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LEGISLATING AIDS AWAY: THE LIMITED ROLE OF LEGAL PERSUASION IN MINIMIZING THE SPREAD OF THE HUMAN IMMUNODEFICIENCY VIRUS

*John M. Dwyer**

Michael Kirby has a fully developed gift that he shares fully. For many years now, he has observed and commented on the effects of a deadly virus on human behavior and the effects of that behavior on the longevity of that virus. In a unique manner, Justice Kirby has given us the benefit of his reflections on the AIDS epidemic with the clarity of his messages and their inherent warnings, never being compromised by his compassion for those infected.

He had fought tirelessly to minimize the discriminations suffered by so many who are infected with the human immunodeficiency virus (HIV). Disturbed by so much individual suffering, he has observed firsthand the weakening of public health strategies which are associated with fear and ignorance.

To paraphrase Charles Dickens, AIDS has brought out the best in people and the worst in people. Michael Kirby's best is minimizing the damage done by other people's worst. It is an honor to contribute a paper to this issue of the *Journal*, which recognizes the contribution of an extraordinary jurist and humanitarian.

I. INTRODUCTION

The Premier of an Australian State established an expert committee to advise him on the wisdom of some legislation planned to minimize the spread of HIV:

My Government has decided to introduce a law that will make it a criminal offense for anyone infected with HIV to have sex with another, without informing them of that fact. A year in jail and a fine of \$5,000 will follow conviction. If a doctor who has diag-

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nosed an infection with HIV does not tell a patient that this is the law, he will be fined \$500. We have to stop the spread of this disease, we think that such a legislation will help but of course before we proceed, we want your opinion.

We met, we deliberated and gave the Premier the benefit of our unanimous conclusion.

Don't do it Premier, the law is unenforceable. Many individuals in high-risk groups will avoid being tested for the presence of antibodies to HIV in their blood so that they cannot be accused under such a law. The vindictiveness of a jealous lover may be enough to see someone imprisoned. Such a law will hinder, not help, our efforts to fight the spread of HIV.

The Government went ahead anyway with the law as originally outlined to us. The Premier explained that "they [the public] expect me to be tough about this thing." Posturing had become more important than policies and in the month after the new regulations became law, 12,000 fewer people were tested for HIV than in the previous month.

Many examples of perhaps well-intentioned but heavy-handed and misguided attempts to legislate away an infectious disease could be cited. A government here mandated contact-tracing by government officials to find the sexual partners of HIV-infected individuals. A government there legislates that names and addresses of all infected individuals must be notified to the Department of Health. In both cases, the chance to test, find and counsel HIV-infected individuals, thus helping them and others, is compromised. In their frustration, confronted by an epidemic that constantly provokes public reaction, politicians frequently try to legislate AIDS away. In this paper, I will argue that there is a need for urgent intervention but that there are few legal manoeuvres that can help.

II. POLICIES TO MINIMIZE THE SPREAD OF HIV

Michael Kirby has often reminded his audiences around the world that good law, like good policies, can only be built from a thorough understanding of the problem being addressed. The basic facts required to look at the question of the law and the AIDS epidemic are as follows:

Every eighteen seconds someone, somewhere is infected with HIV. The scale of the epidemic has not been exaggerated. On average, HIV-infected individuals have their immune system destroyed by this virus over a nine-year period, resulting in the acquisition after that time of an immune deficiency state (AIDS). Once defenseless, many organisms may seize upon the opportunity presented and infect an unresisting host in a way that would be impossible if even meager defensive forces were available. Patients with

AIDS seldom survive for more than two and a half years from the onset of their first opportunistic infection.

During the long incubation period between infection and AIDS, those infected remain well but infectious. Carriers of HIV can infect another during anal, vaginal and occasionally oral intercourse when infected sexual secretions move from one body to another. Particular cells of the immune system located in an organ which lies on top of the great vessels coming out of the heart in the chest—the thymus gland—become infected with HIV. The specific cells involved are known as T4 lymphocytes. It is normal for sexual secretions to contain significant number of T4 lymphocytes. In an HIV-infected individual, those T4 lymphocytes will contain virus. T4 cells are also found in blood and breastmilk, the only other biological fluids that are infectious in an HIV-infected individual.

Within three months of infection, virtually 100% of patients develop tell-tale antibodies in their bloodstream that reveal their infection and infectiousness. Commonly, such individuals are said to be “HIV-positive.” HIV is never contracted during social intercourse. One cannot be infected by HIV from mosquitos, toilet seats, sitting next to an infected individual on an aeroplane, sharing household utensils, or nonsexual intimacies such as the hugging and kissing enjoyed by friends and family members.

There is no vaccine to prevent infection and no cure. Twelve million people are now infected and that number is likely to reach forty million by the year 2000, unless successful intervention strategies are introduced urgently. The Asian region is destined to have more infected people than any other area, but currently, it is Africa that has the most infected individuals. More than one million Americans are infected with HIV. Eighty percent of the twelve million infections thought to have occurred so far have been contracted during vaginal intercourse. Overwhelmingly, HIV infection is a heterosexually-spread disease. Ten percent of cases have been contracted through infected blood while six percent of cases have occurred in homosexual men. Anal intercourse is an effective way of spreading the infection particularly to the passive partner, but it is obvious from the above figures that it is sexual activity, not sexual preference, that spreads HIV. The AIDS pandemic is composed of a series of mini-epidemics. The major reservoir of the virus in San Francisco is in gay men but in India and increasingly elsewhere, it is in heterosexual women.

Prevention strategies known to be successful when implemented intelligently involve two major programs. For those as yet uninfected, educational messages that personalize the information have a chance to moderate potentially dangerous behavior and are all important. For those already infected,

education that helps them to realize that their lifestyle or medical encounters (for example a blood transfusion) may have put them at risk of infection is critical. In the western world, HIV infections remain pocketed in particular high-risk groups and it would not be cost-efficient to test everybody to find all those infected. Such a strategy, which unfortunately is desirable in some developing countries, is impractical because of the cost involved. Thus, in both the developed and developing worlds, we are totally dependent on having those people who may have been infected realize the fact and come forward for testing and counselling. Ten years of study make it perfectly clear that the vast majority of those who know they are infected will not infect anybody else.

That same ten years of experience tell us that individuals will not come forward to be tested if they feel that in so doing they will subject themselves to discrimination (he must have done something wrong or why would he want to be tested?) and breaches of confidentiality that will often result in the subsequent loss of family, friends and often, employment. Confrontation of the individual found to be HIV-infected with ignorance, prejudice, a judgmental attitude and the withholding of the compassion that ceases pain adds immeasurably to the suffering of the individual and to the suffering of the society in which such people live. The AIDS epidemic highlights (in a unique manner) the truism that countering discrimination not only protects individuals but entire societies. From the above, one hopes it is clear that public health policies and any laws that might strengthen those policies must focus on the creation of an environment that facilitates voluntary testing programs.

How often have I been asked by angry, if superficial, observers of the AIDS scene why HIV/AIDS is not treated like "other diseases." Usually it is other sexually-transmitted diseases that are the subject of the query. Sometimes people refer back to the well-remembered campaigns of the 1950s when many, quite appropriately, were required to have chest x-rays and perhaps a period of isolation if found to be infected with tuberculosis. Why are we not equally vigorous in searching for HIV-infected individuals? Why do we, who care for people infected with HIV, argue against the handing over of the names of those infected to public health authorities? Why don't we quarantine those who are infected to prevent them from infecting others? In many western countries where homophobia is far more frequent than HIV infection of homosexual men, one will often hear the concern voiced that health authorities are being "soft" on HIV-infected individuals because homosexual lobby groups have "hijacked the public health agenda."

There is no tradition in public health for isolating infected individuals un-

less they can infect others through casual contact. To quarantine someone because somebody else, usually of their own free will, might engage in behavior that would see them infected with HIV makes no sense, violates human rights and is impractical. Only Cuba has a policy of quarantining those found to be HIV-infected. Where would America house its one million HIV-infected men, women, and children? For how long would they be incarcerated? Quarantining someone who by inadvertently coughing over a group of people in a crowded train may infect many with tuberculosis makes sense. Quarantining those infected with HIV does not. In fact, any such attempts may only delude those whose behavior puts them at risk that quarantine laws are protecting them from an encounter with an HIV-infected individual. The nonsense of such an argument is further compounded by the realization that infected individuals can be infectious but not have tell-tale antibodies in their bloodstream for three months after infection. The strict adherence of an isolation policy would require the entire population to be tested every three months.

AIDS is not like any other disease of modern times. You have to look back to the fear, ignorance, and prejudice that added so much to the suffering of people with leprosy in earlier centuries to find a parallel. Ironically, leprosy also had a totally undeserved reputation as a highly infectious disease. If Jack contracts syphilis and tells his friend Bill about his painful penicillin injection, Bill's reaction is likely to be a slap on the back or a punch on the arm while a wink he exclaims "Jack you rascal you!" The exact same behavior that may see someone infected with HIV may result in that person being despised, ostracized, regarded as evil and subjected to discrimination. To illustrate these points, let me tell you true stories to provide emphasis, a strategy so successfully and frequently used by Justice Kirby. Here are some accounts from my own personal experience.

A country doctor received a notice from the Red Cross Transfusion Service, recommending that his patients who were transfused with a blood product between 1980 and 1985 be tested for HIV; the risk of infection for any individual was low but finding those infected was important. When Tom came for his annual check-up, his doctor ordered an HIV test for antibodies to HIV, but Tom was not informed as the doctor did not wish to worry him. Tom had been given a blood transfusion in 1983 after a car accident. Two weeks later, on a Friday afternoon, the doctor was amazed to receive the news that Tom was infected with HIV. He called Tom on the telephone and spoke to his wife Mary, since Tom was still working in the fields. "Mary," he said, "you are going to have trouble believing this, but Tom has AIDS." Tom in fact did not have AIDS, he was infected with HIV. A shocked Mary turned to her friend Susan who was in the kitchen at

the time and said, "Oh my God Susan, Tom's got AIDS." She continued her conversation with the doctor who suggested that both Tom and Mary should come and see him on Monday, when they could discuss what it all meant.

There were many tears in that family that night and when Mary went to shop at the supermarket in town on the Saturday morning, an embarrassed store manager asked her if she would shop elsewhere. The news that Tom had AIDS was all over town. Tom did not have adequate life insurance. He would lose his property, lose his friends, and lose his respected position in his small community. This case illustrates why it is so important that informed consent be obtained before HIV testing, why results should never be given to patients over the phone, how cruel communities can be if they are ignorant and uncaring and how we must continue to strive to make sure that the medical profession is adequately educated about this disease. AIDS is not just another infectious disease.

Robert had been infected with HIV for three years when he needed some dental care. He asked me if he should inform his dentist that he was HIV-positive. I said he should, assuring him that he could expect the same degree of confidentiality from his dentist as from his doctor. He visited his dentist, who had an office in the city building where Robert worked as a middle-level executive with an accountancy firm. Robert told his dentist he was HIV-positive. The work was done and Robert returned to his office. Subsequently, we were to learn that the dental nurse heard Robert's conversation with his dentist and in one of those "Now-Jane-you-won't-tell-another-soul-will-you-but-can-you-believe-that" type stories, the dental nurse told another person of Robert's problem. The second person told a third and when Robert arrived at work the next morning, he found his desk in the corridor outside his firm's offices. Although anti-discrimination laws prevented Robert from being fired, his working conditions soon became intolerable, and within six weeks he gave up the fight and escaped from his sufferings by jumping off the top of that very same building. AIDS is not just another infectious disease.

At an Anti-Discrimination Board hearing, Stan told the judge that he had been to see a surgeon because his general practitioner was concerned about a small pea-sized lump in his left breast. The surgeon said that the lump should be removed for, although it was rare, cancer could occur in the male breast, and this lump was suspicious. Stan was told that it was to be a very simple "day-only" procedure performed with local anaesthetic. Robert was in the operating suite, his chest shaved and somewhat sedated when the surgeon approached him to ask him if he had an HIV test. "No," replied the

drowsy Stan, "why do you ask?" The young intern who was helping the surgeon had taken a history from Stan on his arrival at the hospital and learned that Stan was gay. Without an HIV test, the surgeon refused to operate and, still drowsy from the effects of the pre-medications, Stan was unceremoniously bundled out of the hospital within half an hour. Subsequently, Stan did have an HIV test which was negative.

The surgeon in question, who admitted that he was not immunized against hepatitis B (a viral infection 100 times more infectious than HIV) and admitted that he had operated on patients he knew were infected with that virus, addressed the judge. "Your Honor, if I had gone ahead with that procedure and this patient had been infected with HIV my operating room staff would have been at greater risks of becoming infected with a deadly virus than if they had sexual intercourse with this man. And what's more, in that very same operating room, hip replacement surgery was scheduled for the following day. The sterilizing procedures that would be necessary after the operation on Stan's lump would have put that operating room out of action for 24 hours." Much expert testimony followed indicating that the doctor's concerns were totally unjustified and that duty of care had been breached, but the judge ruled in favor of the surgeon. AIDS is not just another infectious disease.

In Kentucky, a prisoner found to be HIV-positive is burned to death in his cell by terrified inmates. In Florida three little HIV-infected children appeal to the courts for help when parents at their local school refused to allow them to attend. The court rules in their favor, and the parents and friends association reluctantly acquiesce but purchase a caravan that they place at the back of the school yard. Each day when the children come to school, they must attend classes in the caravan where volunteer teachers attend to them. In some parts of India, a law currently allows HIV-infected individuals to be locked up without trial indefinitely. AIDS is not just another infectious disease.

III. THE LAW, LAWYERS AND THE FIGHT AGAINST HIV

Lawyers do have a major role to play in reducing the human and socio-economic toll associated with 10,000 of us being infected with HIV every twenty four years. For all the reasons described above, the protection, and in much of the world, the institution of basic human rights may well decide who wins the battle between HIV and humans. If this is a championship fight, we are in the tenth round already and well behind on points. Those who trivialize human rights are helping to fuel this epidemic.

In India, it is certain that unless the status of women is promoted and

protected; it will be the country most affected by HIV. Increasingly, it is women and their children especially, but not exclusively in the developing world, who are suffering the worst of this epidemic. When I lecture in the developing world, I talk of HIV as the “poverty” virus, for increasingly inequalities related to gender, race and wealth are contributing to the spread of HIV. Clearly, there is a vicious cycle involving poverty, hunger, the desire to feed one’s children, drugs, and entrance into the world of commercial sex.

An apparent dilemma is currently injected into many legal discussions of the way AIDS may be minimized using legal maneuvers. “How can we protect the rights of the individual and simultaneously protect the rights of society when a fearsome epidemic is upon us?” In fact there is no conflict at all. At the moment the only way to protect society is to protect the individual. Punitive laws, which their designers hope will protect society, do exactly the opposite if they prevent us from building a bridge to reach commercial sex workers, drug-users and, in many a society, gay men who in their disenfranchisement are particularly vulnerable to HIV. Women who have no rights when it comes to negotiation in a sexual situation are unable to protect themselves against HIV. For them laws such as those dealing with rape within marriage, the age of marriage, or indeed the age of sexual consent become particularly important.

Only laws that establish and protect a supportive environment for people affected by the epidemic contribute positively to the fight against AIDS. There is no doubt in my mind that health officials should frequently sit down with lawyers to look at any existing legislation that is hindering efforts to stop the spread of HIV. Often, the removal of unenforceable and destructive laws is far more important than the introduction of new measures. For example, in a number of countries there are laws that restrict the availability of condoms and condom promotion. Laws may determine what can and cannot be discussed in the media. If such laws interfere with the dissemination of safer sex information, they are destructive in the context of the HIV epidemic. Laws that make it difficult to commerce needle and syringe exchange programs need urgent attention.

Using what many people would regard as a “lesser of two evils” approach, a very effective strategy has been developed that, when implemented, minimizes the rate at which HIV infection increases among intravenous drug-users. It is the equipment used by intravenous drug-users, not the drugs, that spread HIV. Giving drug users clean needles and syringes will facilitate the fight against HIV. The contact between drug-users and the supplier of needles and syringes they require has had very positive effects, often leading

to the establishment of self-help groups among drug-users and diversion of many into methadone programs.

In a number of countries, and even in one State of my own country, Australia, laws that proclaim homosexual acts to be criminal offenses represent legal barriers to better public health policy. Misguided laws related to the immigration and travel of HIV-infected individuals in the United States have had serious side-effects. A major international meeting on HIV was moved from Boston to Amsterdam simply because of such laws. America has a far more significant AIDS problem than Holland.

Many conferences in many countries have resulted in HIV-infected individuals producing declarations which specify the rights of people infected with this virus. The law can most certainly play a role in ensuring that legislation does protect the rights demanded: for example, the right to privacy, the right to protection against unlawful search and seizure, and the right to protection against unlawful detention. The true incidents related above surely emphasize the need for anti-discrimination laws that can act as a deterrent and help redress wrongs done to people who are so often and so cruelly denied employment, housing, and access to health care.

In most societies, lawyers are particularly influential not least because of their interest in and a capacity to become involved in legislative processes. Would that here were more lawyers like Michael Kirby, for such individuals do provide an example which, if sufficiently emulated, might yet let us turn a tragedy into a triumph, as a compassionate and educated society eradicates this virus from the face of the earth. This could be done without medicines providing a cure or a vaccine. After all, this is a virus that only infects humans, so that if humans were to spare each other from this virus for two generations, HIV would disappear. Without doubt, informed lawyers can do more than most to argue for sensible laws and polices and help communities generate the appropriate response to this epidemic.

IV. CONCLUSION

Let me close with an eloquent summary of the situation presented by Michael Kirby at the First South African Conference on AIDS and the Law in June 1992. Talking about lawyers and the AIDS epidemic, he noted: “[O]ur eyes should be bright with the resolve to do practical things to slow the spread of this infection. In the little part which the law has to play in this great drama, we should be protectors of basic rights. They matter most when they are most at risk.” At his moment, in many countries, HIV has put basic rights at risk, and therefore the protection of these rights matters enormously.

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