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AIDS: Testing Democracy - Irrational Responses to the Public Health Crisis and the Need for Privacy in Serologic Testing, 19 J. Marshall L. Rev. 835 (1986)

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ARTICLES

AIDS: TESTING DEMOCRACY—IRRATIONAL RESPONSES TO THE PUBLIC HEALTH CRISIS AND THE NEED FOR PRIVACY IN SEROLOGIC TESTING

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I. INTRODUCTION

> AIDS is the modern day equivalent of leprosy. AIDS, *or suspicion of AIDS*, can lead to discrimination in employment, education, housing and even medical treatment.[1]

AIDS hysteria abounds due to the generally uninformed position of elected officials, government agents, church and community leaders, many doctors and lawyers, and the public at large. The panic is fueled by proposals[2] to test twenty or more million Americans with the blood analysis linked to AIDS (the HTLV-III antibody test), and then to discriminate against those with positive blood test results by expelling them from their schools, discharging them from their jobs (including military service), depriving them of custody or visitation with their children, refusing them insurance for life and health coverage, denying them medical and nursing home care, denying aliens permanent resident status,[3] and on and on.[4]

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1. South Fla. Blood Servs. v. Rasmussen, 467 So.2d 798, 802 (Fla. App. 1985), *cert. granted* (Fla. Feb. 24, 1986)(No. 67,081). This was not the first, nor will it be the last, analogy to leprosy. *See, e.g.*, D. ALTMAN, AIDS IN THE MIND OF AMERICA 21 (1986); Comment, *Protecting the Public from AIDS: A New Challenge to Traditional Forms of Epidemic Control*, 2 J. CONTEMP. HEALTH L. & POL'Y 191, 192 (1986).

2. *See, e.g.*, Staver, *Required AIDS Testing, Reporting Urged*, Am. Med. News, May 2, 1986, at 1, col. 1 (proposal to modify California law which now prohibits testing); *California Official: Mandatory Tests*, Windy City Times, Apr. 24, 1986, at 4, col. 2 (proposal for mandatory testing in California); Staver, *CDC Urges More Blood Testing for High-Risk Groups*, Am. Med. News, Apr. 18, 1986, at 9, col. 1 (recommending routine testing without regard to psychological impact on those who test positive); Krieger, *To Include Individuals In High-Risk Groups: PHS Urges Expanded Screening for AIDS*, Am. Med. News, Mar. 28, 1986, at 8, col. 1 (Public Health Service proposal); *Blood Testing: Mass Testing of High-Risk Groups Urged to Combat Spread of Infection*, 1 AIDS POL'Y & L. (BNA) No. 5, at 1 (Mar. 26, 1986); Altman, *U.S. Urges Blood Test for Millions With High Risk of AIDS Infection*, N.Y. Times, Mar. 14, 1986, at 1, col. 5.

3. *See* Medical Examination of Aliens (AIDS), 51 Fed. Reg. 15354 (1986); *Immigrants to be Screened for HTLV-III in HHS Plan*, 7 OFFICIAL NEWSLETTER OF THE NAT'L COALITION OF GAY STD SERVICES 59 (Feb.-Mar. 1986).

4. *See Screening of Blood for AIDS Raises Civil Liberties Issues*, N.Y. Times, Sept. 30, 1985, at 1, col. 2.

Without regard for these concerns, some doctors and hospitals are even secretly performing the HTLV-III blood test on patients who appear suspicious (meaning that they or their visitors are suspected of being gay).[5]

That AIDS hysteria exists is well-illustrated by the example of a misinformed and careless law professor who recently advocated mandatory HTLV-III antibody testing for the entire population of the United States.[6] Also, according to a Los Angeles Times poll published in December, 1985, 48 percent of those surveyed would approve of identity cards for those who test positive for antibodies to the HTLV-III virus, and 15 percent favored tatooing those exposed to HTLV-III.[7] Author and editor William F. Buckley, Jr. has suggested that "[e]veryone detected with AIDS should be tatooed in the upper forearm, to protect common needle users, and on the buttocks, to prevent the victimization of other homosexuals."[8] In the

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5. *See infra* text accompanying note 407.

6. Duncan, *Public Policy and the AIDS Epidemic*, 2 J. CONTEMP. HEALTH L. & POL'Y 169 (1986)(two and a half page commentary completely bereft of any medical or legal research, except for a single footnote to a New York Times article); Duncan, *Professor Defends Proposal for AIDS Testing*, Nat'l L.J., June 9, 1986, at 12, col. 2; *Professor Stirs AIDS Controversy With a Call for Universal Testing*, Nat'l L.J., May 5, 1986, at 4, col. 2. Professor Arthur S. Leonard of the New York Law School noted serious constitutional problems and described Professor Duncan's proposal as "irresponsible," "ludicrous," and "a reaction of panic rather than thoughtfulness." Leonard, *AIDS Testing Proposal Seems Ludicrous*, Nat'l L.J., May 12, 1986, at 14, col. 2. The authors concur in Professor Leonard's assessment of Professor Duncan's proposal, and, indeed, would ourselves use much stronger language in criticizing Professor Duncan's inane comments. As an alternative, Professor Leonard suggests that "[p]eople who are engaging in sex for recreation rather than procreation should in all cases avoid fluid exchange, and those engaging in sex for procreation should seek out the antibody blood test to determine the prudence of such activity." *Id.* at col. 3. "Fluid" really means blood and semen, not saliva, tears, and perspiration which have not been shown to be a vehicle for transmission of the HTLV-III virus. Professor Duncan's proposal for national mandatory screening is shared by the extremist Mark Fairchild, political protoge of the right-wing fanatic Lyndon LaRouche. *Would-be Governor Fairchild Spells Out His Philosophy*, Chicago Trib., May 11, 1986, § 5, at 4, col. 1. In a freak accident of Illinois politics, Mr. Fairchild won the 1986 Democratic primary nomination for the position of lieutenant governor of Illinois, and Janice Hart, another LaRouche follower, won the nomination for Secretary of State. *'LaRouchies' force state to take notice*, Chicago Trib., Mar. 23, 1986, § 1, at 1, col. 3. The fact that the LaRouche extremists are strong advocates of mandatory testing should hopefully serve as a political vaccine against any attempts to implement the proposal. *See The LaRouche vaccine*, Chicago Trib., Mar. 24, 1986, § 1, at 14, col. 1.

7. Phair, *The antidote for AIDS hysteria*, Chicago Trib., Apr. 2, 1986, § 1, at 13, col. 1. In a different poll conducted for the Christian Broadcasting Network, 70% of the 518 surveyed thought the entire nation should be tested, and 79% thought that homosexuals should be required to take the antibody test as a precondition of employment as a food handler, doctor, or day care nurse. *Gallup poll: Test country for AIDS*, Windy City Times, Jan. 9, 1986, at 2, col. 2. More recently, a poll conducted for the American Bar Association found that a majority of lawyers believe that social restrictions imposed on persons with AIDS are illegal. *Lawyers oppose most-AIDS-related discrimination*, 72 A.B.A. J. 34 (June 1986). The only area where lawyers considered actions not to be illegal was the military. *Id.*

8. Buckley, *Identify All the Carriers*, N.Y. Times, Mar. 18, 1986, at 27, col. 3.

military sector, officials at the Pentagon have confirmed that a forced tatooing proposal won a first-round approval.[9] Elsewhere, identity cards to show antibody status have been marketed and required by employers.[10] Legislation to isolate and quarantine persons who test positive for HTLV-III antibody was introduced in Colorado,[11] while the Reagan Administration also debated quarantine measures.[12] These proposals in both the military sector and society at large raise serious political and constitutional issues concerning individual liberty and the right to privacy. The proposals for quarantine are reminiscent of the internment of Japanese-Americans at the outbreak of World War II[13] and the internment of lepers on the

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Mr. Buckley analogizes his tatoo to the Scarlet Letter designed to stimulate public obloquy.

9. Bush, *Tatoos Called Loathsome*, 7 OFFICIAL NEWSLETTER OF THE NAT'L COALITION OF GAY STD SERVICES 21 (Feb.-Mar. 1986).

10. Fall, *Antibody Free ID Cards for Sale in Denver*, 7 OFFICIAL NEWSLETTER OF THE NAT'L COALITION OF GAY STD SERVICES 44 (Feb.-Mar. 1986) (Colorado health officials stress that the $20 card is rendered useless every time the cardholder has a sexual encounter); Keen, *"Protection" ID Cards for People Testing Antibody Negative*, 7 OFFICIAL NEWSLETTER OF THE NAT'L COALITION OF GAY STD SERVICES 44 (Feb.-Mar. 1986)(Los Angeles City Council's attempt to shut down a business which sells cards for $100); McDaniel, *Houston Food Handlers May Need "Health" Cards*, 7 OFFICIAL NEWSLETTER OF THE NAT'L COALITION OF GAY STD SERVICES 44 (Feb.-Mar. 1986)(some Houston City Councilmen trying to require cards as a condition of employment in restaurants, despite the fact that AIDS is not a "food-borne" disease and that the test does not show viral status); *Houston Votes Against 'Health Cards'*, Advocate, Apr. 29, 1986, at 20, col. 2 (proposal rejected); *Cal. City says no to HTLV-III test*, Windy City Times, Dec. 19, 1985, at 3, col. 2 (rejecting a resolution offered to require antibody testing of restaurant and bar workers in Calumet City, Illinois); *Miami Vice: Dade County Proposal Would Issue AIDS Health Cards*, N.Y. Native, Oct. 7-13, 1985, at 12, col. 3 (proposed ordinance to require 80,000 food-service workers to carry cards "certifying" that they have no communicable diseases).

11. Colorado House Bill 1290, 55th Gen. Assembly, 2d Sess., as amended by the Colorado Senate Committee of Reference Report of Mar. 12, 1986. The bill was later killed by its author when the Senate and House of Representatives failed to reach a compromise on their two different versions of the bill. *Colorado Legislators Vote Down AIDS Control Measure*, Advocate, June 24, 1986, at 20, col. 1; *Colorado Quarantine Legislation Abandoned*, N.Y. Native, June 9, 1986, at 11, col. 1; *Colorado quarantine bill dead*, Windy City Times, June 5, 1986, at 5, col. 1; *Quarantine: Lack of Accord Kills Colorado Bill*, 1 AIDS POL'Y & L. (BNA) No. 9, at 2 (May 21, 1986); *Colorado Bill "Good as Dead"*, Windy City Times, Apr. 24, 1986, at 4, col. 2. However, the mere fact that a bill to quarantine seropositive individuals was even introduced has terrified civil liberties activists, medical personnel, and members of at-risk groups because of the possibility of the bill's re-introduction. *Quarantine: Isolation, Testing for AIDS Proposed in Colorado Legislation*, 1 AIDS POL'Y & L. (BNA) No. 8, at 1 (May 7, 1986); *Group to Fight Quarantine*, Windy City Times, Apr. 17, 1986, at 4, col. 4. *See also Quarantine Idea Dropped* N.Y. Times, Jan. 17, 1986, at 9, col. 6 (Texas proposal to quarantine persons with AIDS abandoned).

12. Bush, *First Blood*, N.Y. Native, July 1, 1985, at 16, col. 3. The article notes that any quarantine of those possibly exposed to the HTLV-III virus would include President Ronald Reagan, Ex-President Richard Nixon, and Pope John Paul II because each received blood transfusions before blood was being screened for HTLV-III antibody. First Lady Nancy Reagan and former First Lady Pat Nixon would also be included as the presumed sex partners of persons at risk. *Id.*

13. O'Connor, *AIDS hysteria?*, Chicago Trib., Feb. 12, 1986, § 1, at 14, col. 6

island of Molokai, Hawaii, and the proposals for tatooing seem strikingly similar to Nazi Germany's tatooing of Jews, homosexuals, and other groups.[14]

Testing for antibodies to HTLV-III is dangerous because it is viewed as a "litmus test" for AIDS,[15] which it simply is not. In the first year of testing for antibodies to HTLV-III, the test results have been misused and abused to violate civil rights.[16] While some have

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(comparing calls for quarantine of persons with AIDS to the quarantine of Japanese Americans).

14. Even without proposals for tatooing, "[t]he blood test for HTLV-3 virus [sic] is getting to be like the yellow star in the 1930's." Lewin, *AIDS and Job Discrimination*, N.Y. Times, Apr. 15, 1986, at 30, col. 1 (quoting attorney Mark Senak's remarks on the blood test for HTLV-III antibody). In a similar spirit, a prison warden recently suggested different colored uniforms for prisoners with AIDS. He abandoned the proposal after he was reminded of the Nazi system of colored triangles used in concentration camps during World War II. *See Gays and Nazi Death Camps: After 40 Years Still a Sad, Sordid Chapter in the History Books*, Advocate, Jan. 21, 1986, at 36, col. 1 (lamenting the nonrecognition of Nazi atrocities committed against those forced to wear the pink triangle).

15. Speech by Thomas B. Stoddard, Executive Director of the Lambda Legal Defense and Education Fund, at the University of Chicago (Feb. 26, 1986). In an address at the Health Law Institute of the DePaul University College of Law, Kristine Gebbie commented that popularity of the HTLV-III antibody test can be explained by the social fact that people "are used to dealing with tests." (Apr. 11, 1986).

16. Several recent articles have appeared on the issue of whether society can discriminate against persons with AIDS. *See, e.g.*, Freedman, *Wrong Without Remedy*, 71 A.B.A. J. 36 (June 1986); Leonard, *Employment Discrimination Against Persons With AIDS*, 10 U. DAYTON L. REV. 681, 689-703 (1985); Parry, *AIDS As a Handicapping Condition—Part II*, 10 MENTAL & PHYSICAL DISABILITY L. REP. 2 (1986); Comment, *AIDS: A Legal Epidemic?*, 17 AKRON L. REV. 717 (1984); Comment, *Preventing the Spread of AIDS by Restricting Sexual Conduct in Gay Bathhouses: A Constitutional Analysis*, 15 GOLDEN GATE U.L. REV. 301 (1985); Note, *The Constitutional Rights of AIDS Carriers*, 99 HARV. L. REV. 1274 (1986); Comment, *Protecting the Public From AIDS: A New Challenge to Traditional Forms of Epidemic Control*, 2 J. CONTEMP. HEALTH L. & POL'Y 191 (1986); Comment, *AIDS—A New Reason to Regulate Homosexuality?*, 11 J. CONTEMP. L. 315 (1984); Rabin, *The AIDS Epidemic and Bathhouses: A Constitutional Analysis*, 10 J. HEALTH POL., POL'Y & L. 729 (1986); *Survey on the Constitutional Right to Privacy in the Context of Homosexual Activity*, 40 U. MIAMI L. REV. 521 (1986); Comment, *Fear Itself: AIDS, Herpes, and Public Health Decisions*, 3 YALE L. & POL'Y REV. 479 (1985). It should also be recognized that the problems discussed in this article are by no means unique to the United States, so that the responses of other nations can help guide the American response. *See, e.g.*, Harfi & Fakhry, *Acquired Immunodeficiency Syndrome in Saudi Arabia*, 255 J. A.M.A. 383 (1986) (transfusion-related transmission of AIDS); Gelpi, *AIDS and the Donation of Blood in Saudi Arabia*, 255 J. A.M.A. 2441 (1986)(antibody screening of imported blood); Holzgreve, *AIDS nach kunstlicher Insemination*, 128:6 MÜNCHNER MEDIZINISCHE WOCHENSCRIFT 28 (1986)(liability for AIDS transmitted by artificial insemination); *New Zealand Insurance Co.'s to Screen Applicants*, N.Y. Native, June 9, 1986, at 7, col. 1 (denying insurance coverage to gays in New Zealand); *Switzerland sets example*, Windy City Times, June 5, 1986, at 4, col. 4 (reporting on responsible social activism in Switzerland, where a basic educational pamphlet has been distributed to every household in the nation); *British Insurers Don't Want At-Risk Groups*, Windy City Times, Apr. 17, 1986, at 4, col. 4 (British insurers want those suspected of belonging to "high-risk" groups to take the test for HTLV-III antibodies, denying insurance coverage to those who refuse to take the test); *Brazil launches AIDS campaign*, Am. Med. News, Jan. 10, 1986, at 37, col. 2

urged widespread testing, they have paid insufficient attention to the personal suffering and discrimination which almost inevitably follows any such testing and which is not warranted given the fact that current testing is useful only for screening blood and organ donations, and for research.[17] For example, the management of a Texas corporation handed the following note to a ten-year employee, after he tested positive for antibodies to HTLV-III:

> Tommy-
>
> You're not supposed to come into the office. The checks are not in. We will mail it to you. Also, your sick benefits will start back now that you've taken *the test*. . . . Be sure that you do not come back to the office.
> Shirley[18]

This incident is but one example of what is happening nationwide, as the fear of developing AIDS sparks irrational, insensitive, and illegal responses to the AIDS epidemic.[19] For persons with AIDS and those at risk of contracting AIDS, these responses have made calling a lawyer as inevitable as calling a doctor.[20]

(campaign to stop spread through education); *Soviets Try to Quiet AIDS Fears*, Washington Post, Dec. 12, 1985, § A, at 31, col. 4 (educational lecture in Moscow drew more than 1,000 listeners); *AIDS Scare: Bangladesh to Ban Used Clothes Imports*, Advocate, Oct. 29, 1985, at 22, col. 2 (Bangladesh reported to have considered banning imports of used clothing from the United States for fear that the clothing might spread AIDS); *Aids: "Wir müssen die Löcher stopfen*, Der Spiegel, Sept. 15, 1985, at 19, 20 (against contact tracing in West Germany).

17. *See infra* notes 155-69 and accompanying text.

18. *Panic, Hysteria Overrule Reason in Workplace Response to AIDS*, Am. Med. News, Jan 10, 1986, at 1, col. 1, 3.

19. Several volumes could be written alone on the varied responses to AIDS. One woman phoned a hospital emergency room to ask whether her son should wear gloves when using a public telephone. Musto, *Better Latex Than Never*, Village Voice, May 27, 1986, at 32, col. 1, 3. Television studio technicians refused to tape an interview with a man who had AIDS. *The indiscriminate killer*, Maclean's, Aug. 12, 1985, at 38, col. 1 (Canadian newsmagazine). In Maryland, a judge initially ruled that defendants who had tested positive for HTLV-III antibodies did not have the right to trial in a public courtroom, but would have to be tried at the county prison. Harding, *Courtroom Controversy Erupts Over HTLV-III Antibodies*, 7 OFFICIAL NEWSLETTER OF THE NAT'L COALITION OF GAY STD SERVICES 43 (Feb.-Mar. 1986). In Peoria, Illinois, church goers became concerned that they could contract AIDS during communion. *Fear of AIDS changes communion practices*, Peoria Journal-Star, Nov. 2, 1985, § A, at 10, col. 2. In Del Ray Beach, Florida, a prostitute with AIDS is under electronically-monitored house arrest because jail employees feared contracting AIDS if she were to be housed at the jail. The woman must wear a three-ounce transmitter which beeps every 35 seconds and signals the computer in the local Sheriff's office. The signal stops if the woman moves more than 200 feet from her base. Windy City Times, Nov. 21, 1985, at 6, col. 4. These examples illustrate that the hysteria which surrounds AIDS can be as devastating as the disease itself. *See* Pike, *AIDS Hysteria Getting Worse Than Disease*, Lincoln [Nebraska] Star, Sept. 21, 1985, at 10, col. 3. *See also* Beck, *Putting AIDSphobia To Use*, Chicago Trib., Nov. 21, 1985, § 1, at 18, col. 3.

20. Gest, *AIDS triggers painful legal battles*, U.S. News & World Rep., Mar. 24, 1986, at 73.

II. PRELIMINARY OBSERVATIONS

First, although the AIDS epidemic is a genuine health crisis, the existence of a crisis does not warrant panic and hysteria. We already know a great deal about AIDS, especially about its transmission. It is not casually transmitted:[21] it will not be spread through coughing, sneezing, shaking hands, and other ordinary contacts. If casual transmission were possible, most of the population would have contracted AIDS by now. Instead, the overwhelming number of people are entirely safe.

Second, the Centers for Disease Control (CDC) report that, as of June 9, 1986, there have been 21,517 cases of AIDS reported in the United States.[22] The reference to such a precise number by an official agency of the federal government may be misleading the public to believe that the reported number accurately reflects the reality of the AIDS crisis. That number is preposterous as an accurate indication of the actual extent of AIDS cases in this country. The true number is significantly more than the number officially reported.[23] The under-reporting is confirmed by the substantial nationwide incidence of mysterious deaths from cancer and pneumonia which are not reported as deaths attributed to AIDS.[24]

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21. Curran, Morgan, Hardy, Jaffe, Darrow, & Dowdle, *The Epidemiology of AIDS: Current Status and Future Prospects*, 229 SCIENCE 1352, 1357 (1985).

22. N.Y. Times, June 13, 1986, at 1, col. 3. The most recent numbers can be obtained by calling the Centers for Disease Control at 1-(404) 329-3286. In 1981, the CDC formed a task force to establish risk factors, conduct laboratory research, and disseminate timely information on AIDS. The CDC, a part of the United States Public Health Service, is one of the nation's primary resources for epidemiologic investigations. Curran, *Protecting Confidentiality in Epidemiologic Investigations by the Centers for Disease Control*, 314 NEW ENG. J. MED. 1027 (1986).

23. Some have suggested that AIDS may have been around for years without having been identified and reported. Certainly, in the early years after its discovery, many cases went unreported before medical professionals were generally informed about the existence of the disease. Additionally, other factors account for the failure to identify and report cases of AIDS, such as: doctors may not notice the association with AIDS if the person afflicted does not seem to be in a risk group, either by concealment or denial; some of the opportunistic diseases which are diagnostic for AIDS are rare and doctors who are not well informed about AIDS may not recognize it, or may not care to diagnose AIDS; and these preceding factors are even more important outside the major metropolitan areas because substantial numbers of gay and bisexual men from smaller communities have traveled to big cities, engaged in sexual activities, and consequently carried the risk of contracting AIDS back to those communities. *See Doctors Cite Stigma of AIDS In Declining to Report Cases*, N.Y. Times, May 27, 1986, at 1, col. 1.

24. While we have collectively noted numerous instances of newspaper and other accounts of such deaths, we obviously feel constrained not to illustrate them with specific references here (so as not to violate, after death, the concerns that such individuals may have had during their lives). We have also observed the phenomenon of the failure of some published accounts to make any reference whatsoever to the cause of death among persons who may well have been in the high-risk groups. Worldwide, there is substantial underreporting of AIDS, from the Soviet Union and Eastern Europe, to the third world countries of Africa and Latin America. Such un-

Many persons with AIDS do not want their disease correctly reported for any number of reasons. Basic to this concern is the fact that most persons with AIDS do not wish the stigma of AIDS to befall themselves or their families.[25] The concern about protecting family is especially great where the person with AIDS lives in small-town America, with its relative lack of anonymity, and/or is a married man with a wife and children. Further, there is fear that if AIDS is diagnosed the person will lose his employment and perhaps be denied housing, medical care, or visitation with his children. Certainly, the person can fear the loss of friends, companionship, and comfort that results from the leprosy syndrome referred to in the introduction to this paper.[26] In other instances, deaths related to AIDS will be hidden for business reasons, such as in the fashion industry where rumors of AIDS could tarnish the affected designer's lines of clothing.[27]

Third, morbid as it may be to say, AIDS is a growth industry. The picture, according to all projections, will become significantly more bleak in the next few years. In the United States alone, as many as 270,000 cases of AIDS may exist by 1991.[28] A substantial number of non-medical people and institutions devote themselves exclusively to the AIDS problem. There exist operators of shelters for persons with AIDS; counselors of persons with AIDS and their friends and families; and lawyers dealing with all aspects of the AIDS problem (such as estate planning for persons with AIDS, litigation aimed at ending discriminatory practices, and so on). When

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derreporting is attributable to political, economic, and medical reasons. *See, e.g.*, First Penn-Pacific Life Ins. Co. v. Mock, No. 85 C 6432, slip. op. at n.3 (N.D. Ill. Feb. 11, 1986); ALTMAN, *supra* note 1, at 15, 24, and 174; *Doctors Cite Stigma of AIDS In Declining to Report Cases*, N.Y. Times, May 27, 1986, at 1, col. 1; *Deaths unreported in Calif.*, Windy City Times, Feb. 27, 1986, at 4, col. 4 (more than ⅓ of the deaths of married men may go unreported); Letter from Manfred Byrd, Jr., Windy City Times, Jan. 9, 1986, at 9, col. 2 (describing a case where "[t]he cause of death listed on his death certificate is cardiorespiratory arrest. However, AIDS was listed as a contributing factor in his death"). People do not die of AIDS itself. Those who contract AIDS will die of an opportunistic infection such as *pneumocystis carinii* pneumonia.

25. *Doctors Cite Stigma of AIDS In Declining to Report Cases*, N.Y. Times, May 27, 1986, at 1, col. 1.

26. *See supra* note 1 and accompanying text.

27. *See* Giteck, *The Coffin as Closet*, Advocate, July 8, 1986, at 5, col. 1; *A Designer's Death: AIDS and the fashion industry*, Newsweek, June 9, 1986, at 25, col. 2.

28. *Tenfold Increase In AIDS Death Toll Is Expected by '91: Illness Likely to Rise Among Heterosexuals and Spread in Nation, U.S. Predicts*, N.Y. Times, June 13, 1986, at 1, col. 3; *PHS projects 270,000 cases of AIDS reported by 1991*, Washington Blade, June 13, 1986, at 3, col. 1. *See also Rise in AIDS Virus Infection Is Detected*, N.Y. Times, June 26, 1986, at 11, col. 1. Other predictions for the United States placed the number as high as 400,000 by 1990. *"Sterben, bevor der Morgen graut:" Aids und die grossen Seuchen*, Der Spiegel, Sept. 23, 1985, at 76, 85. The worldwide total of those exposed to the HTLV-III virus may reach 50,000,000 by 1990. *Id.*

the substantial number of medical people and institutions are added to the list, the AIDS industry is massive. This industry will have to grow as the disease spreads. At least two phenomena almost necessarily correlate with this observation. One is that wherever there is big business, there are unscrupulous people. Con artists will bilk persons with AIDS, and their families and friends, with unfounded claims of cures, of tests for AIDS, and of life-extending drugs and treatments.[29] Exhorbitant charges will be extracted from desperate people.[30] The second point is our next observation.

Fourth, the public at large will pay for the cost of the AIDS problem. The public will pay directly the costs for the many persons with AIDS who do not have sufficient health insurance coverage or who cannot afford to pay the high price of caring for those with AIDS. For the first 10,000 cases of AIDS, the hospital costs averaged an estimated $147,000 per person nationally.[31] Taxpayers are paying for all of the government sponsored research and testing of vaccines and potential treatments for AIDS.[32] Taxpayers are paying for all of the HTLV-III antibody testing conducted by government, including all antibody testing of military recruits and personnel.[33]

Indirectly, the public will pay in innumerable other ways. The

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29. Ritzert, *Wenn AIDS zum Geschäft wird: Zweifelhafte Empfehlungen für Verzweifelte*, 128:10 MÜNCHNER MEDIZINISCHE WOCHENSCHRIFT 20, 20-21 (1986). *See also* Chase, *The AIDS Business*, Wall St. J., June 26, 1986, at 1, col. 6. Premature claims of treatments and cures have been all too common. Numbers of PWAs have traveled to France, Mexico, the Phillipines, and other countries in search of the hope for a cure, unfortunately to no avail. *See, e.g.*, ALTMAN, *supra* note 1, at 88-89.

30. *See, e.g., Manufacturer Cuts Price of AIDS Drug Ribavirin in Mexico*, Advocate, June 10, 1986, at 20, col. 1 (reducing price of an antiviral drug which previously jumped to three times its purchase price after studies suggested that the drug might be capable of blocking HTLV-III).

31. Hardy, Rauch, Echenberg, Morgan, & Curran, *The Economic Impact of the First 10,000 Cases of Acquired Immunodeficiency Syndrome in the United States*, 255 J. A.M.A. 209, 210 (1986); *AIDS care costs are target of study*, Am. Med. News, Jan. 10, 1986, at 37, col. 1. Regional figures vary widely. In San Francisco, for example, community services and volunteers have lessened the average cost to only $40,000 per patient. Rita Fahrner, Speech at the Health Law Institute of the DePaul University College of Law (Apr. 11, 1986). Costs could be cut by offering less costly and more appropriate home-based care, instead of hospitalization in all instances. *See New York plans outpatient AIDS care*, Am. Med. News, Jan. 10, 1986, at 32, col. 1. *See also Insurance: Industry Tries to Cut Cost of Care*, 1 AIDS POL'Y & L. (BNA) No. 9, at 6 (May 21, 1986).

32. *See Cost of AIDS Care and Who Is Going to Pay: Hearing Before the Subcomm. on Health and the Environment of the House Comm. on Energy and Commerce*, 99th Cong., 1st Sess. 203 (1985)(one of three hearings on AIDS issues compiled in Serial No. 99-45); *U.S. House votes AIDS $ increase*, Windy City Times, June 6, 1986, at 5, col. 1 ($346 million AIDS budget approved); *$41 Million Rescission Asked in 1986; Reagan Requests $213 Million for 1987*, 1 AIDS POL'Y & L. (BNA) No. 2, at 1 (Feb. 12, 1986); *AIDS research funding increased by Congress*, Am. Med. News. Jan. 10, 1986, at 9, col. 1.

33. *Congress and AIDS funding*, Windy City Times, May 22, 1986, at 4, col. 3 (Military spending more than $52 million on antibody testing).

public will pay higher insurance premiums for life and health insurance caused by so many thousands of people dying prematurely after long and expensive periods of medical care. Insurance companies can only pass the costs of AIDS coverage on to others.[34] The cost of medical care will rise for all of us, as public and private providers absorb losses sustained from the unpaid bills of persons with AIDS and pass them along to others. Not least of all, the public will pay the price of the significant loss of time and talent of the persons who die, of the friends and families who are distracted by the whole agony and process of the death, and of the medical and other support professionals who are struggling to solve the mystery of AIDS and to care for those afflicted when those professionals could be concentrating on other medical problems.

Fifth, AIDS is a fatal disease, and there may well never be a cure, although a vaccine to prevent the spread of AIDS may be found.[35] Even though figures show that fewer than all of the persons with AIDS have died, the only reason is that those still living have simply not yet had time to die. Part of the reason for reporting figures showing that AIDS is not a 100% fatal disease is undoubtedly to encourage persons with AIDS to have hope for a cure and to fight the disease, and this reason is commendable. Human dignity must be preserved even if human life cannot be.[36] But, the reality is that everyone with full-blown AIDS will die within a relatively short period of time, usually within five years of being diagnosed as having AIDS. A virus causes AIDS, and medical science has been relatively impotent in the face of viral infections.[37] We cannot cure hepatitis; we cannot cure the common cold. At best, we can hope to discover a vaccine against the spread of the disease, but even that

34. Additionally, the insurance industry can take positive steps to reduce medical costs without reducing the quality of care. *Insurance: Industry Tried to Cut Cost of Care*, 1 AIDS POL'Y & L. (BNA) No. 9, at 6 (May 21, 1986).

35. Fischinger & Bolognesi, *Prospects for Diagnostic Tests, Intervention, and Vaccine Development in AIDS*, in AIDS: ETIOLOGY, DIAGNOSIS, TREATMENT, AND PREVENTION 55, 68-72 (V. DeVita, S. Hellman, & S. Rosenberg, eds. 1985); Francis & Petricciani, *The Prospects for and Pathways toward a Vaccine for AIDS*, 313 NEW ENG. J. MED. 1586, 1590 (1985); *Vaccine takes its 'very first steps'*, Chicago Trib., June 24, 1986, § 1, at 4, col. 4; *U.S. researcher says success of vaccine for disease 'slight,'* Dallas Times Herald, June 24, 1986, § A, at 1, col. 5; *Prototype Vaccine For AIDS Is Said to Offer Promise*, Wall St. J., June 23, 1986, at 6, col. 4; *Vaccine breakthrough reported*, Windy City Times, June 5, 1986, at 5, col. 1; *Medical Update: Progress Reported On AIDS Vaccine*, 1 AIDS POL'Y & L. (BNA) No. 10, at 6 (June 4, 1986).

36. Engelhard & Billie, *AIDS: A Killer Confined—AIDS victims need help from the OR staff but fear can block the availability of that help, reprinted in* HEALTH LAW INSTITUTE, DEPAUL UNIVERSITY COLLEGE OF LAW, AIDS: MEDICAL, LEGAL, ETHICAL, AND SOCIAL DIMENSIONS OF A HEALTH CRISIS 313, 316 (1986). *See also Health Care: Hospice Official Sees Conflicting Needs for AIDS Patients*, 1 AIDS POL'Y & L. (BNA) No. 10, at 4 (June 4, 1986).

37. Bayer, *The AIDS Crisis*, 11 J. HEALTH POL., POL'Y & L. 171, 172 (1986).

eventuality is years away. Further, it may be that, as with the hepatitis B vaccine, the vaccine will have to be administered to each person over a period of time with the consequence that the vaccine will not be fully effective until the end of the innoculation process. Additionally, the fact that few vaccines are 100% effective may make drug companies reluctant to market a vaccine because of the possibility of lawsuits.[38]

Although full-blown AIDS is invariably fatal, infection with the HTLV-III virus may result in a wide range of outcomes in any individual. Some who have been exposed to HTLV-III may develop AIDS, some may develop a milder, non-fatal form of infection known as AIDS-related complex (ARC), some may develop generalized lymphadenopathy syndrome, but most will develop no disease at all.[39] Current medical evidence has failed to show any form of casual transmission of the virus, and AIDS cannot be considered a "contagious disease" as defined in most medical arenas.[40]

A consequence of the inevitable fatality of full-blown AIDS is that many who are the victims of discrimination will not have the strength to press lawsuits. The high costs of medical treatment also encourages persons with AIDS to settle their discrimination cases rather than litigate test cases to establish precedent which might benefit others. This accounts, in part, for the relatively small number of cases litigated to date with regard to persons with full-blown AIDS. A different situation exists with those who merely possess antibodies to HTLV-III, however. These people will remain healthy, and will have the physical strength to fight legal battles in the courtrooms.

Sixth, homophobia, which is an unreasonable fear of homosexuality, has further exacerbated anxieties associated with AIDS. Because many who do not understand the medical aspects of AIDS are consequently frightened about the disease, there may be a tendency for people to focus this fear on the issue of homosexuality. For a significant number of Americans, homosexuality remains a religious and moral issue.[41]

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38. *Vaccine questions raised*, Windy City Times, May 1, 1986, at 27, col. 1.

39. Wong-Staal, Shaw, Hahn, Salahuddin, Popovic, Markham, Redfield, & Gallo, *Genomic Diversity of Human T-Lymphotropic Virus Type III (HTLV-III)*, 229 SCIENCE 759, 762 (1985).

40. Sande, *Transmission of AIDS: The Case against Casual Contagion*, 314 NEW ENG. J. MED. 380 (1986).

41. Viele, Dodd, & Morrison, *Caring for Acquired Immune Deficiency Syndrome Patients*, 11 ONCOLOGY NURSING F. 56, 57 (May-June 1984). *See also* M.V.R. v. T.M.R., 115 Misc. 2d 674, 681, 454 N.Y.S.2d 779, 783 (Sup. Ct. 1982)("judges themselves are frequently not free from anti-homosexual preferences"); *Survey on the Constitutional Right to Privacy In the Context of Homosexual Activity*, 40 U. MIAMI L. REV. 521, 525 (1986) ("Judeo-Christian opposition to homosexuality derives from the lengendary account in Genesis of the fire and brimstone destruction of Sodom

AIDS is not punishment for gay men because of any "sexual preference."[42] The gay rights movement has been seriously hampered because many people consider "choosing" to be gay a decadent, deviant decision. Very few people consciously exercise a true sexual "preference" to be gay or bisexual. Ask a heterosexual individual whether he or she would consider having sex with a person of the same gender. The answer is likely to be instantaneous and firmly negative. Then, ask the same individual whether he or she made a conscious choice, or whether something inherent caused the reaction. The point is that, just as heterosexuals do not weigh the issues and decide to be heterosexual, gays and bisexuals do not choose their affectional identity.[43] The phrases "sexual orientation" and "affectional identity" would be preferable.[44]

Because gay and bisexual people have not chosen their orientation, the mere status of being gay or bisexual does not justify punishment. Even if some gay and bisexual people do engage in immoral and illegal conduct with regard to sex, drugs, or alcohol, so do heter-

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and Gomorrah"). In the child visitation case discussed *infra* at notes 300-04, Judge John Beatty recused himself because he stated that he could not be unbiased toward gay people. Advocate, July 8, 1986, at 26, col. 2; Burks, *Cook County Judge refuses case involving gay father,* Windy City Times, June 5, 1986, at 1, col. 3; *Gay Father's Refusal of Test Reviewed by Fourth Judge,* 1 AIDS POL'Y & L. (BNA) No. 10, at 3 (June 4, 1986); Tybor, *Judge refuses to hear case, cites gay's lifestyle,* Chicago Trib., May 29, 1986, § 2, at 1, col. 2. In a poll conducted for the Christian Broadcast Network, 50% of the 518 surveyed thought that homosexuality was a sin, and 21% thought that AIDS was a punishment from God. *Gallup poll: Test country for AIDS,* Windy City Times, Jan. 9, 1986, at 2, col. 2; *Gallup's finding: Test nation for AIDS,* Chicago Trib., Jan. 3, 1986, § 1, at 16, col. 3.

> Professor Jacques Ruffie of the College de France, Paris, has written that: Even from a moral viewpoint this ridiculous attitude toward AIDS transmission is condemnable. An ill-informed public can easily combine AIDS and homosexuality. When, in New York, I told the parents of a boy whom they had withdrawn from school that their son ran no greater risk of infection in his classroom than in the subway or a restaurant, they answered, "But he could have been influenced by the infected student and become a homosexual." The infected student, who had received a blood transfusion in connection with an operation, was seven years old! I think about the child who, for the rest of his life, will be labelled on the suspicion that he is dangerous and of the deep degredation he will experience and which is impossible to correct.

Ruffie, *AIDS: Punishment from the Gods?,* Windy City Times, Apr. 24, 1986, at 11, col. 1, 4 (translated from Dagens Nyheter, Stockholm, Mar. 23, 1986).

42. One writer in Washington, D.C. states that:

> Those who see divine retribution in AIDS should remember several facts:
> (A) All the available evidence indicates that AIDS originated in central Africa, where it primarily affects heterosexuals;
> (B) Lesbians are at lower risk for AIDS than any other group, which disproves any theory of "punishment for homosexuality"; and
> (C) Most importantly, AIDS is caused by a virus. It is not caused by a lifestyle.

Cunat, *AIDS is not divine retribution,* Washington Blade, June 13, 1986, at 21, col. 4.

43. *See, e.g.,* NATIONAL LAWYERS GUILD, SEXUAL ORIENTATION AND THE LAW 1-93 (1985).

44. For a historical discussion on the social effect of terminology, see Herzer, *Kertbeny and the Nameless Love,* 12 J. HOMOSEXUALITY 1 (1985).

osexual persons. More importantly, agonizing death is hardly the appropriate sanction. Furthermore, there is no evidence that AIDS has been restricted to individuals guilty of some kind of transgression.

The HTLV-III virus is an indiscriminate virus which strikes without regard to sexual identity or affectional orientation. It is not selective on a moral basis. Likewise, when people outside an initial risk group are unfortunate enough to contract AIDS, they cannot be characterized as the only "innocent victims" of the AIDS crisis. Additionally, persons with AIDS are always persons. This article makes a conscious effort to avoid phrases such as "AIDS victim" and "patient with AIDS" in favor of the term "person with AIDS," or PWA. This is the term which persons with AIDS themselves use, and it better reflects both the medical and legal status of those individuals. PWAs will allow themselves to be called patients only when they are hospitalized.[45] This article also avoids use of the term "intravenous drug abuser," in favor of the non-judgmental term "intravenous drug user."[46] Any effort to extend the much-needed health education to this group will not be helped by using terminology which makes a moral judgment and thus alienates those at risk. Self-injected use of intravenous drugs must be distinguished from medically-supervised uses of intravenous drugs. Those in hospitals and doctors' offices will not be exposed to unsterilized needles, and therefore are not included in the term "intravenous drug users" for the purposes of this article.

Finally, the AIDS crisis is providing an excuse for some anti-gay individuals and groups to further their aims. Under the guise of concern for public health, such people and groups hope to suppress the gay community. That was their agenda before the AIDS crisis, and they are enlisting some additional support because of the crisis.[47] We must be cautious because, without a cure or vaccine, AIDS control is really people control.[48] The only way to prevent the sexual transmission of the disease known as AIDS is to modify behavior, but sexual behavior only. The only effective way to influence sexual conduct is through education, not suppression of the gay

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45. Viele, Dodd, & Morrison, *Caring for Acquired Immune Deficiency Syndrome Patients*, 11 ONCOLOGY NURSING F. 56, 58 (May-June 1984).

46. In this regard, the authors were influenced by a speech by Dennis Altman at Cook County Hospital in Chicago (Feb. 3, 1986). *See also* ALTMAN, *supra* note 1, at 24.

47. Meislin, *AIDS Fears Said to Increase Prejudice Against Homosexuals*, N.Y. Times, Jan. 21, 1986, at 12, col. 1. One extreme example arose in the state of Washington, where petitions were filed for a referendum which would make illegal the hiring of gays and lesbians in that state. *Washington state referendum struck down by court*, Windy City Times, June 5, 1986, at 4, col. 3.

48. Speech by Paul Varnell at The John Marshall Law School Seminar, *A Beginner's Guide to Medical and Legal Issues in the AIDS Crisis* (Apr. 19, 1986).

community.[49]

Until the time when education prevails over irrational fear and political manipulation, constitutional rights, including the right to privacy, must be used to protect PWAs and individuals perceived to be at risk for AIDS. Indeed, the issue of privacy in serologic testing will be the single most important privacy issue of this decade.[50]

III. Medical Background

Any rational resolution of the issues involved with AIDS and HTLV-III blood testing will ultimately turn on a thorough understanding of the medical issues involved. Much of this information develops quickly, and new medical announcements appear on almost a daily basis.[51]

A. *Scope of the AIDS Crisis*

In May of 1981, the first reports of what appeared to be a relatively new disease of the immune system were described.[52] The acquired immune deficiency syndrome (AIDS) has since become the major public health concern and primary focus of medical research of this decade. While the unique clinical manifestations of the disease allowed early recognition of a distinct entity, much confusion remains as to an accurate and acceptable definition of the syndrome.[53] Currently AIDS is described as the occurence of a disease

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49. Rhonda Rivera, Associate Dean of the Ohio State University Law School, has framed the question: "Will the American response to AIDS be the ultimate test of our system as a democracy and bastion of secular individualism?" Speech at the Health Law Institute of the DePaul University College of Law (Apr. 12, 1986).

50. One companion issue to HTLV-III antibody testing may be found in random urinalysis tests to detect drug use. *See Legality of employee drug tests eyed at conference,* Des Moines Register, May 31, 1986, § S, at 6, col. 2. Another companion issue may be found in polygraph testing. *Lie detectors can zap your job hopes,* Chicago Sun-Times, June 4, 1986, at 37, col. 1; *cf.* Comment, *The Polygraph and Internal Police Investigations: When Will Illinois Lawmakers Side with the Citizen to Identify Instances of Police Misconduct?,* 19 J. Marshall L. Rev. 431 (1986). Like HTLV-III antibody testing, both urinalysis and polygraph testing have inherent, substantial margins of error which make reliance upon these tests questionable. Although neither urinalysis nor polygraph testing is discussed in this article, the constitutional analysis of those tests may parallel the analysis of HTLV-III antibody testing.

51. This phenomenon has been called the "Research Discovery of the Day Club." Kristine Gebbie, Speech at the Health Law Institute of the DePaul University College of Law (Apr. 11, 1986).

52. Gottlieb, Schroff, Schanker, Weisman, Fan, Wolf, & Saxon, *Pneumocystis Carinii Pneumonia and Mucosal Candidiasis in Previously Healthy Homosexual Men: Evidence of a New Acquired Cellular Immunodeficiency,* 305 New Eng. J. Med. 1425, 1428-30 (1981).

53. Council on Scientific Affairs, *Status Report on the Acquired Immune Deficiency Syndrome: Human T-Cell Lymphotropic Virus Type III Testing,* 254 J. A.M.A. 1342, 1342-45 (1985). In Dassey, *AIDS and Testing for AIDS,* 255 J. A.M.A. 743 (1986), Dr. David Dassey points out that there is a difference between AIDS and

predictive of a cell-mediated immune dysfunction in a person with no known reason for such a dysfunction. More specifically, the occurence of at least one life-threatening opportunistic infection[54] or the development of certain malignant tumors is required before a patient may be categorized as having AIDS.[55] The definition is a clinical one.

As of June 9, 1986, there had been 21,517 cases of AIDS reported to the CDC.[56] Of these cases, there have been 11,713 deaths attributed to AIDS in the United States alone.[57] Extrapolating from the number of reported cases of AIDS, the CDC further estimates that there are approximately 200,000 cases of ARC,[58] and that 500,000 to 1,000,000 individuals may be currently infected with the HTLV-III virus presumed to be the cause of AIDS.[59] A recent study from New York City cited AIDS as the leading cause of death in males aged 30 to 39 years, the second leading cause of death among women aged 30 to 34 years, and among the five leading causes of death in all New York City males aged 25 to 54 years.[60]

HTLV-III disease in response to the Council on Scientific Affairs report. He emphasizes that the criteria for diagnosing AIDS were chosen on purely epidemiological grounds rather than being based on strictly medical data.

54. Opportunistic infections are those produced by organisms which do not affect people whose immune systems are working properly. UNITED STATES DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES, NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES, UNDERSTANDING THE IMMUNE SYSTEM 12 (1985)(National Institutes of Health Pub. No. 85-529).

55. Centers for Disease Control, *Update on Acquired Immune Deficiency Syndrome (AIDS)—United States*, 31 MORBIDITY & MORTALITY WEEKLY REP. 507, 513 (1982).

56. N.Y. Times, June 13, 1986, at 1, col. 3.

57. *Id.*

58. *Id.* AIDS-related complex (ARC) appears to be a closely related but milder form of infection that develops in people exposed to the HTLV-III virus. Researchers are uncertain as to whether persons may develop ARC alone or whether ARC preceeds the development of "full-blown" AIDS. Further follow-up studies will be necessary to settle this issue. *See* Killen, *AIDS-Related Complex: A Definition*, AIDS MEMORANDUM 1, 4 (1984)(more information on ARC).

59. Curran, Morgan, Hardy, Jaffe, Darrow, & Dowdle, *The Epidemiology of AIDS: Current Status and Future Prospects*, 229 SCIENCE 1352 (1985). Exposure to HTLV-III does not equate with AIDS, nor does it equate with ARC. In an otherwise excellent survey on the right of privacy, it was incorrectly reported that "[r]esearchers estimate that 500,000 to 1,000,000 Americans have ARC." *Survey on the Constitutional Right to Privacy In the Context of Homosexual Activity*, 40 U. MIAMI L. REV. 521, 628 (1986)(citing a telephone conversation). This number, again, relates to the number of people who may have been exposed to the HTLV-III virus, not the number of persons with ARC. *See, e.g*, District 27 Community School Bd. v. Board Educ. of the City of New York, No. 14940/85, slip. op. (S. Ct. Queens County Feb. 11, 1986); *Tenfold Increase in AIDS Death Toll is Expected by '91: Illness Likely to Rise Among Heterosexuals and Spread in Nation, U.S. Predicts*, N.Y. Times, June 13, 1986, at 1, col. 3. The highest estimated number to date comes from doctors at New York Medical College, who estimated that 1,765,470 individuals have been exposed to the HTLV-III virus. Sivak & Wormser, *How Common Is HTLV-III Infection in the United States?*, 313 NEW ENG. J. MED. 1352 (1985).

60. Kristal, *The Impact of the Acquired Immunodeficiency Syndrome on Pat-*

B. *Epidemiology*

The recognition of any new disease entity derives from and is understood through accurate and precise epidemiological data. AIDS is perhaps one of the best examples of this statement. The earliest reports of a new epidemic included the description of a rare pneumonia and a rare type of cancer among gay men.[61] These reports also included descriptions of frequent use of inhalent drugs and some use of intravenous drugs.[62] The majority of case reports were received from New York and California, areas with high populations of gay and bisexual males and intravenous drug users.[63]

The emerging picture was clearly compatible with the development of a new disease entity. The geographical distribution and apparent "selection" of certain populations to be affected was highly suggestive of a transmissible agent as the cause. The prevalence of AIDS in the gay male population pointed to sexual contact as a feasible mode of transmission. Indeed, early studies found that increased numbers of sexual partners and promiscuity correlated well

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terns of Premature Death in New York City, 255 J. A.M.A. 2306, 2306-10 (1986). *See also* Freiberg, *AIDS Is Leading Cause of Death in New York City*, Advocate, June 10, 1986, at 20, col. 1; Altman, *AIDS Cases in U.S. Expected to Rise: Official Also Tells Conference That More Areas of Nation Are Reporting Disease*, N.Y. Times, May 7, 1986, at 6, col. 1; Eckholm, *Number of AIDS Cases Up Sharply in New York City*, N.Y. Times, Apr. 25, 1986, at 1, col. 5; *"Sterben, bevor der Morgen graut:" Aids und die grossen Seuchen*, Der Spiegel, Sept. 23, 1985, at 76, 84.

61. The pneumonia was shown to be caused by *pneumonocystis carinii*, a parasite that only causes infection in persons with weakened immune systems. One of the drugs used to treat this pneumonia is pentamidine and is available only from the CDC. After receiving several requests for the drug, investigators began to look for a common association among the patients. Frequent homosexual contacts and parenteral (intravenous) drug use emerged as common denominators among several of the patients. *See* Centers for Disease Control, *Pneumocystis pneumonia—Los Angeles*, 30 MORBIDITY & MORTALITY WEEKLY REP. 250, 250-52 (1981). The rare cancer was shown to be Kaposi's sarcoma, a malignant tumor of blood vessel cell origin occuring in the skin, lymph nodes, or other organs. Prior to the outbreak of the AIDS epidemic, the disease was seen mainly in elderly men of Mediterranean extraction. Purdy, Colby, Yousen, & Battifora, *Pulmonary Kaposi's Sarcoma*, 10 AM. J. SURGICAL PATHOLOGY 301, 301 (1986). However, African children and young adults have been shown to have a higher incidence of Kaposi's sarcoma. There are also several reports of persons with weakened immune systems or kidney transplants who subsequently develop Kaposi's sarcoma. Penn, *Kaposi's Sarcoma in Organ Transplant Recipients*, 27 TRANSPLANTATION 8, 10 (1979); Gange & Jones, *Kaposi's sarcoma and immunosuppressive therapy: an appraisal*, 3 CLINICAL AND EXPERIMENTAL DERMATOLOGY 135, 135-46 (1978). In 1981, the CDC reported on the development of Kaposi's sarcoma in 26 gay men, several of whom also had serious pneumonia diagnosed. Centers for Disease Control, *Kaposi's Sarcoma and Pneumocystis Pneumonia Among Homosexual Men—New York City and California*, 30 MORBIDITY & MORTALITY WEEKLY REP. 305, 305-08 (1981).

62. Centers for Disease Control, *Pneumocystis Pneumonia—Los Angeles*, 30 MORBIDITY & MORTALITY WEEKLY REP. 250, 250-52 (1981).

63. Centers for Disease Control, *Kaposi's Sarcoma and Pneumocystis Pneumonia Among Homosexual Men—New York City and California*, 30 MORBIDITY & MORTALITY WEEKLY REP. 305, 305-08 (1981).

with the development of AIDS.

The incidence[64] of AIDS in heterosexual intravenous drug users was also reported about 1981. The common practice of sharing contaminated needles is thought to explain the appearance of AIDS in this group.[65] The possibility of a blood-borne agent became a central focus of attention. If intravenous drug users developed AIDS through contaminated blood, what about other patients exposed to large amounts of transfused blood?

In 1982 the CDC reported the development of AIDS in patients with hemophilia.[66] Hemophilia is a disorder of the blood clotting system due to an inadequate amount of various clotting factors. Treatment involves transfusions of the missing factor which is obtained from donated blood. While hemophiliacs represent a group which receives multiple blood transfusions other persons who received blood transfusions have also developed AIDS. Yet, of the millions of blood transfusions each year, only about 300 cases of transfusion-related AIDS have been reported.[67]

There is currently much controversy over the inclusion of persons with Haitian ancestry or nationality as a risk group for AIDS. Part of this controversy may stem from the strong cultural taboo in Haiti against homosexuality. Still, an approximately 40 times higher incidence of AIDS has been reported in Haitian immigrants who entered the United States after 1978 than those who entered the United States before 1978.[68] Careful examination of the Haitian population and intravenous drug users has shown that newborn chil-

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64. "Incidence" is a medical term to denote a specific number of cases which arise within a specific time period.

65. The practice of sharing needles developed from the unavailability of clean needles for intravenous drug users. In the drug culture, the sharing of a needle came to have a strong emotional value. *See Education, not free needles, can halt AIDS spread,* Am. Med. News, Jan. 10, 1986, at 42, col. 1.

66. Centers for Disease Control, *Pneumocystis Carinii Pneumonia among Persons with Hemophilia A,* 31 MORBIDITY & MORTALITY WEEKLY REP. 365 (1982).

67. Most of the AIDS-related complications have occured with the transfusion of whole blood or several different components of blood, including contaminated immune gamma-globulin. There is also a correlation between the number of units transfused and the likelihood of developing AIDS. Transfusion-associated AIDS accounts for less than 2% of the cases of AIDS in the United States. The routine screening of blood for antibody to HTLV-III will most likely eliminate blood transfusions as a mode of transmission for AIDS. Curran, Jaffe, Kaplan, Zyla, Chamberland, Weinstein, Lui, Schonberger, Spira, Alexander, Swinger, Ammann, Solomon, Auerbach, Mildvan, Stoneburner, Jason, Haverkos, & Evatt, *Acquired Immune Deficiency Syndrome Associated With Transfusions,* 310 NEW ENG. J. MED. 69 (1984); Steele, *HTLV-III Antibodies in Human Immune [Gamma]-Globulin,* 255 J. A.M.A. 609 (1986).

68. Hardy, Allen, Morgan, & Curan, *The Incidence Rate of Acquired Immunodeficiency Syndrome in Selected Populations,* 253 J. A.M.A. 215 (1985). It should be stressed, however, that no evidence has ever arisen to suggest that Haitians are biologically more susceptable to contracting AIDS.

dren may be exposed to AIDS if the mother is infected.[69] Sexual transmission among heterosexual partners has also been documented,[70] and current opinion includes sexual partners of members from a high risk group as being at risk of developing AIDS themselves.

From the epidemiological data and medical research that has been conducted, certain conclusions can be drawn with respect to the initial groups that are perceived to be at increased risk of exposure to HTLV-III:[71]

> 1) all men who have had unsafe sexual contact with another man as far back as 1977;[72]2) persons sharing hypodermic needles, especially for self-injected intravenous drug use, but also for other purposes, such as tatooing;[73]3) persons with clinical or laboratory evidence of infection (symptoms of AIDS);
> 4) persons born in countries where heterosexual transmission is thought to play a major role, such as in Haiti and some central African nations;[74]5) male and female prostitutes and their sex partners;[75]

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69. Goedert & Blattner, *The Epidemiology of AIDS and Related Conditions*, in AIDS: ETIOLOGY, DIAGNOSIS, TREATMENT, AND PREVENTION 1, 21 (V. DeVita, S. Hellman, & S. Rosenburg eds. 1985); Rubenstein, Sicklick, Gupta, Bernstein, Klein, Rubinstein, Spigland, Fruchter, Litman, Lee, & Hollander, *Acquired Immunodeficiency with Reversed T4/T8 Ratios in Infants Born to Promiscuous and Drug-Addicted Mothers*, 249 J. A.M.A. 2350 (1983); Thomas, Jaffe, Spira, Reiss, Guerrero, & Auerbach, *Unexplained Immunodeficiency in Children*, 252 J. A.M.A. 639 (1984).

70. There are several articles on heterosexual transmission of AIDS. There is also a reportedly high incidence of AIDS among female prostitutes who are thought to be exposed from bisexual male customers or male customers exposed from self-injection of intravenous drugs. Calabrese & Gopalakrishna, *Transmission of AIDS From Man to Woman to Man*, 314 NEW ENG. J. MED. 987 (1986)(additionally noting that other household members were not exposed to the HTLV-III virus); Centers for Disease Control, *Heterosexual Transmission of Human T-Lymphotropic Virus Type III/Lymphadenopothy-Associated Virus*, 34 MORBIDITY & MORTALITY WEEKLY REP. 561, 561-63 (1985); Polk, *Female to Male Transmission of AIDS*, 254 J. A.M.A. 3177-78 (1985).

71. This list was compiled from the numerous medical reports available. Some of the specific language differs from that used by the Centers for Disease Control, for example, the inclusion of the word "unsafe" to describe the male-to-male sexual contact in point number one. The CDC has always stated that any male-to-male contact will put a person at increased risk, though the CDC repeatedly states that the HTLV-III virus can only be transmitted by specific bodily fluids—blood and semen. The normal CDC language then, of any male-to-male sexual contact since 1977, is over-inclusive. The characterization presented here is thus medically justifiable rather than politically motivated.

72. The date is derived from the long incubation period of AIDS and the introduction of the virus to the United States around that time. The term "safe sex" refers to activities such as rubbing, kissing, hugging, and sexual activities which do not involve the exchange of blood or semen. The term "unsafe sex," conversely, refers to activities where blood and semen are exchanged, such as unprotected anal intercourse.

73. *Id.* Black, Dolan, DeFord, Rubenstein, Penk, Robinowitz, & Skinner, *Sharing of Needles Among Users of Intravenous Drugs*, 314 NEW ENG. J. MED. 446 (1986). Tatooing needles are shared in prisons. Glasbrenner, *Prisons confront dilemma of inmates with AIDS*, 255 J. A.M.A. 2399 (1986).

74. For example, Belgian scientists are convinced that heterosexual sex is the

6) persons who have received untested blood, and blood products, especially hemophiliacs, but excluding hepatitus B vaccine (heptavax), and persons who have received untested donated organs;[76]7) newborn infants of infected mothers;[77] and

8) persons who have had sexual contact with a person with AIDS or a known HTLV-III related condition or infection, and sex partners of persons at increased risk of exposure.[78]

The epidemiology of AIDS has allowed the identification of groups at risk for the disease and paved the way for both the identification of a transmissible agent as the cause of AIDS and information on modes of transmission of the agent. The identification of apparent risk groups affords better clinical management and research directions, but also imposes serious psychological, social, legal, and political dilemmas that remain to be solved. This is because those groups that were initially identified as being at greatest risk were politically unpopular groups,[79] intravenous drug users and gay and bisexual men. The spread of AIDS by heterosexual relations presents additional challenges to medical research, with attending new social, legal, and political dilemmas.[80]

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chief means of AIDS transmission in Rwanda. *Is Nobody Safe From AIDS?*, Economist, Feb. 1, 1986, at 79, 80. Much remains unknown about specific sexual practices in these countries, specifically the frequency of anal intercourse. African nations have excluded foreigners from pursuing any research which would identify their countries as the source of AIDS, in order not to jeopardize their economically vital tourist industries. *Politics blocks study, prevention of AIDS in Africa*, Am. Med. News, Jan. 10, 1986, at 3, col. 1; Altman, *Linking AIDS to Africa Provokes Bitter Debate*, N.Y. Times, Nov. 21, 1985, at 1, col. 1. Following reports of AIDS in Haitian-Americans, tourism in Haiti declined by 20%. Vieira, *The Haitian Link*, in UNDERSTANDING AIDS: A COMPREHENSIVE GUIDE 90, 98 (V. Gong ed. 1985).

75. *Cf.* Eckholm, *Prostitute's Impact on Spread of AIDS is Debated*, N.Y. Times, Nov. 5, 1985, at 15, col. 1.

76. *See* Fincher, de Silva, Lobel, & Spencer, *AIDS-Related Complex in a Heterosexual Man Seven Weeks After a Transfusion*, 313 NEW ENG. J. MED. 1226, 1226-27 (1985). Hepatitus B vaccine is excluded because HTLV-III is destroyed in the purification process. UNITED STATES PUBLIC HEALTH SERVICE, WHAT GAY AND BISEXUAL MEN SHOULD KNOW ABOUT AIDS 13 (1985). *See also* Kato, Iwasaki, Kimura, & Togo, *Hepatitus B Vaccination and AIDS*, 254 J. A.M.A. 53 (1985); Upfal, *The Risk of AIDS After Hepatitus Vaccination*, 253 J. A.M.A. 2960 (1985); Muylle, Vranckx, & Peetermans, *No HTLV-III Antibodies After HBV Vaccination*, 314 NEW ENG. J. MED. 581 (1986).

77. Curran, Morgan, Hardy, Jaffe, Darrow, & Dowdle, *The Epidemiology of AIDS: Current Status and Future Prospects*, 229 SCIENCE 1352, 1355 (1985).

78. *See supra* note 71.

79. These groups have even been described as "politically disposable" because a "mainstream voter" is considered to be removed from gay and bisexual sex and intravenous drug use.

80. *Spread of AIDS Among Women Poses Widening Challenge to Medical Field*, Wall St. J., June 26, 1986, at 5, col. 1; Norwood, *Heterosexuals: A New Risk Group*, Village Voice, May 27, 1986, at 19, col. 1.

C. *The Cause of AIDS*

Epidemiological data support the theory that a transmissible agent is the cause of AIDS.[81] Evidence includes the sudden onset of an apparently new disease, the limited geographical distribution with eventual spread, the occurrence in socially disparate groups prone to infectious diseases, and finding common sexual contacts between affected individuals. A similar pattern of transmission is seen with hepatitus B, known to be caused by a virus. Thus, attention was initially focused on the possibility of a virus as the causative agent of AIDS.

Further studies on patients with AIDS revealed a consistent defect in a particular cell known to be involved in the immune system. Attack of this cell, called the T-helper cell, appeared to be the major underlying defect in persons with AIDS. In the fall of 1982, Dr. Robert Gallo at the National Institute of Health reported the isolation of a virus from persons with AIDS. The virus was a new type of human T cell leukemia [lymphotropic] virus and was called human T cell lymphotropic virus type III (HTLV-III). Simultaneously, Dr. Luc Montagnier and his collegues at the Pasteur Institute in Paris isolated a virus and called it lymphadenopathy associated virus (LAV).[82] While still somewhat controversial, most researchers believe that HTLV-III and LAV are the same virus or mutations of the same virus.[83] Thus, some authors have proposed the use of more neutral terms, such as AIDS-Related Virus (ARV),[84] AIDS-Associated Virus (AAV),[85] AIDS-Associated Retrovirus (ARV),[86] and AIDS Retrovirus (AIDS RV).[87] Recently the International Committee on

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81. Curran, Morgan, Hardy, Jaffe, Darrow, & Dowdle, *The Epidemiology of AIDS: Current Status and Future Prospects*, 229 SCIENCE 1352, 1352 (1985).

82. Dr. Montagnier actually isolated the virus first from patients with a disorder called generalized lymphadenopathy syndrome, which appears to be a milder form of infection with the AIDS virus. Lymphadenopathy refers to swollen lymph nodes which are a primary site of T cells in the body. Dr. Montagnier has since isolated LAV from persons with AIDS. Barre-Sinoussi, Chermann, Rey, Nugeyre, Chamaret, Gruest, Dauguet, Axler-Blin, Vezinet-Brun, Rouzioux, Rozenbaum, & Montagnier, *Isolation of a T-Lymphotropic Retrovirus from a Patient at Risk for Acquired Immune Deficiency Syndrome (AIDS)*, 220 SCIENCE 868 (1983).

83. OFFICE OF TECHNOLOGY ASSESSMENT, CONGRESSIONAL BOARD OF THE 99TH CONGRESS, REVIEW OF THE PUBLIC HEALTH SERVICE'S RESPONSE TO AIDS: A TECHNICAL MEMORANDUM 3 (1985); Barin, McLane, Allan, Lee, Groopman, & Essex, *Virus Envelope Protein of HTLV-III Represents Major Target Antigen for Antibodies in AIDS Patients*, 228 SCIENCE 1094, 1094 (1985).

84. AIDS-Related Virus is the Australian compromise to the battle between France and the United States.

85. Coynik, *Novel Treatment for Kaposi's Sarcoma Reported*, Gay Chicago Mag., June 19-29, 1986, at 30, col. 1.

86. Hoxie, Haggarty, Rackowski, Pillsbury, & Levy, *Persistent Noncytopathic Infection of Normal Human T Lyphocytes with AIDS-Associated Retrovirus*, 229 SCIENCE 1400 (1985).

87. Rabson, Daugherty, Venkatesan, Boulukos, Benn, Folks, Feorino, & Martin,

the Taxonomy of Viruses has recommended the name Human Immunodeficiency Virus (HIV) to avoid unnecessary confusion.[88]

Current evidence overwhelmingly supports the proposal that HTLV-III is the cause of AIDS. The significance of this finding cannot be understated. While there is much confusion about the disease and an apparent failure of the medical community to effectively conquer AIDS, much insight is available about AIDS from a comparison with other viral infections. The close association of patterns between the HTLV-III virus and the hepatitus B virus, for example, may guide research in the control of AIDS.

The viral nature of AIDS has allowed a better understanding of how the disease occurs and has paved the way to develop various screening tests to indicate prior exposure to the virus. Public concern and misplaced hysteria have also added new and serious social, political, legal, and economic dimensions to the management of persons with AIDS, ARC, and those with antibodies to the HTLV-III virus. The public health picture becomes increasingly clear as the pieces of the medical puzzle fall together. Therefore, any policy or public legislation can only be formulated after a careful analysis of the medical facts surrounding AIDS.

D. *How HTLV-III Causes Disease*

In order to better appreciate both the usefulness and limitations of serological testing for HTLV-III antibody, a basic understanding of the immune system and how HTLV-III causes diseases is necessary. The immune system is comprised of that set of cells and organs in the body concerned with recognizing and destroying foreign objects which enter the body. The environment exposes us to a constant bombardment of foreign objects, including microorganisms, viruses, dust, and other particulate matter. The body has a wide range of defense barriers to protect itself from such invasions. The skin, upper respiratory tract secretions, sneezing, coughing, tearing, and acidic stomach fluid are all examples of these defenses. Occasionally, overwhelming numbers of especially aggressive agents break through these defenses. When this happens, the immune system will be activated to handle these intruders.

A foreign object that should not normally be in the body is known as an antigen. The function of the immune system is to rec-

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Transcription of Novel Open Reading Frames of AIDS Retrovirus During Infection of Lymphocytes, 229 SCIENCE 1388 (1985).

88. *A Different Kind of AIDS Fight*, Time, May 12, 1986, at 86, col. 1. The conflict has only added to the confusion and has failed to quell competing egos. The authors have chosen to use the term HTLV-III instead of the more cumbersome HTLV-III/LAV for the sake of ease in reading and possible familiarity to the reader.

ognize, attack, and destroy any antigen. The immune system's response depends on the type of antigen present. Some people will recognize common material, such as dust, pollen, or cat hair, and mount an immune response against those antigens. This is known as an allergic reaction and is controlled by the immune system. Many doctors have evidence that the immune system can recognize and attack cancer cells in the body. These doctors believe that cancer may develop several times during an individual's lifetime, and only when the immune system is weakened or fails does the cancer become detectable. In some situations, the immune system may mistakenly "recognize" normal body cells as being foreign. When these "mistaken" antigens are attacked, disease results. Examples of diseases thought to have a so-called autoimmune basis include rheumatoid arthritis, lupus,[89] and Goodpasture's syndrome.[90]

Perhaps the most well-known role of the immune system is in its ability to recognize and attack invading microorganisms, such as bacteria, viruses, parasites, and fungi.[91] Each cell in the immune system plays a unique role in the recognition, destruction, and memory[92] of an immune attack on an invading microorganism. The cells of the immune system and their functions are characteristically divided into two closely related but distinct systems, the humoral immune system and the cellular immune system.

Broadly speaking, the humoral immune system is involved in protecting against bacterial invaders. The major cell of the humoral immune system is the B cell, which is thought to be derived from the bone marrow and is found in lymph nodes, the spleen, and other immunological tissue. When activated, the B cell is transformed into a plasma cell which is capable of producing substances known as antibodies. Each stimulated plasma cell produces antibodies against a single target. The target for the antibody is an antigen which has

89. Lupus is more fully known as systemic lupus erythematosus (SLE).

90. Goodpasture's syndrome is a disease that primarily affects young males and is thought to be due to an immune attack of both the lungs and the kidneys. While the disease may sometimes be controlled with steroids, dialysis, or kidney transplants, many of these patients ultimately die of kidney failure.

91. Bacteria, parasites, and fungi are all lower classed organisms that may infect numerous higher animals and plants and thus cause a wide range of diseases. Viruses are unique simplified units of genetic material and protein that are known to infect plants, animals, parasites, fungi, and bacteria. Viruses also cause a wide range of diseases in humans, including chicken pox, polio, hepatitus, the common cold, and most recently, AIDS. Viruses have also been implicated as playing a role in multiple sclerosis and diabetes in children. Viruses are known to cause cancer in animals, although the search for a cancer-causing virus in humans has been unsuccessful thus far.

92. The memory function of the immune system is referred to as immunity. Certain cells are known as memory cells and occur in response to most antigens. These cells remain in the body producing a much more rapid and efficient response the next time the original antigen gains entrance to the body. Thus, with an intact immune system, a person is protected from future infection by the same organism.

gained entrance to the body and triggered an immune response. The antibody is a molecule that seeks out the antigen, combines with the antigen, and the "leads" the antigen to its destruction by other cells of the immune system.[93]

The cellular immune system is chiefly regulated by T cells and is essentially involved in protection against viruses, fungi, and parasites. While certainly an oversimplification, persons with defects in the cell-mediated[94] immune system would, therefore, be expected to have difficulty in fighting off infections by viruses, fungi, and parasites. This is the case with AIDS, and thus the cellular immune system is the major site of attack for the HTLV-III virus.

T cells are derived from the thymus[95] and are found throughout the body, being especially populous in lymph nodes and the blood stream where they are constantly "looking" for foreign invaders. Although there are now known to be many subsets of T cells, the fight against infection seems to be activated by special cells called T-helper cells. Once these cells have initiated an immune response, the response is "turned off" by T-suppressor cells. The HTLV-III virus preferentially attacks and destroys T-helper cells. The resultant excess of T-suppressor cells shuts down any immune response and allows foreign invaders to attack unchallenged.

The result of this over-suppression of the cell-mediated immune system is the inability to combat infection, particularly with viruses, fungi, and parasites. Normally, people are exposed to a wide range of such agents and, with an intact immune system, can effectively prevent discernible harm from infection. Any infection that occurs in a person that would normally be prevented by an intact immune system is referred to as an opportunistic infection.

The role of cancer surveillance throughout the body is also thought to be performed by the cellular immune system. Persons with defective T-helper cells might be expected to develop certain

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93. An antibody is a chemical molecule referred to as an immunoglobulin. The immunoglobulins consist of five classes in humans, namely A, G, M, D, and E. Immunoglobulin G (IgG) is the major antibody involved in attacking microorganisms. Modern laboratories are capable of measuring the total amount of immunoglobulins or specific antibodies in certain situations. After infection with a certain antigen, a subsequent rise in the level of the corresponding antibody is often detectable by blood test measurements. This is often taken as an indication of infection. For a comprehensible reference source, see UNITED STATES DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES, NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES, UNDERSTANDING THE IMMUNE SYSTEM (1985)(National Institutes of Health Pub. No. 85-529).

94. The term cell-mediated immune system is the same as cellular immune system.

95. The thymus is a small gland in the anterior portion of the chest and is most prominent in infants and children. While the main function of the thymus is largely unknown, it is the site where the T cells mature. The "T" stands for thymus-derived cells.

forms of cancer. Several reports of a previously rare type of cancer called Kaposi's sarcoma have been reported in persons with AIDS.[96] Kaposi's sarcoma is known to occur in persons whose immune system has been weakened from other causes, such as kidney transplantation. Recently, another type of cancer called non-Hodgkins lymphoma has been reported in exceptionally high incidence among gay males at risk for HTLV-III infection.[97]

The pattern of viral infections varies and depends on the infecting virus, the medical status of the person affected, and the interaction between the person and the virus. Viruses are small particles composed essentially of genetic material and proteins. Most viruses infect human cells by injecting their own genetic material into the human cell and taking over the functioning of the host cell. The effect of a viral attack may be the death of the host cell with replication of many new virus particles,[98] transformation of the host cell to an abnormal state,[99] or no obvious immediate effects.[100]

The HTLV-III virus, the causative agent of AIDS, appears to attack the T-helper cells and results in lytic infection.[101] The preferential attack on T-helper cells, paradoxically, makes it impossible to initiate an immune response against the attack.[102] The result is a continued inability to protect against opportunistic infections or developing malignancies. The current diagnosis of AIDS depends entirely on the clinical identification of specific types of these opportunistic infections and malignancies.

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96. Centers for Disease Control, *Kaposi's Sarcoma and Pneumocystis Pneumonia Among Homosexual Men—New York City and California*, 30 MORBIDITY & MORTALITY WEEKLY REP. 305, 305-08 (1981).

97. Ziegler, Beckstead, Volberding, Abrams, Levine, Lukes, Gill, Burkes, Meyer, Metroka, Mouradian, Moore, Riggs, Butler, Cabanillas, Hersh, Newell, Laubenstein, Knowles, Odajnyk, Raphael, Koziner, Urmacher, & Clarkson, *Non-Hodgkin's Lymphoma in 90 Homosexual Men: Relation to Generalized Lymphadenopathy and the Acquired Immunodeficiency Syndrome*, 311 NEW ENG. J. MED. 565, 568 (1984). *See also* Levine, Gill, Meyer, Burkes, Ross, Dworsky, Krailo, Parker, Lukes, & Rasheed, *Retrovirus and Malignant Lymphoma in Homosexual Men*, 254 J. A.M.A. 1921, 1924-25 (1985).

98. This is a so-called lytic action of a viral infection. The virus injects its genetic material into a human cell, reproduces many copies of itself, kills the human host cell, and releases the newly formed viral particles to infect other cells. The common cold viruses work in this manner.

99. Current research suggests the idea that certain viral infections alter the host cells' own genetic material producing a cancer cell. This may simply be a normal lytic infection gone wrong. The virus is unable to kill the host cell and inadvertantly initiates a cancerous growth. The feline leukemia virus in cats is an example.

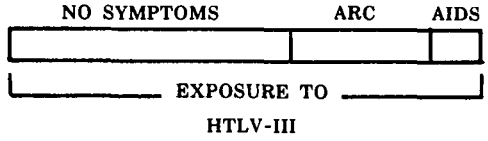
100. This may represent an attempt by the host to fight the viral infection or may be a slow or latent viral infection. Latent infections are seen when the virus "hides" inside apparently normal cells and then produces infection at a later time, such as when the body is under stress. Adult shingles is caused by a latent viral infection with the chicken pox virus. Herpes is another example of a latent infection.

101. The T-helper cells are thus destroyed by the virus.

102. The difficulty in managing AIDS should thus be apparent.

While this is the scenario for persons who develop AIDS, there is a wide range of milder conditions produced by infection with the HTLV-III virus. The acronym of AIDS implies a syndrome, not a specific and single disease state. The body is capable of instituting a protective response against the viral attack in many instances. Following exposure to the virus there is an attempt to confine it to the lymph nodes, a site where many of the cells involved in an immune response are located. This pattern of defense is identical to the way the body handles any viral infection. Many physicians now believe that a majority of individuals exposed to the HTLV-III virus may be able to end the infection by stopping the virus in the lymph nodes. Some persons will develop symptoms, such as enlarged lymph nodes for more than six months without other symptomatology. This condition has been referred to as persistent generalized lymphadenopathy syndrome.[103] Persons with this syndrome probably do not progress to the development of AIDS.

Some persons may develop a disease state that includes fever, night sweats, weight loss, diarrhea, and fatigue following exposure to HTLV-III. This constellation of symptoms is often referred to as AIDS-Related Complex (ARC). Persons who develop ARC may go on to develop AIDS or may remain free of the medically debilitating effects of "full-blown" AIDS. The incubation period between exposure to the HTLV-III virus and the appearance of AIDS, ARC, or generalized lymphadenopathy syndrome is unknown.[104] The risk of developing AIDS after exposure to HTLV-III may be 1 to 10 percent, and the risk of developing ARC may be 20 to 40 percent.[105] Thus, the majority of people exposed to the virus may remain healthy and free of symptoms. This can be visualized by a diagram, which illustrates that most of those exposed to the HTLV-III virus will not develop symptoms.



Although the HTLV-III virus attacks the cellular immune system, the humoral immune system is capable of responding to the infection. As with any viral infection, the B cells are stimulated to form plasma cells which produce antibodies directed against the

103. Lymphadenopathy means enlarged lymph nodes.

104. The incubation period may range from 15 months to 7 years.

105. ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS FOUNDATION, GUIDE TO PUBLIC HEALTH PRACTICE: HTLV-III ANTIBODY TESTING AND COMMUNITY APPROACHES 2 (1985).

HTLV-III virus. This process, called seroconversion, appears to be complete sometime around the seventh week after exposure. Thus, a person will not develop antibodies until several weeks after exposure to the virus.

While the response of seroconversion is uncertain, the response is the basis of a laboratory test to detect antibody. An HTLV-III antibody test is used to detect past infection with the HTLV-III virus.[106] The proper use of the HTLV-III antibody test is limited to protecting the national blood supply, screening organ donations, and to assist in research of AIDS and HTLV-III related problems. The HTLV-III antibody test should not be used for general screening or as a precondition for immigration, child custody and visitation, employment, evidence of insurability, admission to nursing homes or hospitals, or admission to school because the antibody production in response to HTLV-III does not indicate the form of HTLV-III infection that the individual will develop.[107]

Most viral infections result in a rise in the antibody levels following exposure and initiation of an immune response. Often one group of antibodies rise before other groups of longer lasting and more effective antibodies. Also, the process of seroconversion, or the time from exposure to a detectable rise in antibody level, may be quite variable. For these reasons any antibody testing is subject to error and usually requires repeat testing over time. Currently, physicians recommend that anyone tested for antibodies to HTLV-III should be re-tested 2 to 3 months after the initial test.

E. *Criteria For Diagnosing AIDS*

The HTLV-III antibody test has no diagnostic, prognostic, or predictive value. It cannot forecast whether individuals will or will not contract AIDS. In order to fully appreciate the role which HTLV-III testing holds, it is critical to understand the criteria for diagnosing AIDS. AIDS cannot be diagnosed solely on the basis of an antibody test for HTLV-III. Instead, a long and still developing list of criteria for diagnosing AIDS has been utilized.[108]

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106. An antibody response only indicates that a person was exposed to the virus. The antibody test will not delineate which individuals will develop AIDS, ARC, or remain healthy.

107. Further, irrational fears of transmission should not validate use of the antibody test. *See* Friedland, Saltzman, Rogers, Kahl, Lesser, Mayers, & Klein, *Lack of Transmission of HTLV-III/LAV Infection to Household Contacts of Patients With AIDS or AIDS-Related Complex With Oral Candidiasis*, 314 NEW ENG. J. MED. 344 (1986); Sande, *Transmission of AIDS: The Case Against Casual Contagion*, 314 NEW ENG. J. MED. 380 (1986).

108. *See* Centers for Disease Control, *Update on Acquired Immune Deficiency Syndrome (AIDS)—United States*, 31 MORBIDITY & MORTALITY WEEKLY REP. 507, 507-13 (1982).

1. The presence of a reliably diagnosed disease at least moderately predictive of cellular immunodeficiency. Specific diseases are necessary to diagnose AIDS and these may include one or more of the following:

a. Certain malignant tumors, such as
   (1) Kaposi's sarcoma[109] in patients under 60 years of age; or
   (2) non-Hodgkins lymphoma;[110]
b. Certain infections by protozoa, such as
   (1) *pneumocystis carinii* pneumonia;[111](2) cryptosporidium diarrhea;[112] or
   (3) toxoplasmosis gondii infection;[113]
c. Certain infections with fungi, such as
   (1) candida species;[114] or
   (2) cryptococus neoformans;[115]
d. Certain infections with viruses, such as
   (1) cytomegalovirus;[116](2) herpes virus;[117](3) hepatitis virus;[118]

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109. Kaposi's sarcoma is a rare form of cancer affecting blood vessel cells in the skin, lymph nodes, or other organs of the body. While it is seen predominantly in elderly males of Mediterranean extraction, normally there has been an increased incidence of this cancer among persons with AIDS. *See* Centers for Disease Control, *Kaposi's Sarcoma and Pneumocystis Pneumonia Among Homosexual Men—New York City and California*, 30 MORBIDITY & MORTALITY WEEKLY REP. 305, 305-08 (1981).

110. Non-Hodgkin's lymphoma is a malignant tumor affecting lymphocytes, a subset of white blood cells involved in the immune system. Current evidence indicates that B cells are predominantly involved in these tumors.

111. *Pneumocystis carinii* is a protozoan causing an opportunistic pneumonia. This is the most common initial presentation of AIDS. *See* Masur, Michelis, Greene, Onorato, Vande Stowe, Holzman, Wormser, Brettman, Lange, Murry, & Cunningham-Rundles, *An Outbreak of Community-Acquired Pneumocystis Carinii Pneumonia: Initial Manifestations of Cellular Immune Dysfunction*, 305 NEW ENG. J. MED. 1431, 1436-37 (1981); Centers for Disease Control, *Update on Acquired Immune Deficiency Syndrome (AIDS)—United States*, 31 MORBIDITY & MORTALITY WEEKLY REP. 507 (1982).

112. Cryptosporidium has been reported as causing a profuse, watery, and chronic diarrhea in persons with AIDS. Centers for Disease Control, *Cryptosporidiosis: Assessment of Chemotherapy of Males With Acquired Immune Deficiency Syndrome (AIDS)*, 31 MORBIDITY & MORTALITY WEEKLY REP. 589 (1982).

113. Toxoplasmosis gondii is a protozoan that causes disease of the central nervous system and the eyes.

114. Candida is a fungus or yeast that is quite commonly found in humans when the immune system is impaired. Candida may overgrow, especially in the throat or esophagus.

115. Crypotococcus neoformans is a fungus that may cause severe pneumonia, meningitis, or total body dissemination.

116. Cytomegalovirus (CMV) is a common opportunistic infection seen in persons with AIDS. Cheeseman, Sullivan, Brettler, & Levine, *Analysis of Cytomegalovirus and Epstein-Barr Virus Antibody Responses in Treated Hemophiliacs: Implications for the Study of Acquired Immune Deficiency Syndrome*, 252 J. A.M.A. 82, 83 (1984). CMV may cause a wide range of diseases, including pneumonia, encephalitus, esophagitis, and hepatitis. Because CMV presents special risks for pregnant women, many pregnant nurses will not be allowed to work in an AIDS hospital unit.

117. Herpes virus causes skin lesions that are particularly severe and prolonged in persons with AIDS. Quinnan, Masur, Rook, Armstrong, Frederick, Epstein, Manischewitz, Macher, Jackson, Ames, Smith, Parker, Pearson, Parillo, Mitchell, Straus, *Herpesvirus Infections in the Acquired Immune Deficiency Syndrome*, 252 J. A.M.A.

e. Certain infections with bacteria, such as
(1) mycobacterium tuberculosis;[119] or
(2) other atypical mycrobacterium.[120]
2. The absence of an underlying cause for the immuno-deficiency or of any defined cause for reduced resistance to disease.[121]

Recently the CDC has expanded the criteria for diagnosing AIDS to include certain special circumstances where the combination of a positive antibody test and the presence of a specific disease condition warrants a diagnosis of AIDS:[122]

1. In the absence of the opportunistic diseases required by the current case definition, any of the following diseases will be considered indicative of AIDS if the patient has a positive serologic or virologic test for HTLV-III:
(a) disseminated histoplasmosis (not confined to lungs or lymph nodes), diagnosed by culture, histology, or antigen detection;
(b) isosporiasis causing chronic diarrhea (over 1 month), diagnosed by histology or stool microscopy;
(c) bronchial or pulmonary candidiasis, diagnosed by microscopy or by presence of characteristic white plaques on the bronchial mucosa (not by culture alone);
(d) non-Hodgkins' lymphoma of high-grade pathologic type (diffuse, undifferentiated) and of B-cell or unknown immunologic phenotype, diagnosed by biopsy;
(e) histologically confirmed Kaposi's sarcoma in patients who are 60 years old or younger when diagnosed.

2. In the absence of the opportunistic diseases required by the current case definition, a histologically confirmed diagnosis of chronic lymphoid interstitial pneumonitis in a child (under 13 years of age) will be considered indicative of AIDS unless tests for HTLV-III antibody are negative.
3. Patients who have a lymphoreticular malignancy diagnosed more than 3 months after the diagnosis of an opportunistic disease used as a marker for AIDS will no longer be excluded as AIDS cases.
4. To increase the specificity of the case definition, patients will be excluded as AIDS cases if they have a negative result on testing for serum antibody to HTLV-III, have no other type of HTLV-III test with a positive result, and do not have a low number of T-helper lymphocytes or a low ratio of T-helper to T-suppressor lymphocytes. In the absence of a positive test result, patients satisfying all other criteria in the definition will continue to be included.[123]

As a close reading of the criteria indicates, the mere presence of

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72 (1984).

118. There is an increased incidence of hepatitis virus in persons with AIDS.

119. Mycobacterium tuberculosis is the bacterium which causes tuberculosis.

120. Atypical mycobacterium are bacteria closely related to mycobacterium tuberculosis and may infect lymph nodes, lungs, liver, spleen, or bone marrow.

121. *See supra* note 108.

122. Centers for Disease Control, *Revision of the Case Definition of Acquired Immunodeficiency Syndrome for National Reporting—United States*, 34 MORBIDITY & MORTALITY WEEKLY REP. 373, 373-75 (1985).

123. *Id.*

HTLV-III antibodies does not indicate that a person has AIDS or will develop AIDS. A person can only be diagnosed as having AIDS when a life-threatening opportunistic disease is present. AIDS-related complex may be diagnosed by finding symptoms such as fever for more than three months, weight loss of greater than fifteen pounds, unexplained profound fatigue, recurring night sweats, lymphadenopathy for more than three months, and severe and persistent diarrhea. Again, antibody testing is not considered in reaching a diagnosis. AIDS continues to be largely a clinical diagnosis and only under certain circumstances, as described above, does the person's antibody status come into play.

Conversely, the absence of HTLV-III antibodies does not mean that a person does not have the HTLV-III virus, or that the person will remain free of the HTLV-III virus. We simply do not know enough about the disease to know the full importance of HTLV-III antibody test results. With a negative test result, it might be that the person has been exposed to the virus, but has not yet converted to a positive antibody status. Just as with other types of blood testing, the test can only show the status of the person at the time blood is drawn from the body. Of course, those who test negative might also contract the disease by future exposure to infected blood or semen, and would need routine periodic testing if an accurate antibody status is desired.

F. *Modes of Transmission*

The AIDS epidemic has generated a great deal of medical research. While much information has been gained on the modes of transmission for the HTLV-III virus, there continues to be an unfounded public concern expressed over this disease. Unjustified fears and misplaced hysteria must be recognized and addressed prior to legal or legislative actions concerning persons with AIDS, ARC, or antibodies to HTLV-III. The belief that AIDS may be spread by casual contact has resulted in irrational suggestions for mass screening programs, expulsion of infected children from the classroom, dismissal of all antibody-positive military personnel, and various calls for quarantines.

The CDC has maintained an active role in calming an overreactive public and developing useful guidelines on restricting the transmission of the virus. Current belief is that the virus can be spread by sexual contact, contaminated blood or organs, and from mother to unborn fetus (i.e. vertical transmission). The HTLV-III virus has been isolated in greatest concentrations from blood and semen, and it is these fluids that are referred to in the phrase "exchange of bodily fluids." Exposure to the virus is possible only when a person's

blood stream is directly mixed with an infected individual's blood or semen, and this may explain the high incidence of AIDS in initial risk groups. All evidence indicates that the HTLV-III virus is not spread by tears, sweat, sneezing, or saliva.

Over 70% of the reported AIDS cases occur in homosexual and bisexual males, many of whom were sexually promiscuous before the AIDS crisis.[124] The frequent practice of anal intercourse reported among many members of this group probably explains the rapid spread of AIDS in gay men. Because the virus is present in high concentrations in semen and there are often multiple abrasions and tears in the rectal mucosa[125] during anal intercourse, the virus has direct access from semen into the blood system of the recipient.

In a California study of one thousand thirty-five men, a significant correlation between continued anal intercourse over a two year period and the appearance of antibodies to HTLV-III was found.[126] Men who engaged in oral-genital sex only for two years did not have a significant rate of conversion in their antibody status. Those men who engaged exclusively in oral sex or remained celibate with seroconversion reported a history of anal intercourse prior to the two year period studied.[127] A necessary conclusion is that not homosexual men, but rather men and women who engage in receptive anal intercourse, are the groups most at risk for the sexual transmission of AIDS.

Although there has been some confusion concerning the heterosexual spread of AIDS, there is mounting evidence that male-to-female and female-to-male spread may occur through sexual intercourse.[128] Heterosexual spread is thought to be the predominant mode of transmission in Africa, albeit the incidence of anal intercourse among African prostitutes is uncertain.[129] Presently, sexual

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124. *See* Murphy, *Philosophy in the Bedroom*, 96 CHRISTOPHER STREET 33 (1985)(perspective on how AIDS has affected sexual liberty). *See also Sex in the Age of AIDS*, Advocate, July 8, 1986, at 42, col. 1. As a matter of reporting, when a person is both an intravenous drug user and has had homosexual sex, he will be placed in the category for homosexuals. This reporting practice, in turn, affects public perception of how the disease is spread. *See 70 percent of Persons with AIDS Use Drugs*, Windy City Times, Nov. 21, 1985, at 6, col. 3.

125. The rectal mucosa is the innermost layer that lines the wall of the rectum.

126. Lyman, Ascher, & Levy, *Minimal Risk of Transmission of AIDS-Associated Retrovirus Infection by Oral-Genital Contact*, 255 J. A.M.A. 1703 (1986). The appearance of antibodies to HTLV-III is taken to mean exposure to the HTLV-III virus.

127. *Id.*

128. Calabrese & Gopalakrishna, *Transmission of HTLV-Infection from Man to Woman to Man*, 314 NEW ENG. J. MED. 987 (1986); Redfield, Markham, Salahuddin, Wright, Sarngadharan, & Gallo, *Heterosexually Acquired HTLV-III/LAV Disease (AIDS-Related Complex and AIDS): Epidemiologic Evidence for Female-to-Male Transmission*, 254 J. A.M.A. 2094 (1985).

129. *See Politics blocks study, prevention of AIDS in Africa*, Am. Med. News,

partners of members of high risk groups are considered to be at an increased risk of developing HTLV-III infection.[130]

A recent poll has shown that a majority of the public believes AIDS can be spread by casual contact despite the lack of any evidence to suggest that the HTLV-III virus can be spread by saliva, tears, sweat, or nasal secretions.[131] The recent reports of isolating the HTLV-III virus from saliva and tears had added to the misconception that casual transmission of AIDS is possible. Attempts to isolate the virus from saliva have been infrequent, and when achieved, the levels of virus are reportedly much lower than corresponding blood levels. One recent study attempted to isolate the HTLV-III virus from 83 saliva samples taken from patients with AIDS. Of those samples, there was only one where the virus was identified, and this person had active oral lesions at the time of the study.[132] There is no evidence at the present time that the HTLV-III virus can be spread through kissing or oral sex.[133]

The most compelling evidence against casual transmission has come from a comprehensive study in New York where 101 household contacts of persons with AIDS were followed for up to four years.[134] The study examined the antibody status of persons living with and taking care of known persons with AIDS. Household or casual contacts are defined as persons who are living with, feeding, bathing, and caring for persons with AIDS. Household contacts have been reported to share food, toothbrushes, and sleeping quarters with persons infected with the HTLV-III virus. Only one subject developed evidence of infection.[135] The investigators concluded that there is no evidence that household contacts are at an increased risk of infection with the HTLV-III virus.[136] Furthermore, they state

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Jan. 10, 1986, at 3, col. 1.

130. Centers of Disease Control, *Additional Recommendations to Reduce Sexual and Drug Abuse-Related Transmission of Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus*, 35 MORBIDITY & MORTALITY WEEKLY REP. 152 (1986).

131. *Poll Finds Many AIDS Fears That the Experts Say Are Groundless*, N.Y. Times, Sept. 12, 1985, at 9, col. 1.

132. Ho, Byington, Schooley, Flynn, Rota, & Hirsch, *Infrequency of Isolation of HTLV-III Virus From Saliva in AIDS*, 313 NEW ENG. J. MED. 1606 (1985).

133. Lyman, Ascher, & Levy, *Minimal Risk of Transmission of AIDS-Associated Retrovirus Infection by Oral-Genital Contact*, 255 J. A.M.A. 1703 (1986); Sande, *Transmission of AIDS: The Case against Casual Transmission*, 312 NEW ENG. J. MED. 380 (1986).

134. Friedland, Saltzman, Rogers, Kahl, Lesser, Mayers, & Klein, *Lack of Transmission of HTLV-III/LAV Infection to Household Contacts of Patients With AIDS or AIDS-Related Complex with Oral Candidiasis*, 314 NEW ENG. J. MED. 344 (1986).

135. This was in a child who was thought to have been exposed to the virus at birth. *Id.* at 346-47. *See also Study of AIDS Victims' Families Casts Doubt on Disease's Spread*, N.Y. Times, Feb. 6, 1986, at 1, col. 1.

136. Friedland, Saltzman, Rogers, Kahl, Lesser, Mayers, & Klein, *Lack of*

that there exists a similarity between the HTLV-III virus and the hepatitis B virus in terms of epidemiology, populations affected, and presumed modes of transmission. Because the hepatitis B virus can be isolated from saliva but not transmitted by casual contact, the same conclusion can be drawn with respect to the HTLV-III virus.

The other obvious source of exposure to the HTLV-III virus is through contaminated blood or organs. This explains the higher incidence of AIDS observed in hemophiliacs, recipients of blood or blood products, transplant patients, and intravenous drug users who share contaminated needles. The transmission of the HTLV-III virus to health care workers following injury with contaminated needles from persons with AIDS has been documented in one case, but the overall risk of transmission appears to be low,[137] and perhaps even non-existent.[138] The transmission of AIDS from a health care worker to a patient has never been documented.[139] There is no rationale at the present time to test or dismiss any health care workers from patient contact duties.[140]

Thus, despite the hysteria, current medical research supports the following conclusions on the transmission of the HTLV-III virus:

1.) The disease has been confined largely to the populations identified as high risk groups without significant spread to other populations.[141]
2.) There is now evidence that AIDS, as well as other sexually transmitted diseases,[142] may have stabilized among homosexual and bisexual men in New York City and San Francisco, following successful behavior modification and educational programs.[143]

Transmission of HTLV-III/LAV Infection to Household Contacts of Patients With AIDS of AIDS-Related Complex with Oral Candidiasis, 314 NEW ENG. J. MED. 344, 346 (1986).

137. Centers for Disease Control, *Summary: Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy Associated Virus in the Workplace*, 34 MORBIDITY & MORTALITY WEEKLY REP. 681 (1985); Weiss, Saxinger, Rechtman, *HTLV-III Infection Among Health Care Workers: Association with Needle-Stick Injuries*, 254 J. A.M.A. 2089 (1985).

138. Henderson, Saah, Zak, Kaslow, Lane, Folks, Blackwelder, Schmitt, La-Camera, Masur, & Fauci, *Risk of Nosocomial Infection with Human T-Cell Lymphotropic Virus Type III/Lymphadenopathy Associated Virus in a Large Cohort of Intensively Exposed Health Care Workers*, 104 ANNALS INTERNAL MED. 644 (1986).

139. Centers for Disease Control, *Summary: Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace*, 34 MORBIDITY & MORTALITY WEEKLY REP. 681 (1985); Sacks, *AIDS in a Surgeon*, 313 NEW ENG. J. MED. 1017 (1985).

140. *New Guidelines for Hospitals Say Employee Screening is Unnecessary*, Daily Lab. Rep. (BNA) No. 28, at A-4 (Feb. 11, 1986).

141. It is not possible to make the same characterization about AIDS in Africa, where AIDS is a heterosexual venereal disease. *AIDS Has Spread 'Almost Everywhere' In Africa, Zaire Doctor Tells Parley*, Wall St. J., June 24, 1986, at 10, col. 1.

142. Specter, *Caution in Sexual Behavior Is Driving Down the Syphilis Rate: Most of the decline is among homosexual men*, Washington Post Nat'l Weekly Ed., Aug. 26, 1985, at 32, col. 1.

143. *New Cases of AIDS Leveling Off in New York City*, N.Y. Times, Mar. 21, 1986, at 28, col. 1; Staver, *AIDS Rate Levels in S.F., N.Y. Gays*, Am. Med. News, Jan.

3.) Although AIDS can be spread through sexual contact, there is increasing evidence that specific sexual acts, not sexual orientation or promiscuity per se, result in transmission of the disease. In particular, receptive anal intercourse has been linked to the development of HTLV-III infection. There is no evidence that kissing or oral sex serve as modes of transmission.

4.) A permanent, monogamous sexual relationship introduces no new risks of sexual transmission, provided that neither person is infected or becomes infected with HTLV-III.[144]

5.) Transmission of AIDS from a mother to an unborn fetus is possible.

6.) Early in the course of developing guidelines for AIDS, health care workers were reported to have a slightly increased risk of exposure following needle-stick injuries with contaminated needles used on persons with AIDS.[145] The most recent study of health care workers has shown that none of over 500 persons exposed to bodily fluids of persons with AIDS developed antibodies to the HTLV-III virus.[146] Another study reports that there are only 10,000 HTLV-III viral particles per milliliter of blood in infected individuals, as compared to 10,000,000,000,000 hepatitis B viral particles per milliliter of blood.[147] Although there is a risk of exposure to hepatitus B in health care workers, the evidence suggests that this does not occur with the HTLV-III virus.[148]

7.) HTLV-III may be spread by exposure to contaminated blood, blood products, or donated organs, and through contaminated needles often shared by IV drug users. Routine screening will virtually eliminate transfusion-associated AIDS, which currently accounts for less than 2% of reported AIDS cases.[149]

8.) Sexual contact with persons already exposed to the HTLV-III virus may cause an increased risk of infection. Spread from male-to-female and from female-to-male has been reported.[150]

9.) Casual household contact does not result in the transmission of HTLV-III. Current research shows no evidence of spread through saliva, tears, sweat, coughing, sneezing, or kissing.[151]

10.) The routine screening of donated blood implemented by the Food and Drug Administration[152] and the recent recommendations by the Centers for Disease Control to reduce transmission of the HTLV-III

24-31, 1986, at 1, col. 1. *See also* German Information Center, *AIDS Increase Slowing*, Week in Ger., May 23, 1986, at 6 (predicting a similar result in West Germany because of successful public education).

144. Centers for Disease Control, *Acquired Immunodeficiency Syndrome (AIDS)*, 34 MORBIDITY & MORTALITY WEEKLY REP. 75S (1985) (supplement).

145. *See supra* note 137.

146. *See supra* note 138.

147. Sande, *Transmission of AIDS: The Case against Casual Contagion*, 313 NEW ENG. J. MED. 380 (1986).

148. Levy, Kaminsky, & Morrow, *Infection by the Retrovirus Associated with the Acquired Immunodeficiency Syndrome*, 103 ANNALS INTERNAL MED. 694 (1985).

149. General Biological Products Standards, Additional Standards For Human Blood and Blood Products; Serologic Test For Antibody to Human T-Lymphotropic Virus Type III (HTLV-III), 51 Fed. Reg. 6362 (1986).

150. *See supra* note 128.

151. Sande, *Transmission of AIDS: The Case against Casual Contagion*, 314 NEW ENG. J. MED. 380 (1986).

152. *See supra* note 149.

virus can help limit the spread of AIDS.[153]

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153. The following are the CDC recommendations to prevent transmission to health care workers:

> 1. Sharp items (needles, scalpel blades, and other sharp instruments) should be considered as potentially infective and be handled with extraordinary care to prevent accidental injuries.
> 2. Disposable syringes and needles, scalpel blades, and other sharp items should be placed into puncture-resistant containers located as close as practical to the area in which they were used. To prevent needlestick injuries, needles should not be recapped, purposefully bent, broken, removed from disposable syringes, or otherwise manipulated by hand.
> 3. When the possibility of exposure to blood or other body fluids exists, routinely recommended precautions should be followed. The anticipated exposure may require gloves alone, as in handling items soiled with blood or equipment contaminated with blood or other body fluids, or may also require gowns, masks, and eye-coverings when performing procedures involving more extensive contact with blood or potentially infective body fluids, as in some dental or endoscopic procedures or postmortem examinations. Hands should be washed thoroughly and immediately if they accidentally become contaminated with blood.
> 4. To minimize the need for emergency mouth-to-mouth resuscitation, mouth pieces, resuscitation bags, or other ventilation devices should be strategically located and available for use in areas where the need for resuscitation is predictable.
> 5. Pregnant [health care workers] are not known to be at greater risk of contracting HTLV-III/LAV infection than [health care workers] who are not pregnant; however, if a [health care worker] develops HTLV-III/LAV infection during pregnancy, the infant is at increased risk of infection from perinatal transmission. Because of this risk, pregnant [health care workers] should be especially familiar with precautions for the prevent[ion of] HTLV-III/LAV transmission.

Centers for Disease Control, *Summary: Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace*, 34 MORBIDITY & MORTALITY WEEKLY REP. 681, 684 (1985). The CDC adapted its guidelines from Garner & Simmons, *Guidelines for Isolation Precautions in Hospitals*, 4 INFECTION CONTROL 245, 245-325 (1983), and Williams, *Guidelines for Infection Control in Hospital Personnel*, 4 INFECTION CONTROL 326, 326-45 (1983). The following are the CDC recommendations to reduce sexual and drug abuse-related transmission of the HTLV-III virus:

> 1. Community health education programs should be aimed at members of high-risk groups to: (a) increase knowledge of AIDS; (b) facilitate behavioral changes to reduce risks of HTLV-III/LAV infection; and (c) encourage voluntary testing and counseling.
> 2. Counseling and voluntary serologic testing for HTLV-III/LAV should be routinely offered to all persons at increased risk when they present to health-care settings. Such facilities include, but are not limited to, sexually transmitted disease clinics, clinics for teaching parenteral drug abusers, and clinics for examining prostitutes.
>
> a. Persons with a repeatedly reactive test result . . . should receive a thorough medical evaluation, which may include history, physical examination, and appropriate laboratory studies.
>
> b. High-risk persons with a negative test result should be counseled to reduce their risk of becoming infected by:
>
> (1) Reducing the number of sex partners. A stable, mutually monogamous relationship with an uninfected person eliminates any risk of sexually transmitted HTLV-III/LAV infection.
>
> (2) Protecting themselves during sexual activity with any possibly infected person by taking appropriate precautions to prevent contact with the person's blood, semen, urine, feces, saliva, cervical

Thus, sexual contact where an individual's blood system is ex-

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secretions, or vaginal secretions. Although the efficacy of condoms in preventing infections with HTLV-III/LAV is still under study, consistent use of condoms should reduce transmission of HTLV-III/LAV by preventing exposure to semen and infected lymphocytes.

(3) For IV drug [users], enrolling or continuing in programs to eliminate [self-injection] of IV substances. Needles, other apparatus, and drugs must never be shared.

c. Infected persons should be counseled to prevent the further transmission of HTLV-III/LAV by:

(1) Informing prospective sex partners of his/her infection with HTLV-III/LAV, so they can take appropriate precautions. Clearly, abstention from sexual activity with another person is one option that would eliminate any risk of sexually transmitted HTLV-III/LAV infection.

(2) Protecting a partner during any sexual activity by taking appropriate precautions to prevent that individual from coming into contact with the infected person's blood, semen, urine, feces, saliva, cervical secretions, or vaginal secretions. Although the efficacy of using condoms to prevent infections with HTLV-III/LAV is still under study, consistent use of condoms should reduce transmission of HTLV-III/LAV by preventing exposure to semen and infected lymphocytes.

(3) Informing previous sex partners and any persons with whom needles were shared of their potential exposure to HTLV-III/LAV and encouraging them to seek counseling/testing.

(4) For IV drug [users], enrolling or continuing in programs to eliminate [self-injection] of IV substances. Needles, other apparatus, and drugs must never be shared.

(5) Not sharing toothbrushes, razors, or other items that could become contaminated with blood.

(6) Refraining from donating blood, plasma, body organs, other tissues, or semen.

(7) Avoiding pregnancy until more is known about the risks of transmitting HTLV-III/LAV from mother to fetus or newborn.

(8) Cleaning and disinfecting surfaces on which blood or other body fluids have spilled, in accordance with previous recommendations.

(9) Informing physicians, dentists, and other appropriate health professionals of his/her antibody status when seeking medical care so that the patient can be appropriately evaluated.

3. Infected patients should be encouraged to refer sex partners or persons with whom they have shared needles to their health-care provider for evaluation and/or testing. If patients prefer, trained health department professionals should be made available to assist in notifying their partners and counseling them regarding evaluation and/or testing.

4. Persons with a negative test result should be counseled regarding their need for continued evaluation to monitor their infection status if they continue high-risk behavior.

5. State and local health officials should evaluate the implications of requiring the reporting of repeatedly reactive HTLV-III/LAV antibody test results to the state health department.

6. State or local action is appropriate on public health grounds to regulate or close establishments where there is evidence that they facilitate high-risk behaviors, such an anonymous sexual contacts and/or intercourse with multiple partners or IV drug [self-injection] (e.g. bath-houses, houses of prostitution, "shooting galleries").

Centers for Disease Control, *Additional Recommendations to Reduce Sexual and*

posed to infected semen, intravenous drug users, those persons transfused with untested and contaminated blood or transplanted organs, and vertical transmission from mother to an unborn child, represent the only known modes of transmission of the HTLV-III virus. Heterosexual contacts may be at increased risk of exposure to the virus, while health care personnel appear not to be at increased risk of exposure. Education aimed at altering high risk behavior and screening of donated blood provide the most crucial courses of action in preventing the spread of AIDS. Quarantines, expulsions, blacklisting, and mandatory testing will have little impact on prevention of this disease and may actually prove counter-productive in the search for information on the transmission of AIDS and the ultimate eradication of this epidemic.[154]

G. *Testing for Antibody to HTLV-III*

The analysis of any disease may develop from one of two basic approaches. The development of criteria to ascertain an accurate diagnosis and then to implement appropriate treatment is one approach. Another approach is to focus on prevention of the disease. Common examples of preventative measures include screening programs, vaccination, and behavior alteration.[155] The AIDS epidemic has resulted in much information on the diagnosis and possible treatments of the disease. Research has also focused on prevention and, in particular, screening tests and recommendations have been developed.

A simple test to detect antibodies has been developed and is intended for use in screening donated blood as a measure of transmission prevention. The test is intended only for screening purposes and has absolutely no diagnostic, prognostic, or predictive value in determining who will develop AIDS. In order to better comprehend the prescribed indications for the test and its limitations, one should understand how the test is done.

Any viral infection triggers an immune response which includes the production of antibodies that attempt to attach themselves to portions of the invading virus and destroy it. The antibodies are generally directed against one or more of the protein components of the virus. The HTLV-III virus elicits such a response. These antibo-

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Drug Abuse-Related Transmission of Human T-Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus, 35 MORBIDITY & MORTALITY WEEKLY REP. 152, 153-54 (1986)(footnotes omitted).

154. *See* Comment, *Fear Itself: AIDS, Herpes and Public Health Decisions*, 3 YALE L. & POL'Y REV. 479, 480 (1985).

155. Examples of behavior alteration to prevent disease include maintaining a low-salt diet to help lower blood pressure, and cessation of smoking to help prevent chronic lung disease and cancer.

dies may be detected by several different types of tests. The antibody test does not directly detect the presence of the virus. Rather, by recognizing such antibodies, one infers that an individual has been exposed to the virus.

The specific types of antibodies that are produced and the specific proteins that induce their production are uncertain. Early in the course of HTLV-III infection some time is required before the presence of the antibody is detected. The length of time is unknown but is reported to be between six days and eight weeks in one study.[156] While most infections result in a rise in the IgG class of antibodies, there is also a rise in the IgM class early in the course of infection. This may be the case with HTLV-III.[157] The currently available licensed test for HTLV-III antibody detects only antibody of the IgG class.

Thus, early in the course of exposure to HTLV-III, antibodies will not be present. Recent reports also indicate that late in the course of full-blown AIDS many patients completely lose their antibodies to HTLV-III. Individual variation in testing kits, and the occurrence of falsely positive tests may further confound the interpretation of test results.

The current test for screening donated blood and organs is known as the enzyme-linked immunosorbent assay (ELISA).[158] The development of several different licenced ELISA test kits, each with different criteria for determining a positive result, has led to the lack of a single definition of a positive test result.[159] The sensitivity of this test has thus been questioned with the CDC reporting that "the pattern of positive tests varied in different regions of the coun-

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156. Cooper, Gold, & Maclean, *Acute AIDS Retrovirus Infection*, [1985] LANCET 537, 537-40.

157. *See* Rapoza, *AIDS and Testing for AIDS*, 255 J. A.M.A. 745 (1986).

158. ELISA tests are generally performed in the following manner:

1. Plastic dishes with wells containing portions of disrupted virus particles are obtained from the manufacturer.
2. A sample of blood is drawn from a patient and placed in the wells. If antibodies to the virus are present, they will attach to the disrupted viral particles.
3. A pre-prepared solution of antibodies that attach to other antibodies (i.e. antihuman globulin serum) with an attached enzyme is added to the wells. If there are HTLV-III antibodies attached to the virus particles, then the antihuman globulin-enzyme complex will attach to the HTLV-III antibody.
4. The enzyme then causes a change in color in the well if HTLV-III antibody is present.
5. The degree of color change and the total number of wells experiencing a color change may be taken as various measures of antibody positivity.

159. ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS FOUNDATION, GUIDE TO PUBLIC HEALTH PRACTICE: HTLV-III ANTIBODY TESTING AND COMMUNITY APPROACHES 2 (1985). *See also Helping Battle AIDS: Five Companies May Soon Be Selling Tests to Detect AIDS Antibodies in the Blood*, Fortune, Apr. 15, 1985, at 57, col. 3; *LAV/HTLV-3 Screening Test Permits Issued to Five Companies*, 6 OFFICIAL NEWSLETTER OF THE NAT'L COALITION OF GAY STD SERVICES 25 (Aug.-Sept. 1984).

try by the test kit used."[160] The current sensitivity of the ELISA antibody test ranges from 60% to 97%.[161]

While the ELISA test is not 100% accurate, another test, known as the Western electroblot or Western blot is thought to be nearly 100% accurate in detecting antibodies to HTLV-III. Presently, any strongly positive ELISA test is first repeated, and then followed by a Western blot test for confirmation. The Western blot requires more sophisticated procedures and is more expensive than the ELISA test, which explains why it is not used for mass screening programs. But, even the reliability of the Western blot may be challenged. There is already a case report of a false positive antibody test using the Western blot technique, reiterating the limitations of any laboratory test.[162]

Currently, standard interpretation requires that only a reproducible strongly positive ELISA test or an initially positive ELISA test with subsequent confirmation by a Western blot test can be taken as a truly positive indication of antibody status. Other researchers believe that even a repeatedly positive ELISA test is not a reliable indicator of true antibody status.[163] Furthermore, a weakly reactive ELISA test tends to correlate poorly with subsequent Western blot analysis and was "judged to be non-specific for HTLV-III infection."[164] Interpretation of a positive test result must be individualized on the basis of the type of test kit used, the geographic region, and the use of subsequent confirmatory tests.

The CDC has commented on the difficulty of interpreting a positive test result for any given individual. A false positive test result is possible with any laboratory test, and this is also true for the HTLV-III antibody test. One case report of a false positive Western blot test revealed that antimitrochondrial antibodies were present in blood in a pattern similar to HTLV-III antibodies.[165] Another study further reports that antibodies to nuclear antigens, human leukocyte antigens, and human T cell antigens has been found highly corre-

160. Centers for Disease Control, *Update: Public Health Service Workshop on Human T-Lymphotropic Virus Type III Antibody Testing—United States*, 34 MORBIDITY & MORTALITY WEEKLY REP. 477, 477-78 (1985).

161. Sensitivity refers to the ability of the test to actually predict what it is intended to predict. *Id.*

162. Saag & Britz, *Asymptomatic Blood Donor With A False Positive HTLV-III Western Blot*, 314 NEW ENG. J. MED. 118 (1986).

163. Rapoza, *AIDS and Testing for AIDS*, 255 J. A.M.A. 744 (1986).

164. Centers for Disease Control, *Update: Public Health Service Workshop on Human T-Lymphotropic Virus Type III Antibody Testing—United States*, 34 MORBIDITY & MORTALITY WEEKLY REP. 477, 477-78 (1985).

165. Antimitochondrial antibodies are antibodies directed against mitochondria, an intracellular structure, and are seen in various autoimmune disorders. Saag & Britz, *supra* note 162, at 118.

lated with a false positive ELISA test.[166]

In the case of HTLV-III antibody testing, a false positive indicates that the results of the testing procedure produces a positive result when, in fact, the person has not been exposed to the HTLV-III virus and antibodies are not present. There are several explanations for this, including the accidental positivity produced by structurally similar but unrelated antibodies, differences in test kits, a weakly positive test,[167] and statistical variation inherent in any test of this nature. The actual rate of false positive test results is not known with certainty. Also, in any population where HTLV-III infection is not prevalent, the rate of false positive test results will be quite high.[168]

Finding a false negative test result is also possible. These results indicate that no antibody is detectable even though the person has been exposed to the virus. The rate of false negative test results is reported to be 1% in some studies.[169] Causes of false negative results may include error in administration of the test, variation in test kits, and the time frame following exposure and before seroconversion, and late in the course of AIDS, when antibody levels fall. Thus, caution is strongly advised when interpreting an individual test result.

The reliability of any test is enhanced when the rates of false positives and false negatives are kept to a minimum. A low rate of false positives will lead to a high rate of false negatives, and this is undesirable. False positive test results will incorrectly identify healthy persons as having been exposed to the virus, whereas false negative test results will allow persons with past exposure to escape detection. Obviously, the use of the HTLV-III for diagnostic or prognostic purposes is inadequate. The only acceptable use of the current ELISA antibody test is in the screening of donated blood and organs, and for research purposes.

The HTLV-III antibody test, though frequently misnomered as an "AIDS test," must be thought of only as an antibody screening

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166. Britz, Zimmerman, Mundon, O'Connor, & Bush, *HTLV-III ELISA: A Sensitive and Specific Test for Detection of Antibodies to HTLV-III*, in INTERNATIONAL SYMPOSIUM OF MEDICAL VIROLOGY (1985).

167. The significance of a weakly positive test result is unknown, but probably does not represent exposure to the HTLV-III virus.

168. Centers for Disease Control, *Provisional Public Health Service Inter-Agency Recommendations for Screening Donated Blood and Plasma for Antibody to the Virus Causing Acquired Immunodeficiency Syndrome*, 34 MORBIDITY & MORTALITY WEEKLY REP. 1, 1-5 (1985).

169. Groopman, Hartzband, & Schulman, *Antibody Seronegative Human T-Lymphotropic Virus Type III (HTLV-III)—Injected Patients with Acquired Immunodeficiency Syndrome or Related Disorders*, 66 BLOOD 742, 742-44 (1985); Yomtovian, *HTLV-III Antibody Testing: The False Negative Rate*, 255 J. A.M.A. 609 (1986).

test. The test does not directly detect the presence of the HTLV-III virus, but rather antibodies thought to be induced by the virus. While this is considered to be adequate for screening purposes, we have pointed out some of the major flaws of utilizing such a test for any other purpose. Recently a test was developed to detect the virus directly, although its use remains experimental.[170] These antigen detecting tests have been developed in a laboratory, but their routine use is neither cost-effective nor practical. Further, antigen testing is subject to the same flaws and limitations as antibody testing.

H. *Psychological Aspects of Antibody Testing and Breaches of Confidentiality in Testing*

Just as important as the medical aspects of testing is the psychological aspect of learning a positive test result. When a person is told that he or she has developed antibodies to HTLV-III, the person may not fully understand what that result actually means. This, in part, is because medical science is also unable to fully prognose the scope of an HTLV-III infection. Additionally, when the results are leaked to others, the individual with antibodies must not only deal with the personal "crisis" of understanding the test results, but must now also deal with the reactions of others.

Far too frequently, these reactions are most injurious to those who have tested positively. For example, a fifteen year old boy with hemophilia who tested positive for HTLV-III antibodies was expelled from his Hobart, Indiana high school after officials learned the results of his "confidential" test.[171] The boy was then mentally and physically abused by other teenagers, and was eventually driven out of his hometown. He now lives with his grandparents in another state. Other teenagers in Colorado and California have been expelled from their high schools when school officials learned results of the supposedly confidential tests. In an even more disturbing case, an army private from Alabama committed suicide after other army personnel learned that the man had tested positive for HTLV-III antibodies.[172] Two other suicides were reported in Illinois after results

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170. *Abbott develops test for antigens*, Am. Med. News, Apr. 17, 1986, at 4, col. 4.

171. *Antibody Positive Boy Flees Abusive Peers*, 7 OFFICIAL NEWSLETTER OF THE NAT'L COALITION OF GAY STD SERVICES 44 (Feb.-Mar. 1986); Am. Med. News, Jan. 24-31, 1986, at 37, col. 3.

172. Chibbaro, *Soldier Tested for AIDS Hangs Self at Walter Reed*, 7 OFFICIAL NEWSLETTER OF THE NAT'L COALITION OF GAY STD SERVICES 47 (Feb.-Mar. 1986). This cannot be viewed as an isolated incident, because the trauma of learning about a positive antibody result can be psychhologically devastating. *See* Funk, *Suizid nach Trauma*, 99 FORTSCHRITTE DER MEDIZIN 1867 (1981). After the soldier's suicide, the army created a special hospital ward in which to isolate those with antibodies to HTLV-III. France, *Military Creates Ward for HTLV-3 Positive Soldiers*, Advocate,

were made known for positive tests for HTLV-III antibodies,[173] and at least three suicide attempts were reported in California.[174] Another man murdered his girlfriend after he tested positively for HTLV-III antibodies, suspecting her of having transmitted the virus to him.[175]

These illustrations dramatize the significance and potential for abuse of HTLV-III antibody testing. Due to the concern that a positive result, or perhaps even submitting to the test at all, will cause an individual to be labelled as gay or a drug abuser, many people do not care to be tested. They do not want to know their antibody status, and they certainly do not want it to become public knowledge either that they had the test performed or its results. Almost all gay men and intravenous drug users have to deal with the daily pressure and anxiety of wondering whether they will develop AIDS. They have a haunting fear of dying an early and agonizing death. As this pressure mounts, some have found it too much to tolerate, especially if faced with some insistence by an outside authority to undergo an HTLV-III antibody test or if faced with a positive test result. The AIDS hysteria, illustrated by the other examples set out in this article, only increases the risk of psychological pressure and abuse from others if the confidentiality of the test is not maintained.

The unspoken but fallacious rationale behind voluntary testing for HTLV-III antibodies is that the person, once he or she learns the test result, will engage in some type of behavior modification.[176] For example, if a person tests positive, he or she will theoretically refrain from engaging in high-risk sexual activity involving the exchange of blood or semen so as not to infect anyone else with the virus should he or she be carrying the virus in addition to the antibodies.[177] Conversely, if a person tests negative he or she will theoretically refrain from engaging in high-risk sexual activity involving the exchange of blood or semen so as not to risk infection with the virus from anyone else who is carrying it. In both cases, the result in

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Mar. 18, 1986, at 14, col. 1.

173. Speech by Bill Mannion at The John Marshall Law School Seminar, *A Beginner's Guide to Medical and Legal Issues in Response to the AIDS Crisis* (Apr. 19, 1986).

174. *Navy Recruits may have tried suicide*, Windy City Times, Jan. 9, 1986, at 4, col. 2.

175. *Man kills girlfriend over AIDS*, Windy City Times, May 1, 1986, at 4, col. 3.

176. This has been called the "unproven assumption" behind voluntary testing. Speech by Jeff Levy at the Health Law Institute, DePaul University College of Law (Apr. 11, 1986).

177. Centers for Disease Control, *Acquired Immunodeficiency Syndrome (AIDS)*, 34 MORBIDITY & MORTALITY WEEKLY REP. 75S, 76S (1985) (supplement). Unfortunately, it is entirely possible that the exact opposite result may occur. A person told that he or she has antibodies to HTLV-III may abandon all hope and all respect for the health of his or her partners by purposefully engaging in unsafe sex.

anticipated behavior modification is identical, and this is the fallacy of expecting results from voluntary blood testing. There is no medical treatment available for a positive antibody test for HTLV-III, only psychological counseling and support groups to help minimize the tragedies described earlier in this section.

Given the trauma of voluntary testing, what, then, can be the purpose behind inducing psychological trauma into American society by widespread proposals for mandatory testing? Persons who test positive will be devastated by that information. Depression will outweigh clinical advantages.[178] If the public health goal is to educate people to avoid practices which involve the exchange of blood and semen, that goal can be reached by education without testing. Education, not mandatory testing, should be the agenda for public health because it presents a less restrictive alternative to the infringement of the constitutional rights presented later in this article.

I. *Summary*

Although there has been much concern about AIDS and the modes of transmission of the HTLV-III virus, we have presented the most recent and complete medical background available for the legal issues which we later discuss. Perhaps the major issue that has arisen from the AIDS crisis is the development of the HTLV-III antibody test and the proper indications for its use. The HTLV-III antibody test is not a test for humans—it is a test for research and for protecting donated blood and organs. The philosophy of encouraging voluntary testing is, in reality, an attempt to educate at-risk individuals about the disease and how it is spread. Education and counseling should be the major goal of the public health response to AIDS. The test should not be used as an indication of those persons who may develop AIDS.

The Association of State and Territorial Health Officials Foundation[179] has devised the following general principles regarding HTLV-III antibody testing:[180]

> 1. The HTLV-III antibody test is used to detect the presence of antibody to HTLV-III Virus, which denotes that the person is or has been infected with HTLV-III. Used alone, the HTLV-III antibody test is not a test to diagnose [AIDS].

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178. Byron, *The Hidden Risks of Antibody Screening: This Is Not Only a Test*, Village Voice, May 27, 1986, at 29, col. 1.

179. The Association of State and Territorial Health Officials Foundation can be contacted through the Public Health Foundation, 1220 L. Street, N.W., Washington, D.C. 20005.

180. ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS FOUNDATION, GUIDE TO PUBLIC HEALTH PRACTICE: HTLV-III ANTIBODY TESTING AND COMMUNITY APPROACHES 4 (1985).

2. The HTLV-III antibody test is an extremely important procedure for protecting the nation's blood supply, and is a valuable test to assist research efforts into AIDS and HTLV-III related problems. The test has other selective clinical and public health applications, and has been added as a criterion in the application of the recently-redefined case definition of AIDS.[181]

3. At the present time, the HTLV-III antibody test has limited utility for purposes other than stated above. The HTLV-III test should not be used for generalized screening or as a precondition for employment, evidence of insurability, admission to hospitals, or admission to school.

4. The HTLV-III antibody test should only be performed with the individual's consent. That consent should include specific reference to the test, and should not be part of blanket consent procedures.

5. Because of the serious potential for social and psychological harm to the individual resulting from the HTLV-III antibody test results, great care must be taken to inform the public and health care professionals about limitations in current understanding of the test results and of the entire disease process related to HTLV-III infection, including AIDS.

6. Information gathered from the testing or counseling of individuals must be kept strictly confidential.[182]

The Association states further that the main use of voluntary testing for high-risk groups is to reinforce the risk reduction message and reiterate educational efforts. The lack of prognostic and diagnostic value of the antibody test is stressed. Thus, the ELISA antibody test achieves its greatest usefulness in screening donated blood, and possibly in enforcing education of high-risk individuals. Education may be achieved without antibody testing and the attendant legal risks and implications.

The recent calls for expanded screening of high-risk groups by the CDC[183] and the Public Health Service,[184] as well as such ludicrous proposals by the California state Health Director to give the state the power to conduct mandatory testing[185] and other calls to

181. The antibody test played no role in the original disease definition, but now plays a role in diagnosing select cases. *See* Centers for Disease Control, *Revision of the Case Definition of Acquired Immunodeficiency Syndrome for National Reporting—United States*, 34 MORBIDITY & MORTALITY WEEKLY REP. 373, 373-75 (1985).

182. ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS FOUNDATION, GUIDE TO PUBLIC HEALTH PRACTICE: HTLV-III ANTIBODY TESTING AND COMMUNITY APPROACHES 4 (1985).

183. Staver, *CDC Urges More Blood Testing for High-Risk Groups*, Am. Med. News, Apr. 18, 1986, at 9, col. 1.

184. Krieger, *To Include Individuals In High-Risk Groups: PHS Urges Expanded Screening for AIDS*, Am. Med. News, Mar. 28, 1986, at 8, col. 1.

185. Staver, *Required AIDS Testing, Reporting Urged*, Am. Med. News, May 2, 1986, at 1, col. 1; *California Official: Mandatory Tests*, Windy City Times, Apr. 24, 1986, at 4, col. 2.

test all Americans[186] have given the question of HTLV-III antibody testing the most serious political, social, and legal overtones. The known medical facts of HTLV-III infections, the limitations of testing, and the indications for using the test must be carefully and cautiously evaluated. The following points are general principles concerning what is currently known about HTLV-III testing:

1. The most commonly employed test used to detect infection with the HTLV-III virus is an antibody test known as ELISA.

2. The reliability of the ELISA test has been seriously questioned because:

a. The test only detects antibodies, not virus particles.

b. There are known times when antibodies are not detectable even when infection is present, e.g. before seroconversion and late in the course of full-blown AIDS.

c. There is an indeterminate rate of false positive results wrongly assessing a person of past exposure to the virus.

d. There may be an uncertain rate of false negative test results wrongly assessing a person with past exposure as being free from exposure.

e. There is currently a great deal of variation between persons, test kits, and interpretation of test results throughout the country.

3. In any given person the outcome of infection with the HTLV-III virus is unknown. Apparently, only a minority of those exposed will develop AIDS and thus the test is not a prognostic indicator of who will develop disease. Antibody testing indicates exposure to the virus, but not the subsequent clinical course.

4. The HTLV-III antibody test has no diagnostic, prognostic, or predictive value.

5. The only universally agreed indication for the use of the test is in screening donated blood.

6. The only benefit in administering the test to high-risk groups may be to further enforce education about AIDS and the prevention of its transmission within these groups.

7. The development of a test that directly detects viral particles may be completed in the future, but the political, social, and legal issues will remain the same.

In a recent letter to the Journal of the American Medical Association,[187] Dr. David Dassey commented on the importance of viewing AIDS as a syndrome, not a single disease entity. Dr. Dassey stated that:

As long as we refer to this condition with the mystical acronym 'AIDS,' people will refuse to see that this is simply another viral infection, albeit more insidious and life-threatening than most. There are legitimate reasons to maintain reporting and surveillance for cases of

186. *See supra* note 6 and accompanying text.
187. Dassey, *AIDS and Testing for AIDS*, 255 J. A.M.A. 743 (1986).

AIDS. Let's make it clear, however, that persons with asymptomatic or mildly symptomatic HTLV-III disease have their own needs and concerns, one of which is knowing that not all such infections are fatal.[188]

IV. Legal Background

Numerous legal issues are presented by persons with AIDS, ARC, and antibody to HTLV-III, as well as by those forced to submit to HTLV-III antibody testing. This section of our work surveys federal statutory and constitutional law of direct relevance.[189]

A. *The Rehabilitation Act of 1973*

The Rehabilitation Act of 1973, as amended,[190] prohibits discrimination in employment on the basis of handicap by federal contractors and recipients of federal financial assistance.[191] The act defines handicapped individuals to include persons "otherwise qualified" to work but having "a physical or mental impairment which substantially limits one or more of such person's major life activities, . . . [having] a record of such impairment, or . . . regarded as having such an impairment."[192] Not only does the Act prohibit discrimination, it requires that an employer "reasonably accomodate" the handicapped person if such accomodation would not cause the employer undue hardship.[193]

The threshold question with respect to AIDS is whether AIDS, ARC, or having tested positive for antibodies to HTLV-III constitutes a "handicap" as that term is defined by the statute.[194] It has been argued that AIDS is not encompassed by the statute because it

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188. *Id.*

189. Many states have statutory and/or constitutional provisions which may differ from the federal ones. Each such state's laws should be referenced. Helpful sources in this regard are 8A Lab. Rel. Rep. (BNA) and 3 Fair Empl. Prac. (CCH). The popular press has made reference to both first amendment free speech and fourth amendment search and seizure protection applicable to persons with AIDS. To the extent that any such claims are colorable, they are beyond the scope of this article.

190. 29 U.S.C. § 791 (1982).

191. The Act also applies to the federal government as an employer itself.

192. Reasonable accommodation relevant to persons with AIDS may include job restructuring, part-time or modified work schedules, or assignment of an employee who becomes handicapped to another position with comparable pay.

193. The section 503 regulations define "qualified handicapped individual" as one "capable of performing a particular job with reasonable accommodation." 41 C.F.R. § 60-741.2 (1986).

194. This is a critical issue because, generally, in the absence of a statutory directive to the contrary, an employer is free to terminate employees "for a good reason, for a bad reason, or no reason at all."

is a communicable disease.[195] At least one case has arisen to consider the issue, and that case refused to exclude persons with AIDS from among the class of persons protected by the Rehabilitation Act.[196] It correctly decided that because Congress did not exempt communicable diseases from the definition of handicap—particularly because it did exempt other conditions, including some drug use—Congress must have intended that persons with communicable diseases would be beneficiaries of the Act's protection.[197]

In April of 1986, the Civil Rights Division of the Department of Justice concluded that persons with AIDS met the criteria under the Rehabilitation Act of 1973 because they have a physical impairment that substantially limits one or more "major life activities."[198] The Civil Rights Division also suggested that those with antibodies to HTLV-III, but without symptoms, may be protected because the Rehabilitation Act covers people who are "regarded as" having an impairment, whether or not that perception is correct.[199] The Civil Rights Division stated that "because of public hysteria connected with the disease, persons with AIDS frequently become social pariahs, irrationally ostracisized by their communities because of medically baseless fears of contagion, and people's historic fear of both disease and the sick."[200]

In late June of 1986, the Civil Rights Division opinion was superceded by an opinion authored by Charles J. Cooper, head of the Justice Department's Office of Legal Counsel.[201] According to this later opinion, if a person with AIDS was dismissed from a job or excluded from a federal program solely because that person had AIDS, the dismissal would be illegal.[202] However, if the person was fired or excluded because of concern that he or she would spread the disease, the advisory opinion states that it would not necessarily be

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195. While those that are medically uninformed identify AIDS as a contagious disease, it is an infectious disease because the HTLV-III virus is not airborne and thus not spread by casual contact. A contagious disease is one which is spread by casual contact. An infectious disease is one that may be caused by any microorganism.

196. Shuttleworth v. Broward County Office of Budget and Management Policy, FCHR No. 85-0624, slip. op. (Fla. Commission on Human Relations Dec. 12, 1985). *See infra* notes 225-28 and accompanying text.

197. As a general proposition, remedial legislation is to be given expansive reading.

198. *Law protects AIDS victims, agency says,* Lincoln [Nebraska] Sunday Journal-Star, June 8, 1986, § F, at 3, col. 5.

199. *Id.*

200. *Justice Department says decision not final on AIDS,* Washington Blade, June 13, 1986, at 1, col. 2.

201. Memorandum for Ronald E. Robertson, General Counsel, Department of Health and Human Services, from Charles J. Cooper, Assistant Attorney General, Office of Legal Counsel, United States Department of Justice (June 20, 1986)(hereinafter cited as Memorandum).

202. *AIDS victims rights' limited,* Chicago Trib., June 24, 1986, § 1, at 4, col. 4.

illegal.[203] The Cooper opinion states that:

> [W]e find it highly significant that Congress, in enacting section 504, gave no indication that it intended to disturb the venerable body of federal and state law giving public health officials broad powers to prevent the spread of communicable diseases. We accordingly are convinced that no such change was intended.[204]

The Cooper opinion thus found that "the disabling physical or mental effects of AIDS constitute handicaps," but that the "ability to communicate AIDS" or any other contagious disease is not itself a handicap for purposes of the Rehabilitation Act of 1973.[205]

The Cooper opinion's deferrence to "fears of contagion" in the workplace is neither medically nor legally justifiable.[206] The only work-related transmission possible in a normal setting arises with prostitution, which is not federally subsidized and thus would be outside the purview of the Rehabilitation Act. Medical evidence simply does not support workplace transmission. The Cooper opinion fails to recognize existing medical evidence, and wrongfully condones irrational employer responses to an employee with AIDS. A New York Times editorial commenting on the Cooper opinion stated that:

> Error and meanness suffice the opinion on AIDS issued last week by Charles J. Cooper . . . . His ruling, based on a mistaken reading of medical opinion about transmissibility of the disease, invites employers to dismiss people who have it, or who carry [antibodies to] the AIDS virus, simply by invoking their fear of the disease being spread.
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> . . . [A]ccording to all medical evidence, AIDS is not spread casually. Mr. Cooper cites only a single medical opinion to the contrary, a statement attributed to William Haseltine of Harvard that AIDS *could* be transmitted through saliva and that "there are sure to be cases . . . of proved transmission through casual contact." But that statement . . . misrepresented Mr. Haseltine's views, as . . . later explained in a published letter.
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> No one should want to curb the powers of public health officials to control a disease as deadly as AIDS. But to throw [persons with AIDS] out of their jobs is a capitulation to unwarranted fear that protects no one. By his muddled insinuations and prejudiced reading of the medical evidence, Mr. Cooper is inciting fear. Worse, he provides a powerful incentive for those in the known risk groups not to take the AIDS antibody test. A positive result could, under his ruling, cost them their jobs.
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> So far some 22,000 cases of AIDS have occurred in the United

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203. *Rights Law Offers Only Limited Help on AIDS, U.S. Rules*, N.Y. Times, June 23, 1986, at 1, col. 2.

204. Memorandum, *supra* note 201, at 1-2.

205. *Id.* at 23-27. *See also AIDS threat ruled basis for firing*, Dallas Times Herald, June 24, 1986, § A, at 1, col. 1.

206. *Activists say AIDS ruling blurs job issue*, Dallas Times Herald, June 24, 1986, § A, at 6, col. 1.

> States. None are known to have been spread by casual contact. Until there is one, there's no justification for Mr. Cooper's opinion.[207]

Persons who do not have AIDS but are perceived by others as having it either because they have ARC, test positively for the HTLV-III antibody, or because they are believed for any other reason to have AIDS, are as entitled to protection under the Act as are persons with full-blown AIDS because of the explicit, and expansive, definition of handicap contained in the Act.[208] This conclusion is consistent with the legislative history of the Act:

> The new definition [of handicapped individual] clarifies the intention to include those persons who are discriminated against on the basis of handicap, whether or not they are in fact handicapped, just as title VI of the Civil Rights Act of 1964 prohibits discrimination on the ground of race, whether or not the person discriminated against is a member of a racial minority. This subsection includes . . .those persons who do not in fact have the condition they are perceived as having, as well as those whose mental or physical condition does not substantially limit their life activities. . . . Both of these groups may be subjected to discrimination on the basis of their being regarded as handicapped.[209]

The need for an expansive reach of the Act is clear. Employers have perceived those with antibodies to HTLV-III as being afflicted with AIDS, despite the erroneous nature of that perception. As the United States District Court for the District of Hawaii noted, "[i]t is little solace to a person denied employment to know that the employer's view of his or her condition is erroneous. To such a person the perception of the employer is as important as reality."[210]

In a case that will provide an important analogy in AIDS litigation under the Rehabilitation Act, the United States Court of Appeals for the Eleventh Circuit found that a teacher who was fired from her job solely because of her susceptability to tuberculosis had a valid claim under section 504 of the Rehabilitation Act. The case, *Arline v. School Board of Nassau County*,[211] directly presents the issue of whether a "communicable disease" can constitute a handicap under the Rehabilitation Act. The Supreme Court will hear arguments in *Arline* in its next term.

In *Arline*, an elementary school teacher was fired from her job after suffering three relapses of tuberculosis. After being denied relief in Florida administrative proceedings, she brought suit in fed-

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207. *A License to House AIDS Victims*, N.Y. Times, June 26, 1986, at 22, col. 1.

208. *Activists say AIDS ruling blurs job issue*, Dallas Times Herald, June 24, 1986, § A, at 6, col. 1.

209. Joint Conf. Rep., Sen. Rep. No. 93-1270, 93d Cong., 2d Sess., 35003, 35010, *reprinted in* 1974 U.S. CODE CONG. & AD. NEWS 6373, 6389.

210. E.E. Black, Ltd. v. Marshall, 497 F. Supp. 1088, 1097 (D. Hawaii 1980).

211. 772 F.2d 759 (11th Cir. 1985), *cert. granted*, 106 S. Ct. 1633 (1986).

eral court alleging that her dismissal violated section 504 of the Rehabilitation Act because her susceptibility to tuberculosis made her a "handicapped individual."[212] She presented evidence that the decision to dismiss her was unreasonable and discriminatory because the risk that she would infect her students was minimal. Alternatively, she argued that even if nonsuspectibility to tuberculosis was a necessary teaching qualification, the school district failed to make a "reasonable accomodation" in the form of an administrative position or other teaching possibilities. The district court delivered an oral opinion which found that a contagious disease is not a "handicap" within the meaning of the Rehabilitation Act, stating that "it's difficult for this court to conceive that Congress intended contagious persons to be included within the definition of a handicapped person. . . ."[213] The district court also found that the school board had no obligation to afford the teacher alternative positions because it had an overriding duty to protect the public from contagious diseases.

The Court of Appeals reversed, finding that the language of all the relevant terms of section 504 supported a conclusion that persons with contagious diseases are within the coverage of section 504, and that neither the language of the Act nor regulations promulgated by the Department of Health and Human Services gave any indication that chronic contagious diseases are to be excluded from the definition of "handicap." Any contrary result, according to the court, would subvert congressional intent by encouraging recipients of federal funds to make economic decisions on the cost of providing "reasonable accomodation" rather than legitimate decisions about the employee's capabilities. The court refused to allow section 504 to be used "to shield an entity from liability for making decisions which 'arbitrarily deprive genuinely handicapped persons of the opportunity to participate in a covered program.' "[214] Accordingly, the school district could not hide behind a general "duty to the public" when the medical evidence did not support the result.

The references to communicable diseases in *Arline* will inevitably be linked to AIDS when the Supreme Court decides the case. An affirmance of the Court of Appeals would be consistent with the Rehabilitation Act's language and legislative history. But, even if the Court reverses on the basis that tuberculosis is not a handicap, it will not foreclose the protection which the Rehabilitation Act offers to persons with AIDS. This is because AIDS is not an air-borne dis-

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212. *Id.* at 760-61.

213. *Id.* at 761.

214. *Id.* at 765 (*citing* Southeastern Community College v. Davis, 442 U.S. 397, 412 (1979)).

ease, but instead is a blood-borne disease.[215] This means that while AIDS can be considered an "infectious" disease, it does not qualify as a "communicable" disease because of the established modes of transmission. Persons with AIDS may still be "perceived" as being handicapped, and thus still enjoy the protection of the Rehabilitation Act.

After considering the question of whether AIDS fits within the scope of the Rehabilitation Act, the next questions concern what defenses to actions brought pursuant to the Rehabilitation Act an employer may raise, and with what success. First, an employer may argue that client and coworker fear of contagion will adversely affect the employer's business interests. If one assumes, as one must given the current medical and scientific evidence, that AIDS is not contagious in the workplace, this defense should fail.[216] The "customer preference" defense was soundly rejected by the court in *Diaz v. Pan American World Airways, Inc.*[217] In that case, Pan American, which limited flight attendant positions on most flights to females, argued that its customers preferred to be served by women. "Sorry," announced the Supreme Court, ". . . it would be totally anomalous [to the purposes of remedial legislation] if we were to allow the preferences and prejudices of the customers to determine when . . . discrimination is valid."[218]

Secondly, an employer may argue the increased costs related to the provision of health insurance make employment of the subject persons unnecessary. There are two reasons why any such defense is unlikely to prevail. First, in other areas of employment discrimination law, the courts have quite routinely rejected defenses premised on projected and speculative increased costs.[219] In fact, at the present time there is no reason to believe that persons who have merely tested positively for HTLV-III antibody will require extraordinary health care. More significantly, implicit in the Rehabilitation Act's requirements of nondiscrimination and affirmative action in the form of reasonable accomodation, is the possibility, if not probability, of some increased cost to an employer. This represents Congress' attempt to redistribute some of the costs of being handicapped to those employers made subject to the Act.[220]

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215. *See supra* note 195.

216. This premise is critical. If a disease is highly contagious an employer would not violate the Act by refusing to allow contagious persons to work. To require otherwise would not be "reasonale." Reasonableness is the standard by which the statute judges proposed accommodation.

217. 442 F.2d 385 (5th Cir.), *cert. denied*, 404 U.S. 950 (1971).

218. *Id.* at 387-89. *See also* Palmore v. Sidoti, 466 U.S. 429 (1984).

219. *See, e.g.*, Chrysler Outboard Corp. v. Department of Indus., Labor, and Human Relations, 14 Fair Empl. Prac. Cas. (BNA) 344 (Wis. Cir. Ct. 1976).

220. The Supreme Court made this clear with respect to the increased cost, to

Finally, the employer may argue that the incapacities of persons with AIDS, because of their disease, render them unsuitable as employees. This argument may be addressed in either of two ways. It must be understood, however, that the defense can only be relevant as to persons with full-blown AIDS—certainly not to persons who have merely developed ARC or have tested positive for HTLV-III antibody. If a PWA has become significantly *debilitated*, he may no longer be "otherwise qualified" to perform his job. Recall that the Act protects only those persons who are qualified to work notwithstanding their handicap. A person substantially unable to perform job functions need not be accomodated by an employer.

On the other hand, if the handicapped person is suffering some disabilities because of AIDS but is still able to work part of the time or at part of his or her work, the issue posed is the extent to which an employer must accomodate the PWA. Under regulations implementing section 504 of the Act, an employer must make reasonable accomodation to the known physical or mental limitations of an otherwise qualified handicapped applicant or employee, unless accomodation would impose an undue hardship on the operation of its program.[221] Factors to be considered in determining whether an accomodation would cause undue hardship include: the overall size of the employer (the number of employees, number and type of facilities, and budget size); the type of operation, including the composition and structure of the employer's work force; the nature and cost of the accomodation necessary; and the effect of the accomodation on productivity and safety.

In addition to the federal statutory scheme, analogous state statutes exist in 42 states[222] and the District of Columbia.[223] In each

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employers, of insurance benefits which Title VII, 42 U.S.C. §§ 2000e1-17 (1982), requires be provided to women. Employers argued that if they were made to provide medical and temporary disability coverage for pregnancy-related matters, their costs would be vastly higher. The Supreme Court declared "the question of fairness to various classes affected by the statute is essentially a matter of policy for the legislature to address . . . when insurance risks are grouped, the better risks always subsidize the poorer risks." But, concluded the Court, Title VII mandated *no* gender discrimination so even cost differentials could not justify gender discrimination. City of Los Angeles v. Manhart, 435 U.S. 702 (1978).

221. *See, e.g.*, 13 C.F.R. § 113.3-1(d) (1986); 28 C.F.R. § 41.53 (1986); 45 C.F.R. § 84.12 (1986); and 49 C.F.R. § 27.33(a) (1986).

222. Five additional states prohibit discrimination only in the public sector. Leonard, *Employment Discrimination Against Persons With AIDS*, 10 U. DAYTON L. REV. 681, 690 (1985); Parry, *AIDS As a Handicapping Condition—Part II*, 10 MENTAL & PHYSICAL DISABILITY L. REP. 2, 3-4 (1986). *See, e.g.*, The Illinois Human Rights Act, ILL. REV. STAT. ch. 68, §§ 1-103(Q) and 2-102(A) (1985). In addition to prohibiting discrimination on the basis of handicap in employment, the Illinois Act prohibits discrimination with respect to real estate transactions, access to financial credit, and the availability of public accommodations. Ill. Rev. Stat. ch. 68, § 1-102(A) (1985). Other state laws are reprinted in 8A Lab. Rel. Rep. (BNA) Fair Empl. Prac. Manual, and 3 Empl. Prac. Guide (CCH). These laws vary considerably. For example,

state, however, subtle variations in the specific language of each state's laws may produce different results for the spectrum of HTLV-III infection. In Utah, for example, the attorney general issued an opinion which said that having AIDS-related afflictions may be classified as a handicap under Utah's antidiscrimination statutes, but that simply contracting the HTLV-III virus would not qualify as a handicap.[224] Thus, the question for each individual state is whether the state statute is sufficiently analogous to the federal scheme to also protect those who have been fired from jobs because they have tested positive for HTLV-III antibody.

In *Shuttleworth v. Broward County Office of Budget and Management Policy*,[225] the Florida Commission on Human Relations determined that AIDS constituted a handicap under the Florida Human Rights Act. The decision was based upon the plain meaning of the term 'handicap' and the medical evidence presented to the Commission. The employer had fired the employee with AIDS "due to a lack of knowledge as to the severity and communicable aspect of the disease in consideration of protecting the [employee], other county employees, and the public."[226] Additionally, the employer asserted that it could not "assume the risk of allowing even one person to unwittingly contract AIDS because of the [employee's] presence at the work site."[227]

The commission rejected the employer's contentions based upon substantial medical evidence that AIDS was not transmissible in the workplace. The commission further found that the continuously evolving nature of the facts and information relative to AIDS could not be allowed to stand as justification for denying an individual his livelihood. The commission directed the employer to rely on the medical and scientific communities' expertise, which had determined that there was no risk of workplace transmission and thus no justification for firing the employee with AIDS.[228]

Shuttleworth is a good decision because it places the matter squarely in the hands of the experts. As the result indicates, reliance upon the medically established modes of transmission protects both

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some expressly exempt communicable diseases from their coverage.

223. D.C. Code § 1-2501 (1981). For a discussion of the applicability of the D.C. Human Rights Act of 1977 to Persons with AIDS and those who test positive for antibody to HTLV-III, see Letter of Oct. 15, 1985 from John H. Suda, Acting Corporation Counsel for the Government of the District of Columbia, to Councilmember John Ray.

224. Advocate, May 27, 1986, at 22, col. 3.

225. FCHR No. 85-0624, slip op. (Fla. Commission on Human Relations Dec. 12, 1985).

226. *Id.*

227. *Id.*

228. *Id.*

the interests of the employer and the employee. Although the decision is binding only in Florida, *Shuttleworth* provides rational guidance for other states which will confront alleged discrimination under similar state laws.

B. *Constitutional Law*

HTLV-III blood testing constitutes a major intrusion into the life of the person tested. First, learning the results of a positive test can be traumatic. Although a positive result does not mean that one has AIDS or even that one will contract AIDS, it is traumatic for an individual even to learn of a positive result. Second, there are no effective guarantees as to the confidentiality of test results or the purposes to which results may be put. Individuals with positive results have already become subject to discrimination. The AIDS hysteria in the general public can be expected to lead to even further discrimination. AIDS cases and the classification of high-risk groups has been used unfairly as a basis for social and economic discrimination. Thus, if an individual were forced to submit to a mandatory test or divulge whether he had been tested and with what result (e.g., in an application for housing or insurance), or if the results became known, the consequences could be devastating. Persons with AIDS and those perceived of as having AIDS who are discriminated against by government, or an agent of government[229] (because constitutional claims can only be brought against governmental defendants or their agents), may have as many as four constitutional arguments to raise with respect to such discrimination.

1. *Procedural Due Process*

As a matter of procedural due process of law, a person is entitled to adequate notice and hearing when deprived of governmental rights or interests to which he or she has a "legitimate claim of entitlement."[230] A person has a legitimate claim of entitlement to a property right, such as the right to one's job, or to a liberty interest in one's reputation, honor, and integrity. According to the companion cases of *Board of Regents v. Roth*[231] and *Perry v. Sinderman*,[232] "a person's interest in a benefit is a 'property' interest for due process purposes if there are . . . rules or mutually explicit understandings that support his claim of entitlement to the benefit. . . ."[233]

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229. For a discussion of the state action requirement, see Lewis, *The Meaning of State Action*, 60 COLUM. L. REV. 1083 (1960).

230. Board of Regents v. Roth, 408 U.S. 564, 577 (1972).

231. 408 U.S. 564 (1972).

232. 408 U.S. 598 (1972).

233. *Sinderman*, 408 U.S. at 601.

Hence, not only may a contract, statute, or ordinance give rise to procedural due process, so may a policy (in the case of *Sinderman*, his employer routinely renewed employment contracts notwithstanding the fact that the contract expressly stated it need not be renewed and non-renewal need not be preceeded by notice and hearing). Because of this "de facto tenure program,"[234] the Court held that Sinderman had the requisite objective expectation ("more than an abstract need or desire for it . . . [h]e must have more than a unilateral expectation of it") to entitle him to due process before his employer could terminate him. Accordingly, a PWA could raise a due process claim against a governmental employer (or other provider of benefits), if the PWA can point to a contract, statute, ordinance, or policy upon which he could objectively rely to claim a property interest.[235]

With respect to one's liberty interest, more than the integrity of one's reputation must be affected in order for the protection of procedural due process to apply. As the Court stated in *Paul v. Davis*,[236]

> [w]hile we have in a number of our prior cases pointed out the frequently drastic effect of the "stigma" which may result from defamation by government . . ., this line of cases does not establish the proposition that reputation alone, *apart from some more tangible interests, such as employment*, is either "liberty" or "property," by itself sufficient to invoke the procedural protection of the Due Process Clause.[237]

Given that a PWA or one perceived to have AIDS who is discriminated against because of his disease (or a perception of it) will, frequently, suffer the loss of a job[238] or other "tangible interest," the requirement of showing such injury will presumably prove no major obstacle.

Once a person has established an entitlement to procedural due

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234. *Id.* at 600.

235. *Roth*, 408 U.S. at 577.

236. 424 U.S. 693 (1973). *Paul* may be read to stand for the proposition that a "mere" objective basis for claiming entitlement to procedural due process need exist before that right is affected. Alternatively, *Paul* may stand for the proposition that one has no legitimate claim unless government has guaranteed the interest would not be affected without due process. If this reading of *Paul* prevails, a policy or "de facto program" would not constitute a sufficient basis for a "legitimate claim of entitlement" to procedural due process.

237. *Id.* at 701 (emphasis added).

238. One of the early cases involved a United Air Lines flight attendant who had AIDS and was removed from flying status although he was able to work. The company was allegedly worried about exposing passengers to the disease, although a spokesman said that United was acting primarily to protect the employee. The attendant successfully challenged his removal from flight status, and was reinstated with back pay. McClenahen, *The Privacy Invasion: In a Job Setting, How Personal is "Too Personal?"*, Industry Week, Nov. 11, 1985, at 50, 50-51.

process, there comes the question of the type and amount of procedural protection to which he is due. The Supreme Court has answered this question in two apparently contradictory ways. In *Mathews v. Eldridge*,[239] the Court said that the type and amount of notice and hearing to which one was due was to be determined by considering, and balancing, three factors: (1) the nature of the private interest that will be affected; (2) the risk of erroneous deprivation of such interest through procedures actually used by government and the probable value, if any, of additional or substitute safeguards;[240] and (3) the government's interest, including fiscal and administrative burdens that additional or substitute procedural requirements would entail.[241]

The interests which PWAs are likely to have affected are terribly important (e.g. jobs, child visitation rights). Very often persons are treated as though they have AIDS when they merely tested positive for the HTLV-III antibody.[242] There is a significant probability that one who has tested positively has an erroneous test result and hence any decision based on that result would be unwarranted. Finally, given that even full-blown AIDS cannot be transmitted by casual contact and the presence of ARC or HTLV-III antibodies present no health threat to others, plaintiffs here should generally prevail in their claim that they are entitled to extensive notice and hearing before being deprived of their rights.

2. *Substantive Due Process and Equal Protection*

As a general rule, the police power allows government to act, without judicial invalidation of that action, provided the challenged action is intended to serve some "legitimate" public purpose and is "rationally related" to serving that purpose. This is termed "minimal" judicial scrutiny and virtually all of the time results in the challenged action being upheld.[243] The rationale for this judicial deference is the constitutional doctrine of separation of powers. As a general proposition, the legislature must be free to make rules and regulations without interference by the judiciary. It is assumed that incorrect rules will be rectified by the normal political processes. However, the Court is sensitive to the fact that sometimes the pre-

239. 424 U.S. 319 (1976).

240. The concern here is the probability that a person's life, liberty, or property will be wrongly denied given existing notice and hearing as opposed to more and better (from the plaintiff's perspective) notice and hearing.

241. *Mathews*, 424 U.S. at 335. The concern of this last factor is, basically, the cost to the government of providing more or different quality or quantity of notice and hearing.

242. *See supra* notes 15-19 and accompanying text.

243. *See, e.g.*, Plyler v. Doe, 457 U.S. 202 (1982).

mise upon which the general rule is based is faulty, such that extreme judicial deference would be inappropriate.

As a matter of substantive due process, any governmental[244] infringement of a "fundamental," or fundamentally important, right is permitted only if it can be justified as "necessary" to serving "compelling" governmental interests.[245] From the perspective of persons with AIDS, ARC, and antibodies to HTLV-III, the problem with the applicable case law is that rights they believe to be fundamentally important, such as employment, education, and housing, have been held by the Court not to be "fundamental."[246] The consequence of these decisions is that discrimination against those with AIDS, ARC, and antibodies to HTLV-III with respect to jobs, schools, and other rights need only survive "minimal scrutiny." Provided the challenged action is intended to serve some "legitimate" public purpose and is "rationally related" to serving that purpose, the Court will not substitute its judgment for that of local government.[247]

Similarly, as a matter of equal protection, unless the class of persons being discriminated against is "suspect,"[248]—and courts will probably decide that those with AIDS, ARC, or antibodies to HTLV-III are not[249]—discrimination against them will be subject only to minimal scrutiny.[250]

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244. *See supra* note 229 and accompanying text.

245. *See supra* note 243 and accompanying text.

246. *See* Plyler v. Doe, 457 U.S. 202, 218 (1982); United States v. Carolene Prods. Co., 304 U.S. 144, 152 n.2 (1938).

247. Craig v. Boren, 429 U.S. 190 (1976); Massachusettes Bd. of Retirement v. Murgia, 427 U.S. 307 (1976); San Antonio Indep. School Dist. v. Rodriguez, 411 U.S. 1 (1973).

248. Plyler v. Doe, 457 U.S. 202 (1982). The rationale for this judicial deference is the constitutional doctrine of separation of powers. As a general proposition, the legislature must be free to make the decisions (regulations) without excessive interference by the judiciary.

249. The Supreme Court has instructed that classes of people are "suspect" if they are: discrete (one can readily identify them as members of a class); insular (either by choice or involuntarily they are not assimilated into mainstream society); a minority; politically powerless (both with respect to whether they are entitled to vote and whether they have political efficiacy—known in Chicago as "clout"); historically discriminated against; whether the characteristic upon which they are classified is mutable; and whether the characteristic upon which they are classified is relevant to the purpose for which they are being discriminated against. City of Cleyburne v. Cleyburne Living Center, 105 S. Ct. 3249 (1985); Frontiero v. Richardson, 411 U.S. 677 (1973); United States v. Carolene Prods. Co., 304 U.S. 144 (1938). *See also* Note, *Cleyburne Living Center v. City of Cleyburne: The Irrational Relationship of Mental Retardation to Zoning Objectives*, 19 J. MAR. L. REV. 469 (1986).

When classes are suspect, discrimination against them will be strictly scrutinized because, though generally the political process can rectify improvident legislative or executive decisions, when persons negatively affected by governmental action lack the opportunity to avail themselves of the political process, it is proper for the judiciary to thrust itself into an enquiry about the rightness of that political process. *See Plyler*, 457 U.S. at 218.

250. The Court has regularly expressed a disinclination to add to the list of

Given that both substantive due process and equal protection challenges will be subjected to minimal scrutiny, the inquiry must first be whether the public concern about the health and safety of those with AIDS, ARC, or testing positively for HTLV-III antibody and others with whom they come in contact, serve a "legitimate" public purpose. There can be no argument but that the goal of public health is a proper one.[251] The crux of this constitutional right, then, turns on whether discrimination is "rationally related" to that proper purpose. Put differently, the inquiry in each case must be whether the action complained of actually does protect public health or safety. Although some older cases suggest that the test for a requisite "rational relationship" between a challenged state action and its purpose is "any conceivable basis,"[252] more recent cases suggest that there has to exist some truly reasonable correlation between what government has done and what it intended to do.[253]

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classifications it seems suspect. *See Plyler*, 457 U.S. at 219; *Rodriguez*, 411 U.S. at 28. Most recently, in *Cleyburne*, the Court decided that even mentally retarded persons are not suspect. For the same reason that this aspect of *Cleyburne* was incorrectly decided, so too, unfortunately, would the Court probably decide that PWAs are not suspect. *See* Connor, *Zoning Discrimination Affecting Retarded Persons*, 29 J. URB. & CONTEMP. L. 67 (1985). *See also* Note, *Cleyburne Living Center v. City of Cleyburne: The Irrational Relationship of Mental Retardation to Zoning Objectives*, 19 J. MAR. L. REV. 469 (1986).

251. *But see supra* notes 47-49 and accompanying text.

252. *See, e.g.*, Williamson v. Lee Optical, 348 U.S. 483 (1955); Kotch v. River Boat Pilot Comm'rs, 330 U.S. 552 (1947).

253. The bathhouse cases are a bit more problematic. Bathhouses are the sites for a broad continuum of social and sexual activities. Rabin, *The AIDS Epidemic and Gay Bathhouses: A Constitutional Analysis*, 10 J. HEALTH POL., POL'Y & L. 729, 730 (1986). Some facilities cater to homosexuals and bisexuals, while other facilities cater to heterosexuals. *See Straight club closed down*, Chicago's Gay Life Mag., Dec. 12, 1985, at 7, col. 3 (New York "swinger's club, the first heterosexual club to be closed in response to the AIDS crisis). Most homosexual men have never been to a bathhouse, but instead meet their sexual partners in at least as many ways and places as heterosexual men do. Rabin, at 731. Many of the gay men who have visited bathhouses, however, have done so in part as an affirmation of gay identity with the strong value of self-identification. In City of New York v. New Saint Marks Baths, 497 N.Y.S.2d 979 (Sup. Ct. 1986), and State of Georgia ex rel. Slaton v. Fleck & Assocs., 622 F. Supp. 256 (N.D. Ga. 1985), bathhouses allegedly "used predominately as meeting place for males and . . . continuing and frequent incidents of lewdness, oral and anal sodomy, and sexual contact between various male patrons . . . ." (*Slaton*, 622 F. Supp. at 257), were closed for the asserted purpose of reducing the spread of AIDS. To the extent that AIDS is spread by men and to the extent that closing bathhouses would decrease the occurrence of acts that contribute to the spread of AIDS, closing bathhouses would appear to make sense. It was following this rationale that the New York trial court in *New Saint Marks Baths* upheld the closings.

The case might have been analyzed differently, however. Closing bathhouses may not decrease the amount of sexual (or illicit) activity occuring. It may merely result in the location of that activity shifting. In fact, it has been argued that closing bathhouses has resulted in a rise in public sexual activity—such as in parks, forest preserves, and public restrooms. *See* Kohorn, Achtenberg, Hitchens, Coles, Steel, 6 McShane, DRAFT PRELIMINARY REPORT: AIDS AND THE REGULATION OF BATHHOUSES 8 (Aug. 9, 1984)(submitted to the Public Protection Committee, Board of Supervisors, City and County of San Francisco).

The two major "rational basis" questions related to AIDS-based discrimination are: whether treating all persons who test positively for HTLV-III antibodies as if they had AIDS rationally serves any legitimate purpose, and whether segregating or quaranteening PWAs from parts of society rationally advances any proper public purpose. The answer in both cases must be in the negative because each is so imperfect a way of addressing legitimate health concerns as to be irrational. Before examining specific cases, two facts must be recalled: the test to detect HTLV-III antibodies is both unreliable (erroneously overreportive of positive results) and properly useful only for screening donated blood and organs. There exists no evidence at the present time that the AIDS virus can be spread by casual contact—or even through such intimate contact as kissing or oral sex.

With these critical facts in mind, we can explain why most courts that have thus far been called upon to decide cases of discrimination against PWAs or persons perceived to be at risk for exposure to HTLV-III have decided in ways favorable to the victims. Presently, the areas of concern about governmental involvement with mandatory HTLV-III antibody testing include child custody and visitation, pre-marital requirements, public education, military service, and prison operations.

3. *The Right to Privacy*

The final aspect of constitutional law of critical importance to those with AIDS, ARC, and antibodies to HTLV-III is the right to privacy. The right to privacy is protected by the federal constitution, state constitutions and statutes, and the medical profession's obligation to protect the confidentiality of patient records.

Secondly, when bathhouses which host large numbers of high risk persons are allowed to remain open, they may well be able to play an important educational role in the AIDS crisis. *See* Rist, *Policing the Libido*, Village Voice, Nov. 26, 1985, at 17, col. 1. Educational notices and programs, condom distribution, and bathing facilities may make sexual activity safer there than in the locations to which it shifts when they are closed. Rabin, *The AIDS Epidemic and Gay Bathhouses: A Constitutional Analysis*, 10 J. HEALTH POL., POL'Y & L. 729, 742 (1986).

Finally, current attendance at bathhouses is approximately 10-20% of what it was before the AIDS crisis, because people are staying away of their own accord. Most of these establishments will probably soon close because of financial exigencies. It may well be that when the gay and bisexual community itself declares that bathhouses should no longer operate, this declaration will constitute a much more powerful educational message than a governmental mandate that the bathhouses must close. *See AIDS and Individual Rights: Privacy Versus the Risk to the Public*, N.Y. Times, Dec. 15, 1985, § E, at 6, col. 3.

a. *The Constitutional Right of Privacy*

The right to privacy has been considered a fundamental constitutional right by the Supreme Court for decades.[254] Further, the first amendment's protection of the freedoms of expression and free association also protect the right of privacy.[255] Because the issues raised by AIDS are so closely connected to many issues of gay rights, the very recent Supreme Court decision of *Bowers v. Hardwick*[256] is of importance. In *Hardwick*, Georgia's sodomy statute was challenged on the basis that it violated an alleged constitutional right to engage in private, consensual homosexual activity.[257] Although the statute applied to both homosexual and heterosexual conduct, the privacy challenge to the constitutionality of the statute in *Hardwick* was limited to private, consensual homosexual activity.[258] In part, the

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254. *See* Griswold v. Connecticut, 381 U.S. 479 (1965); Pierce v. Society of Sisters, 268 U.S. 510 (1925); Meyer v. Nebraska, 262 U.S. 390 (1923). *See also* Seng, *The Constitution and Informational Privacy, or How So-Called Conservations Countenance Governmental Intrusion into a Person's Private Affairs*, 18 J. MAR. L. REV. 871, 872-76 (1985); Comment, *Homosexuals in the Military: They Would Rather Fight Than Switch*, 18 J. MAR. L. REV. 937, 948 (1985).

255. The first amendment provides that:

> Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances.

U.S. CONST. amend.I.

256. 54 U.S.L.W. 4919 (June 30, 1986), *reversing* 760 F.2d 1202 (11th Cir. 1985).

257. The statute defined sodomy as "any sexual act involving the sex organs of one person and the mouth or anus or another . . . ." GA. CODE ANN. § 16-6-2 (1984). For many years, Georgia's sodomy statute did not apply to lesbians. *See* Thompson v. Aldredge, 200 S.E. 799, 800 (Ga. 1939).

258. On August 3, 1982, the Atlanta police arrested Michael Hardwick, a gay man, for committing the statutory crime of sodomy in the bedroom of his own home. After the criminal charges were dismissed, Hardwick brought a civil action in the United States District Court for the Northern District of Georgia to challenge the statute's constitutionality. Hardwick contended that he was a practicing homosexual, that he regularly engaged in private, homosexual acts, and that he would continue to do so in the future. The district court granted the defendants' motion to dismiss for failure to state a claim. The district court held that Hardwick had no legal claim because of the "binding" effect of the United States Supreme Court's summary affirmance in Doe v. Commonwealth's Attorney for Richmond, 425 U.S. 901 (1976). *See* Comment, *Homosexuals in the Military: They Would Rather Fight Than Switch*, 18 J. MAR. L. REV. 937, 956-57 (1985). In *Doe*, the Supreme Court affirmed the district court, which upheld Virginia's sodomy law and rejected arguments that the sodomy statute denied the plaintiff's right to privacy.

The Eleventh Circuit held that the statute interfered with Hardwick's fundamental right to privacy, and remanded the case to determine whether the state of Georgia could prove a compelling interest in forbidding the behavior and that the statute was the least restrictive way to protect this state interest. Hardwick v. Bowers, 760 F.2d 1202 (11th Cir. 1985). The Eleventh Circuit relied upon the line of cases culminating with *Griswold*, which have upheld the privacy of certain intimate relationships, to decide that within the parameters of the right to privacy there exists the right to have private, non-commercial consensual relations with an adult of the same sex.

State of Georgia argued that the statute was necessary to curtail the spread of AIDS.[259]

In *Hardwick*, a sharply divided Supreme Court denied that previous Supreme Court decisions conferred a right to privacy which extended to consensual homosexual sodomy. To the majority, it was critically important that proscriptions against sodomy had ancient roots,[260] and that sodomy was entirely unlike the privacy rights theretofore recognized by the Court as fundamental. Fundamental rights, according to the Court, concerned "family, marriage, or procreation. . . ."[261] In the majority's opinion, gay couples or relationships simply—and to the Court, obviously—do not implicate matters of "family." In *Hardwick*, then as in many other recent cases, the Court has eschewed taking an expansive view of its "authority to discover new fundamental rights imbedded in the Due Process Clause."[262]

As to the plaintiff's arguments that, even were the right at stake here not fundamental, the challenged statute could not survive even minimal scrutiny for it served no legitimate purpose but rather only served to enforce the presumed belief of a majority of the electorate in Georgia that homosexual sodomy is immoral and unacceptable, the Court stated:

> The law, however, is constantly based on notions of morality, and if all laws representing essentially moral choices are to be invalidated under the Due Process Clause, the courts will be very busy indeed. Even respondent makes no such claim, but insists that a majority's sentiments about the morality of homosexuality should be declared inadequate. We do not agree, and are unpersuaded that the sodomy laws of some 25 states should be invalidated on this basis.[263]

Justice Powell wrote a separate concurring opinion which agreed that there was no fundamental right involved, but stated that prison sentences of up to 20 years for consensual, homosexual

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259. Brief of Petitioner Michael J. Bowers, Attorney General of Georgia, at 37, Bowers v. Hardwick, 54 U.S.L.W. 4919 (June 30, 1986), *reversing* 760 F.2d 1202 (11th Cir. 1985).

260. The Court observed: "Sodomy was a criminal offense at common law and was forbidden by the laws of the original thirteen States when they ratified the Bill of Rights. In 1868, when the Fourteenth Amendment was ratified, all but 5 of the 37 States in the Union had criminal sodomy laws. In fact, until 1961, all 50 States outlawed sodomy, and today 24 States and the District of Columbia continue to provide criminal penalties for sodomy performed in private and between consenting adults. *Hardwick*, 54 U.S.L.W. at 4921 (footnotes omitted).

261. *Id.* at 4920. The majority opinion also made the biologically astute observation that no connection had been demonstrated between "procreation on the one hand and homosexual activity on the other . . . ." *Id.*

262. *See supra* note 243-53 and accompanying text. This and other similar phrases constitute the tests of the Court for whether a right is fundamental.

263. *Hardwick*, 54 U.S.L.W. at 4922. *See also* Plyler v. Doe, 457 U.S. 202 (1982); San Antonio Indep. School Dist. v. Rodriguez, 411 U.S. 1 (1973).

acts could violate the eighth amendment's prohibition against cruel and unusual punishment: "Under the Georgia statute a single act of sodomy, even in the private setting of a home, is a felony comparable in terms of the possible sentence imposed to a serious felony such as aggravated battery, first degree arson, and robbery."[264] While the Court has refused to extend the constitutional right of privacy to consensual, voluntary homosexual activity within the home, Powell's concurrence recognizes that these non-commercial private acts of consenting adults may not be subject to prison terms.

Justice Blackmun and Justice Stevens wrote dissenting opinions, in which Justices Brennan and Marshall joined.[265] Justice Stevens found that Supreme Court precedent established two basic propositions. First, the fact that a State's majority in power views specific practices as immoral is an insufficient justification upon which to uphold a law prohibiting the practice. Second, individual decisions concerning the intimacies of physical relationships, even when not intended for procreation, are a form of "liberty" within the protection of the due process clause of the fourteenth amendment.

In addition to the grounds upon which Justices Blackmun and Stevens based their dissenting opinions, major flaws in logic taint the majority opinion. Specifically, the majority fails to recognize the nature of the right of privacy. The Court stated that it would be "difficult" to permit voluntary, consensual, private homosexual activity in the home while "leaving exposed to prosecution" adultery, incest, and other sexual crimes.[266] Privacy can and should protect private, consensual, voluntary acts. Incest, in stark contrast, is frequently forcible, non-consensual, and non-voluntary. As such, it is not "difficult" to leave incest open to criminal prosecution because a violation of personal integrity is involved. There also is no difficulty in prosecuting "other sexual crimes" such as beastiality, because it does not involve the consenting acts of two adults. Neither is there difficulty in prosecuting adultery, because the act of adultery represents a breach of a marriage contract authorized by the state.

Hardwick's reliance on the course of history is also unjustifiable. If all cases were decided simply on the basis that it follows a deeply-rooted history, the United States would still have slavery, miscegination statutes, and other laws which have long been abandoned by contemporary society.

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264. *Hardwick*, 54 U.S.L.W. at 4922 (Powell, J., concurring)(citations to statutes omitted).

265. *Id.* at 4927 (Stevens, J., dissenting). Justice Blackmun also wrote a separate dissenting opinion. *Id.* at 4923 (Blackmun, J., dissenting).

266. *Id.* at 4922.

It is entirely unrealistic to imagine that the Supreme Court's decision will end voluntary, consensual homosexual activity. *Hardwick* can, however, drive those relationships underground in the states where prosecution is threatened under similar statutes.[267] The Court has thus pronounced that the limits of the federal constitutional right of privacy may be drawn at private, consensual, voluntary homosexual activity. Yet, what the federal right of privacy has failed to protect may still find safe haven in state protection of the right of privacy.

b. *State Protection of the Right of Privacy*

On a state level the right of privacy has been expressly protected in several state constitutions.[268] The protection of the right of privacy may be stronger when it is express than when it is implied. Where the right is expressly protected, state courts must determine whether the state constitutional right of privacy is broad enough to include what *Hardwick* refused to recognize.

c. *Private Protection of the Right of Privacy and Anonymous Alternative Testing Sites*

Even outside the federal and state protection of the right of privacy, clinics and other health care institutions involved in testing for antibody to HTLV-III should have adopted some type of guidelines or system to protect the confidentiality of their patients.[269] For example, at the Howard Brown Memorial Clinic in Chicago (a leading community-based gay health clinic), a person coming in for HTLV-III antibody testing can only secure an appointment over the telephone. At that time, the person will be assigned a number and given an appointment for the test. No names or other identifying procedure is used. Under this system, the Howard Brown Memorial Clinic (HBMC) has taken all precautions to protect the identity of persons coming in for testing. Yet, some persons who utilize this procedure have chosen to pay for their antibody tests with a personal check or credit card, which diminishes the confidentiality of the testing pro-

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267. *See Survey on the Constitutional Right to Privacy in the Context of Homosexual Activity*, 40 MIAMI U.L. REV. 521 (1986).

268. *See, e.g.*, CAL. CONST. art. 1, § 1; ILL. CONST. art. I, § 6. For other information on the state law of privacy, see Hanson, *Illinois and the Right of Privacy: History and Current Status*, 11 J. MAR. J. PRAC. & PROC. 91 (1977) (constitutional basis of Illinois privacy law); Comment, *Privacy in Illinois: Torts Without Remedies*, 17 J. MAR. L. REV. 799 (1984)(tort basis of Illinois privacy law).

269. For a report on other alternative testing sites, see Centers for Disease Control, *Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus Antibody Testing at Alternate Sites*, 35 MORBIDITY & MORTALITY WEEKLY REP. 284 (1986).

cedures. Fortunately, HBMC has both an excellent record and reputation for protecting the confidentiality and identity of all persons who use the clinic. Additionally, HBMC has a federal government contract to conduct a health study of gay men in conjunction with the National Institutes of Health and, by law, the records of the study are protected against subpoena or official inspection.

d. *Additional Privacy Protections of Medical Records*

The ability to conduct medical research may be conditioned upon the willingness of research subjects to cooperate. Concerns about confidentiality will threaten to jeopardize medical research and public health control measures unless they are adequately and credibly addressed.[270] When adverse consequences would flow from public disclosure of participation in medical research, individuals condition their participation on a guarantee of anonymity and privacy.

In *Farnsworth v. Proctor & Gamble Company*,[271] the United States Court of Appeals for the Eleventh Circuit considered the privacy needs of the Centers for Disease Control in connection with personal information furnished by female participants in the Center's Toxic Shock Syndrome studies. The court's language would apply equally to future AIDS research:

> [T]he Center's purpose is the protection of the public's health. Central to this purpose is the ability to conduct probing scientific and social research supported by a population willing to submit to in-depth questioning. Undisputed testimony in the record indicates that disclosure of the names and addresses of these research participants could seriously damage this voluntary reporting. Even without an express guarantee of confidentiality there is still an expectation, not unjustified, that when highly personal and potentially embarrassing information is given for the sake of medical research, it will remain private.[272]

A valuable part of the right of privacy thus is the right to avoid publicity concerning private medical facts.[273]

In addition to the case law, states have enacted statutes and promulgated regulations to additionally protect the privacy of medical records. Illinois law, for example, restricts access to hospital records to the patient, his or her physician, or authorized attorney. Hospital records can only be examined when a written request is

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270. Curran, Morgan, Hardy, Jaffe, Darrow, & Dowdle, *The Epidemiology of AIDS: Current Status and Future Prospects*, 229 SCIENCE 1352, 1357 (1985).

271. 758 F.2d 1545 (11th Cir. 1985).

272. *Id.* at 1547.

273. Head v. Colloton, 331 N.W.2d 870, 876 (Iowa 1983).

delivered to the hospital administration.[274] A patient may similarly authorize another to examine physician's records of the patient when accompanied by a written request.[275]

Blood banks, also, are to report results of tests directly to the licensed or authorized physician who ordered the test.[276] Additional emergency regulations were promulgated in Illinois to require blood banks to inform donors that each unit of blood to be donated will be tested for evidence of infection with HTLV-III. The emergency regulations provide further that

> Confirmed HTLV-III virus [sic] test results (e.g. Western blot) will be disclosed in a confidential manner to the donor's physician or the donor no later than 55 days after the date of the donation. . . . A consent to such disclosure must be signed by the donor before the donor's blood is collected.[277]

The reference to HTLV-III *virus* test results is repeated in other areas of the Illinois regulations, and discloses that these regulations were adopted upon the mistaken assumption that the HTLV-III testing currently being performed can identify the presence of virus rather than antibody. The distinction, again, is of present infection as compared to possible past exposure. As yet, there is no commercially-available test for the HTLV-III virus.

Despite the mistaken basis from which the Illinois regulations proceed, the regulations continue with a comprehensive list for protecting the initial test results:

> A) The donor shall be advised to contact the blood bank for an appointment to discuss the results of the tests. If initial notification is made by mail, the correspondence must be general in nature (e.g. no references to specific diseases or test procedures shall be made). If the donor does not respond to the initial notification by mail, or if the blood bank chooses not to use such initial notification procedures, the donor shall be advised through certified mail with restricted delivery, messenger or personal visit to contact the blood bank for an appointment to discuss the test results[;]B) The medical director of the Blood Bank or the medical director's designee shall be available for a scheduled appointment with the donor at the earliest possible date requested by the donor and shall present and explain the results of HTLV-III virus testing [sic] only in a person to person interview;
> C) If the donor has not contacted the Blood Bank . . . or if the donor has failed to follow through with the scheduled appointment, the confirmed test result(s) shall be sent to the donor by certified mail with restricted delivery, messenger or personal visit accompanied by explanatory and referral information which has been provided by the Department or equivalent information;
> . . .

274. ILL. REV. STAT. ch. 110, § 8-2001 (1985).
275. *Id.* § 8-2003.
276. *Id.* § 607-102.
277. 10 Illinois Register (1986).

> E) If a donor expressly so requested in writing and provides the name and address of his or her physician, the results shall be sent to the physician by certified mail;
> F) HTLV-III virus [sic] test results shall be treated as confidential and shall be disclosed only as authorized in writing by the donor.[278]

The wisdom of the regulations must be questioned on three grounds. First, the personal visits to the home may be subject to abuse if conducted in an insensitive or non-discrete manner. In any event, they will be psychologically devastating. Second, the regulations make no provision for the severe psychological problems from learning about a positive antibody result, no matter how deliberately the results are given. An adequate counseling and support structure must be established both to allay individual fears and to promote education for responsible personal choices. Third, there is no provision to protect further disclosure of the results. Results could be compiled in a central registry where access is unrestricted and thus subject to the potential abuses discussed in this article.

The importance of preserving the privacy of medical records cannot be over-stressed. In California, a man was fired from his job after his medical records were improperly leaked to his employer.[279] He did not have AIDS, but public rumor quickly spread that he did have AIDS.[280] The man has since received numerous crank phone calls, and his house was set on fire.[281] Others can only be protected when the confidentialty and privacy of their medical records are preserved.

In *South Florida Blood Service v. Rasmussen*,[282] Florida's Third District Court of Appeal quashed a discovery order which would have required a blood bank to disclose the names and addresses of fifty-one volunteer blood donors. The discovery request came in connection with a tort suit for personal injuries sustained in a car accident. While hospitalized for his injuries, Donald Rasmussen received fifty-one units of blood. Rasmussen later developed AIDS. A physician's opinion was that Rasmussen contracted the AIDS virus from the hospital transfusions. Rasmussen then sought to discover the names and addresses of each blood donor. The defendant argued that Rasmussen failed to justify any invasion of the private and confidential records of the blood service agency and its volunteer donors.[283] The Florida Court of Appeal agreed. It recog-

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278. *Id.*
279. Comment, *AIDS: A Legal Epidemic?*, 17 AKRON L. REV. 717, 735 (1984).
280. *Id.*
281. *Id.*
282. 467 So.2d 798 (Fla. App. 1986), *cert. granted* (Fla. Feb. 24, 1986)(No. 67,081).
283. *See Confidentiality: Identity of Blood Donors Sought in Suit Over Accident*, 1 AIDS POL'Y & L. (BNA) No. 12, at 2 (July 2, 1986).

nized two zones of privacy. The first involved "the decision-making or autonomy zone of privacy interests" limited to highly personal matters such as marriage, procreation, contraception, family relationships, and education.[284] The second zone of privacy protected the confidentiality interest in avoiding disclosure of personal matters.[285] The court characterized Rasmussen's discovery request as one which would invade the confidentiality zone of privacy.[286]

The appellate court first considered the blood donors' expectation of privacy, stating that "these fifty-one donors did not anticipate, when they altruistically donated blood, that some future litigant would intrude into these most personal aspects of their lives."[287] Further, this "probing by strangers into these areas of one's life is itself an invasion of privacy entitled to consideration."[288] In perhaps the most significant language of the opinion, the appellate court considered the ramifications of possible disclosure to persons outside the litigation:

> AIDS, or suspicion of AIDS, can lead to discrimination in employment, education, housing and even medical treatment. If the donors' names were disclosed outside the litigation, they would be subject to this discrimination and embarrassment, even though most, if not all the donors, would not be AIDS victims in fact, but only innocent suspected victims. It cannot be doubted that the donors have a strong interest in remaining free from both the intrusion of litigants into their private lives and the oppressive effects of possible disclosure outside the litigation. This interest is protected by the state and federal constitutions and falls within the disclosural privacy zone. . . .[289]

Thus, in a victory for the right of privacy, the appellate court quashed the trial court's discovery order.[290]

In addition to the right of privacy, the court's second consideration was to ensure the safety and adequacy of the national blood supply.[291] Testing of blood for HTLV-III antibodies was not widely used at the time the appellate court reached its decision. It remains to be seen how the Supreme Court of Florida will treat this second policy concern now that the Food and Drug Administration has promulgated regulations to screen blood for HTLV-III antibodies. Yet, the appellate court's pronouncement remains valid, that it is

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284. *Rasmussen*, 467 So.2d at 802.

285. *Id.* The court described this as "essentially an interest in confidentiality." *Id.*

286. *Id.* at 804.

287. *Id.* at 802.

288. *Id.* (citing Plante v. Gonzales, 575 F.2d 1119, 1135 (5th Cir. 1978), *cert. denied*, 439 U.S. 1129 (1979)).

289. *Id.*

290. *Id.* at 804. The appeal from this case was argued before the Florida Supreme Court on May 5, 1986. *Confidentiality: Identity of Blood Donors Sought in Suit Over Accident*, 1 AIDS POL'Y & L. (BNA) No. 12, at 2 (July 2, 1986).

291. *Rasmussen*, 467 So.2d at 803-04.

"in the public interest to discourage any serious disincentive to voluntary blood donation such as an intrusive probe into the most intimate details of one's life."[292] Thus, the court completely denied discovery to protect "both the donor's privacy interest and society's interest in a strong and healthy volunteer blood donation program."[293]

The identical issue in *Rasmussen* will undoubtedly be litigated in other cases. For example, in *Keller v. St. John's Hospital of the Hospital Sisters of the Third Order of St. Francis*,[294] a subpoena for deposition and discovery seeks production of "copies of any reports, names, addresses, medical reports, questionnaires, etc. from or regarding all persons who donated blood to Guy Keller in February, 1983. . . ."[295] The plaintiffs, Guy Keller and Martha Keller, sued "Individually and as Representatives of a Class of all Persons who may Receive Future Blood Transfusions Administered by Defendants." Guy Keller contracted AIDS and later died of an opportunistic infection. This suit, like *Rasmussen*, seeks to learn the identity of those who donated blood. For the reasons advanced by the Florida Appellate Court in *Rasmussen*, Illinois courts should quash the *Keller* subpoena.

e. *Waiver of the Right to Privacy*

Privacy is a constitutional right which may be waived. In large part, control of information is personal and private. Accordingly, personal control of certain information can be voluntarily waived.

One AIDS-related example of the waiver of privacy arose in a Florida bankruptcy case, *In re Peacock*.[296] In Florida, some judges required persons with AIDS to wear face masks during courtroom proceedings.[297] Concerned about this now-repudiated practice, Mr. Peacock's attorney announced during a pre-trial conference that his client "had been diagnosed as a victim of pre-AIDS syndrome" and inquired of the court whether any "special precautions" would be required during trial. The court was competently advised by the Centers for Disease Control that no special procedures are required because there is no risk of transmitting the HTLV-III virus in a

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292. *Id.* at 804.
293. *Id.*
294. No. 85-CH-157, Cir. Court of the 7th Judicial Cir., Sangamon County, Illinois.
295. Subpoena for Deposition and Discovery of Documents, Keller v. St. John's Hosp. of the Hosp. Sisters of the Third Order of St. Francis, No. 85-CH-157, Cir. Court of the 7th Judicial Cir., Sangamon County, Illinois.
296. 59 Bankr. Rep. 568 (S.D. Fla. 1986).
297. *Id.*

courtroom setting.[298] Accordingly, the court wisely found no justification for any "precautions." Continuing on the issue of waiving privacy, however, the court stated that it "would not have mentioned the matter out of respect for the privacy of the debtor, but for the fact that the debtor, himself, elected to make public in open court the fact that he was afflicted with AIDS."[299]

C. *Substantive Cases and Areas of Concern*

The following is a survey of the major areas of due process, equal protection, and privacy litigation concerning persons who have or are perceived to have AIDS or an AIDS-related condition and who are at increased risk for AIDS.

1. *Child Visitation and Custody*

There are many gay parents of minor children who are the subject of disputes about visitation and custody.[300] In a growing number of instances, one parent has raised the matter of AIDS as a means by which to attempt to deprive a gay or lesbian parent of visitation or custody. The complaining parent has taken advantage of AIDS hysteria to allege a danger of infection to the minor children if allowed to visit with, or reside in the household of, their gay or lesbian parent. Mothers have even done so where the fathers exhibit no signs of AIDS, and even though there is no risk of casual transmis-

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298. *Id.* The court relied on a letter from Dr. D. Peter Drotman, a medical epidemiologist, and the CDC recommendations for prevention of HTLV-III transmission in the workplace. Centers for Disease Control, *Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace*, 34 MORBIDITY & MORTALITY WEEKLY REP. 682 (1985).

299. *In re* Peacock, 59 Bankr. Rep. 568 (S.D. Fla. 1986).

300. *See, e.g.*, NATIONAL LAWYER'S GUILD, SEXUAL ORIENTATION AND THE LAW § 1.03 (1985); Bagnell, Gallagher, & Goldstein, *Burdens on Gay Litigants and Bias in the Court System: Homosexual Panic, Child Custody, and Anonymous Parties*, 19 HARV. C.R.-C.L. L. REV. 497 (1984); Brownstone, *The Homosexual Parent in Custody Disputes*, 5 QUEENS L.J. 199 (1980); Clemens, *In the "Best Interests of the Child" and the Lesbian Mother: A Proposal for Legislative Change in New York*, 48 ALB. L. REV. 1021 (1984); Goodman, *Homosexuality of a Parent: A New Issue in Custody Disputes*, 5 MONASH L. REV. 305 (1979); Leitch, *Custody: Lesbian Mothers in the Courts*, 16 GONZ. L. REV. 147 (1980); Rivera, *Our Straight-Laced Judges: The Legal Position of Homosexual Person in the United States*, 30 HASTINGS L.J. 799, 883-904 (1979); Rivera, *Recent Developments in Sexual Preference Law*, 30 DRAKE L. REV. 311, 327-36 (1980-81); Rivera, *Queer Law: Sexual Orientation Law in the Mid-Eighties—Part II*, 11 U. DAYTON L. REV. 275, 327-71 (1986); Wilson, *Homosexuality and Child Custody: A Judicial Paradox*, 10 THURGOOD MARSHALL L. REV. 222 (1985); Recent Developments, *Lesbian Child Custody*, 6 HARV. WOMEN'S L.J. 183 (1983); Walter, *Gay Father Awarded Custody of Son*, Advocate, July 8, 1986, at 13, col. 1; *A Homosexual Father Gains Custody of Son*, N.Y. Times, July 1, 1986, at 11, col. 4; Skoloff, *Today's 'Innovative' Lifestyles Become Issues in Custody Cases*, Nat'l L.J., May 26, 1986, at 24, col. 1.

sion of AIDS. More incredibly, fathers have capitalized on the hysteria against lesbian mothers, even though lesbians constitute the lowest risk group in the country for AIDS.[301]

In November of 1985, in the case of *Doe v. Doe*,[302] a Chicago trial court ordered a gay father to undergo HTLV-III antibody testing in the course of a dispute about extended overnight visitation after the mother raised the spectre of AIDS and asked that the father be tested. The father refused to be tested and succeeded in obtaining a reconsideration by the court.[303] Court-ordered testing presents a number of serious problems. First of all, there is a significant confidentiality problem. Most divorce proceedings are not happy and agreeable times for the parties. To order HTLV-III antibody testing in the course of such a proceeding is to divulge the test results to the father's enemy, his ex-wife. There is little if any way to limit further dissemination of this information by the adverse party. Furthermore, court personnel, including bailiffs, clerks, and judges, may have access to the test results even if the court file is impounded to avoid public access. The confidentiality of test results cannot be assumed, especially in the wake of the corruption disclosed in Chicago's Operation Greylord probe and in other bribery cases involving public officials across the nation.

Secondly, there are major practical problems. Assume that the father had submitted to the test and obtained a negative test result. The court would have to supervise the retesting of the parents periodically for the time the children remained minors (about 9 years in *Doe*). The reason for this is that, as with blood testing for other diseases such as syphilis and hepatitus, a blood test is indicative of the patient's condition only as of the time the blood is drawn. The

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301. *See, e.g.*, Cunat, *AIDS is not divine retribution*, Washington Blade, June 13, 1986, at 21, col. 4.

302. 78 D 5040, Cir. Ct. Cook County, Il., County Dept., Dom. Rel. Div. For general reports of this case, see Freiberg, *Judge Rules AIDS Test Not Necessary for Gay Father*, Advocate, July 22, 1986, at 22, col. 1; Burks, *Gay father gets new court hearing*, Windy City Times, June 26, 1986, at 11, col. 1; Tybor, *New Hearing for gay father: Judge sets aside AIDS screening in visitation cast*, Chicago Trib., June 12, 1986, § 2, at 6, col. 2; *Gay Father Ordered to Take HTLV-3 Test: Chicago Judge Makes AIDS a Custody Issue*, Advocate, June 10, 1986, at 15, col. 1; Burks, *Cook County Judge refuses case involving gay father*, Windy City Times, June 5, 1986, at 1, col. 1; *Gay Father's Refusal of Test Reviewed by Fourth Judge*, 1 AIDS POL'Y & L. (BNA) No. 10, at 3 (June 4, 1986); Cose, *Judge quits AIDS case*, Chicago Sun-Times, May 29, 1986, at 3, col. 1; *HTLV-III test becomes issue in child custody case*, Am. Med. News, May 9, 1986, at 14, col. 1; Burks, *Gay father's case postponed*, Windy City Times, May 1, 1986, at 3, col. 1; *Fear of AIDS shadows visitation fight*, Chicago Trib., Apr. 28, 1986, § 2, at 1, col. 2; Baim, *Blood test ordered for gay father*, Windy City Times, Mar. 13, 1986, at 2, col. 2; Shipp, *AIDS Test at Issue in Homosexual's Bid to Have Children Visit*, N.Y. Times, Apr. 28, 1986, at 9, col. 2.

303. Professor Closen, one of the authors of this article, became the pro-bono attorney for Mr. Doe in December of 1985 and successfully argued the case for the reconsideration of the November, 1985 order.

incubation period might be underway, and the blood in the patient might seroconvert to positive the very next day, the next week, or the next month. How often would the court have the parties submit to re-testing? Monthly? Weekly? Would there be a court appearance each time a result were obtained? What would be the cost of such procedures, involving the time of nurses, doctors, medical technicians, lawyers, judges, court personnel, and the parties themselves? Further, any costs which are paid by the parents deprives the children of those funds for their support.

Third, the order of the blood test in *Doe*, which dealt with extended overnight visitation, was preposterous because the gay father continued to have ordinary visitation with his children after the order was entered, even though he had not submitted to the test, without any objection from the mother. The father took his children out of the mother's home for a day at a time to the movies, the zoo, and lunches, and he hugged them and kissed them on the cheek. Thus, it appeared as though the mother did not genuinely fear any health risk to the children from their father, but that she was using the AIDS hysteria to prevent him from having extended overnight visitation with his children.

In addition to the preceeding three points, the father asserted medical and constitutional arguments on his own behalf. He argued that a positive HTLV-III antibody test would not show that he was infected or that he had AIDS. Indeed, he correctly contended that if he had AIDS, even if he were on his deathbed, he should be entitled to visit with his children because their health would not be threatened.

On June 11, 1986, the order requiring an antibody test was vacated on the basis of an insufficient record from the proceedings which brought about the original order. Those original proceedings were held *in camera* via a telephone conference call between the judge, attorneys for the father and mother, and a medical expert. The conversation was not recorded, nor was any court reporter present. An affidavit of the medical expert, however, described his testimony during the telephone conference:

> (a) the AIDS virus is spread by way of intimate sexual contact (through blood and semen);
> (b) there is no competent medical evidence that the AIDS virus is spread by way of casual contact, such as through saliva;
> (c) the father should pose no threat to his children with regard to the transmission of the AIDS virus;
> (d) a positive HTLV-III test shows only the presence of antibodies, not that a person has AIDS or will contract AIDS;
> (e) a negative test result shows only the antibody status as of the time the blood is drawn, and because the incubation period is unknown the blood might seroconvert the next week, the next month, the next year, or sometime thereafter; and

(f) in the context of a child visitation dispute, an HTLV-III antibody test result is meaningless.[304]

On the basis of an insufficient record, the court vacated the order and set the matter for a hearing in July, 1986.

In *Jordan v. Jordan*,[305] a New Jersey trial court ruled that a father who had AIDS should not be barred on that basis from having visitation rights with his daughter. The case arose when the father, who previously was without visitation privileges, petitioned to amend his divorce decree so that he could visit his two-year-old daughter. His ex-wife contested the petition when she learned that he had AIDS. The court considered the medical evidence presented, and correctly determined that there would be no risk of contagion to the daughter. The court thus allowed "supervised visitation." In New Jersey, supervised visitation means that a social worker or other officer will be present with the father during his visits. It does not in any way restrict the father's contact with his daughter. He can hold her and enjoy all the normal familial contacts.

2. *Pre-Marital Testing*

Legislation to mandate pre-marital testing for HTLV-III antibody has been proposed in at least eleven states.[306] Some of the proposed legislation has provided that anyone testing positive for antibody to HTLV-III would be denied the right to marry.[307] The United States Supreme Court decision in *Loving v. Virginia*,[308] however, held that freedom to marry the person of one's choice was "one of the vital personal rights essential to the orderly pursuit of happiness."[309] Such a fundamental right can be interfered with only if the state action doing so is "necessary" to serving a "compelling" public purpose.[310] The HTLV-III antibody test is not necessary to serving

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304. Doe v. Doe, 78 D 5040, Cir. Ct. Cook County, Il., County Dept., Dom. Rel. Div., Affidavit of Steven Kalish, M.D. (June 11, 1986).

305. No. FV 12-1357-84, N.J. Super. Ct., Chancery Div., Middlesex Cty. *See also* 1 AIDS POL'Y & L. (BNA) No. 10, at 6, col. 1 (June 4, 1986).

306. Alabama House Bill 21 (introduced Jan. 14, 1986); Delaware House Bill 434 (introduced Jan. 30, 1986); Georgia House Bill 1190 (introduced Jan. 13, 1986); Illinois House Bill 2565 (introduced Nov. 5, 1985); Indiana House Bill 1059 (introduced Jan. 7, 1986); Michigan House Bill 5276 (introduced Jan. 8, 1986); New Jersey Assembly Bill 1485 (introduced Jan. 14, 1986); New York Assembly Bill 8436 and Senate Bill 7006 (both introduced Jan. 8, 1986); Pennsylvania House Bill 2032 (introduced Jan. 22, 1986); Rhode Island House Bill 7024 (introduced Jan. 7, 1986); Rhode Island House Bill 7024 (introduced Jan. 7, 1986); South Carolina House Bill 3246 (introduced Jan. 14, 1986).

307. *See, e.g.*, Illinois House Bill 2565 (introduced Nov. 5, 1985).

308. 388 U.S. 1 (1967).

309. *Id.* at 12.

310. *See supra* notes 230-53 and accompanying text (discussion of "compelling" public purpose).

any public purpose given the test's irrelevancy and unreliability. Thus, any statute which would deny a person who has tested positive for HTLV-III antibody the right to marriage should be stricken as unconstitutional. As yet, none of the proposed bills have been enacted, so their constitutionality has not been challenged.

3. *School Attendance*

The American Academy of Pediatricians, the nation's major professional association of pediatricians, has recommended that children with AIDS be allowed to attend schools in a normal fashion.[311] Courts in several states have held that schools should not exclude students with AIDS because the risk of transmitting HTLV-III in a school setting is so slight. In New York City, three children who did not have AIDS were allowed to return to school after being removed from classes because of suspicions that boyfriends of the students' mothers had AIDS.[312] In New Jersey, a 4-year-old girl with AIDS and the 9-year-old brother of a youngster with AIDS were barred from classrooms until a medical advisory panel confirmed that there was no risk of transmitting HTLV-III.[313] In Orange County, California, a judge ordered the re-enrollment of an 11-year-old hemophiliac, noting that merely having HTLV-III antibodies was not enough reason to send him home.[314] Yet, despite the medical recommendations and judicial precedent, discrimination still exists in the schools. In Fort Lauderdale, Florida, thirty-five teachers filed a grievance to remove from school a seventeen-year-old student who had tested positive for antibodies.[315] In Indianapolis, a 13-year-old filed a lawsuit after he was banished from his junior high school

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311. Eckholm, *Pediatrician Group Urges Schools To Admit Most Pupils With AIDS*, N.Y. Times, Oct. 24, 1985, at 16, col. 1. The academy further stated that, to protect infected children from ostracism, the number of school personnel aware of the children's identity "should be kept to a minimum needed to assure proper care of the child and detect situations where the potential for transmission may increase." *Id.* Those situations were not identified, but may have referred to the theoretical child with AIDS who goes bezerk in the lunchroom and starts biting other children. *See also Normal schooling urged for most AIDS patients*, Chicago Trib., Oct. 8, 1985, § 2, at 3, col. 5 (also urging education of students and their parents); *Schule/AIDS: Wie Schnupfen*, Der Spiegel, Sept. 16, 1985, at 271, col. 1 (comparing the risk of AIDS in a school to barring children from ever attending classes because they had the "sniffles"). A task force of the American College Health Association has also recommended that students with AIDS be allowed to continue to attend classes and live in dormatories with other students. The task force additionally recommended against antibody testing of teachers and students. Am. Med. News, Jan. 10, 1986, at 42, col. 1.

312. *AIDS Suspicions Cited in Ouster of 3 Students*, N.Y. Times, Oct. 4, 1985, at 14, col. 1.

313. Gest, *AIDS triggers painful legal battles*, U.S. News & World Rep., Mar. 24, 1986, at 73, 74.

314. *2 to Return to School*, N.Y. Times, Oct. 4, 1985, at 14, col. 2.

315. *Teachers Want Student Out*, Windy City Times, Mar. 20, 1986, at 4, col. 4.

when it was discovered that he had been exposed to HTLV-III while receiving a blood transfusion.[316] An Indiana candidate for political office asked the State Health Commissioner to identify students with AIDS, release the names of their school districts, and then isolate and quarantine the students.[317]

In *New York State Association for Retarded Children, Inc. v. Carey*,[318] a school board proposed to segregate forty-eight mentally retarded children who were asymptomatic carriers of hepatitus B, commonly known as serum hepatitus. The hepatitus B virus, like HTLV-III, is transmitted by the exchange of bodily fluids. The United States Court of Appeals for the Second Circuit struck the school board's plan as violative of section 504 of the Rehabilitation Act of 1973,[319] and held that the board had failed to justify its restrictive policy as necessary to prevent transmission of the disease. The court held that such evidence was needed in order to overcome the strong showing of harm to the children whose isolation was proposed, observing:

> the formation of special classes for this small group of children will naturally lead to a decrease in the curricular options that are available for each child, and an increase in the number of children with different needs, and different levels of functioning, who must be placed together in a single classroom. Separation of the carrier children will also limit the extent to which they can participate in schoolwide activities such as meals, recesses, and assemblies, and will reinforce a stigma to which these children have already been subjected.[320]

4. *Testing in the Military*

Homosexuals have been systematically discriminated against in the United States Armed Forces more than in any other area of employment in the last three decades.[321] During World War II, the military employed psychiatrists in an attempt to expel gays from the armed forces.[322] Now, since the development of an antibody test for HTLV-III, the military appears to have found another way to discourage gays from enlisting, to encourage gays to terminate their service in the military, or to oust those gays who test positive.

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316. Gest, *AIDS triggers painful legal battles*, U.S. News & World Rep., Mar. 24, 1986, at 73, 74.

317. *Lynch demands names of PWAs*, Gay Chicago Mag., May 15, 1986, at 75, col. 2. The Indiana State Board of Health correctly refused to comply with the candidate's request. *Id.* at 76. col. 1.

318. 612 F.2d 644 (2d Cir. 1979).

319. 29 U.S.C. § 794 (1982).

320. *Carey*, 612 F.2d at 650-51.

321. Comment, *Homosexuals in the Military: They Would Rather Fight Than Switch*, 18 J. Mar. L. Rev. 937, 939 (1985).

322. *Id.* at 940.

In October, 1985, the Department of Defense began antibody testing of all military personnel, incoming recruits, members of the Reserve Officers Training Corps (ROTC) programs, and seniors at military academies.[323] The rationale articulated for ordering the tests was "force readiness reasons." Secretary of Defense Casper Weinberger stated that "[m]ilitary personnel are subject to special and unique physical requirements and challenges such as immunization with multiple live virus vaccines including one to protect against smallpox, exposure to diseases in hostile environments, and the potential for 'buddy system' blood donation during military contingencies."[324]

When a recruit is found to be antibody positive, he is excluded from joining the military. The military has mishandled how it informs these recruits of a positive test result. One midwest recruit was put in an office with a doctor and his sergeant. He was told "this doesn't mean you have AIDS, but it does mean that you are very sick and must get help." He was prohibited from joining the military. After being informed of his antibody status in such a harsh and cursory manner, the would-be soldier was forced to undergo extended psychiatric counseling. He has not developed AIDS.[325]

Military personnel who refuse to take the antibody test are subject to court-martial, with punishment ranging from a bad-conduct discharge to a six month prison term.[326] One sailor recently refused to submit to the antibody test, arguing that the test violated the fourth amendment's protection against unreasonable search and seizure.[327] He was sentenced to 45 days confinement, reduced to the lowest enlisted rank, and discharged for bad conduct.[328]

Military personnel who take the antibody test are discharged when the test results are positive.[329] Some of these discharges have been "less than honorable."[330] Some of these discharges also expressly list the individual's antibody status on the discharge.[331]

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323. Gest, *AIDS triggers painful legal battles*, U.S. News & World Rep., Mar. 24, 1986, at 73.

324. Keller, *Military Reclarifies Discharge Policy on AIDS Test*, N.Y. Times, Oct. 29, 1985, at 1, col. 2. *See also AIDS Antibody Rate Is Higher in Older Recruits*, N.Y. Times, Apr. 2, 1986, at 8, col. 3.

325. This account is based on a personal interview with the would-be recruit.

326. *Sailor Refuses to Take Antibody Test*, Advocate, June 10, 1986, at 20, col. 1; *Sailor refuses to take test*, Windy City Times, June 5, 1986, at 5, col. 2.

327. *Jail for Refusing AIDS Testing*, N.Y. Times, June 24, 1986, at 8, col. 4.

328. *Sailor found guilty*, Dallas Times Herald, June 24, 1986, § A, at 6, col. 2.

329. *Pentagon Bars 66 After AIDS Test*, N.Y. Times, Nov. 27, 1985, at 11, col. 2.

330. For a survey of military discharges, see Comment, *Homosexuals in the Military: They Would Rather Fight Than Switch*, 18 J. MAR. L. REV. 937 (1985).

331. Byron, *The Hidden Risks of Antibody Screening: This Is Not Only a Test*, Village Voice, May 27, 1986, at 29, col. 1, 2.

When the antibody status is so listed, the individual's antibody status will forever be subject to potential abuses from registries of positive results.[332]

Although a recent poll of lawyers showed that 65% favored "keeping [PWA's] out of the military,"[333] neither PWAs nor persons with positive HTLV-III antibody test results should automatically be denied the opportunity to serve in the military. As long as they are able to perform their duties, such individuals do not pose a threat to either national security (force readiness) or their comrades in arms. Concerns about buddy system blood donations will not be resolved by limiting blood donations to people who submit to testing and who have negative test results because their blood might seroconvert later. Thus, there is no way to guarantee the integrity of blood drawn from one soldier and transfused directly to another on the battlefield (an infrequent occurrence in modern warfare based on surgical strikes). The blood needs to be tested for HTLV-III antibodies.

5. *Proposed Registries*

Once a person has tested positive for antibodies to HTLV-III, concern arises as to who will have access to test results and for what purposes the information will be used. This is a serious concern given the probable discrimination, stigmatization, and other adverse consequences in employment, insurance, education, and other areas that will follow disclosure of positive test results. The danger lies in the fact that central registries of persons with AIDS, ARC, and antibodies to HTLV-III are accessible to many persons.

One flagrant example of a breach of registry confidentiality occurred on national television. On the television show *60 Minutes*, reporter Mike Wallace had occasion to interview a politician best remembered for his role as chief henchman of Senator Joseph McCarthy. During the interview, Wallace asked his interviewee whether he had AIDS. The man, shaken by the bluntness of the question, denied that he had AIDS. Wallace, prepared for the denial, announced "I have a friend who says your name is on the National Institutes of Health computer list as a person with AIDS."[334] The man said there must have been some mistake, and that he would have his name removed immediately. He should have instead asked Wallace how he obtained confidential information about an individ-

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332. *See infra* notes 334-42 and accompanying text.

333. *Lawyers oppose most AIDS-related discrimination*, 72 A.B.A. J. 34 (June 1986).

334. Webster, *Trusting and AIDS*, Windy City Times, Apr. 10, 1986, at 8, col. 1.

ual's health from federal government lists.[335]

The Wallace announcement emphasizes the need for limiting the use of any antibody status report to statistical analysis and medical research. Some proposed legislation, however, fails to do this. For example, legislation was introduced in Pennsylvania to identify all blood donors who test positive for antibodies, compile a central registry, and transmit the name, address, and age of each donor to blood banks throughout the Commonwealth.[336] The bill contained no guarantee of privacy or confidentiality. After vociferous protest, the Pennsylvania registry proposal was abandoned.[337]

In New Mexico, officials at the Health and Environmental Department are considering a statewide registry of people who test positive for the HTLV-III antibody.[338] In Arizona, a bill requiring mandatory reporting to the Arizona Department of Health Services all blood donors testing positive for HTLV-III antibody has cleared the Arizona House Judiciary Committee.[339] Some speculation has arisen considering the implications of registries and other lists of those who are seropositive for HTLV-III. In addition to the economically important issue of insurance coverage, concern has centered on whether antibody status will be used to deny employment, educational opportunities, medical treatment, child visitation, and so on. Just as important is the concern expressed by a critic of the previously mentioned Pennsylvania legislation.[340]

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335. *In Government We Trust?*, Windy City Times, Apr. 10, 1986, at 9, col. 1.

336. House Bill 1940 would have provided a new section to the Pennsylvania Blood Bank Act:

> (a) Donated blood shall be tested for the presence of acquired immune deficiency syndrome (AIDS) virus [sic] in accordance with screening test procedures approved by the Department of Health.
>
> (b) Identification of all donors who show positive signs of exposure shall be made, including the name, address and age of the donor and the date and place of bleeding and testing, and transmitted to the Department of Health.
>
> (c) Donors shall be notified when positive signs of an antibody have been detected, the blood shall be deferred for use and the donor shall be advised to consult with a physician for counseling and further testing.
>
> (d) The Department of Health shall distribute to each licensed blood bank a list of donors whose blood has reacted positively to the approved test for acquired immune deficiency syndrome antibody.

H.B. 1940, Gen. Assembly of Pennsylvania, 1985 Session (No. 2585). The bill was referred to the Committee on Health and Welfare on November 27, 1985, where it would later die. Letter from Lawrence Evan Frankel to Mark E. Wojcik (Feb. 13, 1986).

337. *Pennsylvania Drops Registry List Idea*, 7 OFFICIAL NEWSLETTER OF THE NAT'L COALITION OF GAY STD SERVICES 50 (Feb.-Mar. 1986).

338. *New Mexico Considers HTLV-III Antibody Positive Registry*, 7 OFFICIAL NEWSLETTER OF THE NAT'L COALITION OF GAY STD SERVICES 46 (Feb.-Mar. 1986).

339. *Bill Clears Arizona Committee*, Windy City Times, Mar. 20, 1986, at 4, col. 4. Blood bank officials in Arizona warned that the bill would have "disastrous effects" and could dry up blood supplies in Arizona. *Arizona Seeks to Report HTLV-3 Positives*, Advocate, Mar. 18, 1986, at 23, col. 1.

340. Letter from Lawrence Evan Frankel to Jane Mendlow, Legislative Assis-

> [N]o effort to combat AIDS will be productive unless those at risk and those perceived to be at risk are assured that the government is not collecting their names and that information about them will not be used by anybody to violate the civil rights or dignity of those individuals. If gay men even believe that the government might compile a list of their names for any reason whatsoever, they will not seek medical treatment or take necessary preventative steps to combat the transmission of AIDS for fear of being reported to the government or being asked to report on their friends and sexual partners.[341]

Because of the dangers of discrimination associated with collecting names of those with antibody to HTLV-III, proposals for registries will have only a counter-productive effect on controlling the spread of AIDS.[342] Education, not registration, is a preferred alternative.

6. *Testing and Prisons*

AIDS is not yet a major health *problem* in the nation's jails and prisons, but it has become a major *concern* of medical care officials at correctional facilities.[343] This concern arises because inmates of penal institutions include people with a history of intravenous drug use[344] and males who engage in homosexual activities.[345] Moreover,

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tant to the Speaker of Pennsylvania's House of Representatives (Jan. 2, 1986).

341. *Id.* Mr. Frankel was wise enough to include specific recommendations, which should be adapted to appropriate local organizations that may have to lobby against similar legislation in other states:

> If the Commonwealth hopes to stem the spread of AIDS it is necessary that policies be developed in cooperation with groups like the Philadelphia AIDS Task Force, the people in Pittsburgh who are working on this issue, and other groups experienced in dealing with persons with AIDS. These people are acutely aware of the concerns about health care and civil rights of those at risk, those perceived to be at risk, and gay men in general. These same people can offer expert advice on which policies will work and which will be counter-productive. Such consultation clearly was not done in the drafting of this legislation.

Id. at 2. Another activist addressing an Illinois registry proposal wrote that

> [The Illinois Department of Public Health] proposal to register positive HTLV-III antibody test results will guarantee that no one will take the test. The risk that this information will be misused is too high. What the state should be doing is offering guidelines to guarantee the anonymity of antibody test results. Nothing less will work.

Drake, *The AIDS epidemic in Illinois*, Chicago Trib., Mar. 16, 1986, § 5, at 2, col. 3, 5.

342. *Wir werden keine Meldepflicht einführen*, Der Spiegel, Sept. 23, 1985, at 89, col. 1.

343. W. GAUNAY & R.L. GIDO, ACQUIRED IMMUNE DEFICIENCY SYNDROME: A DEMOGRAPHIC PROFILE OF NEW YORK STATE INMATE MORTALITIES 1981-1985 2 (1986) (study prepared for the New York State Commission of Correction); T. HAMMETT, AIDS IN CORRECTIONAL FACILITIES: ISSUES AND OPTIONS xiii (1986) (study prepared for the National Institute of Justice, United States Department of Justice).

344. In jurisdictions with a large incidence of AIDS, the majority of cases occur among those with histories of self-injection of intravenous drugs. In New York's state correctional system, 95% of the inmates had a history of intravenous drug use. Centers for Disease Control, *Acquired Immunodeficiency Syndrome in Correctional Facilities: A Report of the National Institutes of Justice and the American Correc-*

makeshift tatooing with shared needles and other sharp objects, a common practice in prisons, poses an additional risk of infection with the HTLV-III virus.[346] Six state prison systems and at least seven city and county jail systems are now screening or planning to screen all inmates, all new inmates, or all inmates belonging to at least one high-risk group.[347] More importantly, correctional systems are agreeing on the importance of providing education on AIDS to inmates and staff.[348]

In Alabama, House Bill 25 provides for the quarantining of inmates who are diagnosed as carriers of the HTLV-III virus. In Arizona, House Bill 2136 provides for examination of prisoners for exposure or presence of AIDS, despite the fact that there is no commercially-available test for the presence of AIDS virus. In California, Senate Bill 1513 would mandate testing of anyone sentenced to a county jail for a term exceeding three days or to a term in a state prison. In Florida, House Bill 279 would mandate testing of anyone convicted of prostitution. In Michigan, House Bill 5247 would require that convicted prisoners be tested for exposure to AIDS and subsequently that prisoners who test positive would be isolated. Another Michigan proposal, House Bill 5279, would mandate testing of persons arrested for prostitution or solicitation. In New Jersey, Assembly Bill 1491 would allow testing of persons arrested for certain crimes. In Virginia, House Joint Resolution 125 directs the Department of Corrections to study the screening of prisoners for AIDS when they are released on parole or work furloughs.

In *Lareau v. Manson*,[349] prison overcrowding compelled the United States Court of Appeals for the Second Circuit to allow mandatory testing for communicable diseases in newly admitted inmates. The court stated that it would be "unnecessary to require evidence that an infectious disease has already spread in an over-

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tional Association, 35 MORBIDITY & MORTALITY WEEKLY REP. 195, 196 (1986). Incarceration is not itself associated with any risk of HTLV-III transmission. *Id.* at 198; Centers for Disease Control, *Acquired Immune Deficiency Syndrome (AIDS) in Prison Inmates—New York, New Jersey*, 31 MORBIDITY & MORTALITY WEEKLY REP. 700, 701 (1983).

345. *Fear of AIDS growing in prisons: High percentage of inmates natural prey for disease*, Houston Post, Dec. 1, 1985, § D, at 2, col. 1. *See also* P. BUFFUM, HOMOSEXUALITY IN PRISONS (1972).

346. Glasbrenner, *Prisons confront dilemma of inmates with AIDS*, 255 J. A.M.A. 2399, 2404 (1986).

347. Centers for Disease Control, *Acquired Immunodeficiency Syndrome in Correctional Facilities: A Report of the National Institute of Justice and the American Correctional Association*, 35 MORBIDITY & MORTALITY WEEKLY REP. 195, 197 (1986); *Few prisons screen inmates for HTLV-III exposure*, Am. Med. News, Apr. 11, 1986, at 39, col. 1.

348. Glassbrenner, *Prisons confront dilemma of inmates with AIDS*, 255 J. A.M.A. 2399, 2404 (1986).

349. 651 F.2d 96 (2d Cir. 1981).

crowded jail" before allowing prison officials the right to test prisoners for communicable diseases.[350] Although *Lareau* arose before testing was developed for antibodies to the AIDS virus, prisons may cite the case as precedent to test prisoners. If mandatory prison testing is ordered, the prisoners' constitutional rights must be protected. There is a strong danger that if such information becomes known in the closed and sometimes violent prison environment, those who are antibody positive for HTLV-III will face additional discrimination and possible physical harm from other inmates and guards.[351]

Some discussion has arisen suggesting possible quarantine of prisoners with AIDS. An early case upheld a prison quarantine of three inmates with AIDS. In *Codero v. Coughlin*,[352] the United States District Court for the Southern District of New York dismissed prisoners' claims that their quarantine violated their constitutional rights of equal protection, due process, privacy, free expression and free association, and freedom from cruel and unusual punishment. The court lamented that the genesis and transmission of AIDS was poorly understood. However, because medical knowledge has greatly progressed since the summer of 1984 when the case was decided, the prisoners' claims could be successful if presented again.

Another case, however, relied heavily on medical testimony to deny a petition to isolate prisoners with AIDS in a separate correctional facility. In *LaRocca v. Dalsheim*,[353] the court recognized that "it is not one's status as a homosexual or drug addict that invites the disease, but the activities associated with and performed by homosexuals and IV drug users that is believed to imperil them."[354] Accordingly, "[c]essation of those activities before infection would, according to the medical authority, presumably foreclose the disease."[355] To that end, the court denied the motion to isolate the prisoners with AIDS and instead ordered that each inmate be

350. *Id.* at 109.

351. Centers for Disease Control, *Acquired Immunodeficiency Syndrome in Correctional Facilities: A Report of the National Institute of Justice and the American Correctional Association*, 35 MORBIDITY & MORTALITY WEEKLY REP. 195, 197 (1986). An inmate at Pennsylvania State Prison petitioned the Court of Common Pleas in Huntingdon County either to release him or to guarantee that he would not be exposed to a fellow prisoner who is HTLV-III antibody positive. The inmate who tested positive was confined to the infirmary because inmates damaged property during a demonstration protesting his presence in the prison. *Inmate files AIDS suit*, Gay Chicago Mag., Apr. 3, 1986, at 61, col. 2. Although this demonstration only caused property damage, it is easily conceivable that the violence could turn to physical harm to the seropositive inmate if an opportunity arose.

352. 607 F. Supp. 9 (S.D.N.Y. 1984).

353. 210 Misc.2d 697, 467 N.Y.S.2d 302 (Sup. Ct. Dutchess County 1983), *aff'd*, 104 A.D.2d 445, 479 N.Y.S.2d 155 (N.Y. App. Div. 1983).

354. *Id.* at 705, 467 N.Y.S.2d at 309.

355. *Id.* at 706, 467 N.Y.S.2d at 309.

handed a copy of an AIDS brochure prepared by the New York State Department of Health. The *LaRocca* decision, in both its reliance on medical evidence and its order to disseminate educational information to dispell fear, constitutes an excellent decision which should be followed by other courts.

Recently, prisoners with AIDS have been segregated into their own living quarters where they prepare their own meals and otherwise conduct themselves away from other prisoners. This practice appears objectionable under constitutional standards. Certainly, if prison officials move to mandate HTLV-III antibody testing of inmates, such an action would violate a number of the constitutional guarantees described above.

7. *Testing and Insurance*

Closely related to employment issues is the issue of insurance coverage. When someone loses a job because of AIDS or HTLV-III related discrimination, the insurance coverage coincident with the employment will often be one of the casualties. This is especially unfortunate for a person with AIDS who will face medical bills of unknown dimension, and be ineligible to obtain substitute insurance.[356] This problem is chiefly an American concern, in contrast to countries with socialized medicine where medical insurance is not job-specific. Thus, the wisdom of testing for LAV antibody in France will not be challenged as an attempt to oust people from insurance pools.

The insurance industry has complained, as one part of a larger insurance crisis,[357] that it cannot afford to sustain payments for the

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356. When a person with AIDS is denied insurance by private insurance companies, possible replacements are not widely available. Two possibilities are Blue Cross/Blue Shield and state insurance pools in the limited places where these programs are offered. PWAs may be able to obtain Blue Cross/Blue Shield insurance where the plans have an annual or continuous open-enrollment period during which they have to sign up all comers at standard rates, regardless of health, as long as they reside within the plan's area of operation. But, as with most health insurance plans, there may be a waiting period before coverage will begin for illnesses. Quinn, *Paths open for health-uninsurable*, Lincoln [Nebraska] Star, May 31, 1986, at 10, col. 4, 5. The second possibility for PWAs may exist in state insurance pools, which offer coverage at greater premiums for those who have been turned down by private insurance companies. A PWA will not be denied coverage, but there will be a waiting period before the pool will cover an existing illness. Insurance pools are in effect in Connecticut, Florida, Indiana, Minnesota, North Dakota, and Wisconsin, and are proposed for Montana and Nebraska. *Id.* at col. 6. These state pools are the model for proposed federal legislation recently introduced by Representative Barbara Kennelly in the House and Senator John Heinz in the Senate.

357. *See, e.g.*, Wojcik, *Tracing the Fibers of Asbestos Litigation: When Do An Insurer's Duties of Defense and Indemnity Arise?*, 36 FED. INS. & CORP. COUN. Q. 283 (1986).

medical expenses of persons with AIDS.[358] Consequently, the industry has taken to the HTLV-III antibody test as a means of discriminating against those perceived to be at risk of contracting the disease. In addition to closely examining applicants' medical histories, insurance companies are frequently rejecting those who have had a sexually transmitted disease and those who have any single symptom that is sometimes associated with AIDS.[359] Several insurers have required insurance applicants to undergo antibody testing as a pre-condition for insurance. Recognizing that this is an improper means of determining insurability and risk assessment, a number of state legislatures have enacted or proposed legislation to prohibit insurance companies from using the HTLV-III antibody test in assessing insurability. States which have not yet enacted any protective legislation should follow this new trend in the law. This legislation is discussed in the next section of this article, which covers legal liability for transmission of HTLV-III, codification of the right to privacy in serologic testing, and the need for consent in any testing performed.

V. Legal Directions

New legal directions will emerge as the AIDS crisis progresses. This section considers trends in liability for transmission of HTLV-III, state legislation and local ordinances concerning uses of serologic testing, and the need for consent in any testing performed.

A. *Legal Liability for the Transmission of HTLV-III*

Liability for transmission of HTLV-III can be raised in a person-to-person tort context, a blood transfusion context, an occupational transmission context, or in a criminal context.

1. *Contact Tracing and Tort Liability for Wilful Transmission of HTLV-III*

Lawsuits for alleged transmissions of the AIDS virus may comprise the next national wave of tort litigation.[360] In a case that may

358. *Nation's AIDS epidemic triggers insurance woes for millions of people,* Am. Med. News, Apr. 11, 1986, at 1, col. 3.

359. This would include unexplained swelling of the lymph nodes, night sweats, fever, diarrhea, or drastic weight loss. *Id.* at 37, col. 1. *See also* Freiberg, *Antigay Insurance Co. Sued: Sought to Exclude Single Males,* Advocate, June 10, 1986, at 13, col. 2.

360. In Augusta, Georgia, a woman has filed a $5 million lawsuit against a man with AIDS who bit her index finger. She was attempting to help the man after he went into a seizure in a grocery store. The woman alleged that she has undergone "extensive medical testing and psychiatric counseling," but has not yet developed an-

serve as precedent for liability in wilful HTLV-III transmission, a woman in California successfully sued the man who knowingly gave her genital herpes. In *Kathleen K. v. Robert B.*,[361] the woman alleged negligent infliction of emotional distress. The man based his defense on the right to privacy. California's Second District Court of Appeal rejected the defense, finding that "[t]he right to privacy is not absolute, and in some cases is subordinate to the state's fundamental right to enact laws which promote public health, welfare and safety, even though such laws may invade the offender's right of privacy."[362]

The right of privacy thus failed when a venereal disease was knowingly transmitted. Similarly, as indicated in *Kathleen K.*, a different result may be reached if the disease was unknowingly transmitted, such as will occur by the unknown number of asymptomatic persons who carry antibodies to the AIDS virus. A footnote in the *Kathleen K.* decision specifically identified the AIDS virus as being included in the category of viruses for which a cause of action may be found when knowingly transmitted.[363]

In Maryland, House Bill 1279 was introduced to provide that ignorance of being a carrier of the HTLV-III virus would not be a defense in a civil action against an individual for transmission of AIDS. The bill seeks to impose a duty to determine if one is a carrier. Presently, however, it is not possible to determine whether one is a carrier of the AIDS virus.[364]

Some public debate has encouraged contact tracing of those who test positive for HTLV-III antibody.[365] But, such proposals

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tibodies to HTLV-III. *AIDS Crisis Update*, Advocate, July 8, 1986, at 22, col. 2. Other cases have arisen, and are sure to arise in the future. *See, e.g.*, Gest, *AIDS triggers painful legal battles*, U.S. News & World Rep., Mar. 24, 1986, at 73 (describing a lawsuit by parents of an AIDS-stricken three-year-old near Washington, D.C. who have sued the American Red Cross and a local hospital over a transfusion he received at birth); Daniels, *Estate Sues Rock Hudson's Ex-Lover for Blackmail, Theft and Prostitution*, Advocate, Apr. 15, 1986, at 17, col. 2 (counter-suit in the case where Rock Hudson's ex-lover has sued him for the possible transmission of HTLV-III, even though the man has not developed antibodies to HTLV-III); *Hudson's estate charges blackmail*, Chicago Trib., Mar. 13, 1986, § 1, at 18, col. 1 (more details on the $14 million lawsuit against Hudson's estate).

361. 150 Cal. App. 3d 992, 198 Cal. Rptr. 273 (1984).

362. *Id.* at 996; 198 Cal. Rptr. at 276.

363. *Id.* at 996 n.3; 198 Cal. Rptr. at 276 n.3.

364. *See supra* notes 81-107 and accompanying text.

365. *See, e.g., Contact Tracing: Officials Cite Useful Role Outside High-Risk Groups*, 1 AIDS POL'Y & L. (BNA) No. 10, at 5 (June 4, 1986); *Contact tracing considered*, Windy City Times, May 15, 1986, at 4, col. 4 (Michigan legislation proposed); *Wisconsin may approve statewide contact tracing*, Windy City Times, Apr. 17, 1986, at 3, col. 1; *CDC Urges Testing, Contact Tracing*, 7 OFFICIAL NEWSLETTER OF THE NAT'L COALITION OF GAY STD SERVICES 50 (Feb. - Mar. 1986); *Listing of AIDS Victims, Tracing Their Sexual Partners Suggested*, L.A. Times, Jan. 20, 1986, § 1, at 10, col. 1; *Traditional Tracing Strategy Proposed for AIDS*, Chicago Trib., Nov. 15,

serve to further prove the lack of understanding of HTLV-III transmission, because meaningful contact tracing is virtually impossible.[366] The incubation period for seroconversion of the blood is not so definitive as to allow identification of relevant contacts. Potentially, many millions of people would be involved. Moreover, as we currently have no way of determining the presence of the infectious virus in a person and can do nothing about the medical result that one tests positive for HTLV-III antibody, there is no real reason to engage in contact tracing. A less intrusive course of action would be to use any available funds for general education on the modes of transmission of HTLV-III.

2. *Blood Banks and Blood Product Manufacturers*

The nation's three major blood collection groups are the American Red Cross, the American Association of Blood Banks, and the Council of Community Blood Centers. These three agencies collect virtually all of the donated blood in the United States. Accordingly, they are concerned about patients who received blood infected with HTLV-III, and thus have discussed asking all their member blood collection agencies to identify all hospitals that have received plasma, platelets, and red cells from seropositive donors.[367] Hospitals would then have the option of asking physicians to notify patients who were transfused with these products.[368] Any such notice, however, would then expose the physician, the hospital, and the blood collection agency to a potential lawsuit for strict product liability or negligence.

In *Hyland Therapeutics v. Superior Court*,[369] a hemophiliac contracted AIDS after being treated with Factor VIII blood clotting

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1985, § 5, at 8, col. 1. The concept of contact tracing requires antibody positive individuals to indentify sexual partners to a public health worker for contact by the worker. Given the long latency period with AIDS, if a proposal for contact tracting is implemented, the individual would have to recall and indentify her or his sexual contacts for the past 5 to 7 years. Any proposals to implement contact tracing for HTLV-III antibody must be based on the strictest confidentiality of any information provided. Some of the most vociferous politicians urging contact tracing have themselves admitted that collecting names of those individuals who test positive for the HTLV-III antibody is not medically necessary. *Turnock Admits Collecting Names Not Really Necessary*, Windy City Times, Apr. 10, 1986, at 3, col. 3 (Mr. Turnock is the Director of the Illinois Department of Public Health). *See also In Government We Trust?*, Windy City Times, Apr. 10, 1986, at 9, col. 1 ("No, Mr. Turnock, keeping lists is not the answer when discrimination and prejudice are a reality").

366. *Aids: "Wir müssen die Löcher stopfen*, Der Spiegel, Sept. 16, 1985, at 19, 20.

367. *Agencies to urge hunt for recipients of blood from HTLV-III donors*, Am. Med. News, Apr. 18, 1986, at 1, col. 3.

368. *Physicians to play key role: Blood groups to begin 'look-back' program*, Am. Med. News, June 20, 1986, at 3, col. 1.

369. 220 Cal. Rptr. 590 (Cal. App. 1985).

products which contained the HTLV-III virus. After his death, his heirs sued the manufacturers of the blood clotting products on theories of negligence and strict liability. His widow also alleged that before her husband died he communicated the AIDS virus or antibodies to her. Her suit was based solely on her having a positive HTLV-III antibody test result.

The manufacturers defended on the ground that a California statute required proof that a blood product manufacturer was either negligent or intentionally at fault.[370] The appellate court ruled in favor of the blood product manufacturers, finding neither strict liability nor any proof of negligence or intentional fault.[371] *Hyland* declined to allow any action to be maintained against the blood bank. The case arose, however, before antibody testing for HTLV-III was widely used by blood banks, and hence a different result might be reached at the present time.[372]

The issue in transmission cases must turn on when the HTLV-III virus or antibodies were transmitted. A cause of action should never be allowed for the mere presence of HTLV-III antibodies because there is no injury from merely developing antibodies. If a person later acquires some opportunistic infection,[373] then a cause of action might be allowed if causation is established.

3. *Hospital Liability for Needle-Stick Transmission*

Working closely with blood and body fluids, health care workers are understandably concerned about their vulnerability to the disease.[374] Hospitals face potential liability if it can be proven that a

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370. Section 1606 of California's Health and Safety code provides:

> The procurement, processing, distribution, or use of whole blood, plasma, blood products, and blood derivatives for the purpose of injecting or transfusing the same, or any of them, into the human body shall be construed to be, for all purposes whatsoever, the rendition of a service by each and every person, firm, or corporation participating therein, and shall not be construed to be, and is declared not to be, a sale of such whole blood, plasma, blood products, or blood derivatives, for any purpose whatsoever.

For a list of other jurisdictions with similar statutes, and for an explanation of the public policy behind these statutes, see W. PROSSER, LAW OF TORTS 638 (4th ed. 1971); J. WHITE & R. SUMMERS, UNIFORM COMMERCIAL CODE 347-48 (2d ed. 1980); Comment, *Retailing Human Organs Under the Uniform Commercial Code*, 16 J. MAR. L. REV. 393, 409-10 (1983).

371. *Hyland Therapeutics*, 220 Cal. Rptr. at 592.

372. Since *Hyland*, blood screening for HTLV-III antibody has been made mandatory throughout the United States. General Biological Products Standards, Additional Standards For Human Blood and Blood Products; Serologic Test for Antibody to Human T-Lymphotropic Virus Type III (HTLV-III), 51 Fed. Reg. 6362 (1986).

373. *See supra* note 54 (definition and description of opportunistic infections).

374. Weiss, Goedert, Sangadharan, Bodner, The AIDS Seroepidemiology Collaborative Working Group, Gallo, & Blattner, *Screening Test for HTLV-III (AIDS Agent) Antibodies: Specificity, Sensitivity, and Applications*, 253 J. A.M.A. 221, 224

health care worker contracted AIDS in an employment setting. Although health care workers face potentially frequent exposure to persons with AIDS, ARC, or those who test positive for antibodies to HTLV-III, the CDC has recommended against routine serologic testing to control the spread of AIDS.[375] This is because the risk of workplace transmission is extremely low and can be further minimized by using simple blood precautions. Use of the standard blood precautions is a far less intrusive and much more desirable procedure for hospitals and other health care institutions to adopt. With these precautions, the actual reason why a particular person's blood must be treated carefully is not identified; the person may have antibodies to HTLV-III, be a carrier of hepatitus B, or be a excluded for some other reason, but the specific reason will not be known because there simply is no reason to know. The precautions used in handling the suspect blood will be the same for all persons, and the person's privacy will be protected.

A different concern arises with needle-stick transmission. Although hundreds of needle-sticks occur annually, only one AIDS-related case of HTLV-III seroconversion after an accidental needle-stick has been documented.[376] Nonetheless, the issue of hospital liability for HTLV-III transmission by needle-stick is of major concern to hospitals and other health providers.[377] The San Francisco General Hospital Infection Control Committee has devised guidelines for health care workers which recommend that needles not be recapped to prevent HTLV-III transmission by a needle-stick.[378] However, a hospital might still be faced with a charge of work-related HTLV-III transmission.

One recommendation which can be made to a hospital is for it

(1985).

375. Centers for Disease Control, *Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus during Invasive Procedures*, 35 MORBIDITY & MORTALITY WEEKLY REP. 221, 223 (1986); Centers for Disease Control, *Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy Associated Virus in the Workplace*, 34 MORBIDITY & MORTALITY WEEKLY REP. 682, 691 (1985).

376. Sande, *Transmission of AIDS: The Case against Casual Contagion*, 34 NEW ENG. J. MED. 380, 381 (1986) (a British woman acquired the virus after receiving a microinjection of blood after an arterial puncture). The woman, who was not a health professional, was caring for a Ghanian man who was diagnosed posthumously as having had AIDS. N.Y. Times, Feb. 7, 1986, at 13, col. 1, 3.

377. For example, the topic was heavily debated in March, 1986, at a Chicago Bar Association seminar on labor law problems of health care institutions, and in April, 1986 at a conference sponsored by the Health Law Institute of the DePaul University College of Law and the American Academy of Hospital Attorneys of the American Hospital Association.

378. San Francisco General Hospital Policy, *reprinted in* HEALTH LAW INSTITUTE, DEPAUL UNIVERSITY COLLEGE OF LAW, AIDS: MEDICAL, LEGAL, ETHICAL, AND SOCIAL DIMENSIONS OF A HEALTH CRISIS 19 (1986).

to ask anyone who suffers a needle-stick injury to take an HTLV-III antibody test immediately after the accident. The period at that time will be too short for any positive antibody result to register because the person will have had an insufficient time to develop antibodies. If the result is negative for antibodies, the test should be repeated in 2-4 months, according to current medical estimates of seroconversion time. If the health care worker tests positive at that time, it will evidence the element of causation from the needle-stick accident in the absence of other conduct in the interim which might have caused some risk of transmission of HTLV-III. However, there is no way to predict the outcome of exposure to the HTLV-III virus, so any worker's compensation or other pecuniary awards must wait until an actual injury can be proven, such as the development of AIDS or another harmful manifestation of HTLV-III infection.

4. *Criminal Liability for Transmission of HTLV-III*

Several cases have raised the issue of criminal liability for transmission of HTLV-III. Each of the attempts to date has assumed that HTLV-III could be transmitted by saliva. Although trace amounts of HTLV-III have been found in the saliva of persons with AIDS,[379] saliva is not one of the "bodily fluids" capable of transmitting AIDS.[380]

The most notorious of these cases is *People v. Richards*.[381] The case arose in Flint, Michigan, when a man with antibodies to HTLV-III spat at four police officers who arrested him after a traffic accident.[382] The officers charged the man with assault with intent to murder.[383] A jail physician doubted that the officers were ever at risk or that the prosecutions would be successful.[384]

Two other cases have concerned bites of police officers. In *People v. Julius*,[385] a man bit a San Francisco police officer. The hoped-for felony prosecution failed after the man refused to submit to a

379. Eckholm, *Saliva Is Discounted as Threat in Spread of AIDS*, N.Y. Times, Dec. 19, 1985, at 1, col. 1.

380. *See supra* notes 141-154 and accompanying text.

381. No. 85-1715F4, 68th District Court, Flint, Michigan.

382. *AIDS Fears are Cited In Charge of Assault*, N.Y. Times, Dec. 8, 1985, at 17, col. 3. In another traffic case, a motorist in Sweden avoided the blood test for drunken driving by telling police officers that he had AIDS and would bite anyone who approached him. Without evidence of blood alcohol content, the Swedish police were forced to let the man go. *Driver avoids drunk test*, Windy City Times, Oct. 3, 1985, at 9, col. 2.

383. Gest, *AIDS triggers painful legal battles*, U.S. News & World Rep., Mar. 26, 1986, at 73; *Man with AIDS charged with attempted murder for spitting on officers*, Windy City Times, Dec. 12, 1985, at 4, col. 4.

384. Am. Med. News, Jan. 10, 1986, at 42, col. 3.

385. No. 761210, San Francisco Municipal Court.

blood test.[386] The court apparently agreed that it was without authority to order mandatory testing. The prosecution's efforts were also nipped when defense attorneys discovered that the policeman was gay, and that his former lover had contracted AIDS. A similar case arose in *People v. Prarie Chicken*,[387] where a man suspected of having AIDS plead guilty to a felonious assault charge for biting an officer in El Cajon, California.[388] The prosecutors agreed to reduce the felony assault charge to a misdemeanor if doctors determined that the police officer was not exposed to the HTLV-III virus.[389]

In addition to these cases, bills have been introduced in six states to provide criminal penalties for transmission of HTLV-III. In Colorado, House Bill 1144 would criminalize wilful exposure of another by a person who has grounds to suspect that he is infected with AIDS. In New Jersey, Assembly Bill 869 was introduced to criminalize blood donation by a person who is infected with a communicable disease, and Assembly Bill 1443 was introduced to make the commission of an act of sexual penetration by a person who knows he is infected by AIDS a petty disorderly person offense. In Oklahoma, House Bill 1698 would make the intentional spread of AIDS a felony punishable by imprisonment. In Pennsylvania, House Bill 1787 would criminalize knowing transmission of AIDS through sexual intercourse, with the first offense a misdemeanor and subsequent offences second degree felonies. In South Dakota, Senate Bill 193 would make knowingly engaging in activity which causes the spread of AIDS a Class 1 misdemeanor. In West Virginia, House Bill 1393 would make the transmission of AIDS first degree murder.

B. *Codifying the Right of Privacy to Protect Against Abuses in Serologic Testing*

California, Wisconsin, and Florida have codified the right of privacy to protect against abuses in HTLV-III antibody testing. The statutes in California and Wisconsin are specific to the HTLV-III antibody test. The Florida statute is drafted in broader language which will cover both HTLV-III antibody and antigen testing, should an antigen test become commercially available. The District of Columbia also passed a bill which bans insurance companies from using the HTLV-III antibody test for the next five years, until the AIDS hysteria has subsided and decisions can be made in a more

386. Galante, *AIDS' Expanding Legal Frontier*, Nat'l L.J., Feb. 3, 1986, at 3, col. 1.

387. No. CRE-77357, San Diego Superior Court.

388. Galante, *AIDS' Expanding Legal Frontier*, Nat'l L.J., Feb. 3, 1986, at 3, col. 1.

389. *Id.* at 8, col. 1. *See also Inmate with AIDS charged after bite*, Chicago Trib., May 25, 1986, § 1, at 14, col. 1.

rational context.

1. *California*

a. *State Legislation*

California's legislation provides that no person shall be compelled to identify anyone who has taken a test for antibodies to HTLV-III.[390] Civil and criminal penalties exist for unauthorized disclosure, including a civil right of action for actual damages and a misdemeanor for disclosure.[391] The legislation prohibits any testing without written and informed consent, and further provides that the HTLV-III antibody test not be used in any instance for determining insurability or suitability for employment.[392]

b. *Municipal Ordinances in California*

At least eight California cities have adopted ordinances barring discrimination against those with AIDS or ARC.[393] San Francisco's ordinance additionally addresses the issues of privacy in HTLV-III antibody testing. Section 3809 of the San Francisco Municipal Code provides in part:

> (a) No person shall require another to take any test or undergo any medical procedure designed to show or help show that a person has AIDS or any of the associated conditions covered by this Article.
> (b) Subsection (a) does not apply to an employer who can show that the absence of AIDS is a bona fide occupational qualification.[394]

Oakland, California also passed an ordinance to prohibit mandatory testing for HTLV-III antibodies unless "the public health is threatened."[395]

2. *Wisconsin*

Wisconsin has enacted legislation much like California's. Act 73 prohibits HTLV-III antibody testing as a condition of employment or prospective employment, as well as prohibiting any pay or benefit to an employee or prospective employee in return for taking the

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390. 1985 Cal. Legis. Serv. ch. 1519 § 199.35.
391. *Id.* § 199.37.
392. *Id.* § 199.38.
393. The cities include San Francisco, Los Angeles, West Hollywood, Hayward, and Oakland. The Los Angeles Municipal Ordinance is reprinted in Comment, *Protecting the Public From AIDS: A New Challenge to Traditional Forms of Epidemic Control*, 2 J. CONTEMP. HEALTH L. & POL'Y 191, 209 (1986).
394. San Francisco Munic. Code § 3809 (1986).
395. *Oakland, Calif., Passes AIDS Antidiscrimination Bill*, Advocate, May 27, 1986, at 17, col. 2.

test.[396] Wisconsin law also prohibits insurance companies from requiring, directly or indirectly, anyone to reveal whether the individual has submitted to the HTLV-III antibody test, or what the results of the test were. Wisconsin law further prevents insurance companies from conditioning the provision of insurance coverage on the HTLV-III antibody test, and from determining policy rates or any other aspect of insurance coverage on whether a person has tested positive or even taken an HTLV-III antibody test.

In addition to requiring informed consent before taking the test, Wisconsin requires informed consent for disclosure of any test result. As in California, civil and criminal liability will result in intentional unauthorized disclosure, and civil liability for negligent disclosure.[397]

3. *Florida*

Florida's legislation is not specific to the HTLV-III antibody test. This is not a disadvantage, however, because the legislation is more flexible and can be later utilized if it happens that an antigen test for HTLV-III is developed and commercially marketed.[398]

The Florida legislation provides specific procedures to implement a program of serologic testing. First, the program cannot be triggered until the Secretary of the Florida Department of Health and Rehabilitative Services declares that a threat to the public health exists when there "is the occurrence of an infectious disease that may be transmitted from human to human through serologic or other means."[399] After making such a declaration, the secretary is directed to order "such preventative, treatment, and ameliorative measures as shall be advisable from medical and public health perspectives. . . ."[400]

Second, the Secretary of the Florida Department of Health and Rehabilitative Services may "direct that a system of alternative testing sites be established through the county public health units or through contracts for voluntary serologic testing of individuals to identify those individuals who may have, or be at risk of developing, an infectious disease."[401] Each alternative testing site is required to report the specific results of the test to the individual receiving the test. The statute also provides for the Department of Health and Rehabilitative Services to specify procedures for "follow-up, referral

396. 1985 Wis. Laws 73 § 103.15.
397. *Id.* § 146.025.
398. *See supra* note 170 and accompanying text.
399. 1985 Fla. Laws ch. 85-52 § 381.606(1).
400. *Id.*
401. *Id.* § 381.606(2).

for psychological and social services, and similar measures for persons who receive a positive result to a serologic test."[402]

Third, the privacy provision of the Florida statute recites that "[n]o person may be compelled to identify or provide identifying characteristics which, if disclosed, would identify any individual who receives or has received a serologic test."[403] Consent to disclose a serologic test result can only be obtained from the person who received the test. Test results may, however, be disclosed during medical or epidemologic research without the individuals' names or any identifying characteristics.

Fourth, the Florida legislation prohibits use of the serologic test conducted under a declaration of the Secretary of the Department of Health and Rehabilitative Services to be "used to determine if a person may be insured for disability, health, or life insurance, or to screen or determine suitability for, or to discharge a person from, employment."[404]

4. *District of Columbia*

The District of Columbia City Council unanimously passed a 5-year moratorium to prohibit insurance companies from denying coverage, setting rates, or altering benefits because an individual has tested positive for "the probable causative agent of AIDS" or declined to take a test.[405] The bill also bars underwriting decisions based on age, marital status, area of residence, occupation, sex, or sexual orientation.[406]

The 5-year moratorium is an extremely sensible, pragmatic, and medically justified result. The enforced time period breaks the hysteria in the insurance arena to implement testing without regard to adverse collateral consequences. While a total ban would have been preferable to many civil rights groups, the moratorium will impose a period of reassessment when the moratorium expires or is about to expire. Hopefully that reassessment will be accompanied by vigorous public debate of the legal, medical, and underwriting issues involved. The moratorium concept presents a highly practical compro-

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402. *Id.* § 381.606(6)(c).
403. *Id.* § 381.606(4)(a).
404. *Id.* § 381.606(5).
405. D.C. Act 6-170 (1986). *See D.C. Council Enacts Tough Insurance Law: Measure Bars Use of HTLV-3 Test for Applicant*, Advocate, June 24, 1986, at 12; *Ray insurance bill heads to Congress*, Washington Blade, June 13, 1986, at 10, col. 1; *Insurance: DC Bill Barring AIDS Bias Wins Final Approval*, 1 AIDS POL'Y & L. (BNA) No. 10, at 2 (June 4, 1986); *Insurance: DC Council to Vote on Banning Use of Testing*, 1 AIDS POL'Y & L. (BNA), No. 8, at 3 (May 7, 1986). The insurance industry spent over $200,000 lobbying against the bill. *Insurers opposing AIDS bill in D.C.*, Am. Med. News, May 30, 1986, at 2, col. 1.
406. D.C. Act 6-170 (1986).

mise for those jurisdictions which are still debating a total ban on insurance testing. It promises a period of thoughtful reflection rather than irrational response.

C. *Consent and Liability for Non-Consensual Testing*

During the course of writing this article the authors have learned that some doctors and hospitals are secretly conducting HTLV-III antibody tests on their patients, at least on their "suspicious" patients. Such clandestine testing is objectionable and improper for a host of reasons. It is an invasion of the patient's privacy rights. Such testing constitutes an illegal search. In a number of ways, there is no guarantee of confidentiality. If the patient's medical charts show the mere fact that the test has been ordered, some stigma may attach to all who have access to the chart. If the test results are recorded in the chart, the problem becomes worse, particularly if the test result is positive. Even if the doctors and hospitals who secretly order the test do not record it in the patient's official chart, some parties must know the test was conducted and its results. Those facts will be recorded somewhere. The patient, under such circumstances, has no assurance of any confidential handling of the report. Finally, a number of constitutional transgressions occur when a governmental facility or doctor orders the test secretly.

An HTLV-III antibody test should only be performed with an individual's informed consent. That consent should include specific reference to the HTLV-III test, and should not be part of blanket consent procedures.[407] The consent form should also accurately indicate how a positive result will be kept confidential, and accurately show the particular person who will learn the result. If more than one person is to learn the result, separate consent should be obtained before any subsequent disclosure. In the absence of a complete guarantee of confidentiality, the individual should not consent to the test. Anonymity is the best guarantee of confidentiality.

A problem can potentially arise with an individual's written signature on a consent form when testing is anonymous. To protect those who administer the test, an individual giving informed consent may sign the consent form only with initials, or with some other mark to preserve the person's anonimity. A witness, typically the counselor, can then co-sign the form to attest that the initials are of the person who has consented to take the HTLV-III antibody test.

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407. Association of State and Territorial Health Officials Foundation, Guide to Public Health Practice: HTLV-III Antibody Testing and Community Approaches 4 (1985).

VI. Conclusion

Every dimension of the AIDS crisis is tragic. The terribly unfortunate incongruity suggested by many of the responses to the crisis identified in this article is that those responses serve only to worsen the tragedy. Of course, all of us are suffering the human and financial losses of the AIDS crisis. To discriminate against persons with AIDS, ARC, or positive HTLV-III antibody test results is to increase the emotional and economic costs. Thus, for example, to discharge employees is to harm them psychologically (as well as others who care about them) and to risk their becoming burdens on the public welfare system, for, without employment and its accompanying income and insurance, such persons may find themselves forced to turn to public assistance.

Persons with AIDS, ARC, and positive HTLV-III antibody results should not be treated like lepers. There is no medical justification for doing so. Even though medicine and science cannot specifically categorize a risk group for 100% of the reported cases, this does not mean that there is any risk of casual transmission. The small percentage of cases where a risk factor cannot be categorized is attributable to those persons who do not cooperate in completing the questionaires, either through lack of desire or through illness, and those who deny association with any risk group, such as Haitians who deny past homosexual experiences because of the strong cultural taboo in Haiti against homosexuality.

What AIDS requires is public education and rational thought. Much of the crisis deals with personal choices which individuals should be encouraged to make after appropriate education in the medical aspects of transmission. Since the modes of transmission have been medically identified as limited to exchanges of blood and semen, any discrimination based on misinformation or conjecture must be eliminated or prohibited. No one has the right to make another person the victim of his or her ignorance. Until the ultimate goals of successful public education and medical research are achieved, constitutional guarantees, including the right of privacy, must be utilized to protect individual rights. Legislation should concentrate on protection of victims of irrational discrimination.

Some recent developments in response to the AIDS crisis are genuinely and profoundly disturbing. That some people would propose tatooing and quarantine, that the Department of Justice would invite discrimination in employment, that state officials would use AIDS to justify sodomy statutes, and that the Supreme Court would uphold the constitutionality of a sodomy statute (thereby diminishing the privacy rights of gay people) are irresponsible enough. But a recent ABA poll indicated that between 9% and 39% of lawyers re-

garded discrimination against persons with AIDS as proper in such areas as employment, housing, and education and that another 10% to 19% were unsure.[408] These statistics are frightening when we are reminded that lawyers should be leaders in the fight to uphold and protect the legal and constitutional rights of all people, and that lawyers are highly educated professionals who should not so readily succumb to hysterical and irrational tendencies. We find the warning of Dennis Altman in his thoughtful book *AIDS in the Mind of America* to be a fitting, but terrifying conclusion:

> In the Third World, where AIDS may reach levels far greater than in the West, it is already clearly linked to heterosexual transmission. If this linkage becomes more widespread in the United States and other developed countries, it will no longer be possible to think of AIDS as essentially linked to homosexuality. Such a development, while tragic for the increased numbers who will become sick, will at least make clear that the disease has been laden with too much symbolic baggage, and that thinking about disease as the issue of particular groups rather than as a general health problem is invidious. A comparison with anti-Semitism comes to mind. After the trauma of the Holocaust most of us would agree that its existence is not merely a Jewish problem, that it poses a challenge to everyone because a society that tolerates such prejudice is that much less a good and a just society. The same test, I would argue, can be applied to the way in which a society deals with a new and lethal disease, even when—especially when—those it strikes come largely from unpopular and distrusted groups.[409]

408. *Lawyers oppose most AIDS-related discrimination*, 72 A.B.A. J. 34 (June 1986).

409. D. ALTMAN, AIDS IN THE MIND OF AMERICA 192 (1986).