LEGAL IMPLICATIONS OF AIDS

Papers presented at a seminar held by the Legal Research Foundation at the University of Auckland on 17 May 1989

Legal Research Foundation
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FOREWORD

The Hon Mr Justice Barker
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The idea for a seminar on the Legal Implications of AIDS was prompted by the Foundation's receipt of an earlier version of Mr Doug Hodgson's paper on HIV testing. It is the Foundation's policy to promote research and debate on topical legal issues. In New Zealand, discussion of AIDS has to date been dominated by medical experts, the AIDS Foundation, and the media. It seemed timely to involve the legal community in this debate. Since planning of the seminar began, proposals for anti-discrimination legislation in this country have highlighted the need for the legal issues surrounding AIDS to be fully explored.

The contributors are eminently qualified to examine the legal implications of AIDS in New Zealand. Mr Justice Kirby provides an international perspective on legal issues and AIDS. Mr Bill Dillon, MP outlines the policy and legislation initiatives of the New Zealand Government in responding to the challenge of AIDS. Mr Doug Hodgson canvasses the difficult legal and policy issues raised by HIV testing in New Zealand. A philosophical perspective is provided by Dr Grant Gillett, whose paper considers the complex ethical issues which surround AIDS. Mr Justice Wallace and Mr Warren Lindberg provide commentaries from the Human Rights Commission and the AIDS Foundation respectively.

The Legal Research Foundation is grateful to all the contributors for their time and effort in preparing and presenting such thought-provoking and scholarly papers. Our gratitude is also expressed to Qantas Airways for its ongoing financial support of the Foundation.

Judge's Chambers
High Court
LEGAL IMPLICATIONS OF AIDS*

The Hon Justice Michael Kirby,**
President of the New South Wales Court of Appeal,
Member of the World Health Organisation Global Commission on AIDS

Introduction

An Australian judge once described law as "marching with medicine, but in the rear and limping a little".1 The IVth International Conference on AIDS in Stockholm disclosed the global challenge to communities and individuals presented by Acquired Immuno-Deficiency Syndrome (AIDS). The World Health Organisation (WHO) Report to the Conference revealed just short of 100,000 notified cases of AIDS; an estimate of at least twice that number in actuality; and an estimate of the numbers infected with Human Immuno-Deficiency Virus (HIV) of between five and ten million persons.2 Elsewhere, I have summarised my perceptions of the main conclusions to be drawn from the Conference - scientific, economic and social.3 In this essay, I will survey some of the chief legal responses to AIDS which have occurred to date, as communities respond to their differing perceptions of AIDS, and the ways in which the law should deal with identified aspects of it.

Inevitably, there are a number of limitations which affect the utility of an article of this kind. The law is local. Even in a unitary state national and local government authorities (legislators, administrators and courts) will establish rules of varying kinds affecting AIDS. In federal countries, there may be even greater diversity of lawmaking at federal, state and local levels. Approaches to epidemic control vary enormously according to the political system which operates, its responsiveness to popular opinion and its ability to deal with the problem authoritatively. This point has been made many times when comparing public health laws and policies on alcoholism in, say, the United States and the Soviet Union. Furthermore, law does not exist in isolation. It is part of the mosaic of social regulation. It is shaped by the institutions which make it and upon which it must operate. As well, the perceived

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* Based upon a contribution by the author which is published in AIDS (1988), 2 Suppl, s 209 - s 215.
** Member of the World Health Organisation Global Commission on AIDS; Trustee of the AIDS Trust of Australia; Honorary Fellow, Legal Research Foundation; Commissioner and Member of the Executive Committee, International Commission of Jurists; President of the Court of Appeal of New South Wales. The views stated are personal views.
needs for law depend upon the perception (and actuality) of the size and nature of the problem being tackled. The WHO statistics show the wildly uneven distribution and differing patterns of AIDS in different countries, at this stage of the epidemic. Finally, there are limitations of knowledge that must be acknowledged. Whereas medical and other scientists, dealing with the human body, work upon phenomena which are universal and, relevantly, unvarying, it is not so in the law. The legal systems which operate throughout the world are fundamentally different, although there are two large groupings. One of these groupings is represented by the common law system, derived, ultimately, from England. This system is substantially followed in most English-speaking countries. It lays emphasis upon the role of the judge as an expositor of law. Even legislation enacted by elected legislators (or subordinate regulations made by administrators under delegated power) reflect the intended interaction of such legislation with judge-made law. The other major grouping is the civil law system, derived principally from France. In this system the role of the judge is important but less so. Codification and general statements of the law are more common.

All of this is simply to introduce what follows by words of necessary caution about the applicability of legal rules established in one jurisdiction to respond to AIDS in the differing legal environment of another. At some points (as in international travel) domestic laws interact. They then affect foreign nationals. But for the most part, though the problem of AIDS is now global, the responses of the legal systems of the world depend upon the local institutions and legal environment. WHO contributes to understandings of the commonality of legislative responses to AIDS by the regular publication of tabular information on legal instruments dealing with AIDS and HIV infection. This circular is published in two parts. One surveys the United States, the epicentre of the epidemic, by reference to legislative instruments, federal and state. The other deals with reported instruments from other jurisdictions around the world. These reports are indispensable. They continue to expand rapidly. They omit judge-made law and much official practice and policy. Substantially they provide a conspectus of legislation, as that word is understood in common law countries. There is no point in reviewing these collections. They disclose the rapid way in which laws have been enacted in many jurisdictions to provide for the screening of blood products, the notification by medical practitioners of suspected or confirmed diagnoses of AIDS and the growing number of jurisdictions which have introduced requirements for compulsory screening of identified groups, such as immigrants and prisoners. It is not my intention to collect and analyse these laws. Instead, it is to give a tour d'horizon of laws on AIDS, so that some notion can be derived of the way in which lawmakers are responding to the epidemic. I will attempt to draw a number of general conclusions.

Criminal Law

Exposure to HIV infection, which may lead to AIDS, is life-threatening. There is no present cure for AIDS. Nor is the development of such a cure foreseeable. A large number - perhaps all - of those who are infected with the virus will suffer serious consequences for their health. Many will die as a result. Accordingly, it is a legitimate purpose of the law to endeavour to protect individuals, communities and nations from the spread of the virus.

A traditional way by which legal systems attempt to inculcate individual responsibility is by the operation of the criminal law. That law, to breach of which penal and other sanctions typically attach, operates imperfectly as the evidence of law-breaking in different communities clearly demonstrates. However, the criminal law can have symbolic value in stating that conduct is punishable and hence is not approved by society. Various theories exist to justify the stigmatisation of conduct by criminal law. According to one theory, it is enough that conduct offends the moral sense of most members of society. This was a traditional basis for laws penalising adult homosexual conduct in many countries, even though there was no complaining victim. But with the spread of HIV, there is a risk of serious actual harm to individuals. This would invoke the other chief theory which underpins the criminal law: protection of the individual from harm.

It is possible that the knowing spread of HIV to another person - or reckless indifference to whether, by sexual or other conduct, the actions of the individual will have that consequence - will already amount to a crime under general provisions of criminal law. Depending on its terms and on the consequences of the act, such conduct might amount to murder, manslaughter or assault occasioning grievous bodily harm, etc. But whether or not this is so, calls are now being made, and sometimes answered, for the provision of specific crimes to penalise the deliberate or reckless spread of this potentially lethal virus.

Responding to such calls, a number of Australian states, for example, have enacted laws to provide a specific penalty in the case of unprotected sexual intercourse by infected persons. In my own state, a person who knows he or she has a proclaimed disease (including AIDS) may not have sexual intercourse with another person unless before such intercourse takes place the other person has been informed of the


risk of contracting the disease from that person and has voluntarily agreed to accept the risk. The penalty imposed is a maximum fine of $5,000.\(^7\) This may seem a modest penalty for activity that may spread a potentially fatal infection.\(^8\) In Victoria, amendments to the Health Act were introduced in 1987 to provide a fine of up to $20,000 for a person who deliberately infects another with AIDS or any other infectious disease. Such laws should be seen as having symbolic rather than practical value. The penalty is inadequate. Proof and enforcement of the law would be extremely difficult. The offender may be dead or very ill by the time of the prosecution. Proof that it was he or she who caused the infection may be next to impossible. Moreover, such laws may have a counterproductive effect, even though unintended. If an element in such crimes is knowledge of one's own HIV status, the provision of such laws may discourage persons from taking the HIV test. Particularly may this be so if there are provisions for reporting of persons who prove HIV positive to the test, with personal identifiers that can be traced. Submitting to the HIV test may itself sometimes be a useful educational step in a course of behaviour modification designed to promote self-protection and the containment of the AIDS infection. Criminal offences, which have only a minor symbolic value and are rarely prosecuted with success, may actually prove counterproductive because they discourage test-taking.

This is not the only area where AIDS and the criminal law intersect. For example, in a recent murder prosecution in Sydney, Australia, the accused contended that he had killed his wife because she admitted an affair and he feared that she had AIDS and would infect the children. In numerous criminal cases, issues relevant to AIDS are now arising. Thus in England, the Court of Queen's Bench held that fear of the giving of a blood sample for detecting the presence of alcohol in the blood of a driver, allegedly on the ground of concern about contracting AIDS in the process, was not a reasonable excuse to justify the refusal.\(^9\) Also in England, the Court of Appeal has reserved for the future the question whether fear of AIDS will justify a higher tariff in the punishment of a person convicted of rape.\(^10\) In South Australia, it has been held that the fact that a prisoner is suffering from AIDS is a consideration relevant to determining the sentence that should be imposed upon him. This was justified having regard to the state of the prisoner's health, his health prognosis and the likely loss of ordinary prison privileges because of isolation, consequent upon the diagnosis of AIDS.\(^11\)

\(^7\) See Public Health (Proclaimed Diseases) Amendment Act 1985, s 3 (inserting s 50N(3) in the Public Health Act 1902 (NSW)).

\(^8\) See Health Amendment Act 1987 (Vic). A similar provision has been enacted in the Soviet Union by the Decree of 25 August 1987 as reported in Izvestia, 26 August 1987, at 2. It provides for deprivation of liberty for up to five years for knowingly transmitting AIDS to another person.

\(^9\) Fountain v Director of Public Prosecutions [1988] Crim LRev 123.


\(^11\) The Queen v Smith (1987) 44 SASR 587.
In some jurisdictions it may be expected that constitutional guarantees of human rights will be invoked to stand in the way of penalising consensual sexual conduct. Recent decisions of the United States Supreme Court holding that states do not violate the federal Constitution when they punish homosexuals for consensual sodomy\(^\text{12}\) and that Army Regulations discharging homosexuals from the armed services\(^\text{13}\) do not breach the Constitution suggest that constitutional limitations will not play a large part in that country in controlling criminal or other laws targeted at the spread of the AIDS infection, whatever the invasion of privacy or breach of other rights involved.

Quarantine and Public Health

Quarantine laws are generally categorised as civil rather than criminal. However, they may impose restriction on individual freedom which are as severe as penal laws. Sometimes they do so without the exquisite protections typically built into criminal process. So far, no community has provided specific laws to quarantine all persons with HIV infection. Such laws would be manifestly unjust and ineffective, at least in the most developed countries. The antibody test does not disclose all who are infected. It would be difficult, if not impossible, to provide resources to house, feed, guard and isolate all such persons. The economic impact of withdrawing from the economy people with (on average) eight, ten or more years of productive contribution would be crippling. Moreover, having regard to the established modes of transmission of the AIDS virus, the risks of the spread of the infection to the whole community remain small. Clearly, the target of laws and policies should be the behaviour that spreads the risk, not the individual.

Nevertheless, calls for quarantine and manifest identification of the infected have occurred.\(^\text{14}\) They will become more common as the infection spreads. In a number of jurisdictions already existing powers of quarantine have been enhanced and made specific to include AIDS.\(^\text{15}\) Lessons have fortunately been learned from the ways in which communities earlier tackled syphilis - also a sexually transmissible disease potentially lethal. An English Royal Commission Report in 1913\(^\text{16}\) made the point that the public health objectives of procuring the identification of the infected, counselling and such treatment as was available, were more likely to be effective for the policy of containment than punishment and quarantine. As with syphilis so with AIDS. Winning the support of those with the burden of infection, and modifying their behaviour, is the strategy that offers most promise at this time.

\(^{15}\) See eg Public Health (Control of Disease) Act 1984 (UK). CFJ Aiken, "AIDS - Pushing the Limits of Scientific and Legal Thought" (1986) 27 J Law Sci & Tech 1 at 5.
\(^{16}\) See "History Says No to Policemen’s Response to AIDS" (1986) 293 BMJ 1589.
Many jurisdictions have enacted laws to provide screening for the presence of HIV. None has so far provided for mandatory screening of the whole population. This has been recognised as ineffective. It is an inefficient use of available public resources. It carries with it the risk of discrimination on a large scale. Notwithstanding rational arguments against screening of particular groups in the community, numerous jurisdictions have so provided. For example, China has recently extended its compulsory testing to all foreigners who apply to live in the country for more than six months. There are many other like provisions, particularly in the laws of countries presently reporting a low incidence of AIDS and HIV. Numerous legal issues are raised by legislation on screening for antibodies to the AIDS virus. They depend largely on the voluntary or compulsory nature of the screening provided; the facility for anonymous screening; and the obligation of those performing the screening to submit identified or purely statistical data to central record keeping facilities. The concern about AIDS registers and data protection has begun to attract the attention of the international and national reviews of this issue. Because of the risk of discrimination, if not immediately then in the long term, the anxiety of potential or actual privacy invasion is added to the anxieties related to health.

The submission to screening, of itself, does not affect in the slightest either the health of the individual tested or the containment of the virus in the community. However, the hope is frequently expressed that submitting to such screening will encourage at least those without HIV infection to modify their behaviour and adopt “safe sex” and other practices so as to limit the cycle of the infection. Screening provides the best possible data on the epidemiology of AIDS. These facts suggest that anonymous screening and de-identified reporting should be encouraged. The provision of facilities for counselling of those undergoing the screening test for HIV was emphasised in a number of sessions at the IVth International Conference. One of the topics most hotly debated was whether, and if so when, a medical practitioner knowing that a patient is infected with HIV has an obligation to warn that patient’s sexual partner(s). In circumstances of persistent refusal or failure of the patient to do so, does a duty to other individuals and to public health override the duty of confidence owed to the patient? Unless legislation is enacted imposing or relieving the medical advisor of liability to do so, such duty would, in common law countries

21 See Dale and Ors, n 19.
probably be worked out by reference to the laws of confidence and negligence. 22

Various other public health issues raised by AIDS have been dealt with by the law. They include such matters as the closing of venues considered responsible for spreading the infection (e.g., bath houses); limitation on acupuncture and organ transplantation by persons infected with HIV; and tracing of sexual partners for the provision to them of counselling about exposure to HIV infection and so on.

**Blood Transfusions**

A major early source of the spread of HIV infection was the blood supply. In developed countries, most of this occurred before the problem of AIDS was generally known and before the antibody test for the presence of the virus was generally available. But even now, in a number of developing countries, inadequate resources are available to test blood products. This point was made during the IVth International Conference.

Numerous legal issues are raised by post-transfusion AIDS. 23 Many have concerned the liability of suppliers of blood products where the product is alleged to have caused the infection of a patient. A number of cases involving allegations of this kind have come before the courts in Australia. In one, an application for the identification of a blood donor was refused. 24 In another, an application to bring legal proceedings out of time, on the ground of delayed diagnosis of AIDS, failed. 25 In some jurisdictions provisions have been urged 26 for a special fund to indemnify those who have acquired HIV or AIDS from blood transfusion. 27 Care must obviously be taken, in acting in this way, not to discriminate between those who have acquired the infection from transfusion as distinct from, say, lawful sexual conduct which was not at the time known to be dangerous. Such a distinction could perpetuate unfair discrimination amongst patients with AIDS, all of whom suffer in the same way. All of them need the support of a caring society.

**Marginalised Groups**

One of the tricky problems presented to lawmakers by AIDS is the fact that, at least

22 Cf *Tarasoff v Regents of the University of California* (1976) 551 P 2d 334.
24 *See Locker v St Vincents Hospital (Darlinghurst)* unreported, (1 October 1985), noted by M D Kirby, "AIDS Legislation - Turning Up the Heat?" (1986) 60 ALJ 324 at 330.
27 The UK Government has made an ex gratia payment of $10 million to enable the Haemophilia Society to set up a trust fund to help haemophiliacs infected with the AIDS virus from infected blood products. (See "Government Gift of $10 M to help Haemophiliacs", The Times (London) 16 November 1987).
in developed countries, the groups initially presenting in large numbers with the HIV infection were already stigmatised and, in some senses, "socially outcast". I refer to homosexual or bisexual men, intravenous drug users and prostitutes. Public opinion polls suggest widespread support, at least in my own country, for mandatory testing of such groups. Thus, a 1987 Australian survey showed 90% support for compulsory testing of homosexuals; 86% for immigrants entering Australia; 83% for prisoners in gaol and even 57% for tourists entering the country.

Democratically elected governments, under the pressure to be seen to be doing something effective in the face of a major epidemic, may be tempted to legislate against particular groups. Migrants, prisoner, drug users and prostitutes, in particular, lack an effective voice to dissuade lawmakers from provision of laws discriminating against them. It is therefore important for those concerned with the science of lawmaking to remind lawmakers of the dangers of unjust discrimination and the probable ineffectiveness of mandatory testing of such groups. To test migrants but not tourists would seem unjustifiable, as the latter, rather than the former, may typically have greater exposure to AIDS. To test prisoners without making administrative arrangements for their care if found to be HIV positive is pointless. Yet in prisons around the world (including in my own country) compulsory testing is now increasingly occurring. To provide for testing of prisoners and not to provide for condoms and for the control of the spread of the infection by intravenous drug users is irresponsible.

In a survey conducted for the National Health and Medical Research Council of Australia it was disclosed that about 12% of men in the sample admitted to homosexual behaviour during their lives. The actual proportion might well be higher. The possibility of sexual activity in crowded prisons, where normal sexual outlets are impossible, must be acknowledged by a society in whose charge the prisoners are. There is growing recognition of public acceptance of this fact. As was pointed out in Stockholm, one of the advantages of the sexual revolution in developed countries has been a growing realism about human sexuality and willingness to face candidly its consequences.

This realism may, in due course, produce an important legal revolution concerning intravenous drug users. The reports to the Stockholm Conference made it plain that in the United States and Europe heterosexual intravenous drug users are now a rapidly growing proportion of those presenting with HIV infection (estimated 25%
in the United States; 30% in Europe). 33 This fact has led, in a number of jurisdictions, to the provision of sterile syringes in an exchange program designed to curb the spread of HIV. An Australian report suggests that up to one in every ten returned needles in the inner city of Sydney is infected with HIV. This constitutes a "substantial increase" in the apparent spread of the virus amongst intravenous drug users. 34 The introduction of syringe exchange programs requires a degree of political courage. This is especially so at a time of national concern in many countries about the growing use of narcotic and other drugs. However, it also represents recognition of the fact that the present legal response to drug control, at least in some developed countries, is failing. There is a growing willingness to contemplate (or at least to experiment with) treating the problem as one of public health. A discussion paper issued in Australia in February 1988 reviewed, for the first time, various options designed to control what was described as "the second AIDS epidemic". This is the spread of HIV by way of the sharing of syringes and later sexual intercourse to the general community. 35 Editorials in a number of Australian newspapers are now facing candidly the possible need to provide heroin and other drugs to intravenous drug users as part of a strategy to prevent the risk of the spread of the AIDS virus into the general community. Illegality and covert supply of drugs tends to promote this risk. 36 This is a remarkable development. But it reflects the growing recognition of the seriousness and extent of the problem of AIDS. A drastic problem may necessitate drastic solutions. It may concentrate the mind on those measures most likely to be effective.

Other Issues

Numerous other issues require attention in any review of the impact of AIDS upon the law. They include:

* The provision of laws against discrimination against people with HIV or AIDS whether in employment, 37 housing, 38 the provision of social security or otherwise.

* The regulation of insurance and the extent to which insurers may seek to protect themselves from unjustifiable liability while requiring policy

34 J Gold quoted Sydney Morning Herald, 10 February 1988, at 8.
36 See eg Melbourne Herald, 6 June 1988; Melbourne Age. 17 June 1988.
holders to answer questions, undergo screening for HIV or otherwise. Different problems arise in different jurisdictions, having regard to the provision or absence of publicly funded health care. In the absence of such provisions, the entitlement to the protection of private insurance may be critical. Questions addressed, for example, to whether a person has submitted to screening, or sexual orientation as such, might be unfairly discriminatory. Yet so might prohibitions on the provision of insurance to particular groups, given that it is behaviour and not membership of a group, as such, that puts a policyholder at risk.

Family law may be affected, as for example in those jurisdictions which provide for dissolution of marriage on the ground of matrimonial fault such as adultery. Particular issues of child abuse; the rights of sexual partners and the position of families devastated by the loss to AIDS of an income earner, all need consideration. An interesting consequence of the introduction of laws requiring pre-marriage tests for HIV in some jurisdictions of the United States was reported in Stockholm. It was that applications for marriage licenses had fallen by 60%. This simply demonstrates the need for more careful consideration in the design of laws.

Concern has been expressed about the neuropsychiatric aspects of HIV infection and about whether dementia will provide justification for compulsory screening of employees in some occupations. A number of airlines are now requiring flight and cabin crew to submit to HIV tests, ostensibly upon this basis. A committee of the WHO has questioned the need for such tests. It pointed out that mental impairment is likely to show up in advance of other symptoms thereby removing the justification of universal screening, with its serious dangers for discrimination.

Reports of the first tests of AIDS vaccine were made to the Stockholm Conference. Vaccines present issues for the legal liability of those individuals and corporations involved in such tests. In some jurisdictions, common law decisions and legislative provisions have heavily burdened vaccine development, for the protection of those who suffer as a consequence. Given the dimension of the global problem of AIDS and the urgency of providing an effective cure and vaccine as quickly as possible, consideration will need to be given to such matters as the protection of drug

companies and the compensation of any who suffer from their urgent activities. 44

* Finally, the likelihood, in present circumstances, of large numbers of persons dying from AIDS has called attention once again to the issue of euthanasia and the need for respect of the terminally ill. 45 Sadly, hysteria can generate pain for the dying and the grieving. In my own state, for example, regulations require that a person known or reasonably suspected to have suffered [from AIDS] should, at the time of death, be placed in double plastic bags, heat sealed with the words “Infectious Disease - Handle with Care” placed on the body in letters of prescribed colour and height. 46 Obviously this procedure has impeded the grieving process. It betrays the right of a deceased person not to disclose the nature of his or her illness. There is no scientific basis for the regulation. AIDS is not transmitted by handling the body of a person who has died in this way. The regulation was simply a response to a trade union demand which was grounded in irrational fear.

Conclusions

This last comment calls attention to the need to base laws on facts. There is also a need to recognise the limited capacity of the law to promote the behaviour modification which is essential, in present medical circumstances, to the containment of HIV and AIDS. The only vaccine we have at the moment, as the Swedish Minister for Health said in Stockholm, is knowledge. 47 This is why, at least at present, legal regulation whould be addressed to facilitating public education, the ready provision of condoms with water-based lubricants and the ready availability to people concerned about their probable risk, of anonymous HIV screening. Such screening may be the first step on the road to self protection and the protection of others.

It is in this sense that the report of the United States Commission led by Admiral Watkins (which coincided with the Stockholm Conference) is most important. That report emphasised the need, paradoxical though it may at first seem, to accompany laws and policies on AIDS with the provision of protection against discrimination of those who are infected. The lesson is there from the earlier legal regulation of syphilis. Attempts to deal with syphilis punitively, by stigmatisation, contract

44 Cf National Childhood Vaccine Injury Act (US); 1986 Pub L 99, 660.
46 Public Health (Funeral Industry) Regulation, 1987 (NSW), Reg 21 (2). Cf Public Health (Control of Disease) Act 1984 (UK) ss 43, 44.
47 Minister Gertrud Sigurdsen, Minister of Health (Sweden), at the IVth International Conference on AIDS, Stockholm, Sweden, June 1988.
tracing and the rounding up of prostitutes provided no effective protection for society. On the contrary, it involved great injustice. It was, above all, ineffective. Injustice in combating AIDS might be tolerated by some. Many in the groups most at risk in developed countries face the prospect of further stigmatisation. They contemplate injustice with resignation and anger controlled by knowledge of long experience. But inefficiency in controlling the spread of HIV is unforgiveable. At risk is nothing less than the health of millions of people.

Just as we are fortunate that this epidemic struck at time when we have the WHO to mobilise the international community and the tools of molecular biology to identify the virus, so we are fortunate as we approach our legal responses. We have the modern means of communication to spread rapidly the educational message. We have the candour which has, in many countries at least, accompanied new approaches to human sexuality. This is helpful in combating stigmatisation and in promoting frank instruction, including to the very young, concerning the modes of transmission and means of protection. We have a new willingness to think radically concerning the groups most at risk, not least for the protection of the rest of the community. We also have a growing knowledge of the science of jurisprudence. And this brings a realisation of the limits of what can be achieved by the law in epidemic control.

That is why the law limps after medicine ... at the rear of the line. For the health of society and the practical containment of AIDS, that is where I would keep it for the present. Over-enthusiasm in enacting laws on AIDS may make some people feel better. But it will have precious little impact on controlling the spread of this epidemic. It may cause serious disadvantages of stigmatisation for those infected, or most at risk, whose co-operation we must win. In this way too many laws may actually impede the control of the spread of AIDS. For the moment, that control depends most on community and individual education. This may seem a strange conclusion for a lawyer to reach. But for my own part, I am sure that:

* effective media news, advertisements and even soap operas broadcast to the general population;
* ready and cheap provision of condoms with water based lubricants; and
* a new approach to illegal drugs

will be a more effective strategy than laws, to stop the spread of this lethal virus – if we are really serious about containing AIDS.

48 See discussion in Sullivan and Field, O W Matthews and V S Neslund, “The Initial Impact of AIDS on Public Health Law in the United States” (1987) JAMA 344 at 346. See also A M Brandt, “AIDS - From Social History to Social Policy” (1986) 14 Law Medicine and Health Care 231 at 233. In 1918 the US Congress allowed more than $1 million for the detention and isolation of venereal carriers. During the War more than 30,000 prostitutes were incarcerated in institutions supported by federal funds. The story is compared with the internment of Japanese Americans during World War II.
COMMENTARY:
LEGAL IMPLICATIONS OF AIDS

The Hon Mr Justice Wallace
Chairman of the Human Rights Commission

The Hon Justice Michael Kirby has provided a tour de force concerning the legal implications of AIDS. He has outlined all the issues with complete clarity and there is nothing which I would add to his remarks. Rather, I shall endeavour to complement his paper by placing before you views on one specific area which is of major concern to the Human Rights Commission, namely discrimination against those who have developed AIDS or who have tested antibody positive.

I begin by affirming that the Human Rights Commission unequivocally supports the introduction of measures to render it unlawful to discriminate against those who have developed AIDS or have tested antibody positive. The Commission has made a specific recommendation to that effect in its review of the Human Rights Commission Act, carried out late in 1987, which is now before the Government. The reasons which make such legislation essential are all set out in Justice Kirby’s paper. Basically they relate to the cruelty and unfairness of discrimination, coupled with the absolute necessity to ensure that those who have contracted AIDS, or suspect they may have done so, are not deterred by fear of discrimination from co-operating in appropriate public health measures to inhibit the spread of the virus.

The Human Rights Commission is, therefore, entirely supportive of measures to prevent discrimination against AIDS sufferers. On the other hand, the Commission also recognises that where necessary others have the right to be protected. Moreover, such is the fear of AIDS, that measures to prevent discrimination must be able to be defended on a sensible, realistic and medically sound basis. Otherwise proposals for legislation will rightly be overwhelmed by a flood of opposition. We must ensure that any legislation is not susceptible to reasonable or soundly based objection.

Bearing in mind those matters I would like to discuss what concrete shape we should give to anti-discriminatory legislation in relation to AIDS. I take the approach of outlining the possibilities rather than dictating solutions, though I will indicate my personal views. There are at least five major issues which require consideration:

1 The first issue is whether AIDS should be specified as a separate ground of discrimination. In some quarters there is support for the inclusion of AIDS under the head of disability or impairment (both physical and mental). When reviewing the Human Rights Commission Act the Commission recommended that it should be unlawful to discriminate on the ground either of disability or AIDS,
but did not make suggestions as to whether disability and AIDS should be dealt with separately.

2 The second issue is the identification of the types of discrimination which should be unlawful. It would seem that the legislation should cover everyone who has developed AIDS as well as those who are antibody positive and those who, while not in either category, may be presumed or suspected to be, eg a parent, partner or friend of a person found to have AIDS, or members of groups such as gay men or intravenous drug users. The inclusion of those presumed or suspected to have AIDS is important because the evidence from overseas shows that people in that category can be the subject of severe discrimination. It should be noted that careful attention to definitions will be required, particularly if AIDS is to be treated as a form of disability or impairment: for example, it can be argued that a person who has tested antibody positive is not yet suffering from any disability or impairment.

3 The third issue is the identification of those matters which the legislation should not cover or, put another way, what exceptions should be allowed on grounds such as the protection of the public or the safety of health professionals and other careers. Determining those matters involves either creating a list of exceptions (which it is difficult to draft adequately and which I do not favour) or, alternatively, developing the North American concept, little used so far in relation to anti-discriminatory law in New Zealand, of bona fide occupational requirement (which I favour). By way of explanation I mention that the concept of bona fide occupational requirement would enable the Equal Opportunities Tribunal to consider, before holding that there was unlawful discrimination, whether there was a proper reason for the discrimination based on an occupational requirement, eg in relation to a health professional with AIDS who should not be employed to carry out procedures which may put a patient at risk. The reverse case may also require to be covered, eg the need for a health professional to be able to take proper steps for his or her own protection.

Recognition of a bona fide occupational requirement defence should be coupled with an acknowledgement that the requirement must go no further than whatever is reasonable in all the circumstances. It should also be noted that a similar result can be reached by recognising a reasonable accommodation requirement, ie an obligation to take reasonable steps to accommodate the needs of those who have contracted AIDS. By using the concepts of bona fide occupational requirement or reasonable accommodation, an anti-discriminatory regime can be developed which takes full account of the rights and obligations of all. Such an approach is entirely in line with the United Nations International Convenants on Human Rights, which accept that rights are not absolute and may be restricted by considerations of public order, health or safety or the need to protect the rights
of others. As examples of a typical bona fide occupational requirement approach I have annexed to this paper copies of (a) the AIDS policy recently adopted by the Canadian Human Rights Commission and (b) the City of Los Angeles Ordinance prohibiting AIDS-based discrimination.

4 The fourth issue relates to legislation concerning testing and the confidentiality of test results. It is clear that, because of the fear of AIDS, there is a widespread public perception that at least certain categories of people should be required to undergo compulsory testing. In this paper Justice Kirby has referred to Australian poll results and there are similar poll results in New Zealand. Thus the Sunday Star of March 19, 1989 reported a poll conducted by it which showed that:

More than half the people surveyed . . . . want compulsory AIDS tests given to everyone entering hospital or getting married.  
A third support the mass testing of all New Zealanders over the age of 16.  
The poll shows widespread concern about the spread of the disease and a hard line attitude to high risk groups.  
A sweeping 87% believe every intravenous drug user should be tested for the virus; and 75% support the involuntary screening of homosexuals.  
Almost half (49%) say applicants seeking life insurance must have the blood test.

For the reasons given by Justice Kirby it seems clear that all forms of mass testing and most, if not all, forms of group testing should be resisted. What is needed is informed, voluntary and confidential testing, with any exceptions to confidentiality covered by appropriate legislation (which should include an obligation to provide counselling for those who test antibody positive). Some States in the USA now have legislation of that type and I annex a copy of an Act adopted in Illinois in 1988 (c).

5 As a fifth and final matter I mention that in the insurance field there are a number of issues which require special consideration. Thus there is debate as to whether insurers should be entitled to require testing: see the commentary by Benjamin Schatz, [1987] Harvard Law Review 1782; and while it may be justifiable for an insurer to ask appropriate questions of people seeking insurance in order to ascertain the extent of the risk the insurer is undertaking, it is highly undesirable that an insurer should ask questions which stereotype or wrongly stigmatise whole groups of people (eg a question concerning sexual orientation asked with a view to excluding all gay men from cover irrespective of whether they have engaged in any conduct placing them at risk). It is encouraging to note that the Life Offices' Association is giving consideration to a code which provides guidelines concerning confidentiality. Such guidelines should emphasise that, while finding out about a person's activities may be permissible, asking about
their sexual orientation and lifestyle is not. There should also be no assumption
that people who have at some time voluntarily taken a test are likely to be at risk.

I conclude by indicating that I have dealt with five important issues as briefly as
possible in order to enable me to keep my comments within the time limit. I would,
however, be grateful to hear any views which participants in the seminar may have.
Since the Government is at this time considering what changes should be made to
the Human Rights Commission Act there is the opportunity to forward any
recommendations or suggestions which may result from this seminar.
CHRC AIDS policy to deal with facts, not fears.

The Canadian Human Rights Commission has adopted the following policy concerning AIDS.

1. The Commission will assist in fostering improved public understanding of AIDS.

2. The Commission will deal with the complaints that allege discrimination
   a) as a result of infection with the Human Immunodeficiency Virus (HIV) on the
      basis of disability; and
   b) due to stereotypical assumptions that an individual is HIV infected based on
      that individual's membership in a group associated with the HIV infection.
      The complaint will be based on the grounds of perceived disability and sex,
      race, colour or national or ethnic origin.

3. The Commission will deal with complaints where the discrimination alleged
   results from association with a person who suffers from the HIV infection.

4. The Commission will consider being HIV infection free a bona fide occupational requirement (BFOR) where an individual assessment has determined no other arrangement of duties is possible and it is an essential requirement of a position that:
   a) the employee perform invasive procedures; or
   b) the employee travel to countries which bar entry to those infected with the
      HIV; or
   c) the employee perform job duties which impinge on the safety of the public
      and performs these duties alone.

   HIV antibody testing should take place only where the above conditions apply.

5. The Commission will not consider employer or employee preference as sufficient to establish a BFOR nor will it consider employee preference sufficient to establish a bona fide justification (BFJ).

6. The Commission will consider a bona fide justification (BFJ) where the service requires invasive procedures which result in exposure to blood or blood products and the risk is real after all reasonable precautions have been taken.

When the Commission launches a complaint, it is dealt with like any other complaint under the Human Rights Act, and the employer must answer a charge of discrimination, which, if proved, can oblige the organization to mend its ways. Since the Commission cannot pursue every case at once, some employers whose employment-availability gap is only moderately satisfactory will be asked to undertake an analysis of their hiring practices.
CHRC adopts AIDS policy
As society becomes increasingly aware of the importance of the war on AIDS, the Canadian Human Rights Commission is doing its part to protect individuals from acts of discrimination that are based on groundless fears. Chief Commissioner Maxwell Yalden has stressed that we must be guided by the best available scientific information on the disease itself and not by misinformed prejudices against individuals or groups. This is the underlying principle of the Commission’s new policy on handling AIDS-related complaints. The Commission’s policy opens the door to complaints from two groups — people who are not infected with the HIV (human immunodeficiency virus) but who say they have been discriminated against either because they associate with people who are infected or they belonged to a group of people that is regarded as especially vulnerable to HIV infection.

Three occupational requirements may on occasion and in very specific circumstances justify treating employees who are infected differently from other employees. The particular situations covered by CHRC policy concern:
- employees who carry “invasive” procedures as an unavoidable part of their work.
- those who must travel to countries which refuse entry to people who test positive for HIV antibodies; and
- situations where sudden deterioration of the brain or central nervous system could compromise essential safety requirements.

People in these three categories may be tested for HIV infection where there is a specific reason to do so. But the Commission is opposed to mandatory testing for all employees or prospective employees. Objections by co-workers to associating with people known to be infected with the HIV will not be accepted as an adequate reason on its own for discriminatory treatment on the part of the employee.

“The Canadian Human Rights Commission in no way underestimates the gravity of AIDS,” Mr Yalden said. “But it is no less important that we distinguish objectively between what does and does not pose a threat to public health. It is our business at the Commission to make sure that the AIDS scare does not become a pretext for totally unwarranted and discriminatory treatment of individuals or groups.”
Los Angeles Ordinance No 160289
§20.950A

The city of Los Angeles, California, has issued Ordinance No 160389, which prohibits discrimination against persons with AIDS or AIDS-related conditions in employment, housing, business establishments, and other public accommodations. This ordinance has been codified in the Los Angeles Municipal Code as Chapter III, Article 5.8., Sections 45.90–45.93, and it went into effect on August 16, 1985.

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Sec. 2, Ordinance 160289
Urgency Clause ......................................................... 20.950A.99

ARTICLE 5.8; PROHIBITION AGAINST DISCRIMINATION BASED ON A PERSON SUFFERING FROM THE MEDICAL CONDITION AIDS, OR ANY MEDICAL SIGNS OR SYMPTOMS RELATED THERETO, OR ANY PERCEPTION THAT A PERSON IS SUFFERING FROM THE MEDICAL CONDITION AIDS WHETHER REAL OR IMAGINARY

§20.950A.001

Sec. 45.80. Statement of Policy: — After public hearings and receipt of testimony the City Council finds and declares:
That the medical condition described as Acquired Immune Deficiency Syndrome and commonly known as AIDS is a deadly disease which has potential to affect every segment of our City’s population.
That AIDS was first recognized in 1981 by the Federal Center for Disease Control based on the study of a pattern of unusual illnesses among young, single men
reported by the medical center associated with UCLA within our City.
That AIDS in the opinion of the scientific and medical community is caused by a
virus, known at HTLV-III or LAV, which attacks and cripples the body’s immune
system, thereby leaving the body vulnerable to opportunistic infections.
That a person afflicted with AIDS suffers a variety of virus and/or fungus-caused
illnesses which debilitate the the body resulting in a high mortality rate within three
years after diagnosis.
That the spread of the virus has occurred through the exchange of blood fluids, ie,
blood, blood by-products, or semen, between individuals.
That no evidence exists to indicate the spread of the virus by casual contact.
That medical studies of family groups in which one or more persons have been
diagnosed with AIDS show no spread of the virus other than through sexual intimacy
or through the exchange of blood (mother to fetus).
That the virus can thrive only in favourable conditions, and cannot exist for a
significant period of time outside the body, and can be protected against by the
application of hygiene, such as the use of chlorine in swimming pools or spas and
the use of household bleach when washing garments or cleaning contaminated
surfaces.
That the public health danger represented by the virus and its subsequent manifes-
tation as AIDS is caused by the lengthy incubation period during which period an
apparently healthy individual may spread the disease to other persons through the
exchange of blood, blood by-products, or semen.
That AIDS while recognized as a national public health emergency has been
concentrated in urban areas with our city representing the third highest number of
cases reported within a local public health jurisdiction.
That AIDS in the opinion of the scientific and medical community will continue to
increase at a high rate within our city for the foreseeable future.
That AIDS by its nature has created a discrete and insular minority of our citizens
who are afflicted with a seriously disabling condition whose ultimate outcome is
fatal.
That the persons afflicted with AIDS represent a segment of our population
particularly victimized due to the nature of the disease and to the present climate of
misinformation, ignorance and fear in the general population.
That discrimination against victims of AIDS and AIDS related conditions exists in
the City of Los Angeles.
That persons with AIDS or AIDS related conditions are faced with discrimination
in employment, housing, medical and dental services, business establishments, city
facilities, city services and other public accommodations.
That such discrimination cuts across all racial, ethnic and economic lines.
That such discrimination poses a substantial threat to the health, safety and welfare
of the community.
That existing state and federal restraints on such arbitrary discrimination are
inadequate to meet the particular problems of this City.
Sec. 45.81. Definitions:— The following words and phrases, whenever used in this Article, shall be construed as defined in this section:

A AIDS: shall mean the disease complex which occurs when an important part of the human immune system is destroyed by the action of a virus known as HTLV-III or LAV. Signs and symptoms of this disease complex are manifested in the afflicted person by a series of virus or fungus-caused illnesses of a chronic nature.

B Condition related thereto: Shall mean any perception that a person is suffering from the medical condition AIDS where real or imaginary.

C Business Establishment: shall mean any entity, however organized, which furnishes goods or services to the general public. An otherwise qualifying establishment which has membership requirements is considered to furnish services to the general public if its membership requirements: (a) consist only of payment of fees; (b) consist of requirements under which a substantial portion of the residents of this City could qualify.

D Employer: Shall mean every person, including any public service corporation and the legal representative of any deceased employer which has any natural person in service.

E Housing Services [Not reproduced]

F Rent [Not reproduced]

G Rental Units [Not reproduced]

H Person: Shall mean any natural person, firm, corporation, partnership or other organization, association or group of persons however organized.

Sec. 45.82 Employment: —

A Unlawful Employment Practices.

It shall be an unlawful employment practice for any employer, employment agency or labor organization or any agent or employee thereof to do or attempt to do any of the following:

1 Fail or refuse to hire, or to discharge any person, or otherwise to discriminate against any person with respect to compensation, terms, conditions or privileges of employment on the basis (in whole or in part) of the fact that such person has the medical condition AIDS or any condition related thereto.

2 Limit, segregate or classify employees or applications for employment in any manner which would deprive or tend to deprive any person of employment opportunities, or adversely affect his or her employment status on the basis (in whole or in part) of the fact that such person has the medical condition AIDS or any condition related thereto.

3 Fail or refuse to refer for employment any person, or otherwise to discriminate against any person the basis (in whole or in part) of the fact that such person has the medical condition AIDS or any condition related thereto.

4 Fail or refuse to include in its membership or to otherwise discriminate against
any person; or to limit, segregate or classify its membership; or to classify or fail or refuse to refer for employment any person in any way which would deprive or tend to deprive such person of employment opportunities, or otherwise adversely affect her or his status as an employer or as an applicant for employment on the basis (in whole or in part) of the fact that such person has the medical condition AIDS or any condition related thereto.

5 Discriminate against any person in admission to, or employment in, any program established to provide apprenticeship or other training or retraining, including any on-the-job training program on the basis (in whole or in part) of the fact that such person has the medical condition AIDS or any condition related thereto.

B **Bona Fide Occupational Qualification not Prohibited; Burden of Proof.**

1 **Bona Fide Occupational Qualification.** Nothing contained in this Section shall be deemed to prohibit selection, rejection or dismissal based on a bona fide occupational qualification.

2 **Burden of Proof.** In any action brought under this article, if a party asserts that an otherwise unlawful discriminatory practice is justified as a bona fide occupational qualification, that party shall have the burden of proving: (1) that the discrimination is in fact a necessary result of a bona fide occupational qualification; and (2) that there exists no less discriminatory means of satisfying the occupation qualification.

C **Exceptions.**

1 It shall not be an unlawful discriminatory practice for an employer to observe the conditions of a bona fide employer benefit system, provided such systems or plans are not a subterfuge to evade the purposes of this Article provided further that no such system shall provide an excuse for failure to hire any person.

[¶20.950A.03]
Sec. 45.83. Rental Housing — [Not reproduced]

[¶20.950A.04]
Sec. 45.84 Business Establishments — [Not reproduced]

[¶20.950A.05]
Sec. 45.85 City Facilities and Services — [Not reproduced]

[¶20.950A.06]
Sec. 45.86 Educational Institutions — [Not reproduced]

[¶20.950A.07]
Sec. 45.87 Advertising: — It shall be unlawful for any person to make, print, publish, advertise or disseminate in any way any notice, statement or advertisement with any respect to any of the acts mentioned in this Article, which indicates an intent to engage in any unlawful practice as set forth in this Article.

[¶20.950A.08]
Sec. 45.88 Subterfuge: — It shall be an unlawful discriminatory practice to do any of the acts mentioned in this Article for any reason which would not have been asserted, wholly or partially, but for the fact that the person against whom such
assertions are made has the medical condition AIDS or any condition related thereto.

Sec. 45.89 Liability: — Any person who violates any of the provisions of this Article or who aids in the violation of any provisions of this Article shall be liable for and the court shall award to the individual whose rights are violated, actual damages, costs and attorney's fees. In addition, the court may award punitive damages in a proper case.

Sec. 45.89 Enforcement: —

A Civil Action.

Any aggrieved person may enforce the provisions of this Article by means of a civil action.

B Injunction

1 Any person who commits or proposes to commit an act in violations of this Article may be enjoined therefrom by a court of competent jurisdiction.

2 Action for Injunction under this subsection may be brought by any aggrieved person, by the City Attorney, or by any person or entity which will fairly and adequately represent the interests of the protected class.

C Non-Exclusive

Nothing in this article shall preclude any aggrieved person from seeking any other remedy provided by law.

D Exception

Notwithstanding any provision of this code to the contrary, no criminal penalties shall attach for any violation of the provision of this Article.

Sec. 45.91. Limitation on Action: — Actions under this Article must be filed within one year of the alleged discriminatory acts.

Sec. 45.92 Severability: — If any part or provision of this Article or the application thereof to any person or circumstance is held invalid, the remainder of the Article, including the application of such part or provision to other persons or circumstances, shall not be effected thereby and shall continue in full force and effect. To this end, provisions of this Article are severable.

Sec. 45.93 Exceptions: —

A No part of this Article shall apply to any bona fide religious organization.

B No part of this Article shall apply where a course of conduct is pursued which is necessary to protect the health or safety of the general public.

1 Burden of Proof. In any action brought under this Article, if a party asserts that an otherwise unlawful discriminatory practice is justified as necessary to protect the health or safety of the general public, that party shall have the burden of proving:

(1) that the discrimination is in fact a necessary result of a necessary course of
conduct pursued to protect the health or safety of the general public; and
(2) that there exists no less discriminatory means of satisfying the necessary
protection of the health or safety of the general public; and

[¶20.950A.990]
Sec. 2. Ordinance No. 160289
Sec. 2. Urgency Clause — The City Council finds and declares that this ordinance
is required for the immediate protection of the public peace, health and safety for the
following reasons. This ordinance will prevent unlawful discrimination against
persons with AIDS or AIDS related conditions in employment, housing, business
establishments and other public accommodations. Such discrimination has denied
these persons the right to maintain lawful employment, enjoy sanitary housing
conditions, seek medical, dental, convalescent and other business services and have
equal access to public accommodation, thereby creating condition inimical to the
public health and safety. Therefore, this ordinance shall become effective upon
publication pursuant to Section 281 of the Los Angeles City Charter.
(c)

Illinois AIDS Confidentiality Act
§22,577

The Aids Confidentiality Act provides for the confidential use of tests designed to identify any causative agent of AIDS. This law was enacted by PA 85-679, Laws 1987 approved and effective September 21, 1987.

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[§22,577.01]
Sec. 1 [Title] — This Act shall be known and may be cited as the “AIDS Confidentiality Act”.

[§22,577.02]
Sec. 2. [Findings of General Assembly] — The General Assembly finds that:

(1) The use of tests designed to reveal a condition indicative of Human Immunodeficiency Virus (HIV) infection can be a valuable tool in protecting the public health.

(2) Despite existing laws, regulations and professional standards which require or promote the informed, voluntary and confidential use of tests designed to reveal HIV infection, many members of the public are deterred from seeking such testing because they misunderstand the nature of the test or fear that test results will be disclosed without their consent.

(3) The public health will be served by facilitating informed, voluntary and confidential use of tests designed to reveal HIV infection.
Sec. 3. [Definitions] — When used in this Act:

(a) "Department" means the Illinois Department of Public Health.
(b) "AIDS" means acquired immunodeficiency syndrome.
(c) "HIV" means the Human Immunodeficiency Virus or any other identified causative agent of AIDS.
(d) "Written informed consent" means an agreement in writing executed by the subject of a test or the subject's legally authorized representative without undue inducement or any element of force, fraud, deceit, duress or other form of constraint or coercion, which entails at least the following:
   (1) a fair explanation of the test, including its purpose, potential uses, limitations and the meaning of its results; and
   (2) a fair explanation of the procedures to be followed, including the voluntary nature of the test, the right to withdraw consent to the testing process at any time, the right to anonymity to the extent provided by law with respect to participation in the test and disclosure of test results, and the right to confidential treatment of information identifying the subject of the test and the results of the test, to the extent provided by law.
(e) "Health facility" means a hospital, nursing home, blood bank, blood center, sperm bank, or other health care institution, including any "health facility" as that term is defined in the Illinois Health Facilities Authority Act.
(f) "Health care provider" means any physician, nurse, paramedic, psychologist or other person providing medical, nursing, psychological, or other health care services of any kind.
(g) "Test" or "HIV test" means a test to determine the presence of the antibody or antigen to HIV, or of HIV infection.
(h) "Person" includes any natural person, partnership, association, joint venture, trust, government entity, public or private corporation, health facility or other legal entity.

Sec. 4. [Consent for Test Required] — No person may perform an HIV test without first receiving the written, informed consent of the subject of the test or the subject’s legally authorized representative.

Sec. 5 [Physicians’ Obligations] — No physician may order an HIV test without making available to the person tested information about the meaning of the test results, the availability of additional or confirmatory testing, if appropriate, and the availability of referrals for further information or counselling.

Sec. 6. [Anonymity of Subject] — A subject of a test who wishes to remain anonymous shall have the right to do so, and to provide written, informed consent by using a coded system that does not link individual identity with the request or result. The Department may, if it deems necessary, promulgate regulations exempt-
ing blood banks, as defined in the Illinois Blood Bank Act, from the requirements of this Section.

[¶22.577.07]

Sec. 7. [Organ or Semen Donations] — Notwithstanding the provisions of Section 4 of this Act, written informed consent is not required for a health care provider or health facility to perform a test when the health care provider or health facility procures, processes, distributes or uses a human body part donated for a purpose specified under the Uniform Anatomical Gift Act, or semen provided prior to the effective date of this Act for the purpose of artificial insemination, and such a test is necessary to assure medical acceptability of such gift or semen for the purposes intended.

[¶22.577.08]

Sec. 8. [Research] — Notwithstanding the provisions of Sections 4 and 5 of this Act, written informed consent, information and counselling are not required for the performance of an HIV test for the purpose of research, if the testing is performed in such a way that the identity of the test subject is not known and may not be retrieved by the researcher, and in such a way that the test subject is not informed of the results of the testing.

[¶22.577.09]

Sec. 9. [Exceptions to Nondisclosure] — No person may disclose or be compelled to disclose the identity of any person upon whom a test is performed, or the results of such a test in a manner which permits identification of the subject of the test, except to the following persons:

(a) The subject of the test or the subject’s legally authorized representative.

(b) Any person designated in a legally effective release of the test results executed by the subject of the test or the subject’s legally authorized representative.

(c) An authorized agent or employee of a health facility or health care provider if the health facility or health care provider itself is authorized to obtain the test results, the agent or employee provides patient care or handles or processes specimens or body fluids or tissues, and the agent or employee has a need to know such information.

(d) The Department, in accordance with rules for reporting and controlling the spread of disease, as otherwise provided by State law.

(e) A health facility or health care provided which procures, processes, distributes or uses:

(i) a human body part from a deceased person with respect to medical information regarding that person or

(ii) semen provided prior to the effective date of this Act for the purpose of artificial insemination.

(f) Health facility staff committees for the purposes of conducting program monitoring, program evaluation or service reviews.

(g) A person allowed access to said record by a court order which is issued in compliance with the following provisions:
(i) No court of this State shall issue such order unless the court finds that the person seeking the test results has demonstrated a compelling need for the test results which cannot be accommodated by other means. In assessing compelling need, the court shall weigh the need for disclosure against the privacy interest of the test subject and the public interest which may be disserved by disclosure which deters blood, organ and semen donation and future HIV related testing.

(ii) Pleading pertaining to disclosure of test results shall substitute a pseudonym for the true name of the subject of the test. The disclosure to the parties of the subject’s true name shall be communicated confidentially, in documents not filed with the court.

(iii) Before granting any such order, the court shall provide the individual whose test results is in question with notice and a reasonable opportunity to participate in the proceedings if he or she is not already a party.

(iv) Court proceedings as to disclosure of test results shall be conducted in camera unless the subject of the test agrees to a hearing in open court or unless the court determines that a public hearing is necessary to the public interest and the proper administration of justice.

(v) Upon the issuance of an order to disclose test results, the court shall impose appropriate safeguards against unauthorized disclosure, which shall specify the persons who may have access to the information, the purposes for which the information shall be used, and appropriate prohibitions on future disclosure.

[§22,577.10]
Sec. 10 [General Ban on Nondisclosure] — No person to whom the results of a test have been disclosed may disclose the test results to another person except as authorized by Section 9.

[§22,577.11]
Sec. 11 [Testing Required by Law] — Notwithstanding the provisions of Section 4 of this Act, written informed consent is not required for the performance of an HIV test upon a person who is specifically required by law to be so tested.

[§22,577.12]
Sec. 12 [Violation as Misdemeanor] — Intentional or reckless violation of this Act or any regulation issued hereunder shall constitute a Class B misdemeanor.

[§22,577.13]
Sec. 13. [Court Action, Remedies Under this Act] — Any person aggrieved by a violation of this Act or of a regulation promulgated hereunder shall have a right of action in the circuit court and may recover for each violation:

1) Against any person who negligently violates a provision of this Act or the regulations promulgated hereunder, liquidated damages of $1000 or actual damages, whichever is greater.

2) Against any person who intentionally or recklessly violates a provision of this Act or the regulations promulgated hereunder, liquidated damages of $5000 or
actual damages, whichever is greater.

(3) Reasonable attorney fees.

(4) Such other relief, including an injunction, as the court may deem appropriate.

Sec. 14. [Recovery of Damages Under Department Rules] — Nothing in this Act shall be construed to impose civil liability or criminal sanction for disclosure of a test result in accordance with any reporting requirement of the Department for a diagnosed case of HIV infection, AIDS or a related condition.

Sec. 15.1 [Health Insurers Excepted] — Sections 1 through 15 of this Act shall not apply to a health maintenance organization, nor to any insurance company, fraternal benefit society, or other insurer regulated under the “Illinois Insurance Code”, approved June 29, 1937, as amended.

Sec. 16. [Promulgation of Rules] — The Department shall promulgate rules and regulations concerning implementation and enforcement of this Act. The rules and regulations promulgated by the Department pursuant to this Act may include procedures for taking appropriate action with regard to health care facilities or health care providers which violate this Act or the regulations promulgated hereunder. The provisions of The Illinois Administrative Procedure Act shall apply to all administrative rules and procedures of the Department pursuant to this Act, except that in case of conflict between The Illinois Administrative Procedure Act and this Act, the provisions of this Act shall control.
GOVERNMENT POLICY AND LEGISLATIVE INITIATIVES ON AIDS

Mr Bill Dillon MP
Chairman of the Justice and Law Reform Select Committee

Introduction

I have been invited to discuss the legislative and policy initiatives being taken by the Government to control the spread of HIV infection. Let me begin by providing some background. The first case of AIDS in New Zealand was reported in 1984. Now a total of 126 people with AIDS has been reported. Half of these people are known to have died, most of whom were between the ages of 20 to 50. The tragedy of this epidemic is the loss to society of the talents and energies of people during the most productive phase of their lives. The prevalence of AIDS in New Zealand appears to be similar to the United Kingdom and parts of Australia. Although most people with AIDS in New Zealand at present are gay men, HIV infection has been reported amongst intravenous drug users and heterosexuals. Some transmission of HIV infection via blood transfusion and blood products occurred before blood-donor screening was introduced three and a half years ago. So far, no instances of mothers passing the infection on to their babies has been reported. The full extent of HIV infection in New Zealand, or indeed anywhere in the world, is unknown. There is only limited data from AIDS testing. So far, more than 400 of us have the HIV antibodies. And this number does not include those of us who may be infected, but have not been tested. The spread of AIDS is kept under review by an AIDS Epidemiological Group. This group is supported by the Medical Research Council and the Department of Health and is based at the University of Otago Medical School. In addition to routine surveillance, the group is involved in collaborative studies of HIV infection in New Zealand.

The Government Response

I would now like to focus on the Government’s response to the challenge of HIV infection and AIDS in New Zealand. Plagues are not new in human history. We have learned from both our failures and successes. We have failed when we have blamed the spread of past infections on groups such as prostitutes or the poor. Racism, sexism and xenophobia provide no answers. However, a notable success was achieved with our troops fighting in the First World War. The use of physical prophylaxis severely curtailed the spread of venereal disease. Our allies took note and followed suit. Our geographic isolation has also given us some time to gauge the responses of other governments to the problems of AIDS. We have learned from their mistakes. In many other countries, notably in North America and Africa, AIDS
took governments and health care systems by surprise. In New Zealand we have been fortunate in that we had a bit of lead time to plan our response before the first instances of people with AIDS and HIV infection were reported. The Government has responded rapidly, appropriately and with innovation. We have balanced individual rights and liberties with our duty to protect public health.

1 Blood Screening
The protection of the blood supply was our first priority. Screening of all donated blood at blood transfusion centres began in October 1985. Donors with HIV infection and those who may have engaged in high risk behaviours have been discouraged from giving blood for several years. Surveys show there has been excellent co-operation from the homosexual community. To date one person has developed AIDS and 13 have developed HIV antibodies as a result of transfusions before the current donor screening programmes were introduced. It is possible that more cases of AIDS may occur among those who received transfusions before the advent of blood donor screening. The Accident Compensation Corporation has awarded compensation to at least six people who acquired HIV from blood transfusions. The claimants were mostly haemophiliacs who received infected blood from Australia before blood screening was introduced. Compensation was paid on the grounds of medical misadventure.

2 Needle Exchange Scheme
The Government acted promptly on the advice of the AIDS Advisory Committee, which presented two major reports to the Minister of Health. Its recommendations were:
- to establish AIDS outpatient clinics;
- education/prevention programmes focused on high risk activities rather than high risk groups; and
- to introduce a needle exchange scheme.

The Needles and Syringes Exchange Scheme is one example of New Zealand’s realistic and innovative approach to curbing the spread of the epidemic. The sharing of HIV-infected needles and syringes is a highly effective means of transmitting the virus. Also, because intravenous drug use is illegal and carries a social stigma, intravenous drug users may not disclose their activities to sexual partners. The risks of intravenous drug users spreading HIV to the wider community via sexual activity or sharing drug-injecting equipment is very significant. With these factors in mind, the Government introduced the Misuse of Drugs Amendment Act which legalised the possession of approved needles and syringes. The Needles and Syringes Exchange Scheme is the first nationwide scheme of its kind in the world. The objectives of the scheme are:
- to provide all intravenous drug users with easy access to suitable needles and syringes at an affordable price;
To encourage the return of used needles and syringes and to dispose of them safely; and

To convey basic health messages to intravenous drug users and to direct them to counselling agencies.

Co-operation has been excellent so far, and there are more than 120 outlets in New Zealand where needles and syringes can be exchanged or sold. The scheme is being monitored and evaluated.

Continuing Education to Prevent Further Infection

For the past five years, the Government has spent a lot of money on AIDS prevention and control. The Health Department has conducted a series of multi-media AIDS education campaigns. Also, an extensive support network has been developed at the local level by the Department's health development units, area health boards and other agencies. The campaigns have been aimed at informing us all about AIDS. The goal is to change attitudes, to persuade people to adopt safer sexual practices and to be supportive of those already infected.

1 Education by Non-Government Organisations

The Health Department also provides funding for those people whose activity puts them most at risk. It contracts appropriate groups to educate those people to take preventative measures. The New Zealand AIDS Foundation is one of these groups. It is the main non-government organisation involved in AIDS-related activities, particularly for gay and bisexual men. Its broad role includes:

— education for prevention;
— providing anonymous and confidential antibody testing; and
— counselling and support for people with HIV infection and AIDS and those who fear that they are infected.

The Department also funds community-based intravenous drug outreach workers in Auckland, Palmerston North, and Christchurch. Their aim is to advise the intravenous drug using population on ways to reduce the spread of HIV infection, manage their drug use and stay healthy. Examples of other groups funded by the Department include:

— the Te Roopu Tautoko Trust, which employs field workers to help Maori groups with AIDS prevention on request;
— the Haemophilia Society, which receives funding for counselling of those who have become infected with HIV by blood transfusion; and
— and the New Zealand Prostitutes Collective, which is developing AIDS-prevention projects relevant to workers in the sex industry, such as those working in massage parlours.
In addition to the above, the Justice Department has encouraged the introduction of AIDS/HIV education in prisons and the Education Department screens an AIDS awareness video in all secondary schools.

2 National Strategy
We are also working on a comprehensive network of national strategies to prevent and manage HIV infection and AIDS. The Chief Health Officer and the AIDS Task Force focus this network. The Task Force provides the basis for an effective team approach to AIDS/HIV prevention strategies. The AIDS Advisory Committee has been replaced by the National Council on AIDS, a more broadly representative body. This Council is responsible for advising the Minister and the Health Department on the scientific, social, legal and ethical issues involved in HIV and AIDS control. Earlier this week the Council sponsored a national AIDS conference at which the Council presented a discussion document, “The AIDS Epidemic: Toward a New Zealand Strategy”.

Submissions from interested groups and individuals are being sought over the next two months. The final strategy is to be presented to the Minister of Health in November.

3 Global Strategy
The Department of Health maintains links with other Government agencies in New Zealand and overseas, particularly the Australian health services and the World Health Organisation. The World Health Organisation Global AIDS Strategy emphasises the need to protect the rights and dignity of HIV-infected persons. It has produced a number of consensus statements on difficult social and ethical issues concerning HIV prevention. New Zealand participates in the Global Programme on AIDS at both international and regional levels. We have sent a number of people with expertise to help countries in the region develop their AIDS programmes. Last year we made a special contribution of half a million dollars to the Global Programme on AIDS in addition to our usual contribution to the World Health Organisation.

Dilemmas
The AIDS epidemic has raised unparalleled legal, medical, social, economic and ethical dilemmas. AIDS has challenged everyone’s perceptions of themselves and others, particularly those groups which are stigmatised by society. Some may still regard AIDS as a justifiable outcome of the “immoral” behaviour of homosexual men and intravenous drug users. HIV infection and AIDS in these groups is seen as self-inflicted. By way of contrast, the haemophiliac or child who becomes infected with the virus is viewed as an “innocent victim”. We must ensure that discrimination is not tolerated and that individual rights are respected. I will briefly outline this
Discrimination

The enactment of the Homosexual Law Reform Act in 1986 amended the Crimes Act. Sex between consenting men or women in private is no longer an offence provided both parties are aged 16 or older. This Act has made the homosexual community much more open to education efforts to prevent HIV. It has also allowed official agencies like the Health Department to work with organisations based in the homosexual community. However, this amendment does not provide legal protection from discrimination against people infected with HIV. Cases of discrimination are known to occur in employment, housing and access to other goods and services. HIV infected individuals currently lack any legal means of redress. The Human Rights Commission believes that the failure to include discrimination on the grounds of disability is an important deficiency in the present anti-discrimination provisions of the Human Rights Commission Act. The Government is presently considering its response.

Antibody Testing

Antibody testing is a highly sensitive issue. Diagnostic tests have been made available through laboratories, on request from general practitioners, hospital staff, and venereologists, and through staff at the New Zealand AIDS Foundation clinics, drug clinics and Family Planning Clinics. The Government accepts that the following principles should apply to HIV antibody testing:

- the test should be voluntary and with informed consent;
- pre- and post-test counselling is essential;
- laboratory request forms should be anonymous;
- records should be confidential; and
- the results should be given face to face (not by telephone).

We remain convinced that public education is the only means to limit the spread of HIV. Antibody testing alone cannot limit the spread of the infection. Compulsory HIV antibody screening programmes for the general public is vigorously opposed by both this Government and the World Health Organisation. Mass screening is an expensive and ethically chilling option. It accomplishes nothing while diverting resources which could be better spent on education and prevention of the spread of HIV infection. The opinion polls show that the public is quick to call for compulsory screening of sectors of the population which it considers to be at risk. This view does not recognise the implications of compulsory testing. Either way, it will be interesting to observe the Bulgarian government carry out its proposed 8.7 million tests. The fact is that most coercive and restrictive measures have little impact on the spread of HIV. Coercive testing alone will not prevent people from acting inappropriately. We do not want AIDS to become a law and order issue. AIDS is a health issue.
3 **Insurance Companies**

Antibody testing is also an issue for insurance companies. The life insurance industry believes it is obliged to differentiate between groups of risks. This ensures that policy holders who are not at risk do not have to pay unacceptably high premiums and protects insurance funds from financial difficulties. They argue that it is legitimate to try to identify, and if necessary, refuse to insure people at risk of contracting HIV. The New Zealand Life Offices Association has recently issued a voluntary “AIDS Code of Practice” for life insurance. The code emphasises the *activity* and not the sexual orientation, or lifestyle, of a person. The code recommends that applicants whose activities place them at risk of contracting HIV be requested to give informed consent to take an HIV antibody test. Confidentiality of records is also stressed. The Association is prepared to investigate claims of unfair discrimination.

4 **Prisoners**

Antibody testing of specific groups perceived to be highly at risk is an issue which is not easily resolved. Prison inmates provide an illustration. Prevention of the transmission of HIV poses particular challenges to managers of penal institutions. The Government has a three-pronged approach at present:

First, the Health and Justice Departments are conducting a prison survey to obtain basic data on knowledge, attitudes and behaviours which could influence the spread of HIV infection. The results will be used to plan and implement prevention strategies.

Second, special sessions on HIV and AIDS for all prison officers are part of staff education programmes. HIV infection guidelines have been disseminated to each institution along with a very good training video.

Third, inmates are offered health education on a voluntary basis, which includes information about HIV as well as other sexually transmitted diseases and Hepatitis B. Prisoners are informed about the needle exchange scheme which operates outside prisons and the techniques of cleaning drug injecting equipment.

HIV antibody testing is at present available to inmates on a voluntary basis. However, because there is a high turnover of prison inmates and they live in close proximity to intravenous drug users and homosexual activity, the safety of both inmates and staff has to be considered. Therefore, the Justice Department proposes to provide for the testing of inmates whose behaviour is considered to place them at high risk of HIV infection. In the Law Reform (Miscellaneous Provisions) Bill, now before the Justice and Law Reform Select Committee, there is an amendment to the Penal Institutions Act 1954. It provides for a prison medical officer to ensure an inmate undergoes an antibody test where the officer considers it desirable, “having regard to the personal circumstances of the inmate”. If the inmate refuses to submit to a test, he or she may be dealt with administratively —

(a) as if he or she was suffering from AIDS, in any case where, in the opinion of the medical officer, the inmate is displaying symptoms of AIDS; or
(b) as if he or she were carrying HIV antibodies, in any other case. This amendment does not provide for compulsory testing. An inmate may refuse to undergo blood tests. Furthermore, it is not intended that this power be used for the blanket testing of the inmate population. The Government believes that prisoners should be treated in a manner similar to other members of the community. Prisoners should not be subjected to any discriminatory practice relating to HIV infection and AIDS, such as involuntary testing, segregation and isolation, except where that is required for the prisoner’s own wellbeing. It is in the interests of us all that inmates have the right to:

- educational programmes designed to minimize the spread of the disease;
- antibody testing on request;
- health care services; and
- information on treatment programmes.

5 Contact Tracing

Other legal and ethical dilemmas include contact tracing and physician-patient confidentiality. Although partner notification has the potential to help prevent HIV transmission, it also has the potential to produce individual and social harm and detract from other AIDS prevention and control activities. Partner notification is acceptable only if:

- the human rights and dignity of the partners and the “index person” are respected;
- partner notification is voluntary, not coercive;
- partner notification is confidential;
- a balanced part of a comprehensive AIDS prevention and control programme;
- undertaken only when appropriate support services are available to index persons and partners.

The Government accepts that tracing should neither be coercive nor statute-based.

6 Physician-Patient Confidentiality

The issue of confidentiality between physician and patient is an ethical dilemma which legislation can only imperfectly address. If a person with HIV is unwilling to inform sexual partners of the risk of infection, are doctors free, or required, to inform unsuspecting sexual partners? I believe the following excerpt from *Duncan v Medical Disciplinary Committee* [1986] 1 NZLR 513 provides some guidance to medical practitioners who are faced with this dilemma. Jeffries J said (at 521):

> There may be occasions, they are fortunately rare, when a doctor receives information involving a patient that another's life is immediately endangered and urgent action is required. The doctor must then exercise his professional judgment based upon the circumstances, and if he fairly and reasonably believes such a danger exists then he must act unhesitatingly to prevent injury or loss of life even if there is to be a breach in confidentiality.
Conclusion
Education is our best strategy for the prevention of HIV infection. Irrespective of what governments can do, it is up to individuals to change their behaviour, particularly their sexual behaviour. The term “high risk group” is an anachronism. Instead, we are focusing on high risk activities. What matters is not what you are— but what you do. We believe that co-operation with the people most affected by the disease is far more effective than ostracising, quarantining or punishing them. Our policies include, rather than exclude, the victims and those at risk. The World Health Organisation has described the AIDS epidemic as a world health problem of extraordinary scale and extreme urgency which represents an unprecedented challenge to the public health services of the world. I have outlined the Government’s response to this challenge. We will continue to respond in order to reduce the spread of HIV, the illness and deaths associated with HIV and AIDS, and to provide a supportive social environment for those who are infected.
THE LEGAL AND PUBLIC POLICY IMPLICATIONS OF
HUMAN IMMUNODEFICIENCY VIRUS ANTIBODY
TESTING IN NEW ZEALAND

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Statements in this document are those of the author and do not represent the views or policies of any government or private body or institution.
I INTRODUCTION

AIDS, the emotive acronym for Acquired Immune Deficiency Syndrome, is now commonly acknowledged to be a global pandemic. It is increasingly the case that AIDS is being perceived not merely as a medical and public health issue but as having economic and civil rights aspects as well. Legislators and public policymakers of many countries are grappling to strike the right balance between the community’s interest in health through control of the spread of the disease and the individual’s interest in personal freedom and privacy.1 Balancing these interests in the context of AIDS is particularly difficult as each interest is so fundamental.

As AIDS and Human Immunodeficiency Virus (hereafter referred to as “HIV”) infection have now reached the shores of New Zealand, the author considered it a favourable time to produce this discussion paper which is intended to help provide New Zealanders with a framework within which fair and balanced decisions on HIV antibody testing can be developed. AIDS cuts across a number of legal fields including criminal law, tort law, constitutional and human rights law, family law, employment law, insurance law and public health law. The present paper sets out to reach tentative recommendations on who might be tested, on what basis, and the extent to which AIDS-related policies should receive a statutory underpinning. These recommendations are based upon current medical knowledge (as understood by a lawyer) and may need to be modified as new medical and scientific knowledge emerges.

II HIV INFECTION AND ANTIBODY TESTING

1 The Nature of HIV Infection

In order to better understand the legal and public policy implications of AIDS, one needs to know something about its medical history and prognosis. The disease itself was first identified in 1981. As a mark of the rapid worldwide spread of AIDS and concomitant concern, the World Health Organisation, a specialised agency of the United Nations, has recently established the Special Programme on AIDS which has been active in supporting national AIDS prevention programmes. The ubiquitous and fatal qualities of AIDS, combined with the absence of any prospect for an immediate cure or preventive vaccine,2 make it a particularly frightening pandemic.

AIDS is caused by a virus known as HIV or HTLV-III (Human T-lymphotropic...
Virus Type III. All persons exposed to the AIDS virus fall into one of the following three categories:

(i) AIDS

AIDS impairs the proper functioning of the body's immune system, leaving the victim unable to combat infection. As a result, persons with AIDS are susceptible to illnesses which do not usually affect those with normally functioning immune systems. These illnesses are often referred to as "opportunistic" infections. The opportunistic infections most commonly found in AIDS victims are Kaposi's Sarcoma, a form of skin cancer, and a severe, atypical form of pneumonia called Pneumocystis Carinii Pneumonia. AIDS is usually accompanied by persistent swelling of the lymph glands, persistent fatigue, a succession of recurring infections such as colds or influenza, frequent fevers and night sweats, weight loss, and/or persistent diarrhoea. Death usually occurs within two to three years of diagnosis.

As a conservative estimate, between five percent and twenty percent of individuals infected with HIV will develop AIDS. As of early 1987, AIDS had struck over 30,000 Americans and killed over 17,000 and is projected to cause over 50,000 deaths each year in the United States by 1991. The US Public Health Service estimates that 270,000 Americans will develop AIDS by the same year. Researchers believe that at least 50,000 people have already died of AIDS in Africa. As of mid-May 1987, 108 countries from all regions had notified the World Health Organisation of a total of 49,329 AIDS cases.

(ii) AIDS-Related Complex (ARC)

Approximately twenty to thirty percent of those individuals infected with HIV will develop ARC, a syndrome characterised by a weakened immune system and much the same symptoms described above which accompany "full blown" AIDS. Although a milder form of AIDS in the sense that infected individuals do not develop

3 Physicians at the New Jersey University of Medicine and Dentistry recently reported the first case in the US of infection by a second deadly AIDS virus, HIV-2: Time, 8 February 1988, 45.
5 Landesman, Ginzburg and Weiss, Special Report: The AIDS Epidemic, 312 New Eng Med 521-525 (No8 1985). More recently, US experts have estimated that twenty to thirty percent of infected persons will develop AIDS or AIDS symptoms within five years of exposure, and the proportion appears to rise sharply thereafter (New York Times, 8 June 1987, C14) possibly to at least fifty percent (Time, 16 February 1987, 40).
6 Time, 16 February 1987, 37.
8 Time, 16 February 1987, 46.
10 Landesman et al, op cit.
life-threatening illnesses in the short-term, ARC can make common illnesses much more severe. ARC is sometimes referred to as “pre-AIDS” since some ARC patients go on to develop AIDS.

(iii) HIV Infection

This is the third and least serious level of diagnosis. Fifty percent or more of those individuals infected with HIV will be entirely asymptomatic with no clinical evidence of AIDS. Many such individuals will be unaware of their condition and may carry HIV and transmit it to others for years before developing symptoms. Even asymptomatic HIV carriers are generally presumed capable of transmitting HIV and, once acquired, it is believed HIV will remain in the body for life. The Atlanta, Georgia-based Centers for Disease Control (hereafter referred to as “CDC”), the main US federal agency charged with tracking the spread of epidemics, has estimated that, as of early 1987, over one million Americans had been infected with HIV. World Health Organisation officials have estimated that between five million and ten million people around the world carry HIV, and that as many as 100 million will become infected during the next ten years.

2 Modes of HIV Transmission

There is as yet no evidence to suggest that HIV is transmitted by casual daily contact at home, at work, in public places and so forth. Unfortunately, much of the public has overlooked or is unaware of this fact. The resultant fear which is the source of many problems concerning AIDS must be countered by a cautious approach in dealing with the crisis. Compared with other infectious diseases, HIV is relatively difficult to transmit and this quality must be borne in mind from the legal and policy standpoint.

Although HIV has been found in blood, semen, vaginal secretions, saliva, tears, urine and faeces, blood and semen are probably the only infectious fluids. The methods of transmitting HIV are:

(i) penetrative sexual intercourse and exchange of semen or blood between men or between a man and a woman, one of whom is infected;16

11 Idem.
12 Time, 16 February 1987, 37.
13 Ibid, 40.
16 Artificial insemination using infected semen is related to this method of transmission.
(ii) the exchange of infected blood by the sharing of improperly cleansed injection needles and syringes between intravenous drug users;

(iii) the transfusion of infected blood or blood products;\textsuperscript{17}

(iv) the transplantation of infected tissues or organs;

(v) from an infected mother to her baby before or during birth through transplacental contact, and possibly by breast-feeding;\textsuperscript{18}

(vi) the exposure of broken skin or mucous membranes to infected blood.\textsuperscript{19}

3 Who is at Risk?

While in Africa and Haiti, AIDS has primarily afflicted heterosexuals with no history of intravenous drug use, homosexual and bisexual men and intravenous drug users account for ninety-one percent of AIDS cases in the United States, with heterosexual intercourse accounting for a mere four percent.\textsuperscript{20} Thus far, in most developed countries, heterosexual HIV transmission accounts for only a small percentage of AIDS cases.\textsuperscript{21} The heterosexual community is increasingly threatened, however, by intravenous drug users and bisexuals as vectors for spreading HIV. In the United States, for example, the percentage of cases resulting from heterosexual transmission is expected to more than double to nine percent by 1991.\textsuperscript{23}

Other individuals at risk of contracting HIV infection include prostitutes and their clients, children born to an infected mother, the sexual partners of infected individuals, and haemophiliacs receiving transfusions of blood or blood clotting products and other transfusion recipients.\textsuperscript{24}

4 HIV Antibody Tests

The two main commercially available HIV antibody blood tests, the enzyme-linked immunosorbent assay (hereafter referred to as the ELISA test) and the Western blot test, have been developed to screen blood donors as well as to identify carriers diagnostically.\textsuperscript{25} These tests detect the presence in blood of antibodies specific to

\textsuperscript{17} This method of HIV transmission has now been largely controlled by the introduction of effective blood tests and administrative procedures designed to screen donors and their blood.

\textsuperscript{18} Otherwise, HIV transmission within the family is virtually unknown where no sexual relationship has existed.

\textsuperscript{19} Recently in the US, three health care workers were found to be infected and their exposure was attributed to their work where skin or mucous membranes were accidentally contaminated with infected blood. Such instances of infection remain rare however.

\textsuperscript{20} New York Times, 11 May 1987, B5 (Federal health officials’ estimates).

\textsuperscript{21} Time, 25 May 1987, 54.

\textsuperscript{22} Time, 8 June 1987, 21.

\textsuperscript{23} Newsweek, 24 November 1986, 31.

\textsuperscript{24} But see n 17 above concerning the latter group.

\textsuperscript{25} These two tests have also been used for research and surveillance purposes. The tests have only recently been developed, the ELISA having become available for the purpose of screening donated blood in March, 1985.
HIV, the virus which is thought to cause AIDS. The presence of these antibodies infers infection of the body by HIV. A true positive test result means that an individual has been infected by HIV and has developed antibodies to it. Scientists assume that those who test positive are still carrying HIV and are capable of transmitting it. American medical experts have stated that a positive ELISA test result once confirmed by a second ELISA test and by a Western blot test is more than ninety-nine percent accurate.

Any decision to implement widespread HIV antibody testing, however, must acknowledge the shortcomings of the tests currently utilised. The tests do not directly detect the presence of HIV and, in respect of AIDS itself, they are of no prognostic value since they can neither directly detect HIV-related illness nor predict who will succumb to AIDS. The tests also yield "false positive" and "false negative" results. Some individuals will test positive when, in fact, they have not been infected by HIV; others will test negative even though they have in fact been infected by HIV. The tests will identify most, but not all, HIV carriers. While the tests taken in conjunction are extremely accurate, they are far from perfect. Although these false results represent a small percentage of all testing results, their implications are serious both from an individual and legal standpoint.

Negative test results can pose particular problems. A small but significant percentage of individuals exposed to HIV fail to produce antibodies. Other individuals exposed to HIV may not show antibodies since HIV takes a prolonged period of time to provoke antibody production. Thus, early in the course of HIV exposure, antibodies will not be present and negative results will be misleading. The duration between HIV exposure and detectable antibody presence is not precisely known and estimates vary. In any event, HIV carriers will be falsely reassured and preventive measures may be impeded. According to one recent study, the number of false negative test results increases dramatically when a population with a high preva-

26 Antibodies are substances the blood produces to defend against invading micro-organisms. In the AIDS context, the antibodies are largely ineffective in destroying HIV.
27 New York Times, 21 January 1986, B4. The more expensive, sophisticated and time-consuming confirmatory Western blot test is generally regarded as more accurate and specific.
28 This has been estimated to be as high as five percent: see the interim working paper "Human Immunodeficiency Virus Antibody Testing in Canada" (24 August 1987) prepared by Dr M Somerville and Dr N Gilmore for consideration by the National Advisory Committee on AIDS of Health and Welfare Canada (hereafter referred to as "Canadian Working Paper") at 14.
29 Estimates include two weeks to three months after exposure: US Dept of Health and Human Services, Surgeon General's Report on AIDS 10 (1986); six days to eight weeks: Cooper, Gold and Maclean "Acute AIDS Retrovirus Infection" [1985] LANCET 537, 537-540; and in some cases as long as three to six months: Canadian Working Paper at 13.
The rate of false positive results also appears to vary with the prevalence of infection in the population being tested. When persons who are not at high risk for HIV infection are tested, the proportion of false positive results increases. The same study has confirmed this to be the case, although greater accuracy can be expected from persons at higher risk.

5 The Merits and Demerits of Coercive and Voluntary Antibody Testing

A CLASSES OF ANTIBODY TESTING

(i) Voluntary Testing:
Testing is done only with the informed consent of the individual, and does not fall into any other class of testing.

(ii) Routine Testing:
Testing is normally required of an individual unless he or she has a specific, cogent and bona fide objection. In that event, the individual can avoid testing.

(iii) Mandatory Testing:
Testing is either a necessary prerequisite for an individual to obtain a specified status, benefit, service or access to a given situation, or is a consequence of being provided with one or more of these. The individual cannot avoid testing unless he or she is prepared to forego the benefit etc.

(iv) Compulsory Testing:
Testing is required either by law or by policy, and the individual cannot legally avoid, or has no choice to refuse, testing.

In terms of a continuum, then, the coercive nature of testing increases as one proceeds from voluntary testing through to compulsory testing.

31 When ELISA and Western blot testing is performed on a population of 100,000 individuals with a thirty percent infection rate, 1,980 individuals will be falsely labelled negative when in fact they are infected. This compares with only two false negative results when the same population but with only a .03 percent infection rate (i.e., only thirty infected individuals per 100,000) is tested: idem.


33 Above, n 30. When ELISA and Western blot testing is performed on a population of 100,000 individuals with a mere .03 percent infection rate (i.e., only thirty infected individuals per 100,000), eleven false positive results will be yielded compared with twenty-eight true positive results (with two false negative test results). This compares with only eight false positive results and 28,080 true positive results (with 1,980 false negatives) when the same population but with a much higher thirty percent infection rate is tested: idem.

34 According to Dr James Allen of the Centers for Disease Control, "When ELISA is administered to someone in one of the high-risk groups, it is more than 99 percent accurate." New York Times, 17 May 1987, Pt IV, 26.

35 Adapted from the Canadian Working Paper at 36.
As the AIDS death toll continues to mount, more and more jurisdictions are turning either to compulsory testing or mandatory testing for certain groups perceived to be at high risk of contracting HIV and AIDS. In the United States, various state and local officials have begun to agitate for widespread mandatory and even compulsory testing. The US Defence and State Departments have already commenced mandatory workplace testing and, in his first speech devoted exclusively to AIDS, President Reagan called for mandatory tests of selected groups. Nevertheless, antibody testing, especially where an element of coercion is involved, is a complex and sensitive issue and should not be undertaken lightly or indiscriminately. The author shares the concern of the World Health Organisation that "while screening for HIV may appear a relatively simple approach to some of the complex problems associated with AIDS and HIV infection, in fact screening for HIV is extraordinarily complex from an epidemiological, economic, legal, logistic, political and ethical perspective."

The main arguments put forward to support antibody testing in general are:

(i) There is an urgent need to collect and analyse testing data to improve our understanding of AIDS and HIV infection and transmission. Surveillance and research activities based thereon will better enable us to measure the prevalence of AIDS and to monitor how and where HIV is spreading.

(ii) Information obtained from testing can contribute to the control of HIV transmission. This can be achieved in at least two ways. First, HIV antibodies can be detected in blood, organs, tissues and semen thereby preventing potentially dangerous transfusions, transplantations and conceptions. Sec-
ondly, it is argued that neither testing nor education by themselves will halt the spread of HIV. Testing is argued to be an indispensable adjunct to education when aimed at altering patterns of "unsafe behaviour". Although no definitive studies have been published on the effects of testing on behaviour modification in halting HIV spread, it is argued that "A test result can sometimes change behaviour in a way generalized warnings might not." Dr James O Mason, Director of the Centers for Disease Control, has stated that "the primary public health purpose" of testing and counselling is "to induce behavioural changes that minimize" the risk of HIV transmission. Testing helps to protect uninfected individuals by identifying HIV carriers so that the latter will not continue to spread HIV unwittingly.

(iii) Although no cure exists for HIV infection, it is argued that testing can lead to the provision of at least some treatment, education and counselling for HIV carriers at an earlier stage.

D COERCIVE TESTING

A number of public opinion polls conducted in the United States in mid-1987 revealed that the majority of the general public favoured mandatory or compulsory testing, particularly of those individuals in high-risk groups. Proponents of widespread coercive testing cite the pressing need for more detailed and reliable data on the extent to which HIV has spread. Nevertheless, there are at least four persuasive arguments that oppose coercive testing, particularly when it is proposed to be done on a widespread basis:

(i) Ineffectiveness as a public health measure:
At a major conference on antibody testing convened by the US Centers for Disease Control at Atlanta, Georgia in February, 1987 (hereafter referred to as the "Atlanta Conference"), the 800 or so state and local health officials were almost unanimously opposed to either widespread coercive testing or coercive testing of any group, reasoning that, inter alia, such testing would fail as a public health measure and would be unlikely to detect many more cases. Widespread coercive testing is appropriate only when it provides access to a cure, as in the case of tuberculosis. In the absence of a cure for HIV

41 H Dowling, Wisconsin Department of Health and Social Services AIDS Project, quoted in P Reidinger "A Question of Balance: Policing the AIDS Epidemic" ABA Journal (1 June 1987) 69, at 72. The authors of the Canadian Working Paper also acknowledge the possibility that test results may motivate or convince individuals to avoid unsafe behaviour.


44 Opponents of such testing argue that random testing is preferable to the questionable testing of unrepresentative groups which widespread coercive testing would entail. Dr James O Mason, Director of the US Centers for Disease Control, maintains that widespread coercive testing is not justified by current knowledge of how HIV is spreading: New York Times, 11 May 1987, A1, B5.
infection, it is not appropriate. Dr Stephen Joseph, New York City’s Health Commissioner, opposed any type of mandatory testing, citing the inability of such testing to stem the spread of syphilis until treatment was available. Physicians of the United States Veterans’ Administration also question the efficacy of widespread coercive testing in curtailing the spread of HIV infection. It is argued that such testing is not necessary since HIV is not spread by casual contact and, indeed, is relatively difficult to spread compared with other infectious diseases. Unless repeated frequently and systematically, widespread coercive testing would fail to record accurately seroprevalence trends, since a negative result can be rendered meaningless where the individual tested engages in a high risk activity afterwards. Moreover, the shortcomings of any type of antibody testing, whether coercive or voluntary, including the delay between HIV exposure and antibody production and the prospect of false positive results, are particularly acute in the context of widespread coercive testing. Such testing of the general population, where the incidence of AIDS and HIV infection is still relatively minimal, would result in a larger number and proportion of false positives.

(ii) Coercive testing would drive potential HIV carriers underground:
Men who have sex with other men and intravenous drug users, the people currently most at risk of HIV infection, already live at the edge of social tolerance and their cooperation in changing their own behaviour is critical in retarding HIV spread. Coercive testing is perceived by many public health officials and civil rights advocates as the surest way to discourage the very persons most in need of testing and counselling from seeking them. This was the main concern behind the Atlanta Conference delegates’ virtual unanimous rejection of coercive testing. Senior officials of the US Public Health Service and Surgeon General C Everett Koop also consider coercive testing inappropriate in view of the considerable risks of discrimination and social stigmatisation inherent in such testing and the consequent “chilling” effect on potential HIV carriers who might otherwise come forward.

45 Time, 2 March 1987, 44.
47 See Section II.4 above.
Widespread coercive testing is not cost effective:
Various health officials and politicians maintain that widespread coercive testing is not the best use of resources and, as such, would be disproportionately costly to the public health advantages secured. This concern is founded not only upon the reasons for the alleged ineffectiveness of coercive antibody testing as a public health measure, but on the significant direct and indirect costs of such testing as well. These costs include the costs associated with testing and counselling, record-keeping, support services, loss of employment and consequent loss of revenue and productivity, and loss of insurance and housing, possibly leading to the creation of a class of individuals dependent upon society for their welfare. These considerations have prompted a call for more closely targeted testing which represents, it is argued, a less scattered and more focused use of health care resources.

Coercive testing is unduly costly in human terms:
Coercive testing denies to the individual being tested the opportunity to refuse and, as such, raises serious legal and ethical questions and is arguably inconsistent with the rights and freedoms enjoyed by individuals who live in a free society. A positive test result can have a devastating impact upon a person’s life in terms of emotional and psychological costs. This impact may be less in the case of voluntary testing which is founded upon the co-operative attitudes of those seeking health care and their willingness to rely on the associated counselling services. Widespread coercive testing also runs the risk of heaping unfair discrimination onto the illness and suffering of those persons with AIDS and HIV carriers who pose little or no danger of spreading HIV. A positive test result might be construed falsely as evidence that the individual belongs to a high risk group for transmission. As a Florida court has recognised, “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.”

51 Henry A Waxman, Californian Democrat, Chairman of the Subcommittee on Health and the Environment of the House of Representatives Energy and Commerce Committee, has asserted that widespread coercive testing is “the most expensive and least effective way of educating the public”: Evening Post, Wellington, New Zealand, 1 June 1987.
52 See Section II.5.D. (i) above.
53 A recent US Centers for Disease Control study found that testing and counselling cost on average U.S. $45. per person: New York Times, 3 June 1987, B8.
55 See Section II.8. below.
56 South Florida Blood Service Inc v Rasmussen, 467 So 2d 798, 802 (Fla Dist Ct App 1985). See also Section III.2. below.
Three American medical commentators recently argued that "control of the AIDS epidemic must continue to rely on voluntary measures encouraged by vigorous and widespread counselling and education." There is substantial support today amongst public policy-makers, health officials and interested organisations in the United States, the United Kingdom, Australia and Canada for the testing philosophy which this quoted statement embraces. Despite the preference of the US Government for wider routine testing and selective mandatory testing, key health officials and organisations in the US advocate voluntary testing. These include the US Surgeon General C Everett Koop, Robert E Windom, Assistant Health Secretary and Head of the US Public Health Service, the American Public Health Association, and the Trustees and House of Delegates of the American Medical Association. Dr James O Mason, Director of the US Centers for Disease Control, has called for a major increase in voluntary testing while the American Foundation for AIDS Research advocates voluntary, confidential testing accompanied by "intense counselling".

Most delegates who attended the Atlanta Conference favoured encouraging more people to undergo voluntary testing, provided that it is purely an adjunct to counselling and that confidentiality was assured. Conference discussions concentrated particularly on "targeted" testing of high risk groups and in areas of high prevalence of AIDS. Groups concerned with civil rights such as the American Civil Liberties Union favour broad access to voluntary testing, anonymously if possible, but with confidentiality ensured in any event. Indeed, on 30 July 1987, legislation having bipartisan support and providing for selective, voluntary testing was introduced in the US Congress.

Current United Kingdom policy includes free and confidential voluntary testing and counselling services through National Health Service family doctors and hospital clinics. The current voluntary testing policy of the Australian Federal Government

57 M Mills, Dr C Wofsy and Dr J Mills "AIDS: Infection control and public health law" (1916) 314 New England Journal of Medicine 931, 936.
64 Address by John Moore, Secretary of State for Social Services, to the United Nations on AIDS, 20 October 1987, at 4. Nevertheless, in what can amount to selective compulsory testing, pursuant to s35 of the Public Health (Control of Disease) Act 1984 c22, and The Public Health (Infectious Diseases) Regulations 1985, a Justice of the Peace (acting, if he deems it necessary, ex parte at the instance of health authorities) may order a person to be medically examined if satisfied that there is reason to believe that that person is suffering from AIDS or is an HIV carrier, and that it is expedient in the public interest, his/her interest, or that of his/her family that such examination take place.
is based on a general statement of principles jointly agreed to and announced on 15 July 1986 by Dr Neal Blewett, the Minister for Health and Community Services, the Chairpersons of the National Advisory Committee on AIDS and the AIDS Task Force respectively, the Presidents of the Victorian AIDS Council and the AIDS Council of New South Wales respectively, and officials of the Commonwealth Department of Health. At the time of writing, the Canadian Federal Government's position on testing was still being reviewed on an ongoing basis. Voluntary testing programmes have been operating in New Zealand for the past three years through New Zealand AIDS Foundation clinics and general practitioners.

Most of the arguments against coercive antibody testing implicitly lend their support to voluntary testing on a more selective or targeted basis. It is submitted, therefore, that voluntary testing offers a more effective and less restrictive alternative to coercive testing. By emphasising education and cooperation rather than compulsion, persons voluntarily tested are more likely to afterwards engage in behaviour modification regardless of the test results. Nevertheless, to be fully effective, voluntary testing must be accompanied by counselling and by assurances of confidentiality and guarantees against discrimination.

Consequently,

**Recommendation:** The use of coercive antibody testing is unacceptable, unless it can be clearly justified. As a general rule, voluntary antibody testing is preferable.

6 **Counselling**

All individuals at risk should be encouraged to seek confidential counselling from private physicians, sexually transmitted disease clinics and special AIDS clinics where the testing option may be raised with each person. Indeed, individuals should not be tested unless they have received appropriate counselling.

Counselling is necessary or advisable for the following reasons:

65 Subsequently, Dr Blewett announced plans to develop a national strategy for dealing with the AIDS problem, including the issue of antibody testing. At the state level, the New South Wales Privacy Committee, a body established by statute, adheres to the view that all antibody testing should be voluntary, except where the law provides to the contrary: "Privacy and AIDS: The Guidelines" Privacy Bulletin Vol 2, Pt 2 (1986) 2.

66 However, the authors of the Canadian Working Paper (at 35) conclude that as a general principle, compulsory testing is unwarranted.

67 See Section II. 5. D. above.

68 See Sections II. 6., III. 1. and III. 2. respectively.

69 See Section II. 3. above.

(i) it can educate individuals about what AIDS and HIV infection are, their symptoms, and what test results mean;
(ii) since prevention through behaviour modification is critical in controlling the spread of HIV, counsellors should explain fully to individuals the currently accepted view of the best measures available to control its spread;
(iii) it can help to alleviate the emotional and psychological stresses that may accompany testing, particularly where the test result is positive. Counselling can also help to diminish social isolation and economic dislocation which may result in some cases from testing;
(iv) it can educate individuals about what, if any, legal consequences flow from a positive test result;  
(v) the British Medical Association asserts that “With counselling, the majority of infected individuals can be persuaded voluntarily to inform their ... sexual partner(s) of their infected status.”

Recommendation: Testing should be performed only when educative counselling before and following testing are available and offered by trained health care personnel, irrespective of the test result.

7 Education

In the current circumstances, in which there is no cure or vaccine and no possibility of their development in the immediate future, laws and policies should concentrate primarily on promoting the preservation of human life through prevention of HIV transmission. Much of the AIDS crisis revolves around the personal choices which individuals should be encouraged to make after appropriate education designed to persuade them to change their behaviour. Indeed, education, as opposed to antibody testing, should be our first line of defence against AIDS, not only in view of its intrinsic merits but because it constitutes, with or without voluntary testing, a less restrictive alternative to coercive testing. Most public health officials believe that the best way to contain HIV spread is not through widespread coercive testing but through education on how to prevent HIV exposure. As two Canadian commentators have recently pointed out:

71 For example, any legal disabilities that flow from the status of an HIV carrier, such as the prohibition on donating blood, or criminal liability attaching to the act of wilfully transmitting HIV.
72 L Beecham “Support for Confidentiality for AIDS Patients” 294 British Medical Journal 1177 (2 May 1987). There has been a similar co-operative contact tracing system operating in New Zealand.
73 The authors of the Canadian Working Paper have concluded (at 15) that preventing HIV transmission is the only effective control strategy.
74 Dr Stephen Joseph, New York City’s Health Commissioner and a testing critic, states that “Our problem is not finding out who’s infected, but educating everyone about the risks.” Time, 2 March 1987, 44.
Simply informing persons that they are HIV antibody seropositive will not, alone, prevent HIV transmission. Prevention requires everyone, regardless of whether they are or are not infected, to behave safely and to avoid engaging in risk-producing activities. This does not, of itself, require HIV antibody testing.

Recent policy and practice in a number of jurisdictions confirms the perceived value of education in preventing HIV transmission. As the death toll from AIDS continues to mount in the United States, policy-makers and health care officials are turning more vigorously and desperately to educational measures to curb HIV spread. The US Surgeon General C Everett Koop is a leading advocate of the view that sex education is the most effective way to contain AIDS, arguing that candour and condoms are more effective public-health tools than chastity sermons.76 The House of Delegates of the American Medical Association recently approved several Board of Trustees' recommendations concerning the need for greater educational efforts aimed at physicians, students and the general public on the modes and prevention of transmission.77 The educational campaign has already spurred a broad awareness of AIDS throughout much of the United States and important changes in behaviour among some individuals thought to be most at risk.78 A new wrinkle to this campaign was announced recently by Assistant Health Secretary Mr Robert Windom concerning US Administration plans to follow a United Kingdom Government precedent by mailing a brochure on AIDS prevention to every household in the country.79

The United Kingdom Government has also recognised that in the absence of medical defences against AIDS, the influencing of personal behaviour through public education is the main weapon in the fight to limit its spread. Accordingly, the UK Government committed $US 33 million in November, 1986 to a mass media campaign to raise public awareness about AIDS and safe behaviour and particularly to dispel myths about the modes of transmission. The campaign also included the distribution of a leaflet to all 23.5 million households in the United Kingdom.80

The Australian Federal Government and interested organisations such as the Australian National Advisory Committee on AIDS have also acknowledged that

76 Time, 8 June 1987, 22.
78 New York Times, 19 March 1987, A1. The most urgent target of the US prevention campaign, according to many US health officials, is the intravenous drug abusers who have lagged behind male homosexuals in organising themselves, and who are regarded as posing the greatest immediate threat of spreading HIV to the heterosexual population: New York Times, 19 March 1987, B10.
79 Time, 8 February 1988, 45.
80 Address by John Moore, Secretary of State for Social Services, to the United Nations on AIDS, 20 October 1987, at 3. As with any campaign aimed at changing deep-rooted patterns of behaviour, however, a long, sustained effort is anticipated by United Kingdom health authorities to be necessary.
education and information campaigns aimed at prevention are likely to be the most effective. In New Zealand, the Department of Health, the New Zealand AIDS Foundation and gay community groups have published and distributed brochures recommending safe sex particularly by the use of condoms as well as other measures to reduce the risk of being exposed to HIV. The New Zealand AIDS Foundation also sponsored the first “National AIDS Awareness Week” (19-26 September 1987) aimed at promoting safe sex particularly through condom use and greater community awareness. The Hon Justice Michael Kirby, President of the New South Wales Court of Appeal, has urged that “social policy and the law must give a high priority ... to promoting the use of the condom and to explaining ... ‘safe sex’”\(^81\) arguing that “in this time of crisis, the defence of life requires that delicate feelings must give way to the necessities of the moment”.\(^82\) The New Zealand Government has also introduced the “Needle Exchange Programme” to facilitate the exchange by drug users of used needles and syringes for clean ones at pharmacies.

**Recommendation:** Public education, especially for young persons and individuals engaging in high risk behaviour, is essential in containing the spread of HIV and should include information about the modes of HIV transmission and safe and unsafe activities, including the encouragement of safer sexual practices, *inter alia*, through the use of condoms.

### 8 Informed Consent

The general requirement of informed consent is premised on the patient’s right to exercise control over his or her body by deciding whether or not to undergo a proposed treatment. The physician’s duty to disclose relevant information to the patient is said to be based on the fiduciary nature of the physician-client relationship.\(^83\)

A number of jurisdictions have enacted laws or developed policies or practices which require the informed consent of the patient prior to antibody testing. The California Legislature has enacted Assembly Bill 403 (1985) which requires written, informed consent before testing can be administered\(^84\). Dr James O Mason, Director of the United States Centers for Disease Control, has cautioned that individuals should not be tested unless they have given explicit consent and understand that they have a right to choose not to be tested.\(^85\) The Australian Federal Govern-

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84 1985 Cal Legis Serv ch 1519 199.38. See also 1985 Wisconsin Laws Act 73 146.025.
ment’s testing policy includes the requirement of informed consent, and the New South Wales Privacy Committee, a statutory body, has urged that “valid informed consent should be obtained from the person whose blood is to be tested.”86 Conversely, the British Medical Association approved at its 1987 Annual Conference a motion that antibody testing “should be at the discretion of the patient’s doctor and should not necessarily require the [informed] consent of the patient.”87 Concern was expressed by some physicians that testing without consent could constitute an assault 88 as well as an invasion of the tested individual’s privacy. If it is a basic tenet of medical ethics that physicians do not treat patients without their consent, then antibody testing without the patient’s full knowledge and consent would also constitute a breach of medical ethics. Physicians opposing the motion argued that patients with suspected HIV infection should not be treated differently from other patients concerning medical procedures, and that informed consent should be obtained from the patient or guardian before any tests are carried out which could have adverse effects.89 Failure or refusal to obtain informed consent could also create mistrust of physicians resulting in avoidance of consultation for any purpose or concealment of information by “at risk” patients. Two British commentators maintain that there is no chance of defeating the AIDS epidemic if that trust is nonexistent.90 One of them, Professor Michael Adler, a leading AIDS specialist at the Middlesex Hospital, London, warned that “allowing potential patients to feel that they may be tested for AIDS infection without their consent will inevitably drive underground those most at risk”91 and thereby seriously undermine the United Kingdom’s efforts to contain the spread of AIDS. Furthermore, given the imperfections of the antibody tests and the often extreme implications - medical, socio-economic or otherwise - of a positive test result, fully informing patients of the risks involved is critical.92 Consequently,

**Recommendation:** Physicians, clinics and hospitals administering antibody testing should as a routine matter secure the patient’s informed consent prior to testing.93

87 The Times, 3 July 1987, 1.
88 Section 2(1) of the Crimes Act 1961 defines “Assault” as the act of intentionally applying or attempting to apply force to the person of another, directly or indirectly, or threatening by any act or gesture to apply such force to the person of another, if the person making the threat has, or causes the other to believe on reasonable grounds that he has, present ability to effect his purpose.
89 The Times, 3 July 1987, 3.
91 The Times, 3 July 1987, 24.
92 Weldon-Linne and Murphy, op cit at 207. Adler and Jeffries, op cit at 74, have attempted to refute the rationale behind testing without consent-viz. the need to protect the health of physicians, other health care personnel and their families - by arguing that the risk of health care personnel becoming infected is very small and can be countered by adopting careful procedures with all patients, that testing without consent will do little, if anything, to reduce the chances of becoming infected, and that most patients suspected of carrying HIV will consent to a test when properly counselled while those who do not consent can be treated as if they were infected.
93 Accord the Canadian Working Paper at 33.
Counselling services should be available and offered to facilitate obtaining such consent. Such services should include information describing antibody testing, its benefits and limitations, a realistic evaluation of the limitations of confidentiality guarantees, and the possible adverse effects of any release of test results and any other risks and potential testing harms. The informed consent should not be deemed part of "blanket" consent form procedures but should instead include specific reference to the antibody test and a signed acknowledgement from patients that they consent to submit to the test after having been offered counselling services. 94 All individuals tested must have access to their results and the care and counselling that their results require, and must also be given a guarantee of confidentiality of results in the absence of anonymous testing. 95

III THE IMPACT OF HIV ANTIBODY TESTING

1 Confidentiality

Personally identifiable AIDS-related information may wind up in many hands including medical offices, hospitals, clinics, blood-banks, public health agencies and private organisations offering advice and support to persons with AIDS and HIV carriers. Violations of confidentiality, many of them inadvertent, do occur resulting in the disclosure of testing information of a highly personal and intimate nature. The vulnerability of those individuals who have undergone testing to certain adverse consequences 96 underscores the importance of confidentiality in the AIDS context.

The need for confidentiality or anonymity in AIDS antibody testing has been argued on three related footings:

(i) The public interest in controlling the spread of AIDS and HIV:

So long as a vaccine and an effective treatment remain undeveloped, and a better understanding of the various modes of transmission is necessary, the need for more accurate information about HIV remains urgent to impede its further spread. Potential participants may hesitate to contribute to the information-gathering process because they fear invasions of their privacy and consequent stigmatisation and discrimination. Without strict confidentiality guarantees, members of stigmatised groups, who already experience discrimination, are not as likely to undergo

96 See below Section III. 2.
voluntary testing. Fuller participation in testing and information-gathering programmes will be encouraged by protecting potential participants against improper disclosures of sensitive AIDS-related information. This will in turn promote the success of efforts to control and cure the pandemic. US federal disease-control officials recognise the critical role of confidentiality in the development of an effective public health strategy against AIDS, concluding that "the ability ... to assure confidentiality - and the public confidence in that ability - are crucial to efforts to increase the number of persons requesting testing and counselling."  

(ii) Unauthorised possession/disclosure of personally identifiable AIDS-related information may lead to discrimination:

A general lack of understanding about the modes of HIV transmission has led to unfounded fear and over-reaction. As Justice Kirby states, "without strict and effective laws and practices to prevent the spread of the knowledge of a positive result ... the risk must be run in current conditions of anxiety and alarm, that those found positive will suffer discrimination heaped upon natural anxiety and possibly illness." Indeed, it seems unreasonable to expect individuals to respond to medical advice by seeking testing if, in so doing, they risk social isolation and economic dislocation. Anonymous testing or the confidentiality of test results would secure protection not only for individuals with "true positive" results but for the significant number of those individuals with "false positive" results as well.

(iii) Unauthorised possession/disclosure of personally identifiable AIDS-related information may constitute an invasion of privacy:

The literature on AIDS is replete with references to considerations of privacy and the notion that the release of such sensitive personal information without consent abrogates the individual right to control information about oneself. Although New Zealand law does not recognise any general right to privacy, specific rules of law and legislation do protect some aspects thereof. The trend in some overseas jurisdictions appears to be towards the fuller development of this right.

Some overseas jurisdictions have adopted the principle of confidentiality either as

97 Even individuals outside these groups are understandably reluctant to come forward for testing as society is often quick to infer from statistics illustrating the majority of AIDS victims and HIV carriers are homosexual or bisexual males that any individual with AIDS or HIV is homosexual or bisexual.


100 M D Kirby, op cit, Paper, at 14.

101 See Section II.4.
a matter of policy or as a statutory prescription. Both the United Kingdom and
Australian Federal Governments favour confidential testing as a matter of policy. At
the Australian state level, the New South Wales Privacy Committee, a statutory
body independent of government which acts as a sort of privacy ombudsman,
believes that "great emphasis must be placed on assuring complete confidentiality
to likely AIDS and 'at risk' groups. Only this will encourage the maximum number
of people likely to be affected to come forward for testing." Several American state legislatures have gone further and embodied the confidenti-
ality principle in legislation. The California Legislature has enacted legislation
which prohibits compelling the identification of any individual who has taken an
antibody test and provides civil and criminal penalties for unauthorised disclosures
of the test results to third parties. Similarly, Florida legislation provides that no
person shall be compelled to identify any individual who has taken an antibody test,
and only the test subject can consent to the disclosure of a test result. The
Wisconsin Legislature has also enacted legislation providing for the confidenti-
ality of test results. The Wisconsin statute requires informed consent for the
disclosure of any test result, imposes civil penalties for negligent disclosure and
criminal liability for intentional disclosure, and restricts permissible disclosures to
the test subject and certain other persons or agencies.

In terms of the scope of permissible disclosure, few would question the inclusion of
the test subject and his or her personal physician within the class of authorised
disclosures. However, other disclosures are more controversial when conflicts arise
between respect for confidentiality and a duty to warn others of possible risks of HIV
transmission. Some commentators argue that the traditional confidentiality of the
physician-patient relationship should be upheld in the case of persons with AIDS
and HIV carriers such that personal health data should not be disclosed to anyone for
any purpose other than the health care of that patient, unless the patient has
previously consented. Nevertheless, this traditional rule of ethics may not be
entirely appropriate in the case of a new and fatal disease such as AIDS when others,
such as spouses and other sexual contacts, are at substantial risk. Three American

102 Address by John Moore, Secretary of State for Social Services, to the United Nations on AIDS, 20
October 1987, at 4; see also n 65 above and the accompanying text.
104 At the federal level, a bill containing protections to keep testing and counselling records
confidential was introduced in Congress on 30 July 1987. Negligent unauthorised disclosure
would entail a civil fine of up to US $2,000 while wilful unauthorised disclosure would constitute
a criminal misdemeanour involving a US $10,000 fine or a year in jail.
105 1985 California Legislative Service ch 1519 s 199.35 and California Health & Safety Code s.
199.21(a)-(d) respectively.
107 1985 Wisconsin Laws Act 73 146.025.
108 L Beecham “Support for Confidentiality for AIDS Patients” (2 May 1987) 294 British Medical
Journal 1177 (British Medical Association's advice on confidentiality).
commentators argue: 109

Doctors who reasonably believe that the patient’s contacts would be jeopardized if there were no disclosure should seek the assistance of public health authorities. If that assistance is unavailable or unavailing, disclosure after careful consideration and consultation, in our view, would be morally and legally defensible.

In deference to the concern that confidentiality not be allowed to override health dangers, proposed federal legislation on AIDS introduced in the US Congress in July 1987 permitted notification of the risks involved to the spouses and sexual contacts of infected individuals. Life itself becomes the overriding consideration here.

AIDS research also presents conflicting considerations. Such research can involve the study of identifiable medical records. Some argue that the duty to protect the public health and the necessity to collect data warrants an overriding of the right to confidentiality to facilitate research into AIDS and HIV transmission. Nevertheless, the legislatures of at least three American states do not accept this argument. In Florida, test results may be disclosed during medical or epidemiologic research but without the test subject’s name or other identifying characteristics. 110 A New York law bars publication of AIDS research data in such a way that the identities of test subjects could be inferred, 111 while a California law protects against disclosure of all personally-identifiable research records unless the written consent of the research subject has been obtained beforehand. 112 It is difficult to see how these statutory requirements could unduly impede AIDS research efforts.

While government agencies and private organisations might be left free to develop their own formal procedures to guarantee confidentiality or anonymity of test results, legislation requiring anonymous or confidential testing is arguably needed for the following reasons:

(i) to help create an atmosphere conducive to voluntary participation by individuals at risk in testing, counselling and education programmes. 113 This will be achieved by denying access to AIDS-related information to those who might use it to discriminate against potential victims. 114 The information-

113 Many of these individuals would arguably be unwilling to be tested unless they were assured that strict statutory confidentiality safeguards had been set in place.
114 Leading public health officials and civil liberties advocates voiced unanimity at the Atlanta Conference on the need for strong legislation to protect those who take the AIDS test from unauthorised release of their names which could lead to discrimination.
gathering process will thereby be enhanced and thus further the research and treatment goals that underlie testing programmes.\textsuperscript{115}

(ii) to provide authoritative guidance by prescribing the permissible uses, holders and disclosures of AIDS-related information and whether or not the written consent of the test subject must be procured in any particular case.

(iii) to provide appropriate penalties designed to deter the unauthorised release of AIDS-related information.\textsuperscript{116}

In addition to, and, \textit{a fortiori}, in the absence of, legislative provisions on confidentiality, clinics and other health care institutions involved in testing should adopt clear and specific confidentiality guidelines. Anonymity has been found in the American experience to be the best guarantee of confidentiality whereby codes or numbers substitute for names or other identifying criteria for the duration of the testing process.\textsuperscript{117} This type of system has been endorsed by the New Zealand AIDS Advisory Committee and is used in New Zealand AIDS Foundation clinics. In the absence of legislation and anonymous testing, clinic or laboratory records of test results should not be released, as a general rule, without the signed consent of the test subject in order to avoid a charge of breach of confidentiality.

\textbf{Recommendation:} As a general principle, testing should only be performed when confidentiality of test results, whether positive or negative, or anonymity of testing, can be guaranteed.\textsuperscript{118} AIDS-related personal information disclosures should be limited to those which are absolutely necessary to control the spread of HIV. Accordingly, legislation should be enacted to prohibit the disclosure of identifiable test results to anyone except:\textsuperscript{119}

(i) the test subject;

(ii) the physician who required the test and other health care personnel directly responsible for treatment;

(iii) a blood bank or centre which has subjected a person to a test to determine the medical acceptability of blood or blood products secured from that person or to investigate HIV infection;

(iv) the spouse and/or sexual partners of a test subject (provided the physician who required the test is reasonably satisfied that the health of the former would be

\textsuperscript{115} Nanula, op cit, 343.

\textsuperscript{116} Dr James O Mason, Director of the US Centers for Disease Control, has urged US state governments to pass "stringent legislation" to punish the unauthorised disclosure of test results: New York Times, 11 May 1987, B5.

\textsuperscript{117} Concern about discrimination has resulted in most voluntary tests offered in the U.S.A. being done anonymously: Time, 2 March 1987, 44. New York City has expanded its anonymous testing sites recently to encourage greater voluntary participation in testing programmes.

\textsuperscript{118} Canadian Working Paper at 5 at 33.

\textsuperscript{119} The test subject should have the option of authorising in writing the disclosure of his or her test results to anyone.
threatened if no disclosure were to be made).

2 Discrimination

Discrimination in the AIDS context can occur in a wide range of areas including employment, insurance coverage, housing, education, the public and private provision of health care, transportation and other goods and services, trade union membership, and access to public places. Ostracism by family and friends and inevitable inferences regarding sexual orientation are also common byproducts of the public concern surrounding AIDS, a concern which is intensified by the belief that HIV can be spread through casual contact. In New York City alone, 314 AIDS discrimination complaints were filed in 1986. In the United States, employers have dismissed persons with AIDS and HIV carriers, persons perceived as having AIDS or HIV, and members of high-risk groups, either on their own initiative or at the request of co-workers. The New South Wales Anti-Discrimination Board has received complaints from not only those who have AIDS or HIV but from those who are assumed to have AIDS or HIV. Included in the latter category are homosexuals or persons perceived as homosexual, haemophiliacs, some ethnic minorities, and health care personnel treating such persons. The Board has received in particular numerous reports of on-the-job harassment, dismissal and attempted segregation of homosexuals and of efforts to force them to undergo tests.

Discrimination in the workplace is particularly noxious to the extent that it is based on fear through misinformation. It is difficult to discern any justification for testing on the ground of protecting others in the workplace when medical science has not established that HIV is spread by casual contact. Dismissal of employees in these circumstances will only increase the psychological and emotional harm and the risk of their becoming burdens on the public welfare system. Unless the stage of affliction of HIV carriers and AIDS sufferers impinges on their ability to satisfactorily fulfil work duties or the workplace requires participation in activities through which HIV could be transmitted, mere uneasiness by co-workers, customers and employers is insufficient to override the important rights at stake. The US Department of Health and Human Services has issued guidelines for AIDS in the workplace which discourage routine blood testing and restrictions on employees who have AIDS or HIV. Pending the enactment of appropriate anti-discrimina-

120 Time, 2 March 1987, 44.
123 Time, 25 May 1987, 60.
124 See n 15 and accompanying text.
125 Summary: Recommendations for Preventing Transmission of Infection with Human T-Lymphotrophic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace, 34 Centers for Disease Control: Morbidity and Mortality Weekly Rep 681 (15 November 1985).
tion legislation, government-sponsored education would help to quell the unfounded fears of employers and employees alike.

Several US state legislatures have passed comprehensive AIDS anti-discrimination legislation. California legislation prohibits employers from demanding that an applicant for employment or current employee submit to testing or divulge test results to determine suitability for employment. 126 Wisconsin legislation similarly prohibits employers requiring testing as a condition of employment of any employee or prospective employee and also prohibits termination of employment of a tested employee. 127 Florida legislation also prohibits testing to be used to determine suitability for employment as well as unlawful discriminatory practices against persons with AIDS by education authorities, insurers, labour organisations, and persons offering rental accommodation. 128

Recommendation: Legislation should be enacted to minimise irrational differential treatment of persons with AIDS, HIV carriers, and persons commonly perceived as falling into these categories by virtue of their belonging or allegedly belonging to certain at risk groups. 129 Pending the enactment of such legislation, government-sponsored public education programmes 130 designed to correct misconceptions concerning the modes of HIV transmission should be devised and implemented.

IV REPORTING OF AIDS AND HIV ANTIBODY RESULTS

Various jurisdictions have had to confront difficult questions concerning whether reporting should be confined to cases of AIDS itself or include as well positive HIV

126 199.21 of the Health & Safety Code, as amended by Assembly Bill No 488 of the 1985-86 Regular Session.
127 1985 Wis Laws Act 73 103.15.
128 1986 Fla Laws HB 482. At the local government level, the Los Angeles City Council unanimously passed Ordinance 160289 (19 August 1985) banning discrimination against persons with AIDS or any condition related thereto in employment, housing, medical and dental services, business establishments, city services and other public accommodations. In the employment context, discrimination in hiring, promotion and termination practices and the segregation of employees is prohibited.
129 As Justice Michael Kirby has cautioned, however, AIDS discrimination laws may not be a panacea since it is difficult to prevent discrimination happening in practice under current conditions of community alarm; discrimination laws, moreover, generally operate slowly to change community attitudes: see MD Kirby "The Five Commandments for New Legislation on AIDS", Paper delivered to the World Health Organisation Symposium on AIDS, Annecy, Switzerland, 20-21 June 1987, at 14. At the time of writing, the New Zealand Government was considering, but had not yet decided on, a Human Rights Commission recommendation that the prohibited areas of discrimination under the Human Rights Commission Act 1977 be widened to include "AIDS or AIDS related conditions or HIV virus" and "sexual orientation". See Review of the Human Rights Commission Act 1977: Report to the Minister of Justice (21 August 1987).
130 See Section II.7. above.
antibody test results, whether reporting should be performed on a "name-specific" or anonymous or confidential basis, and whether reporting should be compulsory or voluntary in nature.

The arguments put forward in support of case reporting and the information it provides include:

(i) better overall control of the spread of AIDS and HIV infection through measurement of their spread and distribution patterns;
(ii) the facilitation of discovery of a cure, vaccine and/or other preventive or treatment measures;
(iii) better planning of future health care requirements;
(iv) identification of high risk areas enabling appropriate education programmes to be implemented where most needed;
(v) where reporting is name-specific, the facilitation of adequate treatment of victims and, if such treatment is impossible or unavailable, ensuring that they are warned and, if necessary, isolated, and that their partners are identified and tested.

Reporting of cases of HIV infection and particularly of AIDS itself has become a common legal response in various overseas jurisdictions to the AIDS pandemic. In Denmark, Iceland, Norway, Sweden, France and South Korea, AIDS has been made a notifiable disease whereby physicians are legally required to notify cases to public health officials. Physicians, hospitals and laboratories throughout the United States are required by law to report AIDS cases to public health authorities, failure to do so entailing fines and, in a few cases, prison sentences. Since 1982, AIDS cases have been reported in the United Kingdom on a voluntary and confidential basis. AIDS was proclaimed a notifiable disease under New Zealand's Health Act 1956 in 1983, and proclaimed an infectious disease under New South Wales's Public Health Act 1902 in 1984. Several Canadian provincial public health statutes have included AIDS as a notifiable disease to be dealt with similarly with other communicable diseases.

A legal requirement to report cases of HIV infection does not appear to be as common although the trend is towards such a requirement. Ontario's Health Protection and Promotion Act, SO1983, c 10 requires physicians to report the names and addresses of persons diagnosed as having either AIDS or HIV to the local

132 Pursuant to The Infectious Diseases Order 1983, SR 1983/146, AIDS was added to the list of infectious diseases contained in the First Schedule, Section B of Part I of the Act that are notifiable to the local Medical Officer of Health.
medical officer of health. Some jurisdictions have opted for confidential or anonymous reporting of positive HIV antibody test results while others have insisted on name-specific reporting. Since 1982, cases of HIV infection have been reported in the United Kingdom on a voluntary and confidential basis. Sweden requires mandatory reporting of cases of HIV infection as do a number of Canadian provincial public health statutes, with or without identification of the test subject. Pursuant to a recent amendment to New South Wales’s public health legislation, a positive HIV antibody test result is now a notifiable condition requiring physicians to report cases in a coded form to public health authorities.133 South Korean legislation requires physicians to submit to the appropriate authorities the names of those patients who have been infected with HIV as well as those who have AIDS. As of February, 1987, nine US states134 had already required that the names of all people who test positive for HIV be reported to health authorities. Trustees of the American Medical Association, however, favour the reporting of cases of HIV infection to public health officials only “on an anonymous or confidential basis.”135

In view of the severe consequences of AIDS and the need to acquire more information to better control it, an argument can be made for the compulsory reporting of all cases of AIDS and HIV infection. Nevertheless, it is submitted that the usefulness of reporting name-specific information to public health authorities does not outweigh the adverse social and economic consequences to infected persons of possible disclosure of the fact of their infection. Indeed, compulsory name-specific reporting may have a chilling effect on persons voluntarily undergoing testing because of a perceived fear that leakage of information concerning victims and carriers could result in an invasion of their personal privacy and discrimination.136 This potential discouragement of some individuals from undergoing testing may undermine research efforts by diminishing the representativeness of the sample of known persons with AIDS and HIV carriers. As one US commentator contends:137

133 Public Health (Proclaimed Diseases) Amendment Act 1985. Provision for disclosure of identity is made whenever necessary to safeguard the public health.
134 Arizona, Colorado, Idaho, Kentucky, Minnesota, Montana, New Jersey, South Carolina and Wisconsin.
136 Dr. Blewett, the Australian Federal Health Minister, has suggested that compulsory reporting, at least in the absence of confidentiality guarantees, might be “counter-productive” in turning away the very people who need to be identified: Sydney Daily Telegraph, 25 September 1985, 8. The New South Wales Privacy Committee has argued strongly for confidentiality guarantees in this context.
137 Nanula, op cit, 339. Nanula argues in n 107 that: “Counselling and treatment of AIDS victims is normally carried out by the personal physicians of the victims, who already know the names of the victims from dealing with them prior to the illness. The use of numbers to identify patients in official reports from these doctors to the public health authorities would suffice to ensure that the doctors receive all the latest knowledge about AIDS from public health authorities and provide proper care for their patients.”
Yet, the inclusion of victims' names in official [physicians'] reports does not significantly contribute to research, counselling or treatment, while it does increase the chances of infringing victims' privacy interests ... Reporting of AIDS cases without including information about identity furthers the public interest in gathering information necessary in the scientific pursuit of a cure for the disease, without imposing any costs on the individual.

It does not appear to be unreasonable to impose a legal duty upon physicians, hospitals, clinics and laboratories to report cases of AIDS and HIV infection to public health authorities provided confidentiality can be ensured. Should difficulties be encountered in providing sufficient safeguards against disclosure of identifiable test results to unauthorised parties, the reporting of test results should be done on an anonymous basis.

Recommendation: All cases of HIV infection as well as AIDS should be reported to the Department of Health pursuant to a compulsory legal requirement. Reporting should be done on an anonymous basis unless confidentiality of identifiable test results can otherwise be ensured.

V CONTACT TRACING

Contact tracing has been used extensively in North America in sexually transmitted disease control programmes. Contact tracing is essentially a search for the past and present sexual partners of an infected individual in order to facilitate their treatment and cure. In the AIDS context, the main goal of tracing differs since there is no cure. Sexual or needle-sharing partners of HIV carriers and persons with AIDS would be notified that they may have been exposed to, and infected with, HIV, and advised to seek testing and counselling. Responsibility for informing contacts may rest with the individual, the personal physician, or the public health authorities.

There are two main types of contact tracing - voluntary notification by the patient or personal physician, and statutory notification by public health authorities. The US Centers for Disease Control has recommended voluntary notification138 which is arguably the least intrusive since it occurs within the confidential health care physician-patient relationship and relies upon the patient's cooperation.139 Voluntary notification has also been recommended by the New Zealand AIDS Advisory Committee and encouraged by the New Zealand AIDS Foundation. Pursuant to statutory notification, public health officials have a statutory power or duty to

ascertain the identity of the relevant partners of an infected individual with a view to preventing further spread of the disease, usually through treatment of these partners. The two US cities with the most cases of AIDS, New York and San Francisco,\(^{140}\) have begun notification programmes, as have state health departments in Colorado, Idaho, Minnesota and South Carolina. However, none of these programmes is comprehensive and most mainly rely on having the infected individual notify partners, with no certainty that this happens or is accompanied by counselling.\(^{141}\)

The advantages cited by proponents of contact tracing include:

(i) Notification and counselling of partners provides them with an opportunity to seek testing and to modify sexual or drug-abusing behaviour.

(ii) Although some argue that educational efforts are a more cost-effective\(^{142}\) means of preventing additional cases of HIV infection than the tracing of contacts when so many individuals are already infected, others argue that tracing efforts amongst heterosexuals have been warranted since the prevalence of infection in that group is much lower, education is more sporadic, and the perception of risk is much less.\(^{143}\) Indeed, the case for contact tracing for all groups may be stronger for New Zealand where the number of cases of AIDS and HIV infection to date is relatively manageable compared with that of the United States.

On the other hand, the disadvantages of contact tracing cited by its opponents include:

(i) The public health benefits would be marginal since investigation of partners is most effective when there is a treatment available. Unlike gonorrhea or syphilis, HIV infection is incurable.\(^{144}\)

\(^{140}\) The San Francisco Department of Public Health administers a limited contact tracing programme to reach those who have been exposed to HIV through heterosexual contact. The programme is not coercive as no one is obliged to reveal the names of sexual partners, and those traced are not required to submit to testing.


\(^{142}\) According to the U.S. Centers for Disease Control, the cost of finding and counselling sexual partners of infected persons ranges from US $90 to $98 for each partner: New York Times, 3 June 1987, B8.

\(^{143}\) Mills, op cit, 933. Another high priority group for contact tracing might be women of child-bearing age since they may not be aware of their exposure to HIV and may proceed to become pregnant with concomitant risk to others as well as themselves: see the statement on contact tracing by the Canadian National Advisory Committee on AIDS (CDWR 1987; 13: 13-14).

\(^{144}\) According to Dr Stephen Joseph, New York City’s Health Commissioner, “Until treatment was available ... [sexual] contact tracing did nothing to stem the spread of syphilis”: Time, 2 March 1987, 44. The San Francisco Department of Public Health has not undertaken routine tracing of the sexual contacts of homosexual men with AIDS because there is no evidence that such tracing would slow the spread of the disease.
(ii) Contact tracing is impractical since the extended incubation periods are not so definitive as to allow precise identification of relevant contacts. Moreover, as persons with AIDS and ARC may be infectious for a considerable period of time prior to being diagnosed, HIV transmission may have occurred too long ago to make tracing practicable.

(iii) The unduly high costs of professional contact tracing in terms of financial and personnel resources. 145

(iv) Breaches in the confidentiality of contact lists could lead to discrimination.

In addition to the foregoing disadvantages of tracing, whether voluntary or statutory, at least two more can be added which are specific to statutory notification:

(i) Coercive statutory tracing measures would seriously undermine other public health strategies to contain AIDS based on the voluntary cooperation of infected individuals concerning testing and behaviour modification, and their trust in the confidentiality of the physician-patient relationship. High risk individuals would thereby be discouraged from coming forward to be tested.

(ii) In the absence of the patient’s consent, contact tracing by anyone, other than by the patient or (with consent) his or her physician, is a significant intrusion into individual rights of privacy.

Recommendation: In the absence of an effective treatment for HIV infection, contact tracing can only provide, at best, a useful complement to risk reduction information programmes targeted at the wider community. Tracing should neither be coercive nor statute-based, but should rather seek to encourage infected individuals to cooperate with their personal physicians and public health authorities in notifying sex or needle-sharing partners for the purposes of counselling and testing. Physicians should encourage their infected patients to notify their contacts. Alternatively, with their patient’s consent, physicians should notify these contacts themselves or seek the assistance of public health officials for this purpose. Physicians should retain a discretion to inform unsuspecting contacts when there is a real possibility that they have been exposed to HIV, despite the infected patient’s refusal of consent to such notification. 146

145 See n 142 above. These costs would vary, of course, with the general prevalence of infection and the health system in a particular jurisdiction.

146 An example of when a physician’s duty to protect the confidentiality of an infected patient’s test results might be overridden by a duty to warn others might be the case of an infected male who refuses to inform his spouse of child-bearing age: 34 Centers for Disease Control: Morbidity and Mortality Weekly Rep 721-726; 731-732 (1985).
VI QUARANTINE

As a public health infection control measure, a quarantine is designed to prevent a carrier from transmitting a (usually highly contagious) disease by physical isolation. In recent US history, quarantines have been instituted to control the spread of severe and highly communicable diseases such as typhoid, smallpox and tuberculosis.147 Quarantine has been used only rarely for persons with sexually transmitted diseases148 and most quarantines of this type have been aimed at prostitutes due to the frequency of their sexual activity.149 In the AIDS context, a number of countries have either instituted, or are seriously contemplating, quarantine measures.150

Although a case will be made shortly for limited quarantine measures, the following arguments against widespread quarantine can be mustered:

(i) Quarantine of all HIV carriers would require a disproportionately high level of public resources. Such a quarantine would have to be supported by a widespread, coercive and periodic testing programme which, in itself, would involve a commitment of public resources of unacceptable magnitude.

(ii) Any widespread quarantine programme would have to be founded upon coercive measures which would tend to discourage persons from seeking testing. This would undermine the alternative public health strategy of securing voluntary compliance by persons at risk.151

(iii) Generally, quarantines have only been deemed necessary when the disease was communicable by casual contact. HIV infection is not spread through such contact.152

(iv) Quarantine of persons with AIDS of HIV would be for an indefinite and lengthy period since HIV may persist in a person for life. So long as an effective treatment remains unavailable, those persons under quarantine would have no way to restore themselves to their previous condition in order to rejoin society.153 Long-term quarantine of large populations in isolated communities has been invoked in this century only for leprosy, and that use

148 Mills, op cit, 934.
149 Gleason, op cit, 224.
150 In Sweden, anyone who knowingly transmits HIV may be isolated against their will in a hospital. In India, the Tamil Nadu state government is holding under virtual house arrest 24 prostitutes who tested HIV positive. In Iceland, the government is planning to quarantine persons who continue to have sexual relations with uninfected partners despite their knowledge that they carry HIV. See Time, 25 May 1987, 58.
151 Curran and Gostin, op cit, 28.
152 See n 14 above and the accompanying text.
153 Curran and Gostin, op cit, 27.
is now widely thought to have been unjustified.\textsuperscript{154}

(v) "False positive" results could result in the lifelong involuntary confinement of healthy persons. Notwithstanding the subsequent discovery of the mistake, a debilitating stigma might well endure for life. On the other hand, "false negative" persons would continue to remain in the community at large.

(vi) Involving as it does an involuntary incarceration, quarantine would prima facie infringe individual liberty,\textsuperscript{155} the right to privacy, the freedom of association and the right to cohabit with one's spouse and children. Moreover, quarantine would involve stigma, discrimination and disruption to the lives of not only HIV carriers but to those of their immediate family as well. A long-term, widespread quarantine must surely entail significant adverse economic consequences as well. Therefore, governments should implement, and only when demonstrably justified, the least intrusive means to control the spread of HIV infection by selecting those options which impair individual rights to the least degree consistent with the protection of public health. Widespread quarantine would needlessly confine many HIV carriers since only a small proportion of the entire population of HIV carriers would be likely to intentionally engage in unsafe sexual behaviour or the shared use of contaminated needles. Hence the desirability, indeed the necessity, for narrowly targeted quarantine laws.

The foregoing arguments underline the need for quarantine laws to be targeted in their application with precision in order to avoid overinclusiveness and consequent injustices. A law authorising the quarantine of all HIV carriers of a particular high risk group would be overinclusive since it would unduly limit casual contacts that are harmless in terms of risk of transmission.\textsuperscript{156} Statutory criteria must consider both the unwillingness or inability of proposed quarantine subjects to behave in a responsible manner. Health professionals concede that some patients are so incompetent that no voluntary measure is adequate to protect the public health. Similarly, a quarantine of HIV carriers who are already engaged in unlawful conduct and are unable or unwilling to avoid high risk activities - viz some prostitutes and intravenous drug abusers - arguably is targeted with sufficient precision. A 1985 amendment to the Connecticut Public Health Statute, for example, authorises a local health director to order the confinement of a person if he or she has reasonable grounds to believe that the person is infected with a communicable disease and is unable or


\textsuperscript{155} Two American commentators describe quarantine as "the most serious form of deprivation of liberty that can be used against a competent and unwilling person" since, \textit{inter alia}, "it is not subject to the same rigorous due process procedures as in a criminal charge" and "[i]t is based upon what a person \textit{might} do in future rather than what he or she has done". See Curran and Gostin, op cit, 26.

\textsuperscript{156} As John Gleason aptly states, "an individual who ... is infected with the AIDS virus is not a threat to others simply by being in the general public." See J A Gleason, op cit, 232.
unwilling to act so as not to expose others to infection.\textsuperscript{157} Pursuant to New York Public Health Law 2120(1)-(3), the New York Board of Health has power to quarantine individuals afflicted with, or carrying, a communicable disease who are unwilling or unable to conduct themselves in a manner so as not to endanger others. Prostitutes, mental health patients and infected individuals who knowingly continue to maintain an active multi-partner sex life would presumably fall within the ambit of these statutory provisions. Similarly, in the United Kingdom, pursuant to sections 37 and 38 of the Public Health (Control of Disease) Act 1984 and the Public Health (Infectious Diseases) Regulations 1985 enacted thereunder, a justice of the peace (acting, if he deems it necessary, ex parte at the instance of health authorities) may order an individual to be removed to, and detained in, hospital if satisfied that he or she is afflicted with AIDS and that proper precautions to prevent the spread of infection cannot or are not being taken thereby causing serious risk of infection to others.\textsuperscript{158}

US courts have held that the quarantine of prisoners is a valid state action because of the extraordinary conditions obtaining in prison. In \textit{La Rocca v Dalsheim},\textsuperscript{159} the Department of Correctional Facilities instituted a plan to segregate persons with AIDS from the other prisoners to inhibit its spread. The court noted that prisons have both a high rate of sexual contact, much of it by force, and intravenous drug use. This, added to the fact that the prison population is constantly changing, makes it foreseeable that infection will spread if precautions are not taken.\textsuperscript{160} The court thus held that the prison had acted reasonably in its attempt to stop HIV transmission and that it was "the state's obligation to provide a safe and humane place of confinement for its inmates."\textsuperscript{161} Consistent with \textit{La Rocca}, the court in \textit{Cordero v Coughlin}\textsuperscript{162} upheld the constitutionality of the quarantine of persons with AIDS, concluding that the quarantine was a reasonable method of attaining the legitimate governmental interest of keeping both the infected and uninfected safe from the harm and tensions that could result if the persons with AIDS were not segregated, and that the rights of privacy and free association are already limited in the prison setting.\textsuperscript{163}

\textit{Recommendation:} Public policy must concern itself with the welfare of those at risk of exposure to HIV as well as with those whose civil liberties may be threatened. Consideration should be given, therefore, to the enactment of limited quarantine legislation that requires, as a condition of quarantine, a determination after a full and fair hearing that a person with AIDS or HIV carrier will not, or cannot, refrain from

\textsuperscript{157} Curran and Gostin, op cit, 27. Cf s 70(1)(f) of the Health Act 1956 (NZ).
\textsuperscript{158} HIV carriers do not appear to fall within the ambit of the provisions, however.
\textsuperscript{159} 467 NYS 2d 302 (NY Sup Ct 1983).
\textsuperscript{160} Ibid 309.
\textsuperscript{161} Ibid 310. The court implied (at 311) that the quarantine of AIDS victims precluded their sexual contact with others and thus diminished the spread of the disease.
\textsuperscript{162} 607 F Supp 9 (DCNY 1984).
\textsuperscript{163} Ibid 10-11.
engaging in conduct likely to spread HIV. Such a limited use of the quarantine power would not be overinclusive since there would be a reasonable and demonstrable relationship between the restriction to be applied and a compelling public health purpose.\textsuperscript{164}

\textbf{VII THE IMPOSITION OF CRIMINAL LIABILITY FOR HIV TRANSMISSION}

Recently a West German court found an HIV carrier guilty of grievous bodily harm and sentenced him to a one-year jail term for having unprotected sexual intercourse with a woman even though he knew of his antibody status.\textsuperscript{165} In Ottawa, Canada, an HIV carrier was charged, after a considerable interval, with common mischief after having knowingly donated infected blood to the Red Cross. Prosecutors had delayed in laying criminal charges because of a lack of precedents and laws dealing specifically with AIDS and HIV.\textsuperscript{166}

It is a common feature of public health legislation to provide for offences concerning the wilful failure to adhere to accepted measures to avoid exposing others to an infectious disease. A number of US states, including Texas, New York, California, Pennsylvania, Colorado and Florida, have statutes which make it a crime for an individual who knows he or she has an infectious venereal disease to have sexual intercourse with another.\textsuperscript{167} These statutes provide a precedent for the use of the criminal law in the AIDS context. Nevertheless, the imposition of criminal liability for HIV transmission has been opposed on a number of grounds, including:

(i) The inherent limitations of the law in modifying behaviour. As one Australian commentator recently observed, "our experience in such areas as alcohol prohibition ... prostitution and drug use should teach us that the criminal law ... is ... relatively ineffective as a mechanism for modifying the behaviour stigmatised."\textsuperscript{168}

(ii) The difficulty in bringing a successful prosecution due to evidentiary and enforceability problems. Those who engage in statutorily prohibited sexual conduct are scarcely deterred due to the extreme underenforcement of such laws.\textsuperscript{169} Even if AIDS prosecutions could reach the courts before the demise

\textsuperscript{164} Curran and Gostin, op cit, 27. A separate recommendation concerning prisoners appears in a subsequent section.

\textsuperscript{165} The Dominion (Wellington, New Zealand), 22 April 1988, 4.

\textsuperscript{166} The Ottawa Citizen, 27 February 1988, B16. The other existing criminal charges that were considered potentially applicable included attempted murder and criminal negligence (which includes intentional or reckless disregard for the safety of other persons).

\textsuperscript{167} Curran and Gostin, op cit, 28.


\textsuperscript{169} Nanula, op cit, 329.
of the offender and/or victim, it would be difficult to prove beyond a reasonable doubt that an individual intentionally or recklessly transmitted HIV especially in those cases which turn on the uncorroborated evidence of the victim who usually would not realise that a former sexual partner exposed him or her to HIV until months or even years later.  

(iii) The perception of health officials that criminalising such behaviour would discourage those individuals who suspect they have been exposed to HIV from coming forward and cooperating with them.

(iv) The objection to the use of criminal law to penalise private sexual encounters between two consenting adults.

Yet the imposition of criminal liability for HIV transmission has been supported on the following grounds:

(i) Knowingly spreading HIV is a cruel and anti-social act given the debilitat­ing and deadly character of AIDS, and is just as dangerous as other behaviour that the criminal law already proscribes.

(ii) The criminal law with its attendant advantages offers a “tighter fit” between means and the relevant public health objective. Each convicted individual will have demonstrably fallen short of what the law has already prescribed as unacceptable conduct; conversely, alternative public health measures, such as the quarantine of individuals who might engage in the proscribed conduct in the future, almost invariably have an overinclusive impact on individuals who will not pose an actual risk to public health.

Despite the disadvantages outlined above, public policy-makers in numerous jurisdictions have considered it necessary to criminalise the wilful transmission of HIV. Bills have been introduced in several US states which would criminalise wilful exposure by an HIV carrier of another either through sexual contact or blood donation. Recent Queensland legislation subjects a person who knowingly infects any other person with AIDS to a penalty not exceeding $10,000 and/or imprisonment for a period not exceeding two years. Pursuant to recent New South Wales legislation, a person who knows he or she has AIDS and has sexual intercourse with another unsuspecting person commits an offence carrying a $5,000 penalty.

170 Curran and Gostin, op cit, 29.
171 Yet it may be argued that these sexual encounters are not consensual if the HIV carrier fails to inform the partner, and that the encounters are not wholly private since they clearly have wider public health implications.
172 These include, inter alia, proof beyond a reasonable doubt of a specific dangerous act which is objectively worded in the statute, a strict standard of procedural due process, rights of appeal, and a penalty proportionate to the gravity of the offence.
173 Curran and Gostin, op cit, 28.
174 Health Act Amendment Act 1984 (No 2), s 2 amending the Health Act 1937.
175 Public Health (Proclaimed Diseases) Amendment Act 1985, amending the Public Health Act 1902.
**Recommendation:** As a mechanism for controlling the spread of HIV, the criminal law does have a deterrent role to play but one which must be subordinate to that of public education, support services and counselling. The criminal law can and should be used to proscribe behaviour likely to communicate HIV when an individual knows that he or she is infected and appreciates the threat to health posed by the behaviour but nevertheless fails to inform sexual or needle-sharing partners of his or her antibody status. Although at least two existing New Zealand statutory provisions could be used\(^ {176}\) or amended\(^ {177}\) to address this problem, given the *sui generis* nature of the medical and social implications of AIDS and HIV, statutory provisions confined specifically to AIDS and HIV should be enacted\(^ {178}\)

**VIII RECOMMENDATIONS ON HIV ANTIBODY TESTING IN NEW ZEALAND**

The following recommendations relate to specific individuals or groups and are based on the presupposition that for testing to be justified:

(i) the benefits of testing must outweigh the potential harm to individuals and the costs to society of testing;

(ii) there must exist a reasonable perceived risk of HIV infection based on such considerations as the current prevalence of infection and the known modes of transmission;

(iii) the selection of individuals or groups to be tested must be clearly defined and must not discriminate irrationally against them.\(^ {179}\)

**1 Persons Entering New Zealand Permanently**

Some countries have already excluded, while others are planning to exclude, permanent entry applicants who test positive.\(^ {180}\) The US Government has instructed the Immigration and Naturalization Service to add HIV to the list of dangerous

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176 The Crimes Act 1961, s 201 provides that “Every one is liable to imprisonment for a term not exceeding 14 years who, wilfully and without lawful justification or excuse, causes or produces in any other person any disease or sickness.” At the time of writing, a Justice Department source advised the writer that it is proposed to retain s 201, as well as to introduce a general “endangering” offence, in the Crimes Bill shortly to be introduced in Parliament.

177 The Health Act 1956, s 92 provides that “Every person who knowingly infects any other person with a venereal disease, or knowingly does or permits or suffers any act likely to lead to the infection of any other person with any such disease, commits an offence and is liable ... to a fine not exceeding $1,000 or to imprisonment for a term not exceeding one year, or to both.” For the purposes of s 92, the definition of venereal disease could be extended to include AIDS and HIV.

178 In Canada, the federal justice department is now looking at ways to revise the Criminal Code to include provisions directed at individuals who knowingly transmit HIV to others.

179 See the Canadian Working Paper at 23-25.

diseases immigrants are tested for and concerning which a positive test result entails exclusion.\textsuperscript{181} The US testing programme covers all immigrants, refugees\textsuperscript{182} and illegal aliens applying for legal resident status. The rationales of these measures transcend the desire to slow the spread of HIV in the country concerned, for, as the authors of the Canadian Working Paper state:\textsuperscript{183}

\begin{quote}
The permanent entry of HIV-infected persons to [a country] could represent a potentially major burden for [its] health and welfare system. The exclusion of such persons may be justifiable where permanent entry to a country is considered to be a privilege. Consequently, mandatory or compulsory testing of anyone applying for permanent entry may be proposed as a method to diminish the additional cost of this disease...
\end{quote}

Nevertheless, mandatory testing and exclusion of all positive applicants would be overinclusive in its reach. Exclusion criteria should also focus on evidence relating to a past history of high risk behaviour on the part of the particular applicant. Therefore,

**Recommendation:** All applicants for New Zealand permanent entry should be tested in their respective countries of origin. Testing should be performed by a New Zealand physician or other authorised health care provider pursuant to certified procedures to ensure the quality and accuracy of the testing. Only those applicants with AIDS (barring countervailing compassionate grounds) or those applicants who test \textit{mv} positive and whose past history evidences behaviour tending to put others at substantial risk should be denied entry. All successful applicants for entry, whether infected or not, should be informed about safe behaviour and the availability of counselling services prior to their arrival.

2 **Persons Entering New Zealand Temporarily**

Belgium, China\textsuperscript{184} and India\textsuperscript{185} now require tests for foreign student visa applicants while the Japanese Government has introduced legislation that would deny visas to foreigners who carry HIV and are considered likely to spread it in Japan.\textsuperscript{186} Other nations, including the United Kingdom, have considered testing those travellers who come from areas where AIDS is widespread.\textsuperscript{187}

\textsuperscript{181} The House of Delegates of the American Medical Association has indicated its approval to testing of would-be immigrants: New York Times, 24 June 1987, A22.
\textsuperscript{182} Refugees might be considered in a special category, however, since they face serious danger if returned to their country of origin.
\textsuperscript{183} Canadian Working Paper at 77.
\textsuperscript{185} New York Times, 1 March 1987, A35.
\textsuperscript{186} New York Times, 1 April 1987, A18. The groups targeted by the Japanese legislation include female prostitutes, male homosexuals and intravenous drug abusers.
The World Health Organisation concluded in 1986, however, that testing of international travellers is not warranted as a measure to prevent HIV transmission and, accordingly, advised its member states against considering such measures.\textsuperscript{188} In March, 1987, the WHO Special Programme on AIDS convened an expert group of epidemiologists and disease control experts to discuss various issues related to HIV infection and international travel which concluded that serious logistic, epidemiological, economic, legal, political and ethical problems are inherent in any proposal to test international travellers for HIV.\textsuperscript{189} The expert group identified the following drawbacks to such a testing programme: \textsuperscript{190}

(i) the extraordinary difficulties in implementation;
(ii) its inability under any circumstances to prevent the introduction and spread of HIV infection;\textsuperscript{191}
(iii) it would divert resources away from more effective educational programmes on AIDS and measures to protect the blood supply from HIV contamination;\textsuperscript{192}
(iv) it would, at best and at great cost, retard only briefly the spread of the HIV pandemic globally or with respect to any particular country.

The WHO itself has reaffirmed its view that testing of international travellers would be a costly and inefficient public health measure with minimal effect.\textsuperscript{193} To the above list of concerns of the expert group over the testing of international travellers can be added the following:

(i) because months can pass between HIV infection and the formation of antibodies, testing would not provide an infallible means of detecting antibody presence in a recently infected individual;
(ii) the significant number of “false positive” test results will bar entry of a corresponding number of AIDS and HIV-free individuals;
(iii) a programme to test international travellers would logically have to apply as well to returning nationals;
(iv) the testing of international travellers with a view to their exclusion in the event of a positive test result would prevent many visitors who may have no intention or opportunity to transmit HIV from contact with family and friends or from pursuing short-term educational or employment opportunities;

\begin{itemize}
  \item \textsuperscript{188} WHO, \textit{In Point of Fact} (1986) A-5.
  \item \textsuperscript{189} Communication from the Director-General of the WHO, Ref: CL 8 1987, 7 April 1987, Geneva.
  \item \textsuperscript{190} Idem.
  \item \textsuperscript{191} No current screening system can prevent the introduction and spread of HIV infection.
  \item \textsuperscript{192} Rather than test, the expert group recommended education programmes directed to both national and international travellers and conveying information on modes of HIV transmission and prevention, and areas of high HIV incidence.
  \item \textsuperscript{193} See above n189.
\end{itemize}
apart from the huge direct costs involved in the testing of all international travellers, the loss of travel and tourism opportunities would affect locals as well as travellers.

**Recommendation:** Coercive testing of individuals entering New Zealand for the purposes of travel or short-term study or work would be too costly, impractical and inefficient. Nevertheless, they should be informed of HIV infection and safe behaviour and the availability of voluntary testing and counselling services. Likewise, New Zealanders travelling overseas should be provided with educational materials on how HIV is transmitted, specific preventive measures and areas of high HIV incidence.

### 3 Prostitutes

Prostitutes face an increased risk of HIV infection from their large number of sexual contacts, and therefore constitute a source of HIV transmission if infected. Prostitutes are considered possible vectors by which HIV is spread from homosexuals, via bisexuals, to the heterosexual community.

Calls have been made for the registration and testing of prostitutes and the quarantine or banning of those who test positive. South Korea and the West German State Government of Bavaria have begun the compulsory testing of prostitutes.\(^\text{194}\) The state of Mississippi issued last year a quarantine order of indefinite duration against an HIV-infected male prostitute which prohibits him from donating blood and having sex without informing his partner of his condition as well as requiring him to attend a sexually transmitted disease clinic.\(^\text{195}\) Consistent with the philosophy of this paper, however, generally such coercive measures should only be implemented as and when it is demonstrated that voluntary cooperation and self-policing by the individuals and groups concerned have failed.

**Recommendation:** Voluntary testing is strongly encouraged for prostitutes, particularly those who have engaged in unprotected sexual activities. Such testing should be supplemented by the promotion of safe-sex methods by and amongst prostitute groups.

### 4 Prisoners

In June 1987, the US Federal Government announced its intention to begin testing

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195 New York Times, 12 February 1987, B17. Breach of these conditions would entail a jail sentence and fine. Although touted to be the best public health measure consistent with the least restriction, problems of unenforceability might occur.
on a routine basis all individuals sentenced to Federal prisons. The West German State Government of Bavaria has ordered compulsory testing for prisoners and individuals in police custody while France tests prisoners in the course of routine medical examinations. There have also been calls for routine testing of prisoners in New Zealand.

The testing of prisoners has been proposed as a means of gauging the extent of HIV infection among prisoners and of protecting uninfected prisoners and prison personnel from HIV infection. The segregation of HIV-infected prisoners has also been advocated to protect not only the health of uninfected prisoners and prison personnel but the safety of the infected prisoners themselves. Proponents of testing and segregation of prisoners cite the special conditions which exist in prison including the closed and dependent nature of the prison environment, the high turnover of prisoners, and the incidence of intravenous drug use and both consensual and non-consensual unprotected sexual intercourse among prisoners.

Calls for testing of prisoners and the segregation of HIV-infected prisoners have tended to be overinclusive and this has been due in part to misunderstandings held by prisoners and prison personnel concerning HIV infection and its transmission. Testing and segregation measures should only be undertaken for medical reasons associated with the welfare of prisoners. The development and implementation of education programmes on HIV infection and safe-sex for both prison inmates and personnel might reduce the level of hostility towards those prisoners known or thought to be infected, thereby reducing the need for, and cost of, segregation. Indeed, segregation should not be ordered simply because a prisoner is seropositive since it is not the antibody status but the propensity for high risk behaviour which is the real concern. Prisoners, especially those who have engaged in high risk activities, should be encouraged to seek testing and counselling.

Given the impracticality of preventing high risk behaviour in prisons, the focus should instead be on eliminating the risks from such behaviour. Sterile needles and syringes should be made available to supplement expanded drug use rehabilitation programmes in order to reduce and ultimately eliminate the risk inherent in needle

196 This initiative was supported by the American Medical Association: see New York Times, 21 June 1987, A26.
197 New York Times, 27 February 1987, B12. At the time of writing, s 155 of the Law Reform (Miscellaneous Provisions) Bill proposes to add to s 36 of the Penal Institutions Act 1954 a provision enabling the medical officer of any penal institution to require an inmate to submit to tests to determine whether the inmate is suffering from AIDS or carrying HIV antibodies if the officer considers that, having regard to the personal circumstances of the inmate, it is desirable that the inmate have such tests. An inmate who refuses to be tested may be dealt with administratively as if he or she were suffering from AIDS or carrying HIV antibodies. In any case where, in the opinion of the medical officer, the inmate is displaying AIDS symptoms or, in any other case, as if he or she were carrying HIV antibodies.
sharing. Pending adoption of a needle exchange scheme, bleach should be made available and prisoners educated in its cleansing properties. Consideration should also be given to the availability of condoms to prisoners.

**Recommendation:** Education programmes on HIV infection and safe-sex should be implemented in prisons. Confidential voluntary testing accompanied by pre- and post-test counselling and informed consent should also be made available to prisoners. Segregation should be reserved for those prisoners who wilfully or negligently infect other prisoners through the use of force or duress in relation to sexual activity, or through the sharing of contaminated drug injection equipment, or in order to protect infected prisoners from victimisation by other prisoners.

5 **Armed Forces**

Sweden has instituted testing of its armed services recruits while France tests its armed services personnel in the course of routine medical examinations. Since October 1985, over three million US Armed Forces recruits and active-duty personnel have been tested on a mandatory basis; recruits testing positive are barred from joining the military while active-duty personnel testing positive are discharged. The US Defense Department has sought to justify its testing and discharge policies on the following grounds:

(i) infected recruits may have adverse reactions to a routine immunisation with multiple live virus vaccines;
(ii) if infected personnel are assigned overseas, the risks of other infections and the unavailability of adequate health-care facilities increase;
(iii) concern for the battlefield need for risk-free emergency blood transfusions;
(iv) concern for the need to be able to deploy personnel anywhere on short notice without worrying about them being weakened by HIV and their possible exposure to various diseases in hostile environments.

These concerns, or some of them at least, might well apply to the New Zealand Armed Forces. Nevertheless, they hardly justify coercive mass (as opposed to selective) testing of recruits and current personnel. Moreover, since medical science has not established that HIV can be transmitted by casual contact, neither persons with AIDS nor HIV carriers should be automatically denied the opportunity to serve, or continue to serve, in the military so long as they are able to perform their duties and pose no risk to others. Therefore,

**Recommendation:** Coercive testing is unwarranted for individuals who are serv-

ing in, or are seeking entry to, the military, except where cogent reasons or specific benefits may justify this. The exclusion or discharge of an applicant or a member of the armed services respectively is unjustified in the absence of evidence of employment-related risk to others or to the health of the HIV carrier or person with AIDS concerned.199

6 Expectant Mothers

The babies of HIV-infected mothers constitute the intended class of beneficiaries of the testing of women contemplating pregnancy, since HIV can pass from mother to infant before or during birth.200 US Surgeon General C Everett Koop’s recommendation201 that any woman who wants to have a baby should voluntarily undergo preconceptual testing appears overinclusive. Therefore,

Recommendation: Voluntary preconceptual testing should be encouraged amongst those women who plan to have children and are at special risk of HIV infection. These include women who have used illegal intravenous drugs or have had sex partners who have used such drugs, women who had sexual intercourse with a bisexual male, and women who reside in areas with a high incidence of HIV infection.202

7 Premarital Testing

France requires testing prior to the issuance of marriage licences to protect the prospective marriage partners as well as their future children.203 In June 1987, President Reagan announced his intention to encourage states to “offer routine testing for those who seek marriage licences” contending that this “might prevent at least some babies from being born with AIDS.”204

Other possible advantages of premarital testing include the provision of counselling opportunities and valuable information about the spread of HIV infection through the general population. In terms of a possible precedent, numerous US states require a syphilis test for marriage licence applicants as a means of limiting the risk of infection to prospective spouses or children. Nevertheless, the trend has been to

199 See the Canadian Working Paper at 74-75.
200 See above n18 and the accompanying text. According to Dr. Walter Dowdle, CDC AIDS Director, there is a 30% to 50% chance of an infected mother transmitting HIV to the newborn: New York Times, 4 February 1987, A16.
202 The thrust of this testing philosophy was generally supported by experts at the Atlanta Conference: New York Times, 25 March 1987, B4. Dr James O Mason, CDC Director, has also supported testing along these lines: New York Times, 11 May 1987, A1.
203 Time, 25 May 1987, 58.
abandon the syphilis test as costly and unproductive." The Center for Disease Control and state public health officials similarly concluded at the Atlanta Conference that routine or mandatory premarital HIV antibody testing would be a very expensive way to turn up a few cases of HIV infection. This view is also held by the American Medical Association which has described premarital testing as "costly and inefficient".

The Centers for Disease Control consider that widespread premarital testing "is unlikely to be very effective even in a community with a high general prevalence of HIV infection" because most HIV carriers are drug users and homosexuals who are already sexually active and in respect of whom the incidence of marriage is low.

Premarital testing raises other concerns such as exposure to HIV between the test and marriage dates and the phenomenon of premarital sex. In areas or countries like New Zealand where there is a relatively low general prevalence of HIV infection, it cannot be considered a cost effective use of public resources to test a large number of individuals to identify a few infected individuals. Also, are applicants who test positive to be denied a marriage licence? Should the ultimate decision to marry and bear children in these circumstances reside with the State or the prospective spouses? Therefore,

**Recommendation**: Although widespread coercive premarital testing is unwarranted, testing should be readily available on a voluntary basis where one or both prospective spouses desire it, especially if they fall within a category concerning which there is a recognised high risk of infection.

8 **Blood, Organ, Tissue, Ovum, or Sperm Donors and Recipients**

The World Health Organisation has acknowledged that testing for HIV infection among blood donors is "a well-accepted and effective ... public health measure." This has been borne out by the effectiveness of current testing programmes in the United Kingdom, the United States, Australia and New Zealand in reducing the transfusion of infected blood. Such programmes must continue and be fully supported. Therefore,

205 Idem. New York recently dispensed with the syphilis test because only a minute proportion of syphilis cases were detected pursuant to premarital testing (and perhaps also because of the suspicion that some couples nowadays have sex before marriage).
208 It is submitted that it would be a brave legislature which would require officials to withhold a marriage licence if a prospective spouse tests positive in the face of persistence of both spouses in their desire to marry and procreate. Nevertheless, the Illinois legislature has introduced legislation to this effect: Time, 2 March 1987, 44.
209 See n 189 above.
**Recommendation:** Testing is essential for all donors of blood or blood products, organs and other tissues intended for transplantation, and for donors of semen or ova collected for artificial insemination or invitro fertilisation. Warnings should be directed to intending donors in high-risk categories pursuant to public education campaigns to refrain from making donations. Voluntary testing should be encouraged for those individuals who received unscreened transfusions of blood or blood products in New Zealand within a period of three years or so prior to the formal commencement of HIV antibody testing for blood or blood products in New Zealand. Such testing is strongly encouraged for recipients of multiple transfusions such as haemophiliacs since a significant proportion of the recipients of unscreened blood and blood products in North America have been found to be infected. Such testing may prevent these individuals, if infected, from unknowingly transmitting HIV and lead to access to counselling and health care services.

9 **Intravenous Drug Users**

Recent medical evidence suggests that HIV transmission has been rapid among persons who share injection equipment when unlawfully using drugs intravenously. These persons constitute a threat both to others with whom they share contaminated injection equipment and to their sexual partners. HIV infection is now endemic among these persons in northeastern United States and particularly in New York City. Intravenous drug users constitute a significant public health threat as they are now considered to be an increasing source of HIV transmission into the heterosexual communities of developed countries. The reduction of the incidence of HIV infection among intravenous drug users would reduce the rate of HIV transmission to the heterosexual community as well as to newborns. The writer concurs with the views expressed by the American Medical Association Trustees and the AMA. House of Delegates respectively to the effect that the coercive testing of all intravenous drug users “would only drive [them] underground and away from the health-care system” and that, accordingly, voluntary testing is likely to be more effective. Despite earnest national and international efforts to curb drug abuse, the New Zealand Government is to be applauded for having recently introduced a scheme for the exchange of used needles and syringes for clean ones at pharmacies. The writer also concurs with the view that the preservation of life itself and the need for prompt and effective action to save that life justifies this hard policy decision.

210 This is the position of the New Zealand Medical Association as articulated in its position paper on AIDS as well as that of the authors of the Canadian Working Paper at 38.

211 The overwhelming majority of AIDS cases attributed to heterosexual transmission to date has been traced to intravenous drug abusers: New York Times, 19 March 1987, B10.


Therefore,

**Recommendation:** Voluntary testing of intravenous drug users, their sexual partners, and those with whom they have shared contaminated injection equipment is strongly recommended. Such testing should be offered as a matter of course through all drug rehabilitation clinics.

### 10 Foreign Service Officers

The US State Department requires testing of Foreign Service applicants, officers and their dependants. While applicants who test positive are automatically rejected, overseas officers and their dependants testing positive are restricted in their service abroad to postings where they would be assured of receiving adequate medical attention. These measures are considered necessary to protect the health of Foreign Service officers and their families since live-virus vaccines, which can accelerate symptoms in HIV carriers, are required of them.

**Recommendation:** Voluntary testing of those Foreign Service applicants, officers and dependants who fall within a high-risk category is recommended. Those officers and dependants who test positive should only be assigned to those countries which can provide them with a standard of medical care requisite to their condition. It is not necessary to exclude applicants who test positive from the Foreign Service where their applications would otherwise succeed so long as their condition does not impair the performance of their duties and steps are taken to ensure that they are posted in countries with adequate health care facilities.

### 11 Persons Entering Hospital

President Reagan proposed in June 1987, that all persons admitted to Veterans Administration hospitals in the United States should be routinely tested for the HIV antibody. Such testing might be thought to assist in more precisely determining the extent of HIV in the general population as well as to enable health care providers to better protect themselves against exposure. Nevertheless, a consensus emerged at the Atlanta Conference opposing mandatory or even routine testing for hospital patients. The American Medical Association has described President Reagan’s proposal as “costly and inefficient”. The costs of testing such a large number of patients appear excessive when compared with the actual low risk of HIV infec-
tion. Indeed, prior to the Reagan announcement, the practice at Veterans Administration hospitals had been to test only those patients who displayed AIDS symptoms or who were considered to belong to high-risk groups. Therefore,

**Recommendation:** Given the low incidence of HIV infection in patients entering hospital and the potential to develop reliable safety practices to protect health care personnel by minimising the small risks involved, it is considered sufficient to confine testing in hospitals to those patients who display AIDS symptoms or belong to a high-risk group.

### 12 Employees and Job Applicants

Benefits of widespread mandatory testing of employees and job applicants might include the elimination of an actual occupational risk of HIV transmission to others, the prevention of a health risk to an HIV-infected employee attributable to a particular occupation, and the reduction of economic costs to employers. Nevertheless, unless there are good grounds to suspect that infected individuals would pose a threat to themselves or others because of the nature of the particular work environment, widespread mandatory employer testing would be costly and inefficient. Therefore,

**Recommendation:** Mandatory testing of individuals who are employed by, or are applying for work in, any private or public enterprise, is unwarranted unless there is persuasive evidence that infected individuals in the particular work environment concerned create a risk of HIV transmission to other employees or a risk of harm to themselves. The exclusion from employment or continued employment of an infected individual where the only operative reason for such exclusion is a positive test result is unjustified when this does not represent a demonstrated risk of HIV transmission to other employees, or of harm to that individual.

### 13 Persons Seeking Insurance

AIDS is posing an increasing economic threat in the United States and it has already impacted on the health budgets of other developed and developing countries. The cost of caring for persons with AIDS in the United States many of whom have been

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219 A large proportion of patients entering hospital are children or elderly persons who pose an extremely low risk of infection: New York Times, 11 May 1987, B5.
221 As in the case of a lab technician, for example.
223 This recommendation might equally apply to educational organisations.
denied insurance, is already estimated to exceed one billion dollars annually. In their anxiety to remain financially stable, insurance companies have begun testing insurance applicants for the HIV antibody with a view to denying coverage or assessing higher premiums in respect of those testing positive. Passionate debates have been sparked over the appropriateness of insurer testing. Denial of medical and life insurance coverage shifts the medical costs of AIDS patients and the financial needs of their dependants onto the State. A public policy analysis in this context must weigh the cost to insurers of forbidding insurer testing against the cost to society of allowing it, in determining the respective shares of the economic burden which it is reasonable to expect governments and insurers to assume.

The arguments for and against insurer testing are finely balanced. Insurance company advocates cite the following arguments favouring such testing:

(i) Without testing, insurers could face massive financial losses because of excessive morbidity and mortality. The financial stability of the insurance industry itself might be undermined.

(ii) Insurer testing for the HIV antibody is consistent with time-honoured and actuarially sound underwriting principles and is done for a reasonable business purpose. Few would question the right of insurers to deny coverage to applicants suffering from heart disease or cancer, and HIV antibody testing provides reliable evidence for an objective determination of an individual’s increased risk of contracting an invariably fatal disease.

(iii) An insurer has a responsibility to treat all its policyholders fairly by creating classifications to recognise the many differences which exist among individuals so that each applicant will either be granted insurance at a premium rate corresponding to the quality of his or her risk or be denied insurance. Since HIV infection is a highly significant risk assessment factor, HIV carriers are in a different risk class than uninfected individuals. Failure to differentiate between these two classes would represent a forced and expensive subsidy from the healthy policyholder to the less healthy in the face of knowledge of existing HIV infection. The insurance industry has a responsibility to those who have not been infected and, if the insuring process is to remain fair and non-discriminatory to uninfected applicants and policyholders, insurers must be permitted to rely on HIV antibody testing in the same manner as they rely on tests for other diseases.

Opponents of insurer testing have produced the following counter-arguments:

225 Time, 16 February 1987, 40.
Without any laws to regulate insurer testing, insurance companies will be free to create an uninsurable high-risk class of individuals whose expenses will have to devolve upon the latter and ultimately the State.

Insurer testing could lead to economic and social discrimination because the confidentiality of AIDS-related records cannot be guaranteed in an imperfect world.

It is unfair to deny insurance to individuals who carry HIV but nevertheless are healthy and may not go on to develop AIDS.227

Insurer testing will endanger the public health since there is an inherent conflict between the threatening character of insurer testing policy and the efforts of most public health experts to convince high-risk individuals that testing can be beneficial and so should be undertaken voluntarily.228

Because testing is costly, insurers are likely to want to test only those applicants whom they consider to be in a high-risk category. Testing is almost certain to be applied, therefore, in a manner that discriminates unfairly against homosexual and bisexual males229 and it may even occur that all applicants believed to be homosexual or bisexual will be tested regardless of other relevant criteria such as degree of risk-producing behaviour.230

Insurer testing is unreliable in view of the unacceptably high number of “false positive” test results.

In the United States, California, Wisconsin and Florida and the District of Columbia have enacted legislation to regulate the testing policies of insurers. In April 1985, California enacted a law231 prohibiting insurers from requiring an applicant to undergo testing or to divulge previous test results for the purpose of determining the applicant’s insurability. In July 1985, Wisconsin enacted a similar but more restrictive measure232 in also prohibiting insurers from requiring an individual to reveal whether he or she has submitted to the test, or what the results of the test were.233 In 1986, the District of Columbia City Council enacted the most restrictive

227 It is, of course, early days for medical evidence to support or deny this argument in terms of an accurate percentage of HIV carriers, if any, who will not go on to AIDS.


229 Ibid 1799.

230 It would appear that a New Zealand insurer could with impunity deny insurance cover to a homosexual male simply on the ground that he is homosexual or believed to be so, since there is no legislation which bans discrimination against homosexuals: see A Borrowdale “Bearing the Financial Costs of AIDS” NBR (8 April 1988) 48. Note, however, the proposed amendment to the Human Rights Commission Act 1977 discussed in n 129 above.


232 1985 Wis Laws 73; Wis Stat Ann 631.90 (West Supp 1986).

233 Apart from this provision, the Wisconsin law prevents insurers from conditioning the provision of insurance coverage on taking the test, and from determining premium rates on whether an individual has tested positive or even taken the test.
legislation\textsuperscript{234} of its kind in the United States in prohibiting the use of all AIDS-related tests during a five-year moratorium period, including tests to appraise the condition of the immune system, and barring underwriting decisions based on sexual orientation. Florida has also banned the use of the test and its results by insurers\textsuperscript{235}.

Numerous US states have recently passed risk pool legislation which is designed to make insurance available to high-risk individuals who would otherwise be considered uninsurable, as well as to assist the insurance industry by spreading the financial burden of these individuals more equitably among insurers, the individuals themselves and existing policyholders. Under a mandatory pooling system, each insurer is required to accept a share of previously rejected applicants proportionate to its share of the state’s insurance market. Premiums for risk pool participants are usually statutorily limited to 150\% to 200\% of the average premium in the state for healthy insureds. The medical costs of risk pool participants often exceed this cap, and these excess costs are passed on to other policyholders.\textsuperscript{236}

Perhaps as problematical as insurer testing is the practice of questioning applicants. Insurers could plausibly argue that answers to questions about submission to the HIV antibody test and test results as well as questions about sexual orientation are as relevant for risk-assessment purposes as answers to questions about smoking and drinking habits. Nevertheless, questioning applicants about the results of previous tests may discourage high-risk individuals from taking the test voluntarily. As the US National Academy of Sciences warned in its report on AIDS:\textsuperscript{237}

\begin{quote}
The general threat of discrimination in ... insurance ... may deter individuals in high-risk groups from being tested to ascertain their antibody status. Since knowledge of antibody status may prompt some individuals to adopt healthier behaviour, social disincentives to testing should be minimised.
\end{quote}

In US states which prohibit insurer testing, insurance companies have resorted to questioning applicants about their sexual orientation as a means of screening out those they suspect of being homosexual or bisexual whom they consider to fall in a high-risk category. It is submitted, however, that an applicant’s sexual orientation in itself is not an appropriate underwriting tool for use either as a justification for testing or as the basis of a question on the application form since high-risk sexual activity is surely a more accurate risk assessment factor. Insurers’ questions on

\textsuperscript{234} DC Act 6-132, 170 (1986). The DC legislation also forbids insurers asking applicants for the results of prior tests and denying coverage because an individual has tested positive or has declined to take the test.
\textsuperscript{235} Fla Stat Ann 381.606(5) (West 1986).
\textsuperscript{236} Schatz, op cit, 1796.
\textsuperscript{237} Institute of Medicine, National Academy of Sciences, Confronting AIDS 169 (1986).
sexual orientation and denial of coverage simply because the applicant is homosexual or bisexual must therefore be prohibited.

**Recommendation:** A fair balance must be struck between absolute banning insurer testing and questioning, and allowing it unrestricted:

* Insurers should be able to decline coverage to applicants who have AIDS just as they may decline applicants with cancer or other terminal illnesses.
* Insurers should be prohibited from refusing coverage, charging a higher premium or requiring testing solely on the basis of an applicant’s actual or alleged sexual orientation.
* Insurers should be prohibited from requiring applicants to reveal whether they have obtained a test or the results of any test.
* Insurers should be prohibited from conditioning the provision of coverage, or fixing the premium rate, on whether an applicant has obtained a test or on the results of any test except when there are valid medical reasons for doing so. Such reasons might include history of drug use, high risk sexual activity, or sexually transmitted disease as well as symptoms like swollen glands, weight loss and night sweats that often precede an AIDS diagnosis. Such reasons are less stigmatising than a positive test result and would therefore be less likely to discourage high-risk applicants from seeking voluntary testing beforehand. 238
* When insurers do test for valid medical reasons, testing must be accompanied by informed consent, when confidentiality of results can reasonably be guaranteed, and when counselling before and after the test is available and offered. 239

14 **Persons Resident in Non-Correctional Institutions**

The differential treatment accorded individuals in correctional institutions vis-a-vis non-institutionalised individuals applies in the non-correctional context as well. Institutionalised individuals are placed in contact with other individuals whom they did not freely choose and cannot avoid; non-institutionalised individuals are free to place themselves in situations of their own choosing where a free and discriminating selection of partners can be made. 240 Institutionalised individuals, therefore, require “enforced” or paternal protection in view of their closed environment and position of dependency.

238 Schatz, op cit, 1795.
239 Perhaps a more effective way for insurers to reduce their AIDS costs is to help prevent its further spread by contributing to educational efforts to control HIV transmission.
Selective testing and isolation in non-correctional institutions may be justifiable for those individuals with impaired mental incompetence and who are sexually active, and those who exhibit violent behaviour, since they might unknowingly or involuntarily expose their partners or victims to HIV or expose themselves to HIV. Therefore,

**Recommendation:** Any type of coercive testing of individuals resident in non-correctional institutions is unwarranted, except where this could reasonably be expected to protect those individuals who are likely to be exposed to or expose others to HIV unknowingly or involuntarily because of sexual activity or violent behaviour. Voluntary testing may be advisable for all other resident individuals.

15 **Persons Convicted of a Violent Sexual Offence**

In order to more effectively implement the previous recommendation concerning the imposition of criminal liability for HIV transmission, the Government may wish to consider the coercive testing of individuals convicted of violent sexual offences such as rape. Although no formal recommendation is being made, the knowledge of a positive antibody status would be beneficial in other contexts as well.

16 **Males Engaging in Homosexual Activity**

A substantial number of New Zealand males who engage in homosexual activity have become infected with HIV and have gone on to develop AIDS. As prevention remains the only effective strategy to control HIV transmission, testing of these individuals can, *inter alia*, prevent them, if they are infected, from unknowingly transmitting HIV as well as providing them with access to counselling and health care facilities. Nevertheless, coercive testing could deter these individuals from being tested and seeking health care. Therefore,

**Recommendation:** Voluntary testing is strongly recommended for those individuals who have engaged in risk-producing homosexual activities, including unprotected sexual intercourse.

241 Idem.
242 This recommendation follows the thrust of the equivalent Canadian recommendation: see the Canadian Working Paper at 68.
243 For sentencing purposes on the conviction for the violent sexual offence as well as to enable victims to seek counselling and testing and, if required, to seek treatment and to adopt safe practices.
244 According to Department of Health statistics supplied to the writer, as at 5 April 1989, 109 out of 124 notified AIDS cases involved homosexual victims. As at 10 March 1989, 229 out of 292 cases of positive HIV antibody tests where the risk group could be ascertained were attributable to homosexual transmission: see appendix a.
245 It is the considered view of the Trustees of the American Medical Association that requiring testing for all homosexuals would "only drive people underground and away from the health-care system": New York Times, 21 June 1987, A26.
17 **Persons with Sexually Transmitted Diseases**

There is evidence that many individuals who are infected with HIV in North America have had a history of sexually transmitted disease.\(^{246}\) Testing may be useful, therefore, to prevent these individuals, if they are also infected with HIV, from unknowingly transmitting HIV to their sexual partners, apart from the obvious benefits to themselves. Several hundred sexually transmitted disease clinics in New York State are now required to offer their patients free, voluntary testing.\(^{247}\)

Therefore,

**Recommendation:** Voluntary, confidential testing should be routinely offered to individuals seeking treatment at sexually transmitted disease clinics.\(^{248}\)

18 **Health Care Personnel**

As two leading British medical commentators have recently stated: \(^{249}\)

> [T]he risk of health workers becoming infected is very small and can be countered by adopting careful techniques with all patients. Around the world hundreds of thousands of health workers have treated patients infected with HIV and only five have become infected as a result of broken skin or mucous membranes being exposed to infected blood. In addition, hundreds of health workers have suffered inoculation injuries while treating patients infected with HIV, and only four are known to have become infected. The risk is thus extremely small.

In view of this minimal risk to health care personnel, the testing of all such personnel is unwarranted. In the absence of a demonstrated risk of HIV transmission, voluntary testing is not necessary either. Nevertheless,

**Recommendation:** Voluntary testing is strongly recommended for health care personnel who may have been exposed to HIV by accident and for individuals who are alleged to be the source of accidental HIV exposures.\(^{250}\)

19 **Children in School and Day-Care Centres**

So far children comprise a very small percentage of the total AIDS population with

\(^{246}\) Canadian Working Paper at 49.


\(^{248}\) Proponents of such testing include President Reagan (New York Times, 1 June 1987, A15), Dr James O Mason, Director of the Centers for Disease Control (New York Times, 11 May 1987, A1, B5), and the Trustees of the American Medical Association (New York Times, 21 June 1987, A26).


infants accounting for most of the cases. Children receiving contaminated blood or blood products and babies born to infected mothers may be infected with HIV. It is considered that there is virtually no risk of acquiring HIV from a family member where no sexual or infected child birth relation exists. Although HIV-infected children could be considered to be a potential threat to other children or adults through play, injuries, incontinence, bleeding or violent behaviour such as biting, there is no evidence to suggest HIV has been transmitted between children under such circumstances, or that there is a risk of HIV transmission in the absence of sexual intercourse or blood transfusion.

The US Centers for Disease Control have promulgated sensible and reasonable guidelines to assist in the formulation of policies concerning the care and education of children with HIV and AIDS. The thrust of the relevant CDC recommendations, which this paper adopts as its own, include:

**Recommendation:** Decisions regarding the type of educational setting for HIV-infected children are best made using the team approach including the child’s physician, public health personnel, the child’s parents or guardian, and school personnel. In each case, risks and benefits to both the infected child and to others in the proposed educational setting should be weighed and balanced.

* Most infected school-aged children should be allowed to attend school since the benefits of an unrestricted educational setting would outweigh the risks of their acquiring potentially harmful infections in the setting and the apparent nonexistent risk of HIV transmission therein.
* For HIV-infected, preschool-aged children in day-care centres and for some neurologically handicapped children who lack control of their body secretions or who display behaviour such as biting, and for those children who have uncoverable, oozing lesions, a more restricted educational environment is advisable until more is known about HIV transmission in these circumstances.

* Concerning the testing of all children entering, or in, school or day-care centres, the danger of HIV transmission to uninfected children and caregivers is so slight that the benefits of testing do not appear to compensate for the harms and costs that flow from such testing. The rationale of most types of medical testing, a cure or vaccine, is also absent. Therefore, mandatory testing of these children is unwarranted; voluntary testing is not necessary either in the absence of a demonstrated risk of HIV transmission. Any testing of these children must be accompanied by the informed consent of the parents or guardian.

* Persons involved in the care and education of HIV-infected children should maintain confidential records. To protect these children from ostracism, the number of school personnel who are aware of a child’s infected status should be kept at a minimum needed to assure proper care of the child and to detect situations (eg, bleeding injury) where the potential for HIV transmission may increase.

* The Departments of Education and Health should inform parents, children and school personnel about HIV transmission in order to secure the best care and education for infected children while minimising the risk of HIV transmission to other children.

20 Children Being Considered for Adoption

As the authors of the Canadian Working Paper have observed, adoption presents a distressing dilemma with respect to HIV antibody testing. A policy not to test children being considered for adoption may endanger public confidence in adoption programmes and lead to unscreened children not being adopted. A policy to test such children could result in HIV-infected children not being adopted since the latter may be perceived to be a potential risk of HIV infection to other family members, to have
a limited life expectancy, or to be an economic burden for the adopting parents. Nevertheless, adoption agencies should consider testing those children at increased risk of HIV infection before placement in the adoptive home, since the adoptive parents must make decisions concerning the medical care of the child, consider the possible social and psychological effects on their families, and take precautions against HIV transmission within the family. Therefore,

**Recommendation:** Testing is strongly recommended for those children who are being evaluated for adoption who are considered to be at increased risk of HIV infection.

**IX CONCLUSION**

It has been observed that a consideration of the history of earlier epidemics suggests that gross over-reaction can occur leading to social disruption and much personal injustice. In an atmosphere of public confusion and panic fuelled by misinformation, increasing pressure will be exerted on politicians and public health officials to confront this new and relentless pandemic by introducing more coercive and restrictive measures. In responding to this pressure through the hasty enactment of AIDS legislation, politicians risk inflicting the community with ineffective, ill-considered and overinclusive laws. As this discussion paper has attempted to illustrate, most coercive and restrictive measures would in fact impact little on HIV spread while imposing disproportionate constraints on the privacy of those individuals most vulnerable to HIV infection. Some such measures may be necessary, however, to deter irresponsible behaviour since even-handed law must enforce individual responsibilities as well as protect individual rights.

As a complex and pressing medical and public health problem which cuts across society, AIDS demands a bipartisan legislative approach based on compassion for the afflicted and solicitude for potential victims. Those who would unduly politicise AIDS could seriously delay measures to save lives. Yet the law may have only a limited, facilitative role to play. Any perception that legislation can provide a "quick fix" for such a complex and controversial public policy issue as AIDS is misguided. The uncertainty and rapid changes in our understanding of AIDS and HIV infection, combined with the harms and costs associated with HIV antibody testing, underscore the need for caution in relying on legislation to deal with the pandemic.

258 Canadian Working Paper at 75.
259 A child's previous exposure to HIV may determine whether it is safe to give the child certain immunisations since some vaccines may be dangerous for such a child.
262 Ibid 80.
The effectiveness of AIDS policies and testing programmes will depend on the confidence of high-risk groups and the extent to which their voluntary participation therein can be secured. This will, in turn, depend upon the degree to which these groups perceive they will be guaranteed confidentiality and freedom from discrimination. Such a guarantee will require a legislative base to be truly effective.

Since the prevention of HIV transmission remains the only effective control strategy, aggressive, coordinated and well-thought-out public health measures are required. Behavioural changes must be encouraged through mass public education and precisely targeted voluntary testing combined with counselling.\textsuperscript{263} Public resources must also be earmarked for the support of community groups encouraging behavioural changes and for the provision of a sufficient number of drug and sexually transmitted disease treatment centers. The discussion and recommendations contained in this paper are intended to stimulate discussion on a wide range of AIDS-related issues, for the time has come for New Zealanders to formulate a comprehensive, effective, coordinated and systematic strategy to control HIV transmission and to deal with its devastating consequences.

\textsuperscript{263} Counselling can contribute significantly to making testing programmes effective in changing behaviour, regardless of test results.
**NZ HEALTH DEPARTMENT STATISTICS:**
Notified cases of AIDS as at 7 April 1989

1. Total no. of cases to date: 124

2. Annual notifications - 1984: 3
   1985: 11
   1986: 19
   1987: 30
   1988: 38
   1989: 23

3. Sex -
   Male: 123
   Female: 1

4. Age group -
   0-9: 0
   10-19: 1
   20-29: 24
   30-39: 48
   40-49: 37
   50-55: 11
   60+: 3

5. Risk group -
   Homosexual: 109
   Homosexual and IV Drug User: 2
   IV Drug User: 2
   Haemophiliac: 2
   Transfusion: 1
   Heterosexual: 1
   Not stated: 7

6. Clinical diagnosis -
   Opportunistic Infection: 93
   Kaposi’s Sarcoma: 12
   Opp. and Kaposi’s: 1
   Opp. and other: 2
   Other: 16

7. Comment/outcome -
   Deceased: 58
   Gone overseas: 6
   Alive: 57
   Unknown: 3

*(this information is not notifiable)*
## Confirmed Tests to HIV Antibodies as at 10 March 1989

1. Total no. positive tests: 424

2. Sex -
   - Male: 392
   - Female: 13
   - Not stated: 19

3. Age group -
   - 0-9: 6
   - 10-19: 11
   - 20-29: 111
   - 30-39: 151
   - 40-49: 71
   - 50-59: 16
   - 60+ : 7
   - Not stated: 51

4. Risk group -
   - Homosexual: 229
   - Haemophiliac: 31
   - Transfusion: 13
   - Heterosexual contact: 6
   - IV Drug user: 7
   - Homosexual IV Drug user: 5
   - Homosexual/Prostitute/IV Drug user: 1
   - Not stated/Unknown: 132

The confirmed antibody positive figures are of limited epidemiological significance as they reflect the number of tests done; and because anonymity is a requirement for co-operation from the "at risk" groups the numbers will include a small (though unknown) number of duplicate tests for some individuals. These figures are collated from the monthly returns submitted by NHI, Auckland Virus Laboratory and Auckland Regional Blood Services Laboratory.
COMMENTARY:
LEGAL AND POLICY IMPLICATIONS
OF HIV TESTING

Mr Warren Lindberg
Director of the NZ AIDS Foundation

The NZ AIDS Foundation grew out of the response of the gay community to the threat of AIDS in NZ, and remains the main channel for those most affected by AIDS and HIV to express their views, responses, and actions with regard to the epidemic. We support the conclusions of Mr Hodgson in his thorough examination of the legal and policy implications of HIV testing, but want to highlight some points, and to argue vigorously for a course of action that we believe is vital to the successful limitation of the epidemic.

In April 1989 there had been 126 cases of AIDS notified in NZ. There were seven cases in which the mechanics of transmission were not known, and three that were transmitted by medical misadventure (blood transfusion before screening was introduced). Of the rest 99% affected men who have sex with men. The pattern of reported HIV antibody tests reflects the same pattern.

Before considering further the role of testing and the law, it is important to know something about this population group that is so overwhelmingly affected by the epidemic. The demography of men who have sex with men is extremely limited: we still use Kinsey’s studies of sexual behaviour in the 1940s and 50s, which suggested that approximately 10% of men predominantly homosexual, and that a further 20% engage in some sexual activity with other men at some time of their lives. Homosexuality has been socially disapproved, and legally punished in our society (although not in all human societies) for hundreds of years. It has been variously defined as a sin, a crime, and a mental disorder to recent times. It was removed from the American Psychiatric Association list of disorders in 1973 and from the WHO list in 1987. Until very recently, brutal “therapies” such as aversion therapy and shock treatment have been applied to people unfortunate enough to have sought “treatment”. Although sexual acts were decriminalised in NZ in 1986, it remains perfectly legal to discriminate in terms of housing, employment, and to refuse goods, services, finance or care to any person on the grounds of their sexual orientation. Men who are homosexual learn to live with socially approved derogation and verbal abuse. Anti-gay violence and suicide are also hard to quantify, but the anecdotal evidence — if not the actual incidence — is increasing.

The consequences of personal rejection, social acrimony, legal discrimination, punishment, and violence are, not surprisingly, severe problems for the individual
in terms of self esteem, sense of social worth, ability to sustain long term social goals, and to trust those in authority. What should be surprising is the high level of individual achievement of many homosexual people, their extraordinary contribution to the professions — especially the caring professions, their ability to sustain a community, and their major commitment to the human rights of others.

So in formulating a public health response to the AIDS/HIV epidemic we believe that a fundamental dictum should be that which Justice Kirby first enunciated in 1986: "Given that the high risk groups are already accustomed to discrimination, alienation and isolation, the introduction of punitive measures, compulsory reporting and criminal offences may be seen as just the latest backlash of a prejudiced society."1

The traditional public health approach to an epidemic of an infectious disease is to identify those infected, to isolate them from those at risk, and to treat. Since it is the only one of the three that may be of any use in this epidemic, HIV antibody testing is obviously very important, and both Hodgson and Kirby have outlined fully the reasons why testing should remain voluntary and not coercive. But, in addition to the questions that Hodgson raises about the purpose of testing, we would wish to raise two others.

1 What will be done differently on the basis of the test result?
2 What are the consequences of the test for the individual being tested?

Hodgson's paper discusses the importance of counselling and education for prevention. We would emphasise that testing and counselling together have been demonstrated to be the most effective intervention for risk reduction that we have. Research in comparable countries (Australia, United States),2 as well as in New Zealand, clearly supports the efficacy of individual counselling and testing in motivating and supporting behaviour change. It does not support testing on its own, nor is individual counselling alone sufficient to sustain behaviour change. Other prevention programmes geared to changing community norms about safe sex are necessary to sustain safer activity. The important point is that testing does not enable the doctor, or the health system, or the law, or anybody other than the patient, to do anything differently as the result of the test — only the individual tested is enabled to reduce his risk.

With regard to our second question, the major consequence to the individual is that,

while it may contribute to his ability to reduce his risk of exposure to HIV, it also increases his risk of exposure to irrational fear, prejudice, and discrimination. The major factor that deters gay and bisexual men from testing is fear of discrimination on the basis of a positive test result. This discrimination may occur on the level of personal rejection by peers, family, and colleagues; or harassment; dismissal by employer, eviction by landlord, or refusal of care by health care workers. But it occurs most frequently from financial interests such as insurance companies.

In New Zealand this discrimination is perfectly legal and is currently flourishing. Without any mechanism to redress perceived wrongs, it is extraordinarily difficult to collect accurate information about them. And as long as there is no legal redress we will not be able to quantify the incidence, or describe accurately the way in which it occurs. But in those places where there is a mechanism, such as New York, sexual orientation discrimination forms a major part of the caseload. (In 1984–5 sexual orientation discrimination was the most common type of problem brought to the NY Human Rights Commission by the public — 32% of the total.) And in New Zealand gay community groups have begun to monitor discrimination in order to substantiate their call for legislation.

A most significant feature of AIDS-related discrimination — both here and overseas — is that it is frequently extremely difficult to separate from homophobia. Fear of AIDS has become indistinguishable from fear of the people seen to be most likely to carry it. This has been characterised as a three-fold pandemic: the silent epidemic of the virus, HIV; the obvious syndrome of illness called AIDS; and the third epidemic — the epidemic of fear. And it is important to recognise who has the most to fear — gay men. Gay men are threatened by our most intimate of relationships. It is our friends and lovers who are dying, and from whom any one of us may have been exposed to the virus before we even knew it existed. We also have to fear discrimination and violence — whether we remain at risk in our intimate behaviour or not.

A recent study of sexual attitudes and behaviour among men who have sex with men in Auckland has identified some of the reasons why safer sex is so difficult to adopt and sustain for some men. These include low self esteem, fear of openly identifying as “gay”, lack of clear sexual identity, difficulty in sustaining relationships. These difficulties are socially constructed — they are not inherent in the homosexual condition. If we are to contain this epidemic our society must examine what it does to homosexual men to produce such low self esteem, and such difficulty in sustaining relationships. Obviously one reason why gay men find it difficult to come to terms with sexual identity and to settle down in a mutually satisfying faithful monogamous

relationship is that they will be discriminated against if they do. Furthermore, if we consider HIV testing, even the fact of having a test may result in discrimination: because by doing so we acknowledge that we may have been at risk. So the number of gay men who have taken an HIV test in Auckland, where there is no protection from discrimination, is only one third of those in Adelaide, where there is anti-discrimination legislation.

The NZ Government’s record in response to AIDS is one of the most enlightened in the world — in terms of policy, funding, and the removal of legal obstacles. As both Kirby and Hodgson have pointed out, the role of law is limited, and certainly cannot provide any “quick fix”. Any attempt to use co-ercive or punitive measures will fail. What we must do is make the world safe for those at risk to seek help, support, education, and fulfilling relationships. And the law can contribute to this in a major way by protecting the rights of those who are most vulnerable, and providing redress for those who are discriminated against unfairly.

In conclusion I should like to quote Dr Jonathan Mann, director of the World Health Organisation’s Global Programme on AIDS: “In every society and every culture AIDS has led people inevitably to face a number of longstanding complex and pre-existing problems in the health and social systems. And we have to recognise the complexity of those problems, because those are some of the most intractably difficult and tragic issues.” And he has recently put this issue more bluntly: “If you have good education and services but the general social climate is discriminatory and stigmatising, then prevention just won’t work.”

4 Mann, speech to first international meeting of AIDS Service Organisations, March 1989.
AIDS: THE INDIVIDUAL AND SOCIETY

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Introduction

The ethical issues in AIDS that are of legal interest concern an individual in his relation to society and in his transactions with others in that society (here, as elsewhere, I use he and him because we only have one female AIDS patient in New Zealand). These issues arise from the facts about AIDS. At present we believe that:

1 HIV causes AIDS;
2 HIV is only transmitted by fresh body fluids;
3 Most people who are infected by HIV will develop AIDS;
4 AIDS is a lethal and incurable disease;
5 There is a “window” between infection and the development of detectable HIV antibodies so that an individual can only be found to be infected after he has already become a danger to others.

In the light of these facts I will examine the following issues that arise in AIDS:

1 Protection of society and the rights of individuals;
2 Sanction of criminal activities;
3 Ethical constraints on transactions between individuals where there is risk involved;
4 Confidentiality;
5 Euthanasia.

1 Protection of Society and the rights of individuals

Some claim that there is no case at all for respecting confidentiality with AIDS because, like tuberculosis and other significant public hazards, it ought to be notifiable. If it were notifiable its detection and the use of the information about individuals that resulted would be a matter of public health and not individual discretion or patient choice. It would be fair to say that in the past the public weal has been given inordinate weight in the balance between public and individual good. Even in the United States “[t]he courts . . . proclaimed public health ‘the highest law of the land’ and announced ‘all constitutionally guaranteed rights must give way’ to its demands. At the same time, however, courts held communicable disease measures constitutional only if they were “reasonable” attempts to prevent the spread of disease”.¹ But it is the very term “reasonable” that indicates the need for

careful ethical thought. Justice Kirby has noted "the law does not exist in isolation. It is part of the mosaic of social regulation . . . the perceived needs for law depend upon the perception (and actuality) of the size and nature of the problem being tackled". At last report there had been 126 cases of AIDS reported in New Zealand, which tallies with predictions by Professor David Skegg in 1987. In the same article he made some alarming remarks about the future: "Although we cannot predict what lies ahead with any confidence, we must warn the public that the possibility of a major epidemic is real".

We have a sound ethical and legal basis for compulsory detection and public health measures designed to prevent the spread of a disease wherever the affected persons pose unavoidable risks to the general populace in their normal everyday activities. But we know that AIDS is not highly infective because, in fact, the only way to transmit the disease is by direct inoculation of one human being with fresh body fluids from another. Thus it is clearly not the case that AIDS can be inadvertently caught by members of the public dealing with HIV positive individuals. What is more, there is no specific treatment for AIDS so that reporting has advantages for those infected or those at risk. Finally, the window of undetectable infectivity (which may be as long as 14 months) means that eradication based on detecting HIV positive individuals is impossible. Therefore, there is no purpose to be served in terms of keeping the public from harm or of eradicating the disease by detecting and reporting HIV positive individuals. Neither is there any reasoned basis on which employers, associates, or clients of HIV positive persons need to know about their status.

There is, moreover, an added ethical factor: to be told oneself or have others told that one has AIDS is to suffer a major change in one’s life. This change is so intrusive and important that there is a strong case for seeking consent to HIV testing. Doctors are professionally dedicated to the ethical principle primum non nocere and we do not, in our general practice, risk a significant harm to a patient without explicit consent. We waive this as we waive our dedication to confidentiality when there is a public danger involved. But these conditions do not apply to HIV infection because there is no risk to the general public outside a specific and reasonably avoidable range of situations. Thus there is no ethical justification for testing any individual for AIDS without consent.

It may be argued that there are some situations where the risk to others makes testing mandatory regardless of the individual’s wishes. The commonly cited scenario is an at-risk person entering medical care. Here there are two possibilities. First, the patient may be unwell but sentient and competent to act in his own best interests.

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2 Justice Kirby, "Legal Implications of AIDS", infra at 1.
4 At 589.
5 With the exception of clients of a prostitute.
Because of the effects of an HIV test it would seem that if such a patient refuses one we ought to take special precautions as if there were a positive test. Second, the patient may be gravely ill with a brain disorder or other major medical catastrophe that has destroyed, perhaps irreversibly, testamentary capacity. If such a person is HIV positive, a good recovery is extremely unlikely and therefore the test would allow a judicious decision to be made about the propriety of intensive (and futile) treatment. Conversely, if the patient is negative then that not only has therapeutic implications but also means that there is no sinister fact creating an ethical dilemma. Thus the only situation in which testing might be done without consent is where the patient is so seriously ill that he is incompetent to consider the request; in this situation there is no ethical problem whichever way the test result goes.

AIDS and the ethical requirement for consent for HIV testing create a problem for medical science. Any community has a clear interest in obtaining good epidemiological data about the disease for the purpose of health planning and the pursuit of measures which may lead to control of that disease. But the ethical constraints on HIV testing and the hesitancy of many of those at risk about knowing whether or not they are affected together make a mockery of any epidemiological work in infection and AIDS. Thus we need to be clear about those constraints and the requirements for consent and confidentiality.

The patient who is at risk from AIDS rightly feels that he has little to gain and much to lose if he is tested and found to be HIV positive. We have, as I have noted, no effective therapy, so that he loses his normal expectation of longevity, and he is faced with an unenviable choice in his relations with others between candour with the risk of ostracization and deceit with its strain and discomfort. Testing for HIV does not necessarily involve a distinct procedure apart from taking blood for other purposes and therefore there is no requirement based on the physical act of testing that would normally be thought to require specific consent. Thus the sole reason for consent is the consequences of the knowledge that the particular individual concerned is HIV positive and the ethical requirement that we make significant information about a person available to him. This is not avoided by not telling the patient because even the knowledge that there is a card which would enter play at any point and that carries such dire consequences for oneself is a significant thing for any person to have to live with. Once there exists an affirmative answer to the question "Have you been tested for HIV antibodies?" your life can never be the same.

Some would argue that true knowledge can never count as a harm but there seems ample reason to doubt this when that knowledge concerns one's HIV status. Thus it appears that we cannot avoid infringing ethical principles if we screen people for HIV antibodies without their consent but that we cannot get good epidemiological data if we insist on consent. However, there is a flaw in the argument. The harm for patient A arises from the fact that he has a positive HIV test. But what the researcher
wants is a measure of how many unidentified and unnamed human beings are HIV positive. Thus there is no conflict. Any sample she obtains from A need not be identifiable as being from A to serve her purposes. The ethical problems can therefore be "finessed". There is no invasion of A's privacy nor is there a potential harm to A, because nothing is known which can be traced to A. In this way the scientifically useful knowledge that x% of patients in the community are HIV positive could be gained without infringing on patients' rights or extracting ethically problematic knowledge about any given individual. The knowledge about A which we ought to surround with norms of consent and confidentiality would not exist to be notified to or withheld from anybody including A himself.

If this recommendation were put into practice it would be true that blood from patients would have been used for research but the lack of special ethical problems with that research would imply that a very general and non-informative form of consent could be gained to the effect that the patient did not mind some of his blood being used anonymously for research. The lack of any material concern to the patient in the situation makes even this seem a little unnecessary. Thus I do not think that any ethical problem stands in the way of epidemiological research into HIV and AIDS provided that the knowledge gained cannot conceivably be traced to any patient involved.

This conclusion has, however, prompted objections from doctors who have asked what they ought to do if they found, say, that one of a thousand patients tested with HIV positive. Could such a doctor, in all conscience, let this individual go undetected and endanger other potential patients within the community? Must we not, therefore, be able to trace the sample and through it the infected individual. But the arguments already advanced resolve this issue. First, we have not sought permission to gain ethically problematic knowledge about a given patient. Second, we must seek that permission where we want to discover the HIV status of an individual. Third, the population is not really at risk and therefore does not need protecting. Fourth, we have served a research interest which has given us knowledge that we did not have that may ultimately benefit the whole community. If, as a result of such an exercise we feel that a group ought to be tested to see which individuals are HIV positive then we must ask each individual we propose to test as to whether he or she will agree. Some may well say "no" and we will, perhaps, fail to find the infected individual, but then we are no worse off than we would have been anyway and as researchers and scientists we (and therefore the members of our community) are much better off. Also we have avoided contravening the requirements of ethical medicine. We may, however, have to live with the fact that among a thousand people we have tested one, we know not who, is HIV positive.

6 An easy method of avoiding duplication of tests could involve testing patients only on their first visit to the hospital after commencing the survey.
2 Sanction of criminal activities

A further ethical problem in public health measures is created by the spread of AIDS in the drug-using community. Here it seems plain that there are two courses open: we could either deny drug users access to needles and allow shared needle use to spread the disease or we could provide exchange needles. The latter measure runs the risk of increasing intravenous drug abuse. The conflict arises from two facts (i) we are committed to rescuing addicts where that is possible but there is no rescue from AIDS; (ii) we treat drug abuse as a crime and do not wish as a society to appear to condone that which we regard as unacceptable.

Perhaps the best we can say is that we obviously do not want more addicts to have to rescue from addiction but neither do we want to turn our backs on one of the genuine causes of mortality among such people. Here we cannot do the ethics without epidemiology in that we need to know whether availability of needles is a genuine factor in the prevalence of dangerous drug abuse and whether AIDS is making a significant long-term difference to its mortality. It seems likely to me that the former is untrue, although I have no evidence to that effect, and that every death from AIDS caught while "in the scene" is a tragedy. For this reason I would support the provision of exchange needles.

A final and broader comment on public health measures to deal with AIDS can be made by drawing on the model of justice developed by John Rawls. On this model, any arrangements in a just society should be acceptable to a group of rational negotiators none of whom know which place in that society they will finally occupy. On this account the resultant constraints on any "marginalised groups" would need to be tolerable to every person whether or not they belonged to such a group. This produces a fine balance between the common weal and minority rights rather than just endorsing the tyranny of a majority.

3 Ethical constraints on transactions between individuals where there is a risk involved.

Justice Kirby raises another important issue: "calls are now being made, and sometimes answered, for the provision of specific crimes to penalise the deliberate or reckless spread of this potentiality lethal virus". I share his reservations about such legislation. "Criminal offences, which have only a minor symbolic value and are rarely prosecuted with success, may actually prove counterproductive because they discourage test-taking". The last worry is consequent upon a clause linking

7 Justice Kirby has discussed marginalised groups, infra at 7-9.
8 At 3.
9 At 4.
culpability to knowledge of one's positive HIV status. We have statutes in New Zealand that could, arguably, be pressed into service in relation to AIDS. "Every one is liable to imprisonment for a term not exceeding 14 years who, wilfully and without lawful justification or excuse, causes or produces, in any other person any disease or sickness".10

Now, it seems entirely right to hold a person guilty of a crime who wilfully infects another person with AIDS whether his evil intent is general or focused on that individual. However the first problem in pressing such a charge, as has been suggested, would be to identify the relevant causative act. But I presume it is possible, where one can identify a pattern of actions some elements of which must have been responsible for a harm, to hold those responsible for them responsible for the harm caused. The second major problem would seem to be to prove that the requisite intent was present given the alternative explanations for the behaviour exhibited. It is far more plausible that the infected partner acted with disregard for the foreseeable consequences of his actions or that he was afflicted by akrasia (weakness of the will). If the former were true then it might be argued that the individual acted with reckless disregard for the safety of another person and that the act or relevant omissions (not emissions) should have been recognised as likely to endanger the health of other partner. To sustain this argument one would, presumably, need to show that even if the critical course of actions was pursued for acceptable reasons there was both an awareness of the possibility of causing harm and a failure to take any measures to forestall it. It could, of course, be argued that an at risk person has reason to believe he may be a danger even if he does not know he is. It is likely however, for the reasons already given, that the clear moral duty will remain just and only that — a moral obligation to care for the welfare of those with whom one has to deal in as much as one's dealings with them impinge on their welfare. Legal measures are likely to act neither as a deterrent from the "reckless" behaviour nor as an incentive for desirable behaviour in this area.

The other plausible scenario involves akrasia or weakness of the will. Here the individual appreciates that he ought to take certain precautions, and not cause danger to another, but he is swayed from adhering to this intention by the occurrent motivation for sexual gratification and perhaps a fear of its denial if he discloses certain information or acts in certain ways. Humans do get swayed from their reasonable, "all-things-considered", best judgments and what sways them has a far less reflective and even-handed lineage than deliberation. For this reason adding further reflective considerations such as laws or moral maxims is singularly unsuccessful. The fact that reason has already failed suggests that further reason will not fare any better and therefore that we must recognise what Hodgson11 has called

10 Crimes Act 1961 s201. I was made aware of this by Peter Skegg.
11 "The legal and public policy implications of Human Immunodeficiency Virus antibody testing in New Zealand", infra.
“the inherent limitations of the law in modifying behaviour”. We could say that here reason has reached its limits of jurisdiction; as Aristotle observes, “if water makes him choke what can you give him to wash it down?”.

What is needed to overcome both of these plausible defects in intention is to change the character and dispositions of the agent concerned so that he intuitively acts out of some concern for others and preserves the commitment to so act in the face of occurrent and conflicting desires and fears. This, of course, is a change which goes beyond the rule of any law and concerns what we might call “the settled habits of the human heart”.

4 Confidentiality

The human heart is directly relevant to the importance of and our respect for confidentiality. There is a potential conflict inherent in the doctor’s duty to protect his patients from harm and his duty to respect confidences. I have explicitly argued that we cannot and need not develop an effective ability to protect the general public or society at large from AIDS. But two cases arise where specific identifiable individuals are at risk of infection: (i) the sexual partner; and (ii) the surgeon or other professional colleague. In most cases we can, I think, agree with the British General Medical Council:

Where HIV infection or AIDS has been diagnosed, any difficulties concerning confidentiality which arise will usually be overcome if doctors are prepared to discuss openly and honestly with patients the implications of their condition, the need to secure the safety of others, and the importance for continuing medical care for ensuring that those who will be involved in their care know the nature of their condition and the particular needs which they will have.

In relation to the first possible case the Council states:

There are grounds for disclosing that a patient is HIV positive or has AIDS to a third party, other than another health care professional, without the consent of the patient only where there is a serious and identifiable risk to a specific individual who, if not so informed, would be exposed to infection.

To my knowledge, the law has set no precedents in this area but lessons may be drawn from some similar situations. In the Tarasoff case “an action was brought against a psychotherapist for failing to warn his patient’s murder victim of the patient’s threats to her life. The majority of the court held that if a psychotherapist determines or should have determined, pursuant to the standards of the profession,
that a patient presents a serious danger of violence to another, the therapist incurs an obligation to use reasonable care to protect the intended victim against such danger".\(^\text{15}\) This decision affirmed both an obligation to warn and constraints on the fulfilment of that obligation: “The therapist’s obligations to his patient require that he not disclose a confidence unless such disclosure is necessary to avert danger to others, and even then that he do so discreetly, and in a fashion that would preserve the privacy of his patient to the fullest extent compatible with the prevention of the threatened danger”.\(^\text{16}\) It would seem that the latter restrictions were the real reason for an apparently contrary decision in New Zealand medical disciplinary proceedings regarding Duncan.\(^\text{17}\) In fact, New Zealand law allows for a breach of confidentiality both where the doctor becomes aware of child abuse and where he believes that a patient is likely to drive while suffering a medical condition which will cause him to be a danger to others. But are we ethically justified in these legally sanctioned actions?

Justification can, I think, be found in the fact that where we have a conflict of duties we appeal to more fundamental commitments to resolve it. We have an ethical commitment to confidentiality on the basis that it harms a person in certain ways for others to be acquainted with facts about him with respect to which he feels sensitive. But the risk of death to another is a more serious harm and justified overriding the conflicting duty. However, there is not only an appeal to relative harms here. I have argued elsewhere that the infected, deceitful individual is “free-loading” on a climate of mutual care and respect by exploiting medical confidentiality and endangering his partner.\(^\text{18}\) Thus, in my discussion, I have overturned confidentiality when two conditions hold. First, an unaffected person must be threatened by identifiable or probable harm and therefore have a claim on the doctor’s promise that she will keep people from harm where she can. Second, the partner, in his own relationships, undermines the values of mutual trust and “responsiveness to the moral features of human interactions” on which confidentiality is based.

5 Euthanasia

The last issue which I shall address is euthanasia. The fact that AIDS is an unpleasant and fatal disease has led to calls for renewed attention to legislation permitting euthanasia. The legal attitude to euthanasia is, at present, to regard it as assisted suicide. We do not have strong legal sanctions in place to forbid assisting a suicide and the reasons for so doing are obvious (one cannot, for instance, retrospectively discern the true wishes of the victim). But the possibility of malign or reckless action bringing about a victim’s death seems remote when this is part of a course of medical

\(^{15}\) Tarasoff v Regents of the University of California (1976) 131 Cal Rpt 14; 551 P 2d 334.
\(^{16}\) At 347.
\(^{17}\) Duncan v Medical Disciplinary Committee [1986] 1 NZLR 513 at 521 per Jeffries J.
care (Dr Crippen aside). It is just implausible to argue that doctors may be found to have in their ranks a number of closet psychopaths and murders who will begin killing their patients in hospital wards throughout the country if we "take the brakes off". What is more, it is quite possible to accommodate euthanasia within a legal system as a carefully constrained practice. In Holland a doctor who has killed a patient will not be prosecuted under the existing homicide legislation if the following conditions are met:19

1 the patient has to be informed about his situation;
2 the physician must have become convinced that the patient's request to terminate his life is the result of careful consideration and that he has upheld his request freely;
3 the physician has come to the judgment that termination of the life of the patient... is justified, because he has come, together with the patient, to the conviction that there are no alternative to the untenable situation of the patient;
4 the physician has consulted another physician included in a list drawn by the Minister.

But I have argued elsewhere that the situation is not as clear as it might be in this area.20 First, I would claim, with the BMA, that the distress of terminal illnesses such as AIDS can be greatly mitigated by good palliative or hospice-type care in which the patient's needs (which are not only physical but also psychological and spiritual) are met.21 Second, there may be many reasons for a euthanasia request, as there may be for a suicide and, when unfolded, these may not amount to a good reason for terminating the patient's life even though they do express real and unmet human needs. Third, there is a link between our practices and the intentions that we tend to form.

That the link goes both ways should give us some pause. When abortion was legalised it was thought that a number of safeguards had been put in place to check a slide towards abortion for ill-considered reasons. Without taking a moral stance on this issue, one can observe that the practice of performing abortions has changed our conception of what is involved. This has reached the point where the moral significance that was once almost universally read into abortion is now no longer readily discerned so that the intention to abort is no longer seen to be as serious and weighty as it once was. Thus the practice has changed the way in which we view the intention. Without saying anything about the link or lack thereof between abortion and killing one can derive certain thoughts about euthanasia from these well-known social observations. It is not only possible but plausible that euthanasia may go

through the same evolution from a thing that is seen as serious and needing careful safeguards to something which is regarded with much more equanimity. But it seems to me that the decision to kill an adult human being should not be lightened in this way. The murderer, as Peter Winch has observed, is changed by his murder.22

Going in the other direction we can consider the effect of endorsing a certain type of intention on the subsequent behaviour of the agents concerned. Aristotle clearly saw that an agent's character is not only the source of her intentions but, in a sense, the sum of those intentions. An agent's character can be regarded as the complex of _hexes_ or settled habits of the heart that she has developed. These "habits of the heart" emerge as a person formulates and commits herself to courses of action in various situations and these conceptions and commitments cumulatively build on each other to form her personality. Thus the intentions that we act upon change us as characters as well as expressing our character. I and many others fear the change that would be induced in the deepest intuitive responses should it become acceptable, initially under closely constrained conditions, for doctors to kill their patients. It would be wrong to call this "brutalizing" but it would be right to worry about its effect on an individual for whom a fundamental axiom (or better disposition) of reason and action was to safeguard and help the suffering and helpless.

Lastly, the events at the end of a person's life are complex. If, with Jean-Paul Sartre, we regard each of us as writing an autobiography of deeds and experiences, then the book is not completed until the life ends. The last sentences of many books do change the whole often in unexpected and unmeasurable ways. Thus there is a kind of reverence, a kind of "hands off" humility that many of us consider is appropriate at this point and that is expressed in what Elisabeth Kubler-Ross has called "the silence that goes beyond words".23 We cannot predict what may happen as death approaches the dying individual. This uncertainty, and the humility which it characteristically occasions, is a further reason why I do not think it right to make the moment of death radically subject to human choice. For all these reasons I would demur from the minority but strident clamour for euthanasia.

Conclusion

I have attempted to outline the points at which law, ethics and AIDS impinge upon one another and to provide an ethical underpinning for the legislative and common law debates that we face in this area. I believe that the ethical arguments critically turn on the uniqueness of each human being and his or her personal engagement and development in relationships with others. If this is clearly kept in mind then we will all act with the humanity that is a _sine qua non_ of right thinking on these issues.

22 Ethics and Action (1972).