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# AIDS: Legal Issues in Search of a Cure

Wendy A. Weber

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## NOTES

### AIDS: LEGAL ISSUES IN SEARCH OF A CURE

*Recognition of AIDS as a new disease has created new legal questions. This article focuses on the constitutional issues surrounding AIDS. Cases involving other communicable or infectious diseases have little precedential value as AIDS is unlike any other disease previously encountered. Advances in medicine, regarding knowledge about the spread and treatment of diseases, as well as the constitutional development of the personal right of privacy, demands a legal analysis that specifically deals with this deadly virus.*

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### INTRODUCTION

Acquired immunodeficiency syndrome (AIDS) is the greatest threat to public health in modern history. The number of AIDS

cases has continually risen since 1981 when AIDS was officially recognized as a new disease. At the current growth rate, AIDS will claim thousands of lives in the next fifteen years, severely crippling the stability and productivity of nations. The legal implications of this medical crisis are overwhelming. Medical uncertainty about the disease's cause, cure and communicable nature has created national hysteria.

There are several theories and statutes on which to base a cause of action for health control measures. This Note will focus on several constitutional issues which are likely to surround the disease AIDS.

## I. THE DISEASE: MEDICAL BACKGROUND AND UPDATE

To effectively understand the legal issues concerning this disease, knowledge relating to its medical background is required. The medical community has reached a consensus on many important aspects. A number of controversial questions, however, still remain. In their efforts to determine the cause of the syndrome, researchers have collected a large body of epidemiological, clinical and immunological data.

### A. Background and History

Acquired immunodeficiency syndrome (AIDS) is the name given to a complex of health problems first reported to the Centers for Disease Control (CDC) in mid-1981.<sup>1</sup> Although the CDC reported the first AIDS cases in 1981, infection occurred earlier due to the incubation period lag-time of four to five years or more.<sup>2</sup> AIDS is a

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1. See Centers for Disease Control [hereinafter CDC], *Kaposi's Sarcoma and Pneumocystis Pneumonia Among Homosexual Men—New York City and California*, 30 MORBIDITY & MORTALITY WEEKLY REP. [hereinafter MMWR] 305 (1981) [hereinafter *New York*]; CDC, *Pneumocystis Pneumonia—Los Angeles*, 30 MMWR 250 (1981); [hereinafter *Los Angeles*]; Masur, Michelis, Greene, Onorato, Vande, Stouwe, Holzman, Wormser, Brettman, Lange, Murray, & Cunningham-Rundles, *An Outbreak of Community-Acquired Pneumocystis Carinii Pneumonia*, 305 NEW ENG. J. MED. 1431 (1981) [hereinafter *Outbreak*]; see also J. SLAFF, & J. BRUBAKER, THE AIDS EPIDEMIC 111 (1985) [hereinafter SLAFF] (best estimates show the presence of AIDS virus or a virus related to AIDS infection in small numbers in central Africa in the early 1970s, at least ten years before the first U.S. cases were detected); Kanki, Kurth, Becker, Dreesman, McLane, & Essex, *Antibodies to Simian T-Lymphotropic Retrovirus Type III in African Green Monkeys and Recognition of HTLV-III Viral Proteins by AIDS and Related Sera*, 1 LANCET 1330 (1985) (researchers believe the disease infected humans from African green monkeys, perhaps as an evolutionary descendant of a virus that has existed in these monkeys for thousands of years.); Langone, *Special Report: AIDS*, 6 DISCOVER 28 (Dec. 1985).

2. See SLAFF, *supra* note 1, at 25.

The true average incubation period may be eight to ten years as studies are ex-

viral disease causing numerous health problems.<sup>3</sup> Persons afflicted suffer a loss of natural immunity against disease which leaves them vulnerable to a variety of rare infections and malignancies that would not otherwise be a threat. These diseases, called opportunistic infections, will eventually kill AIDS patients.<sup>4</sup>

tended. May & Anderson, *Transmission Dynamics of HIV Infection*, 326 NATURE 137, 138 (March 1987) [hereinafter *Dynamics*].

Review of autopsy reports, medical records, and tumor registries across the United States failed to identify any AIDS-like illness prior to 1978. Blood samples indicate the AIDS virus infection occurred in the United States by 1977 and spread geographically by 1980. See CDC Task Force on Kaposi's Sarcoma and Opportunistic Infections, *Epidemiologic Aspects of the Current Outbreak of Kaposi's Sarcoma and Opportunistic Infections*, 306 NEW ENG. J. MED. 248, 248-49 (1985) [hereinafter *Epidemiologic Aspects*]; Jaffe, Choi, Thomas, Haverkos, Auerbach, Guinan, Rogers, Spira, Darrow, Kramer, Friedman, Monroe, Friedman-Kien, Laubenstein, Marmor, Safai, Dritz, Crispi, Fannin, Orkwis, Kelter, Rushing, Thacker, & Curran, *National Case-Control Study of Kaposi's Sarcoma and Pneumocystis Pneumonia in Men: Part I, Epidemiologic Results*, 99 ANNALS INTERNAL MED. 145, 145 (1983) [hereinafter *Epidemiologic Results*].

The initial transmission probably occurred from green monkeys to man by bites, bestial sex, or slaughter for food and clothing. See SLAFF, *supra* note 1, at 112. From Africa, the virus made its way to the western hemisphere in the early 1970's to the country of Haiti. It appears AIDS cases began to appear in Haiti rapidly in 1980. Since a period of two years or more elapses between infection with the virus and the development of AIDS, it can be inferred the AIDS virus probably entered Haiti in 1976 or 1977. Jaffe, Darrow, Echenberg, O'Malley, Getchell, Kalyanaraman, Byers, Drennan, Braff, Curran, & Francis, *Acquired Immunodeficiency Syndrome in a Cohort of Homosexual Men*, 103 ANNALS INTERNAL MED. 210, 210 (1985).

There are two theories as to how the virus made its way from Africa. In one theory, many Haitians moved to Zaire during a cultural exchange in the 1960's and 1970's. Subsequently, they moved to North America and Europe, possibly carrying the virus with them. See generally Piot, Taelman, Minlangu, Mbendi, Ndangi, Kalambayi, Bridts, Quinn, Feinsod, Wobin, Mazebo, Stevens, Mitchell, & McCormick, *Acquired Immunodeficiency Syndrome in a Heterosexual Population in Zaire*, 2 LANCET 65 (1984) [hereinafter Piot]. The other theory postulates that Cuban soldiers fighting in Angola brought back the virus, and infected Haitian prostitutes. SLAFF, *supra* note 1, at 114.

3. See SLAFF, *supra* note 1, at 18; see also, Council on Scientific Affairs, *The Acquired Immunodeficiency Syndrome-Commentary*, 252 J. AM. MED. ASS'N [hereinafter J.A.M.A.] 2037, 2037 (1984) [hereinafter *Commentary*]. The CDC has defined AIDS as:

... a reliably diagnosed disease that is at least moderately indicative of an underlying cellular immunodeficiency in a person who has had no known cause of underlying cellular immunodeficiency or any other underlying reduced resistance reported to be associated with that disease.

*Commentary, supra*, at 2037.

4. Public Health Service, *The Public Health Service Response to AIDS*, 1985 AIDS INFORMATION BULL. (Nov.) [hereinafter AIDS INFORMATION BULL.].

Patients usually died within eighteen months of diagnosis. They suffered from a variety of physical symptoms including persistent fever, diarrhea, night sweats, dry cough, and mental deterioration. See *infra* note 27 and accompanying text. Symptomatic patients were ostracized by family, friends, and the medical community. Public fear heightened as word of the disease spread, because much about the disease was unknown. Confusion persisted in the medical community and the disease incorrectly became known as the "Gay Plague". SLAFF, *supra* note 1, at 117.

*Pneumocystis carinii* pneumonia (PCP), a pneumonia and Kaposi's sarcoma (KS), a cancer of the lining of the blood vessels, were the first such opportunistic infections/malignancies identified.<sup>5</sup> The victims of these diseases were previously healthy individuals who developed a syndrome of infection or neoplasm with no identifiable cause.<sup>6</sup> The sudden occurrence of PCP and KS in a healthy population spurred the CDC to begin an epidemiologic investigation. One common trait was that all were sexually active homosexual males.<sup>7</sup> As the number of cases increased, other populations at risk were identified. These populations included intravenous drug users, prostitutes, Haitian immigrants to the United States, and hemophilia patients.<sup>8</sup> These groups were believed to be infected before 1981.<sup>9</sup>

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5. There were 13 cases of Kaposi's Sarcoma (hereinafter KS), *Pneumocystis carinii* pneumonia (hereinafter PCP), or perianal herpes in homosexual men recorded in 1978-1979. See Hardy, Allen, Morgan, & Curran, *The Incidence Rate of Acquired Immunodeficiency Syndrome in Selected Populations*, 253 J.A.M.A. 215 (1985) [hereinafter Hardy].

6. Between October, 1980 and May, 1981, five previously healthy, young homosexual men were treated for PCP at three different hospitals in Los Angeles. See *Los Angeles*, *supra* note 1, at 250. This observation was striking because PCP previously occurred almost exclusively in immunosuppressed patients. *Outbreak*, *supra* note 1, at 1431.

During this same period, KS was diagnosed with increasing frequency in young men in New York City and California. See *New York*, *supra* note 1, at 305. By July 3, 1981, 26 cases of KS had been reported, all in young, homosexual men. Of these patients, seven had serious infections, including four who had PCP. Peterman, Drotman, & Curran, *Epidemiology of the Acquired Immunodeficiency Syndrome*, 7 EPIDEMIOLOGIC REV. 1,1 (1985) [hereinafter Peterman].

PCP is not a new disease, but one which has occurred almost exclusively in patients with disease-related iatrogenic immunodeficiency. Walzer, Perl, Drogstad, Rawson, & Schultz, *Pneumocystis Carinii Pneumonia in the United States*, 80 ANNALS INTERNAL MED. 83 (1974). KS has been recognized since 1972, but occurred primarily in older men of Mediterranean descent. Patients with immunodeficiencies or recipients of kidney transplants who received immunosuppressive therapy contract KS with much less frequency. Harwood, *Kaposi's Sarcoma in Recipients of Renal Transplant*, 67 AM. J. MED. 759 (1979)

7. See *Los Angeles*, *supra* note 1, at 250-52.

8. SLAFF, *supra* note 1, at 6; CDC, *Update on Acquired Immune Deficiency Syndrome (AIDS)-United States*, 31 MMWR 507 (1982). Urban male homosexuals made up more than 80% of the first 300 cases. SLAFF, *supra* note 1, at 114.

The first case in an intravenous drug user, not a male homosexual, appeared in 1980 and cases increased in 1981. Therefore, infection was spreading among IV drug users during 1979. *Id.* at 114-15.

For a discussion of other at-risk populations, see generally CDC, *Pneumocystis Carinii Pneumonia Among Persons with Hemophilia A*, 31 MMWR 365 (1982) [hereinafter *Hemophilia*]; Evatt, Gomperts, McDougal, & Ramsey, *Coincidental Appearance of LAV/HTLV-III Antibodies in Hemophiliacs and the Onset of the AIDS Epidemic*, 312 NEW ENG. J. MED. 483 (1985); Hardy, *supra* note 5, at 215-20.

9. Several well-defined population groups appear to be at an increased risk for acquiring AIDS. More than 90% of the reported cases have been among the following groups: 1) homosexual/bisexual males, 73%; 2) persons who inject illicit drugs,

When cases began to appear rapidly here and in Europe, early theories linked the virus to the lifestyle of the gay, male, urban community.<sup>10</sup> The spread of AIDS to hemophiliacs, intravenous drug users, Haitian immigrants and females, and through blood or blood products and contaminated IV needles destroyed the theory that this was a gay disease.<sup>11</sup> Even though these theories targeted gay men, sev-

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17% (12% of homosexual-bisexual males also inject drugs); 3) recipients of transfusions of contaminated blood or blood products, 2%; 4) persons with hemophilia or other blood clotting disorders, 1%; and 5) heterosexual partners of people in the other risk groups, 1%. *AIDS INFORMATION BULL.*, *supra* note 4, at 1. The remaining 6% includes Haitians and children born to infected mothers. *See id.*

Initially, Haitian immigrants made up four percent of the reported cases and were tested as a separate risk group. *See* D. ALTMAN, *AIDS IN THE MIND OF AMERICA* 71-73 (1986); Council on Scientific Affairs, *supra* note 3, at 2038. Haitians were first thought to possess some sort of inherent susceptibility to AIDS. Later, experts concluded the presence of HIV in Haitians was due to exposure of the agent, not a genetic deficiency. Haitians are no longer specifically identified by the CDC as a high risk group for HIV infection. SLAFF, *supra* note 1, at 118; WASH. REP. ON MEDICINE AND HEALTH/PERSPECTIVES, RESPONSES TO THE AIDS CRISIS Oct. 21, 1982 [hereinafter WASH. REP.]; Peterman, *supra* note 6, at 11.

Seventy percent of the infants and children with AIDS were born to a parent who had AIDS or who belonged to an identified risk group. Fifteen percent had received transfusions; five percent had hemophilia; and the remaining fifteen percent had no identified risk factor, or there was an incomplete epidemiologic investigation. Curran, Morgan, Hardy, Jaffe, Darrow, & Dowdle, *The Epidemiology of AIDS: Current Status and Future Prospects*, 229 *SCIENCE* 1352, 1352 (1985) [hereinafter *Current Status*].

The proportion of cases outside the identified risk groups has remained relatively stable. CDC, *Update: Acquired Immunodeficiency Syndrome (AIDS)-United States*, 33 *MMWR* 661, 662 (1984). The distribution of the cases in the United States suggests the AIDS pattern is similar to that of hepatitis B, so many of the guidelines for prevention of the spread of AIDS are based on the precautionary guidelines for that disease. Peterman, *supra* note 6, at 6.

10. SLAFF, *supra* note 1, at 117. Other theories included breakdown of the immune system due to excessive ultraviolet exposure in tanning salons. *Id.*

A second theory involved the use of inhalent drugs (i.e. amyl- or isobutyl nitrite) as a sexual stimulant by homosexual men. It was hypothesized that use of these drugs caused or contributed to immunosuppression. *See generally* Marx, *New Disease Baffles Medical Community*, 217 *SCIENCE* 618, 619 (1982); Mavligit, *Chronic Immune Stimulation by Sperm Alloantigens*, 251 *J.A.M.A.* 37 (1984); Shearer, *Allogenic Leukocytes as a Possible Factor in Induction of AIDS in Homosexual Men*, 308 *NEW ENG. J. MED.* 223 (1983).

A final theory focused on an infection due to a weakened immune system caused by exposure to multiple sexual partners' semen and the presence and repeated infections of other sexually transmitted diseases common in homosexuals that "burned out" the immune system. *See* SLAFF, *supra* note 1, at 117.

The problems with these hypotheses are that they cannot explain the following occurrences: (1) the sudden outbreak of AIDS; (2) the transmission by blood products to hemophiliacs or normal recipients; (3) the increased incidence to intravenous drug users, Haitians, infants or equatorial Africans; and, (4) the development of AIDS in many persons who have never used the drugs. *See* Council on Scientific Affairs, *supra* note 3, at 2039.

11. AIDS was viewed as an opportunistic infection-producing disease only in im-

eral hypotheses suggested additional predisposing factors must be present, either to facilitate infection with the AIDS agent or to produce clinical symptoms. Such factors include infectious agents or genetic predisposition.<sup>12</sup> In addition, host resistant factors and nutrition repeatedly have been shown to play a determining role in the outcome of many infectious diseases.<sup>13</sup>

Much of what is known about AIDS, including what is known about its history and presumed mechanisms is based on epidemiological data. Many epidemiologic parameters (i.e., risk factor categories, proportions of patients in each category, patient age, geographic distribution, etc.) have remained relatively unchanged since the discovery of the syndrome.

### B. Etiology

Since the initial description of AIDS, its etiology has been actively sought and frequently debated. In 1983, however, researchers identified the causative agent of AIDS. It is a retrovirus variously termed lymphadenopathy-associated virus (LAV), human T-lymphotropic virus type III (HTLV-III), or AIDS-related virus (ARV). In May of 1986, these three names were replaced by one label. A new retrovirus, called human immunodeficiency virus (HIV), had been iso-

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munocompromised persons. Persons with a normally functioning immune system did not acquire and were not at risk of acquiring the syndrome. A national case control study conducted by the CDC strongly associated a history of sexual contact with large numbers of male partners with the development of AIDS. Such a lifestyle results in exposure to semen and to a host of infectious agents. In this CDC study, male homosexuals with AIDS had a higher prevalence than case controls of antibodies to syphilis, hepatitis A, herpes virus, cytomegalovirus, and Epstein-Barr virus, and an increased history of exposure to non-A non-B hepatitis. See Levy & Ziegler, *Acquired Immunodeficiency Syndrome is an Opportunistic Infection and Kaposi's Sarcoma Results from Secondary Immune Stimulation*, 2 LANCET 78, 78 (1983); see also *Epidemiologic Aspects*, *supra* note 2, at 251.

This theory was disavowed for the following reasons: (1) AIDS had occurred in black Africans of high socioeconomic status with no history of homosexuality or drug use; (2) AIDS had not been reported in non-hemophiliac, non-heterosexual Asians, although some had been immunosuppressed; and (3) the transmission of AIDS has occurred in persons who were not immunosuppressed. Ellrodt, Palazzo, Le Bras Caquet, *AIDS Not an Opportunistic Infection*, 2 LANCET 680 (1983).

These findings may merely be indicative of a sexually active lifestyle rather than actual causation or predisposing factors for AIDS.

12. See CDC, *Pneumocystis carinii Pneumonia among Persons with Hemophilia A*, 31 MMWR 365, 367 (1982); Curran, Lawrence, Jaffe, Kaplan, Zyla, Chamberland, Weinstein, Lui, Schonberger, Spira, Alexander, Swinger, Ammann, Solomon, Auerbach, Mildvan, Stoneburner, Jason, Haverkos, Evatt, *Acquired Immunodeficiency Syndrome (AIDS) Associated with Transfusions*, 310 NEW ENG. J. MED. 69 (1984) [hereinafter Curran] (the large number of homosexual AIDS patients is due to an historical coincidence and not a peculiar attraction for gay men).

13. Council on Scientific Affairs, *supra* note 3, at 2039.

lated from patients with AIDS and those individuals from risk groups.<sup>14</sup> HIV will be used throughout this paper to refer to the retrovirus that causes AIDS. Normally, when a foreign material enters the body, the immune system forms antibodies to remove or destroy the material. T-helper cells permit the antibody response, while T-suppressor cells inhibit antibody formation. The retrovirus of AIDS is an RNA-containing virus which preferentially infects T-helper lymphocytes and destroys them, leaving the host unable to cope with a variety of infections and neoplastic diseases.<sup>15</sup> Normally the ratio of helper-to-suppressor cells is 2:1. In AIDS patients, this ratio is reversed, allowing opportunistic infections to take hold.<sup>16</sup>

Shortly after discovery of the AIDS virus, a blood test was developed to detect the presence of AIDS antibodies. This test is useful to identify persons who have been infected with the agent.<sup>17</sup> However, the significance of a positive test for symptomless carriers and its ability to identify persons likely to acquire or transmit AIDS is unknown.<sup>18</sup>

When a person is infected with a virus, the body's white blood cells normally begin to fight the infection by producing antibodies. Therefore, the presence of antibodies indicates whether or not a person has been infected with a virus. The HIV test reveals antibodies to AIDS and AIDS-related carriers. This is not a test for AIDS, but a test for antibodies to AIDS.<sup>19</sup> An infected person transmits the virus,

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14. See CDC, *Antibodies to a Retrovirus Etiologically Associated with Acquired Immunodeficiency Syndrome (AIDS) in Populations with Increased Incidences of the Syndrome*, 33 MMWR 377 (1984) [hereinafter *Increased Incidences*]. Confusion persisted with the discovery of the virus. French researchers at the Pasteur Institute in Paris and a group led by Robert Gallo at the National Cancer Institute independently identified the causative agent, a virus of the retrovirus family in 1983 and 1984, respectively. The French called it LAV and the American workers, HTLV-III. *Id.*

The Executive Committee of the International Committee on Taxonomy of Viruses recommends the use of the name human immunodeficiency virus or HIV as the vernacular name to replace HTLV-III and LAV. Brown, *Human Immunodeficiency Virus*, 232 SCIENCE 1486, 1486 (1986).

15. See Gallo, Sarin, Gelmann, Robert-Guroff, Richardson, Kalyanaraman, Mann, Sidhu, Stahl, Zolla-Pazner, *Isolation of Human T-Cell Leukemia Virus in Acquired Immune Deficiency Syndrome (AIDS)*, 220 SCIENCE 322 (1983).

Many viruses kill a cell that they invade. Most retroviruses do not. Instead, the DNA copy integrates itself with the chromosomes of an invaded cell. The cell becomes a factory of the retrovirus. As the cell divides, more virus is produced. . . . The AIDS virus can also, through a procedure not fully understood, kill cells, in particular the T-4 cells, master cells of the body's immune system. The destruction of the immune system leaves individuals vulnerable to opportunistic infections and cancers.

Leishman, *A Crisis in Public Health*, THE ATLANTIC, Oct. 1985, at 19, 22.

16. SLAFF, *supra* note 1, at 125, 174.

17. See Silberman, *AIDS Blood Test: Qualified Success*, 122 SCIENCE NEWS 84 (1985).

18. See Council on Scientific Affairs, *supra* note 3, at 2039.

19. *HTLV-III Antibody Positive Individuals, A Clinician's Guide to Evaluation*, 85 EPI-



not AIDS. The HIV test is useful to identify those who have been infected by HIV and capable of transmitting the disease.<sup>20</sup> However, exposure to the virus does not mean a person will definitely develop AIDS or ARC, nor does the presence of HIV antibodies necessarily indicate active infection.<sup>21</sup>

There is a recommended blood test sequence for detecting AIDS antibodies. The enzyme-linked immunosorbent assay (EIA) enables medical specialists to specify the disease associated with HIV exposure and to develop definitions of health problems related to AIDS. If the first EIA is positive, it is repeated. If both EIA tests are positive, a confirmatory test, the Western Blot, is performed.<sup>22</sup> The Western Blot test is only being used as an auxiliary test, however, as it is difficult and labor intensive. For some populations, the EIA alone may be sufficient.<sup>23</sup> As with any serologic test, false-positive and false-negative results are possible.<sup>24</sup> False-positives may result from infections with antigenetically-related or nonspecific test factors.<sup>25</sup> In addition, HIV has been isolated from both antibody-positive and antibody-negative persons.<sup>26</sup>

### C. Spectrum of HIV Diseases

With the discovery of the HIV virus, researchers reported a range of effects of the AIDS agent, from symptomless carriers (seropositive) to an AIDS-related complex (ARC), to a severe life threatening disease (full-blown AIDS). Clinicians observed that the wide range of disease manifestations has necessitated the expansion of the CDC

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DEMOLOGY BULL. No. 3, at 1, 2 (March 1985) [hereinafter *Clinicians's Guide*] (the screening test does not constitute a diagnostic test for AIDS).

20. See Oct. 1985, FDA DRUG BULL., at 1 [hereinafter FDA DRUG BULL.].

21. See *Clinician's Guide*, *supra* note 19, at 2. Originally, the primary purpose of the test was for research on AIDS. During 1984, the FDA approved commercially available tests. The FDA's concern was to screen blood for donation and to assist in preventing cases of AIDS that result from blood transfusions or blood products. The test was licensed as a blood bank screening test and not as diagnostic tool. See FDA DRUG BULL., *supra* note 20, at 2. In addition, the Public Health Service recommends that the test be used to screen blood from organ donors, tissue, and semen intended for human use. CDC, *Testing Donors of Organs, Tissues, and Semen for Antibody to Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus*, 34 MMWR 294 (1985).

22. See Weiss, Goedert, Sarngadharan, Bodner, Gallo & Blattner, *Screening Test for HTLV-III (AIDS Agent) Antibodies*, 253 J.A.M.A. 221, 224-24 (1985) [hereinafter Weiss].

Seventy-five percent of donor samples, positive for HIV antibody in the EIA, were found to be negative with the more sensitive Western Blot test. Hilgartner, *AIDS in the Transfused Patient*, 141 AM. J. DISABLED CHILDREN 194, 197 (1987).

23. Weiss, *supra* note 22, at 225.

24. *Clinician's Guide*, *supra* note 19, at 2.

25. Council on Scientific Affairs, *supra* note 3, at 2039.

26. See FDA DRUG BULL., *supra* note 20, at 3.

definition so that reporting of cases can be more specific.<sup>27</sup> These three disease phases are dependent on various gradations of clinical manifestations. The spectrum of the disease is characterized by a variety of symptoms and disorders.<sup>28</sup>

### 1. Full-blown AIDS

The worst possible outcome of the disease, the fatal phase, is called full-blown (or frank) AIDS and is characterized by life threatening conditions. Despite the retrovirus etiology, there are no clear cut symptoms that indicate loss of immunity. Even so, diagnosis is clinical and depends on the presence of opportunistic diseases.<sup>29</sup> The presence of opportunistic diseases, plus a positive test for antibodies to HIV, can make a diagnosis possible.<sup>30</sup>

Once diagnosed, the life expectancy of these patients is about one year and more than ninety percent contracting AIDS die within two years.<sup>31</sup> The survival rate is unknown, but over eighty percent die within two years of diagnosis.<sup>32</sup> The expected mortality rate is one hundred percent.<sup>33</sup> No one has recovered.<sup>34</sup>

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27. CDC, *Revision of the Case Definition of Acquired Immunodeficiency Syndrome for National Reporting-United States*, 34 MMWR 373, 375 (1985) [hereinafter *Definition*] (it is no longer necessary to have KS or PCP to be diagnosed with AIDS). The original working definition appeared in 1982. *Id.* at 373.

28. See FDA DRUG BULL., *supra* note 20, at 4. AIDS should be viewed on a spectrum. As of December 15, 1987, there were 47,022 reported AIDS cases in the United States. 2 AIDS POLICY & LAW (BNA) no. 25, at 6 (Dec. 30, 1987). The number of ARC cases may be 10 times that of AIDS cases, while the estimates of infected people range up to 2 million. Ford & Quam, *AIDS Quarantine: The Legal and Practical Implications*, J. LEGAL MED. 353, 356-57 (1987). For general definitions of some commonly used terminology, see Fauci, Masur, Gelmann, Markham, Hahn & Lane, *The Acquired Immunodeficiency Syndrome: An Update*, 102 ANNALS OF INTERNAL MED. 800, 801 (1985) [hereinafter Fauci].

29. See Council on Scientific Affairs, *supra* note 3, at 2040. Certain blood tests support the diagnosis. See generally *Increased Incidences*, *supra* note 14, at 377-78.

30. The great majority of AIDS patients have one or both of the rare diseases-KS or PCP. See Selik, Haverkos, Curran, *Acquired Immune Deficiency Syndrome (AIDS) Trends in the United States, 1978-1982*, 76 AM. J. MED. 493, 494 (1984).

31. Harris, *The AIDS Epidemic: Looking into the 1990's*, TECHNOLOGY R., July 1987, at 59, 64 [hereinafter Harris]. The death rate from AIDS is estimated to rise from 1.49 deaths per 100,000 in 1984 to 25.74 deaths per 100,000 in 1991. Scitovsky & Rice, *Estimates of the Direct and Indirect Costs of Acquired Immunodeficiency Syndrome in the United States, 1985, 1986, and 1991*, 102 PUB. HEALTH REP. 1, 7 (1987) [hereinafter *Direct and Indirect Costs*].

32. See Peterman, *Transfusion-Associated Acquired Immunodeficiency Syndrome*, 11 WORLD J. SURGERY 36, 36 (Feb. 1987) [hereinafter *Transfusion-Associated*].

33. C. BARR & M. MARDER, AIDS—A GUIDE FOR DENTAL PRACTICE 23 (1987) [hereinafter *DENTAL PRACTICE*].

34. Resnick, *Antiviral Chemotherapies Directed Against HTLV-III/LAV*, 53 MT. SINAI J. MED. 653, 653 (1986). 250,000 cases are predicted in the United States in 1991. Harris, *supra* note 31, at 59.

By December of 1987, nearly 47,000 cases of AIDS were reported to the CDC in the United States.<sup>35</sup> The disease has been identified in all primary racial and ethnic groups.<sup>36</sup> Ninety percent of the cases occur among young adults, ages twenty to forty-nine years.<sup>37</sup> Experts project that the number of cases of AIDS and HIV-associated diseases will rise at least five-fold in the next five years.<sup>38</sup> Although this rate of spread is decreasing, the overall result is still an increased incidence in all risk groups.<sup>39</sup>

## 2. AIDS-Related Complex

In addition to the development of the complete clinical picture of AIDS, a milder syndrome, referred to as lymphadenopathy syndrome, or AIDS-related complex (ARC), has been described.<sup>40</sup> There is an indistinct line between ARC and AIDS. While full-blown AIDS consists of life threatening conditions, ARC (subclinical immunosuppression) is characterized by non-life threatening conditions. ARC patients suffer from chronic illness, but survive indefinitely.

As a lesser form of AIDS, ARC patients are presumed infectious when their test results reflect a large amount of the virus and show signs of an attacked immune system. Diagnosis is made if they test positive or show two or more clinical manifestations. Confusion has arisen in the classification of patients who manifest signs and symptoms suggestive of the syndrome but who do not manifest the secon-

35. See *supra* note 28.

36. See Council on Scientific Affairs, *supra* note 3, at 2038.

37. *Id.*

38. Farber & Kaplan, *The AIDS Epidemic: Neglected Issues*, 155 J. INFECTIOUS DISEASES 1097, 1097 (1987) [hereinafter *Neglected Issues*], (citing Morgan & Curran, *Acquired Immunodeficiency Syndrome: Current and Future Trends*, 101 PUB. HEALTH REP. 459 (1986)); Boffey, *AIDS in the Future: Experts Say Deaths Will Climb Sharply*, N.Y. Times, Jan. 14, 1986, at C9, col. 3.

270,000 AIDS cases can be predicted in 1991 with 74,000 newly diagnosed cases and 54,000 victims dying in that year. Frosner, *What Can Be Done Against the Further Spread of AIDS?*, 327 NATURE 95, 95 (1987).

39. Selik, *supra* note 30, at 493.

40. Council on Scientific Affairs, *supra* note 3, at 2037. With the development of the virus and blood test, the definite link between ARC and AIDS could be made. It is estimated that for every diagnosed case of AIDS, there are ten cases of ARC. Hollander, *Human Immunodeficiency Virus Infection*, 81 POSTGRADUATE MED. 82, 84 (Mar. 1987).

ARC is characterized by unexplained lymphadenopathy (swollen lymph glands), non-specific symptoms (fatigue, malaise, fever, night sweats, diarrhea, and gradual weight loss), and immunologic abnormalities. Council on Scientific Affairs, *supra* note 3, at 2037. Since HIV invades brain cells, patients can also suffer from neurological problems such as forgetfulness, impaired speech, tremors, seizures, with possible progression to dementia. See Black, *HTLV-III, AIDS and the Brain*, 313 NEW ENG. J. MED. 1538 (1985).

dary complications of the disease.<sup>41</sup>

There is a period of six months to possibly over five years between infection with the HIV virus and the development of the disease itself.<sup>42</sup> This incubation period is typically two to five years.<sup>43</sup> It is not certain that every person will in fact develop the full-blown syndrome, but the general consensus is that ARC patients will eventually develop full-blown AIDS and die.<sup>44</sup>

### 3. Seropositive

The third phase consists of those individuals who have tested seropositive but who remain totally symptomless and feel healthy.<sup>45</sup> As stated earlier, seropositivity indicates exposure to the AIDS virus, but these individuals lack symptoms of any disease.<sup>46</sup> This means they have replicated the virus and converted to antibodies, but do not have the full-blown disease.

It is difficult to determine the precise number of seropositive persons. They clearly exist in epidemic proportion. Current estimates indicate that there are two million Americans infected with the HIV virus.<sup>47</sup> It is also estimated that 1000 persons a day, or one person

41. Fauci, *supra* note 28, at 800.

42. Mason, *Public Health Service Plan for the Prevention and Control of Acquired Immune Deficiency Syndrome (AIDS)*, 100 PUB. HEALTH REP. 453, 453 (1985); Resnick, *supra* note 34, at 653.

43. Thompson, *Like No Other Human Disease*, Wash. Post, Sept. 4, 1985, at 12, col. 1; see also El-Sadr, Marmor, Zolla-Pazner, Stahl, Lyden, William, D'Onofrio, Weiss, & Saxinger, *Four-Year Prospective Study of Homosexual Men: Correlation of Immunologic Abnormalities, Clinical Status, and Serology to Human Immunodeficiency Virus*, 155 J. INFECTIOUS DISEASES 789, 792 (1987).

44. SLAFF, *supra* note 1, at 142; Weller, *From Persistent Generalized (sic) Lymphadenopathy to AIDS: Who Will Progress?*, 294 BR. MED. J. 868, 868 (1987).

45. Schoepel, *Hodgkin's Disease in Homosexual Men with Generalized Lymphadenopathy*, 102 ANNALS INTERNAL MED. 68 (1985).

46. See DENTAL PRACTICE, *supra* note 33, at 84; Hilgartner, *supra* note 22, at 195.

47. SLAFF, *supra* note 1, at 25. AIDS has one of the longest incubation periods of any known infectious disease. Any estimate of a disease's incubation period during an epidemic is underestimated. *Id.* at 76; Harris, *supra* note 31, at 60-61. It has been estimated that, in 1985, for every diagnosed case of AIDS, there were 50 to 100 persons with HIV infections. Hadler, *Tuberculosis and AIDS—Connecticut*, 257 J.A.M.A. 1706, 1707 (1987). The original CDC definition only identified late clinical stages of disease and severely underrepresented the magnitude of the problem. Redfield, *Heterosexual Transmission of Human T Lymphotropic Virus Type III: Syphilis Revisited*, 53 MT. SINAI J. MED. 592, 592 (1986). The number of cases is underestimated because it depends on the number of individuals tested and the results being reported. See Jaffe, Bregman, & Selik, *Acquired Immune Deficiency Syndrome in the United States: The First 1,000 Cases*, 148 J. INFECTIOUS DISEASES 339, 343 (1983); May & Anderson, *Transmission Dynamics of HIV Infection*, 326 NATURE 137, 138 (1987); see generally Lilienfeld & Armenian, *Incubation Period of Disease*, 5 EPIDEMIOLOGIC REV. 1 (1983) [hereinafter *Incubation Period*].

Up to 10 million people world-wide now carry the virus. Comarow, Knight,

every ninety seconds, are being infected.<sup>48</sup> It is expected the infection rate will double every two years until a vaccine is developed.<sup>49</sup>

Experts are not certain how many Americans are currently infected with HIV or how many will go on to develop AIDS. Nearly all those infected remain symptomless for the first year following infection. More than fifty percent of those infected with the HIV virus will eventually develop one or more symptoms associated with infection.<sup>50</sup> The incubation period is long for AIDS—generally two to five years<sup>51</sup>—but not everyone exposed to the virus will develop AIDS.<sup>52</sup> In addition, the period before becoming seropositive after being infected with the virus is believed to be six weeks, but has been found to last over six months.<sup>53</sup> This means that persons could be infected and not become seropositive for weeks.

Officials are uncertain as to what seropositivity means regarding the health outcome, but the Public Health Service (PHS) estimates five to twenty percent of those exposed will actually develop AIDS within two to five years of infection.<sup>54</sup> Accurate projections are un-

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Trimble, Zanker, Chesnoff, *The Bind that Ties All Nations*, 102 U.S. News and World Rep. 64 (Jan. 12, 1987).

48. SLAFF, *supra* note 1, at 159.

49. Harris, *supra* note 33, at 62. By early 1991, 2.5 million Americans may be infected. *Id.* No vaccine is expected until 1990 at the earliest. SLAFF, *supra* note 1, at 6; see also *infra* notes 102-104 and accompanying text.

50. Fifty three percent of seropositive individuals will develop ARC. Harris, *supra* note 33, at 66; see Langone, *supra* note 1, at 39.

51. See Langone, *supra* note 1, at 38. The incubation period is the lag-time between infection and development of the disease. *Incubation Period*, *supra* note 47, at 2. The median incubation period among people who develop AIDS is between four and a half and six years. Harris, *supra* note 33, at 60. In one case, the time period from exposure to detecting the antibody was over seven years. Accordingly, longer incubation periods can not be excluded. See Hilgartner, *supra* note 22, at 195. This is one of the longest incubation periods of any known infectious disease.

52. The AIDS epidemic resembles the polio epidemic. After being infected with the polio virus, some persons experienced nothing, some experienced a bad fever and bone involvement, others were on iron lungs, and still others died. A similar phenomenon occurs with the AIDS virus. *AIDS: The Bottom Line*, MINN. NURSING TODAY MAGAZINE 1 (Jan. 1986).

53. The latency period is the time between infection and production of antibodies. Address by Dr. Michael Greico, ALI-ABA Seminar on AIDS and the Law (Feb. 27, 1986). There may be a few weeks to months during which an infected person will have a negative test. *Transfusion-Associated*, *supra* note 32, at 38. This period is generally thought to average six weeks to two months. The interval from antibody detection to the identification of AIDS in the transfused adult patient has been up to five years. In one pediatric patient, this latency period has been reported to be seven and one half years. Hilgartner, *supra* note 22, at 195.

54. See *Clinician's Guide*, *supra* note 19, at 2. Within three years of the initial infection, approximate 10 to 25 % of HIV positive persons will develop significant immune depression; 5 to 15 % will develop ARC; and 2 to 10 % will develop AIDS. Fahey, Taylor, Korn, Nishanian, *Diagnostic and Prognostic Factors*, 53 MT. SINAI J. MED. 657, 661 (1986).

known, but it is assumed that twenty-five percent of those infected will develop ARC but will not develop AIDS within five years of infection.<sup>55</sup> Among seropositive persons, the risk for developing full-blown AIDS may vary depending on risk groups and other factors such as additional environmental exposure and genetic background.<sup>56</sup> At present, almost one hundred percent of patients with the full-blown syndrome, and more than ninety percent of patients with ARC, are seropositive for the retrovirus.<sup>57</sup>

Seropositivity indicates a carrier state, so that even if an individual never develops AIDS, the individual may transmit the virus to others. Infected persons are capable of transmitting infection for years, even though they may remain asymptomatic. Some experts believe seropositive persons are contagious within weeks of exposure, and once infected, they probably remain infected for life.<sup>58</sup> The degree of infectiousness is unknown, but the virus has been cultured from blood, urine, semen, tears, and saliva of infected individuals.<sup>59</sup> A carrier state is feasible, but not confirmed, and susceptibility or degree of immunity is unknown.<sup>60</sup> Retroviruses may be dormant and if they remain dormant, infected persons could have less infectious periods. This pattern of infectious periods is also observed in herpes. Seropositive persons are assumed infectious, and since they show no outside evidence of infection, the only way to find out if they are infected is to have their blood tested.

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55. Jaffe, *Acquired Immune Deficiency Syndrome and Infections in Homosexual Men*, 148 J. INFECTIOUS DISEASES 339 (1983). Data suggests that all HIV positive patients will eventually develop clinical disease. *Neglected Issues*, *supra* note 38, at 1097.

56. *Clinician's Guide*, *supra* note 19, at 2.

57. Seropositivity is 100% among AIDS patients, 80% among intravenous drug users, 60% among sexually active homosexual men in New York City, and 70% in hemophiliacs. See *Responses to the AIDS Crisis*, WASH. REP. ON MEDICINE AND HEALTH 1, 3 (Oct. 21, 1985) [hereinafter WASH. REP.] (copy on file in the William Mitchell Law Review Office).

58. Unlike herpes and gonorrhea, where signs of infection are exacerbated by skin lesions, AIDS has no noticeable symptoms in infected people for at least one year. Ninety percent of those infected are unaware of their infection. Laurence, *Lymphadenopathy-Associated Viral Antibodies in AIDS: Immune Correlation and Definition of a Carrier State*, 311 NEW ENG. J. MED. 1269 (1984) Ninety percent of infected blood donors were free of overt manifestations of the AIDS virus when they gave the blood. See SLAFF, *supra* note 1, at 140.

59. Moss, Osmond, Bacchetti, Chermann, Barre-Sinoussi, & Carlson, *Risk Factors for AIDS and HIV Seropositivity in Homosexual Men*, 125 AM. J. EPIDEMIOLOGY 1035, 1036 (1987) [hereinafter Moss]. One author notes, however, that when HIV is transmitted during sexual intercourse, no one knows if it is usually passed on in saliva or in some other way. Seale, *HIV Transmitted by Kissing*, 294 BR. J. MED. 705, 705 (1987).

60. WASH. REP., *supra* note 57, at 2. Individuals who are incubating AIDS are assumed to be infectious throughout the incubation time period. *Dynamics*, *supra* note 2, at 140.

#### D. Transmission

The AIDS virus is transmitted through intimate sexual contact, through the sharing of contaminated needles, via infected blood products, and through passage of the virus from infected mothers to their newborns.<sup>61</sup> Since seventy-three percent of those infected are homosexual/bisexual men, the virus is most frequently spread through sexual contact.<sup>62</sup> Sharing of needles accounts for the high incidence of AIDS among men and women who use intravenous drugs.<sup>63</sup> Transmission is believed to occur when infected blood is transfused to a second person via a dirty needle.

In one percent of all cases, AIDS has been associated with receipt of blood transfusions.<sup>64</sup> Transmission via this route has been rare, considering the fact that three million patients receive blood every year.<sup>65</sup> Similarly, cases of AIDS have been reported among hemophiliacs who have no history of homosexuality or intravenous drug use.<sup>66</sup> Patients with hemophilia are generally deficient in factor VIII, a clotting mechanism in blood. This deficiency is treated with a blood product made from the plasma pools collected from thousands of donors. Evidence suggests that receipt of this particular blood product increases the risk of acquiring AIDS.<sup>67</sup>

61. The AIDS transmission pattern closely resembles the transmission pattern of hepatitis B. See *Current Status*, *supra* note 9, at 1355 (exploring the possibility that HIV may be present in the hepatitis B vaccine).

62. See Council on Scientific Affairs, *supra* note 3, at 2037. This is accomplished by the exchange of body fluids, such as semen and blood. See *WASH. REP.*, *supra* note 57, at 1. Several co-factors appear to increase the risk of contracting the virus in this group. The most consistent risk factor is an increased number of different sexual partners. Auerbach, *Cluster of Cases of Acquired Immune Deficiency Syndrome: Patients Linked by Sexual Contact*, 76 *AM. J. MED.* 487 (1984); see also *Epidemiologic Results*, *supra* note 2, at 145-51. Receptive anal intercourse and other practices associated with rectal trauma tears the delicate lining of the rectum and allows the AIDS virus easy entry into the body's circulatory system. Council on Scientific Affairs, *supra* note 3, at 2042.

63. Council on Scientific Affairs, *supra* note 3, at 2041.

64. See generally CDC, *Update: Acquired Immunodeficiency Syndrome (AIDS)-United States* 32 *MMWR* 465 (1983) [hereinafter *United States*].

65. One and one-half percent of AIDS patients have no known risk factors, but have received transfusions of blood or blood products within the last five years. See Council on Scientific Affairs, *supra* note 3, at 2041. Transmission of AIDS may occur through single-unit transfusions or pooled clotting-factor concentrates. Transfusion-associated AIDS is caused by the receipt of a unit of whole blood or blood component from a donor infected with HIV. Patients who received blood components from a large number of donors are more likely to be exposed to the AIDS virus. Blood components implicated in the transmission include red cells, platelets, plasma, and whole blood. See Curran, *supra* note 12, 69-75.

66. Approximately one percent of the reported AIDS cases involve hemophiliacs. *United States*, *supra* note 64, at 466.

67. There is no evidence of transmission through other blood products. Council on Scientific Affairs, *supra* note 3, at 2041.

The distribution of AIDS cases among children with parents in high risk groups is similar to that found in the group of heterosexual adult patients with AIDS.<sup>68</sup> Most infants who are victims of AIDS have been born to infected mothers or to others in high risk groups. The occurrence of symptoms shortly after birth and the absence of infection in older children suggests transmission by one of three routes: in utero, during child birth, or shortly after birth.<sup>69</sup> A survey of the cases reported shows that a majority of infants were born to women drug addicts or Haitians.<sup>70</sup> The remaining children received multiple transfusions at or near birth, or were older hemophiliac children.<sup>71</sup>

### 1. Extension of Transmission

A major concern among health professionals is whether or not the syndrome will extend beyond the established risk groups into the general population. Opinions are split sharply. In the United States, heterosexual transmission is usually man to woman. It is clearly associated with steady heterosexual relationships with persons carrying the AIDS virus or steady heterosexual relationships with seropositive individuals in a high risk group.<sup>72</sup> Anal intercourse is a possible factor in these cases.<sup>73</sup>

For the disease to spread into the general heterosexual population, female to male transmission is a crucial factor. It was once believed that the general heterosexual population was not at risk since the number of heterosexual cases remained relatively constant at one percent.<sup>74</sup> The fact that the AIDS virus had not been found in vagi-

68. See *Current Status*, *supra* note 9, at 1352.

69. See also, Amann, *Is There an Acquired Immunodeficiency in Infants and Children?*, 72 PEDIATRICS 430 (1983); see generally Council on Scientific Affairs, *supra* note 3, at 2040.

70. See Oleske, *Immunodeficiency in Children*, 249 J.A.M.A. 2345 (1983); Rubenstein, *Acquired Immunodeficiency with Reversed T3/T4 Ratios in Infants Born to Promiscuous and Drug-Addicted Mothers*, 249 J.A.M.A. 2350 (1983).

71. The symptoms of AIDS has varied among infants from birth to thirty months of age. Council of Scientific Affairs, *supra* note 3, at 2040. Recently, sero-conversion was described in an infant of a mother who had received a contaminated blood transfusion. The infant appears to have received the AIDS virus from breast feeding or other close mother-to-infant contact. *Current Status*, *supra* note 9, at 1355.

72. See *Heterosexual Transmission of HTLV-III*, 85 EPIDEMIOLOGY BULL. No. 11 at 1 (Nov. 1985) [hereinafter *Heterosexual Transmission*]; CDC, *Heterosexual Transmission of HTLV-III*, 33 MMWR 561 (1985); Harris, *Immunodeficiency in Female Sexual Partners of Men with the Acquired Immunodeficiency Syndrome*, 308 NEW ENG. J. MED. 1181, 1184 (1983) [hereinafter *Female Sexual Partners*]. The actual methods of heterosexual transmission remain undefined.

73. Harris, *supra* note 31, at 63. HIV can be isolated from saliva and semen and from vaginal and cervical secretions. The exchange of body secretions via genital-genital, oral-genital, oral-anal, and oral-oral contact may all play a role in viral transmission among sexually active heterosexuals. *Id.*

74. See Hardy, *supra* note 5, at 215-20.



nal secretions supported this view. In addition, the male genital tract is an insufficient portal of entry for the virus.<sup>75</sup> These experts believed that because there was scant evidence of female to male transmission, with the exception of intravenous drug users, heterosexual spread was very unlikely.

More recently, however, experts believe the potential for heterosexual transmission is clearly present and cite signs of the American spread to support this belief.<sup>76</sup> The fact that heterosexual transmission occurs from persons at risk to monogamous sexual partners indicates sexual spread could occur outside risk groups.<sup>77</sup> Data from Africa has shown that risk factors for AIDS in heterosexual men include sexual contact with prostitutes and large numbers of heterosexual partners. This data demonstrates AIDS can be transmitted both man to woman and woman to man.<sup>78</sup> These cases are clearly linked to heterosexual promiscuity.<sup>79</sup>

In the United States, only seven percent of AIDS cases have been in women.<sup>80</sup> Female to male transmission of HIV, although biologically less efficient, is assumed to occur to a minor degree among men whose only risk factor appears to be heterosexual promiscuity, particularly with prostitutes.<sup>81</sup> The reasons for discrepancies between Zaire and the United States are unclear and may involve unrecognized co-factors among the Zairian population that render them sus-

75. The presence of HIV in vaginal secretions is essential before the disease may be transmitted from woman to man.

76. See generally *Dynamics*, *supra* note 2, at 141; Redfield, *supra* note 47, at 594. Friedland & Klein, *Transmission of the Human Immunodeficiency Virus*, 317 *NEW ENG. J. MED.* 1125, 1128 (1987) [hereinafter Friedland].

77. See *Female Sexual Partners*, *supra* note 72, at 1181-84. Among the nearly 34,000 cases reported by April of 1987, about two percent are people who have been exposed exclusively through heterosexual contact. Harris, *supra* note 31, at 59, 63. Transmission has been from bisexual men and intravenous drug users. *Id.* Experts expect the incidence of HIV infection among female partners of bisexual men to initially rise roughly in proportion to the incidence among homosexual men. *Dynamics*, *supra* note 2, at 141.

78. *Current Status*, *supra* note 9, at 1355. Heterosexual transmission accounts for the larger number of cases in developing countries. Editorial, *A New Strategy to Prevent the Spread of AIDS Among Heterosexuals*, 254 *J.A.M.A.* 2129 (1985). In Africa, where over 90% of the cases occurred through heterosexual transmission, the incidence of male to female cases of AIDS is 1:1. Piot, *supra* note 2, at 65. In the United States, the ratio is thirteen males to one female. Friedland, *supra* note 76, at 1128.

79. *United States*, *supra* note 64, at 465-67.

80. See Council of Scientific Affairs, *supra* note 3, at 2038.

81. Kenyan prostitutes tested for HIV have shown positive 31 to 66%. The range of positivity among American prostitutes tested has been 5 to 40%. The frequency of occurrence of female to male transmission remains controversial. See Friedland, *supra* note 76, at 1129; *Heterosexual Transmission*, *supra* note 72, at 1; Redfield, *Heterosexually Acquired HTLV-III/LAV Disease (AIDS-Related Complex and AIDS) Epidemiologic Evidence for Female-to-Male Transmission*, 254 *J.A.M.A.* 2094 (1985).

ceptible to this pattern of transmission.<sup>82</sup> Nonetheless, there is the possibility of more extensive heterosexual transmission in the future, among both established risk groups and persons outside risk groups, who have had sexual contact with virus carriers.<sup>83</sup> In addition, the epidemiology of HIV resembles that of hepatitis B, an agent that is clearly heterosexually transmissible.

Some scientists believe the AIDS pattern may change due to two factors. One is the high incidence of intravenous drug use among female prostitutes. The other is increasing epidemiological evidence of the bi-directional heterosexual transmission (both male to female and female to male).<sup>84</sup> These factors, together and exacerbated by AIDS' long incubation period, could lead to a greater incidence of AIDS in the heterosexual population.<sup>85</sup>

With the long incubation period, asymptomatic heterosexuals may unknowingly be spreading HIV to sexual contacts. Because of this, individuals in San Francisco were cautioned that if they had had multiple sexual partners since 1978, they should take precautions to limit the transmission of the virus.<sup>86</sup>

## 2. Casual Contact

While the transmission of HIV via blood and semen has been well-documented, speculation by the media and public has caused great concern over the possibility of contracting AIDS through casual contact. Although the virus has been isolated from tears and saliva,<sup>87</sup>

82. See Friedland, *supra* note 76, at 1129-30.

83. See Fauci, *supra* note 28, at 802. The number of heterosexually-transmitted cases in the United States is increasing more rapidly than the proportion of cases in any other category of risk. In 1985, 1.7% of adult cases of AIDS were acquired through heterosexual activity. Projections estimate that by 1991, heterosexual transmission will account for 5% of adult cases. Friedland, *supra* note 76, at 1128.

84. See *Dynamics*, *supra* note 2, at 142.

85. See *DENTAL PRACTICE*, *supra* note 33, at 16; *WASH. REP.*, *supra* note 9.

86. See Echenberg, *A New Strategy to Prevent the Spread of AIDS Among Heterosexuals*, 254 J.A.M.A. 2129, 2129 (1985). See also 2 AIDS POLICY & LAW (BNA) no. 1, at 5 (Jan. 28, 1987) (discussing San Francisco program of notifying all heterosexual partners of positive result on AIDS test for infected person). In addition to the established routes of transmission, it has been suggested that HIV may also be spread by mosquitoes. Researchers in Belle Glade, Florida are investigating this theory on the basis of the similarly spread disease of malaria. The mosquito transfers blood from one person to another. Most experts disclaim this theory as unfounded and extremely unlikely. Studies have found that health care workers, who had been stuck with needles, received a larger volume of infected blood than a mosquito could transmit. Given the workers' low incidence of infection, the chance of infection from a mosquito, able to carry an even smaller amount of blood, is negligible. SLAFF, *supra* note 1, at 35.

87. Friedland, *supra* note 76, at 1132-33. Casual contact has not been reported. *Neglected Issues*, *supra* note 38, at 1099. See Groopman, *HTLV-III in Saliva of People with AIDS-Related Complex and Healthy Homosexual Men at Risk for AIDS*, 226 SCIENCE 447

there has been no evidence of transmission from contact with these fluids. It is unlikely that tears and saliva are involved in the spread of the virus because of the minute quantities of the virus present in these fluids.<sup>88</sup>

Experts vehemently deny the spread of HIV from casual contact such as sharing food, shaking hands, coughing, sneezing or light kissing.<sup>89</sup> Several reasons are cited for this belief. First, transmission from saliva and tears has not been documented.<sup>90</sup> Second, casual transmission of HIV does not occur even among persons exposed to the saliva of infected household members in close day to day contact.<sup>91</sup> Third, HIV is relatively hard to contract. The large majority of the cases have been in two categories, and almost exclusively by the exchange of body fluids through sexual intercourse or through sharing intravenous needles.<sup>92</sup> Compared to other diseases, HIV is largely non-communicable, whereas, for example, tuberculosis can be spread airborne from sputum, malaria by mosquito bite and cholera by sewage contaminated by water or food tainted with feces of an infected person.<sup>93</sup> Fourth, the distribution of HIV cases parallels that of hepatitis B, which is transmitted sexually and parentally.<sup>94</sup> Finally, where health care workers were tested seropositive, all but eight percent belonged to a risk group. Outside the risk groups, no specific occupational exposure could be documented.<sup>95</sup>

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(1984); Russell, *AIDS Virus Found in Patient's Tears*, Wash. Post, Aug. 16, 1985, at A7, col. 1.

88. See Ho, Byington, Schooley, Flynn, Rota, & Hirsch, *Infrequency of Isolation of HTLV-III Virus from Saliva in AIDS*, 313 NEW ENG. J. MED. 1606 (1985); Saviter, White, Cohen, Jason, *HTLV-III Exposure During Cardiopulmonary Resuscitation*, 313 NEW ENG. J. MED. 1607 (1985).

89. *Current Status*, *supra* note 9, at 1356; Friedman, *supra* note 76, at 1132; 98 PUB. HEALTH REP. 306, 307 (1983).

90. See CDC, *Education and Foster Care of Children Infected with HTLV-III/LAV*, 34 MMWR 517 (1985) (no infection occurred in older children and other adults in the household).

91. *Id.*; see also CDC, *Update: Prospective Evaluation of Health-Care Workers Exposed Via the Parenteral or Mucous-Membrane Route to Blood or Body Fluids from Patients with AIDS-United States*, 34 MMWR 101, 103 (1985).

92. See Ford & Quam, *supra* note 28, at 358-39.

93. Although hepatitis-B may be transmitted through mucosal surfaces, including the mouth and eyes, transmission would probably require percutaneous inoculation of infected material or direct contact of blood or blood contaminated secretions with mucosal surfaces. Council on Scientific Affairs, *supra* note 3, at 2041.

94. See Marx, *supra* note 10, at 618; 10 MINN. DEPT. OF HEALTH DISEASE CONTROL NEWSLETTER No. 7, at 4, (Aug. 1983).

95. Hirsch, *Risk of Nosocomial Infection with Human T-Cell Lymphotropic Virus III (HTLV-III)*, 312 NEW ENG. J. MED. 1,2 (1985).

A recent report from England describes a nurse who developed HIV antibody following a needlestick injury and exposure to the blood of an AIDS patient. See *Current Status*, *supra* note 9, at 1355. Less than one percent of health care workers in

Confusion and concern regarding casual spread of AIDS has, in large part, surfaced because of the medical community's reluctance to state with absolute certainty that the spread of HIV by casual contact can not happen. The lack of medical knowledge about AIDS causes experts to distinguish deep kissing from casual contact. Deep kissing involves salivary exchange, whereas more casual contact involves light kissing, touching and simply being in close proximity with an infected person. Some believe, however, that deep kissing can transmit the AIDS virus.<sup>96</sup> The virus is thought to enter via saliva through broken skin in the mouth.<sup>97</sup>

All epidemiologic evidence indicates that food, water, insects and casual contact do not spread HIV.<sup>98</sup> The fact that the disease shows no signs of spreading beyond established risk groups, except to predictable targets such as women who are artificially inseminated with sperm from infected donors, indicates that the virus is ordinarily transmitted only through blood or sexual intercourse.<sup>99</sup> Although new evidence suggests the virus can exist outside the body for hours to days,<sup>100</sup> it has not yet been determined what this actually means in regard to the transmissibility of HIV.

### E. Management

While establishing the source and modes of transmission has improved, confusion regarding the nature of AIDS and an appropriate management mechanism still exist. The epidemic-like spread of this debilitating and fatal disease is likely to impact all human beings. Since first reported to the CDC, there has been an extraordinary increase in the number of cases in the United States and worldwide.<sup>101</sup>

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the United States who have had contact with a contaminated needle or blood from an AIDS patient have tested positive for the HIV virus. 2 AIDS POLICY & LAW (BNA) no. 22, at 6 (Nov. 18, 1987).

96. See SLAFF, *supra* note 1, at 31 (relying on World Health Organization Guidelines recommending refraining from this practice).

97. Saviteer, *supra* note 98, at 1666.

98. Friedman, *supra* note 76, at 1131. Laurence, *The Immune System in AIDS*, 253 SCIENTIFIC AM., 84, 84 (Dec. 1985).

99. Laurence, *supra* note 98, at 84.

100. Address by Dr. James Bellanti, M.D., ALI-ABA Seminar on AIDS and the Law (Feb. 27, 1986).

101. See Fauci, *supra* note 28, at 800. See also Fauci, *Acquired Immunodeficiency Syndrome: Epidemiologic, Clinical, Immunologic, and Therapeutic Considerations*, 100 ANNALS INTERNAL MED. 92 (1984) (doubling of number of affected people every six months).

AIDS has been reported in all fifty states, the District of Columbia, and three United States territories. Nearly 75% of patients with AIDS have been residents of New York, California, Florida, and New Jersey, but proportionately greater increases have been noted recently in other states. See Council on Scientific Affairs, *supra* note 3, at 2038. There has been a leveling off of cases in San Francisco. Boffey, *AIDS in the Future: Experts Say Deaths Will Climb Sharply*, N.Y. Times, Jan. 14, 1986, at 7. Even

No one who has acquired AIDS has yet been cured of this fatal disease.<sup>102</sup> Patients with AIDS eventually succumb to one of the opportunistic infections. A vaccine is urgent, not only because of the large numbers of persons already infected, but also because the number of cases reported reflects only a very small proportion of people already infected.

At present, the outlook for a vaccine is uncertain.<sup>103</sup> Unlike the polio virus, the AIDS virus continually mutates over time which complicates the process of developing an AIDS vaccine. Because of this high mutability of the virus, experts suggest a vaccine will not be available in the near future if at all.<sup>104</sup> The search for a vaccine is complicated by the fact that antibodies are ineffective in eliminating virus-infected cells.<sup>105</sup>

Since researchers have not yet been able to develop a vaccine for HIV, AIDS patients have received various forms of treatment in an attempt to attack and destroy HIV or to correct the underlying immune defect. To date, however, no treatment has proven effective to combat HIV infection. Treatment is usually limited to the management of opportunistic infections or tumors that develop because of

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so, the number of new cases predicted for 1986 reach levels comparable to the most highly feared epidemic in the United States—paralytic polio. The CDC predicted over 12,000 additional cases would be diagnosed between July 19, 1985 and June, 1986. For 1986, the CDC predicted 14,000-15,000 new cases of AIDS, with the vast majority in the two main groups already infected. At its worst in 1952, polio struck 21,000 Americans and claimed 10,000-15,000 lives. *Id.*

Although the numbers are alarming, there is evidence of a slowdown. There are two reasons for the slowdown in the number of diagnosed cases. First, the major risk groups are becoming saturated with infection, which leaves less room for spread. Second, homosexuals appear to be changing practices to avoid exposure to the virus. *Id.* at 9.

See also Clark, *AIDS: A Growing Pandemic*, NEWSWEEK, at 71 (Apr. 29, 1985) (AIDS threatens entire world population); CDC, *Update: Acquired Immunodeficiency Syndrome—Europe*, 34 MMWR 21 (1985).

By March, 1985, 940 cases had been reported from Europe. CDC, *Update: Acquired Immunodeficiency Syndrome—Europe*, 34 MMWR 471 (1985). Other countries reporting cases of AIDS included England, Denmark, Switzerland, Netherlands, Norway, Sweden, Finland, Spain, Italy, Austria, Greece and Belgium. *Id.*

Cases have been reported in nearly twenty countries in Africa; Zaire is the primary country. Piot, *supra*, note 2, at 66. See also Clumeck, *Acquired Immunodeficiency Syndrome in African Patients*, 310 NEW ENG. J. MED. 492 (1984).

102. The two year mortality rate is 70%. Council on Scientific Affairs, *supra* note 3, at 2038.

103. Francis & Petricciani, *The Prospects for and Pathways Toward a Vaccine for AIDS*, 313 NEW ENG. J. MED. 1586, 1590 (1985).

104. Frosner, *supra* note 38, at 95. It took eleven years of concentrated effort to develop a hepatitis B vaccine. Undeniably, the AIDS virus is a more complex medical challenge. Leishman, *A Crisis in Public Health*, THE ATLANTIC 19, 23 (Oct., 1985).

105. Bloom, *AIDS Vaccine Strategies*, 327 NATURE 193, 193 (1987).

the immunodeficiency.<sup>106</sup>

Three types of drugs have been focused on for treating patients.<sup>107</sup> First, antiviral agents are believed to directly attack the virus itself.<sup>108</sup> There is no evidence, however, that this changes the patient's prognosis.<sup>109</sup> In general, antivirals have shown little or no relationship to clinical improvement and often have toxic side effects that limit their potential usefulness.<sup>110</sup> Most researchers believe more than one drug will be necessary. One drug will be necessary to suppress the AIDS virus while another drug will be required to reconstitute the damaged immune system.<sup>111</sup> Second, immune boosters are thought to enhance immune system function.<sup>112</sup> Again, these drugs may do more harm than good, since they stimulate production of new T-cells which may accelerate the progress of AIDS.<sup>113</sup> The

106. DENTAL PRACTICE, *supra* note 33, at 111; see Council on Scientific Affairs, *supra* note 3, at 2041.

107. *Multidrug Treatment Seen Needed to Fight AIDS*, Am. Med. News, Oct. 4, 1985, at 1, col. 4 [hereinafter *Multidrug Treatment*].

Numerous drugs are currently being tested. Azidothymidine (AZT) is the only AIDS drug the FDA has approved for sale. Since AZT does not kill the virus, the patient must continue taking the drug. While the drug has been effective in some patients, some individuals can not take AZT because of the side effects. Schecter, *The Frustrating Fight Against AIDS*, TECHNOLOGY REV., July 1987, at 65. AZT appears to prolong the life expectancy of AIDS patients. *Direct and Indirect Costs*, *supra* note 31, at 16.

Dideoxycytidine (DDC) is another drug that works much like AZT. DDC has fewer side effects and may be just as effective. However, it has not been studied as much as AZT and is not approved by the FDA. Schecter, *supra*, at 65.

108. Several antiviral are currently being investigated as chemotherapeutic agents in AIDS patients. Antivirals suppress replication of HIV. These drugs include suramin, ribvavirin, (which inhibits growth of HIV in test tubes), HPA-33 (the drug Rock Hudson took in France and which is believed to cross the blood-brain barrier), foscainet, and anasamycin. See Buimovici-Klein, Ong, Lange, England, McKinley, Reddy, Grieco, & Cooper, *Reverse Transcriptase Activity (RTA) in Lymphocyte Cultures of AIDS Patients Treated with HPA-23*, 2 AIDS RESEARCH 279 (1986); *AIDS Risk Troubles MDs*, Am. Med. News, Oct. 18, 1985, at 3, col. 3 [hereinafter *Troubles*]. While these drugs may control viral replication, they do not replace lost T-lymphocytes. Barre-Sinoussi & Chermann, *The Etiologic Agent of AIDS*, 53 MT SINAI J. MED. 598, 605 (1986) [hereinafter *Etiologic Agent*].

109. *Troubles*, *supra* note 108, at 3.

110. See Langone, *supra* note 1, at 38. The most serious side effect is the suppression of bone marrow, leaving patients highly vulnerable to bacterial infections. Kolata, *Imminent Marketing of AZT Raises Problems*, 235 SCIENCE 1462, 1462 (1987).

111. McAuliffe, *AIDS: At the Dawn of Fear*, 102 U.S. NEWS & WORLD REP. Jan. 12, 1987 at 60, 68.

112. Immune enhancers stimulate the damaged immune system. These drugs include isoprinosine, gamma interferon (secreted by cells throughout the body to interfere with virus replication and to slow cell division), interleukin-2 (a protein naturally made in the body by white blood cells which help to boost the immune system) and alpha interferon. Lane, *Use of Interleukin-2 in Patients with Acquired Immunodeficiency Syndrome*, 3 J. BIO. RESP. MODIF. 512, 513 (1984).

113. Leischman, *supra* note 104, at 22.

third set of agents are those used to treat the opportunistic infections. Some are effective in temporarily halting infections, but the persistent underlying immune defect ensures they will recur or be replaced by other equally serious infections.<sup>114</sup>

In addition to drug therapy, bone marrow transplantation has been used when a person fails to respond to other drugs.<sup>115</sup> This procedure is used in an attempt to replace the destroyed immune function. Combinations of the three types of drugs with bone marrow transplantation have also been attempted.<sup>116</sup>

The form and timing of treatment is still being investigated. Out of desperation, patients have turned to experimental drug therapies, as well as alternative healing methods.<sup>117</sup> Since drug therapy is very difficult to impossible in patients with the full-blown disease because their immune system has been destroyed, research on the treatment of ARC patients has been initiated.<sup>118</sup>

To date, no drug or product has been found that is capable of sufficiently restoring the immune system of patients with AIDS to prevent opportunistic infection.<sup>119</sup> Doctors have not been able to prolong the life expectancy of persons with AIDS beyond one year after diagnosis because to find drugs both non-toxic and effective against AIDS is difficult.<sup>120</sup> Since there is no specific therapy at present, prevention and educational measures are best to reduce the threat of AIDS and to create awareness of the disease.

Since there is no known cure for AIDS, protective measures, based on knowledge about AIDS and other communicable diseases, are recommended for the prevention of the spread of the virus.<sup>121</sup> Various groups have issued recommendations for prevention.<sup>122</sup>

Because subclinical forms of AIDS exist, recommendations for the

114. *Multidrug Treatment*, *supra* note 107, at 1. Antibiotic therapy for opportunistic infections has not changed over the last six years. Even if the infection is successfully treated, there is little evidence that there is any improvement in the long-term outcome. Hollander, *supra* note 40, at 82.

115. Council on Scientific Affairs, *supra* note 3, at 2041; Hasselt, *Bone Marrow Transplantation in AIDS*, 309 *NEW ENG. J. MED.* 665 (1983).

116. *Multidrug Report*, *supra* note 107, at 1.

117. Alternative healing methods include acupuncture and psychological remedies. Leischman, *supra* note 104, at 22; *Troubles*, *supra* note 108, at 33, col. 2.

118. *See Troubles*, *supra* note 108, at 33, col. 2.

119. Council on Scientific Affairs, *supra* note 3, at 2041.

120. *Troubles*, *supra* note 108, at 33, col. 2.

121. Hepatitis B is used as an analogy to establish precautions for clinical and laboratory staffs. CDC, *Acquired Immunodeficiency Syndrome (AIDS): Precautions for Clinical and Laboratory Staffs*, 31 *MMWR* 577-78 (1982).

122. *See CDC, Acquired Immunodeficiency Syndrome (AIDS): Precautions for Health-Care Workers and Allied Professionals*, 32 *MMWR* 101 (1983); *see also CDC, Summary: Recommendations for Preventing Transmission of Infection with HTLV-III/LAV in the Workplace*, 34 *MMWR* 581 (1985).

prevention of AIDS must extend to all members of groups with an increased incidence of the syndrome. The primary preventative measure for all members of groups with increased incidence is safe sex.<sup>123</sup> In addition to safe sexual practices, precautions have been taken to protect blood products.<sup>124</sup> In March, 1985, serologic testing for the HIV antibody was approved and all blood donors are now being tested.<sup>125</sup> It is believed this test will virtually eliminate the risk of contracting HIV from blood transfusions. Because the incubation period can be more than five years, however, new cases of transfusion-associated AIDS can be expected to appear for some time in persons infected with HIV before the screening test came into

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123. "Safe sex" practices must apply to all sexually-active persons, whether hetero-, bi-, or homosexual. All sexually active persons need to be aware that the greater the number of sexual partners, the greater the risk of acquiring HIV infection or AIDS. Even risks to monogamous individuals are increased if their partners are members of groups at risk for AIDS, if their partners are known sexual contacts of risk group members, or if their partners engage in sex with multiple individuals. See *Heterosexual Transmission*, *supra* note 72, at 2; see also CDC, *Prevention of Acquired Immunodeficiency Syndrome (AIDS): Report of Inter-Agency Recommendations*, 32 MMWR 101 (1983) [hereinafter *Inter-Agency*]; CDC, *Provisional Public Health Service Inter-Agency Recommendations for Screening Blood and Plasma for Antibody to the Virus Causing Acquired Immunodeficiency Syndrome*, 34 MMWR 1 (1985) [hereinafter *Screening Blood*].

124. Guidelines have been issued that ask members of risk groups not to donate blood. See *Inter-Agency*, *supra* note 123, at 101. These guidelines were expanded to include not only group members, but also to men who have had any sexual contact with another male since 1978. See WASH. REP., *supra* note 9. Prevention of AIDS transmission through blood or blood products includes advice to comply with strict medical indications for transfusion, use of autologous blood transfusions, and more careful screening of blood donors. See A. BENENSON, CONTROL OF COMMUNICABLE DISEASES IN MAN 4 (1981). Although autologous transfusions are encouraged, a joint statement released by the American Association of Blood Banks and the American Red Cross strongly recommends that directed donation programs not be conducted. Note, *Denial of Directed Blood Donations: Grounds for Negligence in Transfusion Transmitted Disease Cases*, 12 SAN FERN. V.L. REV. 11, 11 n.2 (1984). There is no scientific basis for the assumption that blood from donors selected by patients is safer than that available from volunteers at community blood banks. See Clark & Abramson, *AIDS: The Blood-Bank Scare*, NEWSWEEK, Jan. 28, 1985, at 62; Westphal, *Potential Liability For Transfusion-Associated AIDS*, 255 J.A.M.A. 195 (1986).

To protect persons with hemophilia, a heat treatment of factor VIII concentrate to kill the HIV virus was instituted in 1984. It is recommended that persons with hemophilia use these products, as follow-up studies of seronegative hemophiliacs suggest that these procedures do not transmit HIV. Preliminary results reported by the FDA show repeated ELISA reactivity in 0.25% of the first 1.1 million units of donated blood tested. See also CDC, *Update: Public Health Service Workshop on Human T-Lymphotropic Virus Type III Antibody Testing-United States*, 34 MMWR 477 (1985); Peterman, *supra* note 6, at 12.

125. Also, donor organs, tissues, and sperm should be tested. Any blood that tests positive is discarded. See *Screening Blood*, *supra* note 123, at 1; CDC, *Testing Donors of Organs, Tissues, and Semen for Antibody to Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus*, 34 MMWR 294 (1985); FDA DRUG BULL., *supra* note 20, at 2.



use.<sup>126</sup>

The availability of the HIV test created another concern. It was feared that people who suspected they had contracted AIDS might donate blood for the sole purpose of finding out if they had AIDS.<sup>127</sup> Since the test produces some false negatives, alternative test sites were established in many communities specifically for those who wanted to be tested. Therefore, persons who suspect they might be at risk of contracting AIDS are able to be tested without the danger of exposing the blood supply to contaminated blood.

Initial attempts to prevent the spread of AIDS have resulted in guidelines regarding safe sexual practices, guidelines for health care workers and blood bank recommendations and screening procedures. Because of the long incubation period for HIV, it has not been possible to assess the net effect of these recommendations.<sup>128</sup> Without a vaccine for HIV, public education regarding this disease remains the most effective form of prevention today.

Not only is this disease extremely debilitating, but it also has a substantial impact on our national health care costs for infectious diseases.<sup>129</sup> Margaret Heckler, former commissioner of the United

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126. It has been estimated that donor screening has prevented 6000 cases of transfusion-transmitted AIDS per year. *Transfusion-Associated*, *supra* note 32, at 38. Some experts believe the HIV test will not entirely eliminate the risk of contracting AIDS from blood transfusions. The latency period is believed to be one day to several weeks before the person converts to a seropositive status. In addition, a small amount of HIV carriers do not produce detectable amounts of antibody. See Laurence, *supra* note 98, at 92. For these reasons, current procedures for screening blood donors may not entirely eliminate the risk of infection from blood transfusions. The current methods appear to be 99% successful in identifying HIV infected blood. Hilgartner, *supra* note 22, at 197. As of February of 1987, many transfusion-associated patients had not progressed to the full-blown state of AIDS. *Id.* at 105.

As of August of 1986, the CDC had recorded 466 cases of AIDS related to the transfusion of HIV-contaminated blood products. This accounted for 1.72% of the total number of AIDS cases. An additional 220 had been reported in hemophiliacs who had received plasma concentrate products. *Id.*

127. Wallis, *AIDS: A Growing Threat*, TIME, Aug. 12, 1985, at 44.

128. There is evidence that safe sex recommendations are being followed, as there has been a decline in rectal and pharyngeal gonorrhoea among males. CDC, *Declining Rate of Rectal and Pharyngeal Gonorrhoea Among Males-New York City*, 33 MMWR 295 (1984); Moss, *supra* note 59, at 1035.

129. The average per patient cost in hospital expenses is \$140,000. Immune function tests alone range from \$100 to \$600. Total treatment could cost \$5.6 billion. *Cost of AIDS Cases Exceeds \$5.6 Billion, CDC Says*, Am. Med. News, May 17, 1985, at 23, col. 1. Direct costs include health care services, hospitalization, and out-patient care. Indirect costs include lost income from disability and premature death. The impact of this disease can be emphasized by considering the years of potential life lost, since most people who contract this disease are young. *Id.* Assuming 9000 cases of AIDS, 7,538 years of work will be lost due to disability, at a cost of \$161.7 million. *Id.* at 23, col. 3. If the incidence of AIDS doubles as is expected, the overall cost of treating all infectious diseases (now estimated to be \$4 billion to \$14 billion a year in direct costs

States Department of Health, has called the AIDS epidemic the nation's number one priority.<sup>130</sup> In spite of this, critics have said that the administration has not given it priority funding. These critics believe national responses from the government, medical community, media and the public have been less than zealous when compared to the reactions which followed outbreaks of toxic shock syndrome and Legionaire's disease.<sup>131</sup>

Unlike the federal government, state governments have somewhat responded to the AIDS situation. AIDS-related legislation has been introduced in almost all 50 states. Ninety AIDS-related proposals have been adopted out of the 550 proposals made in state legislatures.<sup>132</sup> Most of the legislation addresses at least testing and screening, public education, confidentiality, financing and administration or social and medical services.<sup>133</sup> A frequent goal of AIDS-related legislation is the creation of a public entity responsible to coordinate a state's policies with respect to AIDS and to oversee implementation of specific goals and programs.<sup>134</sup>

#### F. Summary

Though the spread of AIDS has reached epidemic proportions in this country, much confusion still surrounds the etiology of the disease. A great deal of public hysteria results from the press disseminating incomplete information and misinformation. Even though researchers have gained much knowledge about the disease's affinity for certain groups and the transmission of the infection, the disease will continue to be a health threat in the United States and throughout the world, until the etiology of AIDS is completely understood. With the discovery of the infectious agent, HIV, epidemiologists have been able to more clearly define the problems surrounding this disease, but much more information is needed to completely calm the hysteria and confusion.

The actual AIDS epidemic includes not only the growing number of people who have been diagnosed with AIDS, but also, the possibly millions who have been infected with the HIV virus. Because of the lengthy incubation and infectious periods of AIDS, a continued rise

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and \$6 billion a year in indirect costs) could skyrocket. Costs can be expected to rise higher as the number of cases continues to increase. *Id.*

130. Isaacson, *Hunting for the Hidden Killers*, TIME, July 4, 1983, at 50.

131. *Id.* at 50-51. A \$411 million AIDS budget for 1987 was almost double the administration's proposal. For fiscal 1988, the administration proposes to increase spending to \$534 million. 2 AIDS POLICY & LAW (BNA) no. 15, at 1 (Aug. 12, 1987).

132. See 2 AIDS POLICY & LAW (BNA) no. 23, at 4 (DEC. 2, 1987).

133. IHPP, *supra* note 131, at 1-24.

134. Intergovernmental Health Policy Project at the George Washington University, *A Review of State and Local Government Initiatives Affecting AIDS*, Nov. 27, 1985, 7 [hereinafter IHPP] (copy on file at William Mitchell Law Review office).

in the morbidity and mortality rates is expected for an extended time period. Every infected individual has a cloudy medical future and should be considered indefinitely infectious. AIDS has been as relentless as leukemia, as contagious as hepatitis, and a vaccine for cure has eluded researchers for years. The uncertain and lengthy process of vaccine development is necessary before prevention through immunization can be attempted, but unless scientists can develop a vaccine, the disease will continue to spread. Education and encouragement of individual responsibility regarding the disease represent the greatest hope of containing the spread of AIDS.

## II. CONSTITUTIONAL ISSUES

### A. Introduction

For many years, infectious diseases of all kinds have resulted in statutes, regulations and court decisions that impose special restraints on both the infected individual's freedom and the society's interest in the protection of public health.<sup>135</sup> As the number of AIDS cases continues to increase, state legislatures are passing initiatives that attempt to strike a balance between the health needs of AIDS patients and the public's concern over the spread of the disease.<sup>136</sup>

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135. See, e.g., ARK. STAT. ANN. §§ 82-612, 82-613 (1976) (quarantine of tuberculosis patients); CAL. HEALTH & SAFETY CODE § 3051 (West 1975) (Communicable Disease Prevention and Control Act); COLO. REV. STAT. § 25-4-405 (West Supp. 1986) (control of venereal disease); FLA. STAT. ANN. § 381.231 (West 1979) (reporting); FLA. STAT. ANN. § 384.21 (West Supp. 1987) (Control of Sexually Transmissible Disease Act); ILL. STAT. ch. 34 § 5001 (Smith-Hurd 1960) (power to quarantine); IOWA CODE ANN. § 139.3 (West 1972) (power to quarantine as related to communicable diseases); KY. REV. STAT. ANN. § 214.020 (Baldwin 1982) (mandate to adopt regulations to prevent the spread of infectious disease); OHIO REV. CODE ANN. § 3707.27 (Baldwin 1987) (vaccination); W. VA. CODE § 26-5A-5 (1986); see generally *State v. Snow*, 230 Ark. 746, 324 S.W.2d 532 (1959) (proceeding to require isolation of recalcitrant tuberculous patient); *In re Culver*, 187 Cal. 437, 202 P. 661 (1921) (petitioner's act in tearing down quarantine placard was a misdemeanor under the Public Health Act); *Crayton v. Larabee*, 220 N.Y. 493, 116 N.E. 355 (1917) (upholding city ordinance which prohibited communication with infected households); *State v. Butts*, 3 S.D. 577, 54 N.W. 603 (1893) (defendant must have knowledge of quarantine before he can have violated order).

136. See *supra* note 132-34. Public health authorities have used a number of means to control communicable diseases in the community. It is the intent of this section to show that decisions regarding individuals infected with the HIV virus must be based on rational thought and on what scientific medical knowledge there is available today.

Statutes were codified to address several issues as a result of legislative action in 1986 and 1987. See, e.g., CONN. GEN. STAT. ANN. § 19a-221 (West 1986) (authorizing confinement of communicable disease carriers); FLA. STAT. ANN. § 381.606 (West 1986) (regulating testing procedures for infectious diseases); FLA. STAT. ANN. § 384.28 (West Supp. 1988) (ordering quarantine of carriers of sexually transmitted disease); IOWA CODE ANN. § 139.2 (1987) (required reporting of any communicable

The legality of measures to control the spread of infectious diseases are determined under principles of constitutional law that require an individual's interest in liberty and privacy to be balanced against the public's interest in health and safety. In balancing the competing interests involved in AIDS-related initiatives, the least restrictive measures should be used. These measures should be based on current medical knowledge about AIDS.<sup>137</sup> If decisions are not medically based, misconceptions about the victims of AIDS and the nature of the disease may influence attempts to safeguard the public health.<sup>138</sup>

The nature of AIDS intensifies constitutional issues for both individual patients and members of high-risk groups and the general public as a whole. For the individual, measures to control the spread of AIDS may invade privacy, constrain civil rights and limit liberty. For the public, the AIDS infection continues to spread with fatal results and increasing financial burdens.

An array of measures, from mild to highly restrictive, are available to public health authorities to protect the public from disease. In approaching the problem of future spread of AIDS, legislators and public health authorities grapple with the possible civil rights infringements of AIDS patients and members of high-risk groups.

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disease); MINN. STAT. §§ 144.4171-.4186 (regulating activities of carriers of communicable diseases); WIS. STAT. ANN. § 146.023 (West Supp. 1987) (required testing of donated blood); WIS. STAT. ANN. § 146.025 (West Supp. 1987) (restrictions on the use of the HIV test).

137. See generally Parent, *Moral, Ethical and Legal Aspects of Infection Control*, 13 AM. J. INFECTION CONTROL 278 (1985) (infection control practitioners are obligated to provide facts and statistical data relating to epidemiologic investigations so that hazards can be recognized and controlled).

138. See Melton, *The Law and Ethics of Psychosocial Research on AIDS*, 64 NEB. L. REV. 637, 677-80 (1985). Public fear exerts pressure on decision-makers for health measures which are not supported by medical necessity. The isolation of HIV antibody and the availability of the test to detect the presence of infection are important developments. However, the test has created privacy problems because of its potential for misuse. Policies are being promoted which will restrict the rights of individuals to education, housing, and insurance, based on their antibody status.

Many homosexual men have been fired from their jobs, evicted from their homes, and refused medical and dental treatment. Homosexuals suffer from prejudice and discrimination without AIDS; they suffer additional prejudice once a diagnosis is made. There is also the threat of criminal prosecution of people with AIDS in twenty-five states that still have sodomy statutes. See *id.* at 655.

A stigma surrounds the risk group populations for AIDS due to the public's generalized fear of the disease. Since the public fears catching the disease, social isolation of these populations has resulted. Some stigma occurs even if an individual does not actually have the disease. Disclosure of the seropositive status will lead to further segregation of these risk populations. See *AIDS: Fear and Loathing*, EMERGENCY MEDICINE, Oct. 30, 1983, at 157.

AIDS regulations affect these individuals' rights to privacy, property, free association and free expression.

This discussion involves the constitutionality of proposed initiatives regarding mandatory testing of those suspected of AIDS infection, AIDS reporting requirements, quarantine of AIDS patients and the closure of bathhouses frequented by homosexual men. Since there is very little case law regarding AIDS, this discussion will draw upon precedents in statutes, regulations and court decisions regarding other fatal or communicable diseases and upon current knowledge about AIDS.

### 1. *Constitutional Basis of Public Health Law*

The United States Constitution reserves the responsibility for public health protection to the states.<sup>139</sup> This responsibility gives the states power to ensure protection and service in the area of public health. Law upon which this authority rests has been well settled for decades.<sup>140</sup>

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139. U.S. CONST., amend. X; see *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 205 (1824) (quarantines and health laws are considered as flowing from the power of a state to provide for the health of its citizens).

140. *Jacobson v. Massachusetts*, 197 U.S. 11, 25 (1905) (state required smallpox vaccination not a violation of due process); see generally Damme, *Controlling Genetic Disease Through Law*, 15 U.C. DAVIS L. REV. 801 (1982) (discussing states' authority and duty to protect public health in connection with genetic disease); cf. Morgenstern, *The Role of the Federal Government in Protecting Citizens from Communicable Diseases*, 47 U. CIN. L. REV. 537, 544-45 (1978) (Constitution reserves responsibility for public health to the states, but when questions of interstate or international health questions are involved, responsibility is delegated to the federal government).

*Jacobson* established that, in the absence of arbitrary and oppressive legislation, the ability of local authorities to promulgate statutes and regulations based on the police power of the state prevails. *Jacobson*, 197 U.S. at 37-38. The court goes on to further define the role of the state:

According to settled principles the police power of a state must be held to embrace, at least, such reasonable regulations established directly by legislative enactment as will protect the public health and the public safety. It is equally true that the State may invest local bodies called into existence for purposes of local administration with authority in some appropriate way to safeguard the public health and the public safety.

*Id.* at 25.

The state's authority to regulate public health has been used to regulate the conduct of those in the health industry. In *Barsky v. Board of Regents of the Univ. of N.Y.*, 347 U.S. 442 (1954), a physician was convicted in a federal court and sentenced to six months in jail because he failed to produce records for a congressional committee. His license was then suspended under a state statute allowing suspension upon being convicted of any crime. The constitutionality of this statute was upheld on the grounds that the state has authority under its police power to regulate conduct of those in the health industry. *Id.* at 449.

The second branch of the states' authority in the public health area is known as the *parens patriae* power, which allows the government, or its agencies, acting on behalf of citizens' welfare, to take steps to protect them from harm. Examples of the

In exercising this broad power, states began to enact various public health measures to control the spread of infectious or communicable diseases. Such measures included compulsory physical examinations,<sup>141</sup> quarantine and closure of public places,<sup>142</sup> compulsory vaccination and immunization programs as a prerequisite to school attendance<sup>143</sup> and blood testing to determine the presence of

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parents patriae power are protective services, guardianship, and certain types of civil commitment. Parry, *AIDS as a Handicapping Condition*, 9 MENTAL & PHYSICAL DISABILITIES RPTER. 402 (1985).

Federal government jurisdiction in the public health field is exercised through direct regulation and in cooperation with or through state programs. Through grants, which provide funds for programs, the federal government uses state programs to carry out federal policy. In order to receive the aid, states must adopt federal standards. See Morgenstern, *supra*, at 544. The CDC issues guidelines on AIDS-related issues, and, depending on a state's conformance to those guidelines, funds are appropriated by Congress. Therefore, the federal government determines the nature and scope of state programs and influences the exercise of the state's police power. Local health authorities initiate measures to control infectious diseases under power derived from the state.

141. Where a person is reasonably suspected of being infected with a communicable disease, or of being a carrier of such a disease, many laws give states the power to compel examination of these persons as a basis for determining further measures that need to be taken for the protection of the public. *E.g.*, *Huffman v. District of Columbia*, 39 A.2d 558 (D.C. App. 1944) (allowing an agency to compel the examination of a person suspected to be infected with a communicable disease).

The police power authority for examination is usually seen in cases that involve criminal charges where the defendant is quarantined for, or ordered to undergo treatment for venereal disease. See, *e.g.*, *Reynolds v. McNichols*, 488 F.2d 1378, 1380 (10th Cir. 1973); *Varholy v. Sweat*, 153 Fla. 571, 573-74, 15 So. 2d 267, 269 (1943); *People ex rel. Baker v. Strautz*, 386 Ill. 360, 368, 54 N.E.2d 441, 445 (1943); *Wragg v. Griffin*, 185 Iowa 243, 252-53, 170 N.W. 400, 403 (1919); *Welch v. Shepherd*, 165 Kan. 394, 394, 196 P.2d 235, 236 (1948); *Ex parte Fowler*, 85 Okla. Crim. 64, 74-5, 184 P.2d 814, 816 (1921).

The state's police power to require an examination is also seen in cases involving an examination as a condition for school attendance. *E.g.*, *Streich v. Board of Educ.*, 34 S.D. 169, 180-81, 147 N.W. 779, 783 (1914).

142. Quarantine is one of the most frequent powers conferred on boards of health. A state may require temporary detention of persons having, or reasonably suspected of having, a communicable disease that is dangerous to the public health. *E.g.*, *In re Halko*, 246 Cal. App. 2d 553, 557, 54 Cal. Rptr. 661, 664 (1966) (tuberculosis); *Moore v. Draper*, 57 So. 2d 648, 649 (Fla. 1952) (tuberculosis); *People ex rel. Barmore v. Robertson*, 302 Ill.422, 431-32, 134 N.E. 815, 819 (1922) (typhoid carrier); *Ex parte Caselli*, 62 Mont. 201, 202-03, 204 P. 364, 364 (1922) (gonorrhoea); *Kirk v. Wyman*, 83 S.C. 372, 374-79, 65 S.E. 387, 388-90 (1909) (leprosy).

A state may also require the exclusion of persons from school who have not been vaccinated for communicable disease. *Hartman v. May*, 168 Miss. 477, 484-85, 151 So. 737, 738-39 (1934); *Duffield v. School Dist.*, 162 Pa. 476, 483-84, 29 A. 742, 742-43 (1894).

States also have police power to prohibit gatherings or congregation of persons during an epidemic. *Montgomery v. Board of Educ.*, 102 Ohio St. 189, 192-93, 131 N.E. 497, 498 (1921).

143. States began to exercise their police power in the 19th century to require

various diseases, as well as a prerequisite to obtaining marriage licenses.<sup>144</sup>

Initially, statutes to regulate public health were challenged on due process grounds.<sup>145</sup> However, the constitutional guarantees of life, liberty and property were not meant to limit the police power as the courts applied a minimum rationality standard of review.<sup>146</sup> States were given substantial discretion to choose among alternative approaches for dealing with public health problems. Consequently, as the regulation required only some "reasonable" relation to public health or public welfare, most measures to control or prevent disease were upheld as a valid exercise of the state's police power.

When applying the minimum rationality standard, early courts re-

vaccinations for various diseases as a prerequisite for school attendance. *E.g.*, *Jacobson*, 197 U.S. at 38; *Abeel v. Clark*, 84 Cal. 226, 230, 24 P. 383, 384 (1890); *Hartman*, 168 Miss. at 484, 151 So. at 739; *Pierce v. Board of Educ.*, 30 Misc. 2d 1039, 1040-41, 219 N.Y.S.2d 519, 521 (N.Y. Sup. Ct. 1961); *Viemeister v. White*, 179 N.Y. 235, 239, 72 N.E. 97, 99 (1904); *Duffield*, 162 Pa. at 483, 29 A. at 742. *But see* *Potts v. Breen*, 167 Ill. 67, 74, 47 N.E. 81, 85 (1897) (state cannot require vaccination where small-pox did not exist in community).

By 1976, 47 states required at least one type of immunization prior to school entry. *See* *Morgenstern*, *supra* note 139, at 545, n.62.

144. Statutes were enacted in many states requiring a blood test before a marriage license would be issued. *See, e.g.*, ALASKA STAT. § 25.05.101-.108 (1977) (repealed 1984); ARIZ. REV. STAT. ANN. §§ 25-103.01 (1976) (repealed 1984); ILL. ANN. STAT. §§ 204-05 (Smith-Hurd 1987); IOWA CODE ANN. § 596.1 (1981) (repealed 1982); KY. REV. STAT. ANN. § 402.310-.314 (Baldwin Supp. 1984) (blood test used for sickle cell anemia testing). *But see* IND. CODE ANN. § 31-7-4-1 (West Supp. 1987) (requiring only women to be tested); NEB. REV. STAT. §§ 121, 121.01 (1986 Supp.) (requiring only women to be tested);

A blood test was authorized in *City of Little Rock v. Smith*, 204 Ark. 692, 693, 163 S.W.2d. 705, 706 (1942). *But see* *Wragg*, 185 Iowa at 252, 170 N.W. at 403 (court ruled that state cannot forcibly withdraw blood from a person to determine if that person is infected with a venereal disease without a state statute in effect).

Most jurisdictions required, as a prerequisite to the issuance of marriage licenses, that blood tests be taken of both male and female partners to marriage. *But see* *Peterson v. Widule*, 157 Wis. 641, 648-49, 147 N.W. 966, 968 (1914) (only men required to be tested). These regulations were upheld on the theory that the state has the power to prohibit marriage of persons affected with diseases that can be transmitted to spouses or inherited by offspring. *Id.*

145. *Kirk*, 83 S.C. at 379, 65 S.E. at 390. Due process required notice and an opportunity to be heard in proceedings which determined whether or not there was a violation. *Id.*

146. *See, e.g.*, *Viemeister*, 179 N.Y. at 237-41, 72 N.E. at 98-99 (recognized that states can enact quarantine and health laws of every description); *see also* L. TRIBE, AMERICAN CONSTITUTIONAL LAW § 6-12, at 340 (1978) [hereinafter TRIBE]. This standard presumes the legislation's validity unless it bears no reasonable relation to the achievement of a proper government objective or it is capricious, arbitrary, or otherwise unreasonable and oppressive. *Damme*, *supra* note 140, at 805. Legislation will not be found invalid unless it is found to be arbitrary, oppressive or unreasonable. *Jacobson*, 197 U.S. at 38; *Varholc*, 153 Fla. at 576, 15 So. 2d. at 269; *People ex rel. Barmore*, 302 Ill. at 432, 134 N.E. at 819.

lied on popular, common beliefs about the spread of disease to support the medical soundness of a regulation.<sup>147</sup> Physicians could do very little to alter the spread of disease, and the measures that were used—vaccination and quarantine—did not require medical knowledge to be initiated. Therefore, courts granted the legislatures great latitude in rulemaking for the control of disease.

## 2. *Modern Approach to Public Health Measures*

Today, public health regulations may be challenged on various grounds. The most significant sections of the Constitution that limit the exercise of a state's police power are located in the due process and equal protection clauses of the fourteenth amendment.<sup>148</sup> When courts rule on a due process violation that does not involve a fundamental right, they will apply the lowest level of scrutiny; and as long as the law is designed to protect society or the health of an individual, the enactment is likely to be validated.<sup>149</sup> As measures to control disease become more restrictive and invasive, however, the minimum scrutiny test becomes increasingly difficult to apply.

Challenges to public health regulations may be based on protections found in the equal protection clause. Equal protection decisions have established that laws infringing on suspect classifications or fundamental rights will be held to a strict scrutiny standard of review.<sup>150</sup> An intermediate tier has been developed to protect "quasi-suspect" classes from legislation that burdens important, but not fundamental rights.<sup>151</sup> A court determines whether or not legis-

147. See *Viemeister*, 179 N.Y. at 237-39, 72 N.E. at 98. Several cases reflected the judicial belief that common sense was at least as important as medical responses. *Id.* "A common belief, like common knowledge, does not require evidence to establish its existence, but may be acted upon without proof by the Legislature and the courts. . . . The possibility that the belief may be wrong, and that science may yet show it to be wrong, is not conclusive. . . ." *Id.* at 240, 72 N.E. at 99.

148. U.S. CONST. amend. XIV, § 1, "No state shall. . .deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

149. See *supra* note 146 and accompanying text.

150. A law which serves a compelling state interest and does so in the least restrictive manner will survive a challenge of its constitutional validity. See *TRIBE, supra* note 146, § 16-12, at 1011, § 16-13m at 1012; see also *United States v. Carolene Products Co.*, 304 U.S. 144, 152-53 n.4 (1938). Classifications based on race, alienage and national origin are suspect. *TRIBE, supra* note 146, § 16-13, at 1010-82.

One of the fundamental rights recognized by the Court is privacy. *Shapiro v. Thompson*, 394 U.S. 618, 629-30 (1969); see *infra* notes 153-64 and accompanying text.

Equality is denied when the government classifies so as to distinguish between persons who should be seen as similarly situated in terms of relevant equal protection principles or fails to classify at all. *TRIBE, supra* note 146, § 16-1, at 993.

151. See *TRIBE, supra* note 146, § 16-33, at 1610. Under this standard, the objective must be substantially related to the achievement of an important state interest.



lation affecting a classification should be subject to higher scrutiny based on the following factors: whether or not the class has suffered a long history of prejudice, whether or not the class lacked significant choice in making decisions, and whether or not a class' characteristics affect their ability to participate in society. Arguably, the high risk groups for contracting AIDS share many of these characteristics and are likely victims of discrimination that could be protected by heightened scrutiny.<sup>152</sup>

One fundamental interest, the right to privacy, is now firmly established as a constitutional liberty protected by the due process clause of the fourteenth amendment. Although the Constitution does not explicitly mention a right to privacy, in a line of cases going back as far as 1891,<sup>153</sup> the Supreme Court has recognized that a right of personal privacy, or guarantees of "zones of privacy," does exist under the Constitution.<sup>154</sup> This emerging right has been found in various areas of the text of the Constitution.<sup>155</sup>

Even though the right has found constitutional protection, it must

Lalli v. Lalli, 439 U.S. 259, 274-75 (1978) (inheritance rights of illegitimate children should be equal to those enjoyed by legitimate children); *Frontiero v. Richardson*, 411 U.S. 677, 682 (1973) (gender classification as quasi-suspect).

152. Before the AIDS crisis, homosexuals had made progress towards finding equal protection of the laws through the decriminalization of state sodomy statutes and through their fight against discrimination in the workplace and housing. But as three-fourths of AIDS patients are gay men, there is now resistance to basic civil rights for these individuals. To date, the Supreme Court has not classified homosexuals as a suspect or quasi-suspect class. See Note, *The Constitutional Status of Sexual Orientation: Homosexuality as a Suspect Classification*, 98 HARV. L. REV. 1285 (1985); Note, *An Argument for the Application of Equal Protection Heightened Scrutiny to Classifications Based on Homosexuality*, 57 CALIF. L. REV. 797 (1964).

153. *Union Pacific Ry. Co. v. Botsford*, 141 U.S. 250 (1891) (the right of common law privacy meant the state did not have the authority to compel a person to submit to a medical examination). "No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." *Id.* at 251.

154. *Roe v. Wade*, 410 U.S. 113, 152 (1973); *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965).

155. See *Doe v. Bolton*, 410 U.S. 179, 211 (1973) (Douglas, J., concurring) (ninth amendment); *Griswold*, 381 U.S. at 484-85 (emanating from the penumbra of the Bill of Rights); *Boyd v. United States*, 116 U.S. 616, 630 (1886) (fourth and fifth amendments).

Several decisions have found the right in the due process clause of the fourteenth amendment. *Roe v. Wade*, 410 U.S. 113, 153 (1973); *Palko v. Connecticut*, 302 U.S. 319, 325 (1967); *Lovisi v. Slayton*, 363 F.Supp. 621, 625-26 (E.D.Va. 1973), *aff'd en banc*, 539 F.2d 349 (4th Cir. 1976). Other decisions found the right in the Equal Protection Clause of the Fourteenth Amendment. *Loving v. Virginia*, 388 U.S. 1, 8 (1967).

Subsequent Supreme Court decisions have firmly established the constitutional nature of the right of privacy. *Carey v. Population Serv. Int'l*, 431 U.S. 678, 684 (1977); *Whalen v. Roe*, 429 U.S. 589, 598-99 (1977).

encompass only those interests "that can be deemed 'fundamental' or 'implicit in the concept of ordered liberty.'"<sup>156</sup> Although Justice Brandeis generally described privacy as the "right to be let alone,"<sup>157</sup> much commentary has been written in an attempt to further define this elusive concept.<sup>158</sup> In recognition of this interest, the Massachusetts Supreme Court has found privacy to be "an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life."<sup>159</sup> In most rulings, the United States Supreme Court has vigorously protected the right to make autonomous decisions in various areas of fundamental importance.<sup>160</sup>

The Supreme Court's most comprehensive attempt to define the constitutional right to privacy came in *Whalen v. Roe*.<sup>161</sup> In *Whalen*, Justice Stevens suggested that the right encompassed something beyond prior Court decisions in that the right embraced both an "interest in avoiding disclosure of personal matters"<sup>162</sup> and also an "interest in independence in making certain kinds of important decisions."<sup>163</sup> The first interest is based on the tort principle that an

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156. *Roe v. Wade*, 410 U.S. at 152. The Constitution contains no discussion of the "right to be a human being; no definition of a person; and, indeed, no express provision guaranteeing to persons the right to carry on their lives protected from the vicissitudes of the political controversies' . . ." (quoting West Virginia State Bd. of Educ. v. Barnette, 319 U.S. 625, 638 (1943)) (emphasis in original) See also *Palko v. Connecticut*, 302 U.S. at 325.

The right of privacy has also been made explicit in state constitutions. See, e.g., ALASKA CONST. art.I, § 22; HAWAII CONST. art.I, § 6.

157. *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting) overruled by *Katz v. United States*, 389 U.S. 347 (1967).

158. See generally Henkin, *Privacy and Autonomy*, 74 COLUM. L. REV. 1410, 1419 (1974) (autonomy or control over personal liberties); Comment, *A Taxonomy of Privacy: Repose, Sanctuary, and Intimate Decision*, 64 CALIF. L. REV. 1447 (1976).

159. *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 742, 370 N.E.2d 417, 426 (1977).

160. *Carey v. Population Serv. Int'l*, 431 U.S. 678, 681-82 (1977) (sale of contraceptives to minors); *Kelley v. Johnson*, 425 U.S. 238, 239 (1976) (decisions relating to police officer's personal appearance); *Roe v. Wade*, 410 U.S. 113, 153 (1973) (abortion); *Eisenstadt v. Baird*, 405 U.S. 438, 453-54 (1972) (contraception); *Loving v. Virginia*, 388 U.S. 1, 12 (1967) (decision to marry); *Griswold v. Connecticut*, 381 U.S. 479, 485 (contraception); *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944) (family relationships); *Skinner v. Oklahoma*, 316 U.S. 535, 541-42 (1942) (procreation); *Pierce v. Society of Sisters*, 268 U.S. 510, 535 (1925) (child education).

161. 429 U.S. 589, 591-93 (1977) (involving a challenge to a New York drug law which required the New York Public Health Commissioner to obtain from physicians the names and addresses of all persons who had received certain drugs and to record the information in a central computer file).

162. *Id.* at 599.

163. *Id.* at 599-600 (citing *Griswold* and other cases in support of both privacy interests). The Supreme Court did not apply a compelling state interest test, but rather the statute was upheld because it rationally related to the legitimate state interest of regulating drug abuse. *Id.* at 598-604.

individual has an interest in avoiding public disclosure of personal facts, and the second interest has its basis in the *Roe v. Wade* decision's holding that an individual has a right to reproductive decision-making. Thus, the *Whalen* Court indicated that the right to privacy encompasses a broader area of protection than just the series of factual situations considered in previous decisions.<sup>164</sup>

Although the right to privacy has been significantly expanded, it is not absolute. Where certain fundamental rights are involved, the Court has held that regulations limiting those rights are justified only if a compelling state interest exists and the means chosen to achieve that interest is the least restrictive available.<sup>165</sup> Courts have gener-

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164. See *infra* notes 200-02 and accompanying text regarding the extension of the right of privacy to personal, medical information. Courts have recognized the *Whalen* right to nondisclosure of personal matters. See, e.g., *Nixon v. Administrator of Gen. Serv.*, 433 U.S. 425, 457 (1977) (acknowledged privacy right of public officials in personal capacity); *United States v. Westinghouse Elec. Corp.*, 638 F.2d 570, 577 (3rd Cir. 1980) (medical records of employees); *Plante v. Gonzalez*, 575 F.2d 1119, 1134 (5th Cir. 1978) (financial privacy of elected officials), *cert. denied*, 439 U.S. 1129 (1979).

Courts have also recognized the second category of "independence in making certain kinds of important decisions." *Whalen*, 429 U.S. at 599-600. These decisions include the right to refuse medical treatment and the right to die. See *In re Quinlan*, 70 N.J. 10, 38-42, 355 A.2d 647 662-64 (1976), *cert. denied* 429 U.S. 922 (1976). The New Jersey Supreme Court in *Quinlan* found that an individual's right of privacy outweighed the state's interest in preserving life, where the individual was a hospital patient maintained on a respirator and could never resume a substantial life. *Id.* See also *Andrews v. Ballard*, 498 F. Supp. 1038, 1046-47 (S.D. Tex. 1980) (discussing privacy rights found in decision to obtain or reject medical treatment); *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 279 A.2d 670, 673 (1971) (recognizing hospital's interests in pursuing medical procedure despite patient's religious objections).

165. The strict scrutiny standard of review shifts the burden to the state and is so difficult to overcome that the selection of the test usually means the demise of the legislation. See *Roe v. Wade*, 410 U.S. at 154-55. The Court rejected the belief that a person has the right to do with one's body as one pleases because of important state interests in public health protection. *Id.* Some state regulation in protected areas is appropriate, as the *Roe* Court noted by stating: "A State may properly assert important interests in safeguarding health, in maintaining medical standards, and in protecting potential life." *Id.* at 154.

The Supreme Court has upheld the strict scrutiny standard in *Carey v. Population Serv. Int'l*, 431, U.S. 678 (1977) and in *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52 (1976). When the strict scrutiny standard is applied to legislation that affects marital privacy, it is an almost impossible standard to meet. Note, *AIDS—A New Reason to Regulate Homosexuality?*, 11 J. CONTEMP. L. 315, 321 (1984). Only one law has ever been upheld by the Supreme Court after being designated a fundamental right and subject to strict scrutiny. *Korematsu v. United States*, 323 U.S. 214, 220 (1944) (federal law justified by the compelling state interest in protecting national security).

In determining whether a right is fundamental, courts first examine the nature of the underlying right sought to be protected. If there is no burden, there is no constitutional issue; so the threshold requirement for strict scrutiny is never met. See gener-

ally found that preservation of public health is a compelling state interest.<sup>166</sup> Legislatures that enact laws based on unsubstantiated fears or that discriminate as a guise to protect the public health, however, are impermissible.<sup>167</sup> Although protecting public health is a compelling interest, an improper purpose is concern over the association of AIDS patients to homosexuality and intravenous drug use. Many challenges of public health legislation and regulation, based on the right to privacy, fail because they fall beyond that right.<sup>168</sup> These regulations are subject only to the rational basis test.<sup>169</sup>

Courts defer to a legislature's determination of what is necessary and desirable to protect and ensure public health.<sup>170</sup> They are likely to find that legal prohibitions on medical treatment involve nothing more than regulation of treatment and are not within the scope of the right to privacy.<sup>171</sup> The right to do as one pleases with one's body has received only limited recognition as a constitutional right.<sup>172</sup> This all-or-nothing approach to privacy protection neglects autonomy interests which, though not considered fundamental, do

ally Appleton, *Doctors, Patients and the Constitution: A Theoretical Analysis of the Physician's Role in "Private" Reproductive Decisions*, 63 WASH. U.L.Q. 183, 184-85 n.3 (1985).

166. Protecting the public from AIDS is considered a compelling state interest. *Brown v. Stone*, 378 So. 2d 218, 222 (Miss. 1979) (compulsory vaccination is a compelling reason to override parental interests), *cert denied*, 449 U.S. 887 (1980).

167. *City of Cleburne v. Cleburne Living Center*, 473 U.S. 432 (1985) (negative attitudes or unsubstantiated fears are not permissible for public health law); *O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975) ("[m]ere public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty").

168. See generally Comment, *Privacy in Personal Medical Information: A Diagnosis*, 33 U. FLA. L. REV. 394, 418 (1981) (neither the physician-patient relationship nor the privacy of medical information have been recognized as fundamental rights).

169. *Harris v. McRae*, 448 U.S. 297, 325 (1980) (legitimate governmental objective of protecting potation life); *Maher v. Roe*, 432 U.S. 464, 478 (1977) (minimum rationality standard used in a series of unsuccessful challenges to government programs that subsidized childbirth for indigent women but did not fund abortions); *People v. Privitera*, 23 Cal.3d 697, 701, 153 Cal. Rptr. 431, 433 (challenged prohibition of laetrile, used for cancer treatment, as a violation of due process) *cert. denied*, 444 U.S. 949 (1979). The California court found that with regard to questions of medical treatment where a danger to health exists, the state regulation is to be judged under the rational basis standard. While the *Whalen* court recognized a right of privacy in personal information, the degree of protection accorded the physician-patient relationship and individual medical information was left unsettled. The court did not discuss the right to privacy. If it had, it would have required a compelling state interest to justify the infringement of the drug law.

170. See Note, *Preventing the Spread of AIDS By Restricting Sexual Conduct in Gay Bathhouses: A Constitutional Analysis*, 15 GOLDEN GATE U.L. REV. 301, 311 n.51 (1985).

171. See, Appleton, *supra* note 165, at 483; Comment, *Current Topics in Law and Policy, Fear Itself: AIDS, Herpes and Public Health Decisions*, 3 YALE L. & POL'Y REV. 479, 483 (1985) [hereinafter *Fear Itself*].

172. See generally Note, *supra* note 165, at 321-23 (1984).

deserve some degree of constitutional protection.<sup>173</sup> Exercise of a state's police power to protect public health has been sustained in a variety of actions, provided that the objective is reasonable, within the scope of authority and the action is related to the objective sought.<sup>174</sup> If a fundamental constitutional right is involved, the action must also be justified by a compelling state interest.<sup>175</sup>

The changing standards of review used by the Supreme Court when privacy is at issue make it difficult to determine just what state action is justified or unjustified.<sup>176</sup> Infectious disease programs have been effective in the past.<sup>177</sup> Early public health case law provides little guidance to modern courts in evaluating AIDS regulations.<sup>178</sup> Although early health law balanced the government's interest in protecting the population from epidemics and unsanitary living conditions against the private rights of individuals, courts relied on common beliefs about the spread of disease and, in its infancy, medicine offered little assistance.<sup>179</sup> Consequently, most regulations were upheld in spite of infringements on individual rights.<sup>180</sup>

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173. See Note, *On Privacy: Constitutional Protection for Personal Liberty*, 48 N.Y.U.L. REV. 670, 703 (1973).

174. *Id.* at 702.

175. *Loving v. Virginia*, 388 U.S. 1, 11 (1967).

176. Note, *supra* note 173, at 702.

177. *Fear Itself*, *supra* note 171, at 480. See also Morgenstern, *supra* note 139, at 537-44.

178. See generally *Fear Itself*, *supra* note 171, at 479-81.

179. *Id.* at 484-85.

180. This attitude endured into the 1950's and 1960's, when quarantined tuberculosis patients challenged state authority. See, e.g., *Moore v. Draper*, 57 So. 2d 648 (Fla. 1952).

Even though medical science has progressed and courts required some necessity to justify a public health regulation, laws were allowed to infringe on individuals' rights, because society thought diseases were menaces and disease-carriers were the cause of their own illnesses. With the hysteria surrounding the AIDS threat, this unjustified reaction could appear again.

Initially, courts upheld the broad power of the state to identify and address public health problems. See *Jacobson v. Massachusetts*, 197 U.S. 11, 37-38 (1905). They felt the most reasonable solution in a democratic society was to allow the majoritarian process to resolve any uncertainty according to their informed views of necessity. See *id.* at 30-31.

This trend changed as the courts began to place greater emphasis on medical criteria in evaluating state action. See, e.g., *Jew Ho v. Williamson*, 103 F. 10 (9th Cir. 1900) (quarantine as a violation of the Equal Protection Clause). The court found the regulation discriminatory and not reasonably related to the goal of preventing bubonic plague as judged by normal medical standards. The quarantine involved 10,000 people and covered ten to twelve city blocks. *Id.* at 21. Since then, courts give less weight to lay perceptions about disease and more to medical evaluation. *People ex rel. Barmore v. Robertson*, 302 Ill. 422, 134 N.E. 815 (1922) (science of public health was recognized and the court relied on laboratory evidence that the plaintiff-owner of a boarding house had typhoid fever). The cases clearly demonstrate a movement toward adopting medical criteria for assessing public health meas-

Medical science and interpretation of the Constitution have evolved significantly.<sup>181</sup> It is inappropriate to use early twentieth century law to evaluate regulations that control AIDS without considering medical and constitutional developments. Through medical advances, most of the diseases that threatened society at the turn of the century have been eliminated as public health threats in the United States.<sup>182</sup> Medical expertise should be used to assess public health threats and responses, as common sense is now an inadequate measure of a health action.<sup>183</sup> AIDS calls for a clarification of public health decision-making standards. Current scientific knowledge has made it possible to develop a basic understanding of AIDS, and this knowledge must be applied to efforts to stop the spread of this disease.

### 3. *Balancing Approach*

Even though the due process and equal protection clauses ensure a basic level of fairness and equity in government action, and the right to privacy provides an important area of decision-making beyond government interference, these protections appear to be inadequate in our modern society. Recent decisions regarding health law have used a balancing test which considers the interests of the government and those of the individual.<sup>184</sup> Proper application of this

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ures. *See also* Crayton v. Larabee, 220 N.Y. 493, 116 N.E. 355 (1917) (city ordinance prohibited communication between infected families or houses and provided valid police power as reasonable to authorize an absolute quarantine).

181. Important medical developments allow a closer targeting of efforts to control communicable diseases. The Supreme Court has expanded and redefined the scope of constitutionally-protected individual rights. *See Fear Itself*, *supra* note 171, at 479.

182. *Id.* One author suggests urgent classification of the law governing state health action under the police power due to controversies involving AIDS and herpes. *See generally* Damme, *supra* note 140, at 801.

The battle against modern disease is fought through vaccine, public education, and improved medical treatment. Comment, *supra* note 171, at 480. *See also* Morgenstern, *supra* note 140, at 541-44 (history of public health programs). Modern medical technology rarely necessitates such public health measures as quarantine and mass vaccination. *Fear Itself*, *supra* note 171, at 480.

183. Courts now rely on medical knowledge, instead of common beliefs, to decide what actions are necessary regarding public health. *New York State Ass'n for Retarded Children v. Carey*, 612 F.2d 644, 651 (2d Cir. 1979) (state plan is required to be executed "in light of the most current medical information"); *LaRocca v. Dalsheim*, 120 Misc.2d 697, 704, 467 N.Y.S.2d 302, 310 (1983) (declining, after consideration of a medical opinion, to require a prison to give all entering prisoners an AIDS test, but granting leave to renew claims as the state of scientific knowledge and hygienic procedures evolved).

184. Although a fundamental right was found in *Roe*, the Supreme Court actually used a balancing test. The shifting weight of competing interests during the course of pregnancy permits different degrees of governmental interference at different points in time. *Roe v. Wade*, 410 U.S. at 163. The balancing test was also used in

test requires the government to satisfy higher burdens to justify invasive health regulations as the scope of the invasion increases. The balancing test is preferable to strict scrutiny because it eliminates arbitrariness, creates greater limits on a court's ability to overturn legislative determinations and imparts a true decision-making process.<sup>185</sup>

Several forms of health regulation have been considered regarding individuals who have AIDS, ARC or who test seropositive.<sup>186</sup> The most widespread public health initiatives regarding AIDS are measures designed to test and monitor those infected with the disease. These measures pose a great risk because persons with AIDS, and even those who merely test positive for HIV antibodies, could be identified and singled out for discriminatory purposes. With the wide variety of measures available, courts must look at the type of regulation imposed to see whether it is warranted. Today, public health officials have broad powers to conduct epidemiological investigations of infectious diseases.<sup>187</sup> Decisions to enact these health measures should be decided by balancing the competing interests involved. This balancing approach may determine the validity of any future law regarding AIDS.

### B. Constitutional Basis For Mandatory Testing

As stated earlier, the FDA approved a test to detect the presence of HIV antibodies to the AIDS virus in early March 1985.<sup>188</sup> The initial use of the test was to protect the nation's blood supply, and to assist epidemiologists in understanding implications of infection with the virus.<sup>189</sup> The question arises whether it should be put to other

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Moore v. City of East Cleveland, 431 U.S. 494, 499-500, 506 (1977); see also Poe v. Ullman, 367 U.S. 497, 542-43 (1954).

In *Nixon*, the Court implied a balancing test in the disclosure of personal matters by balancing the President's interests in privacy against those of the government. *Nixon v. Administrator of Gen. Serv.*, 433 U.S. 425, 439 (1977).

Federal courts have also adopted the test. *Miller v. Rumpf*, 647 F.2d 80, 82 (4th Cir. 1982), *aff'g denial of reh'g*, *Beller v. Middendorf*, 632 F.2d 788 (1980); *Plante v. Gonzalez*, 575 F.2d 1119, 1134 (5th Cir. 1978); *McKenna v. Peekskill Housing Auth.*, 497 F.Supp. 1217, 1224 (S.D.N.Y. 1980); *Hawaii Psychiatric Soc'y Dist. Branch v. Ariyoshi*, 481 F. Supp. 1028, 1043 (D. Hawaii 1979); *McKenna v. Fargo*, 451 F.Supp. 1355, 1380 (D.N.J. 1978).

185. See Comment, *A Constitutional Right to Avoid Disclosure of Personal Matter: Perfecting Privacy Analysis in J.P. DeSanti*, 653 F.2d 1080 (6th Cir. 1981), 71 GEO. L.J. 219, 245 n.217-22 (1982) (the author discusses why courts should use the balancing test of competing interests in disclosure as the proper standard of review for statutes that infringe on the right of nondisclosural privacy).

186. See *infra* notes 188-341 and accompanying text.

187. See, e.g., *supra* note 135 and accompanying text.

188. See *supra* notes 14-26.

189. CDC, *Update: Public Health Service Workshop on Human T-Lymphotropic Virus Type*

uses. As public health authorities began to collect data on the test results, debate over testing, monitoring and data collection has caused a mixture of legislation and regulation. Inconsistencies in practical and theoretical actions among jurisdictions and government agencies have caused legal and ethical questions to arise. One issue that has arisen is whether mass screening programs to determine the seropositive status of individuals is beneficial to the individual or to the public. Because the rate of AIDS infection is progressing geometrically, the question of how to identify carriers and whether to monitor their behavior have become urgent issues of public policy.

Use of the test has been proposed and initiated in many areas.<sup>190</sup> While some believe that the test is a tool to assess the extent of the

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*III Antibody Testing—United States*, 34 MMWR 477, 478 (1985). The American Red Cross requires that every unit of blood donated be tested for the presence of HIV antibodies. See MINN. DEP. OF HEALTH DISEASE CONTROL NEWSLETTER, RECOMMENDED FOLLOW UP FOR BLOOD AND PLASMA DONORS FOUND TO BE POSITIVE OF HTLV-III 37 (1985). They conduct tests on all collections because of their obligation to protect the nation's blood supply. The basis for this policy is that asymptomatic individuals may be infected with HIV virus and are able to transmit infection to others unknowingly. See CDC, *Provisional Public Health Service Inter-Agency Recommendations for Screening Donated Blood and Plasma for Antibody to the Virus Causing Acquired Immunodeficiency Syndrome*, 34 MMWR 477, 477-78 (1985).

The test also raised the concern that other people might want to know their antibody status. A long-term study in San Francisco showed more than 70% of those infected for more than five years have not developed AIDS or AIDS-related illnesses. CDC, *Update: Acquired Immunodeficiency Syndrome in the San Francisco Cohort Study, 1978-1985*, 34 MMWR 573, 575 (1985).

190. The Public Health Service recommends mass testing of high-risk groups in an effort to combat the spread of infection, as they believe people need to know their antibody status to avoid receiving live virus vaccine. In addition, doctors need to use the information to more carefully evaluate any symptoms they might have. See 1 AIDS Policy & Law (BNA) no. 5, at 1 (Mar. 26, 1986).

One such proposed area is for premarital testing. President Reagan included premarital testing in his proposal for sweeping mandatory AIDS tests. See Ford & Quam, *supra* note 28, at 361, *see, e.g.*, 1 AIDS Policy & Law (BNA) no. 1, at 5 (Jan. 29, 1986), and at least one state, Louisiana, has enacted legislation requiring premarital testing. 2 AIDS Policy & Law (BNA) no. 14, at 8 (July 29, 1987).

Another proposed area of testing is in prenatal care. The San Francisco Department of Public Health encourages the test before pregnancy and offers guidelines for screening potential mothers at risk for carrying the virus. 1 AIDS Policy & Law (BNA) no. 1, at 4 (Jan. 29, 1986).

A third area relates to individuals arrested for sex-related crimes. Florida would require screening of persons convicted of prostitution under proposed legislation. See 1 AIDS Policy & Law (BNA) no. 7, at 4, 5 (Apr. 23, 1986) (California proposal for mandatory testing for suspects in sex crimes, patients in state mental institutions, and some prisoners).

A fourth area of proposed testing is in the workplace. Diane McGrath, mayoral candidate, advocated testing of all nurses, doctors, dentists, teachers, foodhandlers, and others who come in "intimate" contact with customers. If they test positive



crisis, to take steps to guard the public health, and to contain medical costs,<sup>191</sup> others believe it is a growing privacy threat.<sup>192</sup> Gay community leaders urge individuals not to take the test because they believe it is an opportunity for civilian governments, corporations and insurance companies to use the test as a principle instrument of discrimination.<sup>193</sup>

These divergent approaches emphasize the different values assigned to the HIV antibody test.<sup>194</sup> However, like that of the armed forces, mandatory testing may be considered for a broader population. Mandatory testing of all individuals for HIV antibodies raises the constitutional issue of whether dissenting individuals must submit to regulations or constitutionally protected rights permit them to refuse the test.

Mandatory programs for the HIV antibody are similar to compulsory vaccination and physical examination programs that have long

twice, she advocated that they then should be removed from their jobs. WASH. REP., *supra* note 57, at 3.

A fifth area of testing is in the armed forces. The Department of Defense routinely tests the blood of all new recruits and those who test positive for the virus are rejected. The most widespread use of the test began October 1, 1985, when the armed forces initiated screening of 2.1 million active-duty personnel. Tarr, *AIDS: The Legal Issues Widen*, Nat'l L.J., Nov. 25, 1985, at 28, col 1.

Finally, a number of insurers have considered proposals to make the HIV antibody test mandatory for persons who apply for life and health insurance (particularly in New York and San Francisco, where there is a higher incidence of infection). *See id.* But *see* Note, *supra* note 165, at 315 (the test should not be used as a reason to regulate homosexual activity through sodomy statutes).

191. Tarr, *supra* note 190, at 28, col. 1 (insurance carriers say that they need to assess the extent of the crisis and take steps to guard the public health and to contain medical costs).

192. WASH. REP., *supra* note 57, at 2.

193. *See generally* 1 AIDS Policy and the Law (BNA) no. 5, at 2 (Mar. 3, 1986) (gay rights groups also oppose the PHS mass testing plan to test all people at high-risk); Russell, *U.S. Sets Workplace Rules*, Wash. Post, Nov. 24, 1985, at A1 (the Department of Health and Human Services has recommended against routine testing in the workplace for the purpose of determining who is infected with the virus; they consider it medically unnecessary, given the evidence that AIDS is not spreading by the type of contact that occurs in most occupational settings); Association of State and Territorial Health Officials, *Guide to Public Health Practices: HTLV-III Antibody Testing and Community Approaches*, Oct., 1985, at 4 (it has been recommended that the test not be used for generalized screening or admission to hospitals or schools) [hereinafter ASTHO].

194. *See supra* notes 22-26, 136 and accompanying text. Several reasons are given for the belief that routine screening should be avoided. These reasons include the fact that there is no cure for the disease, false positives are common, and a mass testing program would be cost prohibitive. In addition, there is no public interest that would be served by routine testing of low-risk populations as the test has an uncertain clinical value and the potential for harmful social, economic, and psychological effects is great. Baum, *AIDS Epidemic Continues Moving Beyond High Risk Groups*, CHEMICAL & ENGINEERING NEWS, Apr. 1, 1985 at 21. *See generally* Tarr, *supra* note 190, at 28.

been used by state and local authorities as measures to prevent the spread of communicable and infectious diseases.<sup>195</sup> Use of mass testing for syphilis became the preferred method of detection after World War II, but was eliminated due to prohibitive cost. Selective testing of suspected high-incidence groups was then initiated. Today, epidemiologic investigation of individual cases of venereal disease and the follow-up of positive serological tests are the two methods used to treat new cases of disease.<sup>196</sup>

Although often challenged, courts have upheld ordinances requiring vaccinations and blood tests as means to protect the public health.<sup>197</sup> As long as the regulation is not oppressive, arbitrary or unreasonable, the minimum rationality test is applied.<sup>198</sup> Under this standard of review, a state has the authority to test an individual's blood for the presence of HIV antibodies on a voluntary basis since it can be shown that it is a reasonable measure that will protect the blood supply and promote research of the disease.

Once a public health regulation becomes more restrictive, however, the minimum rationality test is difficult to apply. A law that addresses disease prevention by *requiring* people to do something

195. See, e.g., VA. CODE ANN. § 32.1-57 (1985) (statutory provisions governing the examination, testing and treatment of persons suspected of being infected with any venereal disease).

196. Premarital blood testing is a valuable surveillance measure. W. BROWN, *SYPHILIS AND OTHER VENEREAL DISEASES* 38-42 (1970).

197. Reynolds v. McNichols, 488 F.2d 1378 (10th Cir. 1973) (ordinance allowing detention of one suspected of having venereal disease is valid exercise of police power); People ex. rel. Baker v. Strautz, 386 Ill. 360, 54 N.E.2d 441 (1944) (holding prostitutes without bond for examination of venereal disease is a valid exercise of police power).

198. See Jacobson v. Massachusetts, 197 U.S. 13 (1905) (where infringement of due process rights is minimal, the court will uphold public health matters as long as the state action is not enforced capriciously and is not overbroad); Bratcher v. United States, 149 F.2d 742 (4th Cir.), cert. denied, 325 U.S. 885 (1945) (physical examination for drug use prior to induction into armed services not an unlawful search and seizure); Ex parte King, 128 Cal. App. 27, 16 P.2d 694 (1932) (only need probable cause to quarantine for communicable infectious disease); Ex parte Arata, 52 Cal. App. 380, 198 P. 814 (1921) (reasonable grounds needed to quarantine); Huffman v. District of Columbia, 39 A.2d 558 (D.C. 1944) (marriage license test was held not to be unreasonable or arbitrary); Strautz, 386 Ill. 360, 54 N.E.2d 441 (1943) (fact that arrested person was a prostitute was considered a reasonable basis for the state to suspect the existence of venereal disease); Welch v. Shepherd, 165 Kan. 394, 196 P.2d 235 (1948) (city ordinance for examination and quarantine valid); Hartman v. May, 168 Miss. 477, 151 So. 737 (1934) (ordinance requiring children's vaccination against smallpox as condition for admission to public schools held reasonable); Ex parte Company, 106 Ohio St. 50, 139 N.E. 204 (1922) (regulations adopted by public health council for quarantine of persons suspected of having venereal diseases held not violative of constitutional provisions). But see Wragg v. Griffin, 185 Iowa 243, 170 N.W. 400 (1919) (state cannot compel defendant to submit to a medical or surgical examination).

would place the statute under the strict scrutiny standard. The involuntary requirement would infringe upon a person's fundamental right of privacy. Consequently, the state would have to demonstrate a compelling interest and show that it was using the least restrictive means to accomplish its goal.<sup>199</sup>

Mandatory testing may possibly infringe upon an individual's protected "interest in avoiding disclosure of personal matters."<sup>200</sup> Unlike compulsory vaccination laws, a positive HIV test could be devastating to an individual.<sup>201</sup> False positive results could cause psychological injuries.<sup>202</sup> Furthermore, disclosure of test results could result in discrimination by wrongly labeling someone a homosexual or an intravenous drug user. As one court stated, "AIDS is the modern day equivalent of leprosy. AIDS, or a suspicion of AIDS, can lead to discrimination in employment, education, housing and even medical treatment."<sup>203</sup>

With the threat of AIDS spreading to the public, a state can regulate AIDS patients under the pretense of protecting public health.<sup>204</sup> A state's demonstration of a compelling interest in public health may present an insurmountable challenge. Therefore, even though the right to privacy is a constitutionally protected interest, a compelling state interest, such as protecting the public from a communicable disease, may limit this right. Only after showing that less restrictive means of controlling AIDS were unsuccessful, however, may a state

199. See *supra* note 150 and accompanying text.

200. Whalen v. Roe, 429 U.S. 589, 599 (1977); see also *supra* notes 161-63 and accompanying text.

201. Evidence of the knowledge of an individual's seropositivity could become the AIDS "yellow star." Black, *The Plague Years*, ROLLING STONE, Apr. 25, 1985, at 41.

202. Note, *The Constitutional Rights of AIDS Carriers*, 99 HARV. L. REV. 1274, 1287 (1986) [hereinafter *AIDS Carriers*]. A positive result might be falsely construed as proof that an individual was gay or a substance abuser. Disclosure of the results could affect an individual's most intimate personal relationships. *Id.* See generally Melton, *supra* note 138, at 651. This commentator discusses the irrational fear of AIDS and how society alienates those thought to have AIDS. *Id.* at 660.

203. South Florida Blood Serv. v. Rasmussen, 467 So.2d 798, 802 (Fla. Ct. App. 1985), *aff'd*, 500 So. 2d 798 (Fla. 1987).

204. See *Roe v. Wade*, 410 U.S. 113 (1973). "[A] State may properly assert important interests in safeguarding health, . . ." *Id.* at 154. Courts continue to recognize that the interests of the community in protecting the general health justify some interference with the liberty of the citizens. Attempts to avoid compliance with reasonable regulations that require physical examinations, on the grounds that the examinations violate constitutional rights and privileges, have generally been unsuccessful. See *State ex rel. Holcomb v. Armstrong*, 39 Wash. 2d 860, 860, 239 P.2d 545, 545 (1952) (involved a chest x-ray for tuberculosis). The *Holcomb* court held that, while freedom of religious belief is absolute, the freedom to act in pursuance of such beliefs is subject to regulation for the protection of society. *Id.* at 863, 239 P.2d at 548.

authorize testing of all individuals.<sup>205</sup> A stronger control program can be justified only if the state shows that: the AIDS epidemic was draining state resources and endangering the public health; voluntary measures had proved inadequate; and more restrictive measures would be necessary to ensure public health. In addition, when choosing the least restrictive means, courts must disregard extraneous public opinion and only allow measures which are medically necessary based on current medical knowledge.

After considering these various factors and the interests involved, it is difficult to imagine an acceptable program for mandatory HIV testing because the utility of the test (other than for protection of the blood supply) is unknown and the risk of invading individual rights is great. Extracting blood samples is an acceptable means of detecting disease, but singling out AIDS high-risk groups for testing would be difficult and may invade privacy.<sup>206</sup> Moreover, implications of seropositivity are unclear. Seropositivity may indicate past infection rather than present infectiousness.<sup>207</sup> There is no consensus on what action should be taken against someone with apparently active infection. Also, mandatory testing is expensive and impractical for large-scale screening.<sup>208</sup>

Mandatory testing may also be counterproductive. AIDS patients may be reluctant to come forward for examination and treatment if they are threatened with criminal prosecution and stigmatization. While the state may have the authority to mandate HIV testing, the question remains whether it would be helpful or beneficial to do so. Unlike public health measures for other diseases, there is no inoculation, vaccine or cure for AIDS.

### C. Reporting Requirements

According to the CDC, more than 40 states now require health care providers to report cases of AIDS to state or local health authorities.<sup>209</sup> Generally, most state statutes require only reporting of ac-

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205. See *AIDS Carriers*, *supra* note 202, at 1287.

206. Tarr, *supra* note 190, at 28.

207. Baum, *supra* note 194, at 21; see also *supra* note 21 and accompanying text.

208. Baum, *supra* note 194, at 21.

209. See IHPP, *supra* note 134, at 22. AIDS cases are voluntarily reported in Montana, Tennessee, and American Samoa. The HIV antibody test is voluntarily reported in Alaska, Illinois, Iowa, Kentucky, Maryland, North Dakota, Utah, Vermont, and American Samoa. Reporting of the HIV test is required in Arizona, Colorado, Georgia, Minnesota and Nevada. See ARIZ. REV. STAT. ANN. § 36-621 (1982) (mandatory reporting of contagious diseases); GA. CODE ANN. § 31-17-2 (1985) (required report of diagnosis of venereal disease); NEV. REV. STAT. ANN. § 441.110 (Michie 1986) (mandatory reporting of ascertained venereal disease); MINN. R. § 4605.7040 (1987) (mandatory reporting of certain communicable diseases including AIDS).

tually diagnosed AIDS cases.<sup>210</sup> However, some states have promulgated strict reporting requirements which require disclosure of identifying information about a person with AIDS.<sup>211</sup> Also, a few states require reporting of all persons who test seropositive.<sup>212</sup>

Regulations that require physicians to report cases of diagnosed AIDS to public health authorities raise problems similar to those raised by mandatory HIV testing.<sup>213</sup> More restrictive reporting regulations that would compel disclosure of AIDS patients' names raise issues of possible privacy infringements. Medical information is of special concern as it may contain more intimate details about a person than any other single record.<sup>214</sup>

The Constitution protects privacy interests, but such interests are secondary to the health and welfare of the community. Privacy concerns with respect to disclosure of private information include not only concerns about how *much* information to compel, but also from *whom* it should be compelled.<sup>215</sup> Even though information is necessary for AIDS surveillance, the question arises as to whether public health authorities have the ability to protect and ensure confidentiality of the information. Confidentiality is crucial, and medical histories involved may lead to the stigmatization of AIDS and the populations it affects.<sup>216</sup>

Even though provisions to protect confidentiality have been in-

210. A "diagnosis" for reporting purposes is based on the CDC definition of AIDS. See *supra* note 29-30 and accompanying text.

211. See 1 AIDS Policy & Law (BNA) no. 1, at 6 (Jan. 29, 1986). Colorado requires disclosure of name, age, sex, address, names and addresses of physicians, and other information. *Id.*; see also 1 AIDS Policy and Law (BNA) no. 8, at 1 (May 7, 1986). Once legislation banning discrimination against AIDS' victims is enacted, the Louisiana AIDS task force recommends instituting a "selective" contact tracing program. Under such a program, the names and addresses of those who test positive and information on their sexual contacts is sought. *Id.*

212. See, e.g., MINN. R. § 4605.7040 (1987). In August, 1985, the Colorado Health Department was the first to mandate that doctors and laboratories report positive test results. See also 1 AIDS Policy & Law (BNA) no. 1, at 6 (Jan. 29, 1986); *id.* no. 6, at 1 (Apr. 9, 1986). Indiana, Idaho, Arizona and Minnesota either request or require reporting of suspected cases of HIV infection to state health officials, as well as confirmed cases of AIDS, ARC and positive tests. *Id.*

213. See *supra* notes 188-208 and accompanying text.

214. The law does not ensure the privacy of medical records. "Breach of privacy fears are not unfounded. Missouri Senator Eagleton's vice-presidential aspirations were dashed in 1972 when his psychiatric records were leaked to the press, even though they were protected by law." Dubro, *Your Medical Records, How Private Are They?*, 3 CAL. LAW., Apr. 1983, at 36.

215. See generally Note, *Public Health Protection and the Privacy of Medical Records*, 16 HARV. C.R.-C.L. L. REV. 265 (1981).

216. See *supra* note 138 and accompanying text. The FDA requires that a record of "unsuitable donors" be available so that blood products from such individuals are not distributed. 21 C.F.R. § 606.160(e) (1987).

cluded in many state reporting statutes,<sup>217</sup> many believe these protections are inadequate.<sup>218</sup> Reporting initiatives may be permissible with appropriate safeguards that the information will not be disclosed or made accessible to unauthorized persons. Confidentiality protections are difficult to control, however, as third parties (i.e., insurers, state agencies and investigators) may be authorized to review confidential information. In addition, as computer technology advances, technical difficulties in protecting confidentiality of electronic files also increases.

Disclosure of information relating to AIDS infection or seropositivity involves mixed interests between individuals and society. While the failure to keep identifying information may deter the development of knowledge that is crucial to understanding AIDS, the failure to adequately protect confidentiality may also adversely affect knowledge about the disease.<sup>219</sup>

### 1. Basic Reporting Statutes

Every state requires health care providers to report communicable diseases to state agencies. Even though physicians have an obliga-

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217. Restrictive reporting statutes raise a number of concerns about confidentiality protections, which many states have recognized by the inclusion of provisions in various regulations concerning AIDS. See, e.g., ILL. ANN. STAT. ch. 126 § 21 (Smith-Hurd Supp. 1987); KAN. STAT. ANN. § 65-118 (1985); N.Y. PUB. HEALTH LAW § 206(1)(j) (McKinney 1971); Act approved June 17, 1987, ch. 543, § 10, 1987 Tex. Sess. Law Serv. 4343-4402 (Vernon); W. VA. CODE § 16-4-6(c)(1) (1985).

Wisconsin and California prevent use of the test by employers and insurance companies. Tarr, *supra* note 190, at 1, col. 3. The Wisconsin and California laws prohibit employers from using tests as a condition of employment, or insurers from using the test as a condition of insurability or to determine rates. Florida's law bars insurers and employers only from using results from tests conducted at state sites where procedures are entirely confidential. Washington, D.C. is considering a proposal that would place prohibitions on the use of the test results by insurers. The ACLU is encouraging jurisdictions to consider restrictive legislation because of confidentiality problems. *Id.* The CDC guarantees confidentiality even though subjects' identities are recorded. Names may only be obtained through court orders and even this is vigorously resisted by the CDC. See Grouse, *HTLV-III Transmission*, 254 J.A.M.A. 2130, 2131 (1985).

Forty-seven states have the authority to protect the confidentiality of individuals reported to have AIDS or HIV antibody positive results. Two states, California and Wisconsin, have enacted specific statutes to protect the confidentiality of AIDS patients. IHPP, *supra* note 134, at 22. Massachusetts also provides for confidentiality of tests for HIV virus. MASS. GEN. LAWS ANN. ch. 111; MINN. STAT. § 70F (West Supp. 1987). In addition, ASTHO recommends that strictest confidentiality be maintained. ASTHO, *supra* note 193, at 4.

218. Collins, *Confidentiality*, in AIDS LEGAL GUIDE (Legal Defense & Education Fund, Inc. 1984) [hereinafter LAMBDA]. Safeguards of confidentiality are relatively non-existent. If there are such safeguards, there are numerous exceptions. *Id.*

219. *Privacy Rules Urged to Spur AIDS Research*, Amer. Med. News, Nov. 9, 1984, at 2, col. 1. (includes guidelines created due to confidentiality crisis).

tion to protect a patient's confidences, they must obey state law.<sup>220</sup> Reporting statutes reflect a legislature's judgment that a patient's interest in the confidentiality of his medical condition is outweighed by society's interest in protecting the public's health.

States have a right to regulate the reporting of certain diseases. As the least restrictive public health initiative, notification of diseases to public health authorities has long been upheld and has rarely been challenged in the courts;<sup>221</sup> and even though laws lack confidentiality provisions, they have been accepted as falling within the state's po-

220. A patient's right to confidentiality begins with the physician-patient privilege. When physicians and hospitals accept the responsibility for treatment, they have a duty to keep confidential all information regarding a patient's diagnosis and treatment except as required to fulfill their duty to report. MINN. R. § 4605.7030 (1987). This privilege is not inherently recognized at common law, but may be created by statute. See, e.g., N.Y. CIV. PRAC. L. & R. § 4504 (McKinney 1963).

The purpose of this privilege is to encourage full disclosure by a patient to the physician, so the physician can make a correct diagnosis and the individual can receive proper treatment. *Camperlengo v. Blum*, 56 N.Y.2d 251, 254-55, 451 N.Y.S.2d 697, 698, 436 N.E.2d 1299, 1300 (1982); *In re Application to Quash Subpoena Duces Tecum in Grand Jury Proceeding*, 56 N.Y.2d 348, 352, 452 N.Y.S.2d 361, 363, 437 N.E.2d 1118, 1120 (1982).

The duty to report certain communicable or infectious diseases is statutorily imposed on health care providers. Physicians must report cases of AIDS to local/state health departments, and they, in turn, report to the CDC in Atlanta. Gellman, *Prescribing Privacy: The Uncertain Role of the Physician in the Protection of Patient Privacy*, 62 NO. CAR. L. REV. 255, 274 (1984). See, e.g., CAL. HEALTH AND SAFETY CODE §§ 3122-3125 (West 1988); COL. REV. STAT. § 25-1-649 (1982); FLA. STAT. ANN. § 381.103 (West 1986); NEB. REV. STAT. § 71-503 (West 1986); N.J. STAT. ANN. § 26:4-2, 26:4-15 (West 1987).

States have a duty to report to the CDC. See, e.g., Privacy Act of 1974, 5 U.S.C. § 552a (Supp. 1987); Pub. Health Serv. Act, 42 U.S.C. § 242m(a) (1982). See also LAMBDA, *supra* note 218, at 18.

221. When reporting statutes have been challenged, the courts have consistently upheld them. *McGuire v. Amyx*, 317 Mo. 1061, 1071-72, 297 S.W. 968, 971 (1927) (smallpox); *Crayton v. Larabee*, 220 N.Y. 493, 504, 116 N.E. 355, 358 (1917) (quarantine); *Derrick v. Ontario Community Hosp.*, 47 Cal. App. 3d 145, 152, 120 Cal. Rptr. 566, 570 (1975). See also CAL. ADMIN. CODE, tit. 17, § 2628 (1982) (reporting of typhoid carriers); MO. REV. STAT. §§ 192.020, 192.040 (1969). See generally Morgenstern, *supra* note 140, at 537 (for reporting laws and government participation). *But see* *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 80 (1976) (abortion reporting requirements must be reasonably directed to the preservation of maternal health and respect patients' privacy and confidentiality).

In *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986), the Supreme Court held that Pennsylvania's abortion reporting statute was an unconstitutional invasion of a woman's right to make a decision on whether or not to have an abortion. *Id.* at 759. The statute required, among other things, the disclosure of the woman's address, age, race, marital status, and number of prior pregnancies. *Id.* at 765. In addition, the statute further provided that the records would be open to the public, with no confidentiality precautions. *Id.*

lice power.<sup>222</sup> The public health function of mandatory reporting of communicable diseases helps prevent the spread of such diseases. Used as surveillance and case-finding tools,<sup>223</sup> most current AIDS reporting statutes require health care providers to report only diagnosed AIDS cases.<sup>224</sup>

Statistics derived from reporting are used to monitor seroprevalence in an area and measure the effectiveness of government prevention programs.<sup>225</sup> These reporting programs, updated periodically to include various diseases (most recently AIDS), are designed to provide some measure of control over the health and welfare of society. They are, therefore, seen as a reasonable and valid exercise of the state's police power. State action (i.e., treatment) is not required by these statutes, but if an epidemic is recognized from the statistical information obtained, escalation to more restrictive control measures is justified.<sup>226</sup>

## 2. Constitutional Basis of Disclosure Reporting Statutes

Production of more detailed, personal information can be compelled under the state's police power to protect public health if believed necessary to establish a cause or mode of transmission of AIDS.<sup>227</sup> Even though basic reporting statutes are constitutionally

222. See *supra* notes 139-140 and accompanying text. Some statutes provide no confidentiality protections. See, e.g., N.H. REV. STAT. ANN. § 7A:1-5 (1987).

223. The purpose of surveillance is to monitor mortality trends, identify emerging risk groups, document geographic spread of disease, and identify areas where preventative efforts may be useful. See Melton, *supra* note 138, at 633 n.15. The CDC is the federal agency that is responsible for coordinating surveillance. The CDC has entered into cooperative agreements with many states for AIDS surveillance. See CDC, *Update: Acquired Immunodeficiency Syndrome - United States*, 34 MMWR 245, 245-48 (1985).

224. Diagnosis is based on the CDC's definition of AIDS. See *supra* notes 27-30 and accompanying text.

225. See discussion *supra* note 223. In *Danforth*, 428 U.S. at 88, the court upheld a Missouri statute that required abortions to be reported to state agencies. The court found that statistical requirements are "essential to the advancement of medical knowledge." *Id.* at 1374. The court placed significance on the fact that the terms required by the state did not require disclosure of the woman's name. They merely required statistical information. Not requiring the woman's name to be on the file significantly reduced any privacy violation. *Id.*

226. Damme, *supra* note 140, at 806. The Conference of State and Territorial Epidemiologists adopted a resolution that AIDS should be a reportable disease in all states and acted to improve reporting and surveillance procedures for AIDS. Brandt, *The Public Health Service's Number One Priority*, 98 PUB. HEALTH REP. 306, 307 (1983). An example of the effectiveness of reporting is the Blood Bank program.

227. See *supra* notes 139-44 and accompanying text. Statutes that require the disclosure of identifying information could arguably be seen as unreasonable or arbitrary, due to inadequate confidentiality provisions, the usefulness of HIV antibody test and the lack of treatment or cure for AIDS. This argument is especially true consid-



permissible, regulations that compel disclosure of identifying information may infringe on an individual's right to privacy.<sup>228</sup> Although the Supreme Court has recognized two constitutionally protected zones of privacy,<sup>229</sup> only one zone is applicable to this issue because it focuses on avoiding disclosure of personal matters. Disclosure of identifying information does affect the decision of whether or not to

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ering the possible detrimental effects on individuals as compared to the questionable benefit society would receive from such disclosure.

228. Various state statutes currently require disclosure of names of infected individuals to public health departments for the purpose of venereal disease control. These are permissible as long as confidentiality provisions are included. See, e.g., ILL. ANN. STAT. ch. 126, § 21 (Smith-Hurd Supp. 1987); see also *People ex. rel. Dir. of Pub. Health v. Calvo*, 89 Ill.2d 130, 432 N.E.2d 223 (1982).

229. See *supra* notes 162-64 and accompanying text. The first branch affords a fundamental privacy right in situations where an individual's freedom of choice has been foreclosed. The interest in collection, maintenance, use and dissemination of information by the government of personal information is an integral part of an individual's liberty. This interest includes the initial collection of information, ensuring the information collected is accurate, how the government uses the information, and to whom, and to what extent government reveals the information. See Hosch, *The Interest in Limiting the Disclosure of Personal Information: A Constitutional Analysis*, 36 VAND. L. REV. 139, 141 n.11 (1983).

The autonomy privacy interest is limited to decision-making interests in highly personal matters. See *supra* notes 162-64 and accompanying text. This type of privacy interest is not at issue in disclosural reporting statutes.

The Supreme Court has recognized both types of privacy interests. See *Whalen v. Roe*, 429 U.S. 589, 599-600 (1977) (court found the possibility of disclosure unlikely but refrained from discussing the nature of the interest and the applicable standard); see also *Carey v. Population Serv. Int'l*, 431 U.S. 678, 699-700, n.25 (1977); *Plante v. Gonzalez*, 575 F.2d 1119, 1122-28 (5th Cir. 1978), cert. denied, 439 U.S. 1129 (1979) (detailed information regarding personal finances is protected by disclosure privacy). Cf. *Doe v. Bolton*, 410 U.S. 179, 196-200 (1973). But see *Paul v. Davis*, 424 U.S. 693 (1976), reh'g denied, 425 U.S. 985 (1976). In *Davis*, the plaintiff claimed he was deprived of his constitutional right to privacy when he was charged with shoplifting, and his name and photo were circulated on a flyer listing other shoplifters. The court dismissed the claim, concluding that the plaintiff failed to allege any governmental intrusion which fell within the scope of a constitutionally protected sphere of privacy. *Id.* at 712-13.

The disclosural right to privacy was also asserted in *Nixon v. Administrator of Gen. Serv.*, 433 U.S. 425, 455-65 (1977). The action involved an alleged violation of the President's privacy by a federal statute which permitted the General Services Administration custody of the President's papers and tapes. The Court held that a privacy interest in nondisclosure inhered in the President's private affairs, including communications with his physician. *Id.* at 459-60.

Congress has also recognized the privacy rationale and has implemented numerous pieces of legislation. The Privacy Act declares that "the privacy of an individual is directly affected by collection, maintenance, use and dissemination of personal information. . ." Privacy Act of 1974, 5 U.S.C. § 522(2)(a)(4) (1982).

Several states have also recognized the right of privacy. In *Katz v. United States*, 389 U.S. 347, 350-51 (1967), the Supreme Court invited the states to participate in the formulation of a right to privacy. "[T]he protection of a person's general right to privacy—his right to be let alone by other people—is, like the protection of his prop-

seek treatment.<sup>230</sup> Although several court decisions recognize a limited right to medical records disclosure, the courts have not delineated the bounds of that right.<sup>231</sup>

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erty and his very life, left largely to the law of the individual states." *Id.* (emphasis in the original).

Several states have enacted constitutional privacy protections. *See, e.g.*, ALA. CONST. art. I, § 22; CAL. CONST. Art. I, § 1; HAW. CONST. Art. I, § 6; ILL. CONST., art. I, § 6; LA. CONST. art. I, § 5; MONT. CONST. art. II, § 10; S.C. CONST., art. I, § 10.

Some states have begun to include informational privacy as a component of their state right of privacy. *See White v. Davis*, 13 Cal.3d 757, 774, 120 Cal. Rptr. 94, 105, 533 P.2d 222, 233-34 (1975) (California provisions protect individuals from privacy invasions by unreasonable information-gathering devices). Moreover, recently, the Alaska Supreme Court held that the state's constitutional privacy section is broader than the federal right, and thus protects privacy in the home as it relates to the use of marijuana. *Ravin v. State*, 537 P.2d 494, 514-15 (Alaska 1975) (Boochaer, J., concurring). In *Board of Medical Quality Assurance v. Gheradini*, 93 Cal App. 3d 669, 156 Cal. Rptr. 55 (1979), a hospital refused to surrender patient records to the medical board which was conducting an investigation into negligence complaints. The California Appellate Court ruled that a person's medical profile is more private than many areas currently recognized as protected under the federal constitutional privacy. *See also Falcon v. Alaska Public Offices Comm'n*, 570 P.2d 469 (Alaska 1979) (law requiring physicians to disclose patient names violated the patient's right to privacy). The court stated that intrusion into the physician-patient relationship, like intrusion into the privacy of the home, required a "high level of justification." *Id.* at 476. *See also Dunaway v. Webster*, 519 F. Supp. 1059 (N.D. Cal. 1981) (disclosure is clearly an unwarranted invasion of privacy).

The surveillance of AIDS patients (interview and follow-up of patients in order to determine the pattern of transmission of an illness) intrudes on privacy. The CDC interview includes detailed information about sexual preferences, drug and alcohol use, medical, travel, and prison histories, etc. CDC Case Reporting Form OMB No. 0920-0008 (rev. April, 1983). Obviously, this type of information is extremely personal. Therefore, this branch of information should include information contained in medical records.

The right to confidentiality has been termed the right to nondisclosure, disclosural privacy, or informational privacy. *See Leigh, Informational Privacy*, 3 HASTINGS CONST. L. Q. 229, 231 (1976), *Project: Government Information and the Rights of Citizens*, 73 MICH. L. REV. 971, 1282-83 (1975).

230. The disclosural privacy right protects information where privacy is threatened both by disclosure of personal information to the government and by the government. *Whalen v. Roe*, 429 U.S. 589, 603 (1977). The court addressed threats to the interest of nondisclosure posed by both the disclosure of private information to the New York Department of Health and the possible dissemination of private information by that department to the public. *Id.* at 600-02. *See also McKenna v. Fargo*, 451 F. Supp. 1355, 1382 (D.N.J. 1978), *aff'd without opinion*, 601 F.2d 575 (3d Cir. 1979).

A due process argument, while not a privacy claim, is also concerned with the government collecting, reporting and disclosing information. *See Doe v. United States Civil Serv. Comm'n*, 483 F. Supp. 539, 566-67 (S.D.N.Y. 1980). Consequently, the right to avoid disclosure of personal matters is implicated in either situation.

231. *See, e.g.*, *Singleton v. Wulff*, 428 U.S. 106 (1976) (recognizing a physician's right to protect the patient's interest in the confidentiality of medical records); *Katz v. United States*, 389 U.S. 347, 350-51 (1967) (the fourth amendment protects an individual's reasonable expectation of privacy). *See also Fisher v. United States*, 425 U.S.

An interest in nondisclosure of information is fundamental and constitutionally protected as long as the information meets the defi-

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391, 399 (1976) (the fifth amendment prohibits government from forcing an individual to divulge self-incriminating information about which only the individual may have knowledge).

The *Whalen* right has been recognized in *Nixon v. Administrator of Gen. Serv.*, 433 U.S. 425, 457 (1977). See also *United States v. Westinghouse Elec. Corp.*, 638 F.2d 570, 577 (3rd Cir. 1980) (OSHA subpoena action requiring Westinghouse to produce medical records of its employees). The *Westinghouse* court recognized the right of an individual not to have private affairs made public by the government. *Id.* This right has been widely recognized. See, e.g., *Plante v. Gonzalez*, 575 F.2d 1119, 1128 (5th Cir. 1978); *Doe v. United States Civil Serv. Comm'n*, 483 F. Supp. 539, 566 (S.D.N.Y. 1980); *Hawaii Psychiatric Soc'y v. Ariyoshi*, 481 F. Supp. 1028, 1043 (D. Haw. 1979); *McKenna*, 451 F. Supp. at 1380.

Although the Supreme Court has referred to the sanctity of the physician-patient relationship, neither the relationship, nor the privacy of medical information have been recognized by the Court as a fundamental right. See *Paris Adult Theater I v. Slaton*, 413 U.S. 49, 65-66 (1973) (privacy is also concerned with intimate relationships and extends to the doctor's office and the hospital); *Doe v. Bolton*, 410 U.S. 179, 219-20 (1973) (Douglas, J., concurring) (the right to privacy has no more conspicuous place than in the physician-patient relationship). One author believes an intermediate level of scrutiny would be the optimal standard, rather than the "all-or-nothing" approach regarding information autonomy cases. Newman, *Privacy in Personal Medical Information: A Diagnosis*, 33 U. FLA. L. REV. 394, 418-20 (1981).

The increasing imbalance of information led Congress to enact the Privacy Act of 1974, which seeks to protect individual privacy by providing safeguards against unauthorized governmental use of personal information. The Act provides that no agency shall disclose any record to any person, or to another without the individual's consent unless it falls within one of the statutory exceptions. Privacy Act of 1974, 5 U.S.C. § 522a(b) (1982). In 1977, however, the Privacy Commission concluded that the Act had not adequately protected the individual's interest in controlling use of personal information after its release to the government. PERSONAL PRIVACY IN AN INFORMATIONAL SOCIETY—THE REPORT OF THE PRIVACY PROTECTION STUDY COMMISSION, 5, 502 (1977). See also Hosch, *supra* note 229, at 149.

In *Gherardini*, 93 Cal. App.3d 669, 156 Cal. Rptr. 55 (1979), the court stated:

A person's medical profile is an area of privacy infinitely more intimate, more personal in quality and nature than many areas already judicially recognized and protected. The individual's right to privacy encompasses not only the state of his mind, but also his viscera, detailed complaints of physical ails and their emotional overtones.

*Id.* at 678-79, 156 Cal. Rptr. at 60-61.

In *Westinghouse*, 638 F.2d at 580-81, the court held that an employee's medical records were entitled to protection.

Medical records stand on a different plane than other relevant material. For example, the Federal Rules of Civil Procedure impose a higher burden for discovery of reports of physicians and the mental condition of a party than for discovery generally. Compare FED. R. CIV. P. 35, with FED. R. CIV. P. 26(b). Medical files are also a specific exemption under the Freedom of Information Act. See Freedom of Information Act, 5 U.S.C. § 552a (1982). The different treatment accorded this information reflects the recognition that information regarding one's body has a special character. This information is more sensitive than the data involving prescription drug use in *Whalen* and thus, it falls within the zone of privacy and is entitled to protection.

inition of personal matter.<sup>232</sup> The *Whalen* court defined personal matter as "personal in character and potentially embarrassing or harmful if disclosed."<sup>233</sup> Essentially an interest in confidentiality, the right of nondisclosural privacy is more than just the disclosure of names and addresses of individuals.<sup>234</sup> Although privacy is not violated if information cannot be linked to an individual, the state cannot compel information of a very intimate and personal nature.<sup>235</sup>

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232. Only fundamental rights are protected. See *supra* notes 153-64 and accompanying text. But see *Bowers v. Hardwick*, 106 S. Ct. 2841, 2844 (1986) (not extended to private, consensual homosexual intercourse); *Paul v. Davis*, 424 U.S. 693, 712 (1976) (interest in one's reputation is not a fundamental right); *Danforth*, 428 U.S. 52, 79-81 (1976) (court upheld statute imposing recordkeeping requirements for health facilities and physicians performing abortions); *J.P. v. DeSanti*, 653 F.2d 1080, 1090-91 (6th Cir. 1981) (social histories not protected). The courts have found that limited disclosure is not a fundamental right when the statute provides safeguards to protect confidentiality. See *Thornburgh*, 476 U.S. 747, 766-68 (1986) (state failed to demonstrate that abortion reporting requirements furthered important health concerns).

Several cases have involved medical records disclosure. *Nixon*, 433 U.S. at 458; *Whalen*, 429 U.S. at 602; *Westinghouse*, 638 F.2d at 577; *Forrester v. United States Dept. of Labor*, 433 F. Supp. 987, 989 (S.D.N.Y. 1977) *aff'd*, 591 F.2d 1330 (1978); *Gherardini*, 93 Cal. App.3d at 679, 156 Cal. Rptr. at 65.

233. *Whalen*, 429 U.S. at 605. One author has defined constitutionally protected personal matter as "'[p]ersonal matter' is information that 1) an individual wants to and has kept private or confidential, 2) that except for the challenged government action can be kept private or confidential, and 3) that to a reasonable person would be harmful or embarrassing if disclosed." Leigh, *supra* note 229, at 240.

234. Several cases have held that disclosure of names alone does not violate the right of privacy. In *Felbur v. Foote*, 321 F.Supp. 85, 89 (D. Conn. 1970), a statute compelled all practitioners of healing arts to report names and other information about drug dependent persons to the health department. The court upheld the statute which required practitioners to report cases of communicable disease because the information was outside the scope of any privilege of confidentiality. See also *People v. Florendo*, 95 Ill. 2d 155, 158, 447 N.E.2d 282, 284 (1983) (names of patients treated at an abortion clinic were released to a grand jury); *People v. Herbert*, 108 Ill. App. 3d 143, 149-50, 438 N.E.2d 1255, 1261 (1982) (release of Medicaid patients' records to grand jury when patients had signed an "Authorization For Release of Information").

Even though maintenance of reputation is an essential element of nondisclosural privacy right, courts have found that reputation alone is not a liberty or property interest protected by the Constitution. *Paul v. Davis*, 424 U.S. at 701; *Whalen*, 429 U.S. at 589 (the disclosural interest applies not merely to disclosure to the government, but also to disclosure of information which if known to the public would harm one's reputation).

235. See *South Florida Blood Serv., Inc. v. Rasmussen*, 467 So.2d 798 (Fla. App. 1985) (constitutional right to privacy prevents state from discovering names of individuals who donated blood). But see *Department of Air Force v. Rose*, 425 U.S. 352, 381 (1976) (personnel files not wholly exempt from disclosure). See also *Marcus v. Superior Ct. of Los Angeles*, 18 Cal. App. 3d 22, 95 Cal. Rptr. 545 (1974). The *Marcus* court held that disclosure of names is permissible, but if confidential information is also included regarding diagnosis, privacy is then violated. *Id.* at 24, 95 Cal. Rptr. at 545.

Because people at highest risk are homosexual men, intravenous drug users, and hemophiliacs, regulations that would compel disclosure of their names would relate to the most intimate details of their lives. Disclosure of AIDS patients' names can lead to information regarding their sexual practices, drug use and medical histories.<sup>236</sup> Consequently, probing into these areas of one's life is an invasion of privacy entitled to protection.<sup>237</sup> In addition, the possibility of disclosure to persons outside reporting agencies can lead to discrimination in employment, education, housing and even medical treatment.<sup>238</sup> Therefore, the privacy interest in disclosure of names and other identifying information falls within the disclosural privacy zone recognized in *Whalen*.

Although the *Whalen* court recognized a disclosural privacy interest, the right is not absolute.<sup>239</sup> When a fundamental right is involved, courts must apply a strict standard of review to state action that infringes on that fundamental right.<sup>240</sup> The government cannot

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236. See *supra* note 215 and accompanying text.

237. When private sexual behavior is involved, mere identification involves some cost to privacy. *Priest v. Rotary*, 98 F.R.D. 755 (N.D. Cal. 1983) (discovery of plaintiff's sexual history prohibited); *Lampshire v. Proctor & Gamble Co.*, 94 F.R.D. 58 (N.D. Ga. 1982) (identity of subjects of a CDC study entitled to protection where the study contained information about medical histories, personal hygiene, menstrual flow, sexual activities, contraception methods, pregnancies, douching, and tampon use). See *South Florida Blood Serv., Inc. v. Rasmussen*, 467 So.2d 798, 803 (Fla. App. 1985). But see *Plante v. Gonzalez*, 575 F.2d 1119, 1135 (5th Cir. 1978) (senator's names discoverable in case where sexual behavior is not involved).

In *Griswold v. Connecticut*, 381 U.S. 479 (1965), the Court held that official inquiry into a person's private sexual habits is within the constitutionally protected zone of privacy. *Id.* at 485. See also *In re Labady*, 326 F. Supp. 924 (1971) (official inquiry into a person's private sexual habits invades the constitutionally protected zone of privacy). But see *Bowers v. Hardwick*, 106 S. Ct. 2841 (1986) (upholding Georgia sodomy statute which made it a crime to engage in consensual sodomy in the privacy of one's home). The zone of privacy is also not recognized in the vaccination and immunization area. See Comment, *An Evaluation of Immunizations in Light of Religious Objections and the Developing Right of Privacy*, 4 U. DAYTON L. REV. 401, 417 (1979) [hereinafter *Religious Objections*].

238. The *Rasmussen* court recognized AIDS patients' and seropositive individuals' strong interest in remaining free from intrusion into their private lives and the oppressive effects that possible disclosure would cause. *Rasmussen*, 467 So. 2d at 802. The dissent, however, believed that the request of names and addresses was not privileged or constitutionally protected and therefore was discoverable information. *Id.* at 806.

239. See *supra* note 165 and accompanying text. See also *Roe v. Wade*, 410 U.S. 113, 154 (1973).

240. See *supra* notes 150-75 and accompanying text. See also *Roe*, 410 U.S. at 153-55 (when fundamental rights are involved, regulations limiting those rights may be justified only by a compelling state interest and must be narrowly drawn to further the legitimate state interest at stake); *Katz v. United States*, 389 U.S. 347, 352 (1967) (fourth amendment protects information that an individual possesses and in which he has a reasonable expectation of privacy, unless the government has a valid reason to

compel an individual to produce information without first demonstrating a justified need that outweighs the individual's interest in confidentiality.<sup>241</sup> As previously discussed, the state's interest in protecting the public's health has long been recognized as compelling.<sup>242</sup> If the state chooses a narrowly drawn means to accomplish a health goal, courts will usually find that the state is operating within the sphere of its constitutional authority.<sup>243</sup>

Arguably, the state's interest in preserving the health and welfare of society is not met by regulations that compel disclosure of AIDS patients' names. Some believe the data is necessary to perform research on AIDS.<sup>244</sup> Others believe that the names of AIDS patients will not be used for research, and if the names are used, the data obtained would not provide assistance in researching the disease.<sup>245</sup> Unless researchers clearly intend to use the data gathered in surveillance, public health officials would probably be exceeding their statutory authority. Mandatory reporting, simply for the sake of reporting, violates a patient's right to privacy. In such a situation, disclosure of highly personal information is compelled without any real state interest.

Disclosure of identifying information regarding AIDS raises a conflict between the right of disclosure of highly personal private matters and the government's right to collect identifying information used to protect the general welfare of its citizens through surveillance and casefinding. Because of the competing interests involved with legislation that compels names of AIDS patients, courts would employ a balancing test to determine if the regulation is narrowly drawn to achieve the state's interest in preserving the public's health.<sup>246</sup> Since a reporting statute is designed to advance the state's

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warrant seizure of the material); *Falcon v. Alaska Public Offices Comm'n*, 570 P.2d 469, 476 (Alaska 1977) (the desire to keep sensitive information private may be overridden only by a strong state interest).

241. See Note, *supra* note 173, at 770-71; see also *Roe v. Wade*, 410 U.S. at 150.

242. See generally Morgenstern, *supra* note 140, at 229-30.

243. See *Griswold v. Connecticut*, 381 U.S. 479 (1965). A ". . . governmental purpose to control or prevent activities constitutionally subject to state regulation may not be achieved by means which sweep unnecessarily broadly and thereby invade the area of protected freedoms." *Id.* at 485 (quoting *NAACP v. Alabama*, 377 U.S. 288, 307 (1964)).

244. *Privacy Rules Urged to Spur AIDS Research*, Am. Med. News, Nov. 9, 1984, at 2, col. 1 [hereinafter *Privacy Rules*].

245. See, e.g., Melton, *supra* note 138, at 660-62; *AIDS Carriers*, *supra* note 202, at 1287-88.

246. The Supreme Court has repeatedly employed a balancing test in decisions that involve fundamental rights. See *supra* notes 184-85. See also *Moore v. City of East Cleveland*, 431 U.S. 494, 499-500 (1977) (the court balanced the claimant's right to be free in her family life against the state's right to prevent overcrowding and to minimize traffic and parking congestion); *Roe v. Wade*, 410 U.S. 113, 154, 162-63 (the

interest in preservation of the public's health, the more relevant and necessary the information is to prevent AIDS transmission, the greater the state's interest is in the disclosure of identifying information. As the sensitivity of the information increases, so does the scope of intrusion. Therefore, regulations should be fashioned so as to minimize the impact of these competing interests.<sup>247</sup>

Many believe the benefits of personalized information regarding antibody status outweigh the small risk of confidentiality in public

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court balanced the claimant's right to decide whether to terminate her pregnancy against the state's right to insure that abortions were performed safely).

The balancing test has been used where the zone of privacy surrounding medical records has been intruded. *See* *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 79-81 (1976) (abortion recordkeeping, reasonably directed to preservation of maternal health, is permissible); *United States v. Westinghouse Elec. Corp.*, 638 F.2d 570, 578-79 (3d Cir. 1980) (the government's interest in investigating a health hazard outweighed employee's privacy interest in medical records); *Hawaii Psychiatric Ass'n v. Ariyoshi*, 481 F. Supp. 1028, 1039 (D. Hawaii 1979) (balancing test applied to statute authorizing searches of records of Medicaid providers); *Division of Medical Quality v. Gherardini*, 93 Cal. App. 3d 669, 680, 156 Cal. Rptr. 55, 58 (1979) (balancing test applied to the rights of a medical board to review doctors' records to substantiate claims of doctor incompetence). *See also* *Nixon v. Administrator of Gen. Serv.*, 433 U.S. 425, 485-59, 462 (1977) (court balanced the President's privacy interests against the interests of the government, upholding the statute because of the minor amount of personal information contained in the records and since disclosure would only be to a small group of government officials); *Whalen v. Roe*, 429 U.S. 589, 598 (1977) (disclosure under New York statute which required the availability of names for certain patients obtaining prescription drugs must be balanced against the reasonable exercise of the state's broad police powers); *Plante v. Gonzales*, 575 F.2d 1119, 1134 (5th Cir. 1978) *cert. denied*, 439 U.S. 1129 (1979) (exercise of the public "right to know" is balanced against the individual's financial privacy); *McKenna v. Peekskill Housing Authority*, 497 F. Supp. 1217, 1223-24 (S.D.N.Y. 1980) (disclosure of visitors' names and prior approval for overnight guests pursuant to housing authority's rules is balanced against the plaintiff's rights of privacy and free association); *Forrester v. United States Dept. of Labor*, 433 F. Supp. 987, 989 (S.D.N.Y. 1977) (disclosure of report of discrimination claim under FOIA must balance the rights of the public against the individual's right of privacy).

The balancing test has been used in grand jury proceedings regarding disclosure of names and other identifying information in medical records. *People v. Florendo*, 95 Ill. 2d 155, 158, 447 N.E.2d 282, 285 (1983) (applying test to uphold subpoena requiring disclosure of patients' names for grand jury investigation); *People ex rel. Director of Pub. Health v. Calvo*, 89 Ill. App. 2d 130, 137, 432 N.E.2d 223, 226 (1982) (names of counseled patients not available to state attorney general after application of the balancing test).

247. *South Florida Blood Serv. v. Rasmussen*, 467 So. 2d 798, 803 (Fla. Dist. Ct. App. 1985) (recognizes privacy right but must be scrutinized when raised in a challenge to a discovery order seeking names of blood donors). *See also* *Rhinehart v. Seattle Times Co.*, 98 Wash. 2d 226, 256-57, 654 P.2d 673, 690-91 (1982) (en banc) (court limited the use of discovery after balancing the interests of the parties in a suit for defamation and invasion of privacy).

health settings.<sup>248</sup> Maintaining public health records is useful in developing information because research is essential to understand, treat and prevent AIDS.<sup>249</sup> Confidentiality concerns can become a stumbling block to health officials' efforts to control diseases, but these concerns should not be permitted to obstruct efforts to control the spread of AIDS.<sup>250</sup> With no vaccine or cure for AIDS, identifying information and reporting of all seropositive individuals help gather information on the demographics of AIDS as well as to keep track of seropositive people who go on to develop the full-blown disease. Since reporting would increase epidemiological information available for use in infection control, privacy must yield when it significantly endangers health.

While some believe that personal information regarding AIDS is necessary to study the disease, others believe that careless reporting and breaches in confidentiality would result in harm to individuals and society.<sup>251</sup> The public interest in preventing the spread of AIDS by the use of reporting statutes would be undermined if disclosure of names were required, as it may cause persons to not come forward to be tested for HIV antibodies. This "chilling" effect on AIDS research would be detrimental and in direct contravention of the statute's purpose.<sup>252</sup> Sources of information may dry up, thereby

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248. Marwick, *Epidemiologists Strive to Maintain Confidentiality of Some Health Data*, 252 J.A.M.A. 2377, 2379 (1984).

249. The identity of subjects is important because it allows investigators to maintain contact with them in epidemiologic studies and to supply needed information. See Echenberg, *A New Strategy to Prevent the Spread of AIDS Among Heterosexuals*, 254 J.A.M.A. 2129 (1985); see also Melton, *supra* note 138, at 658 n.141 (participants in AIDS research may be harmed by failing to keep identifiable information, because researchers find it necessary to verify the reliability of the data). Longitudinal studies (in which participants are observed over time) cannot be performed without maintaining identifiers. Because of its lengthy incubation, longitudinal research is important in understanding the cause of AIDS via follow-up on seropositive results. Grouse, *supra* note 217, at 2130. Information from longitudinal studies about the precise timing of AIDS development may provide important clues about processes underlying the disease. Melton, *supra* note 138, at 658-59.

250. Many persons would act to avoid passing the infection to others if they knew their HIV status, but are unwilling to be tested because of their concerns about confidentiality. Grouse, *supra* note 217, at 2131. Concerns regarding misperceptions of the clinical value of the test, however, and the potential misuse of the test to discriminate against individuals has caused the gay organizations to suggest that high-risk groups not be tested unless they are guaranteed confidentiality, sign an informed legal consent and are referred to counseling. See Collins, *supra* note 218, at 16-18.

251. Grouse, *supra* note 217, at 2131.

252. A few courts have recognized the chilling effect when disclosure is compelled. See, e.g., *H.L. v. Matheson*, 450 U.S. 398, 438-41 (1981) (Marshall, J., dissenting) (possibility of familial discord may prevent minor from seeking assistance); *Eisenstadt v. Baird*, 405 U.S. 438, 450-52 (1971) (no rational connection between interest in discouraging extramarital sexual activities and the sale of contraceptives to unmarried women); *Wynn v. Carey*, 582 F.2d 1375, 1386 (7th Cir. 1978) (minor



endangering the public's health.<sup>253</sup> In addition, disclosure of identifying information would not significantly increase counseling opportunities nor would it facilitate the dissemination of information about treatment should a cure be discovered.

After weighing the competing interests involved in a public health measure, courts have compelled disclosure of patients' names in a variety of factual situations.<sup>254</sup> Disclosure was allowed, however, be-

child's interests in anonymously obtaining assistance is sufficient to override parental interest in involvement); *State v. Saunders*, 75 N.J. 200, 218, 381 A.2d 333, 342 (1977) (people faced with possible prosecution under statute prohibiting fornication will be deterred from voluntarily seeking medical treatment for venereal disease).

Compelled disclosure is likely to substantially restrain individuals from associating with groups. In *People v. Florendo*, 95 Ill. 2d 155, 447 N.E.2d 282 (1983), the Illinois Supreme Court allowed the grand jury to subpoena the names of female patients of an abortion clinic in order to contact them and request waivers of the physician-patient privilege to aid grand jurors in their investigation of crimes of an unspecified nature. The dissent concluded, however, that the majority's decision will likely cause some women to forego abortion rather than face the possibility that their names will be exposed to a grand jury. *Id.* at 166, 447 N.E.2d at 287-88 (Simon, J., dissenting). Similar language was used in *NAACP v. Alabama*, 357 U.S. 449, 462-63 (1958) (compelled disclosure of membership in NAACP may act to dissuade people from joining). See also *Thornburgh v. American College of Obstetricians*, 476 U.S. 747, 766-67 (1986) (disclosure will chill the exercise of the constitutional right to abortion); *People ex rel. Director of Pub. Health v. Calvo*, 89 Ill. 2d 130, 132-33, 432 N.E.2d 223, 224 (1982) (compelled disclosure of Department of Health records relating to the control of venereal disease, without confidentiality assurances, might cause individuals to shun treatment, and physicians and hospitals might be reluctant to file the required reports due to fear of social harassment). *Rasmussen*, 467 So. 2d 798, 804 ("The public interest can be a sufficient reason for prohibiting the discovery of particular information"). After balancing all interests involved, the court in *Rasmussen* found that the threat of decreased blood donation was of sufficient public importance, when combined with the privacy interests of blood donors, to outweigh the plaintiff's interest in discovering the names and addresses of donors. *But see id.* at 805 (Schwartz, C.J., dissenting) (the right of privacy should take second place to revealing names and addresses and the "chill" on donations is mere speculation).

The *Whalen* court recognized that information which becomes publicly known can adversely affect one's reputation. *Whalen*, 429 U.S. 589, 600. See also Reaves, *AIDS and the Law*, 69 A.B.A.J. 1014, 1015 (1983) (some New York doctors will not report AIDS cases to the city health department and the CDC because of the lack of confidentiality safeguards).

Gay groups have also recognized the chill on research. Gay communities will boycott participation in research unless there are confidentiality protections to protect privacy. *Privacy Rules*, *supra* note 244, at 2. They may even provide invalid or incomplete data. *Id.* at 8. In addition, blood banks may be having difficulty obtaining donations because of confidentiality concerns. Grouse, *supra* note 217, at 2131.

253. Marwick, *supra* note 248, at 2377.

254. See *Whalen v. Roe*, 429 U.S. 589, 602 (1977) (disclosure to the state is an essential part of medical practice and is not automatically found to be an impermissible invasion of privacy); *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 80-81 (1976) (abortion recordkeeping permissible for female health reasons and because is not a factor in the abortion decision). The zone of privacy is not recognized in the vaccination and immunization area. See *Religious Objections*, *supra* note 237, at

cause the statutes involved provided adequate safeguards to protect the identifying information from improper disclosure.<sup>255</sup> While many AIDS regulations provide safeguards to confidentiality,<sup>256</sup>

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417. Courts would probably find a compelling state interest automatically in the immunization area. But if the balancing test were used, courts may find the interest in protecting the public health less compelling if there were no current epidemic. *Id.* at 423.

Adequate safeguards were found in several cases. *Whalen*, 429 U.S. at 605 (the threat of public disclosure is a factor in determining the constitutionality of intrusion upon informational privacy rights); *McKenna v. Fargo*, 451 F. Supp. 1355 (D.N.J. (1978)). Applying the balancing test, the *McKenna* court found the city's requirement that applicants submit to a psychological profile test merits interest in seeking out unsuitable applicants and justified the privacy intrusion, as long as access to information was limited and the data would be released for only a limited length of time. *Id.* at 1382. See also *Schacter v. Whalen*, 581 F.2d 35, 37 (2nd Cir. 1978) (in the course of an investigation concerning physicians' professional conduct, the plaintiffs were allowed to subpoena all records of patients treated with laetrile); *People ex rel. Director of Pub. Health v. Calvo*, 89 Ill. 2d 130, 133, 432 N.E.2d 223, 226 (1982) (physician-patient privilege would protect the zone of privacy regarding reports on the control of venereal disease). Additionally, in *Danforth*, abortion reporting requirements were upheld because of adequate confidentiality and retention provisions. *Danforth*, 428 U.S. at 80-81.

255. See *supra* note 254 and authorities cited therein. But see *Thornburgh*, 476 U.S. at 767-68; *Rasmussen*, 467 So. 2d at 804.

256. Many states include confidentiality provisions in their statutes. In Florida, test results cannot be used to determine if a person may be insured for disability, health or life insurance or to screen, determine suitability for, or discharge from employment. FLA. STAT. ANN. § 381.606, subd. 5 (1986). In Massachusetts, confidentiality is assured by the use of a coding system to identify patients, so names are never used. Laboratories are required to assure confidentiality of test results and are required to obtain prior consent of an individual before testing. MASS. GEN. L. ch. 111, § 70F (1987). See, e.g., CAL. HEALTH & SAFETY CODE § 199.30-40 (West Supp. 1988); MINN. STAT. § § 13.01-88 (Supp. 1987) (limits use of confidential and private information collected by state agencies); N.Y. PUB. H. LAW § 2776, subd. 2, (West 1985) (personal data collected by state agency in AIDS-related investigation or report to be kept confidential); WIS. STAT. § 631.90(3)(a) (West 1987) (an insurance company may require an individual to submit to a test for the presence of HIV antibodies if the state epidemiologist finds that the test is sufficiently reliable, however, the insurance company may not require an individual to reveal any prior test results and may not condition the provision of insurance coverage upon a prior test).

The Maryland state AIDS task force recommends that state laws be amended so that health records are non-discoverable except by court order. 1 AIDS Policy & Law (BNA) no. 1, at 7 (Jan. 29, 1986); see also Huber, *Preserving the Confidentiality of Medical Record Information Regarding Non-Patients*, 66 VA. L. REV. 583, 596 (1980) (provides a discussion of the "problems associated with sensitive nonpatient information that a patient's medical record may contain").

Many states prohibit the release of information by enacting statutes that provide that confidential communications between physician and patient are privileged. These prevent physicians from revealing in judicial proceedings confidential information obtained during the patients treatment. See, e.g., MINN. STAT. § 595.02, subd. 1(d) (Supp. 1987).

AIDS patients can be identified from CDC case reports. Marwick, *supra* note 248, at 2377. A major concern is the threat to the CDC's ability to protect the public

many claim that these and other protections are inadequate to justify the release of identifying information.<sup>257</sup> Confidentiality protections

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health as the CDC is currently facing considerable difficulty in keeping sensitive information confidential, including information about sexual practices and information in medical records. *Id.* One author relates that the law does not ensure the privacy of medical records. Dubro, *supra* note 214, at 36.

257. "Safeguards for confidentiality are relatively non-existent and the penalties for breaching those safeguards are filled with exceptions." Collins, *supra* note 250, at 29.

In addition, confidentiality provisions are concerned with the disclosure of information to third parties rather than with information collection practices that might affect an individual's privacy interest. The confidentiality provisions are inadequate for many reasons. The Privacy Commission found current safeguards of medical records inadequate at both the state and the national levels. Submitting such information to the CDC is a risk to confidentiality because names and data are released to a federal public health agency, which may further disseminate the information without the patient's consent. On at least three occasions, the CDC has released lists of names of AIDS patients to local health agencies not affiliated with the federal government. After these incidences, gay rights groups lost faith in the CDC's promises of keeping the information confidential and several local health departments adopted a policy of not providing patients' names to the CDC. Melton, *supra* note 138, at 663-64.

Reports to the CDC include numbered codes that can be linked to a person's name. This computerized system, called Soundex, prevents inadvertent disclosure of identifying information but may easily be broken and names deciphered. *Id.* at 664 (citing Collins, *supra* note 218, at 22)

One statutory protection is the physician-patient privilege—the duty not to disclose confidential information. Although the privilege is given complete or partial immunity to subpoena and other forms of compulsory disclosure, courts will use the balancing test to determine whether the data should be recognized as privileged or important enough to require disclosure. Countervailing interests in protecting the public health may justify limited compelled disclosure of information to appropriate authorities. Therefore, the privilege is inadequate to control confidentiality. Names and addresses of patients may be compelled by subpoena for discovery for litigation and grand jury investigations. *See People v. Florendo*, 95 Ill. 2d 155, 161, 447 N.E.2d 282, 285 (1983) (grand jury's interest in eliminating crimes outweighs individual's interest in confidentiality); *Superior Ct. of Los Angeles v. Marcus*, 18 Cal. App. 3d 22, 25, 95 Cal. Rptr. 545, 547 (1971). *But see Calvo*, 89 Ill. 2d at 137, 432 N.E.2d at 226 (declining to recognize state's interest in obtaining patients' names to aid in investigation of disease control); *People v. Bickham*, 89 Ill. 2d 1, 6, 431 N.E.2d 365, 367 (1982) (privilege protected medical records over investigatory requirements of a criminal investigation); *Lampshire v. Procter & Gamble*, 94 F.R.D. 58, 61 (N.D. Ga. 1982) ("personal identifying information about the participants" in CDC studies was redacted from all documents produced in response to a subpoena).

There is no common law physician-patient privilege; it is only created by statute, and provisions that create the privilege are not always adequate in protecting an individual's right to privacy. *See Note, supra* note 215, at 272-73 (physician-patient privilege only protects medical records from disclosure during the course of litigation and does not shield vast amounts of information revealed casually or through administrative processes).

There is little federal law pertaining to the confidentiality of medical records, but some federal statutes may offer some protection. The Freedom of Information Act (FOIA), 5 U.S.C. § 552 (1982), allows access to information. This act was designed

may not only be inadequate, but these provisions are concerned only with disclosure to third parties. Compelled personal information of AIDS patients involves individual privacy interests. In addition, the significant likelihood of false positive test results reinforces the need for confidentiality.

There are additional problems caused by compelled disclosure of identifying information. Harm may result if identifying information is released to the CDC and other public health authorities for surveillance purposes.<sup>258</sup> The competing interests involved with AIDS are especially pressing as AIDS has involved much publicity and intense public interest. Mandatory disclosure of identifying information and HIV test results may be used to ostracize high risk groups as they may be "blamed" for their illness. The "Gay Plague" characterization of AIDS may lead to more restrictive measures such as the quarantining of high-risk populations.<sup>259</sup>

Since there is no accepted means of controlling the spread of AIDS (other than to discourage unsafe sexual practices), the usefulness of compelling disclosure of identifying information is questionable. Mass reporting of all seropositive individuals is impractical and

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to open the government to the public. Consequently, the CDC is forced to provide material gathered in studies of disease outbreak to attorneys who use the information in court actions.

The Privacy Act of 1974 strongly limits the FOIA by protecting information from being disclosed to the public. 5 U.S.C. § 552a (1982). It does not, however, offer protection to research data. This act regulates all record systems maintained by federal agencies, but there are several exemptions to this act's protections. Records may be released to either the House or to Congress, to the General Accounting Office, or pursuant to an order from a court of competent jurisdiction. 5 U.S.C. § § 552(b)( 8), (9), (10), (11) (1982). In addition, records may be turned over to another agency for civil or criminal law enforcement under 5 U.S.C. § 552(b)(7). Regulations passed by the Department of Health and Human Services broaden the protections created by the Privacy Act. *See, e.g.*, 44 C.F.R. § 5.5 (1987). Private record systems, or those maintained by state or local governments without federal assistance, are exempt from the Act. *Id.* Therefore, the Privacy Act does not provide very strict standards to ensure confidentiality. *But see* Melton, *supra* note 138, at 666-670 (concluding that even though there are some limits placed on the disclosure of identifying information under the FOIA, there is very little protection for AIDS confidentiality information in these acts).

Certain federal institutions, such as the CDC, are mandated by section 308(d) of the Public Health Service Act to assure the supplier of information that the information may not "be used for any purpose other than for which it was supplied" unless the individual supplying the information has consented to the release of that information as determined under regulations prescribed by the Secretary of the Department of Health and Human Services. This section covers all statistical surveys, but it might not cover disease investigations, so it is not a total confidentiality protection. *See* 42 U.S.C. § 242m(d). *See also* Collins, *supra* note 218, at 23.

258. *See* Collins, *supra* note 218, at 17 (identifying consequences resulting from disclosure of AIDS information).

259. *See infra* notes 262-298 and accompanying text.

extremely costly. It is impossible to determine the extent of AIDS' reach in the population because the exact mode of transmission is unknown and there is evidence of heterosexual spread. For the same reasons mandatory testing would not be effective,<sup>260</sup> mass reporting of all persons with AIDS, ARC and seropositive individuals may be found arbitrary and unreasonable and thus a constitutionally invalid police power initiative.

While a complete bar on any disclosure would hamper AIDS research, compulsory disclosure of personal information should be no greater than is necessary to meet the state's compelling interest in preventing the spread of AIDS and developing an effective treatment for the disease. Statutes should promote research on AIDS and protect patients from undue invasion of privacy and other social, legal and economic harms.<sup>261</sup>

#### D. Constitutional Basis of Quarantine Regulations

Some public health officials are concerned that voluntary measures such as reporting and counseling may be inadequate to protect the public health.<sup>262</sup> They believe some AIDS patients may be spreading the disease by ignoring medical advice to abstain from sexual contact, or that some patients may be mentally incompetent and therefore unable to understand their actions.<sup>263</sup> Because of these concerns, AIDS quarantine regulations have been considered in many states.<sup>264</sup> As with other AIDS control measures, quarantine

260. See *supra* notes 188-208 and accompanying text.

261. One commentator recommends a means of extending federal protections, in lieu of a federal statute enactment, to protect the medical records of AIDS patients. He suggests that the director of the CDC issue a "certificate of confidentiality" pursuant to his authority under section 308(a) of the Public Health Service Act, 42 U.S.C. § 242m (1987). Such assurance would cover all surveillance and research actions on AIDS undertaken by the CDC or other involved institutions. The commentator believes this would show a clear intent by the CDC to keep all identifying information immune from subpoena and requests sought under the FOIA. Collins, *supra* note 218, at 23.

262. See generally Russell, *Texas Health Chief Seeks Quarantine in AIDS Cases*, Wash. Post, Oct. 23, 1985, § A2, at 1, col. 4

263. AIDS affects mental status in the later stages of the disease. See generally *supra* note 41 and accompanying text.

264. For the first time, talk of quarantine has caused litigation to appear in forums. Curran, Professor of Legal Medicine at Harvard Medical School, stated that he is preparing standby regulations for cities to apply in confining AIDS patients who willfully persist in giving the disease to others. Adler, *The AIDS Conflict*, NEWSWEEK, Sept. 23, 1985, at 18-24.

Every state has quarantine laws that can be used to isolate people with infectious diseases. Two states, California, and Connecticut, have recently acted to change their laws to make quarantine of AIDS patients easier. CAL. HEALTH & SAFETY CODE § 3123 (1988); CONN. GEN. STAT. § 199-221 (1986). The Connecticut statute permits the quarantine of persons with communicable diseases who are judged to be a

regulations contrast public safety against AIDS patients' rights of due process, confidentiality and privacy.

While few public health officials actually recommend quarantine, the potential for public support is great. Increased public hysteria has resulted because there is no effective treatment or vaccine for AIDS' prevention. The imposition of less intrusive public health measures to control the spread of AIDS could lead to more restrictive initiatives such as quarantine. There is very little known about the treatment for and prevention of AIDS. As with all other AIDS regulations, lawmakers must be careful not to make decisions based on insufficient information.

Quarantine is particularly problematic regarding AIDS because of the large number of people infected, the apparent permanency of the infection, the lack of any effective treatment, and its limited form of communicability. There still may be a rational use of quarantine for those infected individuals who knowingly persist in engaging in high-risk sexual or other activity.<sup>265</sup>

Quarantine is the confinement of persons who have been exposed to a communicable disease for a period of time equal to the longest incubation period of the disease to which they have been exposed.<sup>266</sup> Although effective in the past to prevent the spread of disease, quar-

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threat to the public health. CONN. GEN. STAT. § 199.221 (1986). The CDC has begun looking into federal authority to quarantine. The Texas state health commission planned to seek authority to quarantine patients involuntarily if they seemed to be a threat to the public health. Russell, *supra* note 262, at 1. See also 1 AIDS Policy and Law (BNA) no. 1, at 5 (Jan. 29, 1986); *id.* no. 8, at 1 (May 7, 1986); see also Parry, *AIDS As A Handicapping Condition*, 9 MENTAL & PHYSICAL DISABILITY RPTER. 402, 403 (1985) (AIDS protective actions).

Connecticut and other jurisdictions have proposed quarantine as a proper response to the spread of AIDS in prisons. See Note, *supra* note 165, at 316 Great Britain has already enacted legislation that permits magistrates, in limited situations, to quarantine AIDS carriers. Thomas, *AIDS Victims are Targets of New Rules in Great Britain*, N.Y. Times, Mar. 23, 1985, at 14.

265. *Fabian Story* (May 19, 1986, WCCO-TV, Dave Moore Report, Mpls., Minn.) This report concerned a male homosexual prostitute with AIDS who continued to participate in sex for pay.

266. Quarantine is used two ways. One is to limit the spread of disease by restricting cases and carriers of communicable disease. The second is as an epidemic measure that has an emergency character designed to limit the spread of communicable diseases. Quarantine is not justified when a disease occurs sporadically among widely separate individuals by long time intervals. P. BRACHMAN, *Epidemiology*, in COMMUNICABLE AND INFECTIOUS DISEASES 18-19 (F. Topp & P. Wehrle eds. 1976). See also *Ex parte Culver*, 187 Cal. 437, 442, 202 P. 661, 664 (1921) (quarantine measures are "[t]o keep persons, when suspected of having contracted or have been exposed to an infectious disease, out of a community, or to confine them to a given place therein, and to prevent intercourse between them and the people generally of such community." (citation omitted)).

antine was only used to fight highly contagious diseases.<sup>267</sup> Quarantine is an infection-control option which should be used only in individual cases and for narrowly defined purposes. These purposes might include forcing treatment on noncompliant infected patients with tuberculosis, segregating patients with untreatable diseases such as smallpox, or controlling the spread of highly communicable diseases such as bubonic plague. Quarantine has been used infrequently for patients with sexually transmitted diseases.<sup>268</sup> Long term quarantine of large numbers of people has been used in this century only for leprosy.<sup>269</sup>

Health officials have special authority to order isolation or quarantine to control the spread of disease.<sup>270</sup> Persons subject to quarantine may include those who have been exposed to a communicable disease, carriers of that disease, and those who exhibit symptoms of illness. Quarantine may be used against either a person or a place.<sup>271</sup>

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267. Parmet, *AIDS And Quarantine: The Revival of An Archaic Doctrine*, 14 HOFSTRA L. REV. 53, 71-72 (1985).

Several diseases have been contained by quarantine. See *Kirk v. Wyman*, 85 S.C. 372, 65 S.E. 387 (1909) (quarantine of those afflicted with leprosy). Tuberculosis patients who did not observe infection control instruction of public health officials could be isolated at home or in an institution. See, e.g., CAL. HEALTH AND SAFETY CODE, § 3285 (West 1979). See also *State v. Snow*, 230 Ark. 746, 748, 324 S.W.2d 532, 534 (1959) (statute requiring confinement of tuberculosis strictly enforced); *City and County of San Francisco v. Boyle*, 191 Cal. 172, 177, 215 P. 549, 553 (1923) (state has duty to quarantine tuberculosis patients); *In re Halko*, 246 Cal. App. 2d 553, 554-57, 54 Cal. Rptr. 661, 662-63 (1966) (upholding the constitutional attack of the quarantine of tuberculosis patients); *People ex rel. Barmore v. Robertson*, 302 Ill. 422, 427-28, 134 N.E. 815, 817-18 (1922) (broad discretion in power to quarantine).

268. Parmet, *supra* note 267, at 66-9 (discussing use of quarantine measures for prostitutes thought to be infected with a venereal disease).

269. See A. BENENSON, *supra* note 124, at 4.

270. See *supra* notes 139-44 and accompanying text. See also *Railroad Co. v. Husen*, 95 U.S. 465, 472 (1877) (quarantine allowed for self-protection).

271. California's statutory scheme is typical of compulsory measures to protect the public health. Health officials have the authority to take whatever action is necessary to protect the public health. CAL. HEALTH AND SAFETY CODE § § 3050, 3051, 3110, 3114, 3123 (West Supp. 1988). Quarantine may extend to persons who come in contact with contagious diseases. See *Culver*, 187 Cal. at 440, 202 P. at 663. Quarantine is usually applied to people infected with active cases of tuberculosis and leprosy. See also *infra* notes 297-325 and accompanying text (discussing the closure of bathhouses); see generally *Jones v. Czapkay*, 182 Cal. App. 2d 192, 6 Cal. Rptr. 182 (1960) (no basis for liability against health officers, the county or city in allegations of negligent failure of officials to enforce quarantine of tuberculosis victim from whom the plaintiff contracted the disease). Health officials may make an isolation or quarantine order to a person with a communicable disease whenever the official determines in a particular case that quarantine or isolation is necessary for the protection of the public health. Legislatures are vested with broad discretion in determining what are contagious and infectious diseases. *Halko*, 246 Cal. App. 2d at 557, 54 Cal. Rptr. at 663; *Ex parte Johnson*, 40 Cal. App. 242, 244 180 P. 644, 644-45 (1919).

Like mandatory testing and reporting requirements to control the spread of AIDS, quarantine regulations must meet a two-part constitutional standard. First, there must be a rational relation between the quarantine and the state's legitimate interest in preserving the public's health.<sup>272</sup> Second, quarantine must be the least restrictive means available to protect the community.<sup>273</sup> Public health officials in the past have ordered confinement without explanation or review.<sup>274</sup> Modern courts and statutes, however, insist that due process requirements be applied to quarantine measures. Strict control is necessary since quarantine can severely restrict an individual's constitutionally protected rights.<sup>275</sup>

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272. See *supra* notes 144-47 and accompanying text. This test presumes the statute's validity and courts will not strike it down unless it lacks a reasonable relationship to a legitimate state interest or it is capricious, arbitrary, or otherwise unreasonable and oppressive. *Robertson*, 302 Ill. 422, 427, 134 N.E. 815, 817 (1922). For a health regulation to be a valid exercise of the state's police power and not violative of due process rights, it must be reasonable and bear some relation to the danger of disease spread. See also *Damme*, *supra* note 140, at 805.

There must also be reasonable grounds for a quarantine order. *Varholy v. Sweat*, 153 Fla. 571, 576, 15 So. 2d 267, 269 (1943); *Robertson*, 302 Ill. at 427, 134 N.E. at 817; *Crayton v. Larabee*, 220 N.Y. 493, 503, 116 N.E. 355, 358 (1917).

Detention is justified if the person is one whose habits are such as to warrant the belief that he or she is afflicted with a venereal disease. *Ex parte Caselli*, 62 Mont. 201, 204, 204 P. 364, 365 (1922). Such is the rule when prostitutes are arrested. *Reynolds v. McNichols*, 488 F.2d 1378, 1383 (10th Cir. 1973) (upholding the constitutionality of a "hold and treat" ordinance which authorized limited detention in jail for examination of prostitute reasonably suspected of having venereal disease); *Ex parte Shepard*, 51 Cal. App. 49, 50-51, 195 P. 1077, 1077 (1921) (permissible restraints upon the freedom of persons who are probably sources of infection).

Quarantine orders are impermissible when they are based on mere suspicion. *Ex parte Shepard*, 51 Cal. App. at 51, 195 P. at 1077; *Robertson*, 302 Ill. at 429-30, 134 N.E. at 819; *Hill v. Hilbert*, 92 Okla. Crim. 169, 222 P.2d 166, 169 (1950).

Quarantine orders were issued to hold suspected prostitutes in custody pending trial on the supposition that if released they would spread venereal disease. *Ex parte Arata*, 52 Cal. App. 380, 198 P. 814 (1921); *Ex parte Shepard*, 51 Cal. App. at 49, 195 P. at 1077. The court required only that the state make a showing that the woman be of a class of persons (e.g. prostitutes) likely to have venereal disease in order to establish reasonable suspicion that the woman had venereal disease. A true relation between the statute and the spread of disease was found in *Halko*, 246 Cal. App. 2d at 553, 54 Cal. Rptr. at 661. See also *Huffman v. District of Columbia*, 39 A.2d 558, 561 (D.C. 1944); *Moore v. Draper*, 57 So. 2d 648, 650 (Fla. 1952); *People ex rel Baker v. Strautz*, 386 Ill. 360, 364, 54 N.E.2d 441, 444 (1944); *Ex parte Company*, 106 Ohio St. 50, 52, 139 N.E. 204, 206 (1922); *Caselli*, 62 Mont. at 201, 204 P. at 364.

273. *Jew Ho v. Williamson*, 103 F. 10, 19-20 (C.C.N.C. Cal. 1900). See also *Strautz*, 386 Ill. at 360, 54 N.E.2d at 441; *Robertson*, 302 Ill. at 422, 134 N.E. at 815; *Rock v. Carney*, 216 Mich. 280, 294, 185 N.W. 798, 799 (1921).

274. *Parmet*, *supra* note 267, at 59-62 (validity of state's quarantine action rarely questioned); Comment, *Quarantine: An Unreasonable Solution to the AIDS Dilemma*, 55 U. CIN. L. REV. 217, 221-22 (1986) (discussing very broad powers of government to enact measures such as quarantine laws).

275. See, e.g., *Greene v. Edwards*, 263 S.E.2d 661, 663 (W. Va. 1980) (confinement



Quarantine restricts infected individuals, disease carriers and even healthy people who reside in a quarantined area. Thus, the measures taken, including the period of detention, must be reasonable under the circumstances when attempting to prevent the spread of the disease.<sup>276</sup> A question arises as to how much certainty of infection is required to quarantine. By recognizing that AIDS is incurable and invariably fatal, courts today would probably defer to medical judgment and uphold quarantine measures if it was shown that the medical community believed the measure would be effective. Broad discretion is granted to regulators to determine what measures are necessary to fight an epidemic.<sup>277</sup> Courts will interfere, however, when quarantine measures result in unnecessary and unlawful restrictions upon the individuals affected.<sup>278</sup> As a general rule, the power to quarantine may be exercised when there is a reasonable belief that the person confined is actually infected with a contagious disease. In addition, courts would consider the period of detention or confinement as reasonable, as long as the confinement is necessary to insure the disease's containment.<sup>279</sup>

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of tuberculosis patients); *State ex rel. Hawks v. Lazaro*, 202 S.E.2d 109 (W. Va. 1974) (confinement of the mentally ill). See also *Arata*, 52 Cal. App. at 380, 383, 198 P. at 814, 816; *Robertson*, 302 Ill. at 422, 134 N.E. at 815.

276. See generally *In re Smith*, 146 N.Y. 68, 40 N.E. 497 (1895) (order cannot extend beyond the scope of necessary protection). Many actions were upheld because there were reasonable grounds to believe persons restricted may have been infected. *State v. Rackowski*, 86 Conn. 677, 681, 86 A. 606, 607-08 (1913).

Quarantine has been used as a preventative measure. *Pierce v. Dillingham*, 203 Ill. 148, 150, 151, 67 N.E. 846, 847 (1903) (must be reasonable as mere fear of danger, unsupported by evidence, will not justify the establishment of a quarantine). See also *Jew Ho*, 103 F. at 17.

277. Merritt, *Communicable Disease and Constitutional Law: Controlling AIDS*, 61 N.Y.U.L. REV. 759, 776

278. *Robertson*, 302 Ill. at 432, 134 N.E. at 819. The court allowed the quarantine of a rooming house where some residents contracted typhoid fever. The owner of the house had no symptoms, but was a carrier. The court reasoned that mere suspicion was enough to support quarantine and further noted that where the danger of an epidemic actually exists, quarantine regulations will be sustained by the courts. *Id.* at 432, 134 N.E. at 819. "It is not necessary for the health authorities to wait until the person affected with a contagious disease actually caused others to become sick by contact with him before he is placed under quarantine." *Id.* at 434, 134 N.E. at 820.

Other courts, however, have stated that "[m]ore than a mere suspicion that an individual is afflicted with an isolatable disease is necessary to give an officer "reason to believe" that such a person is so afflicted." *Shepard*, 51 Cal. App. at 51, 195 P. at 1077. See also *Jew Ho*, 103 F. at 10. This case involved an involuntary quarantine action by the City of San Francisco where orientals in 12 blocks and over 15,000 people were quarantined after only nine suspected cases of bubonic plague. The court determined the quarantine unreasonable as the measure restricted and curtailed liberties without due process of law. *Id.* at 26.

279. The period of detention or confinement is as long as is necessary to insure against the disease's spread and will be enforced as long as the individual is contagious. *Halko*, 246 Cal. App. 2d at 558, 54 Cal. Rptr. at 664; *Shepard*, 51 Cal. App. at

Because states cannot act to quarantine individuals based on mere suspicion,<sup>280</sup> AIDS quarantine initiatives cannot be upheld if the only justification is that an individual *might* test seropositive. There must be some demonstrative evidence that an individual poses an actual threat to public health. Since the HIV antibody test is not a fully accurate method of detecting AIDS, proposals to quarantine *known* seropositive individuals pose serious legal questions as to confidentiality and privacy.<sup>281</sup>

Any AIDS control regulation that restricts the movement of an individual impinges on fundamental rights and should be evaluated under the strict scrutiny test.<sup>282</sup> Involuntary confinement for any purpose has been recognized by the Supreme Court as a significant deprivation of liberty that may not be abridged without a showing of compelling necessity.<sup>283</sup> Quarantine would also impair other fundamental rights. These include the freedom of association,<sup>284</sup> the right to privacy,<sup>285</sup> including the right to co-habitate with one's family and spouse,<sup>286</sup> and the right to travel interstate.<sup>287</sup>

In addition to fundamental right infringements, quarantine of homosexual men would also be unconstitutionally overinclusive. Not all AIDS patients are homosexual, and only a minority of homosexual men have AIDS.<sup>288</sup> The HIV antibody test produces a significant number of false positive results, which also creates problems of over-inclusiveness. A quarantine regulation would deter many carriers

49, 195 P. at 1077; *Rackowski*, 86 Conn. at 682, 86 A. at 608; *Robertson*, 302 Ill. at 433, 134 N.E. at 819. Quarantine regulations may be enforced as long as an individual is infectious or contagious and the health official reasonably believes such a person is dangerous to the public's health. *Id.*

280. See *supra* note 152 for a discussion of the attempts to bring quarantine regulations under the protection of constitutional "strict scrutiny."

281. See *supra* notes 209-61 and accompanying text. These principles were recently applied to a case of a Florida prostitute with AIDS when she was confined to her home and ordered to wear an electronic device that signals police if she strayed more than 200 feet from her telephone. Mills, *The Acquired Immunodeficiency Syndrome: Infection Control and Public Health Law*, 314 NEW ENG. J. MED. 931, 934 (1986). Preventing conduct by a form of house arrest is less restrictive than imprisonment and protects the public health interest. However, maintaining it for any length of time is difficult.

282. *AIDS Carriers*, *supra* note 202, at 1282.

283. See *supra* note 165 and accompanying text. See also *Addington v. Texas*, 441 U.S. 418, 425-26 (1979) (standard for involuntarily committing a person to a state mental hospital); *Korematsu v. United States*, 323 U.S. 214, 216 (1944) (exclusion order upheld against American citizens of Japanese ancestry during World War II).

284. *Shelton v. Tucker*, 364 U.S. 479, 485-87 (1960).

285. *Griswold v. Connecticut*, 381 U.S. 479, 485-86 (1965).

286. *Moore v. City of East Cleveland*, 431 U.S. 494, 502-05 (1977).

287. *Shapiro v. Thompson*, 394 U.S. 618, 630-31 (1969).

288. See *infra* note 327 and accompanying text.

from seeking tests or treatment.<sup>289</sup> It is also possible that a quarantine law would be enforced arbitrarily. People who depend on public health facilities for medical assistance are those most likely to come to the attention of government authorities. Randomness would violate the equal protection clause and render quarantine unworkable and unconstitutional.<sup>290</sup>

Even though a proposed quarantine regulation must meet the strict scrutiny test, the state may still safeguard public health. The state must, however, use the least restrictive means to accomplish this objective.<sup>291</sup> After reviewing the type of state action taken to control AIDS, courts would then measure the degree of intrusiveness on the affected group. The alternative which impairs the constitutional rights of the fewest number of people would be permissible.<sup>292</sup> Rational criteria should be used to determine the identity of infected individuals so that intrusion into their privacy and liberty rights are reasonable in light of the AIDS dangers. Few, if any, quarantine actions would be targeted closely enough to pass this constitutional test.

There are many reasons why quarantine is an impractical, if not an impossible, measure for controlling the spread of AIDS. For example, experts lack relevant knowledge about the disease.<sup>293</sup> In the past, quarantine was used to prevent the spread of diseases that were transmitted casually. By contrast, AIDS is spread only through intimate contact with bodily fluids, particularly through sexual inter-

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289. Brief for Amicus Curiae American Psychiatric Association & American Public Health Association at 20-26, *Bowers v. Hardwick*, 106 S. Ct. 2841 (1986) (No. 85-140) (quarantine would be neither an effective nor constitutional means of protecting the public from disease). See, e.g., *Addington v. Texas*, 441 U.S. 418, 432-33 (1979) (state must justify confinement with clear and convincing evidence that it is warranted); *Greene v. Edwards*, 263 S.E.2d 661 (W. Va. 1980) (evidence to warrant commitment must be clear, cogent and convincing).

290. *Kolender v. Lawson*, 461 U.S. 352, 357-58 (1983).

291. See *supra* notes 164-66 and accompanying text. Compulsory measures of various kinds may or may not be constitutionally justified, depending on what is known about a disease's mode of transmission, the degree and duration of infectiousness, and the existence of a symptom-free carrier state. If these variables reach their worst values, courts will then be faced with the question of whether severe invasions of individual rights of infected persons are justified to protect against the rapid spread of AIDS through the general population. The balancing test measures the individual's right of privacy against society's interest in limiting the harm caused by AIDS.

292. See *supra* note 165 and accompanying text. See also *Dunn v. Blumstein*, 405 U.S. 330, 337 (1972) (compelling state interest must be found in instituting voting requirements of a suspect nature).

293. Comment, *supra* note 274, at 231. This author points out that proponents of quarantine measures assume that AIDS is transmitted only through an exchange of bodily fluids. If this assumption is inaccurate, however, quarantine measures may still be ineffective. *Id.*

course or the use of contaminated needles.<sup>294</sup> Experts estimate that up to 1.2 million individuals would probably test seropositive.<sup>295</sup> All of these individuals would have to be quarantined for it to be an effective measure of controlling the spread of AIDS. Also, the HIV antibody test reports false positive and false negative results. Therefore, many people would escape detection.<sup>296</sup> The long latency period may cause thousands of people to become infected and infectious without knowing it. In addition, because there is no cure at the present time, infected individuals would be quarantined for life.<sup>297</sup> For these reasons, a quarantine measure would be impractical.

Although quarantine standards probably could not be drawn sufficiently narrow to withstand constitutional attack, some regulation may be useful for those individuals who act irresponsibly. Care must be taken, however, to draft the regulation based on medical knowledge about AIDS and not to simply impose the measure due to pressure from public fear. Quarantine aimed at those who are considered unwilling to refrain from sexual contacts or from sharing IV needles may appear to be sufficiently narrow to withstand constitutional attack. Out of over one million seropositive persons, however, it is almost impossible to identify the dangerous individuals. Initiation of a quarantine would be based upon predictions of future behavior that could not be confirmed so as to meet the test of least restrictive means. An individual could be confined simply because of assumptions about what he might do in the future. This individual could be seen as lacking self-control, prone to engage in unacceptable behavior and, therefore, a danger to society. In addition, since many jurisdictions have sodomy statutes in effect,<sup>298</sup> an individual could be involuntarily confined without receiving the safeguards of a criminal trial.

Although states have the authority to impose quarantine to control the spread of communicable or infectious diseases, quarantine was only effectively used in the past for diseases that were casually spread and for diseases that could actually be brought under control by

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294. See *supra* notes 61-63 and accompanying text.

295. U.S. DEPT. OF HEALTH AND HUMAN SERVICES, AIDS: INFORMATION/EDUCATION PLAN TO PREVENT AND CONTROL AIDS IN THE UNITED STATES 3 (Mar. 1987). See *supra* notes 47-49 and accompanying text.

296. See *supra* notes 24-26 and accompanying text. The detection failure rate is greater than four percent among people who could potentially transmit the disease. Some persons with AIDS have no detectable HIV antibodies. *Id.*

297. Chase, *Doctor's Efforts to Control AIDS Sparks Battle Over Civil Liberties*, Wall Street J., Feb. 8, 1985, at 1, col. 1. Unlike the one month quarantine for smallpox, an AIDS quarantine would be for life.

298. See Lambda Legal Defense and Education Fund Update, *Free and Unfree States*, Fall 1985, at 1 [hereinafter Lambda Update].

treatment or vaccination. There is no effective treatment or cure for AIDS and the HIV antibody test does not mean a person is infected or infectious. For these reasons, a quarantine initiative to control the spread of AIDS would probably be an unconstitutional restriction on an individual's fundamental rights.

### E. *Constitutional Basis of Bathhouse Closure*

Related to the other constitutional issues is the question of whether states have the power to adopt measures to close homosexual bathhouses and bars.<sup>299</sup> Proposals to close down bathhouses frequented by gay men also raise the conflict between privacy and associational rights and the government's responsibility to protect the public health. While bathhouses offer relaxation and camaraderie, some also facilitate anonymous sexual contact with multiple partners—an ideal mode of AIDS transmission. This legal battle tests the state's authority to limit homosexual behavior for the purpose of preventing the spread of AIDS.

The nature of a public health action to close gay bathhouses is pursuant to the state's traditional quarantine and nuisance abatement laws.<sup>300</sup> To prevent the spread of contagious diseases, health

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299. Two efforts to limit the transmission of AIDS have been made. On October 9, 1984, the Director of San Francisco's Department of Health ordered gay bathhouses and sex establishments closed. Within six hours, six clubs reopened, challenging the order and the city filed briefs seeking a court order enjoining the businesses from operating. The Superior Court allowed the businesses to remain open, but enjoined certain practices and ordered the businesses to hire employees to enforce compliance with the injunction. Renting of private rooms was forbidden and the expulsion of patrons engaging in high-risk sex were also ordered by the judge. Note, *supra* note 170, at 308-09 (citing *San Francisco v. Owen*, No. 830-321 (Cal. Super. Ct., San Francisco County, Nov. 28, 1984)).

In October, 1985, New York closed the Mineshaft Bar, Plato's Retreat and the New Saint Mark's Baths. Two lawsuits in connection with this regulations are pending. N.Y. State Bar Assoc., *The State's Regulatory Response to AIDS 5-6* (Jan. 17, 1986) (on file in the William Mitchell Law Review Office); Tarr, *supra* note 217, at 1, col. 3. The Florida Task Force endorses any appropriate and legal action which might prevent unsafe sexual practices. Report of the Governor's Task Force on AIDS 20 (Jan. 6, 1986) [hereinafter Florida Report] (on file in the William Mitchell Law Review Office). The Indianapolis Board of Health adopted an ordinance that required the closure of commercial establishments where disease may be contracted. As places for anonymous sexual encounters, many people were convinced that bathhouses were spreading death by AIDS and began to consider ways to close them. 1 AIDS POLICY AND LAW (BNA) no. 6, at 6 (Apr. 9, 1986).

300. See *supra* notes 139-40 and accompanying text. See, e.g., CAL. CIV. CODE §§ 3479-3496 (West Supp. 1984) (nuisance); CAL. HEALTH & SAFETY CODE §§ 3000-3125 (West Supp. 1988) (quarantine).

A nuisance is anything which is injurious to health, or is indecent or offensive to the senses, or an obstruction to the free use of property, so as to interfere with the comfortable enjoyment of life or property, or unlawfully obstructs the free passage or use, in the customary manner, of any navigable lake or river, bay, stream, canal, or

officials may close public places and prohibit the assembly of people during the existence of a contagious disease in the community.<sup>301</sup> Health authorities have broad powers to deal with nuisances or other offensive conditions. Exercise of this police power will not be interfered with absent a showing of abuse.<sup>302</sup>

Because quarantine regulations must be based on a reasonable belief that an individual was infected with a communicable disease, the first step is to determine whether bathhouse sexual conduct is likely to result in the transmission of AIDS. Whether it is likely that a bathhouse visitor will have sex with a seropositive individual is a question of fact to be determined by medical testimony and research evidence. Studies show a strong correlation between the number of sexual partners and the likelihood of contracting AIDS.<sup>303</sup> The state would

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basin, or any public park, square, street, or highway. CAL CIV. CODE § 3479 (West 1984). See also Note, *supra* note 170, at 309-14.

"Nuisance *per se* is a term used in both civil and criminal law. It is defined as . . . 'a structure or activity which is a nuisance at all times and under any circumstances. Proof of the act or the existence of the structure establishes the nuisance as a matter of law.'" Harris v. United States, 315 A.2d 569, 572 n.9 (D.C. 1974) (en banc) (where a homosexual health club was found to be similar to a bawdy house and constituted a nuisance *per se*). The common law crime of keeping a disorderly house was the maintenance of premises upon which activity occurred that either created a public disturbance or, although concealed from the public, constituted a nuisance *per se*.

See *supra* notes 263-298 and accompanying text. Quarantine regulations must be based on reasonable grounds, not mere suspicion which was not by facts. The state must have probable cause to believe a person is afflicted with communicable disease. The quarantine cases were decided prior to 1950 and therefore did not address the statutes in light of the constitutional developments of due process, equal protection, and search and seizure. Note, *supra* note 170, at 311. The precedential value of these cases is therefore questionable as applied to AIDS-related concerns.

301. See also Benson v. Walker, 274 F. 622 (1921); State *ex rel.* Dresser v. Ruddy, 592 S.W.2d 789 (Mo. 1980) (en banc).

302. DeAryan v. Bulter, 119 Cal. App. 2d 674, 681, 260 P.2d 98, 101-02 (1953). The protection of the public health is a legitimate exercise of police power. The interest in protecting the public's health is strengthened as the particular threat to health becomes greater. See Roe v. Wade, 410 U.S. 113, 150 (1973) (because the state's interest was stronger in the second and third trimester of pregnancy, due to the increased dangers associated with abortions at this stage, the Court allowed more strict regulation during these time periods). The stronger the state interest in protecting against a threat to the health and safety of the public, the broader the construction given to the statute addressing that threat. See Jew Ho v. Williamson, 103 F. 10 (N.D. Cal. 1900); Note, *supra* note 170, at 309.

In San Francisco, the court refused to close the bathhouses; instead it ordered specific measures to inhibit sex practices likely to transmit AIDS (i.e. remove all doors on bathhouse booths and cubicles, make public all private areas, hire monitors to inspect the premises every ten minutes, and expel patrons observed engaging in high-risk sex activities). Note, *supra* note 170, at 328 (discussing San Francisco v. Owen).

303. Seventy three percent of those with AIDS are homosexual men and the disease is transmitted by anal intercourse. The cases associated with sex practices in-

have to show that restricting sexual conduct in bathhouses would be likely to reduce the spread of AIDS in order to satisfy the reasonable cause requirement of the quarantine cases.<sup>304</sup>

If a correlation is found between bathhouse sex and the spread of AIDS, nuisance law would support closure only if more a narrow means of abating the problem does not exist.<sup>305</sup> Injunctions to abate a public nuisance where the business is not unlawful, should be limited in scope to prevent only those activities which cause the injury sought to be prevented.<sup>306</sup> Bathhouses are not nuisances *per se* because their operation does not violate any state statute. Consequently, a court injunction ordering restrictions in their operation should be only as broad as necessary to stop the spread of AIDS.<sup>307</sup>

An analogy may be drawn, however, between the holding and examination of prostitutes and restrictions placed on bathhouses.<sup>308</sup> As a criminal act, prostitution is seen as a breeder of venereal disease.<sup>309</sup> Similarly, sodomy, a criminal behavior in most states, may be seen as a breeder of AIDS.<sup>310</sup> States might contend that this is a

volve semen to blood and blood to blood contacts. See *supra* note 73 and accompanying text. The frequency of sex activities with different sex partners increases the probability of contracting AIDS. *Epidemiologic Results, supra* note 2, at 147.

304. See *supra* note 272-75 and accompanying text; Note, *supra* note 170, at 313.

305. *Anderson v. Souza*, 38 Cal. 2d 825, 834, 844, 243 P.2d 497, 503, 509 (1952) (en banc) (plaintiffs had burden of showing that airfield could not be operated in any manner which did not constitute a nuisance in attempt to secure a permanent injunction against operation of private airfield). See also *Morton v. Superior Court*, 124 Cal. App. 2d 577, 582, 269 P.2d 81, 85 (Cal. Ct. App. 1954) (injunction sought against operation of quarry).

Where the decree absolutely prohibits any acts, there should be abundant evidence that the continuance of the acts will inevitably result in irreparable injury. In the absence of such strong evidence, the decree should merely enjoin the doing of the particular acts in a manner calculated to injure the plaintiff.

*Id.* at 583, 269 P.2d at 86 (quoting *Thompson v. Kraft Cheese Co.*, 210 Cal. 171, 180 291 P. 204, 208 (Cal. 1930)).

306. *Morton*, at 582, 269 P.2d at 85. "[W]hen the defendant's business is not a nuisance *per se*, the injunction should be limited in scope so as to not enjoin the defendant's entire business if a less measure of restraint will afford the relief to which the plaintiff is entitled." *Id.* See also *People v. Mason*, 124 Cal. App. 3d 348, 354, 177 Cal. Rptr. 284, 288 (1981) (injunction restraining bar from allowing noise emanating from its business to be audible outside its property except for public street too broad; because bar is not a nuisance *per se*, scope must be limited to those measures which afford relief). A *per se* nuisance is one which always operates unlawfully, no matter how operated. Note, *supra* note 170, at 314 n.68.

307. See *Mason*, 124 Cal. App. 3d at 354, 177 Cal. Rptr. at 288 (injunction should go no further than what is absolutely necessary to protect rights of parties seeking injunction against bar).

308. See *supra* notes 270-71 and accompanying text. See also Note, *supra* note 170, at 312.

309. See *supra* note 272 and cases cited therein.

310. See *Lambda Update, supra* note 298, at 1. Twenty-four states and the District

reasonable basis for suspecting the presence of AIDS and thus be allowed to mandate the closure of bathhouses.<sup>311</sup> If a correlation can be shown between sexual intercourse and bathhouse patronage and the spread of AIDS, the issue then becomes to what extent the state can regulate the activities of bathhouse patrons for the purpose of decreasing the transmission of AIDS.

Bathroom closure has been claimed to violate individuals' rights of privacy and association.<sup>312</sup> Although the constitutional right of privacy has been recognized in family and marriage relationships,<sup>313</sup> the Supreme Court recently affirmed that there is no fundamental right to privacy encompassing sexual intercourse.<sup>314</sup> The Court also refused to expand the "substantive reach" of the due process clauses of the fifth and the fourteenth amendments to include homosexual sodomy.<sup>315</sup> Since the Supreme Court has not recognized a fundamental right to adult consensual intercourse, the state need only show a rational basis for restricting adult consensual same-sex

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of Columbia have made sodomy a crime. *Bowers v. Hardwick*, 106 S. Ct. 2841, 2847 n.1 (1986) (Burger, C.J., concurring) *reh'g denied*, 107 S. Ct. 29 (1986) (detailing history of sodomy laws). The Court, in a 5-4 opinion, refused to extend the right of privacy to homosexual sodomy. Whereas marriage, family relationships, and procreation are recognized as fundamental rights, that recognition was not extended to homosexual intercourse because no connection to the three previously recognized rights exist. *Id.* at 2844. Neither is sodomy a fundamental right on its own. *Id.* A fundamental liberty is one that is "deeply rooted in this Nation's history or tradition" or "implicit in the concept of ordered liberty." *Id.* The history of sodomy laws reveals that sodomy is not a fundamental liberty. *Id.* at 2844-46.

Furthermore, sexual conduct between consenting adults is not constitutionally protected from state prohibition or regulation. *Id.* at 2844. The state need only show a rational basis for the restriction on adult consensual same-sex intercourse. *Id.* at 2846. *See also Doe v. Commonwealth's Attorney for the City of Richmond*, 403 F.Supp. 1199 (E.D.Va. 1975) *reh'g denied*, 425 U.S. 985 (1976) (protection of public morals rational basis for sodomy state) *aff'd*, 425 U.S. 901 (1976). There are many indications that some states are using the AIDS threat as a public health justification for reviving sodomy laws. *Reason to Regulate*, *supra* note 264, at 333-38 (1985). Although these attempts have not always been successful, there have been numerous cases of job and housing discrimination against homosexuals as both actual and potential victims of AIDS. Flaherty, *A Legal Emergency Brewing Over AIDS*, Nat'l L.J., July 9, 1984, at 1; Comment, *AIDS: A Legal Epidemic?*, 17 AKRON L. REV. 717, 731 (1984) (discussion of prison housing).

311. In contrast, however, it could be argued that the state is acting on mere suspicion that all homosexuals have AIDS, thereby violating due process. *See Wragg v. Griffin*, 185 Iowa 243, 249-53, 170 N.W. 400, 402-03 (1919) (mere suspicion of venereal disease not valid reason for exercise of authority to quarantine and to protect public from contagious disease where defendant was jailed and blood tests ordered).

312. *City of New York v. New Saint Mark's Baths*, 130 Misc. 2d 911, 497 N.Y.S.2d 979 (1986) (compelling state interest in combatting AIDS overrides rights of privacy and of association).

313. *See supra* notes 153-73 and accompanying text.

314. *Bowers v. Hardwick*, 106 S. Ct. 2841 (1986).

315. *Id.* at 2846.



intercourse.<sup>316</sup>

A due process challenge to government restrictions would probably fail. Since present federal law affords no fundamental right to privacy in adult, consensual same-sex activity, restrictions on this activity to prevent the spread of AIDS are limited only in that they be reasonably based and not arbitrary. The rational basis test would be met by a minimal showing that bathhouse visitors engage in sexual activity which is likely to spread AIDS, and that closing them or restricting the types of sexual activities that are likely to transmit HIV is a reasonable means to stop its spread.

Similarly, the equal protection argument under a traditional two-tier standard depends on whether a fundamental right or a suspect classification is involved. A similar argument can be made under an equal protection challenge. This is true because the classification of homosexual men as a group to be denied sexual intercourse can be rationally supported by evidence that AIDS is spread by anal and oral sexual intercourse, and that it has so far been limited almost entirely to the four high-risk groups in which gay men constitute the large majority.<sup>317</sup>

While some believe that closure is a reasonable restriction to prevent AIDS transmission, others believe that the closure of bathhouses is not a rational response to the state's interest in preventing the spread of AIDS. These people believe that it can be shown that bathhouses are safer places to have sexual intercourse than other environments. Attorneys representing bathhouses and homosexuals claim closings would change the location of the dangerous behavior itself, and that bathhouses have educational programs which make the sexual activity safer. In short, these people believe that closing bathhouses will not stop or curtail the transmission of AIDS.

Even so, the argument that closing bathhouses only restricts the place where the activity occurs, not the act itself, is misleading. The state's interest is clearly to slow the spread of AIDS by limiting dangerous sexual activity in the homosexual population. By closing bathhouses, the state is limiting the opportunity to engage in sexual activity. Therefore, under a rational basis standard, a court would uphold limiting the sexual activity which has been shown to spread AIDS.

But closing bathhouses raises the question of possible infringement of first amendment freedom of association guarantees. The Supreme Court has recognized two distinct types of association protected by the first amendment: freedom to enter into and maintain

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316. *Id.* However, if a state has a state constitutional privacy provision which would include consensual adult intercourse, protection may extend to bathhouse patrons. See, e.g., CAL. CONST. art. I § 1.

317. See *supra* note 9 and accompanying text.

intimate human relationships, and freedom to associate for the purposes of engaging in a protected activity (i.e. speech, exercise of religion).<sup>318</sup> State police power however, has been upheld over claimed intrusions upon freedom of association guarantees where the nature of the assemblage is not for the advancement of beliefs and ideas, but predominantly either social or physical pleasure.<sup>319</sup> If the object of the legislation is the promotion of the public health, an incidental impact on association or expression is insufficient to obstruct the exercise of the state's police power.<sup>320</sup> Because homosexual activity by consenting adults has not been recognized as a fundamental right of privacy, such activity is not generally accorded constitutional protection.<sup>321</sup>

Even if the Court extended the right of privacy to adult consensual homosexual sexual activity, that right would not be protected in commercial bathhouses. Courts have upheld the right of states to prohibit sexual activity in public<sup>322</sup> and in view of spectators.<sup>323</sup> Bathhouse encounters, which often involve anonymous and multiple-partner sex, seem to more closely resemble the Court's definition of public, unprotected activity than protected intimacies.<sup>324</sup>

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318. *Roberts v. United States Jaycees*, 468 U.S. 609, 617-18 (1984) (holding that a private men's club lacked characteristics that would constitutionally justify its decision to exclude women from membership).

319. *See Cornelius v. Benevolent Protective Order of Elks*, 382 F. Supp. 1182, 1195 (D.Conn. 1974) (purely social activity not protected by the right to associate); *People v. Morone*, 150 Cal. App. 3d Supp. 18, 22, 198 Cal. Rptr. 316, 318 (1983) (predominately physical activity outside the protection of the first amendment); *Sunset Amusement Co. v. Board of Police Comm'rs of City of Los Angeles*, 7 Cal. 3d 64, 74, 496 P.2d 840, 845-846 (1972), 101 Cal. Rptr. 768, 773-774, *appeal dismissed*, 409 U.S. 1121 (1973) (physical exercise not entitled to receive first amendment protection).

In finding heterosexual activity not protected by the first amendment, the court stated, "to hold otherwise would require us to adopt the already discredited 'view that an apparently limitless variety of conduct can be labeled 'speech' whenever the person engaging in the conduct intends thereby to express an idea.'" *Morone*, 150 Cal. App. 3d Supp. at 22, 198 Cal. Rptr. at 318 (citing *United States v. O'Brien*, 391 U.S. 367, 376 (1968)). The court went on to indicate that "it is the 'freedom to engage in association for the advancement of beliefs and ideas,' (citations omitted) not the mere assemblage of persons, which is embraced by the First Amendment." *Id.* at 22, 198 Cal Rptr. at 318.

320. *See, e.g., People v. O'Sullivan*, 96 Misc.2d 52, 53, 409 N.Y.S.2d 332, 333 (N.Y. App. Div. 1978).

321. *See, e.g., Bowers v. Hardwick*, 106 S. Ct. 2841, 2843-46 (1986).

322. *Paris Adult Theatre I v. Slaton*, 413 U.S. 49, 66 n.13 (1973) ("there is no necessary or legitimate expectation of privacy which would extend to marital intercourse on a street corner or a theater stage.").

323. *See, e.g., Lovisi v. Slayton*, 539 F.2d 349, 351-52 (4th Cir. 1976).

324. *See, e.g., Harris v. United States*, 315 A.2d 569, 574 (D.C. App. 1974) (en banc) (acts of sodomy in "homosexual health club" not protected by recognized right to privacy). It is also not clear whether a person's right to privacy and association is

Even if a bathhouse closing was subject to heightened scrutiny, courts would not invalidate the action for lack of a close fit between means and ends, or for failure to select the least reasonable alternative.<sup>325</sup> Arguably, there is a close fit based on evidence that the sex activity in bathhouses contributes to the spread of AIDS. In addition, bathhouse closure is not unreasonably restrictive because it would not prevent homosexual men from engaging in intimate association elsewhere. Even under a heightened level of scrutiny, bathhouse closure would be upheld so long as the rule does not exceed the state's authority and if the rule is limited only to those public places exclusively or primarily intended to accommodate frequent and anonymous sexual encounters.<sup>326</sup>

The state must not, however, use AIDS to restrict gay organizations' freedoms. In order to overcome the difficult burden imposed when first amendment rights are implicated, the state would have to show that the proposed regulation is necessary to prevent the spread of AIDS. This burden would not be met as long as there is no medical evidence that casual contact transmits AIDS. Even if casual contact were found to be a mode of transmission of AIDS, regulations restricting meetings of gay groups not organized for sexual activity would be overbroad. The majority of gay people do not carry the

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protected in a closure of a commercial establishment. See also *Paris Adult Theatre I*, 413 U.S. 49; *Stratton v. Drumm*, 445 F. Supp. 1305, 1309 (D.Conn. 1978) (freedom of association rights do not extend to commercial ventures). The privacy protection of sexual activity conducted in a private home does not extend to commercial establishments simply because they provide an opportunity for intimate behavior or sexual release. See generally *Stanley v. Georgia*, 394 U.S. 557 (1969); *Griswold v. Connecticut*, 381 U.S. 479 (1965).

325. *City of New York v. New Saint Mark's Baths*, 130 Misc. 2d 911, 497 N.Y.S.2d 979 (1986). The judge stated that the effort to combat the spread of AIDS was a compelling state interest that overrides the constitutional rights of privacy and association. The court also stated that self-regulatory measures of the owners and the futility of any less intrusive solution to the problem other than closure were inadequate. *Id.* at 914, 497 N.Y.S.2d at 982. Closure might have been attacked on the grounds it was not the least restrictive means to control the spread of infection. *Id.* at 915, 497, N.Y.S.2d at 983. The measures the judge ordered were more specific, so would withstand legal challenge. See *supra* note 302 and accompanying text.

326. An argument against closure may be made on public policy grounds that bathhouses are a useful forum for educating individuals most at risk. *N.Y. Times*, Oct. 19, 1985, at A29, col. 1. See CDC, *Self-Reported Behavioral Change Among Gay and Bisexual Men—San Francisco*, 34 MMWR 613 (1985). See also CDC, *Declining Rates of Rectal and Pharyngeal Gonorrhoea Among Males—New York City*, 33 MMWR 295, 297 (1984).

Many articles have been written recognizing the change in homosexual sex activities due to the fear of contracting AIDS. See, e.g., Coppola, *The Change in Gay Life-Style*, NEWSWEEK, Apr. 18, 1983, at 80; McKusick, *AIDS and Sexual Behavior Reported by Gay Men in San Francisco*, 75 AM. J. PUB. HEALTH 493, 495-96 (1985); Morgenthau, *Gay America in Transition*, NEWSWEEK, Aug. 8, 1983, at 30, 36; Starr, *The Panic Over AIDS*, NEWSWEEK, July 4, 1983, at 20; *Gay Males Altering Sexual Behavior: Researchers*, Am. Med. News, July 20, 1984, at 22, col. 1.

HIV virus<sup>327</sup> and other regulations would provide more direct methods of protecting the public from those who do carry the virus. Therefore, these types of associational restrictions on gay groups would be found constitutionally inadequate.

Regulations to close bathhouses will not solve the problem of AIDS transmission. Application of a rational basis standard of review may result in further restrictions on gay rights in other areas of the law, or a renewed effort to criminalize sodomy. There is a direct conflict between the right of privacy for AIDS individuals and the need to protect the public from the spread of AIDS. As both interests deserve protection, a careful balancing of the competing interests involved could result in a solution that would benefit everyone. Due to the strong policy in protecting the public from the spread of communicable disease and the unprotected position of adult consensual same-sex intercourse among fundamental privacy rights, however, courts are likely to uphold statutes that restrict gay sex in bathhouses.

#### F. *Constitutional Basis of Contact Tracing*

Seropositive reporting of HIV could lead to more restrictive measures. Several states have proposed or enacted initiatives that would require tracing of an infected person's sexual partners.<sup>328</sup> Similar to mandatory testing and reporting requirements, contact tracing also involves possible privacy and associational infringements.

As discussed previously with other public health measures that promote the health and safety of the community, states have the authority to initiate contact tracing as a public health initiative.<sup>329</sup> Con-

327. Seventy three percent of all AIDS patients are homosexuals. Between 3.5% and 9% of eight million adult gay men in the U.S. carry the HIV virus. Landesman, *The AIDS Epidemic*, 312 *NEW ENG. J. MED* 521, 522 (1985). The lesbian community is exposed to the lowest risk of AIDS, and no instances of transmission of the disease between women are known. Brief of Amicus Curiae Lesbian Rights Project, Women's Legal Defense Fund, Equal Rights Advocates, Inc., Women's Law Project & National Women's Law Center at 11, n.10, *Bowers v. Hardwick*, 106 S. Ct. 2841 (1986) (No. 85-140).

328. Several states have proposed or enacted initiatives to require tracing of an infected individual's sexual partners. See 1 *AIDS Policy & Law* (BNA) no. 10, at 5 (June 4, 1986); *id.* no. 8, at 1 (May 7, 1986); *id.* no. 6, at 1 (April 9, 1986). Tracking of the HIV antibody is currently taking place in Arizona, some local jurisdictions in California (as part of research and epidemiological studies), Colorado, and at least one large city in Texas, Vermont and American Samoa. See also IHPP, *supra* note 134, at 23.

Minnesota has enacted a statute to investigate AIDS patients. MINN. STAT. § 144.4171-.4186 (Supp. 1987). The CDC suggests the testing of sexual contacts of individuals who have tested positive. See Echenberg, *supra* note 249, at 2129-30.

329. See *supra* notes 139-44 and accompanying text. *Huffman v. District of Columbia*, 39 A.2d 558, 560 (D.C. 1944) (persons reasonably suspected of having venereal

tact tracing has been used extensively in sexually transmitted disease control programs and for the control of tuberculosis. The proper investigation of contacts of recognized cases of disease is the most effective way of finding the focus of infection and preventing episodes of disease that may occur in a community.<sup>330</sup> Public health officials believe that contact tracing is an effective measure for controlling the spread of AIDS. This method may break through the denial of high-risk individuals, increase the awareness of some who may not realize they are at high-risk and get information to those who are at the highest risk.<sup>331</sup> As long as the disclosure is of a limited scope (i.e. names of spouses or lovers of AIDS patients), the regulation would be a valid exercise of the state's police power to protect the public's health.<sup>332</sup>

As with other state regulations enacted to protect the public health, however, there is also a divergence of opinion as to the validity of contact tracing.<sup>333</sup> One opinion states that efforts to trace AIDS would be enhanced by obtaining the names of sexual partners of persons who test seropositive.<sup>334</sup> Gathering data from AIDS patients and members of high-risk groups, their friends, lovers and spouses would permit a full understanding of the transmission of AIDS. Rules that forbid the disclosure of HIV antibody test results are in direct conflict with the infection control rationale of rules that permit a narrow disclosure where patients have diseases other than AIDS. Even though there is no definitive treatment or cure for AIDS, the information could be used to educate partners of high-risk individuals.

The converse opinion states that simply locating risk group members would likely be intrusive. Without a vaccine or cure for AIDS, contact tracing would be impractical. It is difficult to define what benefit there would be in tracing names of people who may have come in contact with the disease. Thus, the measure may be seen as an unreasonable and unconstitutionally impermissible infringement

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disease mandated to submit to an examination, which is not an unreasonable exercise of the state's police power). See *People ex rel. Baker v. Strautz*, 386 Ill. 360, 54 N.E.2d 441 (1944). But see *Wragg v. Griffin*, 185 Iowa 243, 170 N.W. 400 (1919).

330. See *Minnesota Position Paper on Contact Tracing*, GLC Voice, Feb. 16, 1986, at 1, col. 1 [hereinafter GLC Voice] (on file in the William Mitchell Law Review Office).

331. *Id.*

332. See *supra* note 146 and accompanying text.

333. The investigation of contacts is not justified on a routine basis at this time. See A. BENENSON, *supra* note 124, at 4. The Florida Task Force believes that routine contact tracing would not be helpful at this time. Florida Report, *supra* note 299, at 21.

334. See Echenberg, *supra* note 264, at 2129.

on an individual's rights to privacy and association.<sup>335</sup>

If contact tracing is to be carried out, all new cases of AIDS must be reported. This precept leads to the above discussed problems regarding mandatory testing and reporting requirements.<sup>336</sup> Because names of those who test positive are kept on file, inadvertent disclosure might bar those people from the military and perhaps determine on which side of a quarantine a person will live. If notification would allow the government access to the names of homosexual men, contact tracing would not be an acceptable measure. There is a reluctance of seropositive individuals to incriminate either themselves or their partners.<sup>337</sup>

Another problem with contact tracing is that it would be counterproductive and reduce the effectiveness of other health activities unless homosexuals could be assured of civil rights protections.<sup>338</sup> Education and counseling programs are a more effective means of preventing additional AIDS cases when there are so many individuals already infected.<sup>339</sup>

In addition, contact tracing would be labor intensive and not feasible because of the high prevalence of AIDS in some areas and an overall higher prevalence of HIV infection.<sup>340</sup> Public health authorities cannot uniformly carry out investigations and contact tracing when there are individuals who may be unsuspectingly risking disease. Although a general widespread contact tracing initiative would be impractical, casefinding efforts in heterosexuals may be warranted because the seroprevalence of infection is much lower, education is more sporadic, and the perception of risk is much less.<sup>341</sup>

## CONCLUSION

The AIDS crisis has prompted numerous and diverse initiatives that attempt to put some control on the transmission of the disease. Although states have the power to enact reasonable regulations to protect the public's health, legislatures must be careful to draft AIDS

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335. See *supra* notes 227-47, 282-84 and accompanying text. See also GLC Voice, *supra* note 330, at 1.

336. See *supra* notes 199-208 and accompanying text.

337. See GLC Voice, *supra* note 330, at 1.

338. *Id.*

339. "In the absence of an available vaccine or specific therapy for the treatment of AIDS, broad-scale prevention and control activities must revolve around risk reduction and programs that positively affect behavioral changes and reduce transmission of AIDS infection." CDC, *Results of a Gallup Poll on AIDS—New York City, United States*, 34 MMWR 513 (1985).

340. See Hirsch, *Risk of Nosocomial Infection with Human T-Cell Lymphotropic Virus III (HTLV-III)*, 104 ANN. INTERN. MED. 644 (1986). See generally 1 AIDS POLICY & LAW, no. 21, at 8 (Nov. 5, 1986).

341. See ASTHO, *supra* note 193, at 17.

initiatives based on current medical knowledge about the disease. Whereas early court health cases based their decisions on public opinions about communicable diseases, those cases are inadequate to use as precedential law when enacting AIDS regulations. Interpretation of the constitutional rights of equal protection and privacy have developed in recent years. When personal liberties are at issue, courts should no longer assume that legislatures have sufficiently considered updated medical knowledge about communicable and infectious diseases. Threats on the personal liberties of individuals with AIDS pose a serious threat to the suppression of this often fatal disease. Instead of assisting in the prevention of the transmission of AIDS, legislative restrictions may actually discourage high-risk individuals from being tested for the virus and in pursuing treatment. Research efforts may consequently be undermined.

The rights of individuals and those of society must be carefully balanced so that both may benefit from the regulations that are imposed. Only when the combined interests of all are considered will efforts be capable of defeating this tragic disease.

*Wendy A. Weber*