

# SOME INITIAL THOUGHTS ON SEXUALITY AND GAY MEN WITH AIDS IN RELATION TO PHYSICIAN-ASSISTED SUICIDE

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As a cultural figure, the gay man with AIDS has played an important, though often subliminal, role in efforts to legalize physician-assisted suicide. He was, for example, among the terminally ill “patient plaintiffs” in the physician-assisted suicide cases decided by the Supreme Court in 1997.<sup>1</sup> More recently, he has reappeared among those challenging Alaska’s assisted suicide ban.<sup>2</sup> In numerous other places in the vast literature on physician-assisted suicide, the gay man with AIDS is invoked, sometimes in coded language, as an “ideal” candidate for the practice.<sup>3</sup> Indeed, he has been

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1. *Glucksberg v. Washington*, 521 U.S. 702 (1997) (upholding state law read as banning assisted suicide, including physician-assisted suicide for the terminally ill, against substantive due process challenge); *Vacco v. Quill*, 521 U.S. 793 (1997) (upholding state laws interpreted as prohibiting assisted suicide, including physician-assisted suicide for the terminally ill, against equal protection challenge). See *Lambda Criticizes High Court’s Ruling Against Assisted Suicide* (June 26, 1997), available at <http://www.lambdalegal.org/c/s.dll/pages/library?class=7> (noting that “[g]ay men with end-stage AIDS were plaintiffs in” *Glucksberg* and *Quill*).

2. See, e.g., Aff. of Kevin Sampson, *Sampson v. Alaska*, No. 3AN-98-11288CI (Super. Ct. Alaska Dec. 17, 1998), available online at <http://compassionindying.org/legal/sampson.html>. At the time of publication, *Sampson* is pending before the Alaska Supreme Court.

3. See, e.g., Paul van der Maas & Linda L. Emanuel, *Factual Findings*, in REGULATING HOW WE DIE: THE ETHICAL, MEDICAL, AND LEGAL ISSUES SURROUNDING PHYSICIAN-ASSISTED SUICIDE 151, 167 (Linda L. Emanuel ed., 1998) (discussing “AIDS patients [as] relatively young, well educated, and well aware of the expected course of their disease”); see also, e.g., MARGARET OTLOWSKI, VOLUNTARY EUTHANASIA AND THE COMMON LAW 1-2 (1997) (footnotes omitted) (describing, in coded language, gay men and their autonomous decision-making capacities). (For my critical review of Otlowski’s work, on different but

credited or (depending on one's view) burdened with helping to put the issue on the public's and policy makers' radar screens.<sup>4</sup>

From one perspective, it is not difficult to understand why. One of the strongest arguments for physician-assisted suicide is that it can provide the terminally ill with relief from extreme pain and suffering.<sup>5</sup> Through his body and his story, the terminally ill gay man with AIDS lends an extremely sympathetic face to the campaign to legalize assisted suicide.<sup>6</sup>

But why is his sexuality so rarely, if ever, the subject of discussion in the debate over physician-assisted suicide?<sup>7</sup> We may already have one answer at

related grounds, see Marc Spindelman, *The Risks of a Neat Theory of Euthanasia*, 8 BOOKS-ON-LAW, Nov. 1998, <http://www.jurist.law.pitt.edu/lawbooks/revnov98.htm>.) For somewhat comparable descriptions of gay men with AIDS, see CHARLES F. MCKHANN, A TIME TO DIE: THE PLACE FOR PHYSICIAN ASSISTANCE 18-20 (1999) and Stephen Jamison, *AIDS and Aid-In-Dying: An Historical Link?*, S.F. MED., Mar. 1996, at 27, 27-28. *But see, e.g.*, Mary Evangelisto, *Death With Dignity: End-of-Life Issues for the HIV/AIDS Patient*, 34 J. OF PSYCHOSOCIAL NURSING 45 (1996); Kathleen Welch et al., *The Clinical Profile of End-Stage AIDS*, 12 AIDS PATIENT CARE AND STD'S 125, 126, 128 (1998).

4. *See, e.g.*, Merrill Matthews, Jr., *Would Physician-Assisted Suicide Save the Healthcare System Money? (Or, Is Jack Kevorkian Doing All of Us a Favor?)*, in PHYSICIAN ASSISTED SUICIDE: EXPANDING THE DEBATE 312, 318 (Margaret P. Battin et al. eds., 1998) ("One of the most recent attempts at consensus [to establish clinical criteria for physician-assisted suicide in the United States] came from a group of medical ethics committees located in San Francisco, where the high incidence of AIDS has forced a disproportionately large number of physicians and hospitals to consider requests for physician-assisted suicide.") (footnote omitted). For others who allude to the impact of gay men with AIDS on public attitudes toward physician-assisted suicide, see Susan M. Wolf, *Gender, Feminism and Death*, in FEMINISM & BIOETHICS: BEYOND REPRODUCTION 282, 284 (Susan M. Wolf ed., 1996) ("*Although the AIDS epidemic has called attention to physician-assisted suicide and euthanasia in men*, the cases that have dominated the news accounts and scholarly journals in the recent renewal of debate have featured women patients.") (emphasis added) [hereinafter *Gender, Feminism and Death*]; OTLOWSKI, *supra* note 3, at 1-2; Daniel Callahan, *Foreword*, EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES xiii, xiv (John Keown ed., 1995) (mentioning impact of AIDS pandemic on efforts to legalize physician-assisted suicide).

5. For a classic argument in support of practices like assisted suicide based, in part, on relief from the agonies of life, or mercy, see GLANVILLE WILLIAMS, THE SANCTITY OF LIFE AND THE CRIMINAL LAW 311-350 (1957). For the equally classic reply to Williams, see Yale Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L. REV. 969 (1958).

6. For purposes of this discussion, I will generally bracket the many problems that attend defining "terminal illness" or the class of the "terminally ill."

7. Here and there in the assisted suicide literature, commentators do discuss gay men as gay men, openly and without resort to coded language. *See, e.g.*, Patrick J. E. Bindels et al., *Euthanasia and Physician-Assisted Suicide in Homosexual Men with AIDS*, 347 LANCET 499 (1996); Lee R. Slome et al., *Physician-Assisted Suicide and Patients with Human Immunodeficiency Virus Disease*, 336 NEW ENG. J. MED. 417 (1997) [hereinafter *Physician-Assisted Suicide and Patients with Human Immunodeficiency Virus Disease*]; Lee Slome et al., *Physicians' Attitudes Toward Assisted Suicide in AIDS*, 7 J. OF AIDS 712 (1992); *see also, e.g.*, Brett Tindall et al., *Attitudes to Euthanasia and Assisted Suicide in a Group of Homosexual Men with Advanced HIV Disease*, 6 J. OF AIDS 1069 (1993). But I have yet to encounter a single source in the literature that contains a sustained, systematic and critical examination of what bearing sexuality may (or does) have on the debate over physician-assisted suicide. Even Slome and her co-authors, whose research instrument, for instance, focuses hypothetically on a gay man with AIDS in surveying physician attitudes toward physician-assisted suicide, do not vet the ways in which their chosen hypothetical patient asking for assisted suicide may have influenced (perhaps even skewed) their findings. They do observe, however, that a "physician's being gay, lesbian, or bisexual was . . . positively associated with assisting in a patient's suicide[.]" *Physician-Assisted Suicide and Patients with Human*

hand. In the cultural imagination, terminal illnesses, along with pain and suffering, are universals; they transcend sexual identity.<sup>8</sup> Sexuality is thus assumed *not* to be a criterion, were the practice to become legal, for who would and who would not be eligible to commit physician-assisted suicide.<sup>9</sup>

Still, I cannot help but wonder: Is the sexuality of the gay man with AIDS *really* irrelevant to our decision whether to allow him to end his life through physician-assisted suicide? Is same-sex sexuality – or sexuality, more generally – actually irrelevant to our collective decision whether to allow physicians to assist in his and other patients' suicides?

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*Immunodeficiency Virus Disease*, *supra* at 420, and then briefly go on to suggest (among other things) some possible reasons why. That brief discussion, interesting though it is, may be as close as anyone has come in the assisted suicide literature, to addressing how sexuality, including sexual identity, may affect the conversation about the practice. *But see, e.g.*, Jody B. Gabel, *Release From Terminal Suffering? The Impact of AIDS on Medically Assisted Suicide*, 22 FLA. ST. U. L. REV. 369 (1994) (analyzing discrimination against people with AIDS in the context of "medically assisted suicide" without delving into cultural norms about sexuality).

8. *Gender, Feminism, and Death*, *supra* note 4, at 282 ("[T]he debate over whether to legitimate physician-assisted suicide and euthanasia . . . is most often about a patient who does not exist – a patient with no gender, race, or insurance status. This is the same generic patient featured in most bioethics debates. Little discussion has focused on how differences between patients might alter the equation.") (footnote omitted).

9. Of course, the practice is, in some (arguably limited) circumstances, already legal in the state of Oregon. *See* OR. REV. STAT. §§ 127.800-897 (1999) ("Oregon Death with Dignity Act"). For what it is (or may be) worth, it is unclear from the three reports on the operation of Oregon's law permitting physician-assisted suicide, whether HIV-infected gay men or gay men with AIDS have been among those who have "officially" taken their lives with a physician's help under the law's provisions. *See* Arthur E. Chin et al., *Legalized Physician-Assisted Suicide in Oregon – The First Year's Experience*, 340 NEW ENG. J. MED. 577 (1999); Amy D. Sullivan et al., *Legalized Physician-Assisted Suicide in Oregon – The Second Year*, 342 NEW ENG. J. MED. 598 (2000) [hereinafter *Oregon – The Second Year*]; Amy D. Sullivan et al., *Legalized Physician-Assisted Suicide in Oregon, 1998-2000*, 344 NEW ENG. J. MED. 605 (2001). According to the reports, at least three individuals with AIDS have "received prescriptions for lethal medications" under the statute's provisions. *See* Chin et al., *supra*, at 579; Sullivan et al., 342 NEW ENG. J. MED., at 600; Katrina Hedberg, *Oregon's Death With Dignity Act: Three Years of Legalized Physician-Assisted Suicide* at 16 (table 1) (Feb. 22, 2001), available at <http://www.ohd.hr.state.or.us/chs/pas/00pasrpt.pdf>. One of those individuals died from underlying disease, Chin et al., *supra*, at 579; the other two died after taking a lethal dose of assisted suicide medication. *Oregon – The Second Year*, *supra*, at 600; Hedberg, *supra*, at 16 (table 1). Unfortunately, the presentation of the data in the reports makes it difficult, if not impossible, to say (without some independent knowledge) anything about the sexual orientation of those three individuals.

Even assuming that none of the three individuals with AIDS who took advantage of the Oregon law was gay, one could say (as some have) that laws permitting physician-assisted suicide benefit far more than those individuals, however few, who actually take advantage of the practice. Legalized physician-assisted suicide, one could maintain, offers a certain peace of mind to a much larger group of people, including HIV-infected gay men or gay men with AIDS, who can rest assured that, should the time come, they will be able to take their lives with a physician's help. Quoting no less eminent a figure than the chief judge of the Seventh Circuit, Richard Posner, one might contend: "Knowing that if life becomes unbearable one can end it creates peace of mind and so makes life more bearable." RICHARD A. POSNER, *AGING AND OLD AGE* 239-40 (1995). Such "indirect" benefits of laws permitting physician-assisted suicide, as I have explained elsewhere, may (often) be overstated, particularly if the "safeguards" that are part of such laws truly have "bite." *See* Marc Spindelman, *The Year of Assisting Death: Report on Oregon's Assisted-Suicide Law Paints Too Rosy a Picture*, LEGAL TIMES, Mar. 22, 1999, at 22.

Although I suspect some may find this surprising, participants in the legal debate over assisted suicide have at times acted on the premise that the answer to both these questions is “no.” In arguing their cases in courts, for example, advocates of physician-assisted suicide have relied heavily on judicial precedents involving sexual autonomy or privacy, chiefly those decisions recognizing a woman’s right to abortion.<sup>10</sup> Although these cases are often understood as constitutionally protecting private, consensual sexual choices, proponents of physician-assisted suicide regularly read them more broadly to hold that constitutions guarantee individuals the liberty to make certain major life decisions for themselves.<sup>11</sup>

But notice: If major life decisions, including those about life and death, are constitutionally protected, it stands to reason that decisions lesbians and gay men *as* lesbians and gay men make, for example, about whom to sleep with or to love, should also be constitutionally protected.<sup>12</sup> The sexual decisions lesbians and gay

10. *See, e.g.*, Respondents’ Brief, at 10-22, *Washington v. Glucksberg*, 521 U.S. 702 (1997) (No. 96-110) (Kathryn L. Tucker, Counsel of Record) (relying on what are often conventionally regarded as the Supreme Court’s “privacy” precedents); Respondents’ Brief at 1-4, 18-28, *Vacco v. Quill*, 521 U.S. 793 (1997) (No. 96-1858) (Laurence H. Tribe, Counsel of Record) (relying on Supreme Court’s privacy precedents and also referring repeatedly to language from plurality opinion in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992) (plurality opinion of O’Connor, J., Kennedy, J., Souter, J.)); *see also, e.g.*, Robert A. Sedler, *Are Absolute Bans on Assisted Suicide Constitutional? I Say No*, 72 U. DET. MERCY L. REV. 725, 727-33 (1995) (discussing language from *Casey* plurality opinion).

11. *See, e.g.*, Respondents’ Brief at 19, *Vacco* (No. 96-1858) (“This Court has held that the Constitution protects from governmental intrusion an individual’s right to make certain profound, life-shaping decisions. Those decisions that ‘involv[e] the most intimate 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.’”) (citing *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 851 (1992)). *See also* *Compassion in Dying v. Washington* 79 F.3d 790, 812-13 (9th Cir. 1996) (en banc) (discussing the Supreme Court’s substantive due process decisions, and reading them to have “running through” them, a “common thread . . . that they involve decisions that are highly personal and intimate, as well as of great importance to the individual”).

12. A federal constitutional decision recognizing a right to physician-assisted suicide on grounds of autonomy (or, one might say, on grounds of constitutionally protected “liberty” or “privacy”) would be in tension with the standard reading of the Supreme Court’s ruling in *Bowers v. Hardwick*, 478 U.S. 186 (1986), that there is no fundamental constitutional right under the Due Process Clause to engage in “homosexual sodomy.” *See, e.g.*, Cass R. Sunstein, *Sexual Orientation and the Constitution: A Note on the Relationship Between Due Process and Equal Protection*, 55 U. CHI. L. REV. 1161, 1161 (1988) (footnote omitted) (“In *Bowers v. Hardwick*, the Supreme Court held that the due process clause does not protect the right to engage in homosexual sodomy.”). Thus, it is interesting that in his ruling for the Court in *Glucksberg v. Washington*, 521 U.S. 702 (1997), Chief Justice Rehnquist (who along with Justice O’Connor, had joined Justice White’s *Hardwick* opinion) avoided any reference to *Hardwick*, although *Hardwick* may have supported the judgment he announced in *Glucksberg*. *See* WILLIAM N. ESKRIDGE, GAYLAW: CHALLENGING THE APARTHEID OF THE CLOSET 168 (1999) (“Chief Justice William Rehnquist’s opinion in *Washington v. Glucksberg* (1997), which rejected a general due process right to die, failed even to cite *Hardwick*, even though the opinion sought to revive *Hardwick*’s methodology of declining to recognize a substantive due process right not specifically established in the common law decision.”) (footnote omitted). What may be even more interesting, however, is the pregnant silence that descended around *Hardwick* during the oral arguments before the Court in *Glucksberg* and *Quill*. One searches the transcript of those proceedings in vain for any mention of *Hardwick*’s name. *See* Transcript Proceedings Before the Supreme Court of the United States, *Washington v. Glucksberg*, No. 96-110 (Jan. 8, 1997),

men make, after all, can amount to significant, life-shaping events; in some instances, they themselves can *be* decisions about life and death.

It seems unlikely that these considerations have entirely escaped the notice of proponents of legalized physician-assisted suicide, and they give us yet two other potential answers (one principled, the other strategic) to the question, Why has the gay man with AIDS so rarely been discussed in terms of his sexuality in the assisted suicide debate? As a principled claim about autonomy, one might say that individuals either do or do not have a right to physician-assisted suicide. The social fact that individuals are or identify themselves as lesbian or gay does not change whether they have (or should be afforded) a right to take their lives with a physician's help. To put the point somewhat differently, one might propose that the reason the gay man with AIDS has commonly not been discussed in terms of his sexuality in the assisted suicide debate is that the case for physician-assisted suicide does not in any way turn on (his) sexuality or sexual identity.

Even if we assume for a moment that the case for assisted suicide itself does not turn on sexuality or sexual identity, the creation of a legal right to physician-assisted suicide out of respect for individual autonomy, as I have already suggested, may well have implications for other kinds of legal rights individuals are said to possess, among them the right to sexual autonomy. If so, it would seem to require some act of denial to maintain that same-sex sexuality (or sexuality more generally) is entirely irrelevant to the decision whether we should or should not legalize physician-assisted suicide. Which, I think, can take us a good distance toward understanding what often seems to be a perhaps savvy but certainly strategic choice of legal advocates of physician-assisted suicide: to avoid as much direct talk as possible about same-sex sexuality when arguing for a right to die.<sup>13</sup>

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1997 U.S. Trans. LEXIS 19 (no reference to *Bowers v. Hardwick*); Transcript Proceedings Before the Supreme Court of the United States, *Vacco v. Quill*, No. 95-1858 (Jan. 8, 1997), 1997 U.S. Trans. LEXIS 11 (same).

In its decision in *Quill v. Vacco*, the Second Circuit announced that *Hardwick* controlled the disposition of the autonomy-based claim for a right to physician-assisted suicide. See *Quill v. Vacco*, 80 F.3d 716, 723-25 (2d Cir. 1996). But Judge Stephen Reinhardt, writing the *en banc* opinion for the Ninth Circuit in *Glucksberg*, did not. See *Compassion in Dying v. Glucksberg*, 79 F.3d 790, 813 n.65 (9th Cir. 1996) (*en banc*). Some commentators had noted the (potential) doctrinal significance of *Hardwick* to the resolution of the assisted suicide cases before the Supreme Court decided them. See, e.g., Yale Kamisar, *Physician-Assisted Suicide: The Last Bridge to Active Voluntary Euthanasia*, in *EUTHANASIA EXAMINED: ETHICAL, CLINICAL, AND LEGAL PERSPECTIVES* 225, 228 (John Keown ed., 1995); Marc Spindelman, *Are the Similarities Between a Woman's Right to Choose an Abortion and the Alleged Right to Physician-Assisted Suicide Really "Compelling"?*, 29 MICH. J. L. REF. 775, 807-810 (1996). On the new reading of *Hardwick* I have recently offered, the tension between recognition of a right to physician-assisted suicide, on the one hand, and a right to engage in private, consensual, same-sex intimacies, on the other, may be somewhat eased, if not quite removed altogether. See Marc S. Spindelman, *Reorienting Bowers v. Hardwick*, 79 N.C. L. REV. 359 (2001) (arguing, *inter alia*, that *Hardwick* can be read to have decided not to decide the merits of the "autonomy" or "liberty" claims presented by the case).

13. See *supra* note 12; see, e.g., Respondents' Brief, at 16, *Glucksberg* (No. 96-110) (referring to *Bowers v. Hardwick*, 478 U.S. 186 (1986), without mentioning or discussing same-sex sexuality).

In a way, of course, the choice makes sense. Emphasizing how a right to physician-assisted suicide relates to a right to sexual autonomy on autonomy grounds potentially risks alienating a judge who (or a court that), for whatever reason, is not prepared to follow such a principle to its logical limits.<sup>14</sup> (That the strategic choice may entail, however temporarily, suspending claims of same-sex sexual autonomy may seem to some, including some lesbians and gay men, a small price to pay in order to secure a right to end one's life with a physician's assistance.<sup>15</sup> From the point of view of those who prize autonomy as a signal, trumping value, some autonomy may be better than less or none at all.)

There can be no doubt. Highlighting the relationship between sexuality and death in the context of assisted suicide can be risky. But, I want to suggest, the choice *not* to highlight that relationship, or to avoid any meaningful discussion of it, may have risks, no less significant, of its own. To explain, let us begin by casting our eyes toward another "ideal" candidate for assisted suicide who has repeatedly resurfaced in efforts to legalize the practice: the older woman with cancer.

As a cultural figure like the gay man with AIDS, the older woman with cancer has influenced the public's thinking about physician-assisted suicide. Professor Susan Wolf considers why. Building on the work of Silvia Sara Canetto, Wolf writes that: "[t]here is evidence that the decision to kill oneself is viewed as most

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14. There are, of course, other explanations to be considered for the lack of discussion of same-sex sexuality – or sexuality, more generally – in the conversation over physician-assisted suicide. Susan Wolf has provided useful thoughts about the reigning lack of feminist analysis or critique in the field of bioethics – thoughts that, I think, have obvious implications here. See Susan M. Wolf, *Introduction: Gender and Feminism in Bioethics*, in *FEMINISM & BIOETHICS: BEYOND REPRODUCTION* 1, 14-21 (Susan M. Wolf ed., 1996).

15. For an example of just how far such avoidance can go (and has gone), see Brief of Amici Curiae, Gay Men's Health Crisis et al., *Washington v. Glucksberg*, 521 U.S. 702 (1997) (No. 96-110), and *Vacco v. Quill*, 521 U.S. 793 (1997) (No. 96-1858), available in 1996 WL 711205 [hereinafter GMHC Brief]. The section of the GMHC Brief describing the amici's interest in the cases, contains the following noteworthy portrayal of the Gay Men's Health Crisis and Lambda Legal Defense and Education Fund (noteworthy not so much for what it does say as for what it does not):

The two Amici organizations represent people who have AIDS, some of whom are in the terminal phase of their illnesses. The Lambda Legal Defense and Education fund is a national non-profit public interest legal organization working for the civil rights of people with [H]IV and AIDS. The Gay Men's Health Crisis is the oldest and largest not for profit AIDS organization providing services to people with AIDS and their loved ones, educating the public and advocating for fair and effective AIDS policies. These organizations contend that the state should not be allowed to prohibit their members from receiving the assistance of their physicians in ending their lives when they have decided that life is no longer bearable.

*Id.* at 1; cf. JAMES BOYD WHITE, *ACTS OF HOPE: CREATING AUTHORITY IN LITERATURE, LAW, AND POLITICS* 125 (1994) ("Lawyers naturally work by disagreement, as they argue for contrary results; but in doing this they work by agreement, as well, reaffirming the terms in which their conversation can proceed at all. *Everything that is not arguable is for the moment affirmed.*") (emphasis added).

'understandable' when it is made by an older woman."<sup>16</sup> Continuing, Wolf explains:

[E]ven while we debate physician-assisted suicide and euthanasia rationally, we may be animated by unacknowledged images that give the practices a certain gendered logic and felt correctness. In some deep way it makes sense to us to see these women dying, it seems right. It fits an old piece into a familiar, ancient puzzle. Moreover, these acts seem good; they are born of virtue. We may not recognize that the virtues in question – female sacrifice and self-sacrifice – are ones now widely questioned and deliberately rejected.<sup>17</sup>

Wolf here implies, and elsewhere persuasively argues, that gender permeates the assisted suicide debate.<sup>18</sup> Her focus on the feminine virtues of sacrifice and self-sacrifice provides a useful lens on the powerful cultural forces that may (covertly) animate the public discussion about physician-assisted suicide. But we may come to an even deeper understanding of how cultural norms may influence the conversation about assisted suicide if we introduce the concept of sexuality into the structure of Wolf's analysis.<sup>19</sup>

As a cultural matter, for instance, we might notice that both women and men are "supposed" to make sexual sacrifices, each, of course, in their own, gender-specific ways. One way for women to become "women" in the normative cultural sense, hence to attain social value, is to sacrifice themselves sexually to men.<sup>20</sup> Now, it is anything but a perfect parallel. But men, too, are required to make their own sort of sexual sacrifices. For present purposes, it may be enough to point out one way for men to become "men" in the fullest social sense: to sacrifice that aspect of their humanity that would otherwise resist (or resist acting on) the notion that women are embodied sexual objects for men's use and pleasure.<sup>21</sup>

Once we have come this far, perhaps we can start to see how Wolf's observations can catapult us toward brand new ways of thinking about the impact

16. *Gender, Feminism, and Death*, *supra* note 4, at 296 (footnote omitted) (citing Silvia Sara Canetto, *Elderly Women and Suicidal Behavior*, in *WOMEN AND SUICIDAL BEHAVIOR* 215, 225-26 (Silvia Sara Canetto & David Lester eds., 1995)).

17. *Id.* at 289-90.

18. *See id.*; *see also* Susan M. Wolf, *Physician-Assisted Suicide, Abortion, and Treatment Refusal: Using Gender to Analyze the Difference*, in *PHYSICIAN-ASSISTED SUICIDE* 167 (Robert F. Weir ed., 1997).

19. For a different response to Wolf's argument, *see* Jennifer Parks, *Why Gender Matters to the Euthanasia Debate: On Decisional Capacity and the Rejection of Women's Death Requests*, 30 *Hastings Ctr. Rep.* 30 (Jan-Feb. 2000).

20. For an example of a sustained critique of these structures of sex and sexuality, *see*, for example, CATHARINE A. MACKINNON, *TOWARD A FEMINIST THEORY OF THE STATE* (1989); *see also id.* at 126-54.

21. *See, e.g.*, JOHN STOLTENBERG, *Sexual Objectification and Male Supremacy*, in *REFUSING TO BE A MAN: ESSAYS ON SEX AND JUSTICE* 36 (2000); *cf.* Marc S. Spindelman & John Stoltenberg, *Oncale: Exposing "Manhood"*, 8 *UCLA WOMEN'S L. J.* 3, 6 (1997).

of culturally dominant ideas about sexuality on the conversation over physician-assisted suicide. By virtue of her age, the older woman with cancer is presumed to be beyond sexuality. Her body is noticeably marked as well past the age of sex. What little usefulness she may once have had – what little value – because of her sex, she may have lost through time, through age. Her illness makes it irretrievably so.<sup>22</sup> Consider the description of this woman's body found in the pages of the federal reports. Jane Roe, one of the plaintiffs in the Washington assisted suicide case, was described as:

a 69-year-old . . . who has suffered [for years] from cancer which has . . . metastasized throughout her skeleton. . . . [She] has been almost completely bed ridden [for approximately a year] and experiences constant pain, which becomes especially sharp and severe when she moves. . . . [S]he suffers from swollen legs, bed sores, poor appetite, nausea and vomiting, impaired vision, incontinence of bowel, and general weakness.<sup>23</sup>

Needless to say, this is not a description of a body that evokes desires for penetration or ideas of sex, except perhaps desires or ideas that partake of what we might call – to coin a term to describe the eroticization of death and dying – thanaphilia.<sup>24</sup> Even as she lays dying, the older women with cancer can be sexually defined: if not by what men *do* want, sexually, then by what men *do not* – or what they *should not* – want.

The cultural interdiction against sex with the older woman suffering from

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22. There are certain important questions that I wish to raise, but that I will not venture to answer here. Even these are only a start: How does illness exacerbate the power differentials between the sexes that can make sex, and sex with women who are ill, seem sexy? Is a woman's illness an aphrodisiac? Is a woman's death? How does illness operate in concert with age (for example, old age) to eroticize or de-eroticize women? Are dead women ever sexually desirable? Are women who *seem* or *play* dead? What, if anything, distinguishes the terminally ill woman from the woman who is merely sick and powerless? What are the conditions of death or dying that strip a woman of her sex appeal? Must a woman be alive and well enough so that sexual intercourse can take her life away, symbolically, if not literally? (Why does the expression "out with a bang" spring to mind?) Must the sick woman, in order to be an object of sexual desire, be close enough to death so that sex can seemingly hold out the potential to restore her to life? Does sex give life as it takes it away? How do the answers to these questions, if they do, relate to ideas about penetration and ejaculation, with their presumed capacity to "give life"? And how, perhaps most important of all, do these questions and their answers relate to prevailing cultural ideologies which reflect and materially reinforce women's social subordination? For answers, or at least some discussion relevant to these questions, see ANDREA DWORKIN, *INTERCOURSE* 3-20 (1987).

23. *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1456 (W.D. Wash. 1994).

24. The term, defined (again) as the eroticisation of death and dying, may be helpful in understanding and explaining the structure of sexuality integral, *inter alia*, to certain forms of rape, see, for example Andrea Dworkin, *The Day I Was Drugged and Raped*, *THE NEW STATESMAN*, June 5, 2000, available at <http://www.newstatesman.com>, as well as certain sexual practices, such as "barebacking," within the gay male community. See also, e.g., Rick Sowadsky, *Barebacking in the Gay Community* (May 1999), available at <http://www.thebody.com/sowadsky/barebacking.html>.



cancer may be reflected in, and reinforced by, the strongly aversive emotions, such as horror or disgust, we may experience when thinking about her body.<sup>25</sup> But equally important, those emotions may make her death by physician-assisted suicide seem understandable, desirable – or even “right.”<sup>26</sup> The distance we may wish to put between our bodies and hers may never be so great as when her body is burned to ashes or buried beneath the ground; when, that is, her body has become our memory. Defined throughout life by her sexuality, its loss, through age and disease, fuels the appeal and plausibility of cultural logic that dictates she may be better off not living. This is the logic that holds she may be – or should I say, “is”? – better off dead.

If I am right, we should not be (at all) taken aback if cultural logic offered the gay man with AIDS a similar prescription. And it does.

Because he is gay, the gay man with AIDS is generally presumed not to conform to gender-specific, male norms of sexual sacrifice. His “chosen,” acted-out, sexuality is sometimes regarded as a kind of refusal to be a man.<sup>27</sup> Nevertheless, until he becomes a man *with* AIDS, he is thought to have the capacity – even the duty – to reverse his “choice” and take up his rightful place among the ranks of men. He is thought capable of sacrificing his homosexual proclivities and, in fulfillment of his social obligations, of having sex with, if not also sexually dominating, women. He is thought capable of not (or no longer)

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25. See WILLIAM IAN MILLER, *THE ANATOMY OF DISGUST* 15 (1997) (discussing the relationship between aging bodies and disgust). The cultural interdiction does not, I think, similarly apply to heterosexual men – older or otherwise – who are ill. Reports of men with heart conditions suffering fatal heart attacks while engaged in heterosexual *coitus* might be too common not to notice: for ill straight men, sexual activity may not be prohibited. Sex when ill, for a straight man, may be taken as evidence of his (remaining) vitality – or, one might say, as a sign that he may yet return to an adequate state of “good” health. The same cannot be said of HIV infected gay men or gay men with AIDS. See discussion *infra* notes 26-36 and accompanying text. Of course, there is a general cultural prohibition against same-sex sexual expression, which is complicated in those instances in which gay men are sick or dying. To be sure, there are counter-examples – maybe, exceptions – to the general prohibition against male same-sex sexual activity. The most obvious may be the sex men have with men in environments, such as all male prisons, in which women are not sexually available and in which men can be used as, or be made into, less-than-perfect substitutes for women. See generally Catharine A. MacKinnon, *Oncale v. Sundowner Offshore Services, Inc.*, 96-568, *Amici Curiae Brief in Support of Petitioner*, 8 UCLA WOMEN’S L. J. 9 (1997). Thanks to Margot White for helping me see the contours of this point more clearly.

26. *Gender, Feminism, and Death*, *supra* note 4, at 289-90.

27. See generally, e.g., STOLTENBERG, *supra* note 21. Of course, gay male sexuality does not always actually entail a thoroughgoing repudiation of typical structures of male (or heterosexual) sexuality, notwithstanding claims, like Robin Hardy’s, however qualified, that “gay men may share an inherently equal gender status, unlike heterosexual men and women[.]” ROBIN HARDY, *THE CRISIS OF DESIRE: AIDS AND THE FATE OF GAY BROTHERHOOD* 182 (1999); see also Catherine Waldby, *Destruction: Boundary Erotics and Refigurations of the Heterosexual Male Body*, in *SEXY BODIES: THE STRANGE CARNALITIES OF FEMINISM* 266, 272 (Elizabeth Grosz & Elspeth Probyn eds., 1995) (“[T]he possibilities of anal erotics for the masculine body amounts to an abandonment of [the] phallic claim” that is part of penetrative heterosexual intercourse, including “man’s impenetrability, the exclusive designation of his body by its seamless, phallic mastery.”) (emphasis in original).

sexually dominating, or subordinating himself to, other men.<sup>28</sup>

His illness changes the picture. Its sexual transmissibility makes the gay man with AIDS unwelcome in the brotherhood of men. The possibility he could become a “real man” turns into a veritable threat that he might. He is, of course, a threat in this view intermediately to the women who might become infected with the virus he carries in his body.<sup>29</sup> But, by the disease’s transitive properties,<sup>30</sup> he is ultimately, dangerously, and maybe most significantly, also a sexual threat to others in the community of men.<sup>31</sup> Culturally speaking, the sexuality of the gay man with AIDS may thus evoke not so much ideas of thanophilia, but thanophobia; his sexuality is suicidal, femicidal, and fratricidal.<sup>32</sup>

With these thoughts in mind, let us revisit the assumption mentioned and bracketed earlier, that the case for physician-assisted suicide does not turn on sexuality or sexual identity. As an assumption about how things should be, it

28. See ANDREA DWORKIN, *PORNOGRAPHY: MEN POSSESSING WOMEN* 60 (1981) (“As long as male sexuality is expressed as force or violence, men as a class will continue to enforce the taboo against male homosexuality to protect themselves from having that force or violence directed against them.”).

29. For an interesting and impressively documented discussion of women’s health status in the HIV and AIDS epidemic as having improperly been treated primarily as instrumental for others’ – including men’s – health, see Ruth Faden et al., *Women as Vessels and Vectors: Lessons from the HIV Epidemic*, in *FEMINISM AND BIOETHICS: BEYOND REPRODUCTION* 252 (Susan M. Wolf ed., 1996). Faden and her co-authors, at times, seem to locate gay men’s health within a broader category of what might be called “men’s health.”

30. Of course, one might say that gay men are a “direct threat” to straight men – even in those circumstances where gay men have ostensibly “gone straight.” It is tempting to suppose that such a view may depend, at least in part, on some underlying suspicion about the possibility that those who once identified as “gay men” could ever “be” or “become” straight. To be sure, sexual identity need not be regarded as an aspect of being – an aspect of who a person “is.” But even gay-friendly suspicion about the possibility of sexual conversion may in some instances be grounded in the view of sexuality as fixed, hence not “fix-able,” either descriptively or normatively. Cf. David B. Cruz, *Controlling Desires: Sexual Orientation Conversion and the Limits of Knowledge and Law*, 72 S. CAL. L. REV. 1297, 1381-93 (1999) (discussing “conceptual confusion” in the “conversion” debate surrounding the definition of “homosexuality,” “heterosexuality,” and “change”). I should not fail to mention that some men who identify themselves as heterosexual, too, might perceive the threat formerly gay men may pose to their (heterosexual) health as akin to the (always) potential threat that a traitor, even after repudiation of a betrayal and reconciliation with the group (or ideology) previously disavowed, may repudiate his repudiation and betray the group (or ideology) again.

31. See, e.g., Catherine Waldby et al., *Cordon Sanitaire: ‘Clean’ and ‘Unclean’ Women in the AIDS Discourse of Young Heterosexual Men*, in *AIDS: FACING THE SECOND DECADE* 29, 33 (Peter Aggleton et al. eds., 1993) (“Because masculine desire is conceived as a steady force, always seeking sexual access to women, it is the woman’s behavior over time which determines to what extent men represent an infection threat to each other, via the conduit of the woman’s body.”); *id.* at 34 (“The woman who adjudicates between different suitors and only gives herself to one does not act as a conduit, she safely absorbs the threat that male bodies pose to each other.”); *id.* at 35 (“The woman to be held at the greatest distance is the one who is thought to have entered into an unknown number of sexual relationships with unknown men, or with men who are identified as belonging to ‘risk groups’. She is held off but not necessarily avoided. Distance is maintained through the use of condoms and the practice of casual and secret sex. It is, therefore, a social, not a sexual distance.”).

32. For a case involving the tragic death of one HIV-infected gay man (perhaps by assisted suicide) that uncannily seems to evoke several, if not (quite) all, of these themes, see *People v. Cleaves*, 280 Cal. Rptr. 146 (Ct. App. 1991).

seems beyond dispute. Whatever else may be said of it, the case for legalizing physician-assisted suicide should not rest on, or benefit from, discriminatory cultural norms about sexuality. Nevertheless, as a claim about how powerful cultural norms about sexuality are, or as a claim about how such norms operate in the world, the assumption may be unwarranted, if not inaccurate.

Existing sexual norms lie at or near the heart of the marginalization and de-valuation of gay life. Hideously, they make death associated with AIDS, including death by physician-assisted suicide, seem an inevitable outcome of life lived as a homosexual, hence the lives of gay men with AIDS properly and doubly devalued. It is a disquieting possibility, but one that cannot and should not be overlooked: cultural norms about sexuality may inform the widespread intuition that the gay man with AIDS is an attractive candidate for physician-assisted suicide. It is difficult to see how it could presently be otherwise.

Familiar cultural scripts enable us to imagine that violence might be directed against someone because he identifies or is identified as gay. These scripts do not magically disappear when the issue under consideration is physician-assisted suicide. Anti-gay hate crimes and the so-called "gay panic" and "homosexual advance" defenses – three familiar instances in which the cultural devaluation of gay life is brutally revealed – do not occur in a culture-less vacuum.<sup>33</sup>

Neither does (nor would) physician-assisted suicide. Supporting physician-

33. Amazingly, the legal academic literature contains relatively little by way of sustained, critical analysis of the "homosexual advance" and "gay panic" criminal law defenses. One recent discussion is found in Martha C. Nussbaum, "Secret Sewers of Vice": *Disgust, Bodies, and the Law*, in *THE PASSIONS OF LAW* 19, 35-38 (Susan A. Bandes ed., 1999). See also, e.g., Gary David Comstock, *Dismantling the Homosexual Panic Defense*, 2 *L. & SEXUALITY* 81 (1981); Joshua Dressler, *When "Heterosexual" Men Kill "Homosexual" Men: Reflections on Provocation Law, Sexual Advances, and the "Reasonable Man" Standard*, 85 *J. CRIM. L. & CRIMINOLOGY* 726 (1995); Kendall Thomas, *Beyond the Privacy Principle*, 92 *COLUM. L. REV.* 1431, 1483-84 (1992); Scott D. McCoy, Note, *The Homosexual-Advance Defense and Hate Crimes Statutes: Their Interaction and Conflict*, 23 *CARDOZO L. REV.* 629 (2001); Robert B. Mison, Comment, *Homophobia in Manslaughter: The Homosexual Advance as Insufficient Provocation*, 80 *CAL. L. REV.* 133 (1992). The famous "twinky defense" used by Dan White's lawyers in his trial for the murder of gay activist and San Francisco Councilman Harvey Milk and San Francisco Mayor George Moscone shows something of the reach of the devaluation of the lives of lesbians and gay men. See RANDY SHILTS, *THE MAYOR OF CASTRO STREET* 304-06, 308-23 (1982) (discussing White's trial and defense); see also Ronald J. Tabak, *Are Executions in New York Inevitable?*, 22 *FORDHAM URB. L. J.* 557, 612 (1995) ("[M]ost people forgot that White had succeeded with a 'Twinky' defense and was found guilty only of manslaughter [in connection with the killings of Milk and Moscone].").

Susan Bandes reminds us of one of the most notorious illustrations of how little valued gay life can be within our (legal) culture:

For example, after presiding over a murder trial involving two gay victims, Judge Morris Jackson Hampton made several controversial comments to a reporter, including the following: "These two gays that got killed wouldn't have been killed if they hadn't been cruising the streets picking up teenage boys"; "I don't much care for queers cruising the streets picking up teenage boys. I've got a teenage boy."; "I put prostitutes and gays at about the same level."; "And I'd be hard put to give somebody life for killing a prostitute."

Susan Bandes, *Empathy, Narrative, and Victim Impact Statements*, 63 *U. CHI. L. REV.* 361, 377 n.67 (1996) (citing State Commission on Judicial Conduct, Order of Public Censure of Morris Jackson Hampton, Judge, 238 Judicial District Court, Dallas, Texas (1989) (unreported determination)).

assisted suicide for, and by, the gay man with AIDS can affirm the cultural narratives that make his suicide appear not just comprehensible, but desirable – or to seem inevitable, hence just. Situated in its cultural context, the question assisted suicide advocates often ask, “If you found yourself in this person’s shoes, wouldn’t you want a right to have a physician help end your life?,”<sup>34</sup> can be heard in the case of the gay man with AIDS as being, “Isn’t death preferable to living life as a gay man with AIDS?” Or, “Wouldn’t you want to kill yourself with a doctor’s help if you were a faggot with that faggots’ disease?”<sup>35</sup>

Do not misunderstand. This is *not* a claim that advocates of physician-assisted suicide set out (or intend) to trade on widespread cultural disapproval of same-sex sexuality in making out their case for a “right to die.” Not at all. But, by avoiding direct engagement with the cultural norms about sexuality, which can structure the death-seeking choices gay men and all women make when deciding whether to commit physician-assisted suicide, advocates of the practice may unwittingly hurt, rather than help, the struggles of gay men with and without AIDS, along with lesbians and other women.

And so, we should not fail to notice: the autonomy arguments for physician-assisted suicide look a good deal weaker – or a good deal less unassailable – than they otherwise might, when we realize that lesbians and gay men may be afforded a right to an autonomous death because dominant cultural norms suggest that death is what they do or should desire.<sup>36</sup>

Accordingly, before the lesbians and gay men and others in community with

34. See Yale Kamisar, *Physician-Assisted Suicide: The Problems Presented by the Compelling, Heartwrenching Case*, 88 J. CRIM. L. AND CRIMINOLOGY 1121, 1122 (1998).

35. Michael Rowe reports:

As both a physician treating AIDS and an HIV-positive man, [Dr. Colin] Kovacs is disturbed by the underlying message of facilitating the suicide of a young man with potentially years ahead of him. [Aaron] McGinn’s death throws the question of the value of life into stark relief, and the answers are not easy. “It really upset me,” says Kovacs softly. “What it really said to me was, *You fucking faggots with HIV, life will never be worth living, your life is depressing, it’s inevitable that despite all the new advances you’ll die – you deserve to die. Just go home and kill yourselves and get it over with. You’re too difficult, your life is too chaotic. You’re bruised citizens to begin with and your lives aren’t worth fighting for.*”

Michael Rowe, LOOKING FOR BROTHERS 23 (1999) (emphasis in original). See also CHARLES F. TURNER ET AL., AIDS: SEXUAL BEHAVIOR AND INTRAVENOUS DRUG USE 393-99 (1989) (discussing stigma and the AIDS epidemic, including stigma against gays); *id.* at 396 (“Such animosity toward the sexual behavior of gay men, which is evident in public opinion and laws, has complicated public discussions of the AIDS epidemic and hindered the development of public policies to curb its spread.”); *id.* at 396-97 (“If the AIDS epidemic taxes the health care system as heavily in the future as is now predicted, the public, already lacking in sympathy for these groups, may resent that they are drawing upon resources that could be used for ‘better’ purposes[.]”); *id.* at 397 (“*Should AIDS become endemic within a group, it may even appear rational to some people to deny care to its victims so that they ‘die out’ and no longer make claims on society’s scarce resources.*”) (emphasis added).

36. Judith Butler, *Sexual Inversions: Rereading the End of Foucault’s History of Sexuality, Vol. I*, in DISCOURSES OF SEXUALITY: FROM ARISTOTLE TO AIDS, 344, 360 (Domna C. Stanton ed., 1992) (describing death “as the *telos* of male homosexuality, its genesis and its demise, the principle of its intelligibility”).

them decide, once and for all, what political position to take on physician-assisted suicide, it is imperative that the full panoply of cultural considerations underlying the case for (and, of course, the case against) legalization of the practice be vetted.

It is here that we can finally turn to a discussion of "the family," if only, very briefly, to underscore its importance. The family – and our definition can and must be flexible enough to include same-sex relationships and same-sex marriage – is a cultural institution through and in which the cultural norms we have been considering are often transmitted and reproduced. The definitional fiat that excludes non-traditional, non-heterosexual families from the concept of the family, as the debate over physician-assisted suicide can show, has effects far beyond what is sometimes described as the exclusion's "mere symbolism."<sup>37</sup>

What responsibilities do we have to care for those we love and those we hate when they are sick and dying? What responsibilities do they have toward us, as individuals and collectively? These are among the many concerns of the family. Challenging and reshaping prevailing ideas of this institution are a vital part of a larger project of creating and sustaining new cultural norms that, among other things, do not devalue the lives of non-heterosexuals. In the concept of the family, then, we may have an opportunity to foster meaningful conditions of equality under which physician-assisted suicide would not look as perilous as it currently does for members of socially subordinated groups, including lesbians and gay men.

In the end, I confess I have no ready answers, but only more questions. To mention but a few: How, if it has, has the changing color of the face of HIV and AIDS among gay men changed the gay politics of assisted suicide?<sup>38</sup> How, if at

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37. Cf. Richard A. Posner, *Should There Be Homosexual Marriage? And If So, Who Should Decide?*, 95 MICH. L. REV. 1578, 1587 (1997) (calling "the name 'marriage'" a "symbolic crown") (reviewing WILLIAM N. ESKRIDGE, JR., *THE CASE FOR SAME-SEX MARRIAGE: FROM SEXUAL LIBERTY TO CIVILIZED COMMITMENT* (1996)).

38. See, e.g., Peter Freiberg, *AIDS Demographic Shifts, CDC: Gay Men of Color Infections Pass White Numbers*, WASH. BLADE, Jan. 14, 2000, at 1 ("For the first time, [g]ay and bisexual men of color now outnumber white [g]ay and bisexual men in newly diagnosed AIDS cases."); see also, e.g., The Centers for Disease Control, *HIV/AIDS Among Racial/Ethnic Minority Men Who Have Sex With Men—United States, 1989-1998*, 283 J. AM. MED. ASS'N 995 (2000); Cheryl L. Cole, *Containing AIDS: Magic Johnson and Post[Reagan] America*, in QUEER THEORY/SOCIOLOGY 280, 288-90 (Steven Seidman ed., 1996). Some implications of the racial demographics of HIV and AIDS may be suggested by the interesting research of Gary Stein and Karen Bonuck. See Gary L. Stein & Karen A. Bonuck, *Attitudes on End-of-Life Care and Advance Care Planning in the Lesbian and Gay Community* 10, \_\_ J. OF PALLIATIVE MED. \_\_ (forthcoming) (manuscript on file with author) (reporting that although 68% of lesbian and gay respondents to survey questionnaire indicated they would support legalization of physician-assisted suicide "under a wide variety of circumstances, [and] an additional 24% supported legalization in a few situations," "black respondents were significantly less likely to support legalizing [physician-assisted suicide] under a wide variety of circumstances (Black = 34% vs. White = 73% vs. Latino = 72%)"). Stein and Bonuck go on to indicate, however, that 75% of black survey respondents "could imagine requesting [physician-assisted suicide] for themselves." *Id.* Unlike other studies that have shown disparities in support for legalization of the practice by gender, see, for example, Peter Steinfelds, *Help for the Helping Hand in Death*, N.Y. TIMES, Feb. 14, 1993, at 1, 6 (reporting, *inter alia*, gender differences in

all, will or should it? What impact might technologies capable of transforming AIDS into a “chronic illness” have on lesbians’ and gay men’s attitudes toward physician-assisted suicide?<sup>39</sup> How will we deal with race and class privilege within the gay community, which may leave AIDS to be a “terminal illness” for some, while becoming a “chronic illness” for others?<sup>40</sup> How should we deal with the social fact that sexuality is often a, if not *the*, major part of gay social identity<sup>41</sup> – so that loss of it, as through illness (whether “terminal,” “chronic,” or otherwise) – can mark gay life as having lost what little value it might previously have had?<sup>42</sup> How, if at all, does the social construction, the fiction, of sexual

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exit polls conducted on the day California voters turned back a referendum to legalize physician-assisted suicide and active voluntary euthanasia) (cited in *Gender, Feminism and Death*, *supra* note 4, at 290 n.24), Stein’s and Bonuck’s study of attitudes toward legalization within the lesbian and gay communities revealed “minor differences by age[,] . . . but no differences by gender . . . or HIV status[.]” Stein & Bonuck, *supra*, at 10. Many thanks to Gary Stein for so generously sharing this important research with me.

39. See, e.g., Stephanie H. Michaels et al., *Declining Morbidity and Mortality Among Patients With Advanced Human Immunodeficiency Virus Infection*, 339 NEW ENG. J. MED. 405 (1998); Frank J. Palella, Jr. et al., *Declining Morbidity and Mortality Among Patients with Advanced Human Immunodeficiency Virus Infection*, 338 NEW ENG. J. MED. 853 (1998) (concluding that “the recent declines in morbidity and mortality due to AIDS are attributable to the use of more intensive antiretroviral therapies”); see also Linda C. Fentiman, *AIDS as a Chronic Illness: A Cautionary Tale for the End of the Twentieth Century*, 61 ALB. L. REV. 989 (1998).

40. See, e.g., Palella, *supra* note 39, at 859 (noting that “[p]atients with private insurance were more likely to be prescribed a protease inhibitor than were those covered by Medicare and Medicaid,” and that “[d]eath rates were lower for those with private insurance than for the study population overall and for those in other payer categories; this effect is attributable to differences in the rate of prescription of protease inhibitors”). Compare Robert Steinbrook, *Caring for People with Human Immunodeficiency Virus Infection*, 339 NEW ENG. J. MED. 1926, 1927 (1998) (“[A]ccess to care is worse for those who are poor, black, or Hispanic or who have less health insurance or none.”) (footnote omitted), with Richard E. Chaisson et al., *Race, Sex, Drug Use, and Progression of Human Immunodeficiency Virus Disease*, 333 NEW ENG. J. MED. 751 (1995) (concluding that “[a]mong patients with HIV infection who received medical care from a single urban center, there were no differences on disease progression or survival associated with sex, race, injection-drug use, or socioeconomic status. Differences found in other studies may reflect differences in the use of medical care.”), and with Robert S. Hogg et al., *Race, Sex, Drug Use, and Human Immunodeficiency Virus Disease*, 334 NEW ENG. J. MED. 123 (1996), and Robert S. Hogg et al., *Lower Socioeconomic Status and Shorter Survival Following Human Immunodeficiency Virus Infection*, 334 LANCET 1120 (1994), and MT Schecter et al., *Higher Socioeconomic Status Is Associated with Slower Progression of HIV Infection Independent of Access to Health Care*, 47 J. CLIN. EPIDEMIOLOGY 59 (1994). See also, e.g., David Farrell, *Assisted Suicide A Troubling, Divisive Issue for State Doctors*, DET. NEWS, Nov. 20, 1994, at 4C (quoting Dr. Ralph D. Cushing, a physician who treated people with AIDS at one hospital in an affluent suburb of Detroit, Michigan, as well as in an “inner city” hospital there; according to Dr. Cushing, there is a racial difference in treatment options made available to AIDS patients in the two settings) (cited in Yale Kamisar, *Against Assisted Suicide – Even a Very Limited Form*, 72 U. DET. MERCY L. REV. 735, 739 n.17 (1995)).

41. RICHARD MOHR, *GAYS/JUSTICE: A STUDY OF ETHICS, SOCIETY AND LAW* 232 (1988) (“[F]or the gay male, his sexual orientation is the chief factor of his existence[.]”).

42. See, e.g., Michael W. Ross & Lorna Ryan, *The Little Deaths: Perceptions of HIV, Sexuality and Quality of Life in Gay Men*, in *HIV/AIDS AND SEXUALITY* 1, 13 (Michael W. Ross ed., 1995); see also *supra* note 33.

identity undermine our capacity to speak coherently about these issues?<sup>43</sup> I invite you to join me in thinking through these and other questions.

If I could offer a single, parting thought, it would be this: as we struggle to gain respect for our equality, and with it, the right to author our own lives, we must recognize that our stories can be read other than as we intend, against cultural baselines we disapprove.<sup>44</sup> Moreover, even those who understand our stories as we mean them to be understood, may emulate those stories in ways we might wish they would not. When insisting on authorship, we should not forget. We write not only for ourselves. But both for people we can see and those we cannot.

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43. See, e.g., Janet E. Halley, *Reasoning About Sodomy: Act and Identity in and After Bowers v. Hardwick*, 79 VA. L. REV. 1721 (1993).

44. See MICHEL FOUCAULT, *What Is an Author?*, in *AESTHETICS, METHODS AND EPISTEMOLOGY* 205 (James D. Faubion ed., 1994) (discussing the complexities of the notion of “author”).