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WILL LAW FAIL THE AIDS TEST ?

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I AIDS - NEW, URGENT TEST FOR LAW-MAKING

AIDS tests our legal systems. Justifiable fear about the epidemic spread of the human immuno-deficiency virus (HIV) which causes AIDS (Acquired Immuno-Deficiency Syndrome)[1] results in calls for legislation, and responses by judges and other lawmakers, aimed (amongst other things) at the containment of the epidemic. A decade in law reform and subsequent reflection upon the operation of the law, has taught me to be circumspect, even cautious, about the capacity of law to modify human behaviour. There has been surprisingly little study of the differential impact of the sanctions and remedies available to the law to influence the conduct of individuals, who each have a multitude of motivations and are a complex, ever-changing product of genetic and environmental stimuli.[2] Legislatures pour forth laws in ever increasing number and with enormous detail and complexity. Subordinate law-makers produce even more detailed rules to govern our lives. Judges also make laws, whether in interpreting suggested ambiguities of legislation or by pushing forward the ever-developing principles of the common law.[3] Sometimes, with the aid of law reform or like bodies, legislation is drawn after the assistance of detailed advice on the conduct to be targeted and the precise way the objective can best be achieved. Such procedures are not readily available to judges in their law-making activity, a reason for caution on their part in that regard.[4] But all too often, laws are drawn upon an assumption that they will operate in the desired way - assuming always that the

"desired way" is clearly known to the law-maker. This in turn, is often an unwarranted assumption.

It is for this reason, therefore, that AIDS presents a challenge to law-makers and lawyers. Suddenly, we are faced with a new, global and in many ways frightening and insidious predicament. The toll of AIDS in human suffering is already great and will become much greater. Its burden on economies - especially of developing countries - will be enormous.[5] It appears soon after other infectious diseases had been declared spent and science promised the early conquest of the rest. Venereal diseases, for centuries the scourge of mankind, appeared finally to be tamed. Wonder drugs and advanced technology seemed to promise the eradication of humanity's illnesses. Yet in the space of little more than a decade a new viral epidemic appeared. Its exact origins and duration are unknown, and matter little. It is now a world-wide phenomenon. Its rapid spread is a feature of changing social conditions and ease of international travel. Tackling such a phenomenon in the only way domestic law can - by laws made in each particular jurisdiction - can only partly respond to the size and urgency of the problem facing us. This is why I say that AIDS presents a very modern challenge to the law:

* It makes us face squarely the limits of the law in the control of human behaviour - particularly in activities such as sex and drug-taking where the track record of laws, effective to change behaviour, is often unpromising;

* It encourages us to consider in a more scientific way than we have done previously, the differential use of particular laws as they contribute to the urgent objectives of public health and individual justice;

* It focuses our attention in an acute way upon fine notions of human rights. At a moment in history when the portents for human rights seem otherwise bright, along comes an epidemic that puts those rights - internationally declaimed - to a severe test. Rights matter most when they are hard to accord; and

* It reminds us of the growing international character of the law today. No longer the captives of our own jurisdictions, lawyers and law-makers must increasingly realise that their effectiveness in the attainment of social objectives depends very substantially upon the conduct of other law-makers in other jurisdictions. To fight AIDS, we need a truly international approach to law-making. In this sense, too, AIDS is a child of our time.

II AIDS - NATURE OF THE EPIDEMIC

A useful rule of any law-making - but imperative in the control of an epidemic such as AIDS - is a clear understanding of the features of the target of the law. Good ethics and just laws are more likely to emerge from a clear understanding of the features of the epidemic, its modes of transmission and its characteristics in the community than from preconceptions based upon fear, hysteria, religious conviction or other grounds. If we are really serious about mobilising whatever fragile and imperfect assistance the law can give to impede the spread of HIV and AIDS (and to redress justly the problems that arise where HIV and AIDS have been acquired) it is self-evident that we should be aware - at least in general terms - of the nature of the epidemic and of the virus which causes its spread. To ensure that we keep our sense of proportion, it is also useful to know something about the present size and projected enlargement of the problem. We should be aware of the available therapies and the prospects for a vaccine and a cure. Knowledge of the latter reinforces a sense of urgency about developing effective laws which protect our societies - and the individuals who make them up - from the spread of the virus.

AIDS is a viral infection which suppresses the body's immune system.[6] In the worst cases it goes on to destroy that system, leaving the patient vulnerable to opportunistic infections which would otherwise be resisted. The HIV virus invades and kills the body's white blood cells (called T-lymphocytes or T-cells). As this occurs, diseases which rarely affect a person with an immune system which is intact can prove seriously debilitating (and later fatal) to those infected with HIV. AIDS, caused by HIV, is thus the sine qua non of a serious and often fatal illness. But the end stage illness will typically involve one of a number of infections or malignancies, otherwise quite rare.

The HIV virus has been isolated in most body fluids, including saliva, tears and urine. However, only blood and semen have so far been implicated, by epidemiological evidence, as a cause of transmission. Mosquitoes, sneezing, casual contact, social interaction, toilet seats and doorknobs can be ruled out as modes of transmission. Fortunately for humanity, the HIV virus is not easily acquired. It is important to make this point to repel the worst fears generated by beliefs to the contrary. Such fears have taken their toll in the past. At the turn of the twentieth century it was seriously thought in public health circles that syphilis (a condition then bearing many parallels to contemporary AIDS) was transmitted by means of pens, pencils, toothbrushes, towels and bedding. Naval regulations were promulgated requiring the removal of door knobs from United States battleships during World War I, based upon the belief that they were a source of infection for many of the sailors.[7] We now know otherwise. The

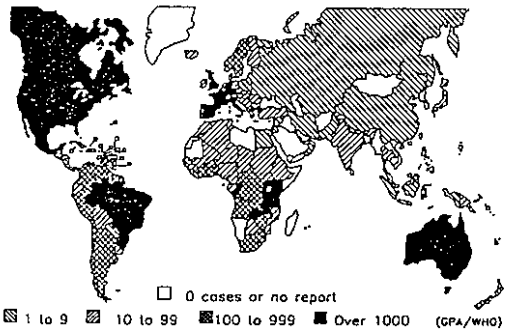
progress made between the two World Wars led to a different attack on syphilis in the Second World War - mainly by troop education and the distribution of condoms. Needless to say, the new methods (although not wholly successful) were infinitely more efficient than the Naval Regulations.

It is also worth noting that during the First World War, as hysteria about the impact of STDs rose in the United States, Congress passed legislation to support the quarantine of prostitutes suspected of harbouring disease. The Act permitted anyone suspected of having a venereal infection to be detained and incarcerated until determined to be non-infectious. As a result more than 30,000 women were held in camps during the War because they were suspected of being "spreaders" of venereal disease.[8] There are many lessons to be learned for AIDS from previous efforts at infection control by legislation.

There are other features of AIDS which have to be noted in designing legal responses. It is useful, for example, to have an idea of the dimension of the problem, now and in prospect, and as clear a sketch as possible of the individuals and behaviour most at risk.

Distribution varies from one part of the world to another as shown by Figure 1.[9]

Figure 1
Reported AIDS cases
1 June 1989



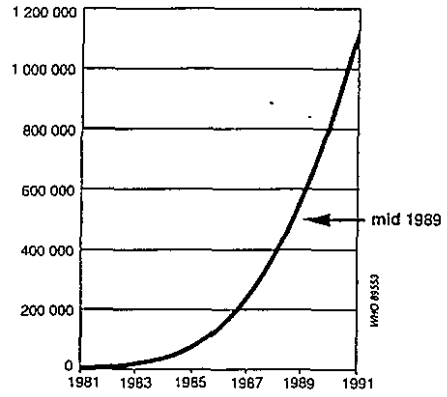
The reported cases of AIDS - and World Health Organization (WHO) estimates of the likely actual figures - are shown in Figure 2.[10]

Figure 2
Reported and estimated AIDS cases
1 June 1989

Area	Cumulative number reported	Number of countries	Estimated
Africa	24 686	47	270 000
Americas	108 830	43	175 000
Asia	369	24	<1 000
Europe	21 855	28	32 000
Oceania	1 451	7	2 000
Total	**157 191**	**149**	**480 000**

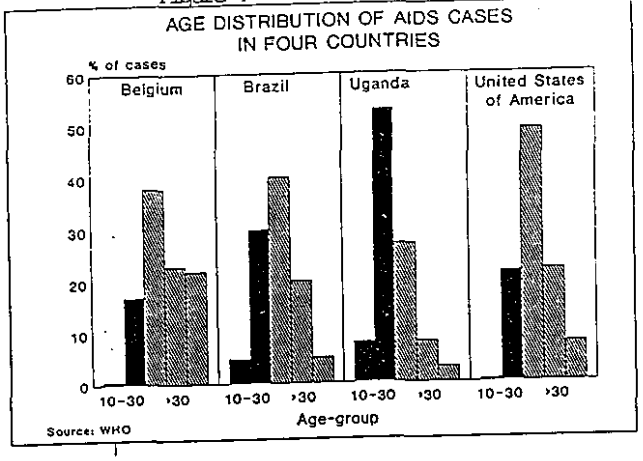
It must be emphasised that these cases represent the third or end stage of the progress of the infection. Like syphilis, AIDS has, typically, a long period of latency (although this varies somewhat according to age, environmental factors etcetera). A long first period of HIV infection may last indefinitely but typically in the adult about 8 years. The second stage (ARC) sees the development of "AIDS Related Complex" - with the onset of physical signs and symptoms usually accompanied by a significant drop in the T-cell count. It is the third stage which is AIDS: a condition diagnosed by reference to a number of now internationally accepted criteria. Although progress from one stage to the next and from AIDS to death can be interrupted or slowed in some cases by therapeutic drugs, the available therapies are imperfect, expensive and not universally available. Furthermore, they frequently present serious side effects. In these circumstances, the WHO projection on the rise in cases of AIDS throughout the world should cause no real surprise. See Figure 3.[11]

Figure 3
Projected Global AIDS Cases



The dimension of the problem we are facing needs to take into account, as well, the fact that, for the iceberg presented by the steeply rising graph of AIDS cases, there is a huge hidden number of apparently healthy people already infected with HIV who show no symptoms. For very many years - perhaps indefinitely - such people will be able to go about their ordinary activities of life. They will be perfectly useful economic and social units. For the vast majority of human beings with whom they come into contact they will present an extremely low - or virtually no - risk of spreading the infection. But for those with whom they mix body fluids - in effect semen and vaginal secretions or blood - they present a risk of spreading the life-threatening virus.

Although AIDS attacks human beings in a common biological manner, different patterns of the infection have emerged in different countries. Figure 4 shows the markedly different age distribution of AIDS cases in four countries studied.[12]



An analysis of the patterns that have emerged from the first decade of study in different parts of the world also discloses three principal variants:

* Pattern I sees most cases of infection amongst homosexual or bisexual males, and urban intravenous drug users. Typical of this pattern was an early spread through blood products (transfusions) between the late 1970s and 1985; but this has now largely ceased in developed countries by reason of procedures of blood screening. Heterosexual transmission, although increasing, is only responsible for a small percentage of cases. New Zealand, Australia, North America and Western Europe fall into this pattern;

* Pattern II involves typical spread of the infection through heterosexual transmission. Here the male/female ratio is approximately 1:1. Mother to infant transmission is common in this group. Intravenous drug use and homosexual transmission occur at a very low level. Some spread still occurs through contaminated blood. This pattern is observed in sub-Sahara Africa, Latin America and especially the Carribean; and

* Pattern III has low levels of infection with homosexual and heterosexual transmission being documented with other cases involving persons having contact with those who have travelled from Pattern I or Pattern II countries. This is the pattern currently found in Eastern Europe, Asia, North Africa and most of the Pacific. Countries are constantly moving from one pattern to another. For example, Thailand is presently experiencing a rapid increase in HIV infection spread through sexual activity and drug use. Among the estimated 60,000 intravenous drug users in Bangkok, the prevalence of HIV infection rose, by WHO figures, from less than 1% in August 1987 to about 40% in January 1989. Obviously, such users - whose sexual activity

will mirror that of the general population - may provide vectors to spread HIV infection rapidly: threatening that Thailand will move from Pattern III to Pattern II.

Against this background of the nature of the infection, its typical modes of transmission, its progress to date and future projection, it can be seen that the overwhelming task of society is to stop the continuing spread of AIDS and HIV which causes it. The inefficacy of some laws (eg on naval doorknobs) suggest that many laws will have no serious effect on controlling the epidemic. They might pander to fear, moral outrage, religious sensibilities. They might soothe emotions, satisfy a democracy that politicians are doing something and produce a feeling of satisfaction, even complacency. But they will do precious little to affect human behaviour at that critical personal moment where the risk is greatest, namely risky (unprotected) sexual activity; use of syringes contaminated with infected blood during the injection of drugs; or a combination of these two.

Despite drastic efforts over centuries, laws aimed at controlling sexual activity have had limited success, even when drastic and severe. Writing in 1943, a US Army Medical Officer explained ominously "it is difficult to make the sex act unpopular".[13] The limited efficacy of the law in that regard has been still further eroded in many countries by changes in sexual practices which have followed the advent of the contraceptive pill and so-called "sexual liberation" of the 1960s. Evidence of the many failures of the law to control the use of both legal and illegal drugs can be seen everywhere. The growing number of cases before criminal courts having some connection with drug use demonstrates the ever-widening boundaries of that problem. In partial recognition of the failure of present strategies, and the need to protect the young drug user from the irreversible consequences of HIV infection, many jurisdictions (including Australia and New Zealand) have introduced laws or practices to permit the supply of sterile syringes for use in the injection of drugs.[14] A clearer (and more honest) acknowledgment of the incapacity of prohibition laws to prevent the spread of HIV by drug injection could not be offered. But the spectre of the increasing numbers of young people, particularly young women, Hispanics and Afro-Americans presenting with HIV infection in the United States, had led to radical legal responses in other countries. They are responses which, but a few years ago would have been unthinkable. They are still controversial. Some advocates for the Black and Hispanic communities in the United States still resist the legal provision of sterile syringes on the ground that the numbers saved from HIV infection would be cancelled by the numbers thereby more readily introduced to IV drug use.[15] A fear of a modern genocide has been expressed. No one suggests that the

choices to be made in the face of AIDS are easy. But they have to be made relatively quickly at this stage of the history of the infection. Wrong (or more likely ineffective) moves now will contribute to the toll of loss. That is why this subject is one of high importance.

III The preventable factor

A review of the history of previous epidemics shows how atypical the recent history of public health in developed countries has been when measured against past epidemics. Whether examined against the universal features of epidemics which have spread over the centuries taking their toll of countless millions or confined to the history of particular jurisdictions struggling with a succession of infections, the picture is plain. Epidemics are an enduring feature of human history. They are not exceptions. They are, on the contrary, the rule. Their history demonstrates the pathetic inadequacy of typical social responses to prevent or control their spread. Recognising these facts does not warrant the adoption of a fatalistic attitude that nothing can be done - whether by education, the law or otherwise. But it does bring home the melancholy fact that, without a cure or a vaccine or preferably both, once an epidemic has started, the capacity of society - with all of its laws - to prevent the spread will be strictly limited.

Of course, if there is a cure and/or a vaccine, the numbers who will suffer will be checked in an artificial way before nature sees the epidemic run its full course. However, for HIV and AIDS there is no present therapeutic approach which has a confirmed record of ridding the body of the virus once acquired. A recent report of a major bone marrow transfusion may promise future success. But the case is isolated, experimental and extremely expensive. Anti retro-viral drugs have been used. The opportunistic infections and associated cancers have been treated. But the restoration of the immune system has not yet been achieved. The only drug to have shown a widespread beneficial effect on persons with HIV infection and AIDS is Zidovudine or AZT. This is the only licensed anti retro-viral drug presently on the market. Its use costs approximately $8,000 per patient per year. This extremely high cost has led to the production of a copy drug in the Republic of South Korea at a fraction of AZT's price but in apparent breach of intellectual property law. There are other promising experimental drugs.

Because of the early isolation of the virus by the Pasteur Institute in Paris (under Professor Luc Montagnier) and the Centres for Disease Control in the United States (under Dr Robert Gallo) we are presented with important opportunities for progress in drug therapy and vaccine development. If we did not know the cause of the epidemic, we would be looking at its progress with unrelieved horror - much as the people in medieval Europe and Asia watched the

spread of the Black Death or the Plague. Our horror today comes from our recent belief that there were no new epidemics, that old epidemics were under control and that science could always provide the miracle cure. For AIDS, in the foreseeable future, there is no "magic bullet". In some senses, the analogy is to the treatment of syphilis with arsenic in the early years of this century: the wide spectrum assault on the body with terrible side effects, no ultimate cure, simply an arrest in the onset of the next stage of the progressive condition. This realisation of the comparative helplessness of medical science at this stage adds to the horror, and community fear of HIV/AIDS. Venereal diseases became less fearsome when they could be cured with a shot of penicillin or their symptoms controlled. Such cannot yet be promised with AIDS. Indeed, at this stage, we do not even know whether a cure will ever be found.

There are special difficulties in developing a vaccine against HIV infection.[16] The concept of vaccination is linked to that of immunity. Unlike most viral diseases which are self-limiting, HIV results in a chronic life-long infection. There are two major medical problems in the way of the development of a vaccine. Putting it simply, these are that vaccination normally depends upon the operation of the immune system whereas HIV attacks that very mechanism. As well, there is enormous antigenic variability in virus isolates produced from HIV infected people. It may be possible to attack this problem with the use of "cocktail" vaccines. But the long fight against the influenza virus - not yet fully successful - demonstrates the problem we face in developing a mass produced, cheap and readily available vaccine against HIV.

If these medical problems present difficulties, the legal and ethical challenge in the way of vaccine development is just as grave. Chimpanzees can be used as animal models. But they are in short supply and may not replicate human responses. The use of controlled human studies in the course of vaccine development will necessarily expose some subjects to risk of acquiring this very serious infection. It is the very urgency of securing a vaccine - and the huge profits that await a successful development - that pushes scientists and drug companies along this path. But the development of testing protocols sensitive to the scientific, ethical, legal, social and logistical challenges involved will require much attention in advance of large scale trials which lie, as yet, in the future.

Without a cure and with no vaccine immediately in sight, societies have turned to a number of weapons to reduce the growth of the curve of infection. They have done so in the hope of increasing the "preventable component". This component potentially numbers millions of human beings. It is therefore essential that every effort should be made to increase it. But realism requires it to be acknowledged that

the component is, as yet, quite small, particularly in developing countries where there are still limited opportunities for AIDS/HIV education. According to WHO, about one-third of new HIV infections are considered "preventable", if a "globally coordinated AIDS programme in concert with national programmes" were introduced. Figures 5[17] and 6 show the projections of a Delphi statistical prediction prepared by the Global Programme on AIDS of WHO.

Figure 5
WHO/GPA Delphi Projections:
Adult AIDS Cases

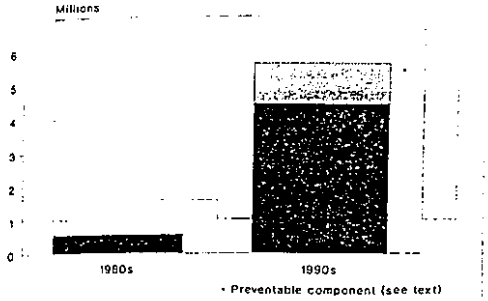
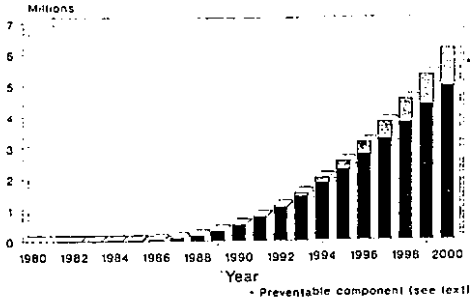


Figure 6
WHO/GPA Delphi Projections:
Cumulative Adult AIDS Cases



IV Education and behaviour modification

So far, a great deal of the effort of AIDS prevention and containment - particularly in developed countries of Pattern I variety AIDS - has been devoted to educational propaganda. By use of the modern media of communication, school instruction, communication with persons exposed to particularly risky conduct an effort has been made by persuasion to secure relevant behaviour modification. There is some evidence in studies of cohorts of homosexual and bisexual men in San Francisco, Los Angeles and New York that significant changes of behaviour has produced a rapid fall-off in the rates of new infections. There are similar studies in Sydney and in other parts of the world.[18] They are often cited as examples of what can be done by education, without heavy-handed legal regulation. Some of the studies must be viewed cautiously. The centres chosen tend to be suitable for rapid communication of information. This may not be possible in other communities without community support networks. For four years of his Presidency, Mr Reagen could not bring himself to use the acronym "AIDS" in any public utterance. The delay in the spread of community health messages in that epicentre of the epidemic, now explained by reference to attributes of sexual modesty and opposition to drug use, demonstrates how AIDS tests the moral alertness of leaders and law-makers. A further problem with the educational model is that every day sees new recruits into sexual activity and intravenous drug use. There is therefore a constant need to reinforce messages because new

entrants may have missed earlier educational efforts.

Then there is the difficulty of carrying the community and its educators with the urgency of the AIDS message and the necessity to target it, in direct and candid language, to those most at risk, including the very young. This present a problem for communities that have long accepted a pose of naivety and a public morality of anti-sexual chastity. Available data, in Pattern 1 countries at least, illustrates the great distance that now exists between these public positions and actual practices.

Australia and New Zealand have shown the limits to which they are prepared to go in the business of AIDS education. It is true that condoms are now frequently mentioned publicly. Scary public alert advertising at huge cost ("the Grim Reaper") produces some general recognition of the existence of AIDS. But education directed at that "critical moment" of sexual activity or drug use gratification is still thin on the ground.

* 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. This reticence was explained by reference to suggested community reaction and advertiser displeasure. But given Pattern I characteristics of HIV infection in Australia, the omission of a specially relevant target group may say something for broadcasting modesty. It says nothing for effective community education to contain an epidemic; and

* In New Zealand, customs officials used the 1963 Indecent Publications Act to seize copies of a book A Modern Girl's Guide to Safe Sex by the Australian author Kaz Cooke. The book was on sale for 12 months after its release and includes information for young women about issues such as AIDS and cervical cancer.

In these responses, Australia and New Zealand are not alone. 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 HIV. However, in the District of Columbia, the Metro Board withdrew 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".[19] And if the New Zealand confiscation of A Girl's Guide appears surprising in 1989, we should remember that in 1912 the United States Post Office confiscated copies of birth control advocate Margaret Sanger's What Every Girl Should Know.[20] This confiscation occurred because the book was considered, in its reference to syphilis and gonorrhoea to be "obscene" under the provisions of the Comstock law. The history of venereal disease

legislation suggests that, even in these allegedly enlightened times, the road ahead - particularly in dealing with young people - and especially on issues such as sex and drug taking will be very rocky. Partial success can be achieved. The degree of success will depend upon the intensity, repetition, candour and vividness of the messages we seek to impart. Some will resist the educational messages that will be effective. They will do so in the name of preserving the modesty and innocence of young people. But they will do so at a great cost until the toll in infection is belatedly seen to outweigh the measure of innocence truly preserved. This is the educational equation. The law is only secondary here. Bodies for AIDS education may be established by law. Laws may need to be amended to facilitate suitable advertising which, until quite recently, would have been regarded as inappropriate. Appropriateness must bend to the new urgencies of our predicament. Lawyers, with a knowledge of the problem we are tackling, and of its nature, can help effective education by promoting the removal of the legal and social obstacles to it.

V The use of legal compulsion

Education addressed to the typical modes of transmission of HIV/AIDS will only ever be partially successful. In the face of this reality and confronted by the grim realities of the epidemic, it is natural that the community should demand, and elected officials propose, legislation with a more drastic impact aimed at punishing those who spread HIV or isolating those who may do so.

Isolation is a traditional response of fearful communities to the appearance of an infectious or contagious condition. Quarantine existed in a primitive form in Biblical times as the record of the treatment of the lepers demonstrates. Leprosy was well established in Western Europe in the early middle ages. It became a relatively common disease from the twelfth and thirteenth centuries.[21] Under typical medieval regulation of leprosy, anyone who noticed a neighbour or even a spouse with a skin infection was obliged to inform the authorities, whether religious or secular. A court was then convened. Leprosy "trials" were numerous. But acquittals were exceptional. Lepers were obliged to submit to various forms of treatment, all of which were useless to the patient because leprosy was at that time incurable. One treatment reported was that of castration: an entirely irrelevant response to containing leprosy. More frequently the sanction was ostracism - exclusion from the community of the faithful, then from all social life and finally being shut up in a leper house. The convicted leper led an austere life without possibility of family connection. Typically he or she was subject to a long list of privations. They were not allowed to bathe in rivers or to go about bare-footed. They had to wear special clothes which singled them out. They were prevented from encroaching on persons who were not

contaminated. They had to attend church services from a distance and in special places. They lost civil rights, could not make a will and were not entitled to a normal funeral. They could not be buried in a Christian cemetery. Restrictions and deprivation of rights such as these set the pattern for the responses during the fourteenth century to Plague and the Black Death. A formal system of administrative measures by way of quarantine appears to have originated in Italy during the second half of the fourteenth century. It consisted in compulsory regulation of people, ships, goods and merchandise coming from regions reported to be affected by the infectious disease. Isolation, temporary removal, plague barriers and the like were introduced because the communities of the time were ignorant (as we are not) of the actual modes of transmission of the deadly condition. This ignorance persisted right up to the nineteenth century. In the second half of the eighteenth century, during the spread of the Plague in London, orders were issued for patients with the Plague to be isolated in hospitals. Families in which there was a sick person were confined to their homes. Visiting inspectors were responsible for reporting houses in which there were "suspects". They were then all prevented from leaving. During an outbreak of the Plague at Marseilles in France in 1720, plague barriers were imposed.[22] It was impossible to pass through them without presenting a "certificate" of good health. Up to almost a century ago, surgeons, even in Britain, ignorant of the modes of transmission of disease, performed one operation after another in the same clothing before washing at the end of their procedures. The result was a shocking spread of disease which modern knowledge of asepsis has helped to control.

Just as in the law it is difficult to eradicate old knowledge acquired at law school, so in the community it is difficult to remove public health/medical models for the control of epidemics derived from earlier times to meet different conditions. There are many examples of this.

* The calls for mandatory universal compulsory testing within the community for HIV, based upon the earlier and successful testing for tuberculosis by X-ray. It is imperative to recognise the fact that there was a cure for tuberculosis. The X-ray led somewhere. There is no cure for HIV. The X-ray leads to no sure therapy. It produces some useful epidemiological data. But it does so at great cost. And the cost includes the risk of discrimination which undoubtedly attaches to knowledge that a person has the infection.

* Then there are calls for mandatory testing of particular groups. In the United States nearly every State had, by the end of the Second World War, introduced mandatory testing of marriage applicants against the presence of syphilis. Numerous states have

now introduced similar regulation to test marriage applicants against HIV. As Dr June Osborn has demonstrated conclusively premarital screening against HIV has been an extremely expensive and ineffective strategy.[23] Illinois introduced such screening in 1988. In the first eleven months only 23 of 150,000 people tested (or 1:6,500) were positive. The cost of finding each of the 23 infected people came to $228,000. Meanwhile the number of people seeking marriage licenses in the state decreased by 25%. Some preferred to remain unmarried. Others went across the border to a state where the test was not obligatory. The combined loss of revenue and low yield led to a call for the abandonment of the programme by the end of its first year. Such a programme throughout the United States would cost more than $100 million annually. It would probably reveal no more than 1,300 infections. But there would be numerous false negative and false positive results. These facts arise from the limitations of the present HIV tests which, in general use, respond to the antibodies produced by HIV and not to the virus itself. Typically such antibodies take 13 or more weeks to appear. Thus a person may be infected with HIV but, being in the "window" period may "pass" the HIV test. That person may then continue with highly risky behaviour - exposing others to the risk of infection, in ignorance of that risk.

* Even when lawmakers draw back from legislation for mandatory testing of the whole community - either because of the costs involved or fear of adverse community reaction - a common feature of legislative strategies in recent years has been the isolation of particular groups for testing. The obsession with testing is hard to eradicate from the public health agenda. But it is rarely truly risky groups who are submitted to tests (eg wealthy single tourists visiting developing countries on "sex tours" who keen for their tourist dollars). Instead, the usual targets are groups who have little public voice and still less political clout. Overseas migrants applying for entry have been targeted in many countries, including the United States and Australia. Visa applicants generally are now commonly asked about HIV status and may have no local citizen with standing to challenge their exclusion. Prisoners are another group frequently singled out. But the provision of treatment or other facilities is rarely equalled by the enthusiasm for testing. More effective means of diminishing the spread of HIV in prisons, incubators and vectors for the epidemic in the opinion of some, would be the ready and anonymous provision of condoms and bleach for the cleaning of syringes, the sharing of which is now the surest way of escalating the spread of HIV amongst prisoners. A third group frequently targeted are those

in the disciplined services, particularly the Armed Services. Subject to their discipline, they cannot resist. But what will happen to service personnel found to be positive? Their presence in the services does not, of itself, present risks of the spread of HIV to other personnel. If they are to be discharged, the burden of their medical attention and social support will only be shifted to the community.

These are some of the reasons why the call for mandatory testing for the presence of HIV should, at this stage of the epidemic, be resisted. It is not cost effective. It is not a useful strategy for the containment of AIDS. Its epidemiological utility is strictly limited. The groups then targeted are commonly low risk groups making the testing even more ineffective. The tests lead to no treatment. But they lead to the risks of discrimination against those found to be infected. It is, perhaps, an understandable response to a medical problem to search for a medical or public health solution. But it is imperative that lawyers - who above all know the limitations of the effectiveness of law - should remind lawmakers, the community and public health and medical experts that the enactment of a law, of itself, guarantees no sure impact on human behaviour. In the face of the AIDS epidemic, our legal responses should be more precisely fashioned, with a greater hope of utility.

Only Cuba has adopted a system of mandatory quarantine of HIV infected citizens. Non-citizens found to be infected are (as in many countries) expelled. Because of the long incubation period of HIV/AIDS - lasting an average of more than 8 years - many people who could otherwise live full lives are isolated. Their families and the economy is deprived of them. This heavy handed approach to the control of the limited behaviour which carries the risk of spreading the epidemic has been condemned in many quarters. It would be difficult, even if we desired it, to spread such a model to other countries. In the United States, with an estimated 1.5 million people already infected with HIV, there is no facility large enough - nor is there barbed wire enough - to isolate all persons infected. The same is probably true of New Zealand, Australia and like countries with Pattern I features. It is certainly true of the poor countries in Pattern II whose medical budgets would not run to universal mandatory testing, still less to AZT treatment or other therapy.

VI What then is to be done?

The realization of the size of the problem, its urgency and the difficulty of confronting it - including by laws - produces much anguish amongst politicians and lawmakers. It should produce a scientific approach to lawmaking amongst lawyers. WHO now publishes regularly a survey of legislation

which has been enacted to deal with AIDS and HIV infection.[24] This survey discloses the very large number of countries which have already adopted provisions for compulsory reporting of HIV and AIDS; provided penal sanctions for the knowing spread of AIDS, providing limited procedures for mandatory screening for HIV; limited facilities for notifying persons at risk of infection; exceptional facilities for the detention of persons continuing to engage in prostitution or risky practises, though infected and so on. The variety of the legislation is enormous. The latest schedule of closely typed summaries reaches 92 pages and there is, as well, a 40 page supplement dealing only with legal instruments adopted in the states and territories of the United States of America.

Elsewhere, I have gathered, in descriptive[25] and summary form[26], a list of the variety of legal issues which have been presented to the courts of many countries by the advent of HIV/AIDS. Within the last year or so in Australia cases have arisen for decision involving the following questions (amongst others):

* Whether, by discovery, a person allegedly infected with HIV by blood transfusion should be entitled to find the identity of an infected blood donor who voluntarily gave blood to a blood bank;[27]

* Whether a person infected by blood transfusion was entitled to recover damages from those responsible for the blood bank and others on the ground that the then current knowledge about HIV required more stringent precautions than the blood bank adopted to prevent the risk of the infection which occurred;[28]

* Whether provisions in a limitation statute for an extension of time were available in the circumstances of the long incubation period of HIV to overcome the statutory bar which had otherwise descended against the bringing of a claim for civil damages;[29]

* Whether a bisexual father with HIV should be denied access to a child of his dissolved marriage not on the basis of any real risk that he would infect the child but because of the mother's fear (though not grounded in real facts) of the risk of such infection[30]; and

* Whether a prisoner with HIV was entitled to have that consideration, an abbreviated lifespan, the lack of prison facilities and the risk of retaliation in prison taken into account in fixing a sentence or determining a non-parole period.[31]

There are many other highly practical problems now arising regularly. Lawyers, judges and law-makers will come to live with AIDS, just as the rest of the community will do. Whole

books are now written on AIDS and the law.[32] It would be futile to endeavour in this paper to cover the myriad of issues raised. I will simply reproduce as a schedule to this paper a list of some of the questions that have been posed.

Every lawyer knows that apart from behaviour modification, the law has a symbolic value. Even though the law of murder will not prevent every murder from occurring, we still have law on the subject in the hope of preventing some but, in any case, to state society's standard and to fix penalties in advance for preordained behaviour that is regarded as antisocial. It is upon this basis that specific laws to attach penal sanctions to the knowing spread of HIV have been justified, whether or not they actually produce a change of behaviour, or a degree of restraint, at what I have called the "critical moment". In New South Wales the Public Health Act 1902, s 50N(3) does not prohibit a person infected with HIV from having sexual intercourse. It sanctions the failure of such a person to inform, and secure the consent of, the other person involved. The penalty for not doing so is a maximum fine of $5,000. This may seem a modest penalty for activity that could spread a potentially fatal infection. In Victoria, amendment to the Health Act introduced in 1987 provide a fine of up to $20,000 for a person who deliberately infects another with AIDS or any other infectious disease. Similar legislation has been enacted in numerous states of the United States, such as Idaho and Florida. The catalogue can be derived from the WHO survey.

Such laws may have little practical value. Clearly the maximum penalty for the offence is not equalled to the damage done. Proof and enforcement of the law would be extremely difficult. The offender may be dead or very ill at the time of prosecution. Proof that it was he or she who caused the infection may be next to impossible. Moreover such laws can sometimes have a counter productive 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 people 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.[33] The most effective way of evading liability for the knowing transmission of HIV infection is to remain ignorant of whether or not one is infected. Yet most observers now agree that "taking the test" voluntarily is often the first step on the path to changed behaviours that helps to isolate a person previously exposed to risk from the risky activities that lead to the spread of this epidemic.

This brings me, finally, to the paradox presented by AIDS/HIV to the law. If we are to be concerned, in the legal response to this problem with more than symbols; if we are to go beyond earnest committees and the mountain of AIDS-speak that now engulfs international conferences in the four corners of the world and if we are to promote (including

by law) measures for the containment of this epidemic, the legal response most urgently called for is one protective of the people at greatest risk.

This is a paradox because the community, imbued with TB tests and earlier quarantine responses, quite naturally considers that the rights of persons infected with HIV, or most at risk of such infection, should be low on the community's agenda of concern. The community should be concerned with itself - and not with those "others". Especially easy is it to stigmatize the "others" when they belong to groups whose activity is already outlawed (as drug users and in some jurisdictions persons engaging in homosexual activity are) or are otherwise beyond the social pale (as homosexuals, bisexuals, prostitutes, drug users, sexually promiscuous people, adulterers and others typically are - whatever their legal status). The paradox derives from a recognition that there is no ultimate tension between the rights of the community to protect itself from these alienated and stigmatized groups and the protection of people in such groups from alienation, stigmatization and discrimination. The tension disappears when it is recognised that, for the better protection of the community as a whole, the behaviour of people most at risk must be urgently modified for their own sake and because they may be vectors for spreading this infection into the wider community.

Without a large island - such as Madagascar (to which the Jews were to be consigned) or Australia (to which an earlier generation of social rejects were sent) the fact must be faced that this epidemic must be controlled from within society. That will require the urgent spread of educational messages and the modification of personal behaviour in activities of great importance to the people involved. Getting into the minds of those people so that they will behave differently at critical moments is not at all easy. But that is what we have to try to do. And that is why increasing attention is being paid in many jurisdictions to the provision of laws to forbid or otherwise to redress discrimination against people on the grounds of HIV infection status, other AIDS related physical disabilities, sexual orientation, drug use or otherwise. In recent weeks the Australian government has agreed to include HIV status and sexual orientation in the list of topics that may be the subject of complaint to, and investigation by, the Human Rights and Equal Opportunity Commission.[34] In New Zealand, the New Zealand AIDS Foundation has urged a similar enlargement of the powers provided under the Human Rights Commission Act 1977 (NZ).[35] Under the state law of South Australia and New South Wales discrimination on the grounds of sexual orientation has for some time been unlawful. It may not be coincidence that research has shown that levels of HIV infection, of verbal and physical abuse and of impermanent personal relationships (conducive to HIV spread) are much higher in Auckland than they are in Adelaide.[36]

The HIV/AIDS epidemic presents a very modern problem to the law and to lawmakers. It invites us, as lawyers, to consider both the limits and the possibilities of our discipline in a matter of great importance to society. It is a matter that literally concerns the life and death of millions of our fellow citizens. This is the reason why this topic is, with respect, more important and more urgent than the latest learning on the rule against perpetuities or the most recently discovered loophole for tax avoidance.

Clearly few lawyers will escape involvement in the coming epidemic of AIDS. Some will die of it. Many will have friends who die too early or, with their families and loved ones, suffer. Lawyers will face a multitude of problems - as the early illustrations show. But the truly important question is how the law itself will go when it is submitted to the AIDS test. The answer to that question depends, in no small part, upon the spread within the legal profession, in all countries of the world, of knowledge about the nature of the epidemic and of the measures against it that are likely to succeed or to fail. In considering the response of the law to HIV/AIDS we will be required, in time, to consider the very operation of the law upon human conduct. It is in this sense that the epidemic will require lawyers to think more rigorously and deeply about the very nature of the law, the content of human rights and the effective protection of individuals and of the community in a time of serious unexpected peril.

FOOTNOTES

* Adapted from a paper to be presented to the Commonwealth Law Conference, Auckland, New Zealand, 19 April 1990.

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1. See M A Hamburg & A S Fauchi, "AIDS: The Challenge to Biomedical Research", in 118 Daedalus, # 2, Spring, 1989, Living with AIDS, American Academy of Arts & Sciences, Cambridge, MA (hereafter Daedalus) Part I, 19 at 21 ff.

2. J J Spigelman, "Sanctions and Remedies in Law Reform", unpublished manuscript, Australian Law Reform Commission, 1977, Sydney.

3. See generally Lord Reid, "The Judge as Law-Maker", (1972) 12 Journal of Public Teachers of Law, 22: M H McHugh, "The Lawmaking Function of the Judicial Process, (1988) 62 ALJ 15, 116; M D Kirby, "The Role of the Judge in Advancing Human Rights by Reference to International Human Rights Norms", (1988) 62 ALJ 514, 516.

4. State Government Insurance Commission v Trigwell (1979) 142 CLR 617, 633.

5. B O de Zalduondo, G I Msamanga and L C Chen, "AIDS in Africa: Diversity in the Global Pandemic", in Daedalus, Part II, 165.

6. For a description see K Mutton and I Gusi, "Acquired Immune Deficiency Syndrome", (1983) Medical Journal of Australia, 540.

7. A M Brandt, "AIDS in Historical Perspective: Four Lessons from the History of Sexually Transmitted Diseases", 78 American Journal of Public Health #4 (1988) 367.

8. K M Sullivan and M A Field, "AIDS and the Coercive Power of the State" in 23 Harvard Civil Rights - Civil Liberties Law Review #1, 139, 155 (1988).

9. J Mann, Global AIDS into the 1990s, World Health Organization, Geneva, 1 (being an address presented on 4 June 1989 at the VTH International Conference on AIDS, Montreal, Canada (hereafter Mann).

10. Mann, 1.

11. Mann, 3.

12. World Health Organization, The Health of Youth: Youth and AIDS, Geneva, 1989, 1.

13. J P Pappas, "The Venereal Problem in the US Army", in 93 Military Surgery, 182 (1943). See also Brandt, 369.

14. New Zealand AIDS Foundation, Briefing Paper on the Inclusion of Sexual Orientation in the Human Rights Commission Act 1977 (NZ), Auckland, 1989.

15. H L Dalton, "AIDS in Blackface", in Daedalus, Part II, 205, 220.

16. Hamburg & Fauci, above n1, 34; J Esparza, "Prospects

for a Vaccine", in World Health Organization, World Health, October 1989, 10.

17. Mann, 5; J Chin, "Understanding the Figures" in World Health (above), 8.

18. B Tindall and ors, 'Sexual practices and condom usage in a cohort of homosexual men in relation to human immuno deficiency virus status' (1989) 151 Medical Journal of Australia, 318.

19. Reported Time Magazine, 7 November 1988, 37.

20. Discussed Brandt, 368.

21. Council of Europe, "Criminal Law and Criminological Questions Raised by the Propagation of Infectious Diseases Including AIDS", Paper for the 16th Conference of European Ministers of Justice, Lisbon, June 1988, Strasbourg, 1988, 3 (Paper M J Ewe-16 (88) 1).

22. Ibid, 6. See also Sullivan & Field (above) n8, 152.

23. J E Osborn, "Public Health and the Politics of AIDS Prevention" in Daedalus, Part II, 135.

24. World Health Organization, "Tabular Information on Legal Instruments Dealing with AIDS and HIV Infection", Geneva, (periodical) (document WHO/GPA/HLE/88.1).

25. M D Kirby, "AIDS Legislation - Turning Up The Heat?" (1986) 60 ALJ 324; M D Kirby, "AIDS & Law" in Daedalus, Part II, 101.

26. M D Kirby, 'The opportunities of AIDS law and the AIDS Checklist' (1977/78) Civil Liberty (NSW) 129. See also D Buchanan and J Godwin, "AIDS - The Legal Epidemic", in (1988) 13 Legal Service Bulletin, 111 and K O'Connor, "Australia's Response" in (1989) 14 Legal Service Bulletin 212; and P Tahmindjis, 'The Legal Response to AIDS in Australia' (1989) Community Health Studies 410.

27. Loker v St Vincent's Hospital (Darlinghurst) & Anor, unreported, Supreme Court of New South Wales (Master Allen), 1 October 1985. Cf Rasmussen v South Florida Blood Service 500 So 2d 533 (1987) (Supreme Court of Florida).

28. H v The Royal Alexandra Hospital for Children, Commonwealth Serum Laboratories Commission and Australian Red Cross (NSW) Division, Supreme Court of New South Wales, unreported, 4 January 1990

29. Dwan v Farquhar [1986] Qld L Rep 600.

30. In the Marriage of B & C (1989) 13 Fam L R 299. Family Court of Australia (Smithers J).

31. The Queen v Smith (1987) 44 SASR 587; 27 A Crim R 315.

32. See eg D C Jayasuriya, "AIDS - Public Health and Legal Dimensions", Martinus Nijhoff, Dordrecht, 1988.

33. B Donovan & Ors, "HIV infection in sexually transmissible disease practice in Sydney: the effects of legislation, public education and changing clinical spectrum" (1990) 1 International Journal of STD and AIDS, 21, 23f. The authors found a 43% decline in persons first requesting tests for HIV immediately following the introduction of legislation announced as "strong action on AIDS" in 1985.

34. L F Bowen, news release by the Deputy Prime Minister and Attorney General, 8 December 1989 (71/89); see also media release by P Morris, Minister for Industrial Relations, 13 February 1990 (6/90).

35. New Zealand AIDS Foundation, above n14.

36. See M W Ross and B R S Rosser, 'Dimensions of sexual behaviour in homosexual men: Response to AIDS in two countries', unpublished paper, manuscript, March 1989. See also S Rosser, 'Evaluation of the Efficacy of AIDS Education Interventions for Homosexually Active Men' in Australia, Dept of Community Services and Health, Report of the Third National Conference on AIDS, AGPS, Canberra, 252.

A LEGAL CHECK LIST

By reference to presently enacted or proposed laws, the following legal check list can be provided, in summary form. It is not exhaustive. It is not meant to provide a badge of approval, or disapproval of the legislation referred to. It is simply a list of some of the chief measures which have been adopted in various jurisdictions, in response to the sudden presentation of AIDS.

International

- Laws prohibiting or limiting travel.
- Laws providing for international certification.
- Laws providing for notification of statistical and epidemiological data to WHO and regional agencies.

Human rights

- Laws providing specific prohibitions against discrimination on the grounds of AIDS or AIDS related conditions (ARC).
- Laws providing protection against discrimination for specified high risk groups notably homosexuals, handicapped persons, drug addicts, etc.
- Laws and judicial decisions extending previously enacted protection, e.g. on the basis of homosexuality or handicap, to AIDS.
- Laws promoting or supporting the removal of media misinformation, hype or the incitement of racial hatred and contempt against stigmatised groups with AIDS or ARC.
- Laws requiring notification of rights and privileges to persons with AIDS and ARC.

Criminal laws

- New laws, or the extension of old laws, punishing knowing transmission of the AIDS virus, without warning.
- Laws and prosecution policies for charging offenders with attempted murder, e.g. in cases of biting police officers.
- Laws and prison policies governing mandatory testing of prisoners, with consequences for isolation and differential punishment.
- Laws and prison policy concerning the provision of condoms and clean syringes in prisons to prisoners to prevent the transmission of AIDS.

Notification laws

- Laws requiring medical practitioners, etc.to notify in statistical or identifiable form reports of patients found positive to the antibodies test.
- Law and judicial decisions relating to warnings and advice to patients, their families, children and others concerning the presence of antibodies.
- Law controlling the dissemination of the above data, including in public or private health insurance systems.

Public health

- Laws controlling donation of blood to blood banks.
- Laws controlling the management, of or requiring closure of, high risk venues (bath houses, massage parlours, etc.).
- Laws authorising tracing of sexual partners.
- Laws forbidding acupuncture and organ transplantation.
- Laws authorising the provision of clean syringes for intravenous drug users.
- Laws and hospital and other practices concerning antibody testing prior to surgery (including dental surgery).
- Provision of mental and dental care for indigent persons with AIDS or ARC.
- Modification of pension laws providing pensions for 'carers', although not married or otherwise related to AIDS patient.
- Provision of counselling, psychiatric and other care.
- Provision of hospices for the dying and grossly disabled, including amendments to taxation and other laws to facilitate the provision of such service.
- Provision of a fund for compensating health workers who acquire AIDS.
- Provision of a fund for compensating haemophiliacs and other victims of AIDS.
- Provision of universal health cover.

Regulatory provisions

- Modification of laws on the use of experimental therapeutic drugs.
- Modification of laws relating to the importation of therapeutic drugs cleared overseas but not yet available locally.

Immigration and travel

- Laws and policies adopted in government airlines concerning carriage of passengers with AIDS and ARC.
- Laws governing mandatory testing of foreign visitors.
- Laws governing mandatory testing of prospective immigrants.

Family law

- Amendment of divorce laws to provide for grounds of divorce on the basis of acquisition by one party of AIDS or ARC.
- Laws and judicial decisions on the award or denial of custody of a child to a parent with AIDS.
- Consideration of laws on intestacy of young persons who die with AIDS and provision for the passing of property, in default of a will, to carers and others in a de facto relationship.
- Amendment of family support legislation to provide for claims on the estates of AIDS victims of carers and others.

Insurance

- Laws forbidding or controlling discrimination in the provision of insurance on grounds related to AIDS or ARC.
- Laws limiting questions and precautions that may be taken by insurers, e.g., limiting questions to relevant behaviour rather than whether the proposer has undergone an antibody test or is a member of a high risk group.
- Laws strictly controlling the dissemination of personal data provided in relation to insurance and AIDS related questions.
- Provision of laws on publicly funded and national health insurance assistance schemes.

Euthanasia

- Modification of laws on suicide and provision of new laws on euthanasia to permit assistance to terminal AIDS patients who so decide, to bring their lives to an end.
- Provision of a 'living will' by which terminal AIDS patients can forbid life sustaining measures in certain circumstances.

Education and positive measures

- Laws to permit education of school children and others concerning the AIDS virus and its risks and means of prevention.
- Laws to provide widespread availability of condoms and to render lawful condom vending machines, and sale of condoms in supermarkets etc.
- Laws controlling the quality of condom manufacture.
- Laws to guarantee confidentiality of AIDS test results, including in social security, medical insurance and other computerised personal data systems.
- Laws targeted on alcohol sale in particular circumstances, where inhibition of 'safe sex' conduct may give rise to particular risks.

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