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ETHICAL PROBLEMS IN TREATING MILITARY PATIENTS WITH HUMAN IMMUNODEFICIENCY VIRUS DISEASES

*Edmund G. Howe**

The emergence of human immunodeficiency virus-related illness ("HIV") over the past decade has engendered several ethical issues in military medicine. Some problems are similar to those encountered in the civilian setting and some differ entirely.¹ This article discusses three of these ethical dilemmas which are of clinical importance to careproviders treating military personnel with HIV-related illness.²

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The opinions expressed herein are those of the author exclusively. They do not represent in any way the views of the F. Edward Hebert Uniformed Services University of the Health Sciences or the Department of Defense.

The International Committee on the Taxonomy of Viruses has proposed the name "human immunodeficiency virus" ("HIV") for the retrovirus that causes AIDS in place of the names human T-cell lymphotropic virus, type III ("HTLV-III"), and lymphadenopathy-associated virus ("LAV"), which were used initially.

1. There is considerable controversy surrounding the issue of whether or not a military physician's obligations to his patient are significantly different from those of his civilian counterpart. See, e.g., Howe, *Ethical Issues Regarding Mixed Agency of Military Physicians*, 23 Soc. Sci. & Med. 803 (1986) [hereinafter *Ethical Issues*]; Howe, *Medical Ethics—Are They Different for the Military Physician?*, 146 Mil. Med. 837 (1981).

2. An ethical concern particularly relevant to this topic is whether or not the military's screening of recruits and active duty personnel is justified. Among the justifications offered are that military recruits, relative to the general population, potentially face higher risks of being ill if infected by HIV because they receive live virus vaccines to which they may become victim, they receive multiple vaccines which may not be fully effective, and they may be sent to areas overseas in which they are at risk of acquiring diseases uncommon in this country. Military personnel might, in addition, be called upon during combat to give blood; if infected, they might transmit the virus.

Some have questioned these rationales, however, alleging that the service's underlying intent is to detect and eliminate homosexuals from the military. Arguments have been offered, for example, in response to the transfusion rationale that servicepersons testing positive could be kept out of combat. See, e.g., Comment, *Protecting the Public From AIDS: A New Challenge to*

The first dilemma discussed in this article involves difficulties associated with a patient's reluctance to discuss his homosexuality with military careproviders.³ The military's former policies regarding homosexual activity may have contributed substantially to this reluctance. Homosexuality is illegal in the military under the Uniform Code of Military Justice ("UCMJ"), and although a policy adopted in 1985 essentially eliminated criminal sanctions against homosexual patients with HIV, such patients who disclosed their homosexuality could still be administratively discharged.⁴ Regardless of the degree, if any, that this reluctance has impaired military caregivers' capacity to meet optimally these patients' needs, it is of clinical concern.

On October 14, 1986, Congress enacted a law which forbids the military from discharging or taking other actions "adverse" to the interests of military patients with HIV who acknowledge their homosexuality.⁵ This law

Traditional Forms of Epidemic Control, 2 J. CONTEMP. HEALTH L. & POL'Y 191, 198 n.48 (1986).

The force of this allegation, however, in the opinion of some, is limited due to the fact that persons affected by HIV include several high-risk groups, including heterosexuals who are extremely sexually active.

3. A somewhat analogous issue not discussed in this article involves servicepersons who acquired HIV-related illness through the illegal use of drugs.

4. Homosexual acts between consenting adults are illegal under the Uniform Code of Military Justice ("UCMJ"). Historically, exclusion of homosexuals from the military in this country has been based on two rationales: homosexuals are a risk to security and they disrupt troop morale. See McCrary, *The Homosexual Person in the Military and in National Security Employment*, 5 J. HOMOSEXUALITY 115, 116 (1979).

The first allegation has been eroded by court decisions which have held that a nexus is not inevitable. It has been suggested that defense attorneys should have clients attract public attention to establish that their clients don't fear disclosure of their sexual behavior. See *Gayer v. Schlesinger*, 490 F.2d 740 (D.C. Cir. 1973); McCrary, *supra* at 134-36, 146.

The "disruption to troop morale" assertion remains credible. As the following quotation reveals, the second rationale continues to receive anecdotal, if not empirical, documentation and it speaks to homosexuals' as well as non-homosexuals' difficulties:

We did not want to engage in any acts on board ship for fear of getting caught.

Getting caught in our rack together would have been too much to bear for both of us.

But the tension of being together, especially on cruises, and not being able to do what we wanted was causing too much tension and was nerve wracking.

Doe v. Chaffee, 355 F. Supp. 112, 113 (N.D. Cal. 1973).

For a recent popular account of difficulties, see Shearer, *Ship of Shame*, Wash. Post, Nov. 9, 1980, § 6 (Parade Magazine), at 22. *But see* Note, *The Constitutionality of Discharging Homosexual Military Personnel*, 12 COLUM. HUM. RTS. L. REV. 191 (1980-81) (suggesting that the military's policy of mandatory discharge of homosexuals is unconstitutional).

Servicepersons who report homosexual relations during epidemiological assessment were granted immunity from criminal sanctions approximately a year ago. Memorandum from The Secretary of Defense, Policy on Identification, Surveillance and Disposition of Military Personnel Affected with HTLV-III (Oct. 24, 1985) [hereinafter Memorandum]. See also discussion *infra* p. 3.

5. National Defense Authorization Act For Fiscal Year 1987, Pub. L. No. 99-661, tit. 7, § 705(c), 100 Stat. 3904, 3816 (1986) (to be codified at 10 U.S.C. § 1102). Section 705(c) of the

eliminated the sanction which many military patients then feared most from revealing their homosexuality — administrative discharge. But in eliminating this concern, certain other ethical dilemmas which are more equivocal and therefore more difficult remain. Values which military careproviders might prioritize when confronting these problems are suggested.

The second dilemma addressed by this article involves the issue of whether military physicians' should initiate attempts to maximize their patients' interests, e.g., such as to assist them in appointing surrogate decision-makers in the event that they become incompetent. Patients with HIV infection in civilian settings may also face difficulties when they wish to appoint sexual partners as substitute decision-makers,⁶ but these difficulties may be compounded if military patients feel particularly reluctant to discuss their homosexual relationships. Specific recommendations on how to address this difficult issue are offered.

The third dilemma discussed in this article involves the conflicts which medical staff face when patients with HIV-related illness are unwilling to tell their sexual partners that they have this disease. Military caregivers may find it easier than their civilian counterparts to protect third parties in these instances for several reasons, such as their immunity from being sued in an individual capacity. Nevertheless, it is suggested that military careproviders

Act which deals with restrictions on use of information obtained during certain epidemiologic-assessment interviews reads as follows:

- (1) Information obtained by the Department of Defense during or as a result of an epidemiologic-assessment interview with a serum-positive member of the Armed Forces may not be used to support any adverse personnel action against the member.
- (2) For purposes of paragraph (1):
 - (A) The term epidemiologic-assessment interview means questioning of a serum-positive member of the Armed Forces for purposes of medical treatment or counseling or for epidemiologic or statistical purposes.
 - (B) The term serum-positive member of the Armed Forces means a member of the Armed Forces who has been identified as having been exposed to a virus associated with the acquired immune deficiency syndrome.
 - (C) The term adverse personnel action includes—
 - (i) a court martial;
 - (ii) non-judicial punishment;
 - (iii) involuntary separation (other than for medical reasons);
 - (iv) administrative or punitive reduction in grade;
 - (v) denial of promotion;
 - (vi) an unfavorable entry in a personnel record;
 - (vii) a bar to reenlistment; and
 - (viii) any other action considered by the Secretary concerned to be an adverse personnel action.

It can be anticipated that this law will spur court action to expand the kinds of situations in which servicepersons could be exempted from other provisions in the UCMJ.

6. Steinbrook, *Special Report/Preferences of Homosexual Men with AIDS for Life Sustaining Treatment*, 314 NEW ENG. J. MED. 457 (1986).

should generally refrain from attempting to protect potential victims, at least until there is clear legal precedent granting their civilian counterparts the authority to disclose communications made by their patients. Otherwise, military physicians risk acting primarily on the basis of power, with neither social consensus or ethical justification supporting their actions.

I. DIFFICULTIES ASSOCIATED WITH INTERVIEWING PATIENTS WHO HAVE ENGAGED IN PRIOR HOMOSEXUAL CONDUCT

The dilemma which, until this year, could arise when military physicians treated servicepersons with HIV-related illness is exemplified by a relatively recent incident involving three Navy personnel who disclosed their prior homosexual conduct to attending physicians during a medical history review. These patients apparently believed that their disclosures would remain confidential. Instead, the attending physicians reported the patients' disclosures to military command; an action which ultimately culminated in administrative proceedings against the naval personnel. The patients felt "betrayed" and brought suit.⁷

The potential criminal sanctions to which military patients with HIV-related illness who disclosed their prior homosexual conduct during an epidemiological assessment were potentially vulnerable were reduced when the Secretary of Defense, Caspar Weinberger, issued a memorandum on October 24, 1985, which granted these patients immunity from criminal prosecution under the UCMJ.⁸ This policy change was not intended, however, to provide servicepersons who had HIV-related illness and who disclosed homosexual behavior complete protection.⁹ Such disclosures, following the 1985 policy change, could still be used in criminal proceedings if other evidence of homosexuality was obtained from independent sources. Furthermore, such disclosures could be used as a basis for administrative discharge. As Peter Wyro, the Pentagon spokesperson for this program stated: "[The Department of Defense ("DOD") memorandum was merely] an effort to balance out the fact that we want the information with a policy that prohibits homo-

7. Smith, *Navy Forces Out Victims Who Admit Homosexual Contact*, *Navy Times*, Aug. 26, 1985, at 4.

8. Memorandum, *supra* note 4.

9. A case in which the "independence" of a serviceperson's homosexual behavior was raised is that of a Navy enlisted man who, after testing positive for HIV infection was later charged with violating "safe sex" orders when having sexual contact with another man in a parked car. The Navy judge dismissed the "AIDS-related" charges because they violated the Navy's own regulation against using the results of HIV screening for criminal purposes. Moore, *AIDS Screening in Military Raises Legal Questions*, *Wash. Post*, Oct. 27, 1986, at A1, col. 4.

sexuality and non-medical drug use."¹⁰

In practice, each branch of the armed services has responded differently when military patients with HIV-related illness divulged their homosexuality. The Army's policy was to obtain epidemiological data on the source of these soldiers' illnesses, and then follow the course of these illnesses while the soldiers remained on active duty; no administrative proceeding, however, would be initiated.¹¹ In the Air Force and Navy, on the other hand, it was the general practice to initiate administrative discharge hearings whenever a patient's homosexual activity was reported.¹² Patients in the Air Force and Navy, accordingly, were more reluctant to reveal their homosexual conduct to their careproviders than their counterparts in the Army.¹³

The degree to which DOD policy has affected the reluctance of HIV patients to reveal their homosexuality is, however, uncertain. This is due to the fact that such reluctance might also result from the illegality and social stigma associated with homosexual behavior in the military, or from the reluctance of caregivers' to initiate discussion of this subject with their patients. Unpublished data obtained by the Air Force, prior to the release of the October 24, 1985, memorandum—obtained from a study of Air Force personnel with AIDS informed they had legal immunity—suggests that the

10. Norman, *Military AIDS Testing Offers Research Bonus*, 232 *SCIENCE* 818 (1986).

11. Army physicians theoretically were required to report these soldiers' homosexual behavior to their commanders who in turn had a responsibility to decide what action should then be taken. Some Army persons were discharged, but in most instances, no discharges occurred because Army physicians neglected to report these persons' homosexual activity to command. Telephone interview with Ernest T. Takafuji, Colonel, MC, USA, Disease Control Consultant, Preventive Military Medicine Consultant Division, Office of the Army Surgeon General (Oct. 27, 1986).

12. Telephone interview with Alfred Cheng, Colonel, USAF, MC, Chief, Preventive Medicine, Office of the Air Force Surgeon General (June 24, 1986) [hereinafter Cheng Interview]; Telephone interview with Michael Stek, Captain, MC, USN, Head of Preventive Medicine, Bethesda, (MEDCOM-241), Office of the Commander, Naval Medical Command (Oct. 28, 1986).

13. Howard DeNike, a San Francisco lawyer who specializes in military law, states: "You cannot expect people to be candid about their condition." Moore, *supra* note 9, at A4.

The reluctance of servicepersons to acknowledge homosexual relations has led some to question the veracity of epidemiological findings regarding military personnel. Redfield found that the likely source of infection in 15 of 41 AIDS patients at Walter Reed Army Hospital resulted from heterosexual, not homosexual contact. Redfield, *Heterosexually Acquired HTLV-III/LAV Disease (AIDS-related complex and AIDS)/Epidemiologic Evidence of Female to Male Transmission*, 254 *J. A.M.A.* 2094 (1985). These results were "viewed with a great deal of skepticism," however, because they conflicted significantly with reported civilian rates. Norman, *supra* note 10, at 820. The Army's findings showing a higher percentage of heterosexually transmitted AIDS cases, were also claimed by some persons to be an attempt to "cover up" the Army's underlying intent to exclude homosexual men from the service. Others believed, in turn, that since many of the servicepersons providing Redfield's data were women, the factual basis for this claim was, at the very least, limited.

effect of administrative sanctions was in fact substantial.¹⁴ Of approximately twenty servicepersons with AIDS surveyed, the proportion who reported prior homosexual conduct was comparable to civilian findings.¹⁵ Anecdotally, some Air Force physicians have indicated that patients with less severe HIV-related illness also discussed homosexuality more freely at that time. Still, the fact that the survey sample was more willing to discuss their homosexuality may have been due to other factors; including a greater ignorance on their part as to the gravity of their illness, than a comparable group would show today.

The degree to which this reluctance, whatever its cause, has actually impaired servicepersons' care is questionable. Civilian patients who have had the opportunity to discuss homosexual concerns with careproviders have reportedly found it beneficial.¹⁶ For example, patients experiencing guilt about transmitting this illness to their sexual partners,¹⁷ or engaging in a homosexual lifestyle,¹⁸ have reportedly reduced their feelings of guilt following discussion with careproviders.¹⁹ Additionally, it is reported that discussions with careproviders may assist homosexual patients in dealing with their reported "internalization" of society's negative image of homosexuals,²⁰ a condition which is often exacerbated when the homosexual acquires HIV related illness.²¹

Military patients' relationships with sexual partners may be disrupted by several factors:²² hospital procedures to control infection may socially iso-

14. See *supra* note 4 and accompanying text.

15. Cheng Interview, *supra* note 12.

16. Christ & Wiener, *Psychosocial Issues in AIDS*, in *AIDS: ETIOLOGY, DIAGNOSIS, TREATMENT AND PREVENTION* (V. Devita, S. Hellman & S. Rosenberg eds. 1985); Furstenbergh, *Social Work and AIDS*, 9 *SOC. WORK HEALTH CARE* 45, 60 (1984); Wolcott, Faway & Pasnau, *Acquired Immune Deficiency Syndrome*, 7 *GEN. HOSP. PSYCHIATRY* 280 (1985) [hereinafter Wolcott & Faway].

"[T]he therapist should be willing to focus initially on the patient's physical symptoms rather than prematurely deflecting the patient from the somatic to the psychological." Perry & Markowitz, *Psychiatric Interventions for AIDS—Spectrum Disorders*, 37 *HOSP. & COMMUNITY PSYCHIATRY* 1001, 1003 (1986).

17. Christ & Wiener, *supra* note 16, at 278; Wolcott & Faway, *supra* note 16, at 285.

18. Furstenbergh, *supra* note 16, at 50.

19. *Workers Help AIDS Victims Handle Stress, Guilt*, *NASW News*, May 1983, at 3, col. 1 [hereinafter *Workers*].

20. Furstenbergh, *supra* note 16, at 50. See also Forstein, *The Psychosocial Impact of the Acquired Immunodeficiency Syndrome*, 11 *SEMIN. ONCOLOGY* 77 (1984).

21. Furstenbergh, *supra* note 16, at 50. See also Morin, Charles & Malyon, *The Psychosocial Impact of AIDS in Gay Men*, 39 *AM. PSYCHOLOGIST* 1288 (1984) [hereinafter Morin & Charles].

22. Hausmann, *Treating Victims of AIDS Poses Challenge to Psychiatrists*, *Psychiatric News*, Aug. 5, 1983, at 1, 8; Morin & Batchelor, *Responding to the Psychological Crisis of AIDS*, 99 *PUB. HEALTH REP.* 4, 6 (1984).

late the patient;²³ staff may deny a patient's partner visiting privileges that a spouse would have;²⁴ and the patient's partner may feel distraught about the patient's illness,²⁵ guilty about transmitting this illness to the patient²⁶ and concerned about his own health and thus, decline to visit.²⁷ Some careproviders, accordingly, advocate treating all those who care about the patient in addition to treating the patient.²⁸

Staff in all three services to whom this writer has spoken have markedly different opinions regarding whether patients' reluctance to discuss their homosexuality affects the care they receive. Some believe that patients' reluctance to discuss homosexual relationships profoundly impairs the careprovider's ability to provide adequate care. Others, however, believe that this reluctance interferes little, if at all, since patients are predominantly concerned with their own illness and have other resources, such as civilian homosexual support groups, to discuss their concerns.

Yet, even if military patients felt uninhibited to discuss their homosexuality with military staff, the potential benefit to these patients might be limited. Although civilian careproviders have reported that discussing these patient's homosexuality provides benefit, they have also stressed the necessity of the caregiver being able to appreciate the patient's special concerns.²⁹ If military careproviders lack specific training in how to counsel homosexual patients, they may be less effective than their civilian counterparts who have received such training.³⁰

Military careproviders had several options available to them under previ-

23. Wolcott & Faway, *supra* note 16, at 285.

24. Morin & Batchelor, *supra* note 22, at 8.

25. *Id.* at 8; *see also* Morin & Charles, *supra* note 21, at 1291.

26. Wolcott & Faway, *supra* note 16, at 285; *see also* Nichols, *Psychiatric Aspects of AIDS*, 24 *PSYCHOSOMATICS* 1083 (1983).

27. Morin & Batchelor, *supra* note 22.

28. Furstenbergh believes, for example, that it is the social worker's role to assist not only the patient with HIV-related illness but also his family. Furstenbergh also posits that the definition of family, in this instance, should be expanded to include the patient's homosexual partners. Furstenbergh, *supra* note 16, at 55. *See also* *Workers*, *supra* note 19.

29. Christ & Weiner, *supra* note 16; Furstenbergh, *supra* note 16; Wolcott & Faway, *supra* note 16.

30. Military careproviders who hold negative attitudes toward homosexual persons, like their civilian counterparts, could also be ineffective in treating these patients and could even do them harm. O'Connor, *Programs in New York, San Francisco Offer Assistance, Mental Health Support to AIDS Victims*, *Psychiatric News*, Sept. 6, 1985, at 8, col. 4 (quoting Sandi Feinblum, Assistant Director of the Gay Men's Health Crisis ("GMHC") in New York City).

Perry reports that three forms of countertransference reactions can take place in careproviders: an unwarranted fear of contagion, a posture of omnipotence and premature referral of patients to a self-help group, such as a support group for homosexuals. Perry & Markowitz, *supra* note 16, at 1004.

ous policies which could have reduced patient's reluctance to disclose their homosexual behavior. For example, if a caregiver was obtaining data for an epidemiological study between October 25, 1985, and October 14, 1986, he could have informed the patient that any information revealed could not be used against him in criminal proceedings, but could be used in an administrative discharge proceeding, and that if in the Army, discharge was most unlikely; but in the Air Force or Navy, it was virtually inevitable. If the data was not used for epidemiological purposes, however, the careprovider could inform the patient that theoretically he had no legal immunity, but again could explain the practical meaning this had within the particular branch of service to which the patient belonged.

Whether the military careprovider had a moral obligation to share this information with the patient is, however, open to debate. Arguably, the patient was responsible for knowing this information, but, whether he was responsible or not, the patient would likely have acquired such information from informal sources. In any case, "warning" all patients in this manner might risk impairing the trust of many. Therefore, since only a small number of patients would benefit, and many would be harmed, it is contended that caregivers should not adopt a policy of routinely warning all patients.

The next dilemma which confronted military careproviders is the question of what should be done if a patient disclosed his homosexual conduct, and depending on what the physician chose, whether or not he should tell the patient of his actions prior to the patient's disclosure. A careprovider had several options available to him: he could directly inform the patient's commander orally or in writing of the disclosure; he could simply write what the patient tells him verbatim in the patient's chart; he could write what the patient tells him, but in euphemistic phrases, presumably devoid of meaning, such as "the patient discussed relationships;"³¹ or he could keep the information entirely to himself and write nothing at all. This last option has several variations. Some military physicians, for instance, tell patients to give them an "official history" which they transcribe in the record and then tell the patients to share whatever else they wish to share, which will be kept "off the record."

If the military careprovider chooses to obfuscate information concerning a

31. Some who have worked as investigators in the armed forces report, however, that physicians' commonly accepted notion — that they can write phrases so vague that they can communicate to other physicians who can "read into them" their meaning but not risk harming the patient — is illusory. Investigators perceiving the hidden meaning of such ambiguity can, for example, confront servicepersons with it and attempt to induce them to acknowledge prior homosexual behavior.

patient's prior homosexual conduct, or keeps it entirely to himself, he may feel personally at risk for not reporting this information to command or for his failure to record it, particularly if this information contradicts previously obtained epidemiological data.³² Military careproviders may also feel guilty when they withhold information for non-utilitarian reasons; they may be violating explicit legal obligations owed to the military, and may be violating implicit moral obligations owed to other soldiers and society.

Caregivers may also fear personal repercussions, a factor which varies according to the branch of service. The Navy, reportedly, places great importance on careproviders' reporting patients' illegal behavior, as is reflected in its strongly worded regulations. In practice, however, no careprovider in the services, to this writer's knowledge, has ever been disciplined for not reporting a patient's illegal behavior.

The military's failure to sanction a military physician for his failure to report homosexual behavior, is, as alluded to previously, probably intentional. The military's having strict regulations against homosexual conduct, but being somewhat lax in enforcing them, may maximally further mutually exclusive but independently important ends.³³ Strict regulations against homosexual practices may discourage gay persons from joining the military and influence those who serve to be discreet. Lax enforcement reflected by the military's failure to discipline caregivers should encourage servicepersons to seek care from military careproviders when they acquire an illness through homosexual acts. The DOD memorandum which provided homosexual patients with HIV-related illness immunity from criminal, but not administrative repercussions, was structured similarly to achieve these seemingly contradictory ends.

The conflicting ethical duties presently encountered by military caregivers when confronting homosexual patients with HIV-related illness are not without precedent. Such conflicts existed previously, for example, whenever staff took sexual histories from servicepersons who engaged in homosexual activities, or drug histories from patients who used illegal drugs. Military careproviders' approach to servicepersons with HIV-related illness (even under the new policies) should, in principle, be the same as in these former situations. However, because the suffering associated with HIV is greater than for most other illnesses, and because the potential effects of this epi-

32. His withholding information may also impair his commander's ability to make prudent choices which, theoretically, could prove dangerous to society. See *infra* note 149.

The epidemiological information obtained may directly benefit not only this society but populations throughout the world. See *infra* note 55 and accompanying text for other examples of national and international implications.

33. *Ethical Issues*, *supra* note 1; Howe, *supra* note 1.

demic are great, a change in caregivers' approaches may be warranted. How these particular considerations might alter previously existing value priorities is examined in later portions of this article.

The following discussion will present ethically optimal approaches to the dilemmas which caregivers have faced until just recently and will examine their implications on medical practice. First, as in earlier situations in which HIV was not a factor, careproviders should, it would seem, have taken the initiative to inform patients of theoretical and actual risks faced by divulging homosexual conduct. Caregivers should not have considered patients responsible for knowing these risks, nor assumed that patients had learned this information through informal sources. Why? The careprovider presumably is in a better position than the patient to know this information and, moreover, the patient is exceptionally vulnerable due to his illness to deny or distort information according to his emotional needs. To inform patients accurately, of course, caregivers must have access to updated information regarding what each service does when a patient's homosexual conduct is reported to command.

If the careprovider planned to reveal information the patient told him, he should have informed the patient prior to the patient's disclosure. This could be accomplished in all cases only if caregivers routinely informed each patient of their policy toward such disclosure at the beginning of every interview. This, as stated previously, might have impaired many patients' trust in their careproviders and might have caused inordinate harm. It is possible, however, that if caregivers warn patients their trust may be enhanced.³⁴ It may be that the most careproviders can do for patients when they have strong conflicting obligations is to inform them that they possess such obligations and indicate to the patient which obligation will be given priority.

34. A somewhat analogous situation exists when psychiatric patients are warned that they have a right to remain silent. It might be expected that a majority would not speak and would lose trust in their physicians. This may, however, not be the case. In Wisconsin, for instance, a state in which psychiatrists must warn patients that they have a right to remain silent, a study revealed that most patients talked readily in spite of the warning. In fact, 42 out of the 50 patients studied followed this course of action. One patient, in fact, after hearing his rights, "seemed reassured" and became more communicative. Clinicians in Illinois, Massachusetts and Hawaii which, like Wisconsin, require the warning, apparently have had similar results. See Miller, *Miranda Comes to the Hospital: The Right to Remain Silent in Civil Commitment*, 142 AM. J. PSYCHIATRY 1074, 1077 (1985).

These findings may, however, be misleading. Mental patients may know, at some level, that they are ill and talk because they know this is the best way to enable their doctors to treat them. Military patients with HIV-related illness may also want to share their homosexuality to maximize their treatment on one level, but their fear of adverse repercussion may, relative to psychiatric patients' fears, be stronger.

Whether a patient's trust would in fact be enhanced could be determined empirically.

Careproviders who plan to reveal what patients tell them have another option available. They can state what they intend to do to only those patients who they believe are about to divulge their homosexual conduct. Caregivers taking this approach would, however, have to anticipate what their response would be if a patient discloses information prior to the physician's warning.

In considering this latter possibility, the caregiver might conclude that the patient already knew, or should have known,³⁵ that the military physician/patient relationship is not confidential and therefore, that the patient was responsible for the consequences of his disclosure. However, this assertion is tenuous, in view of the previously noted fact — that an ailing patient is particularly prone to distortion.³⁶ Moreover, since many military caregivers have treated patients' disclosures as confidential regardless of the reporting requirements of their particular branch of service, patients have had valid grounds for inferring that confidentiality would be maintained. Since the careprovider is a member of the group which creates this ambiguity, he may also have some responsibility to clarify this policy for the patient. Otherwise, the burdens resulting from this discrepancy, the burden of guessing and particularly of guessing wrong, would fall wholly on the patient.

A caregiver who warned patients only when he anticipated that the patient would divulge homosexual behavior could, on the other hand, have kept this information to himself if the patient disclosed the information prior to his warning. The physician would then have to be prepared to suffer the potential adverse consequences for remaining silent. Though punitive repercussions are unprecedented, they remain possible.

Should the military physician risk potential personal sanctions? It is posited that this question should be answered in the affirmative.³⁷ Since civilian physicians have a moral obligation to treat patients with HIV-related illness

35. These assumptions that a patient already knows or should know are, of course, very different in nature. The first is a factual assumption which may or may not be correct. The second assumes a value priority and, therefore, is particularly subject to the caregivers' bias. In this case, it takes for granted, for example, that all servicepersons have equal ability to obtain and use information important to them and have equal opportunity to acquire this ability.

36. Patients tend to perceive physicians as their helpers no matter what their situation. See, e.g., P. APPELBAUM, *CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW* 289 (1985).

37. See, e.g., Jonsen, *AIDS and Ethics*, 2 *ISSUES SCI. & TECH.* 56 (1986). Yet, whatever the degree of present consensus, practice varies. Some surgeons, for example, refuse to do elective procedures on patients with HIV because they are afraid that they might become infected by nicking themselves with their scalpel. Some pathologists similarly fear that they might make a slip and become infected and thus make arrangements with others less afraid to

even at the risk of becoming infected themselves,³⁸ it can be asserted that a military caregiver should be willing to bear the less severe repercussions which might result from his failure to divulge patients' disclosures to command. This position would appear to be particularly viable in view of the fact that no military physician, to date, has been subjected to such repercussions. Consequently, on the basis of this consideration alone, it might not only be praiseworthy for military careproviders to remain silent, but perhaps morally obligatory as well.

What harm would these approaches involve? The military physician would violate his obligations to the military. The military physician's primary responsibilities are to maintain the unit's health and to keep his commander informed on this matter so that this information can be used to make prudent decisions. Like the average military serviceperson, the military physician is obligated to carry out his mandated objectives even when personal needs might be sacrificed.³⁹

When the military physician withholds information from his commander, or indirectly prevents his commander from receiving it, as for example, when he warns a patient prior to disclosure that his divulgement would be reported, the physician fails to fulfill his second military objective — keeping his commander informed about the health of his unit. Yet, in order for the physician to fulfill his first military objective — protecting the unit's health — a physician must maintain the trust of the military personnel. If the military physician reports patient disclosures,⁴⁰ it is likely that the patient will feel betrayed, and that he will withhold all future information. The Air Force experience discussed previously is a case in point.⁴¹ As noted, Air Force physicians discovered that when they could no longer offer servicepersons complete immunity, the patients stopped giving accurate information. Accordingly, since that time the Air Force has been unable to obtain reliable epidemiological data.

The most compelling justification for the approaches outlined above is that they respect the patient's dignity. It is this consideration, primarily, which requires that the military physician warn his patient of the potential ramifications of his disclosure even when the physician believes that the pa-

perform autopsies. The question of whether or not a physician should administer CPR when no apparatus preventing mouth-to-mouth contact is available is also subject to differing views.

38. McCray, *Occupational Risk of the Acquired Immunodeficiency Syndrome Among Health Care Workers*, 314 *NEW. ENG. J. MED.* 1127 (1986).

39. See generally *Ethical Issues*, *supra* note 1.

40. See generally Smith, *supra* note 7.

41. Cheng Interview, *supra* note 12.

tient's behavior should be reported.⁴²

It is arguable that there are some instances in which other values should take precedence. For example, if there is a significant likelihood that a military mission would be endangered, or that other significant harms would occur, the goal of preventing these harms might prevail.⁴³ In addition, in many situations the serviceperson agrees in serving a particular role that if health conditions occur which would potentially impair his functioning, he will go to the military physician for treatment and accordingly, the physician will act in accordance with the mission's needs.⁴⁴ A serviceperson agrees to these conditions, for example, when he becomes a pilot.⁴⁵ In the situations

42. *E.g.*, "In theory, I was supposed to turn in every gay guy who came in. You're supposed to tell every time, that's the rule." Moore, *supra* note 9, at 4, col. 2 (quoting Dr. David Fletcher, a former Army doctor who worked with AIDS patients).

Ethically, military physicians who report all such patient disclosures may be pursuing a so-called "role-specific ethic" in which they accept the judgments of command and continue to perform their duties without independently assessing which obligations — duties as military officers, or as physicians — should prevail.

This approach furthers the authority of command, avoids unequal treatment among servicepersons making similar disclosures, and eliminates the physician's personal risk.

A military physician's subscribing to a role specific ethic in all situations is, however, both theoretically and pragmatically problematic. For a discussion of these problems, see *Ethical Issues, supra* note 1.

43. Numerous examples could be given. Dr. Richard Swengel, Colonel, MC, USA, a neurosurgeon at Walter Reed Army Hospital presents the following scenario as a case in point. His commander was informed shortly after the submarine went to sea that the child of one of his servicemen had been killed. Consequently, the commander was presented with the dilemma whether or not to inform the serviceman and allow him to return home — an action which would have interfered with the mission or inform the serviceman but require him to remain — an action which would potentially interfere with his ability to perform his duties. In this particular situation, a decision was made to inform the serviceman. This decision was based, however, on the fact that the attending physician was familiar with this particular serviceman and was confident in his ability to cope with the situation. Since military policy today precludes such information from being sent to submarines, it is unlikely that this particular dilemma will reoccur.

For descriptions of other situations in which the needs of the military mission may prevail over those of individual patients, see Colbach, *Ethical Issues in Combat Psychiatry*, 150 MIL. MED. 256 (1981); *Ethical Issues, supra* note 1; Howe, *supra* note 1.

Any situation in which mass casualties occur in the military may potentially allow priority to be given to the needs of the mission over those of individual patients. The principle of military medical triage holds that soldiers other than those most severely wounded can be treated when this is necessary to salvage "the greatest possible number of lives for the support of the military mission." See UNITED STATES DEPARTMENT OF DEFENSE, EMERGENCY WAR SURGERY (1st rev. ed. 1975). See generally Smith, *Triage: Endgame Realities*, 1 J. CONTEMP. HEALTH L. & POL'Y 143 (1985).

44. When a serviceperson has a security clearance and has access to vital information or works with nuclear weapons, society itself may be endangered. See *infra* pp. 124-25.

45. The time in which a pilot must react from the moment he first sees a plane in order to avoid it is, for example, a matter of seconds. Since numerous factors could affect his reactions

discussed here, however, the utilitarian arguments which favor a military physician's reporting a patient's admissions are few.

How then should a physician's approach change when he encounters such patients in the future? While the new law passed in 1986 protects servicepersons who disclose past behavior from most adverse actions,⁴⁶ three situations remain potentially problematic. First, if a serviceperson with HIV reveals the identity of his sexual partner and the sexual partner is a serviceperson, the partner could be subject to sanctions. A military physician facing this dilemma will have choices similar in principle to those he confronted prior to the adoption of the new law, for example, deciding first whether or not to report to command an identified partner and, if so, whether to warn the patient. In this instance, however, this physician would not have to warn all patients, but only those who acknowledged homosexual behavior.

Second, the military may specially reconsider a patient's security clearance and possibly revoke it if the patient's homosexual behavior is disclosed. Here, the arguments in favor of the military physician respecting the patient's interests are the same as before the passage of the 1986 law, but the relative importance which such a situation presents to the military and the

and endanger not only his crew but himself, he accepts responsibility for bringing himself to the military physician for conditions he knows may ground him.

One of the few situations in which patients are permitted to incriminate themselves in civilian settings is when they plead insanity as an excuse to a crime. Self-incrimination is allowed in this particular instance because the patients' thoughts, at the time of the crime — information necessary to establish insanity — are unobtainable otherwise. See, e.g., Note, *Requiring a Criminal Defendant to Submit to a Government Psychiatric Examination: An Invasion of the Privilege Against Self-Incrimination*, 83 HARV. L. REV. 648 (1970).

The conflict which then arises if patients have the right to remain silent and to plead insanity is whether or not the jury should be permitted to infer sanity from the patient's choice to remain silent. See, e.g., Matz, *The Sounds of Silence: Post Miranda Silence and the Inference of Sanity*, 65 B.U.L. REV. 1025 (1985).

Potentially, an analogous question could be raised concerning the inference military physicians could make when a serviceperson fails to answer questions regarding his homosexual relations. Cf. *Gayer v. Schlesinger*, 490 F.2d 740, 751, 753 n.28: "[A] willful failure or refusal to furnish or to authorize the furnishing of relevant and material information may prevent the Department of Defense from reaching the affirmative finding required . . . in which event any security clearance then in effect shall be suspended . . ." (The plaintiffs in this case had, however, informed their investigator that they were leading active homosexual lives; they refused to give details on the ground that this invaded their privacy.)

This is most implausible, but illustrates that even the physician who believes it is his duty to report all patients stops short of going as far in reporting his suspicions as an investigator might. Cf. *supra* note 31.

46. The term "adverse personnel action," is to be distinguished from "adverse security determination." In the latter, a greater national interest is at stake and the burden on the government when making claims which oppose a serviceperson's interests is accordingly less. See generally *supra* note 5.

nation when the patient has such a clearance is greater. Consequently, the issue is whether the military physician should report homosexual disclosures made by a serviceperson with HIV infection when such a patient has a security clearance, and, if so, should the patient be warned.

Under these particular circumstances, the physician's obligation to the military and society is stronger and therefore, the question of withholding such information is more problematic. Yet, it is suggested that a gay serviceperson's homosexual behavior alone should not jeopardize his clearance status but rather, the fact that he, as any other individual, is less than trustworthy should. Thus, a military physician might take into account this consideration and assess for himself whether or not the homosexual patient seems trustworthy.

If the physician attempts to make this differentiation himself,⁴⁷ theoretically the so-called role-specific ethic would be violated. If the military physician reports all patients with security clearances who divulge their homosexual behavior, because this behavior represents an increased likelihood that the serviceperson is untrustworthy, from the standpoint of equity, he should also report servicepersons for other behaviors which similarly suggest that they are not wholly trustworthy, such as those who show increased alcohol use, depression, or sexual promiscuity.⁴⁸

But if the military physician elects to report all or even some homosexual servicepersons, should the physician then warn these patients beforehand? This is a close call. In most situations, military or civilian, the physician using his medical role to exploit a patient's vulnerability, even for substantial interests of others, has been questioned.⁴⁹ Yet, this could represent an exem-

47. See discussion *supra* note 42.

48. The value which may be violated here is equity. A criticism which has been raised against some military practices regarding gay servicepersons is that they discriminate against this group. Cf. *supra* notes 2 & 13 for other examples in which discrimination has been claimed.

From the standpoint of equity, commanders may be seen to be enforcing one but not other aspects of military law when they take actions against homosexual servicepersons. See, e.g., *supra* note 9 (the instance of the Navy bringing charges against a homosexual serviceperson with HIV having sexual contact with another man in his car). The military law against sodomy states "Any person who engages in unnatural carnal copulation is guilty of sodomy. Unnatural copulation includes oral and anal sex with persons of the same or opposite sex." Executive Order 12473, 49 Fed. Reg. 17,152 (1984). Equal treatment under this law would seemingly require that similar charges be brought against any serviceperson with HIV engaging in heterosexual contact. But see *Gayer*, 490 F.2d at 747 n.14, in which an official of a clearance program was asked "whether [the] criminality of other kinds of sexual activity proscribed by statute — such as fornication, heterosexual sodomy, adultery — were afforded the same treatment [as homosexual conduct]." He responded that they were not unless there was specific reason to suspect the activity might render the individual susceptible to blackmail.

49. An example of this in the military context is when the physicians treat civilians in

plary case in which the military physician would be justified in using his medical role to "entrap" the patient (by misleading the patient about what the physician would do).

Additional considerations are also germane. Practically, what is the likelihood that dire consequences would occur solely because a military physician did not report the homosexual behavior of a serviceperson with HIV who has a security clearance? The courts have questioned whether homosexual behavior, *per se*, poses a general risk to the military.⁵⁰ Moreover, even if the risk were substantial, the indignity done to a serviceperson by "entrapment" could render the values which the military is protecting worthless. As the late Justice William O. Douglas stated:

[The] concept of "national defense" cannot be deemed an end in itself Implicit in the term "national defense" is the notion of defending those values and ideals which set this nation apart It would indeed be ironic if, in the name of national defense, we would sanction the subversion of . . . those liberties . . . which [make] the defense of the nation worthwhile⁵¹

Under a third situation, a small percentage of patients,⁵² though not hav-

occupied territory in part for military gain. Such gain, for example, was obtained in Vietnam when paramedics treating civilians were able to acquire vital information on enemy troop locations. This information was often obtained from the spouses of North Vietnamese troops. See Bourne, *The Hippocratic Revolt, The Army Physician and Vietnam*, 6 RAMPARTS 57, 58 (1967). See generally R. VEATCH, CASE STUDIES IN MEDICAL ETHICS 61-64 (1977); Neel, *The Medical Role in Army Stability Operations*, 132 MIL. MED. 605 (1967) (for the military rationale in treating such civilians); Vastyan, *Warriors in White; Some Questions About the Nature and Mission of Military Medicine*, 32 TEX. REP. BIOL. MED. 327 (1974); *Ethical Issues*, *supra* note 1; Howe, *supra* note 1.

In occupied territories, however, such care benefits its recipients and for this additional reason especially, in the past, it has been given even when it was known that enemy soldiers were among those who would be treated. See *Health Care for Civilians, Problems of War Victims in Indo China: Hearing Before the Subcomm. to Investigate Problems Connected with Refugees and Escapees*, 92d Cong., 2d Sess. (1972) (testimony of J. Ferger) (for a description of conditions existing in civilian hospitals during the Vietnam conflict).

Furthermore, international law attempts to limit the use of destructive weaponry. It would be inconsistent, in this regard, to preclude medical care which benefits the enemy as a means of pursuing military goals.

Civilian doctors face analogous conflicts in a variety of contexts, such as when deciding whether or not to place a wanted criminal's picture in a dermatology journal. See Gaylin, *What's an FBI Poster Doing in a Nice Journal Like That?*, 2 HASTINGS CENTER REP. 2 (Apr. 1972). All physicians who make their livelihood caring for patients in a sense exploit these patients for profit. See *Ethical Issues*, *supra* note 1 for a discussion of criteria for the distinction between morally permissible and impermissible exploitation.

50. See sources cited *supra* note 4.

51. *United States v. United States Dist. Court For the E.D. Mich.*, 407 U.S. 297, 332 (1972) (quoting *United States v. Robel*, 389 U.S. 258, 264 (1967)).

52. See Norman, *supra* note 10. See also Engel, *infra* note 60, at A7, col. 1.

ing a security clearance, might for personal reasons (other than fear of military sanctions) not want to reveal previous homosexual behavior. In this instance, patients who reveal homosexuality because they feel strong pressure from military physicians to do so would "subjectively" be harmed, though the information they give might benefit others.⁵³

The situation of these servicepersons could be seen as ethically comparable to that of research subjects. (This analogy can be drawn because the patients are ill, and particularly because the patients suffer from a disease which has no cure). When their situation is construed in this manner, all reasonable efforts should be taken to maximize their autonomy. As Jonas has stated:

[A patient's] physical state, psychic preoccupation, dependent relation to the doctor, the submissive attitude induced by treatment — everything connected with his condition and situation makes the sick person inherently less of a sovereign person than the healthy one [C]onsent is marred by lower resistance or captive circumstances, and so on This . . . puts a heightened onus on the physician-researcher to limit his undue power to [the] most important and defensible research objectives and, of course, to keep persuasion at a minimum.⁵⁴

The military physician could implicitly exploit these patients' situations by merely informing them that they were protected from adverse sanctions and then taking a sexual history. Alternatively, a physician could enhance such a patient's decision-making capacity by inquiring prior to taking a sexual history whether the patient had concerns about divulging homosexual behavior and whether he would like to discuss them prior to deciding what to reveal. Even gay patients who choose to reveal their homosexuality should appreciate the offer, and persons who are not gay should recognize also, at some level, that military physicians, in asking this question, are respecting all servicepersons.

But would the epidemiological data otherwise gained from this small group of patients justify not "warning" them? Clearly, the findings obtained from disclosure made by these patients could *potentially* benefit persons in

53. Jonas in his classic article on human experimentation states: "For what objectives connected with the medico-biological sphere should . . . harm [to] human subjects [in] experimentation [be permitted]? We postulated that this must not be just a worthy cause . . . but a cause qualifying for transcendent social sanction Extraordinary damage excuses extraordinary needs." Jonas, *Philosophical Reflections in Experimenting with Human Subjects*, in *CONTEMPORARY ISSUES IN BIOETHICS* (T. Beauchamp & L. Walters eds. 1978).

54. *Id.* at 418. For specific adverse sanctions from which such servicepersons would be protected, see National Defense Authorization Act For Fiscal Year 1987, Pub. L. No. 99-661, tit. 7, § 705(c), 100 Stat. 3816, 3904 (1986) (to be codified at 10 U.S.C. § 1102).

this country and the world.⁵⁵ The key considerations in a military physician's decision should be the *actual* importance of this information weighed against the greater respect shown and benefit to patients who choose not to reveal previous homosexual behavior.⁵⁶ The former in most instances would probably be equivocal, the latter never.

II. MAXIMIZING PATIENTS' AUTONOMY

Patients with HIV-related illnesses sometimes evoke strong negative feelings in their caregivers for a variety of reasons. These may range from careproviders having prejudice against homosexuals and drug users,⁵⁷ to a fear that they might acquire HIV from the patients.⁵⁸ Civilian and military medical personnel who have these feelings may knowingly or unknowingly "act them out" through acts ranging from taking a biopsy of a patient's nasal mucosa after a nosebleed "to eliminate all diagnostic uncertainty," to performing repeated bone marrow aspirations even when the results would not affect a patient's treatment.

This hostility can also be expressed on an institutional level. For instance, patients with HIV infection who would customarily be referred for counseling or inpatient treatment for alcoholism,⁵⁹ might have these resources

55. The United Kingdom has not initiated compulsory testing of military recruits but faces the ethical dilemma of having to find other ways to monitor the spread of HIV in the British population at large. It would be possible, for example, to test blood samples taken for other purposes. But this would be problematic, because subjects found to be positive would have to be informed and their permission to be tested and informed would then not have been obtained. For a further discussion of this issue see Newmark, *AIDS/Confused Ethics of Blood Testing*, 322 NATURE 296 (1986).

56. See generally Lipsett, *On the Nature and Ethics of Phase I Clinical Trials of Cancer Chemotherapies*, 248 J. A.M.A. 942 (1982) in which Lipsett states that:

"The conduct of this process [of obtaining the informed consent of patients in therapeutic research] must also meet the requirement of autonomy of the patient to be respected. In practice, this means that the patient and physician discuss the purpose and methods of the trial and its risks and benefits and that at the end the patient understands as completely as possible."

57. See Wolcott & Faway, *supra* note 16.

58. See Christ & Wiener, *supra* note 16; Furstenbergh, *supra* note 16; Wolcott & Faway, *supra* note 16. See also Beauchamp, *A Second AIDS Epidemic*, N.Y. Times, Aug. 7, 1983, at 21, col. 1; Morgenthau, *Gay America in Transition*, NEWSWEEK, Aug. 8, 1983, at 30.

59. Patients with HIV-related illness, like others, may drink alcohol to relieve their anxiety. Likewise, persons who abuse alcohol may be exceptionally vulnerable to acquiring HIV-related illness due to poor self-care. Inpatient treatment may be more successful than outpatient treatment at preventing alcohol and drug abuse because it provides a better support group which can be utilized by the patient to deal with his health related stress. Flavin, *The Acquired Immune Deficiency Syndrome (AIDS) and Suicidal Behavior in Alcohol-Dependent Homosexual Men*, 143 AM. J. PSYCHIATRY 1440 (1986).

withheld. Rationales might be offered to justify this discrimination,⁶⁰ but its apparent logic may be misleading. The claim might be made, for example, that the needs of these patients are "excessive" and thus, if their needs were met, other patients would suffer. While this claim may be true, taken out of context, other patients who do not have HIV-related disease may also have "excessive" needs and yet receive treatment. Furthermore, resources might be available to meet the needs of both groups of patients having "excessive" needs, but sufficient effort to acquire such needed resources not undertaken.

Ethically, the military has already placed added burdens on servicepersons with HIV-related illness by requiring them to be screened. Some have undoubtedly benefited from learning that they have this illness, but some might have chosen not to be tested.⁶¹ The military's requirement that servicepersons go to medical centers for evaluation of their illness may also, in some cases, have exposed patients' homosexual lifestyles.⁶² The importance

60. Discrimination against patients with HIV infection may also represent racial discrimination. Black military recruits test four times higher than whites for HIV infection and blacks and Hispanics account for 40 percent of U.S. AIDS cases. Engel, *Black Recruits' AIDS Exposure Rate Four Times That of Whites, Tests Show*, Wash. Post, July 19, 1986, at A7, col. 1; Russell, *Blacks and Hispanics Suffer High AIDS Rate*, Wash. Post, Oct. 24, 1986, at A17, col. 1.

Concern about adverse effects which might result if AIDS were identified as a minority health problem has apparently interfered with some education programs. See generally Russell, *supra*.

61. Gary McDonald of the AIDS Action Council, which represents 110 local AIDS organizations, for example, counsels persons not to get tested. See Russell, *supra* note 60; see also *U.S. Recommends Wider AIDS Testing*, Wash. Post, Mar. 14, 1986, at A15, col. 1. Dr. Harvey Fineberg, Dean of the Harvard School of Public Health, supports this approach, he states that "Testing . . . imposes devastating knowledge on an individual that he has a right not to know. An individual has a right to insulate himself from bad news." Morganthau, *The AIDS Epidemic/Future Shock*, NEWSWEEK, Nov. 24, 1986, at 30, 39.

62. In some instances, screening procedures have resulted in servicepersons' informing their families, which otherwise they would have chosen not to do. In one study of civilians, for example, four out of five homosexual men with HIV had not told their families of their homosexuality. Coppola, *Coming Out of the Closet*, NEWSWEEK, Aug. 8, 1983, at 34.

Servicepersons with HIV have also suffered other additional burdens. Screening has resulted in some servicepersons returning to units in which they have been harassed or ostracized. See, e.g., Moore, *supra* note 9, at A8, col. 1 (quoting Dr. John B. McClain, Chief of Infectious Disease Service at Walter Reed who stated that: "Some have been woken up [at Walter Reed] in the middle of the night with 'Hey Joe, isn't it time for your HTLV-III [AIDS] test?' And they didn't know anyone knew.")

An unreported case brought to the attention of the author is illustrative. According to one serviceperson, after leaving his post to be medically evaluated, he was told by his boss to get another assignment and not return. The serviceman tried to change assignments but this did not work out. When eventually he returned to his duty station, he found himself shunned for being a homosexual and "having the plague," and then sought support from his parents. They in turn told him that they loved him but he couldn't live with them and during his brief stay washed his silverware and plates with alcohol after each meal he ate.

Another harm to which servicepersons with HIV may also be exposed is bureaucratic in

presently given to protecting the privacy of civilian patients, in comparison, is exemplified by a National Institute of Health ("NIH") panel's recommendation that blood donors be given a "check-off" form on which they can indicate that their blood not be transfused so that persons with HIV can give blood without exposing others to their disease.⁶³

Equity would require that under normal circumstances patients with HIV receive the same treatment as patients with other illnesses. Since the military has imposed extra burdens, it may have some supererogatory duty to meet these patients' needs even if they are deemed excessive. Institutional discrimination, therefore, if it must exist at all, should favor these patients.⁶⁴

Patients with HIV-related illness are vulnerable to individual or institutional discrimination, and, as with other patients, are particularly vulnerable when they undergo mental deterioration, which occurs in perhaps as many as fifty percent of AIDS patients, and often results in their total incompetency.⁶⁵ For example, a physician may not treat one patient with HIV-related illness when he feels hostility towards that patient on the grounds that such treatment is futile, but continue to treat a patient with another illness, who has an identical chance of survival, for whom he feels no hostility.⁶⁶ Alternatively a physician may discriminate between patients with HIV-related illness. If two AIDS patients have an infection such as pneumocystis

nature. AIDS patients can spend up to five months in the hospital awaiting medical retirement. Moore, *supra* note 9, at A8, col. 1.

63. NATIONAL INSTITUTE OF HEALTH CONSENSUS DEVELOPMENT CONFERENCE STATEMENT/THE IMPACT OF ROUTINE HTLV-III ANTIBODY TESTING OF BLOOD AND PLASMA DONORS ON PUBLIC HEALTH (July 7-9, 1986) [hereinafter NIH CONSENSUS REPORT]. See also Squires, *Panel Urges Donating Blood for Own Use to Cut AIDS Risk*, Wash. Post, July 10, 1986, at A5, col. 1.

64. Some have asserted that patients who have acquired HIV through homosexual behavior, prostitution and IV drug use are not equally deserving of treatment because they have acquired their illness through their own volition. Discriminating against these patients for this reason would, however, violate equity unless other patients with behaviors such as smoking and lack of exercise, which similarly pose self-induced risks to health, were also treated differently. If behaviors such as these were accepted as a valid ground for discriminating against these individuals, persons with HIV might still warrant treatment more than those who, for example, continue to smoke, because many patients with HIV lacked knowledge at the time they engaged in high risk behaviors that acquiring HIV was a potential risk.

65. Perry & Markowitz, *supra* note 16, at 1002. See also Navia, *Dementia Complicating AIDS*, 16 PSYCHIATRIC ANNALS 158 (1986); Snider, Simpson, Nielson, Gold, Metroka & Posner, *Neurological Complications of Acquired Immune Deficiency Syndrome: Analysis of 50 Patients*, 14 ANN. NEUROLOGY 403 (1983) [hereinafter Snider & Simpson]. These patients may also undergo other illnesses such as depression which may further impair their capacity to choose freely.

66. See Steinbrook, Lo, Tirpack, Dilley & Volberding, *Ethical Dilemmas in Caring for Patients with the Acquired Immunodeficiency Syndrome*, 103 ANN. INT'L MED. 787 (1985) [hereinafter Steinbrook & Lo].

pneumonia (a condition where the survival rate approaches only fourteen percent if intubation is required),⁶⁷ a physician might stop treating a young homosexual intravenous ("IV") drug user on the rationale that treatment is futile, but continue to treat a sixty year old man who acquired AIDS from a blood transfusion.⁶⁸

Caregivers, in both civilian and military settings may also discriminate against patients with HIV-related illness not only because they feel hostility, but also because they wish to further cost/benefit interests. Some physicians routinely refuse to admit patients with do-not-resuscitate orders ("DNR's") to intensive care units ("ICU's").⁶⁹ Other physicians attempt to persuade elderly patients to decline certain options, such as being admitted to an ICU or continuing renal dialysis, by informing them that if they use these resources, these resources may become unavailable for younger patients. Still other physicians attempt to persuade terminally ill patients to request DNR orders by sharing with them the worst outcomes that could be expected if they were resuscitated. In each case, the physician hopes to save both staff time and societal resources.

As the number of patients with HIV-related illness has increased, allocating resources justly to this group has become pragmatically difficult. Some AIDS patients in New York City reportedly receive "cheap" hospice care instead of optimal treatment.⁷⁰ In some military and civilian centers in which AIDS patients are concentrated, if AIDS patients' needs were optimally met, they would occupy all the ICU beds.⁷¹

The degree to which the needs and wishes of patients with HIV-related illness requiring hospitalization can be met is limited by the resources which can be made available. As an initial cost-trimming measure, scarce resources could be withheld from patients with HIV-related illness when probable benefits are marginal, to make these resources available to other patients

67. Murray, *Pulmonary Complications of the Acquired Immunodeficiency Syndrome, Report of a National Heart, Lung, and Blood Institute Workshop*, 310 NEW ENG. J. MED. 1682 (1984).

68. Steinbrook & Lo, *supra* note 66.

69. Even if some system of limiting admissions is necessary, this may discriminate among patients who have similar illnesses but have or have not requested DNR orders. Since some patients might withdraw their DNR order if they needed ICU treatment and knew they might not be admitted on this basis, keeping this knowledge from affected patients is ethically questionable.

70. Calazza, *Correspondence*, 314 NEW ENG. J. MED. 1191 (1986).

71. See Steinbrook & Lo, *supra* note 66. In the military, resources at several facilities are being "drained." See also statement of Dr. William Cline, AIDS Program Coordinator at Walter Reed who states that "Almost every department at the [Walter Reed Army] Medical Center has become involved in the AIDS program, diverting many health officers from other duties." Moore, *supra* note 9, at A4, col. 1.

including those with HIV-related illness.⁷² When there are no relevant medical differences between patients with AIDS and other patients, however, cost saving should also include other groups which would benefit.⁷³

Yet, which considerations are "medically relevant" can be widely interpreted. Who determines what is medically relevant is therefore of the utmost significance.⁷⁴ If someone other than the treating physicians make this assessment, the doctors can remain advocates for their patients. Yet, since the physicians most involved know the most about their patients, they are in the best position to judge their relative medical prospects.

In the military, it might be preferable for physicians to remain advocates for their patients by referring decisions involving two or more patients' conflicting interests to persons not involved in the patients' clinical care. Three rationales support this approach. First, patients with HIV should be able to trust military physicians as much as possible. These patients are already exceptionally vulnerable in any setting due to the seriousness of their illness and the corresponding social stigma. Any degree to which this additional distrust can be offset will benefit the patient. Second, military physicians frequently change geographic locations. Thus, it is likely that patients will see several doctors during the course of their illnesses. Again, to whatever extent patients can develop trust under these circumstances is desirable. Third, military physicians customarily work as a unit. Practically, it would therefore, in most instances, be easy for the military physician to arrange for persons outside the treatment relationship to decide questions involving the allocation of limited resources. This approach is already being implemented in some military hospitals to deal with such matters as blood shortages.

When it appears that resources will be inadequate, military careproviders may also have some obligation to explore whether resources can be made available,⁷⁵ or might be available elsewhere⁷⁶ prior to implementing measures to decide who gets treated and who does not.

In the military, this obligation might include, for instance, making sure

72. Steinbrook & Lo, *supra* note 66. See also Veatch, *DRG's and the Ethical Reallocation of Resources*, 16 HASTINGS CENTER REP. 32, 38 (June 1986).

73. Steinbrook & Lo, *supra* note 66. See also Engelhardt, *Intensive Care Units, Scarce Resources and Conflicting Principles of Justice*, 255 J. A.M.A. 1159, 1162 (1986).

74. Steinbrook & Lo, *supra* note 66; Veatch, *supra* note 72; see also Dyer, *Should Doctors Cut Costs at the Bedside?*, 16 HASTINGS CENTER REP. 5 (Feb. 1986); Knaus, *Rationing Justice and the American Physician*, 255 J. A.M.A. 1176 (1986); Miller, *Sounding Board/Why Saying No to Patients in the United States is so Hard*, 314 NEW ENG. J. MED. 1380 (1986); Morreim, *The MD and DRG*, 15 HASTINGS CENTER REP. 30 (June 1985); Strauss, *Rationing of Intensive Care Unit Services*, 255 J. A.M.A. 1143 (1986); Zawacki, *ICU Physician's Ethical Role in Distributing Scarce Resources*, 13 CRITICAL CARE MED. 57 (1985).

75. Steinbrook & Lo, *supra* note 66.

76. Englehardt, *supra* note 73.

that persons responsible for allocating resources are aware that shortages exist, and when this fails, recommending alternative civilian sources available to meet military demands. Although servicepersons requiring some treatments would not have to pay if they received military care, they might have to pay considerable amounts of money if they chose to be treated in civilian hospitals. Nonetheless, patients should be informed of this option because it might enhance their trust in the attending physician.⁷⁷

If resources are totally unavailable, however, deciding between patients' interests is necessary. While utilitarian approaches could be considered,⁷⁸ there is presently no societal consensus concerning which values should be prioritized; consequently the adoption of any one approach by a military physician or a military institution would be highly arbitrary.⁷⁹

If random selection, or some other method of choosing between patients is ultimately undertaken, the question then arises whether or not caregivers should inform patients with HIV why they were denied treatment. In Great Britain some physicians reportedly neglect to tell a patient that he could benefit from dialysis if such treatment is not readily available.⁸⁰ Informing patients in such cases would undoubtedly be exceedingly painful, but informing them in spite of this pain would respect the patient's dignity and might also enhance the possibility that they or persons acting on their behalf might be able to obtain the resources that are lacking.

When resources can be provided, most patients with HIV-related illness seem to benefit from having the opportunity to help plan their treatment. In one study of homosexual AIDS patients, for example, an overwhelming majority of those surveyed wanted to discuss with their physicians what they would want done if they became incompetent, even though they found these discussions difficult at the time.⁸¹ In general, these discussions apparently helped patients feel more in control, and helped some better cope with their illness.⁸²

When careproviders should introduce the question of advance directives is

77. If, on the other hand, patients with HIV were being discriminated against, or these patients perceived that the lack of resources was due to discrimination, informing them would diminish their trust.

78. Childress, *Who Shall Live When Not All Can Live*, 53 *SOUNDINGS* 339 (1970).

79. See Englehardt, *supra* note 73. These authors suggest that a group of patients who might be given lower priority than others are those who could not care for themselves. For a discussion of the application of such an approach to dialysis, see Rescher, *The Allocation of Exotic Medical Life Saving Therapy*, 79 *ETHICS* 173 (1969).

80. Schwartz, *Why Britain Can't Afford Informed Consent*, 15 *HASTINGS CENTER REP.* 19 (Aug. 1985).

81. Steinbrook & Lo, *supra* note 66.

82. Presentation of Mr. Temoshok at the APA Annual Meeting, entitled *A Longitudinal Psychosocial Study of AIDS and AIDS-Related Complex* (May 13, 1986).

presently unclear. At one hospital, this discussion is initiated within hours of the patient's admission. Some patients report, however, that they would prefer discussing this question when they become outpatients; and others report that they would prefer delaying such discussions until after they have come to know their physician better.⁸³ Discussing advance directives is also difficult for careproviders.⁸⁴ AIDS patients, like many with terminal illness, may tend to overestimate their chances of survival.⁸⁵ Consequently, some patients may feel that caregivers who raise such questions deny them hope.⁸⁶ In any case, the decision whether to die an earlier death by withholding treatment or undergo greater pain by receiving treatment is agonizing.⁸⁷ It is in these instances, however, that a patient's personal preference is most important;⁸⁸ the patient alone can choose what is for him the "least worst death."⁸⁹

When caregivers initiate this discussion they should determine what it is that their patients want. Patients may, for instance, state that they want maximum treatment, but in actuality only want to be kept free from suffering.⁹⁰ If the careprovider is not free to be the patient's advocate, he may have greater difficulty pursuing the patient's interests dispassionately. He might be more likely, for example, to persuade the patient that what he really wants is to be free of suffering when the patient's genuine wish is to maximize life.

Careproviders should probably initiate such discussions with all patients who have advanced stages of HIV-related illness, which under the Walter Reed staging classification⁹¹ would include patients in stages WR 3 and above. In general, caregivers should initiate patient discussions early in the course of the illness since patients with HIV-related illness may have even more anxiety and depression than patients with AIDS, presumably because they feel more uncertain concerning their future.⁹² Discussion should be initiated in outpatient settings but only after physicians have had an opportunity to get to know their patient.

83. Steinbrook & Lo, *supra* note 66.

84. Steinbrook, *supra* note 6.

85. *Id.*

86. Jonsen, *supra* note 37.

87. *Id.*

88. Kassirer, *The Toss-up*, 305 *NEW ENG. J. MED.* 1467 (1981).

89. Battin, *The Least Worst Death*, 13 *HASTINGS CENTER REP.* 13 (Apr. 1983).

90. Steinbrook, *supra* note 6.

91. Redfield, Wright & Tramont, *The Walter Reed Staging Classification for HTLV-III/LAV Infection*, 314 *NEW ENG. J. MED.* 131, 132 (1986). Patients in stages WR 3 and above are extremely likely to subsequently develop AIDS.

92. Presentation of Susan Tross at the APA Annual Meeting, entitled *Psychological Impact of AIDS Spectrum Disorders* (May 13, 1986).

When the extent of a serviceperson's illness is not ascertained until he is at a medical center for evaluation and staging, discussion of the patient's advance directives might best be delayed until he can resume an outpatient status. Military careproviders should know at the time what is possible in the jurisdiction in which they treat patients and share these options with them. When, for example, homosexual AIDS patients want sexual partners to make choices for them if they become incompetent, this may be accomplished by means of a Durable Power of Attorney⁹³ or Living Will.⁹⁴ Military careproviders can seek legal assistance to determine whether these or other options are available in the jurisdiction in which they practice. In civilian settings patients sometimes encounter difficulty implementing this desire because family or next of kin are customary surrogate decision-makers. In the military patients who feel reluctant to divulge homosexual conduct will particularly need encouragement to appoint a sexual partner the proxy decision-maker. Even if the military physician believes that he must report whatever the patient discloses regarding prior sexual activity, the patient could still be informed that they can pursue their desire to appoint a sexual partner as a surrogate without explicitly divulging prior homosexual activity.

Military policy may not permit persons other than family or next-of-kin to participate in decisions regarding incompetent patients.⁹⁵ In these instances, caregivers might help a patient who wishes to appoint a sexual partner surrogate decision-maker to bring his request before a civil court. There have been cases in which military policy that prevented a patient from having certain decisions implemented have been overruled by a civil court. An exemplary case is that of *Tune v. Walter Reed Medical Hospital*.⁹⁶ In the *Tune* case, Martha Tune, a seventy-one year old patient who was initially denied her request to discontinue her artificial respiratory support because of an

93. Steinbrook, *supra* note 6. See also Steinbrook & Lo, *Decision Making for Incompetent Patients by Designated Proxy*, 310 NEW ENG. J. MED. 1598 (1984).

94. Bryan, *How Dignified a Death? — Living Wills*, 31 MED. TRIAL TECH. Q. 209 (1984).

95. Do-Not-Resuscitate or "No-Code" Orders, Update AR 40-3 (Feb. 15, 1985) [hereinafter DNR]. Chapter 19 (19.7d) states, "After assessment of the benefits [for or against resuscitation] there may be agreement between the attending physician and the patient's NOK [next-of-kin] or legal guardian. If so, . . . a DNR order will be entered on the patient's medical record."

Withdrawal of Life Support, DASG-PSQ HQDA LTR 40-85, Reference AR 40-3, [hereinafter Withdrawal of Life Support]. Section forty-six states "[regarding withdrawal of life-sustaining treatment] when a patient is incompetent, a decision based on the patient's best interest should be rendered after consultation with the patient's guardian or NOK and the attending physician."

96. 602 F. Supp. 1452 (D.D.C. 1985).

existing military policy, won her case on appeal to a civilian court.⁹⁷

Military caregivers might also take the initiative in asking AIDS patients, in later stages of their illness, whether or not they wish to make a will or funeral arrangements. The latter option is especially important since some funeral homes will not accept or embalm AIDS patients or even give them funerals with open caskets.⁹⁸ Patients with HIV-related illness in military hospitals again could be particularly reluctant to make a will and give belongings to a homosexual partner if they feared the potential ramification of their disclosure. Ideally, patients with HIV-related illness whose families are not near by and who want a homosexual partner to discuss funeral arrangements with their physician should have the opportunity to do so. Again, caregivers could inform patients who are confronted with this dilemma that they can carry out these plans without having to reveal their prior homosexual conduct. If patients are delirious and their family is absent, friends or homosexual partners may be exceptionally helpful in assisting these patients to maintain control. If a patient's psychiatric status is extremely impaired, friends or homosexual partners may also help in arranging for institutional care.

In general, military careproviders should attempt to show AIDS patients and their sexual partners as much respect and care as they would any patient's family or spouse. If, for instance, a patient with terminal cancer asks that treatment be withheld or that a do-not-resuscitate order be written, and that his family not be informed of these requests, a careprovider might, on ethical grounds, choose not to comply. The physician may believe that if a patient keeps this information from his family it will create emotional distance between them and leave them feeling painfully isolated from one another.⁹⁹ An AIDS patient might make a similar request — that his sexual

97. *Id.* Ms. Tune had terminal adenocarcinoma of the pericardium. She seemed clearly competent when informed that if she were removed from her respirator, she would "very likely quickly die." *Id.* at 1453. She acknowledged that she had "no reservations at all." *Id.* The physicians at Walter Reed were sympathetic to her desire to die a natural death, but were unable to comply with her wishes because of an existing Army policy which prohibited removal of a respirator.

98. *E.g.*, Okie, *AIDS Victim Fights for Rights of Others*, Wash. Post, June 15, 1986, at A1, col. 4. (Don Miller surveyed 98 funeral homes in the Baltimore area; 56 indicated some form of discrimination such as refusing to handle AIDS victims' bodies to embalm them or refusing to provide services with open caskets).

Funeral directors are not the only persons refusing to care for or limit their interactions with the bodies of AIDS patients. In the Spring of 1986, for example, Dr. Andrew McBride, the D.C. Public Health Commissioner, personally removed the body of a deceased AIDS patient after city crews refused to move him. Engel, *supra* note 60.

99. In either case, the military physician choosing not to comply with patients' requests would be violating explicit Army policies which instruct careproviders to respect such patients' confidentiality. *E.g.*, "[W]here the competent patient requests that family members not be

partner not be informed. The caregiver in this situation, on the basis of the same concern, might tell the patient that while he will not disclose his condition, he will inform the partner that he (the physician) has a policy of keeping such information confidential.

If a caregiver tells a patient's partner of his policy, this could, of course, alert the partner to the nature of the patient's request. As a result, the patient and his partner, like the patient and his family, might not become isolated from each other. While this approach is paternalistic and coercive, the careprovider could still show care for the patient by explaining his rationale and indicating that he is willing to join the patient and his partner if and when they discuss the patient's wishes.¹⁰⁰

III. DECIDING WHETHER OR NOT TO INTERVENE TO PROTECT THIRD PARTIES FROM ACQUIRING INFECTIONS FROM PATIENTS WITH HIV

When a patient with HIV-related illness is not willing to inform his spouse or sex partner that he has this disease, careproviders may want to inform the partner themselves but may be hesitant to do so from a fear that the patient might sue them. Ethically, there are several arguments which support a caregiver's decision to inform a patient's partner in this situation, even when the patient is asymptomatic. The partner might already be infected, but he could avoid repeated exposure,¹⁰¹ exceptional stress,¹⁰² and exposing subsequent sexual partners.¹⁰³ A woman, for example, could avoid getting pregnant¹⁰⁴ or if pregnant, perhaps choose to get an abortion.

involved in or informed of his or her decision, the patient's decision and request for confidentiality will be documented in the medical record." DNR, *supra* note 95, at (19.6.d); and a competent, alert patient might elect not to inform family members of his decision [to withhold or withdraw life-sustaining treatment] or seek their concurrence. Such decision will be documented in the medical record. Withdrawal of Life Support, *supra* note 95, at (19.a).

100. For a discussion of the ethical aspects of this situation see Howe, When Physicians Impose Values on Patients/An Ethics Consultant's Responsibilities, in *Ethics Consultation in Health Care* (J.C. Fletcher ed.) (unpublished manuscript) [hereinafter *Ethics Consultation in Health Care*]; see also Presentation of Edmund Howe at the APA Annual Meeting, entitled *Emerging Dilemmas in Consultation Liaison Psychiatry* (May 13, 1986) [hereinafter *Howe Presentation*].

101. Human immunodeficiency virus appears less likely to be transmitted by a single contact than other sexually transmitted infections. The likelihood of transmission to a sexual partner after a single heterosexual exposure is only 1%. However, the likelihood of obtaining HIV increases to between 10% and 50% when the heterosexual relations occur on a frequent basis. Peterman & Curran, *Sexual Transmission of Human Immunodeficiency Virus*, 256 J. A.M.A. 2222, 2224 (1986).

102. *Id.*

103. *Id.* A partner could also seek earlier treatment for signs of opportunistic infection.

104. *Id.* at 2224.

A careprovider's potential legal liability may depend on whether the patient has AIDS or a less severe HIV-related illness.¹⁰⁵ If a patient has AIDS, a caregiver who informs the partner is less likely to be civilly liable.¹⁰⁶ Such an act would probably be construed as preventing the transmission of a highly communicable disease or perhaps, preventing the commission of a crime. In nearly half the states, knowing transmission of a communicable disease to other persons is a crime,¹⁰⁷ and some AIDS patients have been specifically told that if they engage in unsafe sexual practice they will be criminally prosecuted.¹⁰⁸

All states presently require physicians to report cases of AIDS. Public health officials could probably attempt to reach AIDS patients' sexual contacts now, but have not because the usual justification, preventing the spread of illness through curative treatment, does not exist for AIDS as it does for many other HIV-related illness.¹⁰⁹ The major preventative measure is education.¹¹⁰ The law generally grants patients greater protection when their HIV-related illness is less severe than AIDS. Physicians are not required to report patients with HIV-related illness less severe than AIDS except in Colorado, in which the board of health requires doctors and laboratories to report the names and address of persons testing positively for HIV.¹¹¹ A California statute, on the other hand, forbids disclosing the results of HIV antibody testing without written authority of the person tested.¹¹² Accord-

105. Mills, *Legal Aspects of Infectious Disease Practice: Typhoid Mary and Other Hazards*, 111 MED. TIMES 83 (1983).

Mills acknowledges that "[i]mproper disclosure of the illness may [result in the patient with AIDS making] a civil claim for damages against the person making the wrongful disclosure," and then states, "nevertheless, such disclosure is proper to those unequivocally at risk." Mills, Crofsy & Mills, *Special Report, The Acquired Immunodeficiency Syndrome*, 314 NEW ENG. J. MED. 931, 932 (1986) [hereinafter Mills & Crofsy]. They go on to add that "[i]n cases of AIDS, disclosures of a similar narrow scope — to the patient's spouse or lover, for example — would not be unlawful on the part of physicians or public health officers." *Id.* at 932. They recommend further that in California, which has passed a statute forbidding disclosure of results of HIV testing, when physicians encounter asymptomatic patients positive for HIV, physicians seek the assistance of public health authorities but if this fails, inform the patient's partners. *But see* Peterman & Curran, *supra* note 101, at 2224, where the authors stated that "steady partners may be the only ones whose risk of infection is high enough to justify the efforts of active contact tracing."

106. Mills & Crofsy, *supra* note 105.

107. Gorney, *The New Laws of Love/The Courts, Sexually Contracted Diseases and a Partner's Right to Know*, Wash. Post, Nov. 14, 1985, at C1, col. 1.

108. Freedman, *Wrong Without Remedy*, 72 A.B.A. J. 36 (1986).

109. *See generally* Mills & Crofsy, *supra* note 105.

110. *Id.* *See also* Presentation of David Ostrow at the APA Annual Meeting, entitled "Psychological Reactions to HTLV-III Exposure" (May 13, 1986).

111. Mills & Crofsy, *supra* note 105, at 934.

112. *Id.* at 934.

ingly, even those who recommend that careproviders inform partners of patients who have less severe illnesses do so more tentatively.¹¹³

Whether careproviders begin to routinely inform the partners of patients suffering from AIDS or HIV-related illness in the future may depend on whether or not courts allow victims who acquire AIDS to sue physicians for non-disclosure. Under *Tarasoff v. Regents of University of California*¹¹⁴ and its progeny,¹¹⁵ psychiatrists must take measures to protect third parties whom they believe their patients intend to harm; this may include warning potential victims. Whether the courts would consider AIDS patients who refuse to inform their partners analagous to mental patients who report violent fantasies has yet to be determined.¹¹⁶ One suit has already been brought by the former sexual partner of the late Rock Hudson against two physicians who were treating Hudson for "conspiring" to keep the knowledge of Hudson's illness from him.¹¹⁷ The outcome of this case, and the question of

113. Okie, *supra* note 98.

114. 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

115. See, e.g., Small, *Psychotherapists' Duty to Warn: Ten Years after Tarasoff*, 15 GOLDEN GATE U.L. REV. 271 (1985); Stone, *Vermont Adopts Tarasoff a Real Barn-burner*, 143 AM. J. PSYCHIATRY 352 (1986).

However, the U.S. District Court for the Middle District of North Carolina has just established a "heightened standard of culpability" for psychotherapists believing that a patient may be dangerous. In this case, the patient threatened not only a third party, but the therapist himself. *Currie v. United States*, 55 U.S.L.W. 2211 (U.S. Oct. 21, 1986)(No. 85-0629).

116. Numerous distinctions have potential legal relevance. For example, in many cases partners may not be harmed by acquiring HIV because they already have become infected. But continued exposure may, on the other hand, still increase a partner's risk. See Peterman & Curran, *supra* note 101. The conflict in these instances might then be less between respecting the patient's confidentiality and protecting the identified partner from harm but more between respecting the patient's confidentiality and providing the partner certain benefits. See *supra* p. 26. That is, harm to the partner would perhaps be offset, but not avoided.

Furthermore, the risk of harm could be reduced by less drastic measures than warning the partner. The patient with HIV could be counselled, for example, to use condoms. Even if he followed this advice, however, the risk to the partner could be substantial. Pregnancy occurs, for instance, even when condoms are used and the rates of HIV transmission may be comparable. Cf. Voeller, *Has the Condom Any Proven Value in Preventing the Transmission of Sexually Transmitted Viral Disease — For Example, Acquired Immune Deficiency Syndrome?*, 291 BRIT. MED. J. 1196 (1985). Finally, when condoms are used during anal sex, they are more likely to break. Cf. Barton, *HTLV-III Antibody in Prostitutes*, 2 THE LANCET 1424 (1985).

117. Freedman, *supra* note 108; Gorney, *supra* note 107. Greenfield reports another case which has even more far reaching implications. A gynecologist knew that the fiance of one of his patients was a homosexual because the fiance was the son of another patient who informed him in confidence of this fact. He also knew that the fiance had lived in San Francisco, and therefore had a high probability of having HIV infection.

He chose not to tell his patient. Later, after this patient discovered her husband was gay and probably had HIV and that her gynecologist hadn't told her, she expressed rage at him for not informing her. Greenfield, *A Gynecological Dilemma Involving AIDS*, 2 CLINICAL PRAC. SEXUALITY 30 (1985).

whether or not it harbingers similar suits in the future, has yet to be determined.

The related legal right of victims to sue sexual partners for keeping information from them has been granted only in the past few years. As recently as 1980 no such right had been recognized. This is exemplified by the case of *Steven K. v. Roni L.*,¹¹⁸ a decision in which the California Court of Appeals rejected a man's suit against his female sexual partner who had deceived him into fathering her child by alleging that she was using birth control. Beginning in 1983, however, courts began to recognize that victims had a right to sue their sexual partners for withholding information. This shift in judicial policy is clearly demonstrated by the fact that the same court which decided *Steven K.* three years earlier held in *Barbara A. v. John G.*¹¹⁹ that a woman who suffered an ectopic pregnancy had a right to sue her lover who told her that he was sterile. This right to "be informed" has been expanded beyond the context of the *Barbara A.* case to include infectious diseases.¹²⁰

The difficulty in allowing these suits is comparable to permitting patients to sue partners for failing to disclose that they have HIV. There may be no means to determine whether such communication actually took place unless a tape recorder is used. Consequently, a defendant who informed his partner of a disease may have no means of proving it. Therefore, in many cases the outcomes of such suits could be highly arbitrary.¹²¹

118. 105 Cal. App. 3d 640, 164 Cal. Rptr. 618 (1980). In this case, the California Court of Appeals threw out the plaintiff's claim that he had suffered financial and mental injury, stating: "[I]t is nothing more than asking the court to supervise the promises made between two consenting adults as to the circumstances of their private sexual conduct. To do so would encourage unwarranted governmental intrusion into matters affecting the individual's right to privacy." *Id.* at 644-45, 164 Cal. Rptr. at 620. See also Gorney, *supra* note 107; Spake, *Trial and Eros/Sex in the Age of Litigation*, 10 MOTHER JONES 25 (1985).

119. 145 Cal. App. 3d 369, 193 Cal. Rptr. 422 (1983). In this case, the plaintiff argued successfully that women suffer greater risk of injury than men when having sex because they can get pregnant. For discussion of the plaintiff's situation before and after this case, see Spake, *supra* note 118.

120. See *Kathleen K. v. Robert B.*, 150 Cal. App. 3d 992, 198 Cal. Rptr. 273 (1984). The California Court of Appeals for the Second District stated in a footnote that "[i]f a person knowingly has genital herpes, AIDS, or some other contagious disease, a limited representation that he or she does not have a venereal disease is no defense. . . ." *Id.* at 996 n.3, 198 Cal. Rptr. at 276 n.3. See generally Annotation, *Tort Liability for Infliction of Venereal Disease*, 40 A.L.R. 4th 1089 (1985).

121. Analogous problems arise concerning whether or not rape occurred when no physical evidence exists, particularly when the sexual partners have previously been lovers or are married. See *State v. Gonyaw*, 146 Vt. 559, 507 A.2d 944 (1985), and discussion in Purdy, *Rape: Adding Insult to Injury*, 11 VT. L. REV. 364 (1986).

It is not hard to imagine that suits for failing to warn a sexual partner about a contagious disease could become a second arena in which the pros and cons of the rape shield law are debated. If a plaintiff who had numerous sexual partners claimed that he had acquired HIV

Even in the absence of legal precedents regarding liability, caregivers could use their fear of lawsuits to pressure patients into informing partners. One civilian careprovider, for instance, told his patient that unless he informed his partner, he (the careprovider) would do so himself, because his lawyer had advised him that he would be better off being sued by the patient for violating his confidentiality than by the patient's sexual partner if she acquired AIDS.¹²² Ethically, this approach would benefit patients' partners and, in addition, might help some patients overcome their denial of the potential lethality of HIV-related illness and feel pride in taking some responsibility for their illness.¹²³

Military careproviders confronting this dilemma might feel more inclined than their civilian counterparts to contact a patient's partner over a patient's objection for several reasons. First, it is unlikely that military careproviders can be sued in their individual capacity and secondly, military physicians have traditionally assumed preventive medical roles in which their obligations to the unit have superceded conflicting obligations to individual patients.¹²⁴

Military caregivers' responsibilities have also customarily extended to a serviceperson's family.¹²⁵ If, for example, a military physician's patient is not adequately providing for his family's needs, the doctor might inform the

from a particular partner, that partner, if sued for failing to disclose his infection, would want to raise that fact as a possible defense. This defense being that some partner other than the defendant actually infected the plaintiff. A key consideration in this analysis would be the probative value of the evidence in question weighed against its "private character." *See, e.g., State v. Patnaude*, 140 Vt. 361, 368, 438 A.2d 402, 409 (1981).

Donald Carlson, a San Francisco, California lawyer, in speaking of the possible claims which could be brought by one sexual partner against another stated: "What about I'll call you next week?, or I'll love you next week? The other person could say, Well, I relied upon that, I just don't have one-night stands." Spake, *supra* note 118, at 29.

122. *See generally Ethics Consultation in Health Care*, *supra* note 100; Howe Presentation, *supra* note 100. If the victim could prove that had he been warned, he would not have acquired HIV, this legal advice might be sound.

123. Perry & Markowitz, *supra* note 16, at 1005. In most cases, patients who knew that they were keeping information that they had HIV from a partner would, at some level, consciously or unconsciously, feel guilty unless they had strong antisocial, sadistic, or psychotic traits. In many cases, therefore, the physician may be successful in persuading the patient to inform his partner. The physician can also offer to assist the patient and his partner to deal constructively with this information, but even if the partner severs the relationship, the patient may be better off than if he had to live with his guilt.

124. *See Ethical Issues*, *supra* note 1; Howe, *supra* note 1. An inconsistency might seem apparent between the military physician's overriding his patient's request to keep information regarding his refusing treatment or regarding a DNR order confidential, but not overriding his desire to keep his partner informed about his HIV related illness. The morally relevant distinction between these two situations is that in the former instances the patient himself will benefit and there is overwhelming professional consensus concerning this outcome.

125. *See* the anecdotal example given *supra* note 43.

serviceperson's commander. Institutionally, as well, the service has developed specific policies to take into account the needs of servicepersons' families. However, there is less institutional pressure on military physicians to intervene to protect civilians (and to do so goes beyond their customary practice) accordingly, they may be more reluctant to contact partners who are civilians.

Ethically, informing a patient's partner even when he is a civilian may be preferable over respecting the patient's confidentiality.¹²⁶ Nonetheless, there is no social consensus, widespread practice, or, with the exception of a few individuals' recommendations,¹²⁷ legal or scientific authority supporting a careprovider's decision to contact an AIDS patient's sexual partners. Military caregivers taking this approach might therefore be acting primarily because they had the power to do so and, for this reason, should probably refrain from contacting an AIDS patient's sexual partner.¹²⁸

Clearly, there are some instances in which military physicians would be ethically justified in using their authority to inform others of the nature of the patient's illness — to support the military mission or prevent medical risk to an entire unit. In other instances, civilian or military careproviders might be justified in placing their views above those of their community when the community acts on the basis of ignorance, prejudice, or fear. The obvious example occurred during World War II when atrocities were per-

126. See Mills, *supra* note 105.

127. *Id.* As a second example, Dean Echenberg, a physician at the San Francisco Department of Health, recommends that heterosexual partners be contacted because they do not suspect that they are at risk and, therefore, are less likely to take the same precautions as members of high risk groups. Echenberg, *A New Strategy to Prevent the Spread of AIDS Among Heterosexuals*, 254 J. A.M.A. 2129 (1985). See also *Two Female "Swingers" Test Positive for AIDS Virus*, Wash. Post, Nov. 14, 1986, at A12, col. 1. (73% of 55 members of swingers groups recently indicated that if they had known they were at risk of acquiring HIV, they would have changed their sexual behavior).

128. The importance of innovative medical decisions being subjected to public scrutiny and debate prior to physicians implementing them is illustrated by a recent dilemma which arose concerning a fetus with anencephaly. The parents suggested that since the fetus would die soon after birth anyway, its organs might be transplanted to another infant needing them.

John Fletcher, an ethicist, had recently co-written an article in which he had argued in favor of such a procedure and, in fact, suggested that immediately after birth, as with adults who are brain dead, the fetus be cooled so that its organs could be best maintained for transplantation to others. Fletcher, *Primates and Anencephalics as Donors for Pediatric Organ Transplants*, in *Fetal Therapy* (in press). When this case arose and the parents requested this procedure, Dr. Fletcher was called in as an ethics consultant. He recommended that cooling not be considered despite the fact that this would heighten the likelihood of benefit to transplant recipients, because this procedure, and cooling especially, had not been widely considered and discussed by the community. (In a few cases known to Dr. Fletcher, in fact, this same possibility had arisen and was opposed).

mitted in Germany.¹²⁹ When, however, military physicians override a patient's objection and inform the partner that the patient has HIV, there is no evidence that factors such as ignorance, prejudice, or fear are present.¹³⁰ Rather, society appears to be giving priority to protecting a patient's privacy over other interests.

Military and civilian careproviders may also want to intervene and hospitalize patients with HIV when they believe they are promiscuous.¹³¹ Some believe, for example, that they should commit such patients to psychiatric wards on the grounds that they are dangerous to others. Obviously, in this case, physicians overriding such patients' interests in this manner might benefit third parties more profoundly by preventing potential victims from ini-

129. *E.g.*, Editorial, *The Brutalities of Nazi Physicians*, 132 J. A.M.A. 714 (1946) in which it is stated that "Perhaps the most serious of all is the failure of German medical organizations and societies to express in any manner their disapproval."

For a description of the process by which German physicians came to collude in these acts see Lifton, *German Doctors and the Final Solution*, N.Y. Times, Sept. 21, 1986, § 6 (Magazine), at 64, col. 1. The instances in which military physicians might have a moral obligation to oppose military authority would generally, however, be rare. For a discussion of the special obligation military physicians might have when conducting biological research see Rosebury, *Medical Ethics of Biological Warfare*, 6 PERSP. BIOLOGICAL MED. 512 (1963).

Other situations could, however, occur. During World War II, for example, Stelling stated:

If pressure from high ranking field officers can be applied to Army Generals and Evacuation Hospitals as well as medical officers in general to such an extent [regarding] their prerogative of protecting the health of the fighting men and guaranteeing that men unfit for combat are kept out of combat, then those hospitals as well as all medical officers are robbed of sacred duties and rights to which their professional knowledge and service entitles them.

Hopkins, *The Marauders and the Microbes*, in CRISIS FLEETING 379-80 (J.H. Stone ed. 1969). See generally Hare, R.M., *Can I be Blamed for Obeying Orders*, in WAR, MORALITY AND THE MILITARY PROFESSION (1979).

130. Some might assert that the strong degree to which society protects the confidentiality of patients with HIV has resulted from pressure put forth by the gay community. The inclusion of heterosexual patients in high risk categories and most recently the FDA's extending advice and protection to prostitutes and heterosexuals engaging prostitutes' services tends to disprove this allegation. Russell, *Prostitutes, Clients on List of Risky Blood Donors*, Wash. Post, Nov. 4, 1986, at A10, col. 1.

If, on the other hand, the present societal policies were the result of mass ignorance, or fear, the question then could rise whether military physicians would be justified in doing what was ethically preferable, because they have the power to do so. On utilitarian grounds, especially, it would seem that they would. For a discussion of the related ethical question of whether a person can act ethically in an unethical context see Callahan, *The Psychiatrist as Double Agent*, 4 HASTINGS CENTER REP. 12 (Feb. 1974). Callahan argues in his piece that one can.

131. For case examples of such patients see Flavin, *supra* note 59, at 1440, 1441; Frances, *Contracting AIDS as a Means of Committing Suicide*, 142 AM. J. PSYCHIATRY 656 (1985).

In another case of which this author is aware, a serviceperson with HIV who felt angry at the military wanted to take out his anger by having sex with other servicepersons to transmit HIV to as many of them as possible.

tially becoming infected.¹³² Professor Richard F. Duncan expressed concern about the full implications of such an impulse:

Should we exile all the carriers to an island or other remote region the way lepers were once treated? Should we quarantine them for life in hospitals or sanitariums? Should we require them to wear conspicuous scarlet A's and warning bells in order to facilitate their avoidance by non-infected persons?¹³³

These measures may not be as implausible as one might imagine. Only a decade ago, the United States Court of Appeals for the Tenth Circuit in *Reynolds v. McNichols*,¹³⁴ upheld an ordinance in Denver, Colorado which allowed authorities to pick up, detain (for up to forty-eight hours), and test persons suspected of having venereal disease; even though they had never been convicted of any offense. More recently in Florida, a prostitute with AIDS was ordered to remain within 200 feet of her home; her compliance with this order being monitored electronically.¹³⁵ Likewise, just recently an "anti-AIDS" proposal was placed on a California ballot, which if it had passed, would have allowed quarantine of AIDS victims and a ban on their employment in restaurants and schools.¹³⁶

132. Some have raised the argument that a small portion of homosexuals, particularly teenagers, have grown up believing that having sex with multiple partners is a safe activity, and consequently, have never acquired adequate abilities to control their sexual desires or to resist others' requests for sex. Since, the argument goes on, these individuals are exceptionally vulnerable and are vulnerable through no fault of their own, this provides a compelling rationale for incarcerating or in some other way preventing promiscuous individuals with HIV from seducing and infecting these individuals.

This assertion is compatible though far from proven by anecdotal reports that some homosexuals have engaged in anonymous sex on a regular basis. The Center for Disease Control ("CDC") reports, for example, that many AIDS victims have had sexual relations with more than 1,000 different partners. Morgenthau, *supra* note 61, at 30. One 36 year old man reports a sexual encounter a day for the past 19 years. *Id.* at 39. Paul Paroski, M.D., past president of the National Gay Health Education Foundation, has also reported more generally that homosexual men traditionally use sex to meet a variety of needs and have not yet found "suitable substitutes" for particular psychological components. Hausmann, *supra* note 22, at 9.

Even if this conjecture were true, one argument opposing this rationale is that "victims" of patients with HIV freely choose to have sexual contact and, at least at present, information concerning the risk of HIV has been widely publicized.

133. Duncan, *Public Policy and the AIDS Epidemic*, 2 J. CONTEMP. HEALTH L. & POL'Y 169 (1986).

134. 488 F.2d 1378 (10th Cir. 1973). See also Curran, *Venereal Disease Detection and Treatment: Prostitution and Civil Rights*, 65 AM. J. PUB. HEALTH 180 (1975).

135. This sanction may have resulted, at least in part, because this person's jailers feared "catching HIV." "I wanted her off the streets, for the protection of the public, but on the other hand, I knew the jail employees were concerned." Garrison, *Hooker with AIDS Confined*, Daily News, Sept. 28, 1985, at 5, col. 1.

136. Schwartz, *AIDS Agreement*, Wash. Post, July 16, 1986, at A6, col. 2. Ron Rose, a Hollywood office administrator and AIDS patient states: "It [the referendum being passed] is definitely going to drive the disease underground . . . if people know their names will be re-

Legally, protective measures of this nature are potentially permissible if the means of control are rationally related to the end sought,¹³⁷ and narrowly tailored to achieve that end.¹³⁸ The cases establishing this criteria have involved such diseases as typhoid fever¹³⁹ and the bubonic plague;¹⁴⁰ illnesses transmitted in an entirely different fashion from HIV.¹⁴¹ For this reason, courts' reasoning regarding HIV might not be analagous. Alternatively, attempts could be made to incarcerate patients with HIV who are promiscuous on the grounds that they are dangerous to others. Unless it could be proven that the patient with HIV is mentally ill, this could represent unlawful preventative detention.¹⁴² If, on the other hand, patients with

ported, they will not go in for treatment." Yet Colorado has required reporting of AIDS patients for several months with apparently no signs that victims have gone underground. See also Mills & Crofey, *supra* note 105, at 934. If so, victims may consider the importance of discovering whether or not they have HIV infection and of obtaining treatment so overriding that the fear of being reported does not deter them. California's Proposition 64, unlike the Colorado law, would have restricted patients with HIV infection from certain jobs such as working in restaurants or schools. Matthews, *Call to Quarantine AIDS Virus Trails in California*, Wash. Post, Oct. 26, 1986, at A9, col. 2. The referendum failed by better than 2 to 1. Morganthau, *supra* note 61, at 32.

A telephone poll conducted by Gallup, Inc. of 756 adults on Nov. 5 and 6, 1986, showed however that 54% wanted to require people with active cases of AIDS to enter quarantine at a public health facility where they can be isolated from the public and treated. *Growing Concern, Greater Precautions*, NEWSWEEK, Nov. 24, 1986, at 32-33.

137. *Camara v. Municipal Court*, 387 U.S. 523 (1967).

138. *Barmore v. Robertson*, 302 Ill. 422, 134 N.E. 815 (1922); *Jew Ho v. Williamson*, 103 F. 10 (C.C.N.D. Cal. 1900).

139. *Barmore*, 134 N.E. 815.

140. *Jew Ho*, 103 F. 10.

141. Since HIV is apparently transmitted almost exclusively by sexual activity, contaminated syringes and transfusions of blood and blood products, other approaches, such as education are likely to be more effective than quarantine.

142. *Williamson v. United States*, 184 F.2d 280 (2d Cir. 1950). As Mr. Justice Jackson stated: "Imprisonment to protect society from predicted but unconsummated offenses is so unprecedented in this country and so fraught with danger of excesses and injustice that I am loath to resort to it, . . ." *Id.* at 282.

Preventive detention is impermissible in American criminal justice. It is claimed by some, however, that as a practical matter, it is regularly carried out when excessive bail is set. This position is exemplified by the following quote:

our hostility towards the notion of preventive detention . . . ought not blind us to the fact that the practice is indulged in by criminal courts every day through the often unfair and ineffective medium of excessive bail, without the candor that is needed to make it visible, controllable, and susceptible to appellate [sic] review and constitutional testing.

Note, *Preventive Detention Before Trial*, 79 HAR. L. REV. 1489, 1493 (1966)(quoting Freed, Preventing Pre-Trial Release — A Personal Reevaluation 4 (Oct. 14, 1965)(unpublished work)). But see *Schall v. Martin*, 467 U.S. 253 (1984) (which to a degree permitted preventive detention of juveniles). See also Mr. Justice Timber's dissent in *United States v. Melendez-Carrion*, 790 F.2d 984 (2d Cir. 1986) in which he stated that: "[T]he constitutional parameters set forth by the Supreme Court, the legislative history of the Bail Reform Act, and the proce-

HIV who wished to infect others were considered mentally ill, civil commitment might be possible. One court has, in fact, declared that even when potential victims are unknown, a physician has an obligation to prevent a patient whom he believes to be dangerous from harming others.¹⁴³ Furthermore, from a psychiatric perspective, the assertion that a patient with HIV who wants to infect others has an underlying mental illness is credible.¹⁴⁴

Again, military physicians who wish to protect potential victims by temporarily hospitalizing promiscuous patients with HIV might find it easier to do so than their civilian colleagues. Military physicians might, for example, be successful in persuading military psychiatrists to admit such patients. Or alternatively, any military physician could deny such patients weekend passes from a military hospital.

Military physicians might also find it easier to take these approaches because they have recommended to their commanders in other contexts that the freedom of servicepersons be limited for the unit's benefit. For instance, military physicians have suggested that commanders make areas in which servicepersons encounter prostitutes off limits, in order to control venereal disease. A classic example is that of General William Slim who dismissed three commanding officers during World War II for failing to impose preventative health measures on their troops.¹⁴⁵ (Customarily, commanders follow physicians' advice because of their obligation to protect their units health).

Once again, however, there is no specific legal precedent or social consen-

dural safeguards provided by the Act permit pretrial detention where a defendant poses a serious threat to the safety of the community." *Id.* at 1011.

Even if possible, commitment of promiscuous patients with HIV infection would most likely be transient and as a practical consideration, might worsen the problem in the long run by exacerbating such patient's, "acting out against others by infecting them." *E.g.*, "It is our belief that punitive and threatening measures against high risk groups are counterproductive, they drive individuals away from responsible behavior and make education almost impossible." NIH CONSENSUS REPORT, *supra* note 63, at 14. *See also supra* note 136.

143. *Lipari v. Sears Roebuck & Co.*, 497 F. Supp. 185 (D. Neb. 1980). The court emphasized in this case the foreseeability of the public being endangered. If the risk of transmission in spite of condoms is significant, as seems likely, this case might have increased relevance. Analogous rulings have not, however, been adopted in other jurisdictions.

144. The patient may, for example, be denying his illness due to panic. Accordingly, he might be hospitalized involuntarily as can other patients with violent or homicidal fantasies. *Cf. Perry & Markowitz, supra* note 16, at 1001.

145. W. SLIM, *DEFEAT INTO VICTORY* 180 (1956). General Slim, after taking command of the Fourteenth Army in 1943, recognized the importance of soldier's taking daily doses of the malaria suppressant Atabrine, and instituted surprise checks of every unit. If the overall results of blood tests was less than 95% positive for Atabrine, he sacked the commanding officer. After three commanding officers were sacked, General Slim accomplished his objective. *See Hopkins, supra* note 129, at 208.

sus to allow civilian or military careproviders to incarcerate promiscuous patients with HIV-related illness over their objection. The NIH panel previously mentioned has, in quite the opposite direction, recommended that criminal sanctions not be imposed on persons who give blood knowing that they have an HIV-related illness, despite the fact that these sanctions would be the sole means by which some blood recipients could be protected.¹⁴⁶ Clinically, a strong case might be made for committing these patients to psychiatric facilities. However, in the absence of civilian physicians having authority to take such action, the ethical grounds for military caregivers' taking such action would be suspect. For reasons essentially similar to those already given for military physicians' not informing the partners of patients with HIV, military physicians should refrain from hospitalizing these individuals against their will.

CONCLUSIONS

Military careproviders are in a better position than many of their civilian counterparts to treat the wide range of psychological and social needs of patients in the communities they serve. They can, for example, take preventive measures to protect the community. When, however, the military physician treats servicepersons who have acquired HIV through homosexual contact, they may have exceptional difficulty meeting this particular group's psychosocial needs, and these difficulties may be compounded when patients are reluctant to divulge their homosexual behavior in the military setting. Such patients may, for example, feel reluctant to issue advance directives, make a will, or even plan funeral arrangements which involve their sexual partners.

Until the recent congressional action, servicepersons with HIV who divulged homosexual conduct risked administrative discharge. Under the new policy, however, military careproviders should inform patients of the current policy and, possibly, of its implications on a patient's security clearance and the patient's sexual partner if identified by name. Furthermore, military physicians should consider telling servicepersons precisely what they would do with any information the patient's provide them regarding their homosexual conduct before it is divulged and, offering them the opportunity to discuss their concerns prior to deciding what they will divulge.

Caregivers offering patients the opportunity for such discussion could make this offer to all patients prior to taking a sexual history or offer it only to patients they suspect would disclose homosexual conduct. In the latter instance, a patient could reveal information prior to the caregiver's "warn-

146. NIH CONSENSUS REPORT, *supra* note 63; Squires, *supra* note 63.

ing” him. In this instance, there are substantial, if not compelling, reasons that a careprovider encountering this situation should keep this information to himself.

Military caregivers, in general, should consider taking several initiatives, each of which might help offset, to some degree, the extra burdens some patients encounter in the military, particularly those due to the patient’s reluctance to divulge homosexual behavior. These include discussing with patients who have advanced stages of HIV-related illness who, if anyone, they would want to make choices for them if they became incompetent and whether they would wish to make a will or funeral arrangements. If these plans involve sexual partners, caregivers should help and encourage patients to pursue these arrangements, but in ways which would not require that the patient explicitly acknowledge his prior homosexual conduct.

Since these tasks could best be carried out if military careproviders had unequivocal roles as advocates of HIV patients, military physicians should not attempt to make decisions themselves when their own patients’ best medical interests conflict. The optimal means of accomplishing this would be to defer such decisions to “neutral” parties, possibly physicians. Further, they should attempt to establish more formal mechanisms for delegating such decisions to persons other than the patient’s primary careproviders. Only then can military physicians remain advocates for their patients and thus, genuinely merit their trust.

Military careproviders may encounter patients with HIV who will not inform their sexual partners. In such a situation, it is suggested that the physician should not inform a patient’s sexual partner over the patient’s objection. Similarly, military careproviders may encounter situations in which they believe that a patient will engage in promiscuous sex, and thus, want to hold him in the hospital for at least a short time, against his will. Again, unless there is a compelling military reason for doing otherwise, the careprovider should probably refrain from informing the partners of patients with HIV-related illness. In both instances, caregivers should still do all they can to attempt to influence these patients to take responsibility for their illness, such as informing their partners about their illness and urging them to take precautions when having sexual relations.¹⁴⁷

Other important ethical issues involving patients with HIV have already and will continue to emerge. Among these are the conditions under which

147. One physician, known to this author, advises patients who insist on having sex without using condoms that they find partners who have also tested positive for HIV. This advice may be ethically questionable because it may put some who already have HIV at greater risk, but it might be effective in helping some patients with HIV limit their social contact with persons not infected.

military patients with HIV should serve as research subjects to provide, for example, epidemiological data. Servicepersons with HIV have already benefitted society by providing such data and, presumably, should continue to do so. The military screening program is the largest effort currently directed at identifying HIV-related illness in persons other than high-risk groups and it has already provided vital information regarding the virus' spread in the general community and the means of its transmission.¹⁴⁸ Consequently, society may, in at least a theoretical sense, owe these patients some compensatory benefit. This provides yet an additional reason that the military, on society's behalf,¹⁴⁹ might attempt to meet these patients' needs as optimally as possible.

148. See generally Engel, *supra* note 60; Russell, *supra* note 60; Norman, *supra* note 10.

149. "The Body of Law and regulations which defines the purpose and methods of organized military power ultimately is one with and indivisible from the moral and legal constitution of the society which supports it." G. BEST, HUMANITY IN WARFARE 23 (1980).

