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The AIDS Epidemic:

A Prism Distorting Social and Legal Principles

Alec Gray

The AIDS epidemic is affecting American society in far-reaching and unexpected ways. It touches our institutions, our value systems, and our private lives. Social issues seem to change and become distorted by the epidemic's prismatic effect. This article examines some of the major public health issues raised by the epidemic, ranging from testing to contact tracing and quarantine. It argues that while the civil rights of individuals may have to be sacrificed to stem the spread of the disease, those rights should not be abandoned unless a clear benefit to the public health would result.

Issues of discrimination in housing, employment, insurance, and medical services are considered to determine whether additional protections are needed. Other measures for contending with the epidemic, including the use of criminal statutes, are reviewed to determine whether they could realistically be expected to have a beneficial effect.

The effect of the disease on personal, private, and religious beliefs is considered, and a legal perspective is applied to the various implications of the epidemic. The conclusion is reached that while there are no easy or simple answers, common sense must be the basis for any workable approach.

To say that AIDS is the public health issue of the century is to state the obvious. The assertion that AIDS is everyone's concern is no longer subject to challenge. The disease has caused and will continue to cause major revisions in the ways in which we live, structure our society, and define our beliefs. It attacks the human body with devastating consequences. It attacks the fabric of our society in ways that are perhaps more subtle but that have equally drastic consequences.

A basic tenet of U.S. political philosophy is that every human being has inalienable rights, including the rights to life, liberty, and the pursuit of happiness. Few things could directly challenge the existence of all three of these inalienable rights. The AIDS epidemic has that potential.

Now, for the first time in recent history, a disease threatens life through the very act of intimacy. By its fatal nature, AIDS directly challenges the right to life of all who are ex-

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posed to it. The means by which the disease is transmitted affects the willingness and ability to engage in intimate sexual relations. The right to pursue happiness through loving and intimate relationships has been challenged. Even the right to liberty has come into question, as more and more political leaders call for the segregation of those who are ill and those who are infected.¹

The central question posed by this epidemic is whether we will be able to maintain our traditional values and principles while dealing with a threat to our very existence. To maintain the health of the entire community, some individual rights may have to be sacrificed. Of particular concern in the legal community is the question of what quantum of protection will justify the lessening of personal freedoms. In this century in this country, thousands of Americans of Japanese ancestry were rounded up and forced to give up their homes, their property, their jobs, and their freedom because of the suspicion that they posed a threat to the country's safety. The action was legally challenged, and the final decision, rendered from the nation's highest tribunal, was that the governmental action was justified and proper.² Yet the idea that a mere suspicion is enough to cause the wholesale termination of personal freedoms is anathema to the American concept of justice and liberty.

In the public health arena, the power of health commissioners to impose quarantine is well known. When faced with a threat to the health of the public, the state, through its inherent police power, can impose burdens and lessen freedoms. Courts have traditionally upheld this prerogative when it is exercised in accordance with the sound discretion of appropriate officials. At the beginning of this century, the U.S. Supreme Court upheld the mandatory inoculation for smallpox.³ Since then, other courts from diverse jurisdictions have upheld the exercise of the police power to meet a health emergency.⁴ Some decisions have indicated that in this regard, the constitutional protections simply do not apply.⁵ This body of law does not date from an ancient period of history. In 1980, the West Virginia Supreme Court of Appeals set forth the minimal due-process guarantees that were to be applied to efforts to quarantine patients with tuberculosis.⁶

In considering these cases, the "reasonableness" standard has traditionally been applied. Because its interpretation relies upon the subjective view of the public health commissioner, this standard is quite troubling. It is not for the court to second-guess the professional judgment of the executive-branch official who is entrusted by law with the power to make this type of decision.⁷

A more useful means for ascertaining the reasonableness of a mandatory public health measure is to determine whether it will afford protection to the public health as a matter of reasonable medical certainty. This requires more than the belief that the matter is necessary or efficacious; it requires that public health officials be able to offer solid medical or epidemiological evidence that the mandatory public health measure will, in fact, be able to protect the public health. If the contemplated measure will offer real protection, then the determination of reasonableness must be made by balancing the degree of intrusion into personal liberties that would result from its imposition against the degree of protection that the measure would provide to the general populace: the greater the intrusion, the greater the degree of protection that must result.

This balancing approach will be called into play as various state and city legislatures and public health departments contemplate and impose new public health measures designed to address the AIDS epidemic. Certainly, the proper authorities must be given the power to address this epidemic. But the measures that are imposed must not compromise

the individual freedoms of those who are affected without a corresponding benefit to the public good.

The extent to which personal liberties may be intruded upon will depend, in part, upon existing statutory schemes. The Constitution provides certain basic guarantees, such as due process and freedom from unreasonable search and seizure. But the more immediate and applicable rights derive from state or federal legislative enactments. For example, it is unlawful for employers who receive money from the federal government to discriminate on the basis of handicap.⁸ Massachusetts has a law that prohibits discrimination against the handicapped in employment but does not prevent discrimination in housing.⁹ Unless there is a statute prohibiting discrimination on the basis of AIDS, a public health measure requiring an AIDS virus test may result in a loss of employment, housing, and insurance for the person being tested. Whenever mandatory public health measures are contemplated, corresponding consideration should be given to whether additional protections are needed to preserve individual civil liberties.

When the general welfare is threatened, it is appropriate for the government to take appropriate action to preserve and protect the common good.¹⁰ Accordingly, it is not surprising that the first round of debate on the AIDS epidemic is occurring in Congress, in the state legislatures, and in public health councils around the country. These are the proper deliberative bodies to formulate policies and to devise the means by which the disease can be treated and its spread curtailed.

But government must deal with the AIDS problem in a separate context as well. It must decide how to deal with those people who have AIDS and who live in or who are confined in public institutions. How to treat persons with AIDS who are in direct state care and what to recommend for or impose on the general public with regard to AIDS should be consistent, or at least not contradictory, even though the considerations for each are somewhat different.

Governmental Response: The General Population

Mandatory Public Health Measures

Traditionally, government has had the right to take drastic and even devastating actions to control the spread of disease.¹¹ Quarantine,¹² segregation,¹³ testing,¹⁴ and vaccination¹⁵ have been not uncommonly imposed on past generations to deal with epidemics. These same measures are being discussed today as potential means for fighting the spread of HIV infection.¹⁶

Testing. The primary focus of most current governmental discussion about mandatory health measures with respect to AIDS is the idea that certain people should be required to be tested for the AIDS virus. This idea has initial appeal. It seems to make obvious good sense to know who has the disease, to learn how widespread the infection is so that the problem can be addressed in an informed manner. The AIDS test is a relatively simple laboratory procedure performed on blood. The degree of intrusion with respect to a person's bodily integrity is relatively minor. The potential benefit seems to be considerable. But if testing is to be imposed, who should be tested and the consequences of the test result must both be determined.

Testing was first imposed for those in the armed forces and for military recruits.¹⁷ Here, the justifications for testing are strong: The armed forces must be healthy. In case of

emergency, all personnel must be available to provide blood transfusions. The armed forces are dispersed throughout the globe. It is proper for this country to take steps to prevent or at least retard the exportation of disease to other countries.¹⁸ The same considerations have led to the mandatory testing of State Department personnel who are assigned to overseas operations.¹⁹ The testing of military personnel for the AIDS virus is not without serious potential consequences. Soldiers have been charged with criminal conduct as a result of having sex after having tested positive.²⁰ A civilian band leader assigned to a foreign army base has been released from duty for having tested positive to the HIV antibody.²¹

Many jurisdictions are considering a mandatory AIDS test for all who apply for a marriage license.²² President Reagan has advocated this idea.²³ It has a superficial appeal. Politicians who suggest premarital testing for AIDS may appear to be doing something to curb the spread of the disease. Traditionally, states have taken action to require that those who are entering the holy state of matrimony undergo venereal disease tests.²⁴ With respect to the AIDS virus, some hold that it would be unfair to the betrothed to enter a marriage in which the partner is infected with a life-threatening disease that could be transmitted to the spouse or to the children, or both.

However, the issue is far more complex. The HIV antibody test is about as accurate as any medical test, but it is not completely accurate. Even with a reliable confirmatory test, there are many instances of false-positive test results.²⁵ If the test is applied in a population with a low prevalence of viral infection, the number of false positives is appreciable. For example, if the test were to be administered to members of the general population (which is presumed to have a low seroprevalence), many true instances of infection would be discovered. But it could also be expected that many false positives would result.²⁶

Applying these false-positive statistics to the notion of premarital testing, it could be anticipated that if all couples about to be married were tested, more than 380 perfectly healthy, happy persons would (incorrectly) be told that they were HIV-positive. The effect that such information would have on the marital plans can easily be imagined. Further, the testing project would cost somewhere in the vicinity of \$100 million,²⁷ and the use of these monies for this sort of testing would mean that funds would not be available to offer testing to individuals who might well be infected and for whom the test would produce more accurate results.

The concept of the state stepping in to require full and informed consent prior to marriage is equally troubling. While it might appear to be a good idea to require potential husbands and wives to be truthful about their medical status, it would similarly be wise to require them to be truthful about their financial status and about their past criminal history.

The proposal for premarital testing should be evaluated with the same criterion that is applied to other public health measures: Is the degree of intrusion into personal liberties justified by the corresponding benefit to the public health? The degree of intrusion could be serious; marriage has long been considered to be a fundamental right,²⁸ and any requirement of premarital testing or disclosure would impose a significant burden on the right of individuals to marry at will, without governmental restriction. The benefit to be derived from the test would be speculative at best. Many, if not most, of those who seek to be married have presumedly already engaged in intimate sexual relations. Testing for those about to be married would not be focused on a population that is particularly at risk of infection, nor would it be imposed at a time when the knowledge derived from the test would be most useful. In this situation, the intrusion into personal liberties would not be justified by a corresponding benefit to the public health.

The president has also advocated the mandatory testing of aliens who are applying for permanent residence status.²⁹ This is a notion whose initial appeal readily dissipates upon even a cursory examination.

Traditionally, quarantine was used to isolate a ship coming in to port which potentially carried infected goods or people.³⁰ The ship was kept in the harbor, and neither anyone nor anything was allowed off the ship until proper inspection could be made to determine that it would not be dangerous to allow disembarking.³¹ It is from this historic perspective that the testing of aliens derives its appeal.

The idea of denying entrance to those infected with a deadly disease may have merit, especially if the disease is not already rampant within the general population. The proposed restriction, however, does not apply merely to individuals outside the United States who are seeking admittance for the first time; it extends to individuals who are already in this country, regardless of the length of their residence. Many of those applying for permanent residence have lived here for years, as students, as temporary workers, or as visitors.³² To assume that it is only after they gain permanent status that they will begin to engage in sexual relations or intravenous drug use is absurd. To now refuse them permanent status is simply unjust and far more serious than closing the barn door after the horse is gone. Requiring them to leave this country may amount to the mandatory exportation of the virus to other nations. This public health measure will have little, if any, effect on the spread of the disease in the United States. All that it will accomplish is to deny citizenship to individuals because of their medical condition.

While to date mandatory testing has been advocated only for the military and for State Department personnel, those seeking marriage licenses, and aliens, other populations will soon be the focus of such efforts. Prostitutes, who are apt to be intravenous drug users,³³ are at least a potential bridge between traditional high-risk groups (homosexual men and intravenous drug users) and the mainstream of society. Besides the use of prostitutes by heterosexual men, it is not unheard of for a "straight" man to employ a male prostitute. Thus, the HIV infection may pass from a prostitute (having been infected through drug use or homosexual acts) to a heterosexual man and from him to his wife, girlfriend, or next sexual partner. The concern about prostitutes has been heightened by media reports of both male and female prostitutes who have continued to work after learning that they were infected with the AIDS virus.³⁴ The public outrage is understandable.

Realistically, it is not clear what can be done about the prostitute-AIDS connection. Suppose a prostitute were charged and convicted and an HIV antibody test were ordered. The prostitute would obviously have to be held in custody until the test results were known. If the results came back positive, there is serious question as to whether the sentencing judge would take that medical status into consideration in imposing a sentence. If a harsher sentence were imposed because of the HIV antibody status, the prostitute would have been punished for having a disease rather than for committing a crime. This concept is antithetical to the American concept of criminal justice,³⁵ especially given the likelihood that the prostitute would have been ignorant of his or her medical status prior to committing the act for which the criminal charges were pressed. It might be possible to make the medical test result part of the probation or criminal record so that the information could be used the next time such charges were leveled against the prostitute. But for the test results to be used, the prostitute would have to be charged with a new crime in which he or she was clearly engaging in the act of prostitution after having been diagnosed as HIV-positive. Further, even if the new crime were enacted, the penalty would not have been pre-specified. A longer and a mandatory prison sentence could be imposed for the new

crime, but it is not clear that this would have an impact on the disease, and the increased penalties might create new problems for the penal system.

Another suggestion for dealing with the AIDS-prostitute problem is to legalize prostitution and require periodic medical examinations of those who seek to work in this field. The idea is that by licensing prostitutes, some check or control could be placed on their medical status, and those who chose to use a prostitute would be able to employ someone whose health had been established. There are two essential problems with this approach. First, even if some prostitutes were working legally, there would still be those who worked without the benefit of a license and a medical certificate. Second, the current test detects antibodies to the AIDS virus, not the virus itself. It takes the body some time, estimated at three weeks to six months, to generate these antibodies after initial exposure to the virus.³⁶ To be sure that a person is free of the virus, it is necessary to test twice, with a six-month interval, and to ensure that during those six months the person engages in no conduct that could expose him or her to the virus. Imposing these restrictions on prostitutes would seem to be particularly unworkable. Finally, the solution is simply impracticable. A prostitute might be licensed and certified as healthy and then become infected, while carrying a certificate of health attesting to a disease-free status and presumably stating that no new test would be required for several months. In the interim, more and more clients would rely on a health certificate that was inaccurate. While the idea of legalized prostitution may be meritorious, it does not gain any support as a tool for fighting the AIDS epidemic.

There are those who take a more altruistic view of the problem concerning AIDS and prostitutes. They suggest that for prostitutes who are engaging in sex in order to finance a drug habit, the solution is to treat the drug addiction. Providing prostitutes with counseling, a chance to develop skills, and help with finding other forms of employment would be ways of doing this. Education about the dangers of drugs and the realities of AIDS might well have a beneficial impact. Clearly, all of this would require more methadone treatment centers, more counselors, more teachers, and more money. But to believe that such efforts would halt the practice of prostitution in the near future would be naive.

The prostitute's client may also be an appropriate party to educate about the dangers to which he is exposing himself and others. Mandatory education programs are now a common way of dealing with drunk drivers.³⁷ Perhaps a mandatory AIDS education program for those convicted of using a prostitute would be helpful. It might provide not only useful information, but also a deterrence from the use of prostitutes in general.

Another group that will likely be singled out for testing are pregnant women, who are now urged to undergo an HIV antibody test. The potential for an infected mother to transmit the disease to a child is quite high.³⁸ Doctors are urging women with identifiable risks for HIV infection to consider this reality in deciding whether or not to have a child.³⁹

The idea of encouraging pregnant women to undergo an HIV test does not pose any risk to civil liberties. It remains for the woman herself to decide whether she wants the information and to decide what to do with the test results. Civil liberties are implicated only when the concept is expanded to *require* that all pregnant women submit to such a test. The true issue is not the test, but the consequence of the test. Will there be a suggestion that infected mothers cannot give birth? If so, what other prenatal tests can be required to ensure that only the healthy procreate and only the well are born?

In this connection, it could be argued that there is a benefit to requiring testing of all pregnant women and a benefit to requiring that women who test positive for the AIDS virus not give birth. Such a requirement would certainly lessen the number of children

born with this fatal and costly disease. However, the degree of intrusion into personal liberties is so total and so devastating that it could not be justified by any countervailing improvement to the public health.

Contact tracing. One public health measure that is currently under discussion is sexual contact tracing, which is a standard public health measure for dealing with venereal disease.⁴⁰ Existing statutes and regulations in most jurisdictions could be readily adapted to AIDS.

Contact tracing involves contacting those individuals who may have been exposed to the disease. It requires that when people test positive for the infection, they reveal the names and addresses of those whom they may have infected. In the AIDS context, this would mean revealing the identity of past sexual partners as well as the identity of those with whom intravenous needles were shared. The identified individuals would then be contacted by public health workers and urged to be tested for the virus. While the standard approach is to phrase the law in terms of a mandatory requirement, there is often no penalty for noncompliance or for inadequate or incomplete compliance.

These laws have generally been upheld as reasonable public health measures designed to deal with venereal disease.⁴¹ Despite the intrusion into personal freedoms, there is an undeniable benefit to the public health. By identifying those individuals who are infected with VD, treatment can be offered which can eliminate the infection within a matter of days. This remedy is simply not available with AIDS. While the sources of infection may be identified, no treatment can be offered to eliminate the infection.

Contact tracing could have a beneficial effect in dealing with the AIDS epidemic, especially in populations with a low incidence of HIV infection. A person who has no suspicion that he or she may have been exposed to the virus is much less likely to practice behavior that will reduce the risk of spreading the disease. Informing infected persons of their HIV status may influence them to terminate conduct that could spread the disease.

Obviously, a program of mandatory contact tracing would have a great impact on the right of individuals to privacy. Whenever a governmental employee asks for the identity of past sexual partners, the potential for abuse is great. The potential for effectively curtailing the spread of the disease, however, is not assured. People can be expected to lie about their sex and drug partners. Some will be dissuaded from being tested if they know that they will be asked to reveal the identity of others. In populations such as the male homosexual communities of San Francisco and New York City, where up to 50 percent of the members of the community are already infected, the potential benefit from such a program would be marginal, as the same people would likely be identified over and over again. The rights/benefits analysis would indicate that in some communities the right of individual privacy may outweigh the unlikely benefits.

In communities with low seroprevalence, there may be a sufficient benefit to the public health to warrant the imposition of contact tracing. Even in these circumstances, every effort would have to be made to preserve the confidentiality of all concerned. If a sufficient matrix of statutory protections exists banning discrimination on the basis of HIV status, the burden on individual liberties may be lessened further, thereby justifying this public health measure.

A more workable approach might be to inform people who do test positive of the nature of the disease and to explain that they may have exposed other people who, perhaps, are in the process of exposing still others. They should be urged to contact those whom they may have infected. As an alternative, a program should be offered to them whereby trained, professional public health workers can contact those who may have been exposed in order

to explain the situation in an anonymous context. Such a program would provide information to those who need it without needlessly infringing on the right of privacy.

Quarantine. A suggestion not openly discussed is quarantining those with AIDS and HIV infection. Quarantine was used earlier in this century to deal with the threat posed by tuberculosis.⁴² Those who were confined in sanatoria (and only after a court determination that they were unable or unwilling to take proper precautions)⁴³ were nonetheless confined apart from the population and against their will.

Tuberculosis is an airborne disease.⁴⁴ A person can contract it simply by being in the same room with someone who is infected. There was an undeniable need for drastic measures to deal with tuberculosis. HIV is transmitted only through the exchange of blood or semen; some type of direct blood-blood or blood-semen contact is required. But the conduct that transmits HIV is private in nature and therefore not easily susceptible to regulation. Those who favor quarantine argue that while AIDS is not communicated as readily as TB, there is no effective way to guarantee that those who are infected will refrain from conduct that will transmit the infection.

An idea that is advanced only by the most zealous is to mark or tattoo those who are infected. The argument goes that if the potentially dangerous conduct cannot be successfully regulated, at least persons who come into contact with those who are infected should have fair warning. The idea is offered as a modern-day version of the leper's bell.

These suggestions are frightening. Few things are more devastating to personal liberty than being quarantined for life. The idea of a tattoo smacks of Nazi Germany and is particularly abhorred by the gay community, since homosexuals were tattooed in the concentration camps and were made to wear the infamous pink triangles.⁴⁵

The first question with regard to quarantine is, Who would be removed? The answer would be, necessarily, all those who are infected. Merely quarantining those with clinical, CDC-diagnosed AIDS would not remove all those who are infected. All who are HIV-positive would have to be removed. All 2 million.⁴⁶ And, because the antibodies to the virus (which is all that the test currently detects) are not present for up to six months after initial infection,⁴⁷ the quarantine effort would have to be ongoing. Designing a plan by which the entire population would be tested routinely twice each year would be staggering. It would dwarf any military registration system that has ever been implemented.

But even if such a system could be designed and put in place, it wouldn't be successful. As noted earlier, the test is not foolproof.⁴⁸ There would be instances of false negatives. In a general population of 100,000 tested, 29 people who are in fact infected would have a false-negative test result⁴⁹ and accordingly would be allowed to remain at large, spreading the virus. Additionally, some people never develop the antibodies, so although they are infected, they would continue to test negative. The potential for abuse and subterfuge would only be increased by the consequences attendant on a positive test result. Dividing the country between the infected and the healthy would jeopardize all notions of liberty and justice. It would separate the country as decisively as the South's secession did.

Another form of segregation must receive more serious consideration. There may be individuals who present a risk to the community at large because they are infected and infectious and are unable or unwilling to conform their conduct in ways necessary to stop the spread of the virus. What is to be done about someone who is HIV-positive and who deliberately sets out to infect other people through sexual relations or the sharing of drug needles? What about the person who, because of limited cognitive capability or symptoms of dementia, is unable to stop dangerous conduct and continues to have unprotected sex or to frequent drug-shooting galleries? Must society sit back and allow this conduct to con-

tinue? Should some type of humane treatment facility be provided where these people could receive help but at the same time be removed from the population at large? If such a civil commitment were to be imposed, procedural safeguards would be needed. It is likely that the commitment would be for the duration of the illness; in the case of AIDS, for life. Some type of periodic review would be needed to determine the individual's continued medical status and his or her current ability and willingness to refrain from conduct that could spread the infection. Provision would have to be made for attorneys to represent these individuals at all commitment proceedings. Wherever the confinement was accomplished, appropriate treatment would have to be available, not only to address the individual's medical needs, but also to provide whatever psychological counseling or other treatment was needed so that the committed person could learn to control the behavior that could lead to spreading the disease.⁵⁰

This type of limited segregation of those individuals who present a clear and unmistakable public health danger, where there is no other alternative to commitment, may have to be considered. It is a difficult suggestion, one that could be considered only as an absolutely last resort. The burden on individual freedom would be extreme and could be justified only if a concomitant benefit could be obtained. Moreover, the question remains whether removing these isolated individuals would have a beneficial effect in terms of stopping the epidemic.

Mandatory Public Education

One of the platitudes of the AIDS crisis is that the only weapon available to fight the disease is education. There is no vaccine, and the available treatments are only experimental. If the disease were polio, the public education program would be extensive and immediate; polio is contracted in "moral" ways.⁵¹ AIDS is spread by sexual conduct and by sharing contaminated needles. American society is reluctant to discuss sex even in private, and the notion of a sexually explicit public campaign is very difficult to countenance. Teaching safe ways to inject drugs is anathema to the current "war" against drug use. As recently as November 1987 there has been a call by some members of the Massachusetts legislature to rescind the funds allocated to the AIDS Action Committee of Massachusetts because the committee published a brochure (not using state funds) that used explicit terms in describing "safe" and "unsafe" sexual practices.

Effective AIDS education must involve school systems. Traditionally, parents have been very concerned about sex education, preferring to control what and how their children are taught about sex. Some states are now making AIDS education a requirement of public education beginning in the elementary grades.⁵² If the layers of difficulty about AIDS education are not already obvious, one additional complication needs to be mentioned. An effective means of reducing the risk of contracting HIV infection is to use a condom during sex.⁵³ Condoms are also a commonly used form of birth control. To advocate the use of condoms and to recommend that they be made available routinely and universally implicates the notion of urging birth control, which is contrary to the teachings of some religions.

Effective AIDS education requires some degree of effective sex education. The virus is transmitted by the "exchange of body fluids," but people need to know exactly what that means. For years, AIDS educators have been urging people to engage in "safe sex" or "safer sex." The slogans have urged "on me, not in me" and people have been advised to use condoms during intercourse. Many assumptions underlie common notions about safe sex. Some educational materials have advised that homosexuality is a cause of AIDS.

Slogans, sayings, and statements have great potential for conveying misinformation, because they generally do not employ explicit terms or refer to precise acts.

The only truly safe sex is sex in which no semen, pre-seminal fluids, or vaginal secretions are put into another person's body. That means that the only sexual activity that is safe, other than kissing, is masturbation or digital manipulation. Safer sex is sex that involves a prophylactic to prevent the infusion of potentially dangerous body fluids. AIDS education must indicate that the virus is present not just in sperm, but also in pre-seminal fluids and in vaginal secretions. That means that a condom should be put on before fellatio, and that cunnilingus is at least potentially dangerous. Homosexuality does not cause AIDS. Certain sexual acts that are frequently performed by homosexual men do present a danger of transmitting the disease. Specifically, anal intercourse is the most efficient sexual means of infusing the virus directly into the bloodstream of another.⁵⁴ Anal intercourse is a not uncommon practice among members of the heterosexual community.⁵⁵ Any indication that anal intercourse is dangerous only if performed between two men and not between a man and a woman is wrong and dangerous.

The intent here is not to provide safe sex counseling, but to demonstrate the type of explicit information that must be conveyed if it is to be of any benefit. Merely to urge the use of a condom during vaginal intercourse and not to tell people that a condom should be put on before foreplay involving fellatio is to mislead. Mention has to be made of these types of sexual practices. People have to know what is dangerous and why.

Obviously, this type of information is not generally found in elementary-school classrooms or on public-television shows. The debate about the morality of AIDS education is being waged across the country. The U.S. surgeon general has personally written a brochure explaining, in layman's terms, what is known about the disease and what is known about how to avoid spreading it.⁵⁶ The federal government will not pay for the distribution of this information to U.S. citizens because the president believes that more emphasis should be placed on sexual abstinence as the best way to prevent the spread of the disease.⁵⁷ Rep. Gerry Studds (D-Mass.), in an act of self-described desperation, has invoked his constitutional franking privilege to distribute the brochure to his constituents.⁵⁸ Others are still debating and delaying the dissemination of needed information because of not wanting to appear to be condoning sexual promiscuity.

New York City produced public service announcements aimed at providing information for the general, straight community about the potential dangers of AIDS. One commercial, showing a stylish young woman putting a package of condoms into her purse as she leaves her apartment for a night out, announces, "Don't leave home without your rubbers."⁵⁹ After the public service programs were produced, none of the three major television networks in New York City would agree to air the spots, claiming they were too risqué.⁶⁰ In the meantime, in that city more men between the ages of twenty-five and forty-four and more women between twenty-five and thirty-four are dying from AIDS each year than from cancer. Certainly, the media have the First Amendment freedom to decide what to air and what to reject. However, unless and until all parties — the government, the media, the state legislatures, and the public at large — recognize that this is a matter of life and death and agree that basic, understandable material must be disseminated widely, there will be no effective public education campaign and thousands more will die.

Housing and Employment Discrimination

Of immediate concern is whether state and federal governments will enact laws protecting those with HIV infection and AIDS from discrimination. Recently, the Supreme Court

decided that communicable diseases can be considered to be handicaps within the federal Rehabilitation Act.⁶¹ Section 504 of this act prohibits discrimination only by the federal government and by those private enterprises which receive federal funds. While it now seems fairly clear that AIDS will be considered a protected handicap under that statute, the question remains whether HIV infection will be included within the statutory ambit.⁶²

Many states, including Massachusetts, have taken the position that AIDS and HIV infection are handicaps under state law.⁶³ Some jurisdictions have enacted statutes that specifically prohibit discrimination on the basis of AIDS.⁶⁴ Some have prohibited requiring employees or job applicants to undergo the HIV antibody test.⁶⁵

The issue to be decided in this context is whether an employer should be able to dismiss an employee who is known to be infected with HIV or who in fact has clinical AIDS. The rights of the employer in this area generally encompass the right to hire the people of his or her choosing. Employers are understandably concerned that other employees will walk off the job if they know they are working with someone who is infected with HIV. There are fears that customers will stop patronizing shops if they know they will be waited on by a person with AIDS. Employers wonder what type of liability they will be exposed to if an employee infects someone else in the workplace. Landlords have similar issues. They are concerned that property values will drop if it is known that a person with AIDS lives in a particular apartment house, and they wonder if other units in that same building will be rentable.

Balancing the rights of landlords and employers against the rights of those stricken with AIDS is not an easy task. The various state legislatures and city councils will have to decide how the balance should be struck. The consequences are of great significance. If discrimination is permitted, it can be expected that those with HIV infection and AIDS will be denied jobs and housing. If discrimination is prohibited, it can be expected that employers and landlords will face increased costs and adverse business consequences.

Another underlying question is, Why should AIDS be treated differently than other illnesses or diseases? There is no great movement to prohibit discrimination against those with cancer or tuberculosis or hepatitis. Why should AIDS be singled out from among all diseases, even from other life-threatening, infectious diseases, for special treatment? The answer seems to be that AIDS *is* different. No other disease carries the stigma associated with AIDS. Because of the way in which AIDS first entered the United States and because of the people who were first affected, AIDS is often associated with illegal or immoral behavior. An AIDS diagnosis often carries the assumption that the patient is a homosexual man or a drug user. The hemophiliac community, while suffering greatly from HIV infection, seems to be trying to distance itself from the AIDS movement so as to avoid the stigma and discrimination commonly associated with homosexuality and drug use. The simple fact is that homosexuals and drug users have not enjoyed an elevated position in society. They have often been subjected to discrimination, and traditionally they have not had great political clout. For these reasons, there is more likelihood of discrimination against those with AIDS.

Further, the very mention of AIDS engenders fear and trepidation. The common understanding is that the disease is universally fatal. It is known to be communicable. These factors combine to make discrimination against those with the disease inevitable. Even in states that have enacted strong laws prohibiting discrimination, the instances of AIDS patients being denied housing, jobs, medical treatment, and other services are amazingly numerous.⁶⁶

AIDS is different from other contagious diseases, and it should be treated differently.

Insurance

Debate is currently raging about the ways in which the insurance industry is attempting to protect itself from claims based on AIDS. The industry obviously is concerned lest huge numbers of new claims for life and health insurance drain its available pool of resources. Those who want protection against future infection with HIV want the benefit of insurance.

The controversy is focusing on the issue of testing. The insurance industry wants to require those applying for insurance, or at least some types of insurance (generally life and disability), to be tested for the HIV antibody. Those with positive test results would not receive insurance policies. AIDS activists are vehemently opposed to any mandatory testing as a precondition to insurance coverage. The range of approaches to this problem spans the horizon. In Washington D.C.,⁶⁷ and in California,⁶⁸ all HIV antibody testing is prohibited. New York State has announced plans to allow testing for life and disability policies but not for health insurance.⁶⁹ In Massachusetts, Insurance Commissioner Peter Hiam took the position that no testing would be permitted in the state as a precondition for receiving insurance coverage. This position was overridden by the governor, and Commissioner Hiam resigned. The new insurance commissioner, Roger M. Singer, held public hearings and promulgated regulations that would have allowed some testing for large life insurance policies, but the regulations provided that the insurance industry must protect and preserve the confidentiality of the test results and that proper counseling must be offered to those who are tested. The regulations imposed additional burdens restricting and regulating the laboratories that could conduct the testing and actually specifying which tests would be considered to be valid. The insurance industry promptly brought a legal challenge and obtained an injunction against the enforcement of the new regulations. As a result, no restrictions or requirements have been imposed on the Massachusetts insurance industry concerning the use of HIV antibody testing.

While the debate has focused on testing, the real question is, Who is going to pay the cost of the epidemic? The current controversy centers around life insurance, but the fear is that testing will next be required for health insurance as well. This conjures up images of people being unable to obtain insurance to pay their medical bills and thereby being denied medical care. If health insurance is not available, those who contract AIDS will be forced upon the public hospital system. That system is already overburdened and may not be able to withstand a large new influx of patients. The welfare system and the tax base may have to pay for the medical care of those who have been denied private insurance coverage.

The testing debate is masking the more crucial issue. If some type of insurance pool were to be created which provided coverage to everyone, regardless of HIV-antibody status, the controversy about testing would disappear. What motivates the AIDS activists is the notion that everyone must be able to receive quality medical care regardless of ability to pay. Insurance pools have been created to cover the cost of other types of ailments. The same basic approach should be pursued for AIDS. There should be a combined effort of public and private funds to guarantee that everyone will receive the necessary medical care, including medicines. In the face of the obvious dimensions of this epidemic, the only realistic solution is to spread the cost as widely as possible. To do otherwise would threaten to bankrupt any single source.

While the insurance testing debate will continue, an effort should be made to focus the discussion on the underlying issue of providing a way of guaranteeing quality medical care to all. This sounds remarkably like the perennial debate on the advisability of univer-

sal medical care, an issue that has been heatedly debated for years on the floor of Congress. AIDS has not created the issue, it has merely added to the urgency of finding a resolution.

Criminal Law Revision

An idea that can be expected to receive more attention in the near future is that of using the criminal law to fight against the spread of AIDS.

To date, only isolated efforts have been made to prosecute persons for attempting to infect others with the AIDS virus. A prosecution has been brought against a soldier who tested positive during routine military testing; it was later learned that he engaged in sexual acts with another male soldier and with a female soldier without telling either person of his HIV status and without using any form of protection.⁷⁰ Another AIDS patient was discharged from a hospital declaring that he was going to go out and infect others. He was arrested later that day, following a sexual attack on a woman; he has been charged with attempted murder.⁷¹

It is certainly possible to draft new statutes that would make sexual activity following a positive HIV test result criminal. These statutes could be general or could be restricted to those convicted of prostitution or other sex or drug-related crimes. The object of such statutes, to punish and deter reprehensible conduct, would be unquestionably legitimate. Of more pressing concern is whether such laws would have any appreciable impact on the spread of the disease.

The IV-drug-user community appears to be the biggest bridge between the current known high-risk groups and the mainstream of American society.⁷² Many recreational drug users in middle America have sex with others who neither use drugs nor engage in high-risk sexual activity. The potential for the AIDS virus to leave the IV drug community and enter the larger pool of straight society is apparent. Intravenous drug use is already illegal in virtually every jurisdiction in the country. It must be anticipated that efforts on behalf of stricter drug enforcement will be advocated as a way of addressing the AIDS epidemic.

Of course, drugs are still commonplace even though the war on drugs has been fought for years. To increase drug enforcement efforts may do nothing more than drive the drug community further underground, making it more difficult to reach its members with appropriate educational material. Again, the proffered solution of stricter drug enforcement might look good and sound appropriate without actually being able to address the problem effectively.

Rather than urge stricter drug enforcement, some AIDS activists are recommending that free sterile needles be distributed to drug addicts so that they do not have to share dirty needles. A somewhat less controversial proposal has been to distribute small bottles of household bleach to the drug addict community which can be used successfully to sterilize needles. Even the simple notion of providing AIDS education in the IV-drug-user community causes debate, as many are urging that current or former addicts should be employed to provide the educational material. These ideas may well be beneficial, practical approaches to reaching the drug-using community. The need to reach that community is of utmost importance. The IV-drug-user category is the fastest growing segment of the HIV-infected population.⁷³ But all of these efforts seem to countenance drug use. To adopt any of these approaches would appear to be admitting defeat in the war against drugs. Some hard choices have to be made.

Governmental Response: Public Institutions

Federal, state, and local governments have to deal with the issue of AIDS in all of their public institutions. Policies must be put into place with respect to whether prisoners will be tested for the AIDS virus; whether schoolchildren who are HIV-positive will be taught separately; whether condoms will be distributed to youthful offenders. These issues raise many charged political and moral questions.

Prisons are particularly difficult institutions to manage. They house individuals who have committed criminal offenses and who are known to be uncooperative, manipulative, and often violent. Many prisoners have a history of drug use. Homosexual behavior is reportedly a fairly frequent occurrence behind prison bars. Prison administrators have an obligation to provide a safe environment for those who are confined against their will.⁷⁴ These considerations raise the question of whether prisoners should be tested for the HIV antibody. President Reagan has declared that all federal prisoners are to be tested.⁷⁵ The Massachusetts commissioner of correction has stated that no mandatory testing policy will be implemented in the Commonwealth.⁷⁶ Some states require testing, but only of those inmates who belong to a high-risk group, that is, homosexuals, hemophiliacs, or IV drug users.⁷⁷

The testing question, in the context of prisons, once again hides the real issue. By itself, testing provides no answers. The real point of controversy is what is to be done as a result of the test. In some jurisdictions, prisoners who test positive will be segregated from the rest of the prison population. If such a policy of segregation is followed, there is the real possibility of creating AIDS prisons to deal with the increased number of infected prisoners. An equally troubling issue is whether HIV status is an appropriate factor to consider in determining parole eligibility.

From a practical point of view, the only reason to test prisoners is to segregate. Whether HIV infection is, by itself, a valid reason to segregate a prisoner is a serious question. If separate AIDS units were established, there would be no reason for them to be any more restrictive, nor would there be any justification for the conditions of confinement to be any more onerous. If the AIDS units were more restrictive or more onerous, the greater punishment would be due to the prisoners' medical status, not their criminal behavior. Punishing people for a medical condition would be subject to a constitutional challenge.

Those who advocate testing and segregating within prisons argue that persons who are infected with HIV present a threat to the health and safety of other inmates. They point out that prison rape is a common occurrence and that the state should not put a person into prison for a relatively minor offense when that person may be raped and infected with a fatal disease. The obvious response is that it is the rapist who should be segregated, not everyone who is HIV-positive.

Another aspect of this discussion has received little attention. While prison rape is undoubtedly prevalent, consensual and situational homosexual activity also occur within prisons. In this type of sexual encounter, it is reasonable to expect that safe sex or safer sex could be practiced. However, in prisons condoms are generally regarded as contraband, since they are often used as a means of smuggling drugs into the prison. If prison officials prohibit the introduction of condoms into the facilities, they may be viewed as obstructing the use of an effective disease preventive.

The same basic considerations pertain in governmental facilities that care for the mentally retarded. Individuals in these facilities not uncommonly have active sex lives. The state may have an obligation to provide instruction on AIDS and on ways of preventing it.

There may even be an affirmative duty to provide condoms to protect the health of the patient population. The position that the problem need not be addressed because sex doesn't occur in these facilities is simply not realistic.

Institutions for the detention of youthful offenders present particularly troubling issues. It is at least realistic to expect that some type of sexual experimentation has occurred prior to incarceration and is probably continuing within the facility. State administrators will have to decide what kinds of education programs should be implemented with regard to AIDS and sex in general. They will have to confront the issue of whether to provide condoms to minors in their care. The most likely course of conduct, and the one that is most dangerous, is simply to deny that the juveniles in these institutions engage in sexual activity.

Public schools too have to confront the issue of AIDS. Some jurisdictions have made AIDS education mandatory,⁷⁸ but the content of those educational programs has yet to be determined. Abstinence, obviously, is an effective way to prevent HIV infection, perhaps the most effective.⁷⁹ But it is unrealistic to believe that teenagers won't have sex or won't experiment with drugs. School systems could be viewed as being irresponsible if they fail to provide information on alternative means of AIDS prevention, such as the use of condoms or the use of bleach to sterilize needles after each use. In state universities and colleges, there can be no denial of sexual and drug experimentation among the student body. The notion of teaching public school students how to use condoms or how to clean their "works" is contrary to the standard concept of reading, writing, and arithmetic. It is at best a difficult problem to decide how these competing interests balance out.

Business Decisions

Businesses are finding themselves unexpectedly on the front line of the AIDS debate. Employers must decide how they will deal with employees who are HIV-positive and whether to implement an on-the-job AIDS education program. They must also decide what type of program they will provide — whether, for example, it should include information on safe sex practices and ways to sterilize needles. Clearly, these are issues that are usually not encountered in the course of normal business operations.

Employees often work closely together, sharing lunchrooms, using the same telephones, and so forth. The hypothetical example arises of an infected employee falling down, injuring himself, and bleeding, then fellow employees rushing to the rescue only to be contaminated by the infected blood. Employees are very frightened by the prospect of having to work with someone who is HIV-infected or who has AIDS. The fear even extends to working with someone who lives with an AIDS patient.

This fear is understandable. The disease is almost universally fatal⁸⁰ and the infection leads to full-blown symptoms in a high percentage of cases.⁸¹ While a great deal is known about the disease, it is still relatively new. Many workers and employers, perceiving a known risk, find it difficult to understand why they have to subject themselves to the danger of working with or employing someone who has AIDS. In cases where employers retain an employee with AIDS, other employees are likely to walk off the job.⁸² These employees could be fired for their actions, but the employer might then find it difficult or even impossible to fill their positions. If the AIDS patient were fired instead, the employer might be subject to a lawsuit alleging unlawful handicap discrimination.⁸³

The solution being developed by businesses and employers is to institute an AIDS education program in the workplace before an actual problem develops, thereby reducing the

anxiety level among employees. The major corporations that have developed AIDS policies have universally decided to treat AIDS as they treat other life-threatening, contagious diseases.⁸⁴ Employees are permitted to retain their jobs as long as they are able to perform the job functions and as long as they do not present a risk to others. When employees are made aware of this policy and the reasons for it, the reaction to a fellow employee actually being diagnosed is often one of sympathy rather than panic or hysteria.

As businesses prepare for AIDS education programs, they too must decide what type of education they will provide. Will the program be limited to explaining the medical and epidemiological aspect of the disease, or will safe sex be discussed? The employer may be understandably reticent, not wishing to appear to advocate sex or drug use. There may be a reluctance to have on-the-job discussion of intimate sexual practices. The employer, however, is in a particularly advantageous position to provide needed information to a large group of people.

All the concerns that employers must take into account apply with equal or greater force to labor unions or collective bargaining units. These labor organizations are dedicated to the purpose of protecting workers and furthering their best interests. The conflict between infected workers and those who fear the disease must be resolved by the unions. They will have to decide whether their primary duty is to protect the infected individual or to protect other workers who are afraid that they may be exposed to the virus. They will also have to decide whether the union itself should undertake an educational campaign, and what type of education should be provided.

The Medical Community

The medical community should not be surprised to find itself in the midst of the AIDS controversy, although perhaps the particular focus of the problem is unexpected. Certainly the debate about what drugs should be prescribed and what treatment should be recommended is normal and regularly occurs with new diseases. Even the medical testimony about whether or not AIDS is casually transmitted, while controversial, cannot be viewed as unexpected.

Part of the current debate concerns the allocation of limited resources and the types of safeguards that must be followed before a new treatment can be certified as effective. The development of AZT has highlighted this problem. First, the drug proved so successful in initial trials that the normal process by which drugs are approved had to be shortened.⁸⁵ The moral dilemma was apparent. Those treated with AZT were living, and those given a placebo were dying. There could be no moral justification for continuing to withhold a valuable form of treatment for purposes of clinical certification.

After AZT was approved, the next conundrum centered on the question of who would be able to obtain the drug, as there simply wasn't enough to go around.⁸⁶ Protocols had to be established to provide the drug to a designated group; those who were the most ill were chosen.⁸⁷ While the decision can hardly be viewed as unjust or unfair, a nagging question remains. If the drug were given to those who were healthier, that is, those whose immune systems had not broken down, would it enable them to stay healthy? Subsequent trials have indicated that when the drug is given to HIV-infected individuals who have yet to show clinical manifestations of the disease, it appears to have beneficial results and the patients are better able to withstand the drug's side effects.

Then there is the final issue generated by the first effective treatment: the matter of cost. A one-year treatment with AZT has a price tag of \$10,000.⁸⁸ What happens if the

drug proves to be effective and patients can't afford the treatment? Will those who can't pay be allowed to die?

While these problems have emerged because of the effectiveness of AZT, they will be repeated as new treatments develop. A mechanism must be found to make all effective treatment available as expeditiously as possible and in a manner that will not put a price tag on the right to life.

The medical community is in the midst of another AIDS controversy. Like other employers, medical-care providers may not discriminate on the basis of handicap. AIDS and HIV infection are likely to be viewed as handicaps, and, in fact, that position has already been sustained by numerous court decisions.⁸⁹ Clearly, hospitals cannot refuse to treat AIDS patients. But a question remains as to whether hospitals have to perform elective procedures on those who are HIV-positive. Repeatedly, dentists are asking whether they have to treat everyone who walks through their doors seeking care. Doctors wonder whether they can ask potential patients if they have been tested for the AIDS virus. Practitioners of all sorts are seeking legal advice as to whether they can refuse homosexual patients. The answers to these questions are governed by the civil rights statutes and other laws designed to protect the handicapped and those with AIDS.⁹⁰ The answers may be somewhat unsettling, as they generally require the medical community to accept patients and not to discriminate on the basis of their medical status or individual condition. The answers seem to require that the medical community accept the increased risk of HIV infection as part of the inherent dangers of the profession.

Another aspect of AIDS discrimination in the medical community is the firing of medical providers who are themselves HIV-positive. Hospitals, clinics, and nursing homes may well be concerned that their patients not be exposed to AIDS. To that end, isolated efforts have been made to remove HIV-positive care givers from their employment. Those efforts have generally not been successful, and the employees have won either reinstatement or monetary damages.⁹¹

Here again, the fear element comes into play. The doctors may fear that they are being exposed to the virus by their patients; the patients have the same fear concerning their doctors. The fear is exacerbated by the law that requires the potential exposure to be endured. This is a part of the controversy that the medical community may not be prepared to address, yet it is a problem that will only continue to grow.

Personal Lives

Five years ago, AIDS was a topic of common conversation only in certain gay bars. Now the topic is repeatedly on the cover of national news magazines. Television talk-show hosts and politicians endlessly discuss the intricacies of the disease. AIDS has entered the American consciousness. It informs many of the daily decisions that are made by everyone.

The sexual revolution has died, a victim of AIDS. Men and women — young and old, gay and straight — are not willing to risk their lives for the momentary gratification of a sensory thrill. Morality has taken a new lease on life. Increasingly, people are willing to accept the health risk associated with sexual intimacy only when there is the potential of a higher reward — commitment or marriage. People are once again dating, not simply engaging in indiscriminate sexual encounters. A person's health history is now fair game for barroom conversation, right along with his or her zodiac sign and favorite movies.

There is a growing sense of mortality. The yuppie and guppie crowds are now talking

about wills, living wills, and powers of attorney. There is a new awareness that fatal diseases don't attack only the old.

While the sexual revolution may have already ended, the end of the drug culture may not be far behind. The First Lady may advocate just saying no to drugs, but the AIDS epidemic may be far more persuasive. Perhaps those who are already addicted to heroin may not be persuaded by the AIDS epidemic to stop sharing needles. It is difficult to persuade people to give up their habit because they may die from AIDS when they risk their lives every day by injecting drugs. But perhaps teenagers who are about to shoot cocaine for the first time will now pause and consider that they may be exposing themselves to a disease for which there is no known cure. AIDS may be the deterrent to drugs which has long been sought.

AIDS is also affecting organized religion. The churches and synagogues cannot ignore the fact that among the dying and ill are their clergy and their followers. No longer does simply condemning homosexual practices suffice. Religions must deal directly with sex, with sex education, with homosexuality, with drug addiction, and with traditional concepts of morality. And, for the church, these disparate elements must all be brought together into some type of cohesive body of thought.

Some organized religions have long espoused the view that the purpose of sex is procreation. Taking this view to its logical conclusion, some religious bodies have condemned those sexual activities which do not, and cannot, lead to conception. Vaginal intercourse in which a contraceptive is used has been forbidden for this reason. Anal intercourse, whether between a man and a woman or between two men, is condemned. Masturbation, too, is prohibited. These teachings lead to a troublesome paradox. The sexual activity the churches permit is one that poses a danger for the transmission of the disease.

Parents are in a very similar position. How shall they explain to their children not to engage in premarital sex and at the same time explain that if they do so, to please do it in a particular way? Parents need to find a way to morally teach their children how to sterilize the needles they use to inject drugs into their veins. They have to find a way to provide information and moral leadership at the same time.

The disease has raised its nefarious head in the home, in the church, in the schools, in the hospitals, and in doctors' and dentists' offices. It has forced confrontations with subjects that many have simply preferred to ignore. Because of the nature of the disease, concepts of morality conflict with notions of fairness. Religious doctrine is opposed to sound public health policies. And as a backdrop to the debate, the number of infected increases at a frightening rate.

Conclusion

There are no easy answers. Each issue that is presented seems to create a paradox from which there is no escape. The best hope is compassion in dealing with those who are ill and concern for the health of everyone. Education is the only weapon in the current arsenal to fight this disease. Education is the most cost-effective way of stopping the spread of the epidemic. While there seems to be universal agreement that education is the best course to pursue, the disagreement concerns what should be told. Isn't the answer to tell everything and to tell it truthfully and completely? If people know what the disease is and how it can be spread and how it can't be spread, won't they then be able to make informed and appropriate decisions concerning their own lives? It is only when people are kept uninformed, when they are denied the facts needed to make decisions for themselves, that

the state has overstepped its bounds and endangered the well-being of the many.

In deciding what public health measures should be imposed, the traditional approach should be followed. The degree of intrusion into personal freedoms must be balanced against the benefit that can be expected to the public health. The medical and epidemiological realities should control, not the hysteria of the crowd. Personal rights may and will have to be sacrificed for the common good; but those rights should be compromised only when it is known that good will result in a sufficient quantity to justify the personal sacrifice.

These answers are simplistic. They espouse nothing more than basic common sense. But, perhaps for at least the moment, common sense is an appropriate guide. 🐼

Notes

1. A bill (HR 1041) was introduced in the Louisiana legislature by Rep. Alphonse Jackson (D) in 1987 which would give state health officials the power to go to court seeking the arrest of anyone with AIDS and to quarantine such persons without the right of a court hearing or bail. The bill was passed by the state House of Representatives, but the governor, Edwin W. Edwards, pledged to veto the measure if it passed the Senate. "Louisiana Governor Pledges Veto If Measure Approved," *AIDS Policy & Law* 2, no. 12 (July 1, 1987): 8–9.
2. *Korematsu v. United States*, 323 U.S. 214 (1944).
3. *Jacobson v. Massachusetts*, 197 U.S. 11 (1905).
4. See *Ex Parte Arata*, 52 Cal. App. 380, 198 P. 814 (1921) (habeas corpus proceeding challenging prostitute's detention pending compulsory testing for venereal disease); *Moore v. Draper*, 57 So.2d 648 (Fla. 1952) (habeas corpus proceeding challenging civil commitment of patient with tuberculosis).
5. See *Ex Parte Caselli*, 62 Mont. 201, 204 P. 364 (1922).
6. *Greene v. Edwards*, 263 S.E. 2d 661 (W.Va. 1980).
7. See *People ex. rel. Barmore v. Robertson*, 302 Ill. 422, 428, 134 N.E. 815, 817 (1922) (judicial deference afforded to decision maker).
8. Section 504, of the Handicapped Rights Act of 1973, 29 U.S.C. Sec. 701–796 (1982).
9. G.L. c. 151B, secs. 1 et seq.
10. See *Jacobson v. Massachusetts*, 197 U.S. 11, 25 (1905) (police power "must be held to embrace, at least, such reasonable regulations established directly by legislative enactment as will protect the public health and public safety").
11. *Ibid.*
12. *Barmore v. Robertson*, 302 Ill. 422, 134 N.E. 815 (1922) (habeas corpus petition challenging reasonableness of quarantine of carriers of typhoid bacilli).
13. *Moore v. Draper*, 57 So.2d 648 (Fla. 1952) (habeas corpus proceeding challenging civil commitment of patient with tuberculosis).
14. *People ex. rel. Baker v. Strautz*, 386 Ill. 360, 54 N.E.2d 441 (1944) (habeas corpus proceeding challenging mandatory testing of prostitute for presence of venereal disease); *Ex Parte Kilbane*, 32 Ohio St. 530, 67 N.E.2d 22 (145) (habeas corpus proceeding challenging regulation providing for mandatory testing of prostitutes and those associating with them, for venereal disease).
15. *Jacobson v. Massachusetts*, 197 U.S. 11 (1905).
16. Colorado recently enacted a law requiring doctors to report all HIV-positive blood tests to the state health department. The law allows for the quarantine of some HIV-positive people for up to

- three months. "Quarantine Bill Backed by Colorado Legislature," *AIDS Policy & Law* 2, no. 8 (May 6, 1987): 4. Rep. William Dannemeyer (R-Calif.) introduced legislation to make HIV-seropositive persons reportable to public health authorities and to require mandatory HIV testing of marriage license applicants, convicted prostitutes and intravenous drug users, clients of sexually transmitted disease clinics, and some hospital patients. "Reporting, Mandatory Tests Asked in Dannemeyer Bills," *AIDS Policy & Law* 2, no. 8 (May 6, 1987): 8.
17. On April 22, 1987, Secretary of Defense Caspar W. Weinberger approved a revised AIDS policy requiring that recruits who test positive for HIV be excluded from the service. "Revised AIDS Policy Okayed; Some Sanctions Authorized," *AIDS Policy & Law* 2, no. 8 (May 6, 1987): 5.
18. *Local 1812, American Federation of Government Employees v. United States Department of State*, 662 F. Supp. 50 (D.D.C., 1987).
19. *Ibid.*
20. Private Adrian Morris was brought before a military court-martial charged with a crime for having engaged in sexual relations with his fiancée, a second woman, and another man without having used a condom and after he had tested HIV-positive. "HIV-Positive Private Faces Assault Charges," *AIDS Policy & Law* 2, no. 9 (May 20, 1987): 3.
21. *AIDS Update*, Lambda Legal Defense and Education Fund 18 (May 1987): 2.
22. A law was enacted in Louisiana requiring that all couples married in the state must test negative for HIV antibodies before they can obtain a marriage license. "Marriage License Tests Approved in Louisiana," *AIDS Policy & Law* 2, no. 14 (July 29, 1987): 8. A bill before the Idaho legislature (SB 1100) would require AIDS testing for marriage license applicants. A similar bill (SB 994) was presented to the Oregon legislature. *AIDS Policy & Law* 2, no. 5 (March 25, 1987): 8.
23. "Bush Opens Meeting by Endorsing Wider Testing Proposed by Reagan," *AIDS Policy & Law* 2, no. 10 (June 3, 1987): 1.
24. Allan M. Brandt, *No Magic Bullet: A Social History of Venereal Disease in the United States Since 1880*, New York, Oxford University Press, 1985, 147–149.
25. Paul D. Cleary, Ph.D., Michael J. Barry, M.D., Kenneth H. Mayer, M.D., Allan M. Brandt, Ph.D., Larry Gostin, J.D., Harvey V. Fineberg, M.D., Ph.D. "Compulsory Premarital Screening for the Human Immunodeficiency Virus," *Journal of the American Medical Association* (Oct. 2, 1987): 1757-1762.
26. Richard A. Knox, "Who should be tested," *Boston Globe*, May 17, 1987, B14.
27. Note 25.
28. *Loving v. Virginia*, 388 U.S. 1 (1967); *Zablocki v. Redhail*, 434 U.S. 374 (1977).
29. "Bush Opens Meeting by Endorsing Wider Testing Proposed by Reagan."
30. See 42 U.S.C. Sec. 269 (1944).
31. *Ibid.*
32. "Public Health Service Urges Ban on Immigrants with HIV Infection," *AIDS Policy & Law* 2, no. 9 (May 20, 1987): 1.
33. See Randy Shilts, *And the Band Played On*, New York, St. Martin's Press, 1987, 508–510.
34. *Ibid.*
35. See *Commonwealth v. Page*, 339 Mass. 313, 159 N.E.2d 82 (1959) (appeal from a commitment as a sexually dangerous person, held that an individual could not be confined in a penal setting because of his mental condition).
36. Cooper, Imrie, Penny, "Antibody Response to Human Immunodeficiency Virus After Primary Infection," *Journal of Infectious Diseases*, vol. 55 (1987): 1113–1118; Marlink, Allan, McLane, et al., "Low Sensitivity of ELISA Testing in Early HIV Infection," letter to *New England Journal of Medicine* 315 (1986): 1549.
37. See Mass. Gen. Laws ch. 90, sec. 24D.

38. Constance B. Wolfsey, M.D., "Intravenous Drug Abuse and Women's Medical Issues," Report of the Surgeon General's Workshop on Children with HIV Infection and Their Families, U.S. Department of Health and Human Services, Washington, D.C., 1987, 33.
39. Centers for Disease Control, "Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS," *Morbidity and Mortality Weekly Report* 36, no. 31 (August 14, 1987): 512.
40. Brandt, *No Magic Bullet*, 151. See also 105 CMR 340.100 (E).
41. *People ex rel. Baker v. Strautz*, 386 Ill. 360, 54 N.E.2d 441 (1944); *Ex Parte Arata*, 52 Cal. App. 380, 198 P. 814 (1921).
42. *Moore v. Draper*, 57 So.2d 648 (Fla. 1952); *Greene v. Edwards*, 263 S.E.2d 661 (W.Va. 1980).
43. See *Greene v. Edwards*, 263 S.E.2d 661 (W.Va. 1980).
44. See Robert Berkow, ed., *The Merck Manual of Diagnosis and Therapy*, Rahway, N.J., Merck, Sharpe & Dohme, Research Laboratories, 1982, 127.
45. See Richard Plant, *The Pink Triangle*, New York, Henry Holt and Co., 1986.
46. Thomas C. Quinn, M.D., "The Global Epidemiology of the Acquired Immunodeficiency Syndrome," Report of the Surgeon General's Workshop on Children With HIV Infection and Their Families, 7.
47. Note 36.
48. Note 25.
49. *Boston Globe*, May 17, 1987, B14.
50. See *Commonwealth v. Page*, 339 Mass. 313, 159 N.E.2d 82 (1959).
51. *The Merck Manual of Diagnosis and Therapy*, 210.
52. On April 9, 1987, New York State announced a new public information and education program, including the development of AIDS curricula for elementary and secondary schools. "Major Education Program Launched by New York State," *AIDS Policy & Law* 2, no. 7 (April 22, 1987): 1; the Pennsylvania Board of Education unanimously approved, on May 14, 1987, a regulation requiring AIDS education in the state's 501 school districts. The regulation includes the provision that AIDS education be taught at least once each year at the elementary, junior high, and high school levels. "School Board Approves Mandatory AIDS Education," *AIDS Policy & Law* 2, no. 9 (May 20, 1987): 5.
53. Surgeon General's Report on Acquired Immune Deficiency Syndrome, 1986, 17.
54. See Warren Winkelstein, Jr., M.D., "Sexual Practices and Risk of Infection by the Human Immunodeficiency Virus," *Journal of the American Medical Association*, 257, no. 3 (January 16, 1987): 321, 323.
55. See David R. Bolling, "Prevalence, Goals and Complications of Heterosexual Intercourse in a Gynecologic Population," *Journal of Reproductive Medicine* 29 (1977): 120-124. Also see Bruce V. Voeller, "Heterosexual Anal Sex," *Mariposa Occasional Papers* 1B (1983): 1-8.
56. See Surgeon General's Report on Acquired Immune Deficiency Syndrome, 1986.
57. See "Dispute on Nationwide Brochure Mailing Continues Between Congress, White House," *AIDS Policy & Law* 2, no. 19 (October 7, 1987): 1.
58. "Studds mails constituents AIDS report," *Boston Globe*, May 19, 1987.
59. "New York's AIDS Ad Campaign Seen Unlikely to Succeed," *AIDS Policy & Law* 2, no. 9 (May 20, 1987): 4.
60. *Ibid.*
61. 29 U.S.C. Sec. 701-796 (1982).

62. See *School Board of Nassau County v. Arline*, 107 S.Ct. 1123, 1128 n. 7 (1987).
63. See *Cronin v. New England Telephone Co.*, Suffolk Superior Court, No. 80332 Memorandum of Decision and Order on Defendants' Motion to Dismiss, August 15, 1986.
64. Mayor Ray Flynn of Boston issued an executive order prohibiting discrimination in the hiring and promotion of city employees on the basis of AIDS, ARC, or HIV infection. *AIDS Update*, Lambda Legal Defense and Education Fund, no. 17 (April 1987).
65. See Mass. Gen. Laws ch. 111, sec 70F.
66. See, for example, *Chalk v. United States District Court, Central District of California*, 832 F.2d 1158 (9th Cir. 1987).
67. See "Senate Moves to Repeal DC Law Prohibiting Tests," *AIDS Policy & Law* 2, no. 19 (October 7, 1987): 3.
68. See "Aetna Concedes Mistake in Requesting HIV Waiver," *AIDS Policy & Law* 2, no. 10 (June 3, 1987): 8.
69. "New York to Ban HIV Tests for Health Insurance," *AIDS Policy & Law*, 2, no. 8 (May 6, 1987): 9.
70. "HIV-Positive Private Faces Assault Charges," *AIDS Policy & Law* 2, no. 9 (May 20, 1987): 3.
71. "HIV-Positive Man Charged with Intent to Kill," *AIDS Policy & Law* 2, no. 10 (June 3, 1987): 6.
72. Martha F. Rogers, M.D., "Transmission of Human Immunodeficiency Virus Infection in the United States," Report of the Surgeon General's Workshop on Children with HIV Infection and Their Families, U.S. Department of Health and Human Services, 1987, 17.
73. See "Needle Exchange Project Rejected by New York State," *AIDS Policy & Law* 2, no. 9 (May 20, 1987): 2.
74. See *Jones v. United States*, 534 F.2d 53, cert. denied 429 U.S. 978 (1976) (Bureau of Prisons is required to exercise ordinary diligence to keep prisoners safe and free from harm).
75. "HIV Testing in Federal Prisons," *AIDS Policy & Law* 2, no. 11 (June 17, 1987).
76. Gregory Witcher, "No AIDS Tests for inmates, state says," *Boston Globe*, May 26, 1987, 1.
77. "AIDS in Correctional Facilities: Issues and Options," National Institute of Justice, U.S. Department of Justice, Washington, D.C., April 1986, 39.
78. Note 52.
79. See Surgeon General's Report on Acquired Immune Deficiency Syndrome, 1986.
80. Ibid.
81. Public health officials consider it very likely that 100 percent of those infected with HIV will eventually develop AIDS or some other lethal manifestation of the disease. "Forum Told That HIV May Always Lead to AIDS," *AIDS Policy & Law* 2, no. 8 (May 6, 1987): 6.
82. Michael R. Brown, "AIDS Discrimination in the Workplace: The Legal Dilemma," *Case & Comment* (May-June 1987): 8.
83. Gregory M. Shumaker, "AIDS: Does It Qualify as a 'Handicap' Under the Rehabilitation Act of 1973?" *Notre Dame Law Review* (1986): 572-594.
84. "Survey Shows Few Firms Implement AIDS Policies," *AIDS Policy & Law* 2, no. 10 (June 3, 1987): 7-8. See also M. Rowe, M. Russel-Einhorn, M. Baker, "The Fear of AIDS," *Harvard Business Review* (July-August 1986).
85. Fourteen months after Phase II trials began on AZT, more than three times as many patients who took placebos had died as those taking AZT. "Mortality Rate Still Lower for Patients Taking AZT," *AIDS Policy & Law* 2, no. 7 (April 22, 1987): 2.
86. Ibid.

87. Ibid.
88. "Cost, Availability of AZT Questioned at House Hearing," *AIDS Policy & Law* 2, no. 5 (March 25, 1987): 1.
89. See *Cronin v. New England Telephone Co.*; *Chalk v. United States District Court, Central District of California*, F.2d (9th Cir. 1987).
90. Harvey Schwartz, Alec Gray, "Can You Say No?" *Massachusetts Medicine* 2, no. 5 (September–October 1987): 39–43.
91. Mother Frances Hospital in Tyler, Texas, offered a monetary settlement to its anesthesia director after the hospital banned him from working directly with patients. "Hospital Settles with Nurse Anesthetist Who Filed Federal Discrimination Suit," *AIDS Alert* 2, no. 5 (May 1987): 80. The Westchester County Medical Center, in New York, allegedly refused to complete the application process of an individual applying for the position of pharmacist when it was learned that he was HIV-positive. *AIDS Update*, Lambda Legal Defense and Education Fund 18 (May 1987).

"I'd like to leave you with an image that came to me quite unexpectedly last Saturday evening while strolling in the mall. It was quite hot, I'd just come from a concert, and I came upon the Vietnam Memorial. It was quiet, it was very dimly lit, there were thousands of names carved in stone — mute testaments to overwhelming sadness. I was struck by the comparisons and similarities with people with AIDS who have also died. That sense of loss, that senseless loss of life, the youth, the confusion, the pain, the suffering, the grief of the survivors.**"**