The John Marshall Law Review

Volume 27 | Issue 2 Article 3

Winter 1995

AIDS: Law, Public Policy, and the Continuing Work of the American Bar Association, 27 J. Marshall L. Rev. 273 (1994)

Barry Sullivan

AIDS: LAW, PUBLIC POLICY, AND THE CONTINUING WORK OF THE AMERICAN BAR ASSOCIATION

BARRY SULLIVAN*

The Board of Governors of the American Bar Association recognized the important legal, social, and human consequences of the AIDS epidemic when it established the AIDS Coordinating Committee in 1987. The mandate of the Coordinating Committee was two-fold: (1) to investigate and make recommendations concerning the proper resolution of the legal issues engendered by the AIDS epidemic, and (2) to coordinate all of the Association's AIDS-related activities. To accomplish these objectives, the Coordinating Committee was constituted in a way that ensured a broad and diverse membership, with representives from 13 different ABA sections, the National Bar Association, and the New York State Bar Association.

The Coordinating Committee first met in early 1988. By June 1988, it had completed work on a 250-page volume entitled *AIDS: The Legal Issues*,[1] which identified and analyzed the issues raised by the AIDS epidemic in 15 different areas of the law. In August 1988, the Coordinating Committee presented an all-day educational program, and distributed large numbers of its book, at the Association's annual meeting in Toronto. In August 1989, the Coordinating Committee, with co-sponsorship from numerous ABA sections and divisions, presented a series of 61 policy principles to the Association's House of Delegates. These policy recommendations, which dealt with 15 different areas of the law, were adopted by the House of Delegates.[2]

---

* Member of the Massachusetts and Illinois bars. Chair, American Bar Association AIDS Coordinating Committee, January 1988 —. Partner, Jenner & Block, Chicago, Illinois. Adjunct Professor of Law, Northwestern University School of Law. Dean-elect, Washington and Lee University School of Law. The views expressed in this paper are solely those of the author and should not be attributed in any way to the American Bar Association or the AIDS Coordinating Committee.

1. American Bar Assoc. AIDS Coordinating Committee, *AIDS: The Legal Issues* (1988).

2. Together with a lengthy report prepared by the Coordinating Committee, these policy principles were later published in the University of Toledo Law Review. *See American Bar Association Policy on AIDS*, 21 Toledo L. Rev. 9 (1989); *Report of the AIDS Coordinating Committee*, 21 Toledo L. Rev. 19 (1989). *See also* Barry Sullivan, *AIDS: Law, Public Policy, And The Work Of The American Bar Association*, 21 Toledo L. Rev. 1 (1989).

In subsequent years, the AIDS Coordination Project of the ABA Section of Individual Rights and Responsibilities, with the assistance and cooperation of the AIDS Coordinating Committee, has conducted numerous educational programs for lawyers and judges on the legal issues relating to AIDS; it has produced a nationwide directory of legal resources for persons affected by HIV and AIDS;[3] it has produced a 30-minute video aimed at educating lawyers about HIV and encouraging them to undertake the *pro bono* representation of persons affected by HIV and AIDS;[4] it has created an organizational and training manual for *pro bono* AIDS volunteer programs;[5] and it has worked with organizations such as the Centers for Disease Control, the National Judicial College, and the National Coalition Against AIDS, in efforts to disseminate balanced, accurate, and unbiased information about HIV and the legal issues concerning HIV to members of the judiciary, the bar, and the public.

The paper which follows, *The AIDS Epidemic and Health Care Reform*,[6] is the latest manifestation of the Coordinating Committee's and Project's efforts to provide some perspective on the legal and public policy issues raised by the AIDS epidemic. From the outset, the Coordinating Committee has sought to influence developments in the law, public opinion, and government policy by providing an informed and dispassionate view of the relevant facts and legal principles, and by encouraging persons of good will to act accordingly. That also is the purpose of *The AIDS Epidemic and Health Care Reform.*

When the Coordinating Committee commenced its work in early 1988, the AIDS epidemic in this country was still largely perceived to be an epidemic whose consequences were principally being felt among male homosexuals and certain discrete minority groups such as Haitian refugees. Fear of AIDS was strongly reinforced by homophobia and racism, and it was with those particular forms of discrimination that virtually all efforts to formulate a reasoned response to the AIDS epidemic were required to contend. The male homosexual community devoted substantial resources to fighting AIDS and AIDS discrimination. Many members of that community pressed for public health and educational efforts, which have now had some substantial success in slowing the spread of AIDS. Even

---

3. *See* American Bar Assoc. AIDS Coordination Project, *Directory of Legal Resources for People with AIDS and HIV* (M. Zavos, ed. 1991).

4. *See* American Bar Assoc. AIDS Coordination Project, *Pro Bono In The AIDS Epidemic* (M. Zavos, ed. 1992).

5. *See* American Bar Assoc. AIDS Coordination Project, *Creating A Pro Bono Project for People with AIDS and HIV* (M. Zavos, ed. 1993).

6. William A. Bradford, Jr., Michele A. Zavos, and The American Bar Assoc. AIDS Coordinating Committee, *The AIDS Epidemic and Health Care Reform*, 27 J. Marshall L. Rev. 279 (1994).

in the gay community, however, much remains to be done. Many of the problems which existed at the onset of the AIDS epidemic, including fear and discrimination, still exist.[7]

The effects of the AIDS epidemic continue to be felt in the gay community, and they are being felt with increased force among other groups. The force of the epidemic has not dissipated, but its social profile has changed somewhat. Thus, by 1991, the National Commission on AIDS was able to note that African Americans constituted 12% of the population, but 28% of AIDS cases; Hispanics constituted 9% of the population, but 16% of AIDS cases; AIDS cases among women were growing faster than AIDS cases among men, with women then accounting for 10% of all AIDS cases; and approximately 31% of all AIDS cases could be linked, either directly or indirectly, to intravenous drug use.[8] Two years later, the National Commission reported that "HIV transmission though injection drug use continues to pose a threat of 'flash fire' spread of infection among drug users, through multi-person use of injection equipment, which can be followed by sexual transmission to their partners."[9] In addition, non-injecting drug use is a significant risk behavior for transmission, based on exchanges of sex for drugs and on the impairment of decisionmaking capabilities.[10] "Expansion of the base of the epidemic, in large part through spread among heterosexuals, continues to gain ground, particularly among communities of color, women and adolescents."[11] Among other things, these facts suggest that the care of women and children will demand the commitment of increasingly greater resources: "births to infected mothers will result in more HIV-infected infants, and the death of infected mothers and fathers will result in growing numbers of 'AIDS orphans.' "[12]

---

7. In its final report, the National Commission on AIDS projected that the number of new AIDS cases among men who have sex with other men would remain level between January 1992 and January 1995, but noted that "AIDS diagnoses, of course, tell a story that is out of date, since it takes an average of 10 years between onset of infection and appearance of AIDS-defining disease manifestations." REPORT OF THE NAT'L COMM'N ON ACQUIRED IMMUNE DEFICIENCY SYNDROME, AIDS: AN EXPANDING TRAGEDY: THE FINAL REPORT OF THE NATIONAL COMMISSION ON AIDS 5 (1993). In addition, the Commission noted a disturbing trend among younger gay men: "While HIV transmission among older men who have sex with men is sharply reduced from the early 1980s, transmission continues at high levels in younger gay men where a 'generation gap' seems to have led to a rejection of warnings from survivors of the first tragic decade." *Id.* at 6.

8. REPORT OF THE NAT'L COMM'N ON ACQUIRED IMMUNE DEFICIENCY SYNDROME, AMERICA LIVING WITH AIDS: TRANSFORMING ANGER, FEAR AND INDIFFERENCE INTO ACTION 12 (1991).

9. REPORT OF THE NAT'L COMM'N ON ACQUIRED IMMUNE DEFICIENCY SYNDROME, *supra* note 7, at 6.

10. *Id.*

11. *Id.*

12. *Id.*

The present situation is a great deal more complex than it was (or we perceived it to be) in early 1988. So too is the pathology of discrimination, which draws not only upon homophobia and racism, but upon additional reservoirs of fear, hatred, and indifference. Thus, it is true today, as it was in 1989, that "the fullest fury of the HIV epidemic has . . . been felt by communities which already are targets of distrust or discrimination."[13] But the diversity of those targets has now widened to include additional communities subject to different forms of distrust and discrimination. The National Commission provided eloquent testimony to this point in a 1991 report:

> It quickly became clear during the Commission's travels that HIV disease could not be understood outside the context of racism, homophobia, poverty, and unemployment — pervasive factors that foster the spread of disease. This web of associated social ills has been referred to as "a synergy of plagues." Poverty and unemployment in the inner cities of the United States entail much more than an inability to pay the bills. In 1991 being poor is a generic risk factor, for it is associated with increased risks of becoming homeless, dying a violent death, and suffering and perhaps dying from a multitude of preventable illnesses. A 1990 study of mortality in New York City's Harlem found that black men in that community were less likely to reach the age of 65 than were men in Bangladesh.[14]

One could readily add other strands to this "web of associated social ills" — homelessness, hopelessness, aimlessness, ignorance, and despair on the part of those who are caught in the web; indifference on the part of those who witness it at a comfortable distance. At all events, these are the conditions with which the architects of health care reform must be prepared to deal.[15] These are the conditions with which our society must be prepared to grapple on many fronts. In this sense, it is good to remember the words of President Roosevelt: "The test of our progress is not whether we add more to the abundance of those who have much; it is whether we provide

---

13. Barry Sullivan, *AIDS: Law, Public Policy, And The Work Of The American Bar Association*, 21 Toledo L. Rev. 1, 4 (1989). *See generally* Barry Sullivan, *When the Environment Is Other People: An Essay on Science, Culture, and the Authoritative Allocation of Values*, 69 Notre Dame L. Rev. 597, (1994).

14. REPORT OF THE NAT'L COMM'N ON ACQUIRED IMMUNE DEFICIENCY SYNDROME, AMERICA LIVING WITH AIDS: TRANSFORMING ANGER, FEAR AND INDIFFERENCE INTO ACTION, *supra* note 8, at 13-14 (1991). *See also* National Commission on Acquired Immune Deficiency Syndrome, *The Challenge of HIV/AIDS in Communities of Color* (1992); Harlon L. Dalton, *AIDS in Blackface*, DAEDALUS, Summer 1989, at 205; SUSAN SONTAG, AIDS AND ITS METAPHORS (1989).

15. *See* George J. Annas, *Control of Tuberculosis — The Law and The Public's Health*, 328 N. Eng. J. Med. 585, 588 (1993) (footnote omitted) ("Infectious agents are likely to proliferate in the future, and old scourges such as tuberculosis may continue to return in newly virulent forms as portions of some of our inner cities begin to resemble Third World countries").

enough for those who have too little."[16] That is the particular challenge laid down in *The AIDS Epidemic and Health Care Reform.*

In closing, I would like to express my continued thanks to my colleagues on the Coordinating Committee for their hard work and support, but especially to William A. Bradford, Jr. and Michele A. Zavos, who worked extensively with the ABA Task Force on Health Care Reform and are the principal authors of *The AIDS Epidemic and Health Care Reform.* I would also like to thank Douglas M. Jarrell, a student at the University of North Carolina School of Law, and Sheryl R. Miller, a student at the Columbus School of Law, Catholic University of America, who contributed greatly to the research and writing of the paper. Finally, I would like to thank the editors of the John Marshall Law Review for their thoughtful and public-spirited undertaking, not only in publishing this paper, but in organizing the symposium in which it appears. In devoting this issue of the Review to this important subject, the editors cause us to reflect on the truth of Justice Frankfurter's observation, that "the bar has not enjoyed prerogatives; it has been entrusted with anxious responsibilities."[17] Let us all endeavor to shoulder those responsibilities as best we can.

16. Franklin D. Roosevelt, Speech at Chicago, October 5, 1937. (Cite to Public Papers of FDR.)

17. Schware v. Board of Bar Examiners, 353 U.S. 232, 247 (1957) (Frankfurter, J., concurring).