervention that threatened public safety,³⁵⁸ North Carolina legislators convened on March 23, 2016, for an unusual single-day special session to pass the Public Facilities Privacy & Security Act, known as H.B. 2.³⁵⁹ This law nullified the Charlotte anti-discrimination ordinance as follows. First, it required public school students and patrons of businesses considered to be public accommodations to use the sex-designated, multiple-occupancy bathroom or changing facility that corresponds with their biological sex. H.B. 2 defined biological sex as “the physical condition of being male or female, which is stated on a person’s birth certificate.”³⁶⁰ Thus, transgender people were prohibited from using the facility consistent with their gender identity unless they were fortunate enough to have been able to change

354. See, e.g., Harris, *supra* note 21, at 588, 592 (arguing that white feminists who seek a “monolithic ‘women’s experience’ that can be described independent of other facets of experience like race, class, and sexual orientation” end up representing a white, heterosexual, middle-class existence as universal).

355. See *infra* text accompanying notes 391–93.

356. See Abrams, *supra* note 102 (discussing debates among feminists about the perils of perceiving female sexuality solely through the lens of male domination); cf. Robinson, *supra* note 110, at 1361 (discussing, in the prison context, the harms of broadly designating gay men as vulnerable).

357. CHARLOTTE, N.C., CODE art. III, chap. 12, § 12-58 (“It shall be unlawful to deny any person the full and equal enjoyment of the goods, services, facilities, privileges, advantages, and accommodations of a place of public accommodation because of race, color, religion, sex, marital status, familial status, sexual orientation, gender identity, gender expression, or national origin.”).

358. North Carolina General Assembly, Senate Floor Debate Hearing on H.B. 2 (Mar. 23, 2016) (Statement of Senator Newton) (“[T]he City Council of Charlotte lost their minds and decided to embark upon a very radical course . . .”).

359. An Act to Provide for Single-Sex Multiple Occupancy Bathroom and Changing Facilities in Schools and Public Agencies and to Create Statewide Consistency in Regulation of Employment and Public Accommodations, 2016 N.C. Sess. Laws 3 (House Bill 2).

360. N.C.G.S. § 143-760(a) (2016).

the gender marker on their birth certificates.³⁶¹ Second, H.B. 2 prohibited Charlotte and all other cities and counties from regulating discriminatory practices in places of public accommodation.³⁶² This provision invalidated Charlotte's protections for LGBTQ people and people of color.

H.B. 2 was met with intense criticism from LGBTQ groups and their allies, including many corporate leaders. The American Civil Liberties Union of North Carolina and local nonprofit Equality North Carolina filed suit immediately, alleging that H.B. 2 violated the Equal Protection and Due Process clauses of the Fourteenth Amendment and Title VII of the Civil Rights Act of 1964.³⁶³ The NCAA refused to select venues in North Carolina to host its marquee events as long as H.B. 2 remained in place.³⁶⁴ Sixty-eight other businesses, including American Airlines, Apple, and Marriott urged a federal court to halt enforcement of H.B. 2 in an amicus brief.³⁶⁵

After a year's worth of criticism and boycotts over H.B. 2, North Carolina enacted H.B. 142, which formally repealed H.B. 2 but did not revive the Charlotte ordinance.³⁶⁶ H.B. 142 removed H.B. 2's requirement that transgender people use bathrooms in public facilities that aligned with their birth certificates. The repeal bill replaced H.B. 2's prohibition on local ordinances regulating bathroom requirements with a temporary moratorium on local anti-discrimination ordinances until 2020.³⁶⁷ In the meantime, H.B. 142 leaves regulation of multiple-occupancy bathrooms and changing facilities to the General Assembly's sole discretion.³⁶⁸ Texas recently considered a "bathroom bill," entitled the Women's Privacy Act, which resembles

361. See generally Dean Spade, *Documenting Gender*, 59 HASTINGS L.J. 731 (2008) (describing the divergent standards for changing one's birth certificate in various jurisdictions). Many jurisdictions refuse to change a gender marker or require genital surgery as a condition to a birth certificate change.

362. N.C.G.S. § 143-760(a) (2016).

363. Chase Strangio, *The Fight Against North Carolina's Anti-LGBT Law Heads to Court*, AM. CIV. LIBERTIES UNION (Mar. 28, 2016), <https://www.aclu.org/blog/speak-freely/fight-against-north-carolinas-anti-lgbt-law-heads-court>.

364. Marc Tracy & Alan Blinder, *N.C.A.A. Moves Championship Events From North Carolina, Citing Anti-Gay-Rights Law*, N.Y. TIMES (Sept. 12, 2016), <https://www.nytimes.com/2016/09/13/sports/ncaa-moves-championship-events-from-north-carolina.html>.

365. Colin Campbell, *68 Companies Join Brief in House Bill 2 Lawsuit*, CHARLOTTE OBSERVER (July 8, 2016), <http://www.charlotteobserver.com/news/politics-government/article88318627.html>.

366. An Act to Reset S.L. 2016-3, § G.S. 143-760 (Mar. 30, 2016).

367. *Id.*

368. *Id.*

H.B. 2.³⁶⁹ At least 17 states have considered a bill directly regulating bathroom access for transgender individuals.³⁷⁰

During the North Carolina legislative debate, proponents of H.B. 2 repeatedly distorted the gender and sexual identities of transgender people. In particular, even though the law touched people of all genders and sexual orientations, the debate quickly reduced to a fixation on transgender women gaining access to women's restrooms and unleashing a parade of horrors. Anti-LGBTQ forces often recast transgender women as "biological males"—men said to pose a threat to the safety of cisgender women.³⁷¹ During the Senate floor debate, Senator Newton proclaimed that the Charlotte ordinance "would allow . . . men into the bathrooms and locker rooms of females—of our daughters, of our wives."³⁷² Some might object that such comments may refer to cisgender men not transmen. Certainly some speakers did not explicitly address whether they saw only cisgender men as a sexual threat to women.³⁷³ However, there is scant evidence that extending protection to transgender people produces a surge of cisgender (or transgender) people entering bathrooms to assault women.³⁷⁴ Moreover, the legislature understood that existing judicial precedent treated a cisgender male entering a woman's restroom as an unlawful trespass, and H.B. 2 did nothing to change this principle except clarify that a transgender woman would be treated as a man.³⁷⁵ As in the HIV context, stereotypes and fear seemed to drive the policy debate more than empirical evidence and an objective concern for public safety. Moreover, people who align transgender access with enabling sexual predators, either explicitly or

369. David Montgomery & Manny Fernandez, *Texas Bathroom Bill Dies Again, Raising Republican Acrimony*, N.Y. TIMES (Aug. 17, 2017), https://www.nytimes.com/2017/08/16/us/politics/texas-bathroom-bill-dies-again-raising-republican-acrimony.html?mcubz=3&_r=0.

370. Jon Herskovitz, *Texas Governor Calls Legislative Session; Could Include Bathroom Bill*, REUTERS (June 16, 2017), <http://www.reuters.com/article/us-texas-lgbt-idUSKBN18X2Q0>.

371. See, e.g., North Carolina General Assembly, Senate Floor Debate on H.B. 2 (Mar. 23, 2016) at 28–29 [hereinafter Senate Floor Debate Transcript] (Statement of Senator Berger).

372. Senate Floor Debate Transcript, *supra* note 371, at 15, 28; see also *id.* at 28 (Senator Berger) (stating that the ordinance "allows grown men to share bathrooms and locker rooms with girls and women").

373. For example, Senator Newton's opined: "anyone, quite frankly . . . could use this Charlotte ordinance as an excuse to be somewhere that we all know they don't belong." *Id.* at 16.

374. More than a dozen jurisdictions have long guaranteed the right of transgender people to use bathrooms that match their gender identities, and law enforcement has not reported an uptick in bathroom assaults as a result. See, e.g., Katy Steinmetz, *Why LGBT Advocates Say Bathroom "Predators" Argument is a Red Herring*, TIME (May 2, 2016), <http://time.com/4314896/transgender-bathroom-bill-male-predators-argument/>.

375. Senate Floor Debate Transcript, *supra* note 371, at 22 (Statement of Senator Blue). And a transgender man would be treated as a woman.

implicitly, draw on long-standing stereotypes that transgender people are mentally ill, deceptive, and threatening.³⁷⁶

During the Senate floor debate, Senator Berger cited a single incident from Seattle in which “a man shows up in a locker room that is being used by a girls’ swim team . . . when confronted, he says ‘I have a right to be here because I’m transgender.’”³⁷⁷ However, according to the Washington State Human Rights Commission, the man never identified as transgender and apparently entered the women’s locker room to make a political claim that allowing transgender access would abolish gender-designated bathrooms.³⁷⁸ This stunt is in line with those of several cisgender men who have dressed up in drag to protest policies protecting transgender bathroom access.³⁷⁹ These performances represent yet another way in which anti-LGBTQ forces misrepresent transgender identities rather than actual evidence that laws like the Charlotte ordinance endanger girls and women.³⁸⁰

In contrast to unsubstantiated fears that equate transgender bathroom access with the victimization of cisgender women, studies show that many transgender people report experiencing discrimination in bathrooms, which can range from being stared at or told to leave to being fired from their job to having the police called to sexual or physical assault.³⁸¹ Some research suggests that transgender women, transgender people of color, and especially transwomen of

376. See GLAAD, *Victims or Villains: Examining Ten Years of Transgender Images on Television*, <https://www.glaad.org/publications/victims-or-villains-examining-ten-years-transgender-images-television> (last visited Feb. 24, 2018) (summarizing media depictions of transgender people as sex workers, villains, and sexual predators). In some respects, transgender stereotypes track popular conceptions of bisexuals as deceptive and dangerous.

377. Senate Floor Debate Transcript, *supra* note 371, at 29.

378. Sydney Brownstone, *Human Rights Commission: Guy Entering Women’s Bathroom in Seattle Was “Absolutely Not Protected Under the Law”*, STRANGER (Feb. 26, 2016, 3:28 PM), <http://www.thestranger.com/slog/2016/02/26/23627451/human-rights-commission-guy-entering-womens-bathroom-in-seattle-was-absolutely-not-protected-under-the-law>. The Human Rights Commission declared that the law does not enable cisgender men to enter women’s bathrooms. *Id.*

379. For example, a middle-aged white man donned a Confederate flag bikini and named himself the “tinkle fairy” to protest Target’s trans-inclusive bathroom policy. His sign proclaimed: “Target lets me tinkle with 6-year-old girls.” Chuck Netzhammer, *The Tinkle Fairy Grants Target’s Wish*, YOUTUBE (May 2, 2016), <https://www.youtube.com/watch?v=qT0NH0dwCaY>.

380. Brownstone, *supra* note 378.

381. Jody L. Herman, *Gendered Restrooms and Minority Stress: The Public Regulation of Gender and Its Impact on Transgender People’s Lives*, 19 J. PUB. MGMT. & SOC. POL’Y 65, 67, 71–72 (2013) (finding that 68% of subjects in Washington, D.C., reported verbal harassment and 9% reported a physical attack); Kristie L. Seelman, *Transgender Adults’ Access to College Bathrooms and Housing and the Relationship to Suicidality*, 63 J. HOMOSEXUALITY 1378, 1388–89 (2016) (finding that people who were denied bathroom access as college students were more likely to have attempted suicide than those who were not denied access).

color are particularly visible and vulnerable to bathroom-access discrimination.³⁸² Because of these obstacles and fear of discrimination, some transgender people avoid going out in public or dehydrate themselves when they do so that they will not have to use the bathroom, which can lead to significant health problems.³⁸³ Some qualitative work discloses bathroom-related stress and coping strategies that many cisgender people would not imagine. For example, some people reported bringing a friend to the restroom for protection. One person said, “If there is a line to use restrooms, I will not. Standing in line usually always results in verbal abuse or denial of access.”³⁸⁴ A gender nonconforming person strained to appear more feminine to avoid discrimination in the women’s room: “I sing and/or talk to people and feminize my walk every time I enter a public bathroom . . . [i]t works under 50% of the time.”³⁸⁵ In sum, a black transman who testified before the North Carolina legislature was correct when he stated the following:

I am not a threat to you. Nor are other transgender people threats to you . . . This is not about protecting privacy. If it was, you’d be just as interested and invested in the citizens of North Carolina who are transgender people who are more statistically subject to harassment and physical violence in restrooms than anyone else.³⁸⁶

We can observe evidence of cisgender hostility to transgender people from other testimony during the H.B. 2 hearings. For example, several advocates for the law misgendered transwomen by referring to them as men or biological males.³⁸⁷ Among those who testified before the House Judiciary Committee, several were young cisgender women. Consider the testimony of Chloe Jefferson, then a junior at Greenville Christian Academy:

When the Charlotte City Council passed their bathroom ordinance, I was immediately fearful . . . Changing in front of my girl peers is already intimidating enough. *Now we add the possibility of males changing and showering alongside me . . .* Girls like me should never be forced to undress or shower in the presence of boys. I would imagine being born *a boy but thinking you’re a girl* is very scary and confusing. But being a teenage girl is confusing, too. Charlotte’s bathroom ordinance allows men complete access to private places

382. See Seelman, *supra* note 381, at 1381; Kristie L. Seelman, *Transgender Individuals’ Access to College Housing and Bathrooms*, 26 J. GAY & LESBIAN SOC. SERVS. 186, 196, 199 (2014) (finding that people of color, people with disabilities, and those more often perceived as transgender were more likely to report denial of access).

383. See Seelman, *supra* note 381, at 1382; Herman, *supra* note 381, at 74–75.

384. Herman, *supra* note 381, at 76.

385. *Id.* at 77.

386. North Carolina General Assembly, Senate Judiciary II Committee Hearing on H.B. 2, at 38–39 (Mar. 23, 2016) (Statement of Reverend Mykal Slack).

387. See North Carolina General Assembly, House Judiciary IV Committee Hearing on H.B. 2, at 23 (Mar. 23, 2016) (Statement of Eliana Smith) (using the term *biological males*); North Carolina General Assembly, Senate Floor Debate Transcript, *supra* note 371, at 28 (Statement of Senator Berger) (referring to “grown men” sharing restrooms with girls and women); *id.* at 29 (referring to someone who “thinks they’re a woman”).

reserved for women. With this access, there's no stopping what people may do. How can my parents possibly send me into a bathroom—public bathroom, knowing that a man could possibly be waiting for me? . . . Everyone should be aware that it would be girls like me who are affected by ordinances like Charlotte and we deserve protection.³⁸⁸

Eliana Smith, a Charlotte resident, linked her fear of transgender people to her history as a survivor of sexual violence:

I was sexually assaulted as a young girl, and in the years that followed, I had a real fear of men hurting me In recent weeks, the thought of what I experienced has come back to my mind as I watched the Charlotte City Council vote to allow biological males into women's bathrooms, locker rooms, and showers I fear even more for my children. How will I be able to go into the bathroom, knowing that at any moment *a man, or someone pretending to be a woman*, could walk in? I won't have peace about my little girls showering and changing at the Y, where there very well could be a man in that room³⁸⁹

Opponents of the law tried to contest the focus on cisgender women as vulnerable. Madeline Goss, a transwoman, said, "I can't use the men's room. I won't go back to the men's room. It is unsafe for me there. People like me die there every day." Goss, who appears conventionally feminine, makes evident that concern with women should extend to transwomen who would be forced to use bathrooms frequented by cisgender men, who are often transphobic. Because Goss has transitioned and appears as a cisgender woman, she lacks the option to assimilate in male bathrooms. Thus, while legislators expressed concern about cisgender girls and women, they were simultaneously supporting a law that would make transwomen more vulnerable by confining them in male bathrooms or requiring them to avoid using public bathrooms. Relatedly, for all the talk about "men in women's bathrooms," the legislature failed to consider the plight of transmen who would be forced to enter women's restrooms—the very scenario that motivated H.B. 2. One way of reconciling the tension between the asserted state interest and means that appear to undermine that interest is that the legislature simply did not believe that a transgender woman could look "like a woman" or a transgender man could look "like a man." In other words, despite surgery, hormone therapy, and other gender-affirming treatment, the legislators apparently insisted on seeing women like Goss as "biological males" and denying their gender identity.³⁹⁰

Judges, including some who are left of center, have similarly refused to respect transgender people's self-identities and have blithely assumed that granting transgender people bathroom access would be dangerous. First, some judges have

388. North Carolina General Assembly, *supra* note 387, at 18–20 (emphasis added).

389. *Id.* at 22–24 (emphasis added).

390. *Cf. id.* at 51 (statement of John Amanchukwu, a Christian minister, who testified that God fixes gender at birth based on physical anatomy).

refused to recognize transgender people as a distinct class warranting protection under the Constitution and civil-rights statutes.³⁹¹ These courts disrespect transgender people's ability to self-define and disregard their actual experiences of discrimination as transgender people by requiring them to style their claims as if they were cisgender men or women who were stereotyped for being insufficiently masculine or feminine.³⁹² Such refusals echo barriers that courts erected decades ago to block black women's race- and gender-discrimination claims. As Kimberlé Crenshaw documented, some courts have let black women assert claims as women *or* as black but not as *black women*. Rather than understanding that recognizing black women's claims simply meets black women where they live, these courts suggested that black female plaintiffs were seeking to "combine statutory remedies to create some 'super-remedy'" that would confer "greater standing" than that available to black men and white women.³⁹³

Second, some courts have treated employers' concerns about letting transgender women use women's bathrooms as legitimate and nondiscriminatory. In *Etsitty v. Utah Transit Authority*, the plaintiff was a transgender woman bus driver who used women's restrooms along her route. Her supervisor, a cisgender woman, expressed concern about this practice and ultimately fired Etsitty because of the "possibility of liability for UTA arising from Etsitty's restroom usage." The supervisor wanted to know whether Etsitty "still had male genitalia" and was anxious about Etsitty "switch[ing] back and forth between using male and female restrooms."³⁹⁴ The Tenth Circuit upheld the termination even though "UTA had received no complaints about Etsitty's performance, appearance, or restroom usage."³⁹⁵ A Ninth Circuit case, *Kastl v. Maricopa County Community College District*,³⁹⁶ is similarly misguided. The court concluded that the college "banned Kastl [a transgender woman and adjunct professor] from using the women's restroom for safety reasons," even though the lower court dismissed Kastl's claim because she was not a "biological woman."³⁹⁷ The Ninth Circuit required no evidence that Kastl would have actually threatened cisgender women or minors. It

391. See, e.g., *Etsitty v. Utah Transit Auth.*, 502 F.3d 1215, 1221 (10th Cir. 2007).

392. *Id.* at 1222. Even these strategies sometimes fail because courts invoke plaintiffs' genitalia to claim that they are not "real women" and thus cannot complain about being stereotyped as women. See, e.g., *Kastl v. Maricopa Cty. Cmty. Coll. Dist.*, No. CB-02-1531-PHX-SRB, 2006 WL 2460636, at *6 (Apr. 22, 2006) (concluding that a transgender plaintiff failed to prove that she was a "biological female" and thus was not a member of a "protected class" under Title VII).

393. Crenshaw, *Demarginalizing*, *supra* note 21, at 141 (quoting *DeGraffenreid v. Gen. Motors*, 413 F. Supp. 142, 143, 145 (E.D. Mo. 1976)).

394. *Etsitty*, 502 F.3d at 1219.

395. *Id.* at 1219–20. The court went on to apply gender-stereotyping theory but concluded that requiring "a biological male" to use the men's room is not a gender stereotype. *Id.* at 1225. The court seemed to think that Etsitty was asking it to let *cisgender* men use the women's room. Hence, the court's misclassification of Etsitty as male and refusal to see that her claim was solely about her need for access *as a transgender woman* had dire doctrinal consequences.

396. *Kastl v. Maricopa Cty. Comm. Coll. Dist.*, 325 F. App'x 492 (9th Cir. 2009).

397. *Id.* at 494. The court then faulted Kastl for not rebutting the safety issue. *Id.*

was enough that the defendant “received complaints from minor students regarding a man using the women’s restroom” and invoked privacy or safety.³⁹⁸ Notably, the judges on the panel consisted of two liberal women and now-Supreme Court Justice Neil Gorsuch, and the district court judge was also a woman.³⁹⁹ These cases suggest how mightily transgender women must fight to be recognized as women.

Even though studies suggest that trans people face a serious risk of discrimination and violence in bathrooms, the dominant policy debate casts transwomen as either sexual predators or people who would enable sexual predation simply by seeking access to bathrooms that match their gender identity. In these cultural narratives, transwomen are not real women, but men “dressed up” as women or “biological males” who are confused about their identities. They are imagined as gender imposters who pose a threat to public health. The general public’s ignorance of transgender people and their struggles with bathroom access facilitate this fundamental inversion of reality in which the very people who are most vulnerable in public bathrooms are reconfigured as a threat to those who restrict their bathroom access—cisgender people.

These challenges may tempt LGBTQ advocates to highlight the most “respectable” transgender women (think Caitlyn Jenner) to overcome transphobic doctrine and attitudes.⁴⁰⁰ Returning to the popular-culture context, an online furor reveals how certain representations of transgender identity can upend conventional alignments of gender and vulnerability. In April 2016, photographer Meg Bitton posted a photo of Corey Maison, a little girl with long, blonde hair and blue eyes.⁴⁰¹ Bitton posted the following text with the photo: “If this was YOUR daughter, would you be comfortable sending her into a men’s bathroom? Neither would I. Be fair. Be kind. Be empathetic. Treat others how you would like to be treated.” The post sparked over 21,000 comments and more than twice as many shares. After

398. *Kastl v. Maricopa Cty. Comm. Coll. Dist.*, No. CB-02-1531-PHX-SRB, 2006 WL 2460636, at *7 (Apr. 22, 2006). An Eleventh Circuit case was more protective of transgender employees in that the court held that discrimination against transgender people constitutes gender discrimination under the Equal Protection Clause and thus demands intermediate scrutiny. *Glenn v. Brumby*, 663 F.3d 1312, 1317 (11th Cir. 2011). Still, rather than rejecting bathroom access as a justification for firing a transgender employee, the court merely held that there was insufficient evidence that concern about restroom access motivated the supervisor’s decision to terminate the employee. *See id.* at 1321.

399. Some feminist scholars have also tried to fence transgender women out of womanhood. *See, e.g.*, Sheila Jeffreys, *The Politics of the Toilet: A Feminist Response to the Campaign to ‘Degender’ a Women’s Space*, 45 *WOMEN’S STUD. INT’L F.* 42, 43 (2014) (arguing that “men who transgender” cannot change their “biological sex”); *see also* Rishita Apsani, *Are Women’s Spaces Trans Spaces? Single-Sex Domestic Violence Shelters, Trans Inclusion, and the Equal Protection Clause* (draft on file with authors) (summarizing feminist arguments against admitting transwomen to women’s domestic-violence shelters).

400. *See, e.g.*, Harris, *supra* note 21, at 591; Ezra Young, *Demarginalizing Trans Rights*, at 10 (draft on file with authors) (“[W]hite, female identified trans people . . . have to date been the go-to narrative in most test-case trans sex discrimination cases.”).

401. Meg Bitton Photography, FACEBOOK (Apr. 26, 2016), <https://www.facebook.com/MegBittonPhotography/posts/10153063771317395:0>.

considerable controversy, Bitton wrote again: “I guess I need to edit this post. Corey IS TRANSGENDER.” One comment stated:

When I first looked at the photo I thought I was looking at a lil girl. After reading the posts I’m still looking at a lil girl. Y’all can’t tell me if you were in a Walmart, mall, Target . . . etc bathroom and this child walked in to use the restroom and went to a stall, you women won’t think twice about it. If her mother would not of said so y’all would of thought she was posting a pic of her beautiful daughter!!! Just admit it!!!⁴⁰²

The North Carolina bathroom-bill debate shows how layered and complex the politics of representation are in LGBTQ contexts. We began this Article by observing how the marriage-equality movement selected a mostly white and affluent group of plaintiffs and instructed them not to discuss or display their sexuality. In North Carolina, anti-transgender forces sought to portray cisgender women as fragile and delicate; hence their choice of traditionally feminine and young women, including victims of sexual assault by cisgender men, to testify before the legislature. LGBTQ advocates pushed back by highlighting transgender women who seemed designed to prove that transwomen can be just as traditionally feminine as cisgender women. But some might worry about a pro-LGBTQ strategy that seeks to leverage traditional femininity and whiteness to secure rights. Would the person on Facebook who leapt to Corey Maison’s defense have been persuaded if Maison could not seamlessly “pass” as cisgender and were not blonde and blue-eyed? Even if this advocacy strategy were successful for trans people who identify as male or female, where would it leave the many people who identify as non-binary or gender-fluid, people who cannot or do not want to assimilate into a binary gender identity? Even if their legal rights were secured, would non-binary women of color enjoy the same protections as someone like Maison or Jenner as a practical matter?

In this brief analysis, we do not purport to offer ultimate answers to these conundrums. Rather, we wish to define the contours of present and future debates about LGBTQ identity and sexuality and call for serious engagement with intersectionality and the interrelatedness of homophobia, biphobia, transphobia, heterosexism, and cisgenderism. We encourage advocates to search for policies that permit people within any identity group space to define it as they see fit, and we urge advocates to avoid establishing any particular segment of the community as the essential transwoman or gay man, for example.

In the bathroom context, we think this means that calls for excluding transgender women from women’s restrooms⁴⁰³ and for imposing only gender-

402. Many other people who commented were not so benevolent. Despite her adherence to conventional standards of beauty and femininity, Maison was misgendered. For example, one person wrote: “To [sic] bad he’s a boy who would be using the boys bathroom #sorrynotsorry”; another asserted: “This isn’t a daughter; it’s a son.” Some commenters invoked the trope of transgender deception from movies like *The Crying Game*: “Hell of a surprise on prom night.”

403. See Jeffreys, *supra* note 399, at 43.

neutral bathrooms across the board⁴⁰⁴ are both misguided. Although there is no reason to expect the protection of transgender rights to trigger an increase in sexual predation, women—cisgender and transgender—face a very real threat of sexual violence. In addition, many cisgender people, especially cisgender women, are likely to experience required multi-user gender-neutral bathrooms as an attack on their sense of self—and one imposed to favor a small minority. Moreover, just as there is a divide among gay men regarding PrEP, there are differences within the transgender community about bathrooms. While some want to dismantle gender, some transgender women consider the ability to use a woman's bathroom as a significant affirmation of their identities as women.⁴⁰⁵ Making all bathrooms gender neutral would frustrate this part of the community's desire to self-define. A more inclusive policy would permit transgender people to use male or female restrooms as they see fit, to push for the creation of additional gender-neutral options, to provide single-stall bathrooms for all genders, which provides an option for non-binary people who do not feel safe or comfortable using a bathroom labeled *male* or *female*,⁴⁰⁶ and to provide adequate security for all bathrooms. Also, the government must educate people about the gender spectrum so that they do not interrogate or seek to forcibly remove any person who does not comport with their conception of a male or female, as is currently being advocated for as part of inclusive sex education.⁴⁰⁷ The ultimate goal of government should be to permit people the freedom to define their gender and sexual orientation according to their own conscience and not denigrate one's standing in society because of one's gender identity or sexual orientation.

CONCLUSION

In closing, we want to sketch an unexpected connection. Psychological scholarship reveals that cisgender heterosexual men and transgender women share a similar anxiety—the fear of being misclassified. Jennifer Bosson and her co-authors have shown that heterosexual men fear being misclassified as gay not only because gay is a stigmatized identity, but also because misclassification threatens a fundamental human need for “belonging and coherence” in one's identity.⁴⁰⁸ It turns out that we all have a need to be “seen by others in a manner consistent with our stable self views.”⁴⁰⁹ This aspiration can be denied in many ways, whether a

404. See Terry S. Kogan, *Public Restrooms and the Distortion of Transgender Identity*, 95 N.C. L. REV. 1205, 1234 (2017).

405. Cf. Sonia K. Katyal, *The Numerus Clausus of Sex*, 84 U. CHI. L. REV. 389, 423 (2017) (“[T]here are dangers in presuming that all people who identify as transgender seek the same thing, a presumption that is categorically flawed . . .”).

406. *Id.* at 460, 474 (discussing a study showing that a significant number of transgender people do not identify as male or female).

407. California Health Youth Act, Assembly Bill No. 329, ch. 309 (2015–2016), https://leginfo.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB329.

408. Jennifer K. Bosson et al., *Gender Role Violations and Identity Misclassification: The Roles of Audience and Actor Variables*, 55 SEX ROLES 13, 13–15, 20 (2006) (conducting an experiment that showed that homophobia was only a partial explanation for heterosexual men's discomfort when they imagined behaving in a feminine fashion before an audience).

409. *Id.* at 14–15.

transwoman is called a “biological male,” a gay man is stereotyped as effeminate or promiscuous, or a straight man is misclassified as gay. While many cisgender heterosexual men work hard to distance themselves from gay men and anything perceived as feminine so that they are not misclassified as gay, some transgender women must constantly insist on being treated as women in a world that often refuses to validate their gender identities. Obviously, there are major differences between these groups in terms of status, power, and vulnerability, and we do not mean to equate them for most purposes. Nonetheless, we find it valuable to identify shared psychological underpinnings among otherwise disparate groups and dynamics in the hopes that we can understand and respect others’ desire for self-definition and the vulnerability they may experience when they feel their self-concept is at risk.

The marriage-equality victory and emergence of transgender rights broaden the spectrum of life possibilities for LGBTQ people. The goal of LGBTQ politics should be to unsettle monolithic conceptions of identity and create greater space for all people to live the identities that are compatible with their values and sense of self, which often include intersecting identities. Challenging sexual/gender stereotypes is the next chapter in this struggle for self-definition. Instead of mimicking homophobia-inflected “lessons in being gay,” we can begin to write our own stories.