Journal of Contemporary Health Law & Policy (1985-2015)

Volume 6 | Issue 1 Article 25

1990

AIDS. PUBLIC HEALTH AND LEGAL DIMENSIONS. By D.C. Jayasuriya. Dordrecht: Martinus Nijhoff (1988).

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Recommended Citation

Kathleen Sazama, *AIDS. PUBLIC HEALTH AND LEGAL DIMENSIONS. By D.C. Jayasuriya. Dordrecht: Martinus Nijhoff (1988).*, 6 J. Contemp. Health L. & Pol'y 440 (1990).
Available at: https://scholarship.law.edu/jchlp/vol6/iss1/25

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As a research scholar, I was overjoyed by the rich and comprehensive Tables of Common Law Jurisdictional Cases[30] and Civil Law Jurisdictions.[31] Comparative analysis is thus expedited greatly by these tables as well as an equally superb subject index.[32] A book without a good index and set of comparative cases and appendices[33] is only half a book for the conscientious scholar and even the casual reader.

In his Preface, the author states the simple goal of his book as being an opportunity "to furnish instances of cross-cultural enrichment in efforts to adapt yesterday's law to the requirements of today and tomorrow through both international and inter-disciplinary co-operation."[34] The key to achieving this goal is, as observed, through informed decisionmaking.[35] Without question, this goal is achieved admirably, with the treatise itself serving as a blueprint of education and hoped-for action in preventing medical malpractice.

AIDS. Public Health and Legal Dimensions. By D. C. Jayasuriya. Dordrecht: Martinus Nijhoff. 1988. 145 Pp. $57.00.

*Reviewed by Kathleen Sazama, M.D.**

Among the abundant literature arising from what has been arguably the worst pandemic in history, this small volume contributes little. The rapidity of crisis events renders most information outdated before it reaches publication. Even so, this book creates a hodge-podge of occasionally inaccurate data concerning some of the public health and legal measures that were in place by mid-1987, data that has been sporadically applied out-of-context or in a surprisingly disjointed manner. Unfortunately, the author overlooked

30. D. GIESEN, *supra* note 9, at 756-810.

31. *Id.* at 810-31.

32. *Id.* at 847-923.

33. *Id.* at 727-55. The Appendices on the Resolutions of the German Legal Professions Congress on Artificial Technologies and The Council of Europe's Recommendations on Use of Human Embryos and Foetuses are especially useful.

34. D. GIESEN, *supra* note 9, at XVII.

35. Kilbrandon, *supra* note 4, at VI-VII.

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the available rich resources in both medical-scientific[1] and legal[2] literature that could have made this work a more significant addition to the AIDS dialogue.

Jayasuriya has compiled, through the use of large type, the equivalent of an average law review commentary. Each of the seven chapters is but a synopsis of the vast knowledge amassed since AIDS was first recognized in 1981, and, unfortunately, errors abound. In addition, fully one-half of the book is devoted to appendices which contain most of the useful information compiled through mid-1987. Their inclusion partially redeems an otherwise disappointing publication.

The seven chapters, comprising the first sixty-nine pages, begin with an overview entitled "Some Dimensions of the AIDS Pandemic" and conclude with "An A to Z Catalogue of Intervention Measures." The intervening five chapters, "A Comparative Survey of AIDS Legislation," "Blood and Blood Products," "Screening and International Travel," "Condoms and the Prevention of AIDS," and "Drug Abusers and the Use of Injections," display the seemingly random order in which pertinent topics of the AIDS epidemic are discussed. Not readily apparent is the recurring theme of disorganization in the contents of each chapter.

Despite its promise, no central cohesive theme arises from the title and weaves throughout the chapters. If the author intended the book to be a litany of various public health and legal interest topics created by the AIDS epidemic, accompanied by a random discussion of international responses to it, then the title is clearly misleading. Far from "offering a new point of view or perspective," this book is a conglomerate of misstatements and inaccuracies presented in a manner that defies comprehension. This confusion is particularly inexcusable in light of timely summary articles[3] available which offered a coherent and logical framework on which to construct interesting international comparisons.

The initial pages of Chapter One offer some examples of the disturbing, careless use of scientific and technical information apparent in this book. Beginning with paragraph one, the characterization of most AIDS patients as "from industrialized countries, though new cases have been detected in

1. AIDS: ETIOLOGY, DIAGNOSIS, TREATMENT AND PREVENTION (V. DeVita, S. Hellman & S. Rosenberg eds. 1986)[hereinafter AIDS ETIOLOGY].

2. *See, e.g.*, Howe, *Ethical Problems in Treating Military Patients with Human Immunodeficiency Virus Diseases*, 3 J. CONTEMP. HEALTH L. & POL'Y 111 (1987); Duncan, *Public Policy and the AIDS Epidemic*, 2 J. CONTEMP. HEALTH L. & POL'Y 169 (1986); Comment, *Protecting the Public from AIDS: A New Challenge to Traditional Forms of Epidemic Control*, 2 J. CONTEMP. HEALTH L. & POL'Y 191 (1986) [hereinafter Comment].

3. Matthews & Neslund, *The Initial Impact of AIDS on Public Health Law in the United States—1986*, 257 J. A.M.A. 344 (1987).

other countries, especially the African continent"[4] inaccurately reflects the situation. Although the U.S. alone presently accounts for 57% of all reported AIDS cases,[5] the following more accurately depicts the geographic concentration of the disease: (1) at the time the first U.S. cases were diagnosed, the disease was also known to be present among Haitians;[6] (2) AIDS probably originated in Africa where it is endemic in some populations, suggested in part by serologic testing of stored blood samples;[7] (3) the per capita rate of HIV infection was nearly as high in 1987 in the Caribbean (53.9/ reported cases per one million in population) as in North America (67.2/ reported cases per one million in population);[8] and (4) as has been true for the past several years and again demonstrated in statistics of the World Health Organization (WHO), the ratio of reported cases is rising in other countries much faster than in the U.S.[9]

Appendix A, AIDS Cases Reported to WHO (as of June 3, 1987), referenced at the end of paragraph one, disappointingly provides only a single data point by country reporting. The table would be significantly more interesting and useful if it included for each listed country such additional information as the date of the first reported AIDS case, several data points in chronological sequence, a listing of the population as of the nearest census date, and a percentage calculation of the relative risk of AIDS in the population on the date reported, or other similar data.[10] The data actually presented is available in more complete and current form, from the World Health Organization or other timely reports.[11]

In the second paragraph, as well as throughout the book, the author mis-

4. D. JAYASURIYA, AIDS: PUBLIC HEALTH AND LEGAL DIMENSIONS 1 (1988).

5. The World Health Organization on September 1, 1989, stated that the number of AIDS cases reported had reached 177,965 since the agency began keeping records in 1979. The number of cases in the United States reached an unprecedented 100,885, making it the largest reporter of cases. 4 AIDS Pol'y & L. (BNA) at 9 (Sept. 6, 1989).

6. Curran, *Acquired Immune Deficiency Syndrome (AIDS): Surveillance and Epidemiologic Observations in the United States*, in THE ACQUIRED IMMUNE DEFICIENCY SYNDROME AND INFECTIONS OF HOMOSEXUAL MEN 208 (P. Ma & D. Armstrong eds. 1984).

7. Essex, *Origins of AIDS*, in AIDS ETIOLOGY, *supra* note 1, at 5.

8. PAN AMERICAN HEALTH ORGANIZATION, AIDS: PROFILE OF AN EPIDEMIC 214 (Table 2) [hereinafter AIDS PROFILE].

9. *U.S., African Nations Lead in Total AIDS Cases Reported*, 4 AIDS Pol'y & L. (BNA) at 10 (Aug. 9, 1989). The number of cases of AIDS reported through July 31, 1989, was 172,143, of which the United States reported 98,255 cases, Brazil reported 6,857 cases and Uganda reported 6,772 cases (the three most affected countries). *Id.*

10. *See, e.g.*, *First 100,000 Cases of Acquired Immunodeficiency Syndrome—United States*, 262 J. A.M.A. 1453 (1989); AIDS PROFILE, *supra* note 8, at 220.

11. *See, e.g.*, UNITED STATES DEP'T OF HEALTH AND HUM. SERV., CENTERS FOR DISEASE CONTROL, HIV/AIDS SURVEILLANCE 5 (Table 1) (May 1989).

takenly uses the term "gestational"[12] rather than "incubation"[13] or "latent"[14] period of HIV. This error is inexplicable in view of the sizable scientific literature available to the author in which the term "latency" is appropriately used to describe the delay between acquiring the virus and the appearance of detectable indicators of its presence.[15]

In the same paragraph, Jayasuriya identifies "target groups of potential victims includ[ing] homosexual and bisexual men and their partners and infants, haemophiliacs, intravenous drug abusers, and recipients of blood transfusions."[16] This list of potential "target victims" inappropriately excludes the sexual partners of the last three categories, who were known to be part of the largely unidentified pool of possibly infected persons in 1987. It also implies that the listed persons are peculiarly susceptible to infection. In fact, it is these persons' activities or state of being that place them at risk of disease, not any special individual predisposition to susceptibility. The sexual partner of a sexual partner of an asymptomatic HIV-infected person may unwittingly become infected because he or she is unaware that his or her sexual partner is also sexually involved with the HIV-infected person.[17] Un-

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12. "Gestation" is defined as:

1. The act of carrying young in the womb from conception to delivery; pregnancy;
2. the development of a plan in the mind;
3. exercise in which one is borne or carried [RARE].

WEBSTER'S NEW TWENTIETH CENTURY DICTIONARY 760 (2d ed. 1979).

13. "Incubation" is defined as: "2. the phase in the development of a disease between the infection and the first appearance of symptoms." *Id.* at 927.

14. Shaw, Wong-Staal & Gallo, *Etiology of AIDS: Virology, Molecular Biology, and Evolution of Human Immunodeficiency Viruses*, in AIDS ETIOLOGY, *supra* note 1, at 17.

15. *See, e.g.*, Landesman, Ginzburg & Weiss, *The AIDS Epidemic*, 312 NEW ENG. J. MED. 521 (1985); Blattner, Biggar, Weiss, Melbye & Goedert, *Epidemiology of Human T-Lymphotropic Virus Type III and the Risk of Acquired Immunodeficiency Syndrome*, 103 ANNALS INTERNAL MED. 665 (1985); Jaffee, Feorino, Darrow, O'Malley, Getchell, Warfield, Jones, Echenberg, Francis & Curran, *Persistent Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in Apparently Healthy Homosexual Men*, 102 ANNALS INTERNAL MED. 627 (1985); Levy, Hoffman, Kramer, Landis, Shimabukuro & Oshiro, *Isolation of Lymphocytopathic Retroviruses from San Francisco Patients with AIDS*, 225 SCIENCE 840, 840-41 (1984); Popovi, Sarngadharan, Read & Gallo, *Detection, Isolation and Continuous Production of Cytopathic Retroviruses (HTLV-III) from Patients with AIDS and Pre-AIDS*, 224 SCIENCE 497, 497-500 (1984); Barre-Sinoussi, Chermann, Rey, Nugeyre, Chamaret, Gruest, Dauguet, Axler-Blin, Vezinet-Brun, Rouzioux, Rozenbaum & Montagnier, *Isolation of a T-Lymphotropic Retrovirus from a Patient at Risk for Acquired Immune Deficiency Syndrome (AIDS)*, 220 SCIENCE 868, 868-71 (1983).

16. D. JAYASURIYA, *supra* note 4, at 2.

17. *See, e.g.*, Duncan, *supra* note 2, at 170 n.1 (quoting Dr. Donald R. Hopkins of the Center for Disease Control who stated that it has become increasingly obvious "that AIDS is being spread largely by people who, though infected, have not become ill." N.Y. Times, Mar. 14, 1986, at 9, col. 1.).

protected casual sexual contact is a far more common phenomenon than is publicly acknowledged in most cultures.

The author continues by expressing a surprisingly naive attitude that "a sudden breakthrough . . . is not unusual in the domain of medical sciences."[18] This statement is a wishful expression by a non-scientist that ignores the reality of long years of unrewarded effort frequently preceding each "sudden breakthrough." In nearly every authoritative paper or article written about this epidemic, the author acknowledges *as an anomaly* the astonishingly, rapid rate with which scientific knowledge about this virus has been gained.[19] June E. Osborn, M.D., Dean of the School of Public Health of the University of Michigan, one of the world's foremost authorities on the AIDS epidemic and the newly elected chairperson of the U.S. National Commission on AIDS,[20] succinctly summarizes the prevailing scientific view that "[a]s the first cases of AIDS were being recognized, the sciences of virology, immunology, and molecular biology were reaching advanced levels of sophistication. If the epidemic had begun 20 years earlier, it might have remained an enigma much longer."[21] One need only consider the protracted search for and persistent failure to find a "cancer cure" to comprehend how rarely "scientific breakthroughs" occur.

Rounding out the uncertainty introduced in his opening remarks, the author then asserts without support that "[l]egislation has a fairly long and perhaps singularly impressive record as an important instrument of change in the domain of public health."[22] The only hint of support for this statement is found where, after making additional unsubstantiated statements about the importance of legislation for public health, the author directs the reader to Chapter Two and Annex B.

Neither Chapter Two nor Annex B provides the anticipated foundation. Although Chapter Two lists various legislative approaches used internationally, no direct reference to specific law as an important instrument of change is ever made. In fact, nowhere does the author provide explicit direction to legislation. Rather, he provides only a listing of legislative acts by country in Annex E. Even in this listing, however, there is only a chronological summary of events without further analysis of the content or discussion of the purpose to which the legislation was directed. The reader is left to unearth

18. D. JAYASURIYA, *supra* note 4, at 2.

19. Shaw, Wong-Staal & Gallo, *supra* note 14, at 13.

20. *New AIDS Commission Convenes, Elects June Osborn as Chair*, 4 AIDS Pol'y & L. (BNA) at 2 (Aug. 9, 1989).

21. Osborn, *The Aids Epidemic: Discovery of a New Disease*, in AIDS AND THE LAW 21 (H. Dalton, S. Burris and the Yale AIDS Law Project eds. 1987).

22. D. JAYASURIYA, *supra* note 4, at 2.

individually how the new amendments affect the existing public health laws of each country.

The reference to Annex B is likewise unsatisfactory in that it provides a comparison of only "Two National Case Studies of Legislative Policies," Austria and the United States. Furthermore, the term "comparison" is misapplied, because the discussion first lists only activities undertaken by Austria, then addresses only state (not federal) activities in the U.S., using an arbitrarily devised alphabetical listing of activities beginning with "Blood Supply" and ending with "Task Forces."

These flaws are a mere sampling of the book's many shortcomings. The fact that they occur in the opening paragraphs calls into question the reliability of the author's presentation and interpretation of other information selectively included. When the author asks the reader to believe that:

> [p]ublic health strategies . . . should take cognizance of at least five categories of people:
>
> —those with AIDS;
> —those with HIV;
> —those exposed to HIV;
> —those belonging to a high-risk group and who may be exposed to HIV;
> —other,[23]

the reader's apprehension concerning the author's lack of knowledge of epidemiology's basic principles is well-founded. In fact, in this epidemic as in so many others in the past, there are two foci of public health measures: to identify and help those already infected (whether or not overtly ill) and to prevent the spread of the disease to those who are not.[24]

The special dilemmas for both public health and legal intervention posed by the AIDS epidemic are due in large measure to two facts: 1) at the time of its appearance, AIDS was primarily a sexually transmitted disease; and 2) it principally infected persons whose sexual activities were considered experimental or non-traditional.[25] The less frequent transmission by blood-containing needles, either from illicit drug use or transfusion of blood products, also poses special concerns. These concerns are magnified when the addicted persons sharing infected needles are women whose offspring suffer the harm of such practices[26] and when eliminating unsafe blood is beyond the

23. *Id.* at 4.

24. Comment, *supra* note 2, at 201.

25. Glasel, *High-Risk Sexual Practices in the Transmission of AIDS*, in AIDS ETIOLOGY, *supra* note 1, at 355-57.

26. Specter, *Third World Nations say They're Losing AIDS War*, Wash. Post, June 13, 1989, at Z6 (Health), col. 2. In Kampala, Uganda, 20 percent of all infant deaths are now caused by HIV infection. *Id.* at Z7, col. 1.

economic resources of third world countries.[27]

Chapter Three, "Blood and Blood Products" provides a cursory reference to the recognition of the United States in 1984 that AIDS was transmissible in blood. It then mentions only France's action to compel blood screening.[28] By failing to state that when the United States licensed the first HIV screening test in March 1985, it not only recommended that all blood collected (for whatever purpose) be screened but also provided the first means by which reliable blood screening was possible, the author precludes cognition of how singular that contribution was to beginning to control the spread of disease.

The majority of this author's discussion of blood products occurs in Chapter Two, beginning with a misstatement regarding the timing of the United States' requirement for HIV testing of blood products.[29] He provides no references for statements regarding requirements imposed by the governments of Spain, Sweden, the United Kingdom, Belgium, France, Austria, the Federal Republic of Germany, Switzerland, Australia, Canada, and Hungary, as well as the Council of Europe. In addition, the author confuses existing regulations by the U.S. Food and Drug Administration (FDA) with new legislation enacted in other countries. The FDA has been responsible for protection of the American blood supply since the amendment of the Public Health Service Act in 1972,[30] while the specific procedures to be followed to accomplish this protection are updated frequently.[31]

As part of the blood products discussion in Chapter Two, the author mistakenly claims that in the state of Tennessee "any person who contracts AIDS from any contaminated blood or blood product will have a cause of action for damages (including medical expenses) against any facility which supplied untested blood or a blood product derived therefrom."[32] No citation is given. Because 48 of the 50 states[33] (including Tennessee) have a "blood shield" statute protecting blood suppliers from liability for transmitting disease, and because no supplier has been held liable for not testing before testing was available,[34] the author's statement may not be completely

27. *Id.* It can cost up to $50 just to eliminate one unit of infected blood in most African countries. Yet places like Zaire and Uganda have less than one dollar to spend each year per person for all their health needs. In the United States, per capita health care spending is almost six hundred dollars. *Id.*

28. D. JAYASURIYA, *supra* note 4, at 38.

29. *Id.* at 14.

30. 42 U.S.C. § 201 (1982).

31. 21 C.F.R. §§ 600-699 (1989).

32. D. JAYASURIYA, *supra* note 4, at 23.

33. The two states without "blood-shield" statutes are New Jersey and Vermont. Sazama, *Legal and Regulatory problems Facing Blood Suppliers*, 6 HEALTHSPAN 8, 14 n.6 (Sept. 1989).

34. *See, e.g.*, Sazama, *Legal and Regulatory Problems Facing Blood Suppliers*, 6 HEALTHSPAN 8, 9 (Sept. 1989).

accurate. Additionally, blood donor disclaimer attestations in countries outside the United States have been generally patterned after the FDA recommendations.

Chapter Four, discussing screening and international travel, opens with a quotation about sex with a prostitute (a quote that strikes this reviewer as being more attuned to the topic of the subsequent chapter, namely, condoms and the prevention of AIDS or perhaps to a consolidation of these two chapters). Generally, the policy considerations underlying requirements for screening and/or testing for selected contagious diseases have been directed toward persons who propose to become resident for some period of time, e.g., foreign students or aliens seeking work, as well as to persons who regularly engage in illicit behavior such as drug abuse or prostitution. As quoted by Jayasuriya, the World Health Organization considered the question of screening and international travel in March 1987 and concluded that HIV screening would serve no useful purpose.[35] This entire chapter can be replaced with that single sentence.

The cursory discussion in Chapter Five appropriately identifies, without reference, the scientific concerns about reliability and the economic reality of condom availability. This chapter provides no information regarding any legal aspects regarding condom use, not even discussing which countries prohibit such interventions and whether new legislation has been proposed or enacted to encourage wider use. The few references included in this chapter address mostly the American experience and provide no insight regarding pending or actual activities for implementing an international strategy of public health or legal impetus to encourage condom use. Discussing condoms without mentioning the accompanying controversy over comprehensive sex educational programs[36] seems singularly abstruse.

The treatment of drug abusers and the use of injections addressed in Chapter Six suffers from a similar lack of both data and analysis, and a discussion of the need for education as the foregoing chapter. Unsupported statements such as "[a] significantly large number of persons with AIDS or HIV in the United States and Europe are parenteral drug abusers"[37] and "[m]any more countries are affected by drug abuse today than some five or ten years ago"[38] leave the reader bereft of a basis to accept them as true. Only two examples of proposals for control of drug dependence, one American and one Italian, are given, with no reference for the Italian action. Fur-

35. D. JAYASURIYA, *supra* note 4, at 48.
36. Voelker, *No Uniform Policy Among States on HIV/AIDS Education*, AM. MED. NEWS, Sept. 15, 1989, at 3.
37. D. JAYASURIYA, *supra* note 4, at 56.
38. *Id.* at 57.

ther, this reviewer would be satisfied with just one example of a country, aside from the United States, in which "AIDS-related activities and drug abuse control work tend to be done by different agencies at the national level."[39]

Chapter Seven, the concluding chapter, consists of "a representative sample of various measures . . . which have been discussed during the past few years."[40] In fact, this chapter substitutes for an index, containing nothing more than an arbitrary alphabetical listing of the author's ideas regarding the subject matter, absent the necessary page references. Jayasuriya offers up this potpourri, disclaiming any responsibility, while advising that:

> this catalogue serves as a convenient check-list for countries to assess the *validity* of any proposal in relation to factors such as
> — medical, scientific and technological readiness and validity;
> — political expediency;
> — economic feasibility; and
> — legal, ethical, cultural and social acceptability.[41]

The omissions are glaring: no reference to access to health care or to the legal system, public health laws, drug development, compulsory screening, anal-receptive sex as high risk activity, high-risk activity for infection, hemophiliacs and spouses at special risk, special programs for infants born infected with HIV, or anonymous testing. The relevance of this chapter is simply not apparent, other than as a substitute for a partial index.

Rounding out the remaining 78 pages are Appendices A through E. Appendices A, B and E have been discussed in the preceding paragraphs. Appendices C and D contain "Guidelines and Recommendations of the U.S. Centers for Disease Control and the World Health Organization," rearranged to suit the author's approach, and "WHO/CDC Case Definition for AIDS," valuable resources only if one has no access to other publications in which both or either appear.

Not included in any appendix, but of greater value to the reader, is a discussion of the WHO global strategy for AIDS control. The strategy was first announced in November 1986, with establishment of the WHO Special Program on AIDS (SPA) in February 1987, and has recently been included in the newest edition of a premier medical reference on AIDS (to which the reader is commended).[42] The plan has three major objectives: (1) To prevent

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39. *Id.* at 60.
40. *Id.* at 62.
41. *Id.*
42. Zagury & Lurhuma, *AIDS Control in Africa*, in AIDS ETIOLOGY, *supra* note 1, at 431-45.

HIV transmission; (2) To take care of HIV-infected persons (to reduce morbidity and mortality associated with HIV-infections; the care of HIV-infected persons is not limited to medical management or to AIDS or AIDS-Related Complex (ARC) patients; combatting discrimination against HIV-infected persons is as vital to the global strategy as provision of medical care); and (3) To unify national and international AIDS control efforts.[43] In a recent symposium on AIDS,[44] the special needs of healthcare workers internationally was addressed.[45]

Many well-written articles[46] and books[47] about both the public health aspects and legal issues surrounding the AIDS epidemic continue to appear. Perhaps a scholarly analysis of international efforts to control AIDS by public health and legislative action will be forthcoming, but this book misses the mark.

FINAL CHOICES: AUTONOMY IN HEALTH CARE DECISIONS. George P. Smith, II. Illinois: Charles C. Thomas. 1989. 198 Pp. $37.75.

Reviewed by Randy Howe, M.D. *

The core argument of this book is that competent individuals should be permitted to take their own life so long as their decision is rational. This

43. *Id.* at 439-43.

44. Brandt, *Health Care Workers and AIDS*, 48 MD. L. REV. 1 (1989).

45. Fluss & Zeegers, *AIDS, HIV, and Health Care Workers: Some International Legislative Perspectives*, 48 MD. L. REV. 77 (1989).

46. *See, e.g.*, *Acquired Immunodeficiency Syndrome Associated With Intravenous-Drug Use—United States, 1988*, 261 J. A.M.A. 2314 (1989); Dalakas, Wichman, & Sever, *AIDS and the Nervous System*, 261 J. A.M.A. 2396 (1989); Turnock & Kelly, *Mandatory Premarital Testing for Human Immunodeficiency Virus*, 261 J. A.M.A. 3415 (1989); Joseph, *Premarital AIDS Testing: Public Policy Abandoned at the Altar*, 261 J. A.M.A. 3456 (1989); Quinn, *AIDS in the Americas: An Emerging Public Health Crisis*, 320 NEW ENG. J. MED. 1005 (1989); Howe, *supra* note 2; Matthews, *supra* note 3; Duncan, *supra* note 2; Comment, *supra* note 2.

47. *See, e.g.*, R. BAYER, PRIVATE ACTS, SOCIAL CONSEQUENCES: AIDS AND THE POLITICS OF PUBLIC HEALTH (1989); AIDS PROFILE, *supra* note 8; R. SHILTS, AND THE BAND PLAYED ON (1987); AIDS AND THE LAW (H. Dalton, S. Burris and the Yale AIDS Law Project eds. 1987); AMERICAN MEDICAL ASSOCIATION, AIDS: INFORMATION ON AIDS FOR THE PRACTICING PHYSICIAN (1987); AIDS ETIOLOGY, *supra* note 1.

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