

NLGLA MICHAEL GREENBERG WRITING COMPETITION

Gay Blood Revisionism: A Critical Analysis of Advocacy and the “Gay Blood Ban”

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I. INTRODUCTION

Since 1984, federal guidelines have effectively banned the donation of blood by men who have sex with men since 1977.¹ Despite this

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1. There have been various iterations of this policy, as discussed below. The policy in question is promulgated by guidelines issued by the FDA's Center for Biologics Evaluation and Research, based on recommendations of the Blood Products Advisory Committee, pursuant to 21 C.F.R. § 640.3 (2006). The guidelines must be followed for blood collection agencies to certify that their blood meets federal standards. The current guidelines are set forth in a 1992 memorandum. FDA, U.S. DEP'T OF HEALTH & HUM. SERV., REVISED RECOMMENDATIONS FOR THE PREVENTION OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) TRANSMISSION BY BLOOD AND BLOOD PRODUCTS (1992), available at <http://www.fda.gov/cber/bldmem/hiv042392.pdf>.

seemingly facially discriminatory policy, one of the few federal policies that makes any differentiation based on sexual orientation, advocacy around the issue has been limited.² While there have been occasional calls for the policy's repeal, no litigation has been filed and no national advocacy campaign has emerged. In fact, of the Web sites of major gay rights organizations, only one even mentions the policy.³ Yet individuals continue to engage in acts of advocacy calling for change, labeling the policy as absurd,⁴ discriminatory,⁵ and even unconstitutional.⁶

These advocates portray the deferral policy for men who have sex with men (hereinafter the MSM policy) as one created out of homophobia, animus towards the gay community, and irrational fear.⁷ One scholar writes that, at the time of its passage, the MSM policy was "clearly intended to discriminate against gay and bisexual men . . . because the class was considered to be promiscuous."⁸ In response to a 1994 article on the policy in the *San Francisco Examiner*, one member of the gay community advanced the common misconception that the policy was enacted only because officials thought sexual orientation, and not blood was what caused the transmission of AIDS.⁹

2. The other notable federal policy that specifically *cares* about the gender of one's sexual partner is the ban on homosexuals in the military, known as "Don't Ask, Don't Tell." 10 U.S.C. § 654 (2000).

3. See Human Rights Campaign (HRC), Blood Donations, *available at* <http://www.hrc.org/issues/4057.htm> (last visited May 3, 2007). Other gay rights groups, most notably Lambda Legal, have from time to time entered the debate and submitted testimony, often in coalition, and commented to the press, when the issue has been raised. See, e.g., Rob Stein, *FDA To Review Ban on Gay Men Donating Blood*, WASH. POST., Mar. 18, 2006, at A6; David Tuller, *Seeing Red*, SALON.COM, Sept. 14, 2000, http://archive.salon.com/health/feature/2000/09/14/gay_blood/index.html.

4. See John G. Culhane, *Bad Science, Worse Policy: The Exclusion of Gay Males from Donor Pools*, 24 ST. LOUIS U. PUB. L. REV. 129, 131 (2005).

5. See, e.g., Sam Hemingway, *UVM Blood Drives To Continue*, BURLINGTON FREE PRESS, Jan. 30, 2006, at 1B (discussing discrimination charges brought relating to blood drives at the University of Vermont).

6. See, e.g., Michael Christian Belli, *The Constitutionality of the "Men Who Have Sex with Men" Blood Donor Exclusion Policy*, 4 J.L. SOC'Y 315, 373-74 (2003) (finding that the MSM policy fails to meet rational basis scrutiny).

7. FDA policy refers to individuals not allowed to give blood based on their membership in a high risk group as being "deferred" from the blood donor pool. See generally FDA, *supra* note 1. These deferrals can range in length from one year (for groups including those who have traveled to certain countries or had sex with an IV drug user) to lifetime (for groups including those who have ever tested positive on an HIV antibody test, though not necessarily HIV+, in addition to MSMs). See FDA, *supra* note 1, at 20.

8. Belli, *supra* note 6, at 368.

9. Ben Carlson, Letter to the Editor, *Drop the Foolish Ban on Blood Donations by Healthy Gay Men*, S.F. EXAMINER, Jan. 26, 1994, at A18. On the contrary, the CDC had gathered enough evidence to know that AIDS was transmissible by blood and sexual contact by January 1983. See COMM. TO STUDY HIV TRANSMISSION THROUGH BLOOD & BLOOD PRODUCTS, DIV. OF

But the truth is, as one political journalist, Larry Bush, commented in winter 1983, “[n]early every one responsible for addressing [the blood issue] has demonstrated extraordinary restraint . . . to the potentially hostile public reaction that might be created by a few incautious words.”¹⁰ The fact that the MSM policy was enacted *in spite of* discriminatory effects, as opposed to *because of* those effects, is of major consequence for advocacy efforts today. Though the misrepresentation of the historical context is likely not intentional, but rather stems from ignorance of advocates (predominantly college students with no connection to the early days of the epidemic), this Article argues that the failure to address the policy’s history properly has led to several problems with the advocacy strategies in use.

Drawing off the work of social movement theorists and the notion of political opportunity structure,¹¹ this Article argues that the history of the MSM policy has shaped the availability and persuasiveness of social and cultural frames for advocacy efforts. Through these frames, history often influences which arguments advocates can make persuasively, as well as what facts are considered relevant.¹² Efforts to change the MSM policy are thus affected by the fact that, in response to the development of AIDS, “the gay community was at first quick to minimize the significance of AIDS and to reassert the right to sexual freedom and autonomy.”¹³

Moreover, in continually focusing on homophobia and discrimination, rather than on changes in science and risk evaluation, advocates fail to engage potential allies and policymakers. The current student-based focus of advocacy activity exacerbates these problems for a number of reasons, including students’ lack of memory of the AIDS crisis, the intersection of their activism and their “coming out,” and a failure to temper their attacks on blood industry officials. Instead of using blood banking organizations as potential allies, advocates have antagonized

HEALTH PROMOTION & DISEASE PREVENTION, INST. OF MED. HIV AND THE BLOOD SUPPLY: AN ANALYSIS OF CRISIS DECISIONMAKING 101-02 (1995) [hereinafter, IOM Comm. Rep.].

10. RONALD BAYER, PRIVATE ACTS, SOCIAL CONSEQUENCES 76 (1989).

11. First set forth by William Gamson and David Meyer, this work has been applied to gay rights litigation by Ellen Ann Andersen as a “legal opportunity structure,” and her language is used throughout here. See generally ELLEN ANN ANDERSEN, OUT OF THE CLOSETS AND INTO THE COURTS (2006); William A. Gamson & David S. Meyer, *Framing Political Opportunity*, in COMPARATIVE PERSPECTIVES ON SOCIAL MOVEMENTS (Douglas McAdam et al. eds., 1996).

12. See ANDERSEN, *supra* note 11, at 12-13.

13. William F. Flanagan, *People with HIV/AIDS, Gay Men, and Lesbians: Shifting Identities, Shifting Priorities*, in LEGAL INVERSIONS: LESBIANS, GAY MEN, AND THE POLITICS OF LAW 195, 197 (Didi Herman & Carl Stychin eds., 1995).

these groups. History has shown that the relationship does not need to be so antagonistic.

Part II of this Article explores the history of the MSM policy, with a particular emphasis on the role of the gay community. Part III provides an overview of advocacy efforts to repeal the MSM policy, particularly on college campuses. Part IV proposes a paradigmatic shift in the framing of arguments against the MSM policy, moving from a focus on stigma and fairness to an engagement with risk analysis. The Article concludes with thoughts on whether, given limited resources, the MSM policy is even an appropriate target of social movement activity.

II. HISTORY AND ITS IMPLICATIONS

It is hard for college students of today to comprehend the degree of uncertainty and fear surrounding AIDS in the gay community, and the United States at large, in the early to mid-1980s.¹⁴ But the story of the restriction on blood donations by men who have sex with men is essentially the story of the early days of AIDS itself, and because of this history and the political and rhetorical power of AIDS today, any attempt to isolate the MSM policy will fail.

A. *The Development of the Policy*

By late 1982, epidemiologists suspected that whatever caused AIDS was a transmissible agent that could be transmitted by blood and sexual fluids, and had a “carrier state,” where individuals could appear healthy, yet still have a communicable form of the disease.¹⁵ As soon as this theory emerged, scientists and public health policymakers knew the nation’s blood supply could be a major vector for what was then known as “Gay-Related Immune Deficiency (GRID).”¹⁶

1. The First Cases and the 1982 Meeting

The first suspected case of blood-related GRID came in early 1982, when a Florida physician reported an elderly hemophiliac patient had developed *pneumocystis carinii* pneumonia, a disease almost exclusively

14. The author, having been born at the beginning of the historical period in question, makes no claim to fully grasp the fear and uncertainty either.

15. Harvey M. Sapolsky & Stephen L. Boswell, *The History of Transfusion AIDS: Practice and Policy Alternatives*, in AIDS: THE MAKING OF A CHRONIC DISEASE 170, 172 (Elizabeth Fee & Daniel M. Fox eds., 1992).

16. Gerald Oppenheimer, *Causes Cases and Cohorts: The Role of Epidemiology in Historical Construction of AIDS*, in AIDS: THE MAKING OF A CHRONIC DISEASE 62 (Elizabeth Fee & Daniel Fox eds., 1992).

associated with GRID.¹⁷ The physician suspected the patient had received contaminated Factor VIII, a life-prolonging clotting factor derived from thousands of blood donors given to hemophiliacs.¹⁸ While it was never confirmed whether this patient actually had AIDS due to his rapid death, his case confirmed the fears of many Centers for Disease Control (CDC) epidemiologists.¹⁹ By June 1982, epidemiologists were able to identify another case of GRID in hemophiliacs.²⁰

In response, the CDC hosted a meeting in July 1982 to discuss possible responses to the potential contamination of the nation's blood supply.²¹ Meeting attendees included leaders from the National Institutes of Health, the Food and Drug Administration (FDA), the blood banking industry, hemophiliac groups, and the National Gay Task Force (NGTF, now the National Gay & Lesbian Task Force (NGLTF)).²² At that meeting, CDC officials supported donor deferral guidelines—asking people in high-risk groups such as gay men, Haitians, and drug users to refrain from donating blood.²³

At that point, many participants remained unconvinced that GRID was blood-related, and opposition to the CDC proposal was widespread.²⁴ Hemophiliac groups, including the National Hemophilia Foundation (NHF), were concerned about labeling hemophiliacs with the stigma of a “gay disease,” and were also wary that panicked hemophiliacs might stop their Factor VIII treatment.²⁵ The gay community response was even stronger, arguing that it was “too soon to push for guidelines”, and that the civil rights of gays outweighed the inconclusive evidence about the risks of transmission.²⁶ The FDA itself was also unpersuaded of any pressing emergency.²⁷

17. See RANDY SHILTS, AND THE BAND PLAYED ON: POLITICS, PEOPLE, AND THE AIDS EPIDEMIC 115-16 (1987).

18. See *id.*

19. See *id.*

20. See *id.* at 160-61; see also CDC, U.S. Dep't of Health & Hum. Servs., *Pneumocystis Carinii: Pneumonia Among Persons with Hemophilia A*, MORBIDITY & MORTALITY WKLY. REP. 165 (July 16, 1982).

21. U.S. DEP'T OF HEALTH & HUM. SERVS., REPORT OF THE OPEN MEETING OF THE PUBLIC HEALTH SERVICE COMMITTEE ON OPPORTUNISTIC INFECTIONS IN PATIENTS WITH HEMOPHILIA (July 27, 1982).

22. See *id.* Notably, this meeting produced a change in the terminology associated with the epidemic. The label GRID had been detested by staffers at the CDC and different scientists were referring to the epidemic by different names. The group settled on “Acquired Immune Deficiency Syndrome” and “AIDS” was born. SHILTS, *supra* note 17, at 171.

23. See SHILTS, *supra* note 17, at 170.

24. See *id.*

25. See *id.*

26. See *id.*

27. *Id.*

The result of the meeting was a “wait and see” attitude, avoiding any communication of the risk to the public.²⁸ The only consensus recommendation was that there was an “urgent need” to determine ways of decreasing infectious risks from Factor VIII.²⁹ Yet the CDC, which lacked direct regulatory authority in this area, remained convinced there was a crisis in the wings.³⁰

2. The January 1983 Meeting

In December 1982, the first two confirmed cases of transfusion AIDS in San Francisco and New York were announced publicly.³¹ Despite these cases, and the other hemophiliac cases attributable to blood products, blood bank community members immediately responded that the evidence of transmissibility of AIDS by blood was still inconclusive and sought to avoid any decrease in confidence in the contaminated blood supply.³²

The next month, CDC epidemiologists called another meeting of constituent group representatives to discuss AIDS prevention more generally.³³ Based on the new data, and cases from the prior five months, participants agreed that it “would be desirable” to develop some method of screening the blood donor pool, but disagreed greatly on how that should be done.³⁴ The options discussed included surrogate testing,³⁵ voluntary restriction of “high-risk” potential donors, and the mandatory exclusion of those at high risk based on interviews or surveys.³⁶ The American Association of Blood Banks (AABB), the American Red Cross (ARC), and the Council of Community Blood Centers (CCBC),

28. *Id.* at 171.

29. Rep. of Open Meeting of July 27, 1982, *supra* note 21.

30. INSTITUTE OF MEDICINE, BLOOD BANKING AND REGULATION: PROCEDURES, PROBLEMS, AND ALTERNATIVES 9 (1996).

31. See CDC, *Possible Transfusion-Associated Acquired Immune Deficiency Syndrome (AIDS)—California*, M.M.W.R., Dec. 10, 1982; see also SHILTS, *supra* note 17, at 206-07, 210-11.

32. See SHILTS, *supra* note 17, at 206-207; see also Robert K. Jenner, *Chronology of AIDS*, in TRANSFUSION-ASSOCIATED AIDS 18, 19 (Robert K. Jenner ed., 1995).

33. Jenner, *supra* note 32, at 20.

34. See U.S. DEP'T OF HEALTH & HUM. SERVS., SUMMARY REPORT ON WORKGROUP TO IDENTIFY OPPORTUNITIES FOR PREVENTION OF ACQUIRED IMMUNE DEFICIENCY SYNDROME (1983).

35. Approximately 80% of those with AIDS tested positive on Hepatitis-B antibody tests available at the time. Some suggested that the Hepatitis-B test thus be used as a “surrogate” until an AIDS test was available. One concern, though, was that many people with Hepatitis-B did not have AIDS, and thus the test would overly narrow the donor pool. The FDA Blood Products Advisory Committee rejected the surrogate testing proposal on these grounds in 1984. See Sapolsky & Boswell, *supra* note 15, at 177.

36. SHILTS, *supra* note 17, at 206-07.

argued that the evidence of transmission through blood transfusions was still not strong enough to justify either excluding gay males from the donor pool or implementing “surrogate testing.”³⁷ They also feared that linking the blood supply and AIDS in the minds of the public would cause panic, and thus reduce both transfusions and donations.³⁸

Gay groups continued to oppose screening vehemently, decrying it as “scapegoating’ homosexuals,” “reminiscent of miscegenation blood laws that divided black blood from white,” and similar to the “rounding up of Japanese-Americans . . . to minimize the possibility of espionage” in World War II.³⁹ A NGTF representative expressed what would later turn out to be a problematic falsehood for prevention efforts: “So-called “fast-lane” gays are causing the problem and they are just a minority of male homosexuals. . . . You’ll stigmatize at the time of a major civil rights movement a whole group, only a tiny fraction of whom qualify as the problem we are here to address.”⁴⁰

The general response frustrated CDC officials greatly. One pounded the table and asked, “[h]ow many people have to die?”⁴¹ The meeting ended with no recommendation or agreed-upon next steps.⁴²

Later that month, the major blood banking groups released a joint public statement in opposition to donor screening, largely in response to NGTF lobbying.⁴³ Gay leaders heralded the announcement, saying things like “We’ve preserved not just gay rights but the human right to privacy and individual choice.”⁴⁴ The National Hemophilia Foundation responded with its own statement, making public its support for direct questioning and screening out of all members of high-risk groups. NGTF responded by denouncing the National Hemophilia Foundation, for its political response, “[p]itting victim against victim” in a “divisive and dangerous” maneuver.⁴⁵

37. Even if only gay males were excluded, there were still concerns about overinclusiveness. Because young white males disproportionately donated blood, blood banks often actively solicited blood donations in organized, urban gay communities. Sapolsky & Boswell, *supra* note 15, at 174. At Irwin Memorial Blood Bank in San Francisco, between five and nine percent of donors were gay men. Irwin’s medical director noted, “[t]hey are very good donors.” SHILTS, *supra* note 17, at 199.

38. See Sapolsky & Boswell, *supra* note 15, at 173.

39. SHILTS, *supra* note 17, at 220.

40. *Id.* at 222 (quoting Dr. Bruce Voeller).

41. *Id.* at 220 (quoting Dr. Don Francis).

42. *Id.* at 223.

43. See *id.* at 224.

44. *Id.* (quoting Dr. Roger Enlow); see also BAYER, *supra* note 10, at 80.

45. BAYER, *supra* note 10, at 81.

But the gay community itself was starting to fracture, questioning what the socially responsible approach was. Many organizations quietly began supporting voluntary deferral, particularly in San Francisco and New York.⁴⁶ Some groups said it would be fine for individuals to exclude themselves voluntarily based on perceived risk, but feared mass exclusion imposed by external actors.⁴⁷ As many individual blood banks sought to discourage all gay men from donating blood, they sought out the engagement of these local gay groups.⁴⁸ For example, the Medical Director of the Washington Region of the Red Cross repeatedly held open fora with the Washington gay community in 1983 to discuss best practices for reducing stigma while reducing HIV transmission.⁴⁹ Perhaps even more remarkably, the feedback he received actually shaped policy decisions.⁵⁰ Meetings like these happened throughout the country. As former New York Blood Center Vice President Dr. Johanna Pindyck noted in 1986: "It is to the credit of the leadership of organizations that represent AIDS risk group members that they have recognized the medical necessity of [the exclusion of high risk groups from the blood pool] and actively support the introduction of socially acceptable ways to accomplish this goal."⁵¹

Pindyck may have been too kind to the gay community, though. In San Francisco, a debate erupted in 1983 between a local group, Bay Area Physicians for Human Rights, and their national parent, American Association of Physicians for Human Rights (AAPHR), when the chapter announced it planned to urge cooperation with the voluntary screening out of gay men at Irwin Memorial Blood Bank.⁵² In return, Irwin had agreed not to ask donors about their sexuality.⁵³ The AAPHR National Convention voted to condemn the move.⁵⁴ In New York, NGTF held a massive press conference denouncing the actions of the New York Blood Center in its attempt to screen.⁵⁵ The National AIDS Forum, a convention that, at the time, mostly included gay men and gay groups, issued a scathing report, saying:

46. *See id.* at 82-83.

47. *Id.*

48. *Id.*

49. *Id.*

50. *See Doe v. Am. Nat'l Red Cross*, 866 F. Supp. 242, 246-47 (D. Md. 1994).

51. Johanna Pindyck, *The Gift of Blood: Social Policy in Evolution, in AIDS AND PATIENT MANAGEMENT* 150, 151 (Michael D. Witt ed., 1986).

52. *See SHILTS*, *supra* note 17, at 238.

53. *See id.*

54. *See id.*

55. *See id.*

The quarantine of blood is an ominous first step towards further social, political, economic and even physical quarantine of a community already denied many basic civil rights protection. Stigmatizing the blood of an already disenfranchised segment of society may permit homophobic and racist forces to accomplish in the name of ‘science’ what they thus far have been unable to fully accomplish politically.⁵⁶

The convention also issued reports condemning the “premature endorsement” of the single virus theory of AIDS and any attempts to alter sexual behavior to reduce risk.⁵⁷

3. The First Guidelines and Community Outreach

As more about the etiology of AIDS became known, it became clear that there was a “latency period,” a period where an individual could transmit HIV and not show any symptoms that even the most experienced clinician could notice, and thus some screening policy was needed.⁵⁸ In March of 1983, the U.S. Public Health Service (PHS), which includes both the FDA and the CDC, issued nonmandatory guidelines on the matter, urging members of groups at “increased risk for AIDS” to refrain from donating plasma or blood.⁵⁹ Notably, the guidelines only included gays who were currently sexually active with multiple partners, had “overt symptoms of immune deficiency,” or had previously engaged in sexual relations with people who now did.⁶⁰ The FDA asked blood collection agencies to provide educational materials on AIDS to donors, and to educate staff about identifying early signs or symptoms of AIDS in potential donors.⁶¹ At the same time, physicians were urged both by blood banks and the PHS to provide transfusions only when “medically necessary.”⁶²

The PHS policy was seen as “very cautious,” but gay community leaders still feared that blood donors would be subject to direct questioning about their sexual orientation and/or practices.⁶³ In response to these concerns expressed by gay community groups, blood collection agencies adopted a variety of screening procedures designed to reduce

56. *Id.* at 326-27.

57. *Id.* at 327.

58. *See* BAYER, *supra* note 10, at 83-84; *see also* IOM Comm. Rep., *supra* note 9, at 70-73 (discussing the meetings and announcements of Jan.-Mar. 1983).

59. *See id.* at 85.

60. SHILTS, *supra* note 17, at 242-43.

61. *See* Jenner, *supra* note 32, at 22.

62. *Id.* at 23.

63. BAYER, *supra* note 10, at 84-85.

stigma and minimize privacy invasion.⁶⁴ In some cases, this involved asking donors to read a pamphlet that listed high-risk groups, including intravenous drug users, MSMs, recent Haitian immigrants, and those who were experiencing any of the known symptoms of HIV.⁶⁵ Donors were instructed that if they fell within any of those groups, they should refrain from donating blood, but no one would ask them why they were not donating.⁶⁶ Alternatively, some groups, including Red Cross chapters, allowed donors to call a confidential toll-free number after they donated blood, where they could instruct that their blood not be used, a process referred to as “confidential unit exclusion.”⁶⁷ This differed from proposals that would require blood collectors to ask donors their sexual orientation directly, a proposal that both gay community groups and FDA officials rejected due to a fear of “being potentially intrusive into personal matters, being possibly unethical, having the potential of institutionalizing a stigma on groups already prone to prejudice and persecution and possibly being ineffective in identifying persons in these high risk groups.”⁶⁸

By the end of 1983, these screening policies became the norm. Gay community groups grudgingly accepted them, with the understanding that, once some sort of test for AIDS was developed, screening would no longer be needed.⁶⁹ By December 1983, one gay rights group, AAPHR, was advocating that the only gay men who should donate blood were those who had been in mutually monogamous relationships for at least three years.⁷⁰

4. The Development of ELISA and the End of Debate?

Throughout 1984, the policy was tweaked, and actually broadened, partially in response to concern that sexual orientation, as opposed to sexual conduct, was being screened.⁷¹ The policy was changed from deferrals of homosexual and bisexual men with multiple partners, to

64. *See id.* at 85-86.

65. Different organizations used different definitions of what constitutes the high-risk group of gay men. Usually, the group included sexually active homosexual or bisexual men, though some organizations narrowed the group to those with multiple partners. *See Smith v. Paslode Corp.*, 799 F. Supp. 960, 969-70 (E.D. Mo. 1992).

66. *See id.*

67. *See Marcella v. Brandywine Hosp.*, 838 F. Supp. 1004, 1008 (E.D. Pa. 1993).

68. *Doe v. Amer. Nat'l Red Cross*, 866 F. Supp. 242, 245-46 (D. Md. 1996).

69. *See BAYER*, *supra* note 10, at 86.

70. *See id.*

71. *See id.* at 92-93.

“males who have had sex with more than one male since 1979.”⁷² This change, although conceivably broadening the scope of the deferral was met by “no sign of protest.”⁷³ Public health ethicist and historian Ronald Bayer explains that the impending development of a blood screening test had seized priority among the gay community.⁷⁴ By late 1984, scientists had identified the virus that caused AIDS, known as HTLV-III.⁷⁵ In 1985, efforts began to develop a procedure for screening blood with the enzyme-linked immunosorbent assay test (ELISA).⁷⁶ At the time, studies showed the test to be 68-100% effective in identifying patients with AIDS.⁷⁷ Bayer notes, “[s]o alarmed had gay groups become about the imminent licensing of the antibody test that early opposition to donor exclusion on the basis of sexual orientation and practices virtually vanished.”⁷⁸

HHS officials had proposed to roll out the ELISA test in 1985 so blood centers could use it to screen all blood donations.⁷⁹ At first, gay rights groups protested this move as well.⁸⁰ They argued that gay men would now disproportionately give blood in order to find out if they had HTLV-III.⁸¹ Because 50% of gay men at the time were estimated to be infected with HTLV-III, they also feared the test would be used as a test for homosexuality, and had concerns about the privacy of test results.⁸² The safety of the blood supply got caught up in the larger imbroglio of privacy and testing, which still is debated today.⁸³ The issue of gays and donor deferral was replaced with concerns about the impact of widespread testing, including dealing with the potential diagnosis of thousands of gay men en masse.⁸⁴

72. *Id.* at 91. The policy was subsequently amended again to cover any men who had had sex with another male, regardless of how many partners.

73. *Id.*

74. *See id.*

75. *See id.*

76. *See id.*

77. Jenner, *supra* note 32, at 26.

78. BAYER, *supra* note 10, at 91.

79. *See id.* at 93.

80. *See id.* at 94.

81. *See id.*

82. SHILTS, *supra* note 17, at 515.

83. *Id.*

84. *Id.* at 539-43.

B. Revisiting the Issue

The Blood Products Advisory Committee (BPAC) reviews its donor deferral policies biennially.⁸⁵ Since the MSM policy's creation, only twice has repeal of the policy been seriously considered.⁸⁶ In September 2000, the BPAC considered moving from a lifetime deferral policy for MSMs to a deferral of five years from the time of last male-male sexual contact.⁸⁷ According to one observer, "[a]t the start of the meeting, the committee agreed that the permanent ban on gay men seemed discriminatory, lacked a firm foundation in science, and should be changed."⁸⁸ The panel considered testimony of the Gay and Lesbian Medical Association, HRC, various hemophilia groups, and AABB—all urging a change in the policy.⁸⁹ Only the American Red Cross urged no change be made.⁹⁰

In a vote of 7 to 6, the committee rejected the move, citing uncertainty in the scientific evidence about the efficacy of blood testing procedures.⁹¹ Skepticism was fueled by the revelation that, by age 40, a full 1/3 of gay men in the United States are infected with human herpes virus-8, a virus used as an indicator of unprotected sexual activity trends.⁹²

In the summer of 2005, the American Red Cross silently reversed its stance on the MSM policy, and joined the AABB and America's Blood Centers (ABC) in support of a one-year deferral period for MSMs.⁹³ Some suggested that student protests were the impetus, but others suggested the generally low blood supply was responsible.⁹⁴ Once the Red Cross joined the other blood industry organizations, the BPAC held a workshop and considered public testimony and other evidence in

85. See generally FDA, BLOOD PRODUCTS ADVISORY COMMITTEE MEETINGS, 1998-2007, available at <http://www.fda.gov/cber/advisory/bp/bpmain.htm>.

86. See generally FDA, BLOOD PRODUCTS ADVISORY COMMITTEE MEETING, March 15-16, 2001, available at <http://www.fda.gov/ohrms/dockets/ac/cber01.htm#Blood%20Products>. See also FDA, BLOOD PRODUCTS ADVISORY COMMITTEE MEETING, September 14-15, 2000, available at <http://www.fda.gov/ohrms/dockets/ac/cber00.htm#Blood%20Products>.

87. Derek Link, *Should Gay Men Be Allowed To Donate Blood?*, TREATMENT ISSUES, Nov./Dec. 2000, available at <http://www.thebody.com/gmhc/issues/novdec00/blood.html>.

88. *Id.*

89. *Id.* Some supported total repeal or deferrals of one year as opposed to the five-year deferral policy proposed, though.

90. See *F.D.A. Panel Rejects Bid To Ease Ban on Blood Donations by Gays*, N.Y. TIMES, Sept. 14, 2000, at A29.

91. *Id.*

92. See Link, *supra* note 87.

93. See Stein, *supra* note 3, at A06.

94. See Steven Bodzin, *Red Cross Eases Ban on Gay Donors*, BOSTON GLOBE, Mar. 18, 2006 (noting Red Cross's failure to say why it changed its stance).

March 2006.⁹⁵ The workshop itself included testimony including a range of viewpoints, but resulted in no conclusive action.⁹⁶

Though opponents of the MSM policy were encouraged by the Red Cross's changed policy and the FDA workshop, they largely remain opposed to *any* deferral policy geared specifically towards MSMs.⁹⁷ Advocacy groups, including several major gay rights organizations, such as Lambda Legal, issued a statement indicating their fundamental disagreement with "equat[ing] any and all MSM activity with high-risk heterosexual sex that would, by current FDA regulations, result in a one-year deferral."⁹⁸ In the past year, there have been no further developments.

III. REACTIVE ADVOCACY

There are three basic arguments that advocates of repeal make. One claim is that evolving technology has made screening for the HIV virus in donated blood sufficiently reliable.⁹⁹ The second is that the system of self-identification means that the policy has negligible benefit, because people lie about their sexual history in order to donate blood (or to avoid explaining why they cannot).¹⁰⁰ The third is that the policy instills fear amongst gays while encouraging a "false sense of security" in heterosexuals.¹⁰¹

Most prominently, these arguments have been made by student groups on college campuses across the country, mostly LGBT student clubs or student government associations that sponsor blood drives. These campaigns have ranged from the 2006 "Fight to Give Life" campaign, where gay student groups at over twenty college campuses led

95. See FDA Workshop on Behavior-Based Donor Deferrals in the NAT Era (Mar. 8, 2006) (transcript available at <http://www.fda.gov/cber/minutes/nat030806t.htm>) (last visited May 5, 2007); Bodzin, *supra* note 94; Stein, *supra*, note 3.

96. FDA Workshop, *supra* note 95.

97. See, e.g., Press Release, Gay & Lesbian Med. Ass'n, Coalition of Advocacy Groups Encouraged by Bold New Dialogue on Possible Blood Donation Policy Change (Mar. 27, 2006), available at <http://www.glma.org/> (follow "Newsroom" hyperlink; then follow "Press Release" hyperlink; then follow "Coalition of Advocacy" hyperlink).

98. *Id.*

99. See, e.g., Press Release, Gay & Lesbian Med. Ass'n, GLMA urges FDA to revise Blood Donation Policy Current FDA Guidelines called "Dangerous, Outdated, Unscientific" (Jan. 24, 2007), available at <http://www.glma.org/> (follow "Newsroom" hyperlink; then follow "Press Release" hyperlink; then follow "GLMA urges" hyperlink).

100. See, e.g., Richard Tate, *Thanks, But No Thanks: Citing a 16-year-Old Ban, the American Red Cross Still Won't Accept Blood Donations from Sexually Active Gay Men*, ADVOC., Oct. 23, 2001, at 22; Tu Thanh Ha, *Gay Lied About Sexual Orientation To Protest Ban on Blood Donations*, GLOBE & MAIL (Toronto, ON), Jun. 11, 1999, at A6.

101. Gay & Lesbian Med. Ass'n, *supra* note 99.

gay male students to blood centers, where they attempted to give blood, to individual protests and the filing of discrimination complaints.¹⁰² In Spring 2007, a group of Harvard Law students joined the fray by creating a website aimed at “bringing sense back into America’s blood donation policy.”¹⁰³ The quality and accuracy of these campaigns range greatly, but there are several common problems that such student advocacy groups present, often tied to the unique dynamic of organizing on college campuses.¹⁰⁴

College campuses are a logical point of action for the MSM policy; students as a whole have shown themselves to be more supportive of gay rights and opposed to discrimination than the general population.¹⁰⁵ More generally, universities have been the site of major social movement activity throughout the twentieth century.¹⁰⁶ But the involvement of gay students on the MSM policy likely has other explanations beyond a general commitment to justice.¹⁰⁷ Student advocates engage in consciousness-raising activities tied to the “[p]ublic performance of the cognitively liberated self,” traditionally a cornerstone of social movement activity.¹⁰⁸ This creation of collective identity is extremely attractive to many college students, many of whom are coming out of the closet and first openly presenting themselves as gay. Further, protest activity presents individuals with the opportunity to strengthen bonds to a gay community, something few students encounter before coming to college.

102. See Andrew Keegan, *FDA Meeting Revisits Ban on Gay Blood Donors: College Students Organize Protest Over Current Policy*, WASH. BLADE, Mar. 10, 2006, at 19, available at <http://www.washblade.com/2006/3-10/news/national>.

103. Bloodsense.org, <http://www.bloodsense.org> (last visited Oct. 27, 2007).

104. There have been a few high school campuses that have reacted, but far too sparse to be considered a movement, or even to identify any discernable patterns. See, e.g., Dana Hull, *Red Cross Seeks to End Gay Blood Ban*, MONTEREY CO. HERALD (CA), Jan. 26, 2007, at B2 (discussing protest activity at a Santa Cruz high school); Vin Moran, *Students Protest Blood Donor Ban*, CONN. POST, Oct. 17, 2006, at A5.

105. See Henry F. Fradella et al., *Sexual Orientation, Justice, and Higher Education: Student Attitudes Towards Gay Civil Rights and Hate Crimes*, 11 TUL. J. L. & SEXUALITY 11 (2002) (noting high levels of tolerance of LGBT persons and support for gay rights on college campuses).

106. Most famously at Columbia University, the University of California at Berkeley, and Kent State University in the 1960s and 1970s. See Eric L. Hirsch, *Sacrifice for the Cause: Group Processes, Recruitment, and Commitment in a Student Social Movement*, in WAVES OF PROTEST 47 (Jo Freeman & Victoria Johnson eds., 1999) (analyzing Columbia University student-led divestment campaign).

107. I use the term gay both out of a combination of habit and convenience, and because, as a policy addressing men who have sex with men, the leadership of advocacy on campuses has been almost entirely gay male.

108. Tomiko Brown-Nagin, *Elites, Social Movements, and the Law: The Case of Affirmative Action*, 105 COLUM. L. REV. 1436, 1504-05 (2005).

While this group identity aspect may increase the number of participants engaged in anti-MSM policy activity, it has negative consequences for the quality of that advocacy. Gay college students are responding out of a sense of indignity, based on the idea that: “Homosexuality is placed in the same class as prostitution and intravenous drug use, practices that also result in a permanent ban on giving. For a well-adjusted, HIV-negative, upper middle-class, homosexual college student, this seems like a smear and smells discriminatory.”¹⁰⁹ Because many college students come out for the first time in college, their attempts to give blood are often the first time they have ever faced personal discrimination. As one student activist commented, “I have never been openly discriminated to my face like that before, and I have never cried as hard as I did when I returned to my room after trying to give blood.”¹¹⁰

Many gay college students in the twenty-first century have also never met anyone with HIV, and certainly do not consider themselves high-risk, regardless of whether they actually are. To many of these students, to be associated with HIV, and the stigma it represents, is in and of itself offensive. One student organizer commented on this, noting that “the two-decade-old ban does nothing more than instill fear [of HIV] in young gay men.”¹¹¹ Clearly, the fear of HIV amongst gay males caused by the MSM policy is nowhere near the levels experienced throughout the 1980s. And many gay community leaders, as discussed below, actually lament the lack of concern and fear of HIV in young gay men of today as a distressing trend.¹¹²

Student advocates often act via disruptive tactics, “aimed at creating conflict to pressure elites.”¹¹³ But as with all disruptive social movement activity, students challenging the MSM policy often “risk alienating the public and policymakers whose support is often necessary to make the changes the movement seeks.”¹¹⁴ For example, at Tufts University, one student brought a discrimination complaint against the student community service group that hosted a New England Red Cross blood

109. Link, *supra* note 87.

110. Marie McCullough, *After His Rejection, Gay Man Challenges Blood-Donor Policy*, PHILA. INQUIRER, Apr. 29, 1995, at B3.

111. Keegan, *supra* note 102.

112. Sharon Bernstein, *HIV Ads Embrace, and Stun, Audience*, L.A. TIMES, Sept. 30, 2006, at A18.

113. Anna-Maria Marshall, *Social Movement Strategies and the Participatory Potential of Litigation*, in CAUSE LAWYERS AND SOCIAL MOVEMENTS 164, 165 (Austin Sarat & Stuart A. Scheingold eds., 2006).

114. *Id.*

drive, potentially subjecting the group and its leaders to disciplinary sanctions.¹¹⁵ This was particularly divisive since many LGBT students were active in the organization's various projects, including a group that raised funds for AIDS research and outreach, and partnered with a number of primarily gay organizations that provided direct services to AIDS patients.¹¹⁶ After generating a number of op-ed articles in the school paper,¹¹⁷ none of which supported any action against the blood drive sponsors, and a number of hostile meetings with school administrators, a "compromise" was reached, where the community service group agreed to provide information about the policy at future blood drives.¹¹⁸ While the action thus raised consciousness around the policy, it also inspired negative attitudes towards the gay community and damaged potential alliances.¹¹⁹ The final outcome likely could have occurred without the filing of charges and attendant loss of allies, and achieved an additional "win" in the form of a positive intergroup dialogue.

Student groups are also challenged by their tendency to have little or no institutional memory. At Columbia University, for example, one student recently wrote an op-ed piece condemning the University's failure to recognize the homophobia of the blood drives hosted on campus.¹²⁰ cursory research indicates, however, that not only had university officials met with students about the issue, but the school's Office of the President had organized a discussion panel about the MSM policy and advocacy to change it.¹²¹ Condemnation of supportive administrators—whose power in this case is questionable—only decreases the likelihood for administrators to continue to support repeal actively. These problems suggest that dispersed college student groups are not

115. See Mark Phillips, *LCS Blood Drive at Risk; LGBT Community Claims Discrimination*, TUFTS DAILY, Apr. 29, 2004, available at <http://www.tuftsdaily.com/news/2004/04/29/News/>.

116. *Id.*

117. See, e.g., Editorial, *Red Cross Policy Not Discriminatory*, TUFTS DAILY, Apr. 29, 2004, available at <http://www.tuftsdaily.com/news/2004/04/29/Editorials/>; Justin Craigie, Opinion, *Blood Drives Should Continue*, TUFTS DAILY, Apr. 30, 2004, available at <http://www.tuftsdaily.com/news/2004/04/30/Viewpoints>.

118. See Patrick Gordon, *Red Cross Blood Drives to Continue On-Campus*, TUFTS DAILY, Dec. 2, 2004, available at <http://www.tuftsdaily.com/news/2004/12/02/News/>.

119. See Phillips, *supra* note 115.

120. Steven Teague, Opinion, *Bad Blood: Exposing the FDA's Homophobia*, COLUM. DAILY SPECTATOR, Apr. 9, 2007, available at <http://www.columbiaspectator.com/node/24737>.

121. See Editorial, *Clean Blood*, COLUM. DAILY SPECTATOR, Oct. 18, 2006, available at <http://www.columbia.spectator.com/node/22507>; Sadia Latifi, *Donation Policy Blasted: Student Says Blood Drive Discriminates Against Gay Men*, COLUM. DAILY SPECTATOR, May 3, 2006, available at <http://www.columbiaspectator.com/node/21678>.

likely to be successful in overcoming a ban on MSM blood donation, at least not without some form of professional guidance and/or national coordination.

IV. CHANGING THE FRAME

Current advocacy tactics rely heavily on the unfairness and stigmatic harm brought about by the MSM policy, as well as its roots in homophobia.¹²² The Harvard Law student initiative, for example argues that “the government” is acting out of “discrimination rather than science, scapegoating rather than equality, paranoia rather than dignity.”¹²³ These justice-based arguments have not been particularly successful, however, in changing the policy. Part of the problem, as expressed by Blood Products Advisory Committee members in their consideration of the policy in 2000, is that the discriminatory effect of the policy is not in question.¹²⁴ To policymakers, the question is whether or not that discrimination is justified by the risk a repeal of the policy would bring.¹²⁵ In fact, this has *always* been the question about the screening policy.¹²⁶

Nonetheless, gay rights advocates consistently dismiss concern about risk as pretext for homophobia, or “plainly absurd.”¹²⁷ Even if the concern about risk is just a sham, though, it is clear that the conflict structure has already been framed around the issue of risk.¹²⁸ Trivializing and dismissing the counterargument will not effectively lead to change. The justice-based arguments advanced also have some fundamental weaknesses. In focusing on risk, while not a slam-dunk argument, advocates can at least get a better understanding of the terms of the debate, and the strategies most likely to persuade.

More broadly, justice-based arguments are not particularly powerful in the current political climate. As David Cole notes, such “claims are

122. See, e.g., Culhane, *supra* note 4, at 131 (stating the MSM policy “erodes self-esteem and contributes to a climate in which other kinds of discrimination are more easily justified”); Policy Resolution, Gay and Lesbian Medical Association, *Urge FDA to Revise Blood Giving Guidelines*, Oct. 25, 1997, revised May 20, 2001, available at <http://www.glma.org/> (follow “Advocacy” hyperlink; then follow “Policy Resolutions” hyperlink; then follow “Urge FDA to revise Blood Giving Guidelines” hyperlink) (noting the personal shame and unfair stigmatization that gay men experience as a result of the policy).

123. Bloodsense.org, *supra* note 103.

124. See *F.D.A. Panel Rejects Bid To Ease Ban on Blood Donations by Gays*, *supra* note 90, at A29 (noting that even those who voted against repeal were sympathetic to discrimination arguments, but were unconvinced by scientific evidence of risk reduction).

125. See *id.*

126. See BAYER, *supra* note 10, at 73 (discussing this debate in 1983-84).

127. Culhane, *supra* note 4, at 131.

128. See Andersen, *supra* note 11, at 11-12.

received more skeptically, and therefore appeals to cost, to self-interest, and to the majority's well-being are increasingly important."¹²⁹ Therefore, he argues, more utilitarian arguments should be embraced by progressives. There are two utilitarian arguments that MSM policy opponents can make. One relies on the chronic blood shortage in the United States. Like calls to repeal "Don't Ask, Don't Tell" in a time of troop shortage, this argument has a dangerous undertone that gay blood (or soldiers) is "good enough" only when other options have been exhausted. More palatable, though, is the argument that the state of blood-screening and decreases in the prevalence of HIV within the MSM population drastically reduce the risk of transmission through donated blood. This Part of the Article analyzes both the weaknesses of the justice arguments and explores the viability of this risk-related argument and the context in which it can be made.

A. *The Flaws of the Justice Argument*

The claim that blood screening is discriminatory and unjust is not new; it is the exact same claim that was made throughout the early 1980s in resistance to various HIV prevention policies, as discussed above. While much has changed in the intervening time, the arguments have not necessarily gained any traction. In fact, claims of injustice in blood screening may have lost valence since the 1980s. Current knowledge about HIV transmission indicates that many delays in enacting prevention policies were deadly, and various constituencies have expressed anger at the gay community for delaying action regarding the blood supply, in particular, in the name of feeling "discriminated against."¹³⁰

Though no one has explicitly asked, if the MSM policy had been in place from Day 1 of the HIV/AIDS epidemic, how many cases of transfusion transmission would have been eliminated? We can get some sense of this from the significant number of cases brought throughout the country challenging a lack of more aggressive screening of blood donors in the early 1980s.¹³¹ In many of these cases, infected persons were able

129. David Cole, *What's a Progressive to Do? Strategies for Social Reform in a Hostile Political Climate*, in *VARIETIES OF PROGRESSIVISM IN AMERICA* 107, 121 (Peter Berkowitz ed., 2004).

130. Robert Koehler, 'Blood and Politics': *Report on HIV, Ethics*, L.A. TIMES, Nov. 30, 1993, at F4.

131. See, e.g., *Doe v. Am. Nat'l Red Cross*, 866 F. Supp. 242 (D. Md. 1994) (considering claim of negligence due to Red Cross' failure to surrogate test or directly question donors about their sexuality); *Marcella v. Brandywine Hospital*, 838 F. Supp. 1004 (E.D. Pa. 1993) (considering claim of negligence against failure to screen out high-risk blood donors); *Seitzinger v. Am. Red*

to track back their blood specifically to a gay man.¹³² Also, for a period of time, the Red Cross and other organizations followed a “[l]ook [b]ack” policy, where they tested old blood samples, and informed those who tested positive.¹³³

The early resistance of the gay community included a sense of denial of the risk gay men faced.¹³⁴ The erroneous belief that only “fast lane” gays were at risk of AIDS led to many other gays staying in the blood donor pool.¹³⁵ But beyond that, there was a sense of disingenuousness in much of the advocacy against screening. In 1983, after a NGTF press conference opposing the screening of blood, Michael Callen, a leader of People with AIDS, took note of this problem. As expressed by Randy Shilts:

He knew that virtually every gay man there had had hepatitis B and that most had engaged in the kind of sexual activities that put them at high risk for AIDS. Not one of them could in good conscience donate blood, Callen thought, and here they were, exuding self-righteous indignation at the thought that someone would suggest they did not have the right to make such donations.¹³⁶

Advocates must take this history into consideration. Their insistence that the blood policy has led to widespread stigmatization and discrimination has no factual support. While, certainly, individual gay men have felt bad about not being able to give blood, it is far-fetched to say this harm is analogous to that caused by antimiscegenation laws. Further, it is hard to argue that the stigma and discrimination in American society that does exist, in lower concentrations than it did when the policy was first enacted, has anything to do with this policy. In fact, many advocates point out that most gay men do not even know this policy exists until they actually try to give blood.¹³⁷

Justice arguments that focus on the “rights” of gay men as opposed to their dignitary interests are similarly weak. While it is true, as

Cross, No. 90-0046, 1992 U.S. Dist. LEXIS 18445 (E.D. Pa. Nov. 30, 1992); *Smith v. Paslode Corp.*, 799 F. Supp. 960 (E.D. Mo. 1992) (challenging blood bank’s failure to surrogate test and/or use a “more aggressive, confrontational interview to screen high risk donors”); *Osborn v. Irwin Memorial Blood Bank*, 5 Cal. App. 4th 234 (Cal. App. 1992); *Price v. Blood Bank of Delaware*, 790 A.2d 1203 (Del. 2002) (considering claim that gay men should have been excluded from the donor pool at an earlier time).

132. See *Marcella*, 838 F. Supp. at 1005; see also *Wadley Research Inst. v. Beeson*, 835 S.W.2d 689, 692 (Tex. Ct. App. 1992).

133. *Marcella*, 838 F. Supp. at 1006.

134. See SHILTS, *supra* note 17, at 222.

135. See *id.*

136. *Id.* at 239.

137. See *Tate*, *supra* note 100, at 22.

advocates point out, that the policy discriminates against “good, caring, decent people that want to help,”¹³⁸ the right to give blood is clearly not absolute—or even one that seems compelling to many people. Thus, the issue again turns to risk, not to whether it would be good if everyone were free to give blood. Advocates do not doubt this, because they often concede that, when the policy was introduced, it was justified.

The final justice argument is perhaps the most complicated one. Grounded in concepts of equality, it demands that gay males be treated the same as others at “similar risk.” It is unclear what this means though, particularly in light of the fact that what *puts* gay men at higher statistical risk for HIV is the fact that they are gay. While some advocates argue that “HIV does not discriminate,” which is literally true, statistics indicate that 71% of all men infected with HIV each year are men who have sex men—even though they represent only 5-7% of the total male population.¹³⁹ This represents over 51% of all HIV cases in the United States, a number that is actually rising after a decline throughout the 1990s.¹⁴⁰ So although it might be nice to believe that “[g]ays per se are not engaging in any high risk behavior simply by being Gay,”¹⁴¹ that sadly is not true.

This implicates what Patricia Cain refers to as the “sameness argument.”¹⁴² When can gay rights advocates argue that gay people are “just the same” as straight people, and when should they? The gay community has fractured over this issue most prominently in the marriage context, as many argue that same-sex marriage is a heteronormative institution with which gay people should not feel the need to conform.¹⁴³ More generally, though “activists often disavow sameness arguments because of their tendency to devalue the very thing that makes [homosexuals] who [they] are.”¹⁴⁴ While increased risk for HIV is not what makes gay men who they are, it certainly is a part of the realistic daily living experience of being a gay man, tied to sexual

138. Ryan Burr, *Blood Feud: Bay Doctor, AIDS Program Director Question Rules that Ban Gay Men, Some Members of Military from Donating Blood*, NEWS HERALD (Panama City, FL), Apr. 24, 2006.

139. CDC, Fact Sheet, HIV/AIDS among Men Who Have Sex with Men, July 2006, available at <http://www.cdc.gov/hiv/topics/msm/resources/factsheets/pdf/msm.pdf>.

140. See *id.*

141. Leland Traiman, *Guidelines but No Guidance: GaySpermBank.com v. FDA*, 9 J. GENDER RACE & JUST. 613, 620 (2006).

142. PATRICIA A. CAIN, RAINBOW RIGHTS 33-34 (2000).

143. See Andersen, *supra* note 11, at 177.

144. CAIN, *supra* note 142, at 277.

practices—a truth that many advocates avoid.¹⁴⁵ Is it possible that increased risk for HIV can be seen as a “natural difference” between gay men and other groups?¹⁴⁶

Outside of the MSM policy, many gay community leaders quite loudly acknowledge that when it comes to HIV risk, gay men are not the same as their straight counterparts. In fall 2006, the Los Angeles Gay and Lesbian Center faced great criticism over its billboard campaign that proclaimed “HIV is a gay disease.”¹⁴⁷ In their defense, the Center’s leaders explained that gay men in the United States have developed a “false sense of security,” and in Los Angeles, a full 75% of HIV cases are MSM.¹⁴⁸ Nonetheless, other LGBT organizations charged the Center with stigmatizing and segregating the gay male population, similar to the arguments made in the blood context. The dispute implicates an argument made by medical anthropologist Nancy Scheper-Hughes, “While all of us can learn to overcome (or at least deal with) stigma and social exclusion, few can beat the virus itself.”¹⁴⁹

B. Understanding Risk

Scheper-Hughes’ statement provides a good launching point for the next concern: examining what the risk of transmitting the virus actually is. But it is also important to understand why public health officials and gay rights advocates see the risk involved so differently.

Public health practitioners traditionally rely on a concept known as the “precautionary principle” in crafting regulatory policy.¹⁵⁰ The precautionary principle encourages policymakers to take the most cautious, risk-averse option whenever an activity potentially threatens

145. See *id.* at 285-86 (discussing hesitance of activists to discuss sex when advocating for gay rights).

146. Though the higher rate of HIV may be the result of social/structural factors, the MSM policy is clearly not the cause of that disparity. Whether there truly are any “natural differences” is a matter of debate. See, e.g., Edward Stein, *Evaluating the Sex Discrimination Argument for Lesbian and Gay Rights*, 49 UCLA L. REV. 471, 507-09 (2001); CAIN, *supra* note 142, at 278-79.

147. See Sharon Bernstein, *Ads Embrace and Stun Audience*, L.A. TIMES, Sept. 30, 2006, at A1.

148. *Id.* This directly contradicts the language of many MSM policy opponents who argue that the MSM policy creates a false sense of security among heterosexuals, and inspires an irrational fear in gay men. See, e.g., Press Release, Gay & Lesbian Med. Ass’n, *supra* note 99 (discussing “false sense of security”); Traiman, *supra* note 141 at 620; Belli, *supra* note 6, at 364-65.

149. Nancy Scheper-Hughes, *AIDS, Public Health and Human Rights in Cuba*, 342 LANCET 965, 967 (1993).

150. See, e.g., David Kriebel et al., *The Precautionary Principle in Environmental Science*, 109 ENV. HEALTH PERSP. 871, 871 (2001).

harm to human health.¹⁵¹ Those proposing an intervention bear the burden of proving that there will be no resultant harm.¹⁵² This zero-tolerance approach has been endorsed by many in the context of the blood supply, including in general public sentiment.¹⁵³ As one commentator has noted, this means that what might be considered an overbroad exclusion in legal terms will often be considered acceptable and even necessary from a public health perspective.¹⁵⁴

The risk of HIV transmission through blood transfusion is still, unfortunately, not zero. Though cases of transfusion AIDS are rare, they do still occur.¹⁵⁵ While the “latency period” in which the presence of HIV in the blood is undetectable gets shorter and shorter each year, it still exists, and approximately ten HIV-infected units slip through the twelve million units each year, resulting in two to three cases of transfusion transmission.¹⁵⁶ Given the higher prevalence of HIV in the gay male population, statistically, an increase in gay male donors would likely increase this ratio, albeit marginally. In light of these statistics, few have proposed an outright repeal of the MSM policy, but merely a reduction in the length of the deferral, to try and reduce the statistics to an “acceptable risk.”¹⁵⁷ Thus, the debate centers over what is an acceptable risk, and what increase in risk is ethically justified in order to reduce feelings of stigma. Contrary to the views of some gay rights advocates, this

151. See *id.* at 871.

152. See *id.* But see Cass R. Sunstein, *Beyond the Precautionary Principle*, 151 U. PA. L. REV. 1003 (2003) (critiquing the precautionary principle).

153. See, e.g., Keegan, *supra* note 102 (quoting FDA spokesman “Congress and the public have made it clear they expect the FDA to ensure the lowest risk feasible concerning transmission of serious infectious diseases by donated blood and blood components”); Editorial, *Blood Stigma, Blood Risk*, N.Y. TIMES, Apr. 29, 1990.

154. Francine A. Hochberg, Note, *HIV/AIDS and Blood Donation Policies: A Comparative Study of Public Health Policies and Individual Rights Norms*, 12 DUKE J. COMP. & INT’L L. 231, 233 (2002).

155. See, e.g., *Japanese Patient Infected With HIV by Donated Blood*, HIV, STD, TB PREVENTION NEWS UPDATE, Dec. 29, 2003, available at <http://www.thebody.com/content/art22967.html>; *Florida: Tainted Donor Blood Infects Two*, HIV, STD, TB PREVENTION NEWS UPDATE, July 19, 2002, available at http://www.thebody.com/cdc/news_updates_archive/july19_02/florida_blood.html; *Texas Man Sues After Being Infected with HIV from Transfusion*, HIV, STD, TB PREVENTION NEWS UPDATE, Apr. 1, 2002, available at http://www.thebody.com/cdc/news_updates_archive/apr1_02/autrey.html.

156. See Deborah Josefson, *FDA Declines To Lift Ban on Homosexual Men as Blood Donors*, 321 BMJ 722 (2000). See also Human Rights Campaign, *supra* note 3.

157. See, e.g., Editorial, *Safe Blood*, L.A. TIMES, Jun. 15, 2006, at 10 (endorsing deferral policy for MSM of “weeks or months” from last sexual activity); Editorial, *Ban Behavior, Not Gays*, ADVOC., Apr. 25, 2006 at 16 (noting Red Cross’ endorsement of a shift to a one-year deferral policy and Lambda Legal’s continued opposition to any specific MSM policy).

judgment is not a “common sense”¹⁵⁸ one that calls for a repeal of the policy.

The decisions of public health officials are obviously not always justified or correct, but it is important to realize this is the framework within which the decision-makers are operating. In refusing to grant any legitimacy to the risk concerns so far, advocates of MSM policy repeal have denied their own movement’s legitimacy. Gay rights advocates who support repealing the MSM policy must recognize that success would create a possible increase of harm to others, unlike other policies such as anti-sodomy laws where the physical security and liberty of the gay population is preserved at the expense of a more ethereal “moral” detriment to opponents. A similar case exists with the fight for same-sex marriage or antidiscrimination laws. But a repeal of the MSM policy would present an ethereal gain for gay individuals—be it in the freedom from stigma or an ability to embrace one’s “civic duty” of donating blood, while possibly posing a concrete harm to others in the form of potential AIDS infection. To dismiss this risk, no matter how minute as “nonexistent” or “homophobia” is not a just response.

V. CONCLUSION

Even if gay rights advocates adapt their strategies, to reflect the real risks associated with lifting the MSM blood ban, as suggested here, it remains unclear whether this policy is even deserving of significant attention. While in an ideal world gay men would be subject to no group-based exclusions, the impacts of the MSM policy are relatively small compared to other discrimination that exists against LGBT individuals. In a hostile political climate, and with limited resources, it is difficult to justify prioritizing the MSM policy. For example, one reason why the Columbia LGBT student group did not join an individual discrimination complaint in 2006 was that they were focusing on developing a response to a recent on-campus hate crime.¹⁵⁹

At the same time, the underlying disparities in HIV rates that continue to exist are troubling. If the energy directed at repeal of the MSM policy were instead targeted at increasing awareness of HIV and condom use in the gay community, perhaps these disparities could be reduced, and the case for MSM policy repeal would be bolstered. As a generation of college students grows up, claiming they only fear AIDS

158. See, e.g., Bloodsource.org, *supra* note 103.

159. See Latifi, *supra* note 121.

because of the MSM policy, perhaps this would be a more advantageous path to embark upon.