AIDS: A Plague upon Your Civil Liberties

Lisa McDougall

University at Buffalo School of Law (Student)
AIDS: A PLAGUE UPON YOUR CIVIL LIBERTIES

by Lisa McDougall

This paper attempts to survey potential legal ramifications of AIDS-based discrimination. Obviously, even though this epidemic is in its infancy, volumes could be written. I have limited my legal analysis to a sampling of AIDS-related discrimination cases and the possible potential for legal redress, at the expense of developing other areas of civil liberties violations, mainly because of necessity. It is a cliche to say that AIDS is a complex puzzle, but what might be added is that each time you open the box there are more pieces, each one commanding absolute attention, making any attempt toward completion an awesome task.

I have separated the paper into two sections, medical aspects and legal aspects. In retrospect the separation is almost arbitrary because of the incredible interdependency that exists. I found this a fascinating area with cause for both pessimism and optimism about human response. While much reaction could be categorized as uneducated and homophobic, the coalitions and political gains made by gay and lesbian communities have shown remarkable strength in guarding civil liberties and educating the public.

MEDICAL ASPECTS

Epidemiology

In the middle of 1981, the Centers for Disease Control (CDC) began to receive some odd information. Reports indicated that healthy, young, gay men were beginning to die suddenly of diseases previously known to strike only people whose immune systems had been suppressed by either immuno-suppressive therapy (chemotherapy) or an underlying disease. In June of 1981, clinical investigators from Los Angeles reported 5 cases of Pneumocystis carinii pneumonia (PCP) to the CDC! None of these men had either an underlying disease nor a history of any immuno-suppressive therapy but all 5 nonetheless showed clinical signs evidencing a disturbed, dysfunctioning cellular immune system. One month later, 26 cases of Kaposi’s sarcoma (KS) were diagnosed and reported to occur in young, homosexual men in California and New York. In the United States before 1981, KS was a rare neoplasm that targeted mainly elderly males of Mediterranean ancestry. Since many of these 26 new cases of KS also had concomitant opportunistic infections, and since the group affected seemed to be young, homosexual males, it seemed likely that there was a link between the KS and the PCP, probably having something to do with an underlying disturbance, then of unknown origin, in the men’s immune system.

Laboratory analysis performed by the CDC showed that patients with KS and PCP had significantly reduced levels of “helper cells,” the white blood cells that assist the immune system in fighting infections. The reason for the lack of “helper cells” was then open to speculation. One hypothesis was that the use of amyl and butyl nitrate inhalants as recreational drugs by gay men served to severely compromise the immune system. But the “recreational drug use theory” alone did not serve to answer many of the questions and as data mounted, this theory, as well as many others, were discarded as inadequate, or incorrect.

By fall of 1981 it became obvious that this newly presenting condition, christened AIDS — acquired immune deficiency syndrome — by the CDC, was not confined to young, homosexual men. Montefiore Hospital in the Bronx reported diagnosing and treating several new cases of PCP and other opportunistic infections in heterosexual men and women who were frequent intravenous drug users.

Miami then reported that autopsy reports performed on 4 recent Haitian immigrants showed all had succumbed to opportunistic infections. A few months later, several more Haitian immigrants were diagnosed as being ill with opportunistic infections. Initial investigations indicated these Haitians were neither homosexuals nor drug users, the only two categories recognized by the CDC at that point in time as being at higher risk. The Haitians were added to the hierarchy.

In early 1982, yet another group was added to the CDC’s list — hemophiliacs who received injections of clotting factors derived from donated blood.

A few months later, in the fall of 1982, an unexplained cellular immune deficiency was reported in a 20 month old infant who had received a platelet transfusion at birth from a man who subsequently died from AIDS, with the infant later dying from PCP. The CDC then confirmed that two adults who had received blood transfusions contracted AIDS, causing a new category to be added, transfusion-associated.

In January of 1983 the list grew as another segment showed itself vulnerable. Infants who had not received transfusions but whose parent or parents were members of any of the previously identified groups were found to have

Lisa McDougall is a J.D. Candidate, May 1986, State University of New York at Buffalo with a concentration in state and local government.
AIDS. Heterosexual partners of members of groups at risk were found to be themselves at risk, comprising yet another category.9

Finally, there is a category of persons with AIDS (PWA) where a "risk group" assignment has not been possible due to a lack of information or the death of the person before data could be gathered.10

These statistical groupings or "risk categories" have already changed from the original hierarchy, with the Haitians as a group being removed. As more epidemiological evidence is gathered, as science increases our understanding of the disease, and as behavioral changes occur, there is a continuing need to re-examine the statistics in a fluid, progressive and meaningful way, rather than trying to fit cases into preconceived, stereotypical groups.

Numbers

In 1979, 11 cases of AIDS were retrospectively diagnosed, by the CDC.

In 1980, 47 were retrospectively diagnosed by the CDC.

In 1981, 260 were diagnosed by the CDC.

In 1982, 994 were diagnosed by the CDC.

In 1983, 2,719 were diagnosed by the CDC.

In 1984, 5,331 were diagnosed by the CDC.

In 1985, as of December 16, 1985, 6,210 were diagnosed by the CDC.

In 1986, it is projected that about 25,000 new cases will be diagnosed.

The above figures through December 16, 1985 total 15,572 cases diagnosed in the United States. Of this total, 8,002 (51%) of PWA have died.

Table 1 provides a breakdown of the number of persons with AIDS (PWA) and their state of residency.

<table>
<thead>
<tr>
<th>Residence of Cases</th>
<th>Number of Cases</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York State</td>
<td>5425</td>
<td>Missouri 81</td>
</tr>
<tr>
<td>New York City</td>
<td>5012</td>
<td>Arizona 80</td>
</tr>
<tr>
<td>California</td>
<td>3593</td>
<td>Minnesota 57</td>
</tr>
<tr>
<td>San Francisco</td>
<td>1721</td>
<td>Indiana 55</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>1306</td>
<td>Oregon 50</td>
</tr>
<tr>
<td>Florida</td>
<td>1050</td>
<td>South Carolina 49</td>
</tr>
<tr>
<td>Miami</td>
<td>498</td>
<td>Hawaii 48</td>
</tr>
<tr>
<td>New Jersey</td>
<td>933</td>
<td>Alabama 37</td>
</tr>
<tr>
<td>Newark</td>
<td>386</td>
<td>Wisconsin 36</td>
</tr>
<tr>
<td>Texas</td>
<td>784</td>
<td>Kentucky 31</td>
</tr>
<tr>
<td>Illinois</td>
<td>338</td>
<td>Oldahoma 30</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>309</td>
<td>Utah 28</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>295</td>
<td>Nevada 24</td>
</tr>
<tr>
<td>Washington, D.C.</td>
<td>279</td>
<td>Tennessee 24</td>
</tr>
<tr>
<td>Georgia</td>
<td>253</td>
<td>Rhode Island 23</td>
</tr>
<tr>
<td>Maryland</td>
<td>221</td>
<td>New Mexico 18</td>
</tr>
<tr>
<td>Puerto Rico</td>
<td>187</td>
<td>Iowa 17</td>
</tr>
<tr>
<td>Washington</td>
<td>183</td>
<td>Kansas 17</td>
</tr>
<tr>
<td>Virginia</td>
<td>171</td>
<td>Delaware 16</td>
</tr>
<tr>
<td>Connecticut</td>
<td>108</td>
<td>West Virginia 12</td>
</tr>
<tr>
<td>Louisiana</td>
<td>167</td>
<td>Arkansas 11</td>
</tr>
<tr>
<td>Colorado</td>
<td>108</td>
<td>Maine 11</td>
</tr>
<tr>
<td>Michigan</td>
<td>102</td>
<td>Mississippi 11</td>
</tr>
<tr>
<td>Ohio</td>
<td>98</td>
<td>Other States 4</td>
</tr>
<tr>
<td>North Carolina</td>
<td>88</td>
<td>Pediatric Cases 226</td>
</tr>
</tbody>
</table>

Of These, 8,002 (approximately 52 percent) are dead.

Problems With The Numbers

The figures above tend to grossly underestimate the magnitude of the problem for two reasons.

First, the AIDS definition employed by the CDC for case surveillance purposes has been criticized as too narrow. The definition restricts a clinical diagnosis of AIDS to "previously healthy persons who have Kaposi's sarcoma (KS) or pneumocystis carinii pneumonia (PCP) and certain other opportunistic infections" that become life threatening in people with an underlying immune disorder.11

This definition does not include people suffering from AIDS-related complex (ARC). ARC itself suffers from a lack of universal definition, but is generally assumed to mean "a heterogeneous group of clinical disorders in high risk individuals, related to but not necessarily prodromal for AIDS, including diffuse lymphadenopathy fever, profound fatigue, weight loss, and diarrhea. ARC is usually accompanied by depressed cell mediated immunity similar to but less severe than that found in AIDS."12 Current thinking is that some cases of Burket's lymphoma and Hodgkin's disease may be AIDS or ARC related, but neither condition is considered by the CDC as evidence of AIDS.13 Various sources estimate that perhaps 5 to 10 times the number of PWA have ARC, perhaps 750,000 to 1.5 million.14

The second reason for the CDC's numbers being underreprentative of the problem is the delay in reporting that occurs when statistics are sent from physicians to local health agencies to the CDC. Meade Morgan, Chief of Statistics and Surveillance Section of the CDC AIDS program recently stated that reporting delays probably mean an additional 15-20% should be tacked on current numbers to compensate.15

Reporting all AIDS cases to the Federal Public Health Service is mandatory under Federal Law.

As of March 31, 1985, Europe reported 940 cases of AIDS to the CDC. Since December 31, 1984, 178 new cases were reported by the 17 countries corresponding with the World Health Organization Collaborating Centre on AIDS. There was an average increase of 14 cases per week.16

Fifty-two percent of the AIDS patients diagnosed 1 year ago and 86% of those diagnosed 3 years ago have died.17

The Creation of "Risk Categories" by the CDC, and Problems Inherent Therein

For statistical purposes, the CDC categorizes PWA by "risk groups." Currently, the CDC recognizes 7 groups that it considers at special risk for contracting AIDS, and arranges these groups hierarchically, as follows: (1) gay or bisexual men, (2) intravenous drug users, (3) hemophiliacs, (4) heterosexuals (who have a sex partner in some other risk group), (5) transfusion-associated, (6) no known risk factor, and (7) pediatric cases.
After diagnosis, a case is categorized by the "first" risk group the PWA falls in. For example, a bisexual, male i.v. drug abuser will be counted only as a bisexual gay male. This is because the CDC has designated bisexual/homosexual behavior as constituting the top risk group. This system of seemingly arbitrary classification has drawn criticism not only from gay rights groups for being defamatory and misleading, but also from those concerned with epidemiological accuracy. The CDC originally defended the classification by saying that this grouping provided a "nice, neat display" of statistics, but in recognition of the inaccuracies perpetuated by lumping the gay bisexual drug users with all gay/bisexual males, a new category will soon be adopted, "homosexual/i.v. drug users."

In light of recent information indicating the high degree of successful AIDS education evidenced by lower rates of all kinds of sexually transmitted diseases within the gay communities and conversely the swelling trend of AIDS associated with i.v. drug abuse, this separating of factors is important to access accurately the epidemiology and impact of behavioral changes.

A detailed examination of the first 1,000 cases of AIDS diagnosed in the United States illustrates the statistical misrepresentation that can occur. The CDC statistical display would break down the first 1,000 cases as follows:

<table>
<thead>
<tr>
<th>Risk Group</th>
<th>M</th>
<th>F</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homosexual or Bisexual Men</td>
<td>727</td>
<td>236</td>
<td></td>
</tr>
<tr>
<td>Intravenous Drug Abusers</td>
<td>236</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haitians</td>
<td>54</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemophiliacs</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None of the other groups</td>
<td>61</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

When added together the above figures total more than 1,000 because of the significant overlapping that occurs which is not illustrated by the CDC statistical method.

A more accurate analysis would tell us that of the first 1,000 AIDS cases the following is true:

<table>
<thead>
<tr>
<th>Single Risk Factor Analysis</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Homosexual or Bisexual Men</td>
<td>632</td>
<td></td>
</tr>
<tr>
<td>Intravenous Drug Abusers</td>
<td>154</td>
<td></td>
</tr>
<tr>
<td>Haitians</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Hemophiliacs</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>None of the other groups</td>
<td>61</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Groups Where Overlapping Occurs</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Homosexual or Bisexual i.V. Drug Abusers</td>
<td>81</td>
<td></td>
</tr>
<tr>
<td>Homosexual or Bisexual Haitians</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Hemophiliacs</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Intravenous Drug Abusers, Haitians</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

It is significant that upon factoring out for overlapping risk groups, 81 of the 727 homosexual or bisexual men of the CDC statistics also appear as i.v. drug abusers.

As of December 16, 1985, the breakdown of AIDS cases by CDC identified patient characteristics was as follows:

<table>
<thead>
<tr>
<th>Risk Group</th>
<th>M</th>
<th>F</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gay/Bisexuals</td>
<td>11,237</td>
<td>0</td>
<td>73.0</td>
</tr>
<tr>
<td>I.V. Drug Users</td>
<td>2,107</td>
<td>556</td>
<td>17.0</td>
</tr>
<tr>
<td>Hemophiliacs, Coagulation Disorders</td>
<td>113</td>
<td>4</td>
<td>1.0</td>
</tr>
<tr>
<td>Heterosexuals</td>
<td>19</td>
<td>144</td>
<td>1.0</td>
</tr>
<tr>
<td>Transfusions</td>
<td>145</td>
<td>96</td>
<td>2.0</td>
</tr>
<tr>
<td>No Known Risk Factor</td>
<td>728</td>
<td>226</td>
<td>6.0</td>
</tr>
</tbody>
</table>

Notably, Haitians are no longer characterized as a risk group, per se. It appears that the original designation may have been in error. Haitian AIDS patients denied i.v. drug use and only 10% claimed to be gay, however, given immigration concerns, it is hardly surprising that epidemiological data concerning sensitive areas may not accurately reflect reality.

The apparent error in the designation of the "Haitians" as a risk category merely underscores the fact that while the use of categorical devices satisfies the need for a neat display of statistics and may even be necessary to understand this disease, their potential inaccuracy should be of overriding concern. As behavior patterns change, the categories will have to change or they will be misleading and useless. For example, if AIDS is as readily transmitted by heterosexuals as some researchers believe, it may only be a matter of years until United States figures represent the 1:1 male/female distribution seen now in Zaire. The hierarchical risk factors would then clearly have to center around types of risky sexual activity, rather than simply the sexual preference of participants.

Causation

The cause of AIDS is generally attributed to the active presence of a retrovirus known as human T-cell lymphotropic virus type III/lymphadenopathy associated virus (HTLV III/LAV). A retrovirus differs from other viruses in
that it stores its genetic program in its RNA and uses a special enzyme, reverse transcriptase, to make a DNA copy of its RNA program. The DNA of the HTLV III/LAV retrovirus is then permanently programmed into the DNA of the host cell. If reproduction of the virus is not triggered, an event about which there is great mystery, the virus can merely be dormant in its host, the T4 cell. While dormant, the T4 cell may be shed, virus and all, into the body of another person, full of the potential to replicate at an alarming rate. The mechanisms variously suggested as triggering replication and therefore, AIDS, are other infections, re-exposure to the HTLV III/LAV virus, generalized malnutrition, pregnancy, and poor health. If replication is triggered, however, the fact that this retrovirus is capable of trans-acting transcriptional regulation (TAT) means that it will be replicated more efficiently than the genetic material of the host cell's normal state. This speeds up viral growth tremendously. The virus uses the T4 cell as a factory, to make a lot more of itself. The virus is then sent out into the bloodstream of the body. Each new virus kills the T4 cell by taking a bit when they bud off. Eventually, as more and more of the T4 cells are killed, the body has no defenses against infection, for that is the job of the T4 cells. Therefore, the PWA is susceptible to any virus, fungus, or bacteria and has no resistance. Even the HTLV III/LAV virus itself may die off at the very end, after rendering the PWA defenseless.

Currently, a legal battle is being fought between Dr. Robert C. Gallo of the Laboratory of Tumor Cell Biology at the National Cancer Institute, the discoverer of HTLV III, and Dr. Luc Montagnier, of the Pasteur Institute in France, discoverer of LAV, over patent rights. Montagnier announced the isolation of LAV in May, 1983, and the Pasteur Institute applied for a U.S. patent to detect the presence of LAV in blood in December, 1983. In April, 1984, Gallo announced his discovery of HTLV III. He applied for and was granted a U.S. patent for a blood test at that time, receiving it in May, 1985. The potential sales are estimated at $100 million. Although scientists agree these viruses are very similar, the French charge the United States with stealing the virus from LAV isolates sent to Gallo, at his request. Montagnier is credited with first isolating LAV from the "lymph node of a Parisian homosexual man with lymphadenopathy syndrome, from hemophiliac brothers, one of whom had AIDS, and from a blood donor recipient pair, both with AIDS." This was followed by the National Institutes of Health reporting that they had isolated "a retrovirus which they had designated HTLV III from 48 patients, including 18 of 21 with ‘pre-AIDS’; 23 of 64 adults with AIDS, and 0 of 115 healthy heterosexuals. Serum antibody to HTLV III was found in 95% of patients with AIDS, 87% of those with lymphadenopathy syndrome, and less than 10% of controls. HTLV III infects and kills T4 cells in vitro. HTLV III and LAV are morphologically and biologically similar and may prove to be identical." Gallo is also accused of misclassifying the virus to fit into the class of HTLV I and II viruses, when actually evidence suggests HTLV III is really in a different family. Montagnier's belief is that the morphology of the disputed virus more closely resembles a lentivirus, a family about which little is known other than that it includes Equine Infectious Virus and visna virus and arguably LAV. They are associated with severe disease, unrelated to cancer, unlike the HTLV I & II oncovirus types. Even Gallo recently admitted that the virus most resembles members of the lentivirus family, as opposed to human leukemia viruses (HTLV I & II).

There is a minority view claiming that there is a connection between African Swine Flu Virus (ASFV) and AIDS. Various theories have been offered to explain how the virus originated. The earliest HTLV-III/LAV seropositive blood sample in the U.S. appears to be from a female San Francisco prostitute who died in 1978. One popular theory is that the green monkey, found in Zaire, harbors a similar virus, labeled STLV-III. The people of Zaire not only live close to the monkeys but eat monkey, suggesting a route of transmission. Further speculation is that the virus traveled from Zaire to Haiti during a period when many Haitians were in Zaire and then returned to Haiti. This same theory holds that gay men on vacation in Haiti brought it back to the U.S. If indeed this theory is true, recent African epidemiological studies indicate it may have only been a product of chance that AIDS was not brought to the U.S. by heterosexual males. In Africa transmission is primarily heterosexual.

Transmission

AIDS is a blood borne disease and the most effective method of transmission appears to be by either transfusion with contaminated blood or the use and re-use of contaminated needles by i.v. drug users. There is certainly irrefutable evidence for blood borne transmission of AIDS. In New York City for example, 40% of the new AIDS victims are i.v. drug users. Nationally, i.v. drug users make up about 17%, although the figure may be greater when the CDC stops counting all gay i.v. drug users as only gay. Hemophiliacs and transfusion-associated AIDS cases add another 3%.

Perinatal Transmission

Pediatric AIDS cases represent 1% of the 15,172 total or 217 cases. Since ARC cases are not reported to the CDC, and since the CDC itself acknowledges that a number of children are probably infected but asymptomatic, the number of HTLV-III/LAV infected children is bound to be greater than 217.
the virus is unknown. The transmission is believed to occur during pregnancy or possibly during labor and delivery. One case has occurred where it is believed that a mother with transfusion-associated AIDS may have transmitted it via breastfeeding. There is absolutely no evidence whatsoever to suggest that even the closest familial contact has caused even a single case of AIDS or ARC and the most recent data compiled by studying 101 household contacts of 39 AIDS patients provides powerful support for the premise that AIDS is not casually transmitted.

What the perinatal data thus far gathered does suggest is twofold:

1) The infected mother is at increased risk of actually developing AIDS herself, either during or after pregnancy because of the changes to her body associated with pregnancy; and

2) If asymptomatic but infected and infectious children were numerous, havoc would be wreaked upon the compartmentalized types of data sorting devices now in place, because any connection with a "risk group" would become so tangential as to be meaningless.

The Evidence Is Against Casual Transmission

The early and mistaken notion that AIDS was a disease capable of easy transmission through casual contact led to many of the reactions that continue to plague civil liberties. The fear of catching this fatal disease led some people to try to bar children with AIDS from attending school. Employers fired people because they had AIDS, were perceived to have AIDS, or merely because they appeared to belong to a group identified as at risk for contracting the disease. Fortunately, calmer heads prevailed when extreme proposals such as the use of quarantine measures were urged.

Current medical research builds a strong case against any significant casual contagion risk. This information buttresses the legal arguments that can be used to combat AIDS-based discrimination. Specifically if AIDS is transmitted only by sexual contact, blood to blood, perinatally and perhaps through lactation, the only legitimate employment restrictions bearing a rational relationship would seem to involve prostitutes, plasma or blood donors, surrogate parents, or wet nurses. This medical evidence destroys any medical basis for regulating occupations such as food handlers or hairdressers. The potential for blood to blood transmission makes regulation of the health care worker category more problematic. Medical data support only specific precautions for health care workers performing invasive procedures.

AIDS As A Sexually Transmitted Disease

There is agreement among researchers that AIDS can be sexually transmitted. Furthermore, there is documentation proving heterosexual transmission of AIDS, although some argue the incidence of heterosexual transmission will always remain lower than the incidence of homosexual transmission.

It should be emphasized that it is the type of sexual activity that determines the risk, not the sexual preference of the participants. It appears AIDS can be sexually transmitted when infected semen, apparently able to carry the virus, mixes with the blood of the sex partner. This mixing of blood and subsequent infection is more likely to take place during anal intercourse than during vaginal intercourse, it is argued, because of anatomical make-up. It is further argued that anal intercourse is a far more common practice among homosexuals than heterosexuals.

The same article points out that the active partner, not just the passive receptive partner is also at risk if the receptive partner were to bleed from the rectum because the urethra of the penis is fragile, covered with a delicate layer of mucosal cells, easily bruised and torn in anal intercourse.

There are other reasons that anal intercourse appears to favor the spread of AIDS. According to gastroenterologist Dr. Donald Kotler of St. Lukes-Roosevelt Hospital, the environment of the colon itself favors infection.

The most common cells found in the colon are B-lymphocytes, but T-lymphocytes, including T-4s, are also present. B-lymphocytes, Kotler says, are the favorite targets of the Epstein-Barr virus (EBV), a member of the herpes family. Everyone is exposed to EBV at some time in his life, usually through kissing, since it lives in the cells of the throat, and when one is once exposed he harbors it forever within the B-cells. Kotler recently found that EBV is present in the mucosal B-cells of the rectum. The implications for AIDS are significant, because EBV is thought to be a co-factor in the development of many cases of AIDS, and at least one study has shown that before the AIDS virus can infect B-lymphocytes growing in a laboratory, it needs to be paired with an EBV virus.

The finding might mean that a recipient's risk of contracting AIDS would be greater if cells infected with EBV virus were already present in his rectum. The person doing the entering would also be at risk, says Kotler, if his blood already carried the AIDS virus and his penis were to pick up the EBV-infected cells from his partner's rectum.

He goes on to point out that semen is probably an effective HTLV-III transporter because of various nutrients in the semen and the extraordinary hardness of the semen itself.

Dr. William Haseltine, a researcher from Harvard Medical School, believes that the HTLV-III/LAV virus is transmitted as easily heterosexually as homosexually. He points out that in Zaire the rate is 1:1 (male to female). The CDC recently attempted to break down any
stereotyping that may have existed concerning who could get AIDS:

Transmission of HTLV-III/LAV from heterosexual men to their female sexual partners has been well established in studies from the United States and elsewhere. Studies of AIDS patients from several developing countries also indicate that female-to-male sexual transmission of HTLV-III/LAV infection occurs in those settings and emphasize the role of female prostitutes in this transmission. A case control study of Haitian men with AIDS in Miami and New York City showed a significant association of AIDS with a history of prostitute contact and with a history of sexually transmitted diseases, suggesting that sexual contact may be a major method of transmission in these heterosexual men.

For persons born in the United States, female-to-male sexual transmission of HTLV-III/LAV has been less evident than male-to-female sexual transmission. ... Female-to-male transmission of HTLV-III/LAV may be less efficient than male-to-female transmission, as has been reported for gonococcal infections. The proportion of women among infected persons is relatively small.40

Efforts at public education will hopefully be clear that while this is not a disease you can catch from a toilet seat, it is equally not to be dismissed as somebody else's problem.

### Table 3

<table>
<thead>
<tr>
<th>Populations</th>
<th>Location</th>
<th>No.</th>
<th>Prevalence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intravenous drug abusers</td>
<td>New York City</td>
<td>274</td>
<td>59</td>
</tr>
<tr>
<td></td>
<td>NJ 5 miles from NYC</td>
<td>204</td>
<td>56</td>
</tr>
<tr>
<td></td>
<td>NJ 5-10 miles from NYC</td>
<td>124</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>NJ 100 miles from NYC</td>
<td>55</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>San Francisco</td>
<td>53</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Persons with hemophilia</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor VIII concentrate recipients</td>
<td></td>
<td>234</td>
<td>74</td>
</tr>
<tr>
<td>Factor IX concentrate recipients</td>
<td></td>
<td>36</td>
<td>39</td>
</tr>
<tr>
<td>Cryoprecipitate only recipients</td>
<td></td>
<td>15</td>
<td>40</td>
</tr>
<tr>
<td>Female prostitutes</td>
<td>Seattle, WA</td>
<td>92</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Miami, Florida</td>
<td>25</td>
<td>40</td>
</tr>
<tr>
<td>Female sex partners of men with AIDS or ARC (two separate studies)</td>
<td></td>
<td>7</td>
<td>71</td>
</tr>
<tr>
<td>Female sex partners of men with asymptomatic HTLV-III/LAV infection</td>
<td></td>
<td>42</td>
<td>47</td>
</tr>
<tr>
<td>Haitians</td>
<td>New York City</td>
<td>97</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Miami, Florida</td>
<td>129</td>
<td>8</td>
</tr>
<tr>
<td>Female blood donors</td>
<td>Atlanta, GA</td>
<td>28,354</td>
<td>0.1</td>
</tr>
</tbody>
</table>

Yet the use of antibody testing has engendered much criticism, because quite apart from being a tool of the technology that can be used against AIDS, the test represents a powerful weapon capable of facilitating "scientific" discrimination. To see this statement as factual description rather than speculative theory, one has to look no further than the armed forces, where all individuals are screened and if seropositive, either denied entry or discharged. The "No Test is Best" slogan adopted by some gay rights advocates is based on a fear that the test would be used easily and wrongly as a surrogate indicator of homosexuality. Employers aware of an individual's test results might practice wholesale discrimination. Without some strong guarantee of complete confidentiality of test results many people would be understandably reluctant to take the test because of potential ramifications in employment, health insurance, and other areas.

The CDC has proposed tracing and testing the sexual contacts of all people who test positive. The leader of the Association of State and Territorial Health Officers, George Degnon, has urged states to require registry of all antibody positive people as well as their sex partners. Wisconsin now requires reporting the name, address, telephone number, age, race, ethnicity and sex of all persons who test positive.43

When confidentiality is not guaranteed by statute and

---

**The HTLV-III/LAV Antibody Test**

The HTLV-III/LAV blood test is capable of detecting the presence of antibodies to the HTLV-III/LAV virus. Named ELISA (enzyme-linked immuno-absorbent assay), it was approved by the FDA for use in March of 1985. The test is not a test for AIDS, nor is such a test available. A positive ELISA result indicates that the individual most likely has been exposed to the virus.

The CDC advises that the presence of positive antibody status should be considered presumptive evidence of current infection and infectiousness, although it is estimated that only 10% of the seropositive people will develop AIDS, and a somewhat higher figure ARC.41

The test is being used as a screening device for the nation's blood supply, virtually eliminating new cases of transfusion-associated AIDS. ELISA can also be used to project epidemiological trends by analyzing HTLV-III/LAV antibody positive development. The following table reflects the current prevalence of the HTLV-III/LAV antibody presence among various segments of the heterosexual U.S. population.
privacy is invaded, people may be discouraged from taking the test. Mere speculation about one's own antibody status cannot prompt the type of self-motivated behavior changes, such as the practice of safe sex, which are desirable from a public health view point.

Commercialism has exploited fear. In Denver, Colorado, Medical Screening Services offers a wallet sized “Social Card.” The card costs $20 and certifies that as of the date stamped the cardholder's blood was certified “antibody free” It is marked “valid only for date tested.”

The CDC has given a clear message that the use of HTLVIII/LAV screening test by employers would serve no worthwhile purpose. The Morbidity and Mortality Weekly Report of November 15, 1985 states:

Because AIDS is a blood borne, sexually transmitted disease that is not spread by casual contact, this document does not recommend routine HTLVIII/LAV antibody screening for the groups addressed [health care workers, personal service and food service workers, and other workers not at risk]. Because AIDS is not transmitted through the preparation or serving of food and beverages, these recommendations state that food service workers known to be infected with AIDS should not be restricted from work unless they have another infection or illness for which such restriction would be warranted.

LEGAL ASPECTS

Discrimination against PWA, people thought to have AIDS, or even seropositive HTLV-III/LAV testers, has taken many forms and become pervasive in certain geographical areas. In San Francisco, for example, at least 20 AIDS discrimination complaints were filed in the first 3 months of 1985.

In New York City, a spokesperson for the Commission for Human Rights claimed there had been over 200 complaints of AIDS-related discrimination since 1983 “in every case imaginable, including employment, housing, public accommodation, insurance, and violence.” More generalized homophobic reactions and responses based on stereotypes may cause carryover discrimination against gays and lesbians. The Commission is receiving a “huge number” of complaints of discrimination based on sexual preference.

A CBS television poll in September 1985 showed that 47% of those polled believed it possible to catch AIDS from a drinking glass used by a PWA, 28% believed it could be caught from a toilet seat and 10% believed office contact or touch would suffice to transmit AIDS. Research tells us this is not so, but misinformation, fear, and homophobia have colored much of the public reaction.

Perhaps even more shocking are the measures which some people are willing to take under the rubric of safety measures, even when such steps are unsupported by any research data, and clearly represent extreme curtailments of civil rights. In a recent poll, 51% of Americans polled favored mass quarantining of PWA and 48% believed in doing the same for HTLV-III seropositive testers.

In a murder case in Connecticut, the accused, diagnosed as a PWA, was escorted into the courtroom by a rubber gloved deputy. Fourteen potential jurors then requested to be excused.

Delta Airlines banned AIDS patients from flying on their planes, but later rescinded the ban.

The president of an insurance agency recently tried to collect, as beneficiary, on a deceased employee's insurance policy. The deceased, a PWA, was fired by that same president because of the diagnosis of AIDS.

The territory is like a legal minefield. For example, attempts at disease control through monitoring sexual activities in places like bathhouses and hotels presents privacy issues. Quarantine measures, flowing from the police power of the states, and suggested for PWA engaging in sexual activities with others, raise legal questions of what is informed consent, how are predictions of dangerousness to be made and what would constitute cruel and unusual punishment. Criminalization, or increased criminal charges for PWA engaging in conduct such as spitting, biting, or prostitution, will certainly push criminal law into new areas.

There have been accounts of discrimination against PWA in all areas of life, including employment, insurance, the military, education, health care, prisons, funeral homes, real estate and housing. This senseless but pervasive and mounting discrimination makes it necessary to find new legal tools and hone old ones in an effort to prohibit AIDS-related discrimination. In the following section some of the current legal tools created to afford protection for the handicapped are shown to provide some assistance for the PWA facing certain types of discrimination. Also, although AIDS is a recent development and is somewhat unique as a medical problem, cases involving other medical conditions exist that provide analogous reasoning. However, assembling these tools and creating analogies is presently a haphazard and piecemeal process borrowing from Federal, State, and sometimes local statutes. Certainly, a unitary, cogent piece of protective legislation on the Federal level prohibiting discrimination against the disabled or handicapped would provide for more uniformity and fairer results. A carefully drafted and expansive definition of disability and/or handicap is essential for people experiencing AIDS-related discrimination.

Currently, Federal law against discrimination provides relief only in limited situations. The Vocational Rehabilitation Act of 1973, 29 U.S.C. § 701 et. seq. provides in § 503 that no Federal contractor or subcontractor shall discriminate in employment on the basis of a handicap and § 504 guarantees similar protections if federal money is involved.
The person who has been the victim of AIDS-related discrimination who does not fall under the aegis of the Federal law may be protected by local ordinance or state statute prohibiting discrimination against someone because they are handicapped, or are perceived to be handicapped.

The AIDS Legal Guide published by the Lambda Legal Defense and Education Fund finds that most states have enacted laws that protect public and private sector employees from discrimination due to a handicap. Many of these laws also have components that provide redress for discrimination in other areas as well, such as housing.

A comprehensive state by state analysis of such legislation as it relates to employment recently appeared in the University of Dayton Law Review. Forty-two states and the District of Columbia have adopted legislation forbidding discrimination against disabled people in the private sector. Most of these jurisdictions also include public sector employment, and five more states forbid discrimination only in the public sector. Arizona, Delaware, Wyoming, Puerto Rico and the Virgin Islands apparently do not have laws that address the situation.

The next question is whether AIDS will fit the various statutorily created definitions of disability and/or handicap necessary to trigger protection. In most jurisdictions this will be a case of first impression.

Georgia and Kentucky specifically exclude protection for people with communicable diseases, and New Hampshire provides protection only for a handicap other than illness. In New York State, a trial court in an eviction case found AIDS to be a disability which triggers protection under the New York Executive Law (Human Rights Law) in People v. 49 W. 12th St. Tenants Corp. New York State's Human Rights Law is applicable to both Federal and State employees.

A local New York city civil rights ordinance, coupled with § 503 of the Federal Rehabilitation Act formed the basis of a recent suit against Columbia University. Plaintiff, represented by attorneys from Lambda, alleged that the school had a policy of refusing employment to PWA. An out of court settlement was reached.

Adding to the complications caused by the inadequate patchwork of current multileveled regulation, effective legal strategy is further hindered by misconceptions about the transmission of AIDS itself.

Much existing legislation balances the handicapped person's right to work against considerations of health and safety, requiring that the worker's condition pose no imminent threat to the other workers or the public. Therefore, it is crucial that accurate information is relayed to the public and potential employers. The CDC recently assisted in that direction by issuing a strongly worded report stating that the public and coworkers will not be endangered by PWA or by people who test HTLV-III positive, with extra precautions necessary only for health care workers who perform invasive procedures.

Current scientific knowledge concerning the etiology of AIDS offers no rational basis for most employment discrimination, yet litigation in the area clearly illustrates that people have been fired because they either have AIDS or are thought to have AIDS. Perhaps in some cases it merely provides a convenient cloak for discrimination against an employee based on sexual preference.

In Dept. of Fair Emp. & Housing v. Raytheon Co., San Francisco advocates of gay rights represented the estate of a former Raytheon employee. After the employee was diagnosed as having AIDS in 1983, he was not allowed to go back to work "unless he could prove AIDS was not casually transmitted or if there was a cure for it." Obviously, if the burden of proof is placed upon the discharged employee, litigation can be both weighty and expensive. Scientific evidence and public health authorities support the case against casual transmission, but if a 100% guarantee is required, rather than perhaps substantial scientific evidence, the burden can never be met.

Another pending case where the employer has tried to defend the action by claiming fear of contagion is a Florida case involving a county budget analyst, once commended by superiors for meritorious work, who was fired in 1984 because the county thought he posed a threat to others when they learned he had AIDS. The employer wanted a "100% guarantee that the employee could not transmit the disease to co-workers or the public."

Other medical conditions have been likened to AIDS for the purpose of facilitating legal analogy. Hepatitis Type B is considered more easily transmitted than AIDS. The New York City Board of Education sought to exclude certain children from regular classes because they were carriers of serum hepatitis. This was successfully challenged in New York State Association of Retarded Children v. Carey. The Second Circuit held that there was a showing of discrimination against the children who were protected by the Rehabilitation Act of 1973, (§ 504, 29 U.S.C. § 794, 1976). The Board of Education therefore had to make a substantial showing that its plan was justified. The Board was unable to demonstrate that the health hazard raised by the hepatitis B carriers was anything more than a remote possibility, and since there was evidence regarding the detrimental effect on the children, the plan was illegal. Given the most current research demonstrating the lack of even intrafamilial transmission of the AIDS virus, any attempt to exclude in the educational setting would seem to be unsupported by any substantial risk to others. Arguably, AIDS-related discrimination victims should be afforded the protection of the Rehabilitation Act that is given to others who experience discrimination based on disability or handicap.

The Federal Vocational Rehabilitation Act was found to provide protection for a school teacher whose special susceptibility to tuberculosis was deemed a handicap, and the school was ordered to accommodate the teacher in Arline v. School Board of Nassau County.

In Chrysler Outboard Corp. v. Wisconsin Dept. of In-
dustry, Labor and Human Resources, the employee suffered from acute lymphatic leukemia. The employer argued that due to plaintiff’s disease, plaintiff was at increased risk of infection from minor injury. Recuperation periods would be longer and result in lost work, and insurance rates for the employer would be higher. The court held these defenses were not available to the employer and that the only issue was whether the plaintiff could do the work.

If the AIDS epidemic had surfaced a decade ago, reactionary policy decisions in the names of public health and disease prevention would have trampled civil liberties. Mainly due to the increased political clout wielded by gay and lesbian alliances, civil liberties issues have been and must continue to be addressed. Legal workers in this area must creatively use medical facts, critical analysis of statistical method and epidemiology, existing case law, and relevant statutes prohibiting discrimination to prevent the erosion of civil rights. Just as static categories do not work well statutes prohibiting discrimination to prevent the erosion of civil rights. Just as static categories do not work well

---

**FOOTNOTES**

7. Curran, James, et. al., Approach to Common Clinical Syndromes 693.
8. Id.
9. Id.
10. Id.
14. AIDS-Related Complex: Social, Medical, supra note 12.
16. Id.
18. Id.
19. CDC Reports AIDS Cases in U.S. Top 15,000, supra note 15.
20. Curran, James, supra note 7, at 695.
22. Frank, Elliot, supra note 6.
26. Curran, James, supra note 7, at 703.
27. Id.
33. Id.
37. Langone, John, supra note 24.
38. Id.
39. Id. at 42.
40. HTLV-III/LAV, supra note 23.
42. HTLV-III/LAV, supra note 23.
45. Recommendations, supra note 36.
52. Id.
55. 34 MMWR 681 (1985).
56. FEP 83-84, L0510, L-33998.
61. 14 Fair Emp. Prac. Cases (BNA) 344 (Wis. Cir. Ct., Dane Co. 1976).