AIDS AND THE LAW

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AIDS IS HARD; hard on the patients who learn the grim news; hard on the health-care workers, who have only 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 lawmakers struggling to bring the cumbersome, imperfect machinery of legal control to bear effectively on intimate personal behavior, which must be modified quickly if the spread of the epidemic is to be slowed. And prejudice and hatred, fueled by fear, are always close at hand.

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 society has a problem, all it needs to do is make some new law and the problem will be solved. They assume that people will modify their conduct to avoid criminal punishment or civil liability.

But obedience to a law, even if everyone is familiar with it, is not certain and cannot be assumed. The law may entirely miss its mark because of its ambiguity or sanctions that cannot be enforced. Want of resources, discriminatory prosecution, or imprecise, ineffective design of the enforcement mechanisms frequently torpedo a law

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which looked fine when first made by the legislator, bureaucrat, or judge but just did not work on the streets.

And then many laws are honored in the breach. The world's societies are overburdened with them. But nobody seems to worry very much about all the communities that are churning out new laws and failing to provide the institutional means to bring old law into harmony with widespread social change.

Even if a new law is well written, precisely and accurately targeted, widely known and generally respected, there is still no guarantee that it will operate on human behavior at the critical moment when its effectiveness counts most.

A recent Australian report is an examination of behavioral change in response to the AIDS epidemic.[1] The authors list the factors they have found influence change. The first is direct knowledge of someone who was sick or who has died as a result of infection with the human immunodeficiency virus (HIV). The second is barriers militating against safe behavior. Laws may discourage people from approaching governments or health services or from acquiring condoms for "safer sex" and sterile equipment for intravenous drug use. The third factor is the use of alcohol and other drugs in sexual and presexual situations. The fourth is the relationship of the subject to his or her sexual partners. Negotiating safer sex with regular partners was found to be much more difficult than with casual partners. The fifth factor involves psychosocial characteristics such as self-image and self-confidence. The sixth is a person's knowledge about his or her HIV infection status. The seventh factor is age: younger and older individuals have demonstrated more difficulty in adapting to essential behavioral change than those between the ages of twenty-five and forty-five.

In a number of the Australian states in which the survey just mentioned was conducted, legislation had been enacted making it an offense for a person who knows that he or she has AIDS, or who has been exposed to HIV, to have sexual intercourse with another unless, before that intercourse takes place, the other person has been informed of the risk of contracting the disease 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

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

Our objective in proposing or making new laws on AIDS must be to contain the epidemic. The Australian health minister (Dr. Neal 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 on 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, about general ineffectiveness. The best known of the administrative measures of earlier times, quarantine, is said to have been developed 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 by factors other than disease.[4] King Philip of France ordered the extraction of the tongues of all blasphemers. He believed, ever so sincerely, that blasphemy had brought the bubonic plague on his country. Modern counterparts spring to mind. In epidemics lepers and Jews were often the targets of official action prompted by public opinion, which had been stimulated by myth and prejudice. Leprosy trials to establish a particular category of infection were well known in earlier centuries. Reporting, incarcerating, disenfranchisement, privation, and deprivation of civic rights have been the usual legal companions of

infections over the centuries. As late as 1832 in Paris, numberless innocent people stricken with cholera were lynched by fearful mobs.

In this age of computer science, space flight, biotechnology, and nuclear fission as AIDS comes upon us, can we do better than in the past? Only if we appreciate several fundamentals. We must candidly acknowledge the limited function of law as a response to AIDS and realize that laws will not be effective until they are based on good data concerning the nature of AIDS, its modes of transmission, and the precise conduct that encourages or diminishes transmission. We must recognize the counterproductive effects of laws and practices that limit the ready supply of condoms or impede the use of sterile needles by intravenous drug users.

We may decide that we prefer a society that clings to the ideals of sexual chastity to a society that teaches young school children explicitly about the dangers of AIDS and facilitates the provision of condoms to all who want them. We may prefer to concentrate on the "war on drugs" rather than on legalizing 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.

HUMAN RIGHTS CONTEXT

In a review of AIDS and the law it is easy to overlook the human-rights context. Many lawyers and lawmakers 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 fundamental values and run the danger of losing its way in a mass of parochial detail. A sensitivity to human-rights principles provides us with the mileposts by which we may find our way across the dangerous landscape of burgeoning laws made to deal with AIDS.

Many of these principles appear in international treaties and customary international law yet may not be enforced in national courts. But it is useful to remember that there are abiding basic values which have been formulated by leading philosophers and lawmakers 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 on the basic 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 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 be educated, and the right to freedom from inhuman or degrading treatment or punishment.[6] We must harmonize our legal responses with these fundamental values, which will endure even after the AIDS peril has been overcome.

THE PERILS OF GENERALIZATION

Now, let me speak frankly of the limitations of law. First of all, law is always local in the sense that its operation is limited to a particular legal jurisdiction. Approaches to epidemic control vary enormously according to the political system in operation—how responsive it is to popular opinion, how authoritatively it can deal with problems.

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 on which it must operate. The felt needs for law depend on the perception (and actuality) of the size and nature of the problem being addressed. Statistics from the World Health Organization (WHO) show the wildly uneven distribution and differing patterns of AIDS at this stage of the epidemic in various countries.

Finally, whereas medical and other scientists dealing with the human body work on phenomena that are universal and unvarying, the legal systems around the world are fundamentally different. 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 on 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 that of civil law, derived principally from France. In this system the rule of the judge as a lawmaker is important but less so. Codification by the legislature

and general statements of the law by text writers are more common in countries of the civil law system.

The foregoing is to introduce what follows by words of necessary caution about the extent to which legal rules established to respond to AIDS in one jurisdiction may be adapted 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 on local institutions and legal environments.

WHO contributes to understanding the commonality of legislative responses to AIDS by the publication of tabular information on legal instruments dealing with AIDS and HIV infection.[7] A circular is published regularly in two parts. One surveys the United States, the present epicenter of the epidemic, by reference to legislative instruments, federal and state. The other deals with instruments reported from other jurisdictions around the world. These reports are indispensable. Although they omit judge-made law and much official practice and policy that is important in matters of public health, the WHO reports provide a conspectus of law enacted in the legislatures of countries operating according to common law.

Laws have been enacted quickly in many countries to provide for the screening of blood products and the notification by medical practitioners of suspected or confirmed diagnoses of AIDS. A growing number of jurisdictions is introducing requirements for compulsory screening of identified groups, particularly immigrants and prisoners. It is not my intention to collect and analyze these laws. Instead, I wish to give a general look at the laws on AIDS, so that some notion can be derived of the way in which lawmakers in many lands are responding to the epidemic.

CRIMINAL LAW

Since exposure to HIV infection may lead to AIDS, which is life threatening, it is a legitimate purpose of the law to endeavor to protect individuals, communities, and nations from the spread of the virus. Through their systems of criminal law, societies attempt to inculcate individual responsibility. Although criminal law operates imperfectly, it sometimes has a symbolic value: it can state that

conduct is punishable and hence is not approved by society. Various theories exist to justify the stigmatization 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 penalizing 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 goal underpinning criminal law: to protect the individual and the community of individuals from harm.

It is possible that in some places knowingly spreading HIV to another person—or being recklessly indifferent to whether by sexual or other conduct the actions of the individual will have that consequence—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.[8] Calls are now being made for the provision of specific criminal offenses by which, on conviction, courts may penalize the deliberate or reckless spread of this 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. The penalty for not doing so 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 "wittingly and deliberately exposing another person to the possibility of being infected" by a person suffering from AIDS or similar disease is unlawful. By an act of 7 January 1986, Florida made it unlawful for a person suffering from HIV infection to continue having sexual 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 offense 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 if there are provisions for reporting persons who prove HIV positive to the test, with personal identifiers that can be traced. The Australian survey I have mentioned shows that submitting to the HIV test may itself sometimes be a useful educational step in a course of behavior modification designed to promote self-protection and the containment of the AIDS infection. Criminal offenses, 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 having had an affair and he feared that she had contracted AIDS from it and would infect the children. I suspect that we will see more defenses 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 giving a blood sample so as to detect the presence of alcohol in the blood of a driver, allegedly on the ground of concern about contracting AIDS in the process, was not considered 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 can justify a higher tariff in the punishment of a person convicted of rape.[13] In South Australia the State Supreme Court has held that the fact that a prisoner is suffering from AIDS is a consideration relevant to the determination of his or her sentence. This was justified with regard to the state of the prisoner's health, his health prognosis, and the likely loss of ordinary prison privileges because of isolation, consequent on 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 U.S. 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 conflict with the Constitution suggest that constitutional limitations will not always play a large part in the United States in controlling criminal or other laws targeted to 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 with respect to such laws in Northern Ireland. That article deals with the guarantee of privacy. 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 to a complaint from 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 the Australian states, the law remains as it is in Ireland. Many commentators have urged the necessity of reform to reduce stigmatization 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 categorized 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 protections typically built into criminal process. Quite frequently quarantine laws reflect the oppressive attitudes that prevailed in more primitive times when quarantine was first developed.

So far, only the country of Cuba has provided a specific law to quarantine all persons with HIV infection. Such a law would be manifestly unjust, impractical, and ineffective 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 impact of withdrawing from an economy people with eight, ten, or many more years of productive contribution would be crippling. Moreover, when one considers how the virus is transmitted, the risk of the spread of the infection to the whole community remains small. Clearly, the target of laws and policies should be the behavior that spreads the risk, not the individual as such. Laws focused on individuals or groups may carry the risk of unjust discrimination or may be too heavy-handed in their operation. 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 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] Fortunately, lessons have been learned from the ways in which communities earlier tackled syphilis, also a sexually transmissible disease that is potentially lethal. An English Royal Commission report in 1913[23] made the point that the public health objectives of identifying the infected, counseling them, and giving them such treatment as was available were more likely to contain the disease than were punishment and quarantine. As with syphilis, so with AIDS. Winning the support of those who bear the burden of infection and modifying their behavior is the strategy that 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. Most commentators have recognized this 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 provided for it. China, for example, has recently extended its compulsory testing to all foreigners who apply to live in the country for more than six months.[25] Many other countries, particularly those reporting a low incidence of AIDS and HIV, have drawn up similar laws.

Legislation to screen for antibodies to the AIDS virus raises numerous legal issues:[26] whether the screening should be voluntary or compulsory, whether the screening facility should guarantee the tested person's identity, and whether those doing the screening should 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 both 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 about invasion of privacy adds to the anxiety about health.

The submission to screening does not in itself affect in the slightest either the health of the individual tested or the containment of the virus in the community. However, undergoing the test may encourage at least those found to be without HIV infection to modify their behavior and henceforth to practice safer sex and to 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. For these reasons, I believe that anonymous screening and deidentified 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 counseling those undergoing the screening test for HIV was emphasized in a number of sessions at the Fourth International Conference on AIDS in Stockholm. One of the topics most hotly debated was whether a medical practitioner who knows that a patient is infected with HIV has an obligation to warn that patient's sexual partner(s) and if so, when. In circumstances of persistent refusal or failure of the patient to tell his or her partners, does a duty to other individuals and to public health override the duty of confidence owed the patient? Unless legislation is enacted to impose or relieve 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]

The law has dealt with various other public health issues that AIDS has raised. They include such matters as the closing of venues considered responsible for spreading the infection (e.g., bathhouses), the limitation of acupuncture for AIDS patients and of organ transplants from persons infected with HIV, and the tracing of sexual

partners so as to provide them with counseling about exposure to HIV infection.

BLOOD TRANSFUSIONS

Early in the epidemic a major source of the spread of HIV infection was the blood supply. In developed countries, most transmission of the virus 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 situations in which 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.

Numerous legal issues are raised by post-transfusion AIDS.[30] Many have concerned the liability of suppliers of blood products when they are alleged to have caused the infection of patients. 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 beyond the time generally fixed by law for that purpose, on the ground of delayed diagnosis of AIDS, failed.[32] In some jurisdictions, provisions have been urged for a special fund to indemnify those who have acquired HIV or AIDS from blood transfusion.[33] In such cases care must obviously be taken not to discriminate between those who have acquired the infection from transfusion rather than from, say, sexual conduct which was not at the time unlawful or known to be dangerous. Such a distinction could perpetuate unjustifiable discrimination among patients with AIDS, all of whom suffer in the same way. All of them need the support of a caring society.

MARGINALIZED GROUPS

One of the most tricky problems AIDS presents to lawmakers is that the groups initially infected with the HIV virus in developed countries were already stigmatized and, in some sense, socially outcast.[34] I refer to homosexual or bisexual men, intravenous drug users, and prosti-

tutes. In Australia, public opinion polls suggest widespread support for mandatory testing of such groups. A 1987 survey showed 90 percent support for compulsory testing of homosexuals, 86 percent for testing all immigrants entering Australia, 83 percent for testing prisoners in jail, and 57 percent for testing tourists entering the country.[35]

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 making 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 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 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 infection by intravenous drug users is irresponsible.[36]

In a survey conducted for the National Health and Medical Research Council of Australia, it was disclosed that about 12 percent of the men in the sample admitted to engaging in homosexual behavior during their lives.[37] This is a lower figure than Kinsey reported in 1948 in the United States (37.9 percent). 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 expected. In many countries public acceptance of this fact is growing.[38] The sexual revolution in developed countries has brought with it an understanding of human sexuality and a willingness to face it candidly and to discuss its consequences, including AIDS and HIV, publicly.

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 with HIV infection (estimated to be 25 percent in the United States and 30 percent in Europe).[39] In a

number of jurisdictions, this fact has led 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 one in every ten returned needles in the inner city of Sydney is infected with HIV. This constitutes a "substantial increase" in the apparent spread of the virus among intravenous drug users.[40] The figure is rising quite rapidly. The introduction of syringe-exchange programs requires a degree of political courage, especially when so many countries are concerned about the rise in use of narcotics and other drugs. These new programs also represent recognition of the fact that the present legal response to drug control is failing. Increasingly, countries are willing to consider (or at least to experiment with) treating the problem as one of public health. A discussion paper issued in Australia in February 1988 included for the first time a review of options designed to control what was described as "the second AIDS epidemic" (the spread of HIV through the sharing of syringes and sexual intercourse to the general community).[41] Editorials turn up now in a number of Australian newspapers suggesting the 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 population at large. Illegality and the covert supply of drugs tends to promote this risk.[42] 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 on the law. They include:

- The provision of laws prohibiting discrimination against people with HIV or AIDS whether in employment,[43] schooling,[44] housing,[45] social security, or otherwise. There are areas where the law may have a positive role to play. Necessarily, the law's power to change deeply felt and long held public prejudices is limited by the considerations already mentioned.

- Family law, which may be affected, for example in legal systems that provide for dissolution of marriage on the ground of matrimonial fault such as adultery.[46] 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 premarriage tests for HIV in some jurisdictions of the United States was reported in Stockholm: applications for marriage licenses fell by 60 percent.[47] This drop 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 or undergo screening for HIV.[48] In the absence of publicly funded health care, entitlement to the protection of private insurance may be critical to guaranteeing a tolerable quality of life for the infected and sick. Questions about whether a person has submitted to screening, for HIV or for sexual orientation, for example, might be unfairly discriminatory. So might prohibitions on the provision of insurance to particular groups, given that it is behavior and not the members of a group that puts a policyholder at risk.

- The neuropsychiatric aspects of HIV infection and the question whether dementia will provide justification for compulsory screening of employees in some occupations, about which concern has been expressed. A number of airlines are now requiring flight and cabin crew to submit to HIV tests, ostensibly on this basis. A WHO committee 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 danger of discrimination.[49] It is mental impairment, not the presence of HIV, that should be the subject of such investigations.

- Reports of the first tests of AIDS vaccine 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.[50] 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 this important work.[51]

- Finally, the likelihood, in present circumstances, of large numbers of persons dying from AIDS, which has called attention once again to the issue of euthanasia and the need for respect for the terminally ill.[52] Sadly, hysteria can generate pain for the dying and the grieving. In New South Wales, for example, regulations require that a person known to have AIDS or reasonably suspected to have suffered from it 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 color and height.[53] 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 grounded in irrational fear. We will see many more such laws before this epidemic is over.

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 behavior modifications, some consequences follow for the containment of HIV and AIDS.

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 Organization to mobilize the international community. We also have the new tools of molecular biology to identify the virus. We have the modern means of communication to spread the vital educational message rapidly. In developed countries, we have greater candor, which has, in varying degrees, accompanied new attitudes toward human sexuality.[54] Such attitudes will be helpful in combating stigmatization 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 realization 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."[55] For the health of society and the practical containment of AIDS and HIV, that is where I would generally keep the law for the present. Overenthusiasm 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. For the time being, control in countries like Australia and the United States depends primarily on community and individual education. That may seem a strange conclusion for a lawyer to reach. But I am sure that it is right.

The only vaccine we have at the moment, or are likely to have in the foreseeable future, is knowledge, as the Swedish Minister for Health said at the International AIDS Conference in Stockholm.[56] This is why legal regulation should at present be addressed primarily to facilitating public education, providing condoms made to a reliable standard, and making anonymous HIV screening readily available. As has been pointed out, such screening may sometimes be the first step on the road to self-protection and the protection of others.

The report of the United States Commission led by Admiral Watkins (which coincided with the Stockholm AIDS Conference) was an important reinforcement of the leadership earlier given by United States Surgeon General Koop. The report emphasized 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 stigmatization, mandatory contact tracing, and the rounding up of prostitutes,[57] provided no effective protection for society. And it involved great injustice. 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 stigmatization. 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 unforgivable. At risk is nothing less than the health of millions of people.

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.[58] I hope that it will not be said then, as it so often has of the past, that the suffering of epidemic was accompanied and even exacerbated by inefficient and unjust laws. This time we must do better.

ENDNOTES

[1]Department of Community Services and Health, *AIDS: A Time to Care and a Time to Act*, policy discussion paper (Canberra: Australian Government Public Service, 1988), 71–72.

[2]Public Health (Proclaimed Diseases) Amendment Act, New South Wales, 1985, sec. 3, discussed in D. Buchanan and J. Godwin, "AIDS—The Legal Epidemic," *Legal Service Bulletin* 13 (1988):114.

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

[4]Council of Europe, "Criminal Law and Criminological Questions Raised by the Propagation of Infectious Diseases, Including AIDS," Sixteenth Conference of European Ministers of Justice, Strasbourg, 1988.

[5]P. Sieghart, "AIDS and Human Rights," British Medical Association, Foundation for AIDS (forthcoming in 1989). See also M. Breum and A. Hendriks, eds., *AIDS and Human Rights* (Copenhagen: Danish Center of Human Rights, 1988).

[6]These "rights" are identified and discussed in Sieghart, 24–67.

[7]See World Health Organization, *Tabular Information on Legal Instruments Dealing with AIDS and HIV infection*, document WHO/GPA/HLE/88.1 (Geneva: World Health Organization, June 1988).

[8]See K. M. Sullivan and M. A. Field, "AIDS and the Coercive Power of the State," *Harvard Civil Rights–Civil Liberties Law Review* 23 (1) (Winter 1988):139; cf. "Scots Criminal Law and AIDS," *Scots Law Times* (18 December 1987):389.

[9]See, for example, J. R. Seale, "Kuru, AIDS and Aberrant Social Behavior," *Journal of the Royal Society of Medicine* (London) 80 (1987):201.

[10]See Public Health Act, 1902, New South Wales, sec. 50N(3).

[11]See Health Amendment Act, 1987, Victoria. 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, *Criminal Law Review*, 35 (London: Sweet and Maxwell, 1988):123

[13]The Queen v. Malcolm, *Criminal Law Review*, 35 (London: Sweet and Maxwell, 1988):189.

[14]The Queen v. Smith, *South Australian State Reports*, 44 (1) (Sydney: Law Book Company, December 1987):587.

[15]Bailey v. The Director of Public Prosecutions, *Australian Law Journal Reports*, 62 (Sydney: Law Book Company, 1988):319; and The Queen v. L. L. Bayliss, unreported, court of Criminal Appeal, New South Wales, 3 November 1988, 15.

[16]Bowers v. Hardwick, *U.S. Supreme Court Reporter*, 106 (1986):284; see discussion in Sullivan and Field, 161.

[17]Watkins v. United States Army, U.S. Court of Appeals, Ninth Circuit, F, 837 (2d) (1988):1428.

[18]Norris v. Ireland, judgment of the European Court of Human Rights, Strasbourg, 26 October 1988 (6/1987/129/180); see *The Times* (of London), 31 October 1988, 35.

[19]See, for example, Department of Community Services and Health, 125.

[20]June Osborn, "The AIDS Epidemic: Six Years," *American Review of Public Health* 9 (1988):574.

[21]W. J. Buckley, Jr., "Combating the AIDS Epidemic," *New York Times*, 18 March 1986, A27.

[22]See, for example, Public Health (Control of Disease) Act, United Kingdom, 1984. Cf. J. Aiken, "AIDS—Pushing the Limits of Scientific and Legal Thought," *Journal of Law, Science, and Technology* 27 (1986):5; and Sullivan and Field.

[23]See "History Says No to Policemen's Response to AIDS," *British Medical Journal* 293 (1986):1589.

[24]Michael D. Kirby, "The New AIDS Virus: Ineffective and Unjust Laws," *Papers* (version anglaise) 203, Ministry of Foreign Affairs, Symposium International de Reflexion sur le Sida, Paris, 22–23 October 1987, 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, *Health Policy* 7 (1987):13. See also discussion in Dale and Ors, "Blood Testing for Antibodies to the AIDS Virus: The Legal Issues," *Congressional Research Service Report for Congress*, 87–738A; cf. G. D. Thomas, "The Perils of AIDS Testing," *Los Angeles Lawyer* 11 (1988):39.

[27] Council of Europe, Committee of Experts on Data Protection, "AIDS Registers and Data Protection," memorandum, 30 March 1987.

[28]See Dale and Ors.

[29]J. D. Piorkowski, "Between a Rock and a Hard Place: AIDS and the Conflicting Physician's Duties of Preventing Disease Transmission and Safeguarding Confi-

[46]R. C. O'Brien, "AIDS and the Family," in W. H. L. Dornette, ed., *AIDS and the Law* (New York: J. Wiley & Sons, 1987):86.

[47]Figures cited in June Osborn, "AIDS—Politics and Science," unpublished, The McNally Lecture, University of Michigan, 5 April 1988.

[48]See, for example, M. Neave, "Anti-Discrimination Laws and Insurance: The Problem of AIDS," *Insurance Law Journal* 1 (1) (Australia, January 1988):10.

[49]World Health Organization, Global Program on AIDS, *Report of the Consultation on the Neuropsychiatric Aspects of HIV Infection*, Geneva, 14–17 March 1988.

[50]Michael D. Kirby, "AIDS, Drugs, Vaccines and the Law—Lessons from the United States Experience," mimeograph, paper for the Australia and New Zealand Association for the Advancement of Science, May 1988.

[51]Cf. National Childhood Vaccine Injury Act (U.S. Public Law 99), 1986, 660.

[52]See, for example, D. Schulman, "Stopping AIDS—Euthanasia," *Tikkun* 2 (3) (1987):14. See also Medical Treatment Act, Victoria, 1988.

[53]Public Health (Funeral Industry) Regulation 21 (2), New South Wales, 1987; cf. Public Health (Control of Disease) Act, United Kingdom, 1984.

[54]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," *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 advertisements 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 edition), 7 November 1988, 37. The road ahead will clearly be slow and difficult.

[55]Justice Windeyer in Mount Isa Mines Ltd. v. Pusey, *Commonwealth Law Reports*, 125 (1970):395.

[56]Gertrud Sigurdsen, minister of health (Sweden), comments at the Fourth International Conference on AIDS, Stockholm, June 1988.

[57]See discussion in Sullivan and Field; and G. W. Matthews and V. S. Neslund, "The Initial Impact of AIDS on Public Health Law in the United States—1986," *Journal of the American Medical Association* 257 (1987):346. See also Allan M. Brandt, "AIDS—From Social History to Social Policy," *Law Medicine and Health Care* 14 (1986):233. In 1918 the United States 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.

[58]See, for example, Allan M. Brandt, "AIDS in Historical Perspective: Four Lessons from the History of Sexually Transmitted Diseases," *American Journal of Public Health* 78 (4) (1988):367; and P. H. Curson, *Times of Crisis—Epidemics in Sydney 1788–1900* (Sydney: Sydney University Press, 1985).