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"AIDS & LAW"

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AIDS IS HARD

AIDS is hard. Hard on the patients who learn the grim news, and on their families and loved ones. Hard on the health care workers, with a limited armory of therapies and no vaccine or cure in sight. Hard on the scientists, working at the edges of knowledge, always under the pressure of a major catastrophe affecting millions of people in virtually every land. Hard on communities daily bombarded by fearsome data; the temptations of prejudice and hatred, fuelled by fear, always close at hand. Hard on politicians, struggling for the responsibility of leadership; advisers saying one thing - political instincts sometimes shouting another. Hard on law-makers struggling to bring the cumbersome, imperfect machinery of legal control to bear effectively upon intimate personal behaviour which must be modified if the spread of the epidemic is to be slowed.

There are several things to be made clear at the outset. Most important is the need to lower expectations. There are limits on what the law can and should do in response to AIDS. It never ceases to surprise me how otherwise intelligent people (including some lawyers)

assume that when you have a problem in society, all you need to do is make new law and the problem will be solved. It is assumed that people will modify their conduct to avoid criminal punishments or civil liabilities. The fact is that laws do not operate that way. Most people are completely ignorant about the detail of the law. Government and legislatures typically do precious little to bring its content to notice. The cases which get reported in the media are often unusual, atypical. Mythologies about what the law is grow as a consequence. For most people, the law is a kind of elaborated Ten Commandments. They only dimly perceive the complex, tangled web of rules made up of international law, national statutes, sub-national (State) laws, local ordinances and judge-made law.

Obedience to a law, even if it is known, is not certain and cannot be assumed. The law may entirely miss its mark by ambiguity or because the sanctions provided cannot be enforced. Want of resources, discriminatory prosecution or imprecise, ineffective design of the enforcement mechanisms frequently torpedo a law which looked fine when first made by the legislator, bureaucrat or judge but just did not work on the streets.

And then there are the many laws honoured in the breach. Our societies are overburdened with them. Nobody seems to worry very much about it. Many think it inevitable in communities which churn out so much new law

and fail to provide adequate institutional means to bring old law into harmony with widespread social changes.

And even if the new law is well made, precisely and accurately targeted, widely known and generally respected, there is still no guarantee that it will operate upon human behaviour at the critical moment when its effectiveness counts for most. A recent Australian report examined behaviour change in response to the AIDS epidemic. The authors listed the facts which they found to influence change. The first was direct knowledge of someone who was sick or who had died as a result of infection with the Human Immuno-Deficiency Virus (HIV). The second was barriers militating against safer behaviour. Here laws may actually discourage people from approaching governments or health services or from acquiring condoms, sterile equipment for intravenous drug use and safe sex. The third factor was the use of alcohol and other drugs in sexual and pre-sexual situations. The fourth was the relationship of the subject to the sexual and other partners involved. Negotiating safer sex with regular partners was found to be much more difficult than with casual partners. The fifth factor involved psycho-social characteristics such as self-image and self confidence. The sixth was knowledge about the individual's HIV infection status. The seventh factor was age: younger and older individuals having demonstrated more difficulty in adapting to essential behaviour change than those between the ages of 25 and 45.

Doubtless other surveys would find other factors. But the point to note at the beginning of this examination of AIDS and the law is the relatively limited impact of law on the behaviour that spreads the virus. So do not expect too much from this piece, unless it is the realisation of the limits of law as a weapon against AIDS.

In a number of the Australian States in which the survey just mentioned was conducted, legislation had been enacted making it an offence for a person who knows that he or she has AIDS or has been exposed to HIV (proclaimed diseases) to have sexual intercourse with another unless, before that intercourse takes place, the other person has been informed of the risk of contracting the diseases and voluntarily agrees to accept that risk.[2] Concern about compliance with that law, and fear of prosecution for the breach, would generally be the very last thing on the minds of individuals approaching potentially dangerous sexual activity. The marginalized groups at greatest risk of AIDS and HIV in societies such as Australia (and the United States) already face various legal and social disadvantages. For most of them, the enactment of "laws against AIDS" would be regarded as just another obstacle to be negotiated in life's journey in pursuit of their particular version of happiness. Prostitutes, intravenous drug users and homosexual and bisexual men are no strangers to social prejudice, often reinforced by punitive laws.

THE CRITERION FOR ACTION: CONTAINING THE EPIDEMIC

So let us get clear from the beginning the limited effectiveness of the law. Our objective in proposing or making new laws on AIDS must be clear - at least to ourselves. The Australian Health Minister (Dr N Blewett) has stated clearly his criterion for AIDS related measures. I take it as my text. It is:

> "Whether it will or will not impede the spread of the disease, whether it will be productive or counter-productive in containing the dissemination of the virus. Any action, however well intentioned, which impedes efforts to monitor, contain and assess the spread of the disease should be rejected."[3]

Reflect for a minute upon the laws and policies adopted to cope with earlier epidemics. They lie in the history books as warnings to us about human pain and cruelty but above all, of general ineffectiveness. The best known of the administrative measures of earlier times, quarantine, is said to have originated in Italy at Ragusa, during the second half of the fourteenth century. Such measures were followed by isolation, temporary removal of suspects, the creation of plague barriers, the use of purifying fires in public places and vicious actions against minorities, who were already stigmatized.[4] King Philip of France ordered the extraction of the tongues of all blasphemers. He believed, ever so sincerely, that blasphemy had brought the Plague upon his country. Lepers and Jews were often the targets of official action in epidemics - prompted by public opinion which could not

resist the stimulation of myths and prejudices. Leprosy trials to establish a particular category of infection, were well known in earlier centuries. Reporting, shutting up, loss of civil capacity, the imposition of privations and the deprivation of civic rights have been the usual legal companions of infections over the centuries. As late as 1832 in Paris, stricken with cholera, numberless innocent people were lynched by fearful mobs.

AIDS comes upon us as we approach the twenty-first century. In the age of informatics, space flights, biotechnology and nuclear fission, can we do better than in the past? The key to a positive answer to this question lies in appreciating several absolutely fundamental necessities. The candid acknowledgment of the limited function and effectiveness of law as a response to AIDS is the first. A realization that laws will only be effective if they are based upon good data concerning especially the nature of AIDS, its modes of transmission and the precise conduct which encourages or diminishes that transmission is another. An appreciation of the counter-productive effects of some laws which may not only fail to be useful but may offend basic human rights and even impede conduct which could help to contain the epidemic is a third. Laws and practices which limit the ready supply of safe protective condoms or which impede the use by intravenous drug users of sterile needles are the plainest cases in point at this time in the AIDS epidemic's course.

We may decide that we prefer a more modest society, clinging to the ideals of sexual chastity to one which teaches young school children explicitly about the deadly dangers of AIDS and facilitates the ready provision of condoms to all who want them. We may prefer to concentrate on the "war on drugs" rather than to legalize the exchange of sterile for used needles or the provision of bleach to users at risk. But we should do so with our eyes open.

THE HUMAN RIGHTS CONTEXT

We should weigh laws and proposed laws concerning AIDS, as well as policies and strategies, constantly against the criteria of their effectiveness in helping to contain the spread of HIV, whilst at the same time respecting other important human rights and social values. It is important to test AIDS laws against the stringent requirements of national and international human rights norms. There are differences in the expression of such basic rights. Many of them, although accepted in international treaties and even by customary international law, are not enforced in national courts. But it is useful to remember that there are abiding basic values which have been formulated by leading philosophers and law-makers over the centuries. In the face of the risks of ill considered actions resulting from panic, it is important to keep our eyes fixed steadily upon the abiding values which civilized communities accept.[5]

There is no human right to spread a deadly virus,

whether knowingly or recklessly. The right to the protection of life is primary. But it must be achieved harmoniously with the protection of other relevant human rights: such as the right to privacy, the right to liberty and security; the right to freedom of movement; the right to marry and found a family; the right to work and to education; and freedom from inhuman or degrading treatment or punishment.[6] These basic rights, as well as others which are relevant, together with the jurisprudence which is fast developing in international and national institutions about them, speak to us both of the limits of just laws and of the ways in which laws may be fashioned to tackle AIDS. We must attend to this issue to ensure not only cost effectiveness but also the harmony of our legal responses with values which are fundamental and which will endure even after the AIDS peril has been overcome.

It is easy in a review of AIDS and law to overlook the human rights context in which AIDS laws are typically developed. Many lawyers, and law makers busy in their offices, courtrooms and legislatures, exhibit an impatience with talk of human rights. A frightened community concerned about the spread of a dangerous virus may be very impatient indeed with such talk. But any review of law on this subject which ignores the human rights dimension will be empty of principle. It will overlook basic values and run the danger of losing its way in a mass of parochial detail. A knowledge of human rights principles provides us

with the mile posts by which we may find our way across the dangerous landscape of burgeoning laws made to deal with AIDS.

THE PERILS OF GENERALITIES

But now, let me admit frankly the limitations which affect the utility of this review of AIDS and law. The law is local. Even in a unitary state, national and local government authorities will establish rules of varying kinds affecting AIDS. In federal countries, there may be even greater diversity of lawmaking at federal, state and local levels. Approaches to epidemic control vary enormously according to the political system which operates, its responsiveness to popular opinion and its ability to deal with the problem authoritatively. This point has been made many times when comparing public health laws and policies on alcoholism in, say, the United States and the Soviet Union.

Furthermore, law does not exist in isolation. It is part of a mosaic of social regulation. It is shaped by the institutions which make it and upon which it must operate. The felt needs for law depend upon the perception (and actuality) of the size and nature of the problem being addressed. The WHO statistics show the wildly uneven distribution and differing patters of AIDS in different countries, at this stage of the epidemic.

Finally, there are limitations of knowledge which must be acknowledged. Whereas medical and other

scientists, dealing with the human body, work upon phenomena which are universal and, relevantly, unvarying, it is not so in the law. The legal systems which operate throughout the world are fundamentally different. It is true that two systems predominate. One of them is represented by the common law system, derived, ultimately, from England. It is substantially followed in most English-speaking countries. It lays emphasis upon the role of the judge as an expositor of law. Even legislation enacted by elected legislators (or subordinate regulations made by administrators under delegated power) reflect the intended interaction of such legislation with judge-made law. The other major system is the civil law system, derived principally from France. In this system the role of the judge as a law maker is important but less so. Codification and general statements of the law are more common.

The foregoing is to introduce what follows by words of necessary caution about the applicability of legal rules established in one jurisdiction to respond to AIDS to the differing legal environment of another. At some points (as in international travel) domestic laws interact. They then affect foreign nationals. But for the most part, although the problem of AIDS is now global, the responses of the legal systems of the world depend upon the local institutions and legal environment. WHO contributes to understanding of the commonality of legislative responses

to AIDS by the regular publication of tabular information on legal instruments dealing with AIDS and HIV infection[7]. This circular is published regularly in two parts. One surveys the United States, the present epicentre of the epidemic, by reference to legislative instruments, federal and state. The other deals with reported instruments from other jurisdictions around the world. These reports are indispensable. They continue to expand rapidly. They omit judge-made law and much official practice and policy which is important in matters of public health. Substantially the WHO lists provide a conspectus of legislation, as that word is understood in common law countries.

There is no point in reviewing these collections. They disclose the rapid way in which laws have been enacted in many countries to provide for the screening of blood products and the notification by medical practitioners of suspected or confirmed diagnoses of AIDS. They also demonstrate the growing number of jurisdictions which have introduced requirements for compulsory screening of identified groups, particularly immigrants and prisoners.

It is not my intention to collect and analyse these laws. Instead, the preliminaries out of the way, it is to give a tour d'horizon of laws on AIDS, so that some notion can be derived of the way in which lawmakers in many lands are responding to the epidemic. I will then attempt to draw a number of general conclusions.

CRIMINAL LAW

Exposure to HIV infection, which may lead to AIDS, is life-threatening. There is no present cure for AIDS. Nor is the development of such a cure foreseeable. A large number - perhaps all - of those who are infected with the virus will suffer serious consequences for their health. Many will die as a result. Accordingly, it is a legitimate purpose of the law to endeavour to protect individuals, communities and nations from the spread of the virus.

A traditional way by which legal systems attempt to inculcate individual responsibility is by the operation of the criminal law. That law, to the breach of which penal and other sanctions typically attach, operates imperfectly as I have already demonstrated. However, the criminal law can sometimes have a symbolic value in stating that conduct is punishable and hence is not approved by society. Various theories exist to justify the stigmatisation of conduct by criminal law. According to one theory, it is enough that conduct offends the moral sense of most members of society. This was a traditional basis for laws penalising adult homosexual conduct in many countries, even though there was no complaining victim. But with the spread of HIV, there is a risk of serious actual harm to individuals. This would invoke the other chief theory which underpins the criminal law: protection of the individual human being and the community of such persons from harm.

It is possible that in some places the knowing spread of HIV to another person - or reckless indifference to whether, by sexual or other conduct the actions of the individual will have that consequence - will already amount to a crime under general provisions of criminal law. Depending on its terms and on the consequences of the act, such conduct might amount to murder, manslaughter or assault occasioning grievous bodily harm etc[8]. Whether or not this is so, calls are now being made, and sometimes answered, for the provision of specific crimes to penalise the deliberate or reckless spread of this potentially lethal virus[9].

Responding to such calls, a number of states in Australia and the United States have enacted laws to provide a specific penalty in the case of unprotected sexual intercourse by an infected person. I have already mentioned the special law in New South Wales in Australia. That law does not prohibit an infected person from having sexual intercourse. It applies the law's sanction for failing to inform and secure the consent of the other person. A person who knows he or she has a proclaimed disease (including AIDS) may not have sexual intercourse with another person unless before such intercourse takes place the other person has been informed of the risk of contracting the disease from that person and has voluntarily accepted the risk. The penalty imposed is a maximum fine of $5,000[10]. This may seem a modest penalty

for activity that may spread a potentially fatal infection[11]. In the state of Victoria, amendments to the Health Act were introduced in 1987 to provide a fine of up to $20,000 for a person who deliberately infects another with AIDS or any other infectious disease. In Idaho, an Act of 24 March 1986 declared that the act of "wittingly and deliberately exposing another person to the possibility of being infected" by a person suffering from AIDS or similar disease was unlawful. By an Act of 7 January 1986, Florida made it unlawful for a person suffering from HIV infection to continue having relations with another person unless that person had been duly informed of the risk of transmission of the disease.

All such laws should be seen as having a symbolic rather than a practical value. Clearly the maximum penalty for the offence is inadequate. Proof and enforcement of the law would be extremely difficult. The offender may be dead or very ill by the time of the prosecution. Proof that it was he or she who caused the infection may be next to impossible. Moreover, such laws may have a counterproductive effect, even though unintended. If an element in such crimes is knowledge of one's own HIV status, the provision of such laws may actually discourage persons from taking the HIV test. Particularly will this be so if there are provisions for reporting of persons who prove HIV positive to the test, with personal identifiers that can be traced. As the Australian survey, already

mentioned, points out, submitting to the HIV test may itself sometimes be a useful educational step in a course of behaviour modification designed to promote self protection and the containment of the AIDS infection. Criminal offences, which have only a minor symbolic value and are rarely, if ever, prosecuted with success, may actually prove counterproductive because the only real effect they may have is to discourage test-taking.

This is not the only area where AIDS and the criminal law intersect. For example, in a recent murder prosecution in Sydney, Australia, the accused contended that he had killed his wife because she admitted an affair and he feared that she had AIDS and would infect the children. I suspect that we will see more defences of this kind even though, objectively, there would be little rational basis for such suspicions. In numerous criminal cases, issues relevant to AIDS are now arising. Thus in England, the Queen's Bench held that fear of the giving of a blood sample for detecting the presence of alcohol in the blood of a driver, allegedly on the ground of concern about contracting AIDS in the process, was not a reasonable excuse to justify the refusal[12]. Also in England, the Court of Appeal has reserved for the future the question whether fear of AIDS will justify a higher tariff in the punishment of a person convicted of rape[13]. In South Australia the State Supreme court has been held that the fact that a prisoner is suffering from AIDS is a

consideration relevant to determining the sentence that should be imposed upon him. This was justified having regard to the state of the prisoner's health, his health prognosis and the likely loss of ordinary prison privileges because of isolation, consequent upon the diagnosis of AIDS[14]. But not all Australian judges have taken the same view[15].

In some jurisdictions constitutional guarantees of human rights will be invoked to protect the privacy of consensual adult sexual conduct. Recent decisions of the United States Supreme Court holding that states do not violate the Federal Constitution when they punish homosexuals for consensual sodomy[16] and that Army Regulations discharging homosexuals, as such, from the armed services[17] do not breach the United States Constitution suggest that constitutional limitations will not always play a large part in that country in controlling criminal or other laws targeted on the spread of the AIDS infection, whatever the invasion of privacy or breach of other rights involved in them. On the other hand, recent decisions of the European Court of Human Rights show the utility of generally stated human rights norms as weapons for striking down laws penalizing homosexuals as such. In the Dudgeon Case Article 8 of the European Convention on Human Rights was successfully invoked against the United Kingdom in respect of such laws in Northern Ireland. That Article deals with the guarantee of private life. More

recently in the Norris Case, the Court invoked the same Article to hold the Republic of Ireland in breach of Article 8 in respect of a complaint by Mr Donald Norris, a campaigner for homosexual rights in that country. Ireland is now required by the Convention to bring its law into harmony with the requirements of Article 8[18]. In half of the Australian States the law remains as it is in Ireland. Many commentators have urged the necessity of reform to reduce stigmatisation and to promote effective AIDS communication to a major at risk group[19]. But there is no operating constitutional or international instrument in Australia to stimulate change and none appears to be forthcoming at this time.

QUARANTINE AND PUBLIC HEALTH

Quarantine laws are generally categorised as civil rather than criminal. However, they may impose restrictions on individual freedom which are as severe as penal laws. Sometimes they do so without the exquisite protections typically built into criminal process. Quite frequently quarantine laws reflect the rather oppressive attitudes which prevailed in more primitive times when quarantine was first developed.

So far, only one community is reported to have provided a specific law to quarantine all persons with HIV infection. This is Cuba. But such laws would be manifestly unjust and ineffective, at least in the most developed countries. The antibody test does not disclose all who are infected. It would

be difficult, if not impossible, to provide resources to house, feed, guard and isolate all such persons. The economic impact of withdrawing from the economy people with (on average) eight, ten or many more years of productive contribution would be crippling. Moreover, having regard to the established modes of transmission of the AIDS virus, the risks of the spread of the infection to the whole community remain small. Clearly, the target of laws and policies should be the behaviour that spreads the risk, not the individual. That is why a general policy of quarantine has been described, rightly in my view, as a brutal and unrealistic approach to the containment of HIV[20].

Nevertheless, calls for quarantine and manifest identification of the infected have occurred[21]. They will become much more common as the infection spreads. In a number of jurisdictions already existing powers of quarantine have been enhanced and made specific to include AIDS[22]. Lessons have fortunately been learned from the ways in which communities earlier tackled syphilis - also a sexually transmissible disease potentially lethal. An English Royal Commission report in 1913[23] made the point that the public health objectives of procuring the identification of the infected, counselling and such treatment as was available, were more likely to be effective for the policy of containment than punishment and quarantine. As with syphilis so with AIDS. Winning the support of those who bear the burden of infection, and modifying their behaviour, is the strategy which offers

most promise at this time, at least in developed countries.

Many jurisdictions have enacted laws to provide screening for the presence of HIV. None has so far provided for mandatory screening of the whole population. This has been recognised as ineffective. It is a grossly inefficient use of available public resources. Furthermore it carries with it the risk of discrimination on a large scale[24]. Notwithstanding rational arguments against screening of particular groups in the community, numerous jurisdictions have so provided. For example, China is one of several countries which has recently extended its compulsory testing to all foreigners who apply to live in the country for more than six months[25]. There are many other like provisions, particularly in the laws of countries presently reporting a low incidence of AIDS and HIV.

Numerous legal issues are raised by legislation on screening for antibodies to the AIDS virus[26]. They depend largely on the voluntary or compulsory nature of the screening provided; the facility for anonymous screening; and the obligation of those performing the screening to submit identified or purely statistical data to central record keeping facilities. The concern about AIDS registers and data protection has now begun to attract the attention of international[27] and national[28] reviews of this issue. Because of the risk of discrimination, if not immediately then in the long term as the epidemic worsens, the anxiety of potential or actual privacy invasion is added to the anxieties related to health.

The submission to screening, of itself, does not affect in the slightest either the health of the individual tested or the containment of the virus in the community. However, the hope is frequently expressed that submitting to such screening will encourage at least those without HIV infection to modify their behaviour and henceforth adopt "safe sex" and avoid the sharing of blood and other practices so as to limit the cycle of the infection. Screening also provides the best possible data on the epidemiology of AIDS. These facts suggest to me that anonymous screening and de-identified reporting should be encouraged. Some purists insist that even then consent of the donor should be obtained; but I do not agree.

The provision of facilities for counselling of those undergoing the screening test for HIV was emphasised in a number of sessions at the IVth International AIDS Conference in Stockholm. One of the topics most hotly debated was whether, and if so when, a medical practitioner knowing that a patient is infected with HIV has an obligation to warn that patient's sexual partner(s). In circumstances of persistent refusal or failure of the patient to do so, does a duty to other individuals and to public health override the duty of confidence owed to the patient? Unless legislation is enacted imposing or relieving the medical adviser of liability to do so, such duty would, in common law countries probably be worked out by reference to the laws of confidence and negligence[29].

Various other public health issues raised by AIDS have been dealt with by the law. They include such matters as the

closing of venues considered responsible for spreading the infection (eg bath houses); limitation on acupuncture and organ transplantation by persons infected with HIV; and tracing of sexual partners for the provision to them of counselling about exposure to HIV infection and so on.

BLOOD TRANSFUSIONS

A major early source of the spread of HIV infection was the blood supply. In developed countries, most of this occurred before the problem of AIDS was generally known and before the antibody test for the presence of the virus was generally available. But even now, in a number of developing countries, inadequate resources are available to test blood products. This is just one of the many instances where costs limit the effective response of developing countries to the impact of AIDS. Another is the prohibitive cost of treatments available, which even in richer countries must be rationed although they are vital to survival of the infected.

Numerous legal issues are raised by post transfusion AIDS[30]. Many have concerned the liability of suppliers of blood products where the product is alleged to have caused the infection of a patient. A number of cases involving allegations of this kind have come before the courts in Australia. In one, an application for the identification of a blood donor was refused[31]. In another, an application to bring legal proceedings out of time, on the ground of delayed diagnosis of AIDS,

failed[32]. In some jurisdictions provisions have been urged[33] for a special fund to indemnify those who have acquired HIV or AIDS from blood transfusion[34]. Care must obviously be taken, in acting in this way, not to discriminate between those who have acquired the infection from transfusion as distinct from, say, lawful sexual conduct which was not at the time unlawful or known to be dangerous. Such a distinction could perpetuate unjustifiable discrimination amongst patients with AIDS, all of whom suffer in the same way. All of them need the support of a caring society.

MARGINALISED GROUPS

One of the most tricky problems presented to lawmakers by AIDS is the fact that, at least in developed countries, the groups initially presenting in large numbers with the HIV infection were already stigmatised and, in some senses, "socially outcast"[35]. I refer to homosexual or bisexual men, intravenous drug users and prostitutes. Public opinion polls suggest widespread support, at least in Australia, for mandatory testing of such groups. Thus, a 1987 survey showed 90% support for compulsory testing of homosexuals; 86% were for testing all immigrants entering Australia; 83% for prisoners in gaol and even 57% for tourists entering the country[36].

Democratically elected governments, under the pressure to be seen to be doing something effective in the face of a major epidemic, may be tempted to legislate against particular groups. Migrants, prisoners, drug users and prostitutes, in

particular, lack an effective voice to dissuade lawmakers from provision of laws discriminating against them. It is therefore important for those with knowledge about the science of lawmaking to remind lawmakers of the dangers of unjust discrimination and the probable ineffectiveness of mandatory testing of such groups. To test migrants but not tourists would seem unjustifiable, as the latter, rather than the former, may typically have greater exposure to AIDS. To test prisoners without making administrative arrangements for their care if found to be HIV positive is pointless. Yet in prisons around the world (including in Australia) compulsory testing is now increasingly occurring. To provide for testing of prisoners and not to provide for condoms and bleach, at least, for the control of the spread of the infection by intravenous drug users is irresponsible[37].

In a survey conducted for the National Health and Medical Research Council of Australia it was disclosed that about 12% of men in the sample admitted to homosexual behaviour during their lives[38]. This is a lower figure than Kinsey reported in 1948 in the United States (37.9%). The actual proportion might well be higher than the Australian survey suggests. The possibility of sexual activity in crowded prisons, where normal sexual outlets are impossible, must be acknowledged by a society in whose charge the prisoners are. There is growing recognition in many lands of public acceptance of this fact[39]. One of the advantages of the sexual revolution in developed countries has been a growing realism about human

sexuality and a willingness to face candidly and to discuss publicly its consequences, including now for AIDS and HIV.

This realism may, in due course, produce an important legal revolution concerning intravenous drug users. The reports to the Stockholm Conference on AIDS made it plain that in the United States and Europe heterosexual intravenous drug users are now a rapidly growing proportion of those presenting with HIV infection (estimated 25% in the United States; 30% in Europe)[40]. This fact has led, in a number of jurisdictions, to the lawful provision of sterile syringes in an exchange program designed to curb the spread of HIV. An Australian report suggests that more than 1 in every 10 returned needles in the inner city of Sydney is infected with HIV. This constitutes a "substantial increase" in the apparent spread of the virus amongst intravenous drug users[41]. The figure is rising quite rapidly. The introduction of syringe exchange programs requires a degree of political courage. This is especially so at a time of national concern in many countries about the growing use of narcotic and other drugs. However, it also represents recognition of the fact that the present legal response to drug control, at least in some developed countries, is failing and is faced with a new and very urgent problem. There is a growing willingness to contemplate (or at least to experiment with) treating the problem as one of public health. A discussion paper issued in Australia in February 1988 reviewed, for the first time, various options designed to control what was described as "the second AIDS epidemic". This

is the spread of HIV by way of the sharing of syringes and later sexual intercourse to the general community[42]. Editorials in a number of Australian newspapers are now facing candidly the possible need to provide heroin and other drugs to intravenous drug users as part of a strategy to prevent the risk of the spread of the AIDS virus into the general community. Illegality and covert supply of drugs tends to promote this risk[43]. This is itself a most remarkable development. It reflects the growing recognition of the seriousness and extent of the problem of AIDS. A drastic problem may necessitate drastic solutions. It may concentrate the mind on those measures most likely to be effective.

OTHER ISSUES

Numerous other issues require mention in any review of the impact of AIDS upon the law. They include:-

* The provision of laws against discrimination against people with HIV or AIDS whether in employment[44], schooling[45], housing[46], the provision of social security or otherwise. These are areas where the law may have a positive role to play. Necessarily the laws power to change deeply felt and long held public prejudices is limited by the considerations already mentioned by me.

* Family law may be affected, for example in those legal systems which provide for dissolution of marriage on the ground of matrimonial fault such as adultery[47]. Particular issues of child abuse; the

rights and liabilities of sexual partners and the position of families devastated by the loss to AIDS of an income earner, all need consideration. An interesting consequence of the introduction of laws requiring pre-marriage tests for HIV in some jurisdictions of the United States was reported in Stockholm. It was that applications for marriage licenses had fallen by 60%[48]. This simply demonstrates the need for more careful consideration in the design of such laws.

* The regulation of insurance and the extent to which insurers may seek to protect themselves from unjustifiable liability while requiring policy holders to answer questions, undergo screening for HIV or otherwise[49]. Different problems arise having regard to the provision or absence of publicly funded health care. In the absence of such provisions, the entitlement to the protection of private insurance may be critical to a tolerable quality of life for the infected and sick. Questions addressed, for example, to whether a person has submitted to screening, or sexual orientation as such, might be unfairly discriminatory. Yet so might prohibitions on the provision of insurance to particular groups, given that it is behaviour (and not membership of a group as such), which puts a policyholder at risk.

* Concern has been expressed about the neuropsychiatric aspects of HIV infection and about whether dementia will provide justification for compulsory screening of employees in some occupations. A number of airlines are now requiring flight and cabin crew to submit to HIV tests, ostensibly upon this basis. A committee of the WHO has questioned the justification for such tests. It has pointed out that mental impairment is likely to show up in advance of other symptoms thereby removing the justification for universal screening, with its serious dangers for discrimination[50]. It is mental impairment, not the presence of HIV, which should be the subject of any such investigations.

* Reports of the first tests of AIDS vaccine were made to the Stockholm Conference on AIDS in June 1988. Vaccines present serious issues for the legal liability of the individuals and corporations involved in such tests. In some jurisdictions, judge-made decisions and legislative provisions have had the effect of impeding or slowing vaccine development[51]. Given the dimension of the global problem of AIDS and the urgency of providing an effective cure and vaccine as quickly as possible, consideration will need to be given to such matters as the protection of drug companies and the compensation of any who suffer from their urgent

activities[52].

* Finally, the likelihood, in present circumstances, of large numbers of persons dying from AIDS has called attention once again to the issue of euthanasia and the need for respect of the terminally ill[53]. Sadly, hysteria can generate pain for the dying and the grieving. In New South Wales, for example, regulations require that a person known or reasonably suspected to have suffered [from AIDS] should, at the time of death, be placed in double plastic bags, heat sealed with the words "Infectious Disease - Handle with Care" placed on the body in letters of prescribed colour and height[46]. Obviously this procedure has exacerbated grief in some situations. It betrays the right of a deceased person not to disclose the nature of his or her illness. There is no scientific basis for the regulation. AIDS is not transmitted by handling the body of a person who has died in this way. The regulation was, I regret to say, nothing more than a response to a trade union demand which was grounded in irrational fear. We will see many more such laws before we are through this epidemic.

CONCLUSIONS

This last comment calls attention once again to the need to base laws on facts. From a recognition of the limited capacity of the law to promote the necessary

behaviour modifications, some consequences follow for the containment of HIV and AIDS. The only vaccine we have at the moment, or are likely to have in the foreseeable future, is, as the Swedish Minister for Health said in Stockholm, knowledge[55]. This is why, at least at present, legal regulation should be addressed primarily to facilitating public education, the ready provision of condoms, made to a reliable standard and provided with water-based lubricants, and the ready availability to people concerned about their probable risk, of anonymous HIV screening. As has been pointed out, such screening may sometimes be the first step on the road to self protection and the protection of others.

It is in this sense that the report of the United States Commission led by Admiral Watkins (which coincided with the Stockholm AIDS Conference) was a most important reinforcement of the leadership earlier given by the United States Surgeon General Koop. The report emphasised the need, paradoxical though it may at first seem, to accompany laws and policies on AIDS with the provision of protection against discrimination of those who are infected. The lesson is there from the earlier legal regulation of syphilis, when it was incurable and often deadly. Attempts to deal with syphilis punitively, by stigmatisation, mandatory contract tracing and the rounding up of prostitutes[56] provided no effective protection for society. On the contrary, it involved great injustice.

And it was ineffective. Injustice in combating AIDS might be tolerated by some. Many in the groups presently most at risk in developed countries face the prospect of further stigmatisation. They contemplate greater injustice with resignation and an anger controlled by knowledge born of long experience. But inefficiency in controlling the spread of HIV is unforgiveable. At risk is nothing less than the health of millions of people.

In the hard battle against AIDS some things, at least, have fallen out right. We are fortunate, for example, that this epidemic has struck at a time when we have the World Health Organisation to mobilise the international community. We also have the tools of molecular biology to identify the virus. We have the modern means of communication to spread rapidly the vital educational message. In developed countries, at least, we have a greater candour which has, in varying degrees, accompanied new attitudes to human sexuality[57]. Such attitudes will be helpful in combating stigmatisation and in promoting frank instruction, including to the very young, concerning the modes of transmission and means of protection. We have in some places a healthy new willingness to think radically concerning the groups most at risk, not least for the protection of the rest of the community. We also have a growing knowledge about the science of jurisprudence: how to make laws which are just and efficient in securing their objectives. It is this

knowledge which brings a realisation of the limits of what can be achieved by the law in epidemic control.

An Australian judge once said that the law "limps after medicine ... at the rear of the line"[58]. For the health of society and the practical containment of AIDS and HIV, that is where I would generally keep it for the present. Over-enthusiasm in enacting laws on AIDS may make some people feel better. But such laws will have precious little impact on controlling the spread of the epidemic. They may cause serious disadvantages of stigmatisation for those infected or most at risk, whose complete cooperation society must win. For this reason too some laws may actually impede the control of the spread of AIDS. For the moment, in countries like Australia and the United States, control depends primarily upon community and individual education. That may seem a strange conclusion for a lawyer to reach. But I am sure that it is right.

One day AIDS may be just a footnote to human history. It may become like all the other epidemics which have come and gone, carrying off their anonymous millions[59]. I hope that it will not be said then, as so often of the past, that the suffering of the epidemic was accompanied and even exacerbated by inefficient and unjust laws. This time we must do better. But how much better we do depends on having knowledgeable lawmakers and a civilized community. Common experience and past history do not given cause for complacency or undue optimism about either.

ENDNOTES

1. Australia, Department of Community Services and Health, Policy Discussion Paper, AIDS: A Time to Care and a Time to Act, Aust. Govt. Publ. Serv., Canberra, 1988, 71-2.

2. Public Health (Proclaimed Diseases) Amendment Act (NSW) 1985 s 3. Discussed in D Buchanan and J Godwin "AIDS - The Legal Epidemic" (1988) 13 Legal Service Bulletin 111, 114.

3. N Blewett cited in Buchanan and Godwin, 114.

4. Council of Europe, 16th Conference of European Ministers of Justice, "Criminal Law and Criminal Logical Questions Raised by the Propagation of Infectious Diseases, Including AIDS", Strasbourg, 1988, 5.

5. P Sieghart, "AIDS and Human Rights", BMA Foundation for AIDS, forthcoming, 1989. See also M Breum and A Hendriks, (Eds) Aids and Human Rights, Danish Center of Human Rights, Copenhagen, 1988.

6. These "rights" are identified and discussed in Sieghard n5, 24-67.

7. See World Health Organisation, Tabular Information on Legal Instruments Dealing with AIDS and HIV Infection, WHO-GPA-HLE-88.1, June 1988.

8. See K M Sullivan and M A Field, "AIDS and the Coercive Power of the State", 23 Harvard Civ Rts-Civ Lib L Rev 139, 163 (1988). Cf Scots Criminal Law and AIDS in the Scots Law Times, 18 December 1987, 389.

9. See eg J R Seale, "Kuru, AIDS and Aberrant Social Behavior" in (1987) 80 J Roy Soc Medicine 200, 201. See also D J Besharov, "Make it a Crime to Spread AIDS", Washington Post, 18 October 1987, D5 and M Barnard, "Curtail Sexual Threat by Law", Melbourne Age, 22 March 1988, 13.

10. See s 50N(3) in the Public Health Act 1902 (NSW).

11. See Health Amendment Act 1987 (Vic). A similar provision has been enacted in the Soviet Union by the Decree of 25 August 1987 as reported in Izvestia, 26 August 1987, 2. It provides for deprivation of liberty for up to five years for knowingly exposing a person to infection and for up to eight years for knowingly transmitting AIDS to another person.

12. Fountain v Director of Public Prosecutions [1988] Crim Law Rev (GB) 123.

13. The Queen v Malcolm [1988] Crim LRev (GB) 189.

14. The Queen v Smith (1987) 44 Sth Aust State Rep 587.

15. Bailey v The Director of Public Prosecutions (1988) 62 Australian law Journal Rep 319; The Queen v L L Bayliss unreported, court of Criminal Appeal (NSW) 3 November 1988.15.

16. Bowers v Hardwick 106 SC 284 (1986). See discussion Sullivan and Field, 161.

17. Watkins v United States Army, 837 F 2d 1428 (1988), USCA Ninth Circuit.

18. Norris Case, unreported, judgment of the European court of Human Rights, Strasbourg, 26 October 1988. (6/1987/129/180).

19. See eg AIDS - A Time to Care, a Time to Act (above) 125.

20. J Osborn, "The AIDS Epidemic : Six Years". Am Rev Public Health 1988, 9 551-83 at 574.

21. W J Buckley Jr, "Combating the AIDS Epidemic", New York Times, 18 March 1986, A 27.

22. See eg Public Health (Control of Disease) Act 1984 (UK). Cf J Aiken, "AIDS - Pushing the Limits of Scientific and Legal Thought" in 27 Jl Law Sci & Tech (1986) 1, 5; K M Sullivan and M A Field, above n8.

23. See "History Says No to Policemen's Response to AIDS" in (1986) 293 BMJ 1589.

24. M D Kirby, "The New AIDS Virus: Ineffective and Unjust Laws" in France, Ministry of Foreign Affairs etc Symposium International de Réflexion sur le Sida, Paris, 22-23 October 1987 (Version Anglaise) Papers, 203, 209ff. Note Council of Europe, Committee of Ministers, Recommendation R(87) 25, 2.

25. As reported, London Daily Telegraph, 8 January 1988, 6.

26. See J K M Gevers, "AIDS, Screening of Possible Carriers and Human Rights" in Health Policy 7 (1987) 13. See also discussion Dale and Ors, "Blood Testing for Antibodies to the AIDS Virus: The Legal Issues", CRS Report for Congress, 87-738A; cf G D Thomas "The Perils of AIDS Testing: 11 Los Angeles Lawyer 39 (1988).

27. Council of Europe, Committee of Experts on Data Protection, AIDS Registers and Data Protection, Memorandum, 30 March 1987.

28. See Dale and Ors above n 26.

29. J D Piorkowski, "Between a Rock and a Hard Place : AIDS and the Conflicting Physician's Duties of Preventing Disease Transmission and Safeguarding Confidentiality". 76 Georgetown L J 169, 175. Cf Tarasoff v Regents of the University of California 551, P 2d 334 (1976).

30. J F Williams, "Blood Transfusions and AIDS: A Legal Perspective" 32 Med Trial Techn Qly 267 (1986).

31. See Loker v St Vincents Hospital (Darlinghurst) & Anor, unreported, SC, (Allen M), 1 October 1985. Noted M D Kirby, "AIDS Legislation - Turning Up the Heat?" (1986) 60 Aust LJ 324, 330.

32. Dwan v Farquhar (1986) Qld Law Reptr 600 (SCQ).

33. New Zealand Herald, 18 June 1988, 24.

34. The United Kingdom Government has made an ex gratia payment of £10 million to enable the Haemophilia Society to set up a trust fund to help haemophiliacs infected with the AIDS virus from infected blood products. (See "Government Gift of £10 M to help Haemophiliacs" The Times (London) 16 November 1987).

35. S Kingman, "AIDS and the Social Outcast" in New Scientist, 10 March 1988, 30.

36. 1987 Aust Election Survey Reported in Australia, AFAO, National AIDS Bulletin, June 1988, 9.

37. WHO, Special Program on AIDS, Statement from the Consultation on Prevention and Control of AIDS in Prison, Geneva, 16-18 November 1987. Contrast T A Coughlin III< AIDS in Prisons : one correctional administrator's recommended policies and procedures: 72 Judicature 63, 70 (1988).

38. Melbourne Age, 8 April 1988, 1.

39. See eg New Zealand Herald, 3 October 1987; 1 March 1988, 8.

40. D C Des Jarlais, "HIV Infection among Persons who Inject Illicit Drugs: Problems and Progress" in Papers of the IVth International Conference on AIDS, Stockholm, Sweden, June 1988.

41. J Gold quoted Sydney Morning Herald, 10 February 1988, 8.

42. L R H Drew and V K Taylor, "The Second AIDS Epidemic: Spread via Needle-Sharing to the General Community: A Review", mimeo, 9 February 1988, Australia, Department of Community Services and Health.

43. See eg Melbourne Herald, 6 June 1988; Melbourne Age 17 June 1988. Contrast D Hanks "The proposal to make heroin available legally to intravenous drug abusers". 149 Medical Journal of Australia 455 (1988).

44. See eg N Fagan and D Newell, "AIDS and Employment Law" in (1987) 137 New LJ 752, 753; J Heilman, "Discrimination" in Los Angeles Lawyer, June 1986, 26.

45. See eg D Kirk, "HIV-Infected Students and School" in M Quackenbush and M Nelson "The AIDS Challenge, Network Publications, Santa Cruz, 1988, 297.

46. See discussion New York Commission on Human Rights, Report on Discrimination against People with AIDS, April 1986, 13 ff.

47. R C O'Brien, "AIDS and the Family" in WHL Dornette, "AIDS and the Law", J Wiley & Sons, 1987, 86.

48. Figures cited in J Osborn, "AIDS - Politics and Science", The McNally Lecture, unpublished paper, Uni of Michigan, 5 April 1988, 5.

49. See eg M Neave, "Anti-Discrimination Laws and Insurance. The Problem of AIDS" (1988) 1 Insurance Law Journal (Aust) 10.

50. WHO, Global Programme on AIDS, Report of the Consultation on the Neuropsychiatric Aspects of HIV Infection, Geneva, 14-17 March 1988.

51. M D Kirby, "AIDS, Drugs, Vaccines and the Law - Lessons from the United States Experience", mimeo, paper for the ANZ Assn Advct of Science, May 1988.

52. Cf National Childhood Vaccine Injury Act (US); 1986 Pub L 99, 660.

53. See eg D Schulman, "Stopping AIDS - Euthanasia", in Tikkun, Vol 2, No 3, 14 (1987). See also Medical Treatment Act 1988 (Vic).

54. Public Health (Funeral Industry) Regulation, 1987 (NSW), Reg 21(2). Cf Public Health (Control of Disease) Act 1984 (UK) ss 43, 44.

55. Minister Gertrud Sigurdsen, Minister of Health (Sweden) comments at the IVth International Conference on AIDS, Stockholm, Sweden, June 1988.

56. See discussion in Sullivan and Field, above n 8; G W Matthews and V S Neslund, "The Initial Impact of AIDS on Public Health Law in the United States - 1986 in 257 Jl AMA 344, 346 (1987). See also A M Brandt, "AIDS - From Social History to Social Policy" in 14 Law Medicine and Health Care 231, 233 (1986). In 1918 the US Congress voted more than $1 million for the detention and isolation of venereal carriers. During the War more than 30,000 prostitutes were incarcerated in institutions supported by federal funds. The story is compared with the internment of Japanese Americans during World War II.

57. But there are limits to this. In Australia, television stations refused to screen part of an AIDS advertisement, approved by the Government, which showed two men in bed along with beds showing men and women. See "No gays allowed on AIDS TV ad" in Sydney Morning Herald, 28 November 1988, 3. In the United States, the Surgeon General in 1988 unveiled a national advertising campaign to promote the use of condoms to help stem the spread of AIDS. But in the District of Columbia, the Metro Board withdrew certain advertisement on buses and trains after pressure. A leading drug store was reported to have banned the November 1988 issue of the popular magazine Spin because it contained a free condom with an advertisement on "safe sex". See Time (Australian ed) 7 November 1988, 37. The road ahead will clearly be slow and difficult.

58. Justice Windeyer in Mount Isa Mines Ltd v Pusey (1970) 125 Cwealth Law Reports 383, 395.

59. See eg A M Brandt; "Aids in Historical Perspective : Four Lessons from the History of Sexually Transmitted Diseases", American Journal of Public Health, Vol 78 No 4, 367; P H Curson, Times of Crisis -Epidemics in Sydney 1788-1900, Sydney Uni Press, Sydney, 1985.