

Legal and Ethical Issues Relating to AIDS

RONALD BAYER¹ & LARRY GOSTIN²



The worldwide AIDS epidemic has posed an extraordinary array of ethical and legal challenges. The work presented here reviews three issues at the heart of the matter: discrimination against HIV-infected people, the limits of confidentiality, and the exercise of coercive government powers to limit spread of the disease. Because the authors are most familiar with the U.S. experience, the review deals primarily with the history of the epidemic in the United States and public responses to it in that country.

Acquired immunodeficiency syndrome (AIDS), the first epidemic disease to strike advanced industrial nations in more than a generation, has posed an extraordinary array of ethical and legal challenges. As a lethal illness, spread in the context of the most intimate relationships, it has forced examination of difficult questions about the appropriate public health role of the State. As a disease of the socially vulnerable (those who have been additionally subject to irrational reactions stemming from fears associated with HIV infection) AIDS has compelled modern societies to face issues involving the need to employ the power of the State to protect the weak at moments of social stress.

Both roles of government—that of advancing the public health and that of defending the weak—have been called upon in the first years of the AIDS epidemic. And although these roles have at times been in conflict, more often (and in ways that have reversed conventional assumptions) it has been clear that the pro-

tection of the public health and of the weak and vulnerable have been interdependent. Moreover, a common theme has emerged: that aggressive protection of the public health requires the State's coercive powers to be exercised with the greatest restraint, and that creation of a social climate of trust is central to the efforts to foster mass behavioral change.

Both ethical considerations and pragmatic concerns have contributed to the adoption of public health strategies that can be broadly defined as voluntaristic—stressing mass education, counseling, respect for privacy. Yet within the broad voluntaristic strategy there have been tensions, sometimes unresolved. Differences among Western liberal societies have been reflected in the salience given to some matters, the extent to which proposed interventions have been deemed problematic or of no particular moment, the compromises that have been struck. The contrast with authoritarian societies has been more stark.

In this essay we will survey three issues at the juncture of ethics, law, and public policy: discrimination against those with HIV infection, confidentiality and its limits, and the exercise of compulsory State powers to limit the spread of HIV infection.

Much of our detailed discussion will be

¹Associate Professor, Columbia University; Fellow, American Foundation for AIDS Research. Mailing address: Columbia University, School of Public Health, 600 W. 168th Street, New York, N.Y., U.S.A.

²Executive Director, American Society of Law and Medicine, and Adjunct Associate Professor, Harvard University, School of Public Health.

drawn from the experience of the United States. It is the epicenter of the epidemic in the developed world. It is also the nation where an extraordinary range of AIDS-related legal activity has occurred and where the most vigorous debate about the ethical issues posed by the threat of HIV has taken place. A close examination of the course of events in the United States provides an opportunity to point out options that other societies might well consider. It will also reveal in a sobering way certain paths to be avoided. We have thus made a virtue of necessity, the United States' experience being the case that we know best.

DISCRIMINATION

Times of epidemic are also times of social tension. Fears exacerbate already-extant divisions, revealing deepening social fault lines. So it is not surprising that discrimination against persons with HIV infection has become a worldwide phenomenon. The AIDS virus has divided individuals, nations, and ethnic, cultural, and sexual groups; and the potential for greater division is ever-present.

On an international plane, some Americans have blamed Haitians and Africans for the epidemic; some Africans have blamed Europeans; in Japan, foreigners have been blamed; and the French "Right" has blamed Arab immigrants (1). This dreary process is not new, as William McNeill has shown in his social history of epidemics, *Plagues and People* (2).

A natural corollary, and an echo of the international quarantines dating from the fifteenth century, has been the creation of travel barriers. Much of the Far East and Middle East, for example, have placed impediments in the way of travel by returning nationals, foreign students, and foreign businessmen infected with HIV (3). And an ever-growing list of nations

demands proof of long-term visitors that they are free of HIV infection.

HIV infection has also been used as a rationale for excluding people from a range of critical social activities. America has read all too frequently about children with HIV being turned away from schools, of employees dismissed from their jobs and losing their life or health insurance, and of AIDS patients being denied appropriate treatment or being forced by circumstances to stay in hospitals because they no longer have a home. Hundreds of cases have been brought before courts and human rights commissions in the United States by people with HIV claiming discrimination. Examples of discrimination have also been reported in many other nations.

Discrimination based upon an infectious condition can be as inequitable as discrimination based on other morally irrelevant grounds such as race, gender, or handicap. The U.S. Supreme Court has recognized that "society's accumulated myths and fears about disability and disease are just as handicapping as are the physical limitations that flow from actual impairment. Few aspects of handicap give rise to the same level of public fear and misapprehension as contagiousness."³

But there is a critical difference between discrimination based upon race or gender and discrimination based upon disease status. An infection is potentially transmissible and can affect a person's abilities to perform work-related tasks. A decision to exclude a HIV-infected person from certain activities because of a real risk of transmission or relevant performance criteria would be understandable and would not breach anti-discrimination principles. However, denying such persons rights, benefits, or

³School Board of Nassau County v. Arline, 107 s.Ct. 1123 (1987).

privileges where health risks are only theoretical or very rare, and when performance is adequate, is morally unacceptable. Since the risk of transmission of HIV in most settings is remote (4), and since persons with HIV infection may function normally when not experiencing serious symptoms, there are no morally acceptable grounds for discrimination.

Irrational fears of AIDS are typically at the root of HIV-related discrimination. Public opinion surveys reveal that a consistent minority harbors anxieties about and antipathies toward those with HIV infection. In the United States some one-fourth of the public believes people with HIV should be excluded from schools, workplaces, and other public settings. Twenty-five percent also assert that individuals suffering from HIV-related disorders should not be treated with compassion. Such findings have been replicated in many regions of the world (5). Fueling both anxieties and antipathies is often a visceral hostility to those groups popularly linked to AIDS—gay men, drug users, and prostitutes.

Not only is discrimination against the HIV-infected morally wrong, it can also be counterproductive from the standpoint of public health. The Institute of Medicine (6), the American Medical Association (7), the Presidential Commission on the HIV Epidemic (8), and federal and state health officials in the United States, as well as public health officials in many other nations and at the World Health Organization (9, 10) have all termed HIV-based discrimination unjustifiable and inimical to the struggle against AIDS.

Fears of a breach of confidentiality and subsequent discrimination discourage individuals from cooperating with vital public health programs and receiving treatment for sexually transmitted diseases and drug dependency. These fears

also mobilize opposition to routine voluntary testing and counseling among people with high-risk behaviors. Such resistance to testing might well melt away if individuals believed they were strongly protected by the law.

In the United States the Federal Rehabilitation Act of 1973, section 504, prohibits discrimination against "otherwise qualified" handicapped individuals. There is little doubt among legal scholars that the 1973 Act applies to AIDS, and probably to HIV infection (11, 12). A recent amendment to the Rehabilitation Act states that a person with a contagious disease or infection is protected if he or she does not "constitute a direct threat to health or safety" and is able "to perform the duties of the job" (13). Lower courts, moreover, have consistently held that HIV-related diseases, including asymptomatic HIV infection, are covered under the 1973 Act.⁴⁻⁶ The major limitation of the 1973 Act is that it is applicable only to programs receiving federal financial assistance and does not extend in any significant way into the private sector.

The 50 states and the District of Columbia have handicap statutes similar to the Federal Rehabilitation Act. In all jurisdictions except five, handicap statutes prohibit discrimination against employees in both the private and public sectors. In 34 states the courts,^{7,8} human rights com-

⁴Chalk v. Orange County Department of Education, 832 F.2d 1158 (9th Cir.) (1987).

⁵Doe v. Ceninela Hospital, 57 u.s.l.w. 2034 (U.S.D.C.D.C. Cal.) (1988).

⁶Ray v. School District of DeSoto County, 666 F. Supp 1524 (M.D. Fla.) (1987).

⁷Shuttlesworth v. Broward Cty., 639 F. Supp 654 (S.D. Fla.) (1986).

⁸Cronan v. New England Tel. Co. (Mass. Sup. Ct. No. 80332) (Aug. 15, 1986). Goaded by their patients and their research subjects, physicians and scientists have amplified the call for protection of clinical records and research files. Even before discovery of the virus etiologically linked to the profound collapse of the immune systems of those who were infected, and before the development

missions, or attorneys general have formally or informally declared that handicap laws apply to AIDS or HIV infection (14).

A recent global survey of AIDS legislation for the World Health Organization found that only five of the 77 nations surveyed had express provisions for the protection of people with AIDS (3). Whether other nations take the path of legislative enactment, create human rights commissions with the authority to investigate cases of discrimination and enforce norms of equity, or rely on other forms of government intervention, what is critical is that as a matter of public policy those vulnerable because of HIV infection be protected. The most elemental notions of human dignity as well as the public health require no less.

CONFIDENTIALITY AND ITS LIMITS

The threat of discrimination has had a profound impact on the extent to which the most articulate among those at risk for HIV infection have demanded ironclad protection of confidentiality.

Both ethical and pragmatic factors contributed to the remarkable emergence of a strong public health interest in articulating and fostering a regime of confidentiality early in the AIDS epidemic. In the face of a serious challenge to communal well-being, the lesson was clear: Privacy and confidentiality are critical to the public health.

When HIV antibody testing began in mid-1985, the importance of protecting confidentiality was already well-understood. Because the test provided the oc-

casional for identifying infected but asymptomatic individuals who would then be subject to employment, housing, and insurance discrimination, public health officials responded by underscoring the critical importance of confidentiality. Indeed, as the United States Centers for Disease Control (CDC) moved toward recommendations for large-scale voluntary testing to accompany an aggressive counseling campaign, they embraced a posture on confidentiality and the need for state and federal legislation to protect HIV records that was striking (16). For those who could not be reassured, for those who believed that no system of confidentiality protection could protect infected persons from the threat of irrational social reactions, health officials responded by providing for testing under conditions of anonymity (17).

In time, the defense of confidentiality endorsed by the Surgeon General, the Association of State and Territorial Health Officials, the American Medical Association, the Institute of Medicine, the National Academy of Sciences, and the Presidential Commission on the HIV Epidemic was to become a centerpiece of the political culture of the national AIDS epidemic. Even before AIDS, all 50 states had enacted generally strong legislative and administrative protection against breaches of medical confidentiality. Since the HIV epidemic's advent a majority of the states have gone further—spurred on by public health officials and advocates of the interests of those most at risk—enacting specific statutes to safeguard the confidentiality and privacy of individuals infected or perceived to be infected with HIV (18). (Internationally, 26 of the 77 countries surveyed for the World Health Organization were found to have legislation regulating confidentiality—3.)

Despite such institutional support, and despite the forceful resistance to political pressures for weakening the commit-

and mass production of the test designed to detect antibody to that virus, researchers, public health officials, and clinicians were thus compelled to address the concerns of the populations most at risk for the new disease (15).

ment to protect confidentiality, there were tensions within the broad medico-political alliance forged in the epidemic's first years. Within the United States, these were most obvious in debates over reporting positive HIV test findings by name to public health departments and in disputes over the extent to which confidentiality might be breached in order to warn unsuspecting sexual partners.

Confidential Reporting of HIV Infection

Soon after the recognition of AIDS by the CDC, state and local health departments had moved to require that physicians and hospitals report, by name, those diagnosed with the new syndrome, thus extending to AIDS the policy that governed venereal and other infectious diseases. The aforementioned global survey of AIDS legislation for WHO found that 51 of the 77 responding nations had enacted legislation for compulsory reporting (notification) of AIDS cases. The United Kingdom Advisory Group has taken a contrasting view, recommending that AIDS not be reportable by law (3).

U.S. officials believed that only such named reporting would permit those responsible for the public health to have an accurate epidemiologic picture of the disease with which they were confronted. Only such reporting would permit application of other appropriate public health measures to the sick. It was widely assumed that the public health required this abrogation of the principle of confidentiality, as had always been the case not only when epidemic threats were involved, but when other infectious diseases posed a challenge.

Many believed that such reporting did not entail any significant breach of confidentiality as long as the public health records thus created were insulated from further disclosure (or subpoena in court

cases)—the Supreme Court had given its imprimatur to public health reporting requirements (*Whalen versus Roe*)—but others were dubious. A deep suspicion of government and a strong cultural tradition of individualism led many physicians—at their patients' behests—to ignore reporting requirements, especially where stigmatized illnesses such as sexually transmitted diseases were involved.

It is thus remarkable, given the salience of concerns about the privacy of individuals with AIDS, that there was little resistance to efforts to mandate case reporting by name. However, the relative ease with which AIDS was incorporated under state and local health requirements governing the reporting of communicable and infectious diseases—in the United States such public health regulations are governed by state rather than national law—did not extend to efforts to make results of the antibody tests reportable (19).

The first successful attempts to mandate public health reporting of HIV antibody test results in the United States came in Colorado, a state with relatively few AIDS cases. Proponents of reporting argued that it could alert responsible health agencies to the presence of people likely to be infected with a dangerous virus; allow such agencies to ensure that such people were properly counseled about the significance of their laboratory tests and about what they needed to do to prevent further transmission of the virus; permit those charged with monitoring the prevalence of AIDS virus infection to better accomplish their tasks; and create the possibility of expeditiously notifying the infected when effective antiviral therapeutic agents became available.

On these grounds it was asserted that failure to undertake the logical step from reporting AIDS to reporting asymptomatic infection with the AIDS virus would

represent a dereliction of professional public health responsibility in the face of a new deadly disease. Responding to concerns about potential breaches in the confidentiality of health department records that could result in social ostracism, loss of insurability, and loss of employment, state health officials asserted that the system for protecting such public health records had been effective for decades. There was no reason to believe that in the case of infection with the AIDS virus the record would be tarnished.

However, those whose lives had led them to fear the intrusions of the State—whatever the putative benign purpose—were intent on thwarting the move toward reporting. Regardless of the historic and prevailing standards of confidentiality that governed public health records, argued opponents, a repressive turn caused by the hysteria associated with AIDS could well result in social policies that even proponents of reporting would consider anathema. Ironically, gay leaders and civil liberties groups argued, reporting by name would subvert the public health by driving high-risk individuals away from testing. To these objections the advocates of reporting responded, “The issue before us is the reality of a tragic epidemic of AIDS, not the theoretical risk [that] our confidentiality system will be breached” (20).

It was a setback for those who feared the impact of reporting that the final report of the President’s Commission on the HIV Epidemic, issued in June 1988 (8), which so forcefully defended the centrality of confidentiality to the public health, recommended that all states follow the course first taken by Colorado—and subsequently followed by an increasing number of states (18 as of this writing). Ultimately more significant, there now appear to be fissures in the broad alliance that had opposed named public

health reporting in states where the level of infection is relatively high. In New York State, for example, the Health Commissioner was challenged in court by major constituents of the medical profession in a suit demanding that the state’s steadfast refusal to mandate reporting be reversed.⁹ Though the court rejected the claims of the plaintiffs, the suit indicated that the shared perspective of the first years of the epidemic was no longer a matter to be taken for granted.

The debate over reporting reveals the ambivalence, or even deep tension, that exists in the United States between respect for personal privacy and the social welfare perspective of public health. In other countries, reporting of HIV infection has been initiated without fanfare. In such settings the very concept of privacy does not preclude such reporting. In Scandinavia, for example, under an ethos that gives priority to social welfare, reporting of HIV using numerical identifiers has been undertaken without controversy (3).

What is critical for policy-makers to consider as they contemplate the prospect of HIV reporting is the impact such measures might have on the goal of limiting the spread of AIDS. That is the public health standard against which all interventions must be judged. It is also the preeminent ethical and legal standard against which proposed actions must be measured. In nations where public health records are fully shielded from disclosure, the conditions for reporting exist. Such conditions are necessary but not sufficient. Most critically, a clear and rational public health justification for named reporting exists. It is not adequate to propose such a course simply because the “public health tradition” appears to dictate it. If the legacy of the historic ex-

⁹New York State Society of Surgeons et al. v. Axelrod.

perience of those most at risk for HIV infection would lead them to avoid testing because of reporting, to move in such a direction would be a grave error. The resolution of such conflicts will not be found in the articulation of abstract principles, but rather in the complex political process of building the foundations of confidence.

Warning Third Parties

Despite the well-established role of public health departments in identifying and notifying the sexual contacts of those reported to have venereal diseases, this strategy of intervention—designed to break the chain of disease transmission—played no role in the early response to AIDS. Not until 1985, with development of the antibody test, was it possible to consider contact tracing, since only the test made it possible to detect the asymptomatic carriers of the AIDS virus. But even after the test became available and it was realized that antibody-positive individuals were also carriers of HIV, contact notification was almost never undertaken by public health departments in the United States. Matters of practicality as well as concern about privacy were involved (19).

Fueling the opposition was deep suspicion about how notification would broaden the extent to which the State would have in its possession the names of the infected, or those whose behavior placed them at increased risk of infection. Contact tracing also raised the specter of the State seeking information about intimate affairs and creating lists of sexual partners. Thus, although contact notification programs were predicated upon the voluntary cooperation of the "index case" in providing the names of those who might have been infected, and upon a promise to preserve the anonymity of the individual providing the names, such

programs were viewed as dangerous. Notifying the potentially infected, even for purposes of warning them about the risk they might pose to others, would represent one more step in a threatening course. In the calculus that thus prevailed, the right to privacy took precedence over the right to know information critical to the shaping of sexual and procreative decisions.

Because of such anxieties, concerns about the costs of such a labor-intensive preventive intervention, and uncertainty about how the absence of therapeutic intervention affected the applicability of the traditional rationale for notification, public health officials were notably reluctant to undertake such programs. When they did so, it was typically in relatively low-prevalence areas. It was not until late 1987 that New York City, the epicenter of the U.S. epidemic, overcame its initial opposition to contact notification and made plans to offer the assistance of public health aides to those who could not, because of fear or shame, personally notify past partners who might have been unknowingly infected with HIV.

By mid-1988 little was left of the fractious controversy. The Association of State and Territorial Health Officials (21), the National Academy of Sciences and the Institute of Medicine (6), and the Presidential Commission on the HIV Epidemic (8) had all given their endorsements to such efforts. The fierce opposition by gay leaders had all but vanished. And so, the ideologic battle having been resolved, what remained were the difficult questions centering on the epidemiologic circumstances that could provide an appropriate context for so individualized and so costly an approach to warning those placed at risk of HIV infection through sexual behavior or drug use.

Interest in the possible role of contact tracing as part of an overall strategy to control the spread of HIV is reflected in a

1989 consultation by the WHO Global Program on AIDS. Also, 12 of the 77 countries included in the previously cited international survey reported the use of contact tracing to identify new cases as a way of preventing the further spread of HIV (3).

There is no question that partner notification will be most appropriate in low-prevalence areas, where general education and warnings about the risk of infection may be less effective. So too is it clear that partner notification has a special role to play in alerting unsuspecting individuals, even in high-prevalence areas, that they may have been infected—the paradigmatic case being the female partners of bisexual men. Especially where deep suspicions and fears about coercion and unwarranted disclosure exist, however, public health officials will have to develop programs that display respect for both index cases and contacts, and will have to demonstrate a capacity to understand the fears of those with whom they are working. In particular, the traditional standards of voluntarism and protection of the anonymity of the index case must be preserved—a critical issue now that some legislatures have begun to consider mandatory measures.

Finally, it would be a tragic parody of public health policy were the “retail” efforts to reach individuals at risk to divert energy and resources from the wholesale requirements of mass education. In the end, both programs of mass education and individual warnings must serve the overriding goal of slowing the spread of HIV infection.

A much broader question—debated for many years—is when, if ever, a physician’s duties extend beyond a patient to endangered third parties. The importance of confidentiality in the clinical encounter derives from two quite distinct sources. On moral grounds, respect for the patient’s dignity and autonomy is

held to require that communications made with an expectation that they will be shielded from others be treated as inviolable. And, from a pragmatic perspective, confidentiality is held critical to candor on the part of the patient; for without assurances of confidentiality, patients might be inhibited from revealing clinically relevant information. Without confidentiality the very possibility of establishing a therapeutic relationship might thus be subverted.

But despite the importance of confidentiality to the practice of medicine, physicians on their own, under pressure from colleagues, and most frequently as a result of state requirements, have at times revealed their patients’ secrets when some threat to the safety or well-being of others was involved. The moral and pragmatic underpinnings of confidentiality have thus yielded to supervening moral and societal claims.

Many courts in the United States have acknowledged the moral imperative of protecting third parties in immediate danger. The course of judicial opinion, however, has been fraught with controversy. In the most celebrated case, *Tarasoff v. Regents of the State of California*,¹⁰ the Supreme Court of California held that if a psychotherapist reasonably believes a patient poses a direct physical threat to a third party, the psychotherapist must warn the endangered person.

The *Tarasoff* decision produced an avalanche of concern about the extent to which patients would be discouraged from confiding their dangerous thoughts to their therapists. Nevertheless, most state supreme courts that have confronted the issue have adopted the *Tarasoff* reasoning (22). A few have not established a *duty* to warn but only an

¹⁰*Tarasoff v. Regents of the State of California*, 17 Cal. 3d 425, 551 p. 2d 334, 131 Cal. Rptr. 14 (Cal. 1976).

authority to do so. Under such a standard, the determination of whether to warn would remain a matter of professional discretion.

In virtually all cases, however, the courts have limited their protective concern to *identifiable* third parties at risk of real and probable harm. For example, one court dealing with the threat of hepatitis B recognized that the duty to warn might exist but would require disclosure only to named sexual or needle-sharing partners, not to the community at large.¹¹

Those who have considered the ethical, as contrasted with the legal, dimensions of the conflict between the claims of confidentiality and the duty to warn have generally asserted that there are circumstances under which the sanctity of the clinical encounter may be breached. When a physician is uniquely positioned to warn an identifiable individual about an intended grave harm, the principles of medical ethics cannot, according to most interpretations, be held to prevent the physician from warning the potential victim in a timely and effective manner. There is less agreement, however, on the extent to which breaches of confidentiality under such circumstances should be morally obligatory or left to the physician's discretion.

It is against this backdrop that clinicians, public health officials, and politicians have struggled with the question of how to act when an HIV-infected patient refuses to inform identifiable, unsuspecting past or current partners about the dangers of infection. In the case of past partners, concern has centered on the possibility that an unknowingly infected individual might act as the unwitting agent of transmission to yet others. In the case of current partners, the focus has been on the possibility of preventing the

transmission of HIV to an as yet uninfected individual.

As these issues were considered, it became clear that the process of warning past sexual partners did not require identification of the source of potential infection. No public health goal would be served by breaching the cloak of anonymity of the index case. Where an infected individual refused to warn a current partner, however, the situation posed graver difficulties. Without revealing the identity of the source of potential infection, it was possible that no effective protective warning could be done.

At the end of 1987 the American Medical Association issued a broad set of statements on the ethical issues posed by the AIDS epidemic (7). In that document the AMA addressed the issue of warning in a forthright manner. Physicians were to try to convince patients of their obligation to warn the unsuspecting. If they failed in that task they were to seek the intervention of public health officials. Only if public health officials refused or were unwilling to take on the responsibility of warning was it the obligation of the physician to act directly.

When the Presidential Commission on the HIV Epidemic addressed this issue in mid-1988, it too endorsed the notion that physicians should have the right to breach confidentiality in order to warn the unsuspecting, despite the centrality of confidentiality to its overall strategy (8). Reflecting a commitment to professional autonomy, however, the Commission held that the decision about whether to breach confidentiality was to remain with the physician and was not to be imposed as a matter of law.

That too was the stance of a wide spectrum of public health officials and the Association of State and Territorial Health Officials (21), which chose to speak of a "privilege to disclose" rather than a duty to warn. Concerned about the potential

¹¹Gammill v. United States, 727 F. 2d 950 (1984).

public health impact of such efforts, the association's mid-1988 publication, *Guide to Public Health Practice: HIV Partner Notification*, urged that the identity of the index case only be revealed in the "rare case" of ongoing exposure by an individual who would under no conditions be suspected as a potential source of harm. Under such circumstances, the guide indicated, public health officials rather than clinicians should be responsible for making the critical determinations and interventions.

In some states the legislatures have sought to clarify professional responsibilities. Most states have given professionals the authority to warn specified groups at risk for HIV but have not made it their duty to warn them. The groups involved have included spouses, emergency workers (e.g., ambulance attendants, law enforcement officials), health care workers, funeral workers, etc.

In general, these laws have created more problems than they have solved. A spouse may be at risk for HIV, but what of equally vulnerable sexual or needle-sharing partners who are not married? At the same time, these statutes appear to sanction breaches of confidentiality in order to warn a person whose level of risk is exceedingly low. (A health care worker's level of risk from mucous membrane exposure is considerably less than 0.01%.) It was just such a slippery slope that worried those who have insisted on the absolute inviolability of the principle of confidentiality.

A rational line needs to be drawn, an equitable and prudent standard established. The starting point must be the firm and explicit protection of confidentiality in law. Only then will it be possible to consider exceptions dictated by the need to protect. The authority to breach confidentiality under exceptional circumstances must be formally acknowledged. But because of the complex balancing of

risks and benefits, it would be a great error to impose a duty to warn on professional health care workers.

COERCION AND ITS LIMITS

Despite the progress that has been made in reducing the incidence of HIV infection—an unprecedented success for health education—widespread publicity given the potential for continued spread of the epidemic has charged the ongoing political debate. In an atmosphere of public health crisis, with little early prospect for effective prophylaxis, impatience with the repertoire of voluntary measures has been growing (23). The fact that the behaviors linked to the spread of HIV infection are volitional and involve acts—sex between men, prostitution, and intravenous drug use—widely regarded as immoral or even criminal has also contributed to the allure of coercion. Some have argued that intentional behaviors posing a threat to the public health should be subject to legal sanctions. Strident calls for "tougher" measures, more specifically for isolation and criminalization, must be understood in this light.

Recourse to the threat of coercion, to the imposition of legal controls as a way of facing the threat of AIDS, has been infrequent in the West. However, 17 nations have enacted legislation placing restrictions on AIDS patients or upon environments conducive to the spread of AIDS. Twelve of these have reserved the right to require isolation, quarantine, or restricted movement of infected individuals. Nine countries have also made exposing another person to transmission of the AIDS virus a criminal offense.

Czechoslovakia's policies are typical of these. That country punishes intentional transmission of the AIDS virus by three years' imprisonment and negligent exposure of others by one year's imprisonment or a fine. The Soviet Union is par-

ticularly restrictive, punishing knowing exposure of another person to the AIDS virus by five years' "deprivation of liberty" and knowing transmission of the AIDS virus by eight years' "deprivation of liberty." Several states or territories of Australia punish the falsifying of health certificates for donated blood or other biological material by a fine and/or up to three years' imprisonment (3).

By far the most coercive approach to AIDS has been adopted in Cuba. There a decision has been made to screen the entire population (a third of the nation has already been tested). Such screening is mandatory. The first groups to be tested have been those traveling outside Cuba since 1975, those having regular contact with foreigners traveling in Cuba, all students coming to study in Cuba, all pregnant women, all prisoners, all patients being treated for sexually transmitted diseases, and the sexual contacts of those found to be infected. Some geographically based mass mandatory testing has also been undertaken.

All those testing positive for antibody to HIV are placed in a quarantine center located in a Havana suburb. Thus far, some 250 have been incarcerated. Parents who are infected are separated from their uninfected children, who may not live at the quarantine camp. Married couples in which one partner is infected are separated. Those who are isolated may visit family members and friends every several weeks, but only under the supervision of a chaperon. Married individuals may visit their uninfected partners, and after full warnings to each about the risks of transmission may have sexual relations. Unmarried residents of the quarantine center are prohibited from having sexual relations.

Though isolation of people with HIV infection has rarely occurred in the United States, an increasing number of state legislatures have enacted statutes

that permit such control. These statutes authorize confinement of infected people who engage in dangerous behavior, rather than confinement on the basis of disease status alone.

The distinction between antiquated disease-based isolation (the standard in Cuba) and more modern behavior-based isolation is pivotal. The former is concerned with an immutable health status and *assumes* that the infected pose a threat to the community. Such assumptions derive from the infectious nature of the diseases prevalent at an earlier time (24). Behavior-based isolation is more directly targeted to the prevention of dangerous acts and is linked to diseases that are transmitted as a result of volitional behavior.

Isolation under public health law, whether status-based or behavior-based, represents a challenge to fundamental conceptions of liberty, because it can be imposed upon a competent and unwilling person without the procedural protection typically afforded those confronted with the threat of criminal conviction (25). As in the case of criminal sanctions, the State seeks to restrict the liberty of those it isolates under public health law because of a concern for the welfare of others. But unlike the criminal sanction, which is typically time-limited, isolation measures tend to be open-ended. From the public health perspective, the primary concern is not what the individual has done in the past but rather what this individual will do in the future. Prevention rather than retribution and deterrence is the goal.

Of course, isolation based on past behavior and limited by a willingness to assume that after some period of control a change in behavior might be expected would be less repressive than imposition of control based on serologic status alone. But grave problems would remain. After how much time would release be

contemplated? And after what degree of certainty about the course of future behavior had been attained? At stake here are the most fundamental matters defining the authority of the State in a liberal society.

In the context of AIDS, any suggestion that isolation measures should be widely applied to individuals who fail to adopt acceptable behaviors must address not only such theoretical matters but a crucial practical question as well: Would the widespread adoption and vigorous enforcement of public health isolation measures affect the course of the AIDS epidemic? There is considerable doubt that the public health would be secured by such measures. Individuals would be controlled, but the goal of mass behavioral change could be adversely affected. Fears generated by the threat of isolation could discourage members of high-risk groups from seeking testing or speaking candidly to counselors about past behavior or behavioral intentions.

Policy-makers and public health officials ought to consider all the potential ramifications of isolation before they embrace such control measures. Appearances may be deceiving and may have counterproductive consequences. Certainly, as the role of such control measures is considered, it will be important to focus on the potential for affecting conditions that give rise to threatening behaviors. The provision of drug abuse treatment programs and the provision of social support services would be crucial in this regard.

As an alternative to the use of isolation, many public prosecutors and state legislators in the United States have turned to criminal law. Such action is politically appealing. The criminal law typically sanctions blameworthy individuals for their dangerous acts. Explicit penalties have been justified on grounds of retribution, incapacitation, and deterrence.

Certainly the transmission of a potentially lethal infection with forethought or recklessness falls within the scope of behaviors the criminal law already proscribes.

From the perspective of those concerned with protecting freedom, the criminal law has many advantages over behavior-based isolation. While statutes permitting isolation typically employ terms such as "incurability" and "recalcitrance," criminal statutes must specify the behavior being prohibited. The language of criminal statutes, if it is to survive judicial scrutiny in the United States, must avoid vagueness, always an invitation to unfair enforcement. Isolation statutes require predictions about future behavior—difficult at best (26)—while criminal statutes focus on behavior that has already occurred. In a similar vein, the standards of proof typically required under criminal law before a deprivation of liberty can occur are far more demanding than those required under public health law. And finally, unlike the indeterminate incarceration characteristic of isolation, criminal sanctions are generally finite and proportionate to the gravity of the offense.

Given these circumstances, would it be unreasonable for society to establish clear guidelines concerning the behaviors it will not tolerate in the context of the AIDS epidemic? Would not criminal laws to punish dangerous acts that risk transmission of HIV be desirable? As we shall see, the overreaching need to foster mass behavioral change and the difficulties involved in meeting the standards of the general criminal law might make benefits resulting from frequent recourse to the crude instrument of the criminal law problematic.

In the United States there have been over 50 criminal prosecutions of HIV-infected individuals because of their behavior. Many of these cases have been

brought against individuals who knew they were infected with HIV and had sexual intercourse without informing their partners. Others involved biting, spitting, kicking, splattering of blood, or donation of blood by an HIV-infected person. Several of the cases involved military personnel (23). (The Department of Defense orders HIV-infected personnel to refrain from unprotected sex and to inform their partners of their condition. Violation of such "safe sex orders" can result in charges ranging from disobeying a military order to assault with a dangerous weapon and attempted murder.)

The outcomes of these cases point up the great difficulties involved in applying the general criminal law to an infectious disease. For one thing, in the nonmilitary cases involving sexual relations it has been very difficult to prove beyond a reasonable doubt (as required by U.S. criminal law) that the accused intended to transmit HIV or acted with reckless disregard for his or her partner's life. For another, in many cases (especially those not involving sexual relations) the risks of transmission posed by the acts cited have ranged from low to exceedingly remote. (None of the defendants prosecuted to date actually transmitted HIV.) For these and other reasons, though there have been convictions, in the overwhelming majority of cases the prosecutions have been dropped or the accused individuals have been acquitted.

Partly in frustration at the difficulty of obtaining convictions under the general criminal law, policy-makers have sought other ways to criminalize behaviors that threaten to transmit AIDS. They have sought to do this primarily by establishing AIDS-specific public health offenses. In this general arena, about half the states already possess public health laws that define engaging in sexual intercourse while knowingly infected with a

sexually transmitted disease as a public health offense (27). However, these public health statutes were created to control the spread of syphilis and gonorrhea; most of them do not apply to HIV, because AIDS is not usually classified as a sexually transmitted disease (28). In response to this perceived legal "gap," some state legislators are now seeking to have AIDS reclassified as a sexually transmitted disease.

Also, several states have enacted AIDS-specific statutes. Modeled after older statutes designed to curb public health offenses, they apply solely to HIV transmission. These AIDS-specific statutes differ in scope, but all make it an offense for a person to knowingly engage in some type of behavior that poses a risk of HIV transmission—sexual intercourse, needle-sharing, blood donation, or, more broadly, attempting to transfer any "body fluid." From the prosecutor's perspective, these statutes have a distinct advantage: There is no need to prove any specific intent. The elements of the crime are usually straightforward. The person knew he was infected with HIV, engaged in well-defined risky behavior, and failed to inform his partner of the risk.

Using this general approach, a statute would make the specified behavior a criminal offense only if all the following elements were present: (1) the person knew he was HIV-positive and had been counseled by a health care professional or public health official not to engage in unsafe sexual or needle-sharing behavior; (2) the person did not notify his partner of his HIV status or did not use barrier protection against an exchange of body fluids; and (3) the person engaged in sexual intercourse or needle-sharing. To establish the offense, it would not be necessary to prove either an intent to harm or actual transmission of HIV.

States may also seek to deter HIV-in-

fecting individuals from intentionally donating blood or tissue by enacting public health sanctions.

Overall, however, a morbid preoccupation by policy-makers with coercive measures, no matter how carefully crafted, might entail a diversion from the far more difficult task of fostering mass behavioral changes and reinforcing those changes already made. The application of state coercion will make only the most limited contribution toward that goal. More important by far will be programs of focused education, voluntary testing and counseling, and treatment for drug dependence; and it will be through the success or failure of those efforts that the struggle against the further spread of HIV infection will be won or lost. To be sure, such public health measures will be less dramatic than invocation of the states' coercive powers; but such measures are the only ones that may prove effective in the face of AIDS.

CONCLUSION

At the conclusion to his history of the impact of epidemics upon humanity, William McNeill urges us to recognize that our vulnerability to infectious agents is an inherent feature of our existence (2). Therefore, our culture, politics, and social organization will at critical moments be subjected to strains imposed by the threat of disease. For a brief time—due to historical accident and the discovery of antibiotics—we came to believe that infectious diseases and especially the threat of epidemics was no longer a problem for advanced industrial societies. AIDS has provided a sobering antidote to that hubris.

Now, as efforts are made to slow the spread of HIV infection and care for those already sick, the fundamental values of liberal society are being chal-

lenged. The task before us is to define a vigorous course of action that at once protects the public health and the rights of the vulnerable. That is the standard against which we will be judged, and against which history will judge the vitality of liberal societies at a time of crisis.

REFERENCES

1. Sabatier, R. *Blaming Others: Prejudice, Race and Worldwide AIDS*. Panos Institute and New Society Publishers, Philadelphia, 1988.
2. McNeill, W. *Plagues and People*. Anchor Press, Garden City, 1976.
3. Curran, W. J., and L. Gostin. *International Survey of Legislation Relating to the AIDS Epidemic*. World Health Organization, Geneva, 1988.
4. Friedland, G. H., and R. S. Klein. Transmission of the human immunodeficiency virus. *N Engl J Med* 317:1125-1135, 1987.
5. Blendon, R. J., and K. Donelan. Discrimination against people with AIDS: The public perspective. *N Engl J Med* 319:1022-1026, 1988.
6. Institute of Medicine, National Academy of Sciences. *Confronting AIDS: Directions for Public Health, Health Care, and Research*. National Academy Press, Washington, D.C., 1988.
7. American Medical Association. Prevention and control of AIDS: An interim report. *JAMA* 258:2097-2103, 1987.
8. United States Government Printing Office. *Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic*. Washington, D.C., 1988.
9. World Summit of Ministers of Health on Programs for AIDS Prevention. *London Declaration on AIDS Prevention*. London, 28 January 1988.
10. World Health Organization. World Health Assembly Resolution 41.24, Avoidance of Discrimination in Relation to HIV Infected People and People with AIDS. WHO document A/41/VR/15. Geneva, 1988.
11. Annas, G. J. Not saints but healers: The legal duties of health care professionals in the AIDS epidemic. *Am J Public Health* 8(7):844-849, 1988.

12. Kmiec, D. W. Memorandum for Counsel to the President: Application of Section 504 of the Rehabilitation Act to HIV-infected Individuals. U.S. Department of Justice, Washington, D.C., 27 September 1988.
13. Civil Rights Restoration Act of 1987, P L 100-259 (S. 557), 22 March 1988.
14. National Gay Rights Advocates. AIDS and Handicap Discrimination: A Survey of the 50 States and the District of Columbia. Washington, D.C., 1986; updated as of Jan. 1988 by the American Dental Association: APHA Annual Meeting; Section on AIDS and Dentistry: Legal and Ethical Issues, Nov. 14, 1988. Unpublished data.
15. Bayer, R., C. Levine, and T. Murray. Guidelines for Confidentiality in Research on AIDS. *IRB: A Review of Human Subjects Research*, 6(6), 1984.
16. United States Centers for Disease Control. Recommended Additional Guidelines for HIV Antibody Counseling and Testing in the Prevention of HIV Infection and AIDS. Mimeographed document. Atlanta, 30 April 1987.
17. Association of State and Territorial Health Officials. *ASTHO Guide to Public Health Practice: HTLV III Antibody Testing and Community Approaches*. Public Health Foundation, Washington, D.C., 1985.
18. Gostin, L. Public health strategies for confronting AIDS. *JAMA* 261:1621-1630, 1989.
19. Bayer, R. *Private Acts, Social Consequences: AIDS and the Politics of Public Health*. The Free Press, New York, 1989.
20. *Rocky Mountain News* (Colorado), 13 October 1985, p. 55.
21. Association of State and Territorial Health Officials. *ASTHO Guide to Public Health Practice: HIV Partner Notification Strategies*. Public Health Foundation, Washington, D.C., 1988.
22. Gostin, L., W. Curran, and M. Clark. The case against compulsory case-finding in controlling AIDS testing, screening, and reporting. *Am J Law Med* 12(1):7-53, 1986.
23. Gostin, L. The politics of AIDS: Compulsory state powers, public health and civil liberties. *Ohio State Law J* 49(4): 1,017-1,058, 1989.
24. Gostin, L. Traditional Public Health Strategies. In: H. Dalton and S. Burris (eds.). *AIDS and the Law: A Guide for the Public*. Yale University Press, New Haven, 1987.
25. Merrit, D. Communicable disease control and constitutional law: Controlling AIDS. *NY U Law Rev* 759, 1986.
26. Monahan, E. *Predicting Violent Behavior: An Assessment of Clinical Techniques*. Sage Publications, Newbury Park, California, 1981.
27. Gostin, L. The future of public health law. *Am J Law Med* 12:461, 1986.
28. Curran, W. J., L. Gostin, and M. Clark. *Acquired Immunodeficiency Syndrome: Legal and Regulatory Policy Analysis*. U.S. Department of Commerce, Washington, D.C., 1988.