

Citizens League Report

STOPPING AIDS: AN INDIVIDUAL RESPONSIBILITY

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EXECUTIVE SUMMARY

The truth about AIDS is that stopping it depends on what people do as individuals. Until a vaccine or cure is found, no strategies of direct intervention can be effective against AIDS. Government can help -- both with good programs to support individual responsibility and policies that refrain from counterproductive, if popular, panaceas -- but only individuals can stop the spread of the disease.

Some important facts about AIDS:

- AIDS cannot be spread casually. One must engage in a very specific act (unprotected sexual intercourse or sharing of contaminated intravenous drug needles) to become infected with the AIDS virus.
- AIDS is evasive. The activities that enable its spread are difficult, if not impossible, to monitor. And, in many cases, physical or mental addiction is involved.
- AIDS mostly has affected populations that historically have felt stigmatized by and disenfranchised from the rest of society -- homosexual men and drug users.
- AIDS shows no sexual preference, nor is there any evidence that it is spread more easily through anal intercourse than vaginal intercourse. AIDS is most prevalent among homosexual men apparently because it was introduced in that community. And, since homosexual men have sex mostly with each other, that is where the virus primarily has stayed thus far.

Public consideration of any strategies to stop AIDS must pay careful attention to these facts. They determine what strategies will and will not be effective.

The most effective and efficient way to stop AIDS is through individual responsibility. Every individual must take precautions that assure the virus cannot be spread. Strategies that can effectively encourage individual responsibility are:

- **Providing education.** The general population needs education both to forestall potential hysteria about AIDS and to provide accurate information about how to take precautions against AIDS.

The populations most affected by AIDS thus far need education to stop the spread within their communities. Such education should be targeted to fit the special needs of each population and delivered by individuals and organizations that are trusted by the people to be served.

- **Promoting and expanding voluntary testing and counseling.** Knowledge of their infection status can encourage many people to change their behavior to avoid the spread of AIDS. But the most effective aspect of testing is the counseling that should go along with it. Counseling is an important step toward individual commitment to the often very difficult changes in behavior that are necessary to stop AIDS.

Strategies that won't be effective in stopping AIDS are:

- **Enacting government actions that are coercive or restrictive in nature, such as mandatory testing and quarantine.** To begin with, they are impractical: identifying population groups that might be the targets of such policies would be extremely difficult, maybe impossible. Neither homosexual preference nor drug use is readily identifiable. And even if we could identify them, policing and monitoring the activities that spread AIDS would be nearly impossible.

And, while testing can be an important step toward behavior change, it does not guarantee that a person is not or will not become infected. Testing shows only one point in time, and does not automatically preclude an individual from engaging in activities in the future that risk infection.

Even worse, these types of measures could be counterproductive. Imagine yourself a member of a group that historically has been the target of discrimination. Then imagine your response to a government mandate that your group must be tested or be closely watched. These policies could drive underground the populations in which AIDS is most prevalent, rather than pull them closer to programs that really can bring this disease under control.

As a society, we are fortunate that individual responsibility can stop AIDS. If everyone exercises care in selecting sexual partners, and if those who persist in intravenous drug use will avoid sharing needles, the spread of the AIDS virus can be halted. Almost nobody is at the mercy of AIDS.

But strategies to encourage individual responsibility are not enough. The Legislature should remove barriers that keep some people from taking responsibility.

Public policy changes that can help build an atmosphere to foster individual responsibility are:

- **Ensuring that every individual's AIDS status will be disclosed only to persons who need to know it to provide proper care.** Infection with the AIDS virus is a very personal and often stigmatized status. Individuals who are infected need the assurance that their status will not be shared indiscriminately.

Moreover, very few persons have a need or right to know that an individual is infected with the AIDS virus. Nobody is at the risk of becoming infected through ordinary contact with an infected individual. Even health care workers, who have the greatest occupational fear of AIDS, run almost no risk of infection if they assume all patients are infected and follow recommended precautionary procedures.

● **Ensuring protection against discrimination on the basis of infection with the AIDS virus or affectional preference.**

Individuals who are infected or at risk of infection must have the assurance that, if they voluntarily get tested or come forward for counseling or treatment, they will be protected against unfair discrimination.

● **Repealing the law that makes sodomy (homosexual or heterosexual anal and/or oral intercourse) a criminal act.** Whether or not the sodomy law is enforced, the fact that the primary sexual act practiced by many homosexual men is criminal under Minnesota law discourages some from seeking testing and counseling about AIDS. In many cases, persons who request testing must effectively admit to engaging in a criminal act.

Finally, even though every individual should be able to take responsibility to stop AIDS, some individuals will not. Public policies to deal with infected individuals who are unable or unwilling to avoid putting others at risk include:

● **Maintaining Minnesota's "Non-Compliant Carrier Statute," enacted in 1987.** This law, which should be used only when absolutely necessary, gives the Commissioner of Health appropriate authority to intervene when persons are put at risk by an infected individual. The intervention options available include counseling, treatment, and confinement to supervised living for up to six months.

● **Making an infected individual's intent to transmit the AIDS virus to another person a criminal act.** Such an act would be expected very rarely, but the magnitude of its seriousness is so great that it should be tried under the criminal justice system. When an individual has the intention of transmitting the virus to another, the virus is effectively being used as a lethal weapon.

I.

INTRODUCTION

If AIDS is a crisis, then why doesn't government do something about it? Isn't that what we expect?

The truth about AIDS is that stopping it depends on what people do as individuals. Government can help -- both with good programs to support individual responsibility and policies that refrain from counterproductive, if popular, panaceas -- but only individuals can stop the spread of the disease.

Historically, government placed strict controls on the infected population when epidemics, such as tuberculosis and syphilis, threatened the public health. Mandatory testing was implemented swiftly, and the sick often were quarantined in their own homes or in sanatoriums.

But such traditional measures would be either ineffective or inefficient with AIDS, and probably counterproductive as well. Mandatory testing has obvious appeal. But on examination, it simply is not practical. Identifying the populations most affected by AIDS -- homosexual men and intravenous drug users -- would be nearly impossible, as would policing the sexual and drug-use activities that are responsible for nearly all infection cases.

Moreover, restrictive and coercive measures focused on these populations would create greater feelings of alienation and unwillingness to cooperate than already exist. The targeted populations would be driven underground out of fear of discrimination and violence. AIDS would continue to spread, and tracking it and treating infected individuals would be virtually impossible.

When focused on the general population not greatly affected by AIDS, these measures would be costly and would uncover very few AIDS cases.

The only way the AIDS virus will be stopped, short of a vaccine, is through individual responsibility. Fortunately, individual action can make the difference. Almost nobody is at the mercy of the AIDS virus, because nearly all persons can protect themselves against infection. Direct government action should be unnecessary in most cases.

How the AIDS virus can and cannot be transmitted is key. Transmission can occur only when contaminated body fluids get into another's body system -- through unprotected sexual intercourse, sharing of contaminated intravenous drug needles, transfusions of contaminated blood and blood components, and from mother to fetus. Conversely, the best medical evidence indicates the AIDS virus cannot be transmitted casually, through objects such as toilet seats, through kissing, or through contact with infected blood that does not penetrate the skin.

Nearly all transmissions of the AIDS virus today are the result of unprotected sexual intercourse and sharing of contaminated intravenous drug needles. The only persons who cannot protect themselves against AIDS are unborn fetuses whose mothers are infected, victims of rape, and persons who receive blood transfusions (the latter is highly unlikely due to blood screening).

Persons who are infected with the AIDS virus must cease or change activities so that they do not transmit the virus to others, and persons who are not infected must cease or change activities that risk infection. The spread of the AIDS virus should come to a near halt, once individual responsibility is the norm in all populations.

MINNESOTA'S CENTRAL STRATEGY FOR STOPPING AIDS, THEREFORE, MUST BE TO BUILD A STRONG SENSE OF INDIVIDUAL, PERSONAL RESPONSIBILITY.

Government programs should be designed to work with individuals, supporting the ability to take that responsibility. Counseling and education, as well as general efforts to support and encourage healthy lifestyles, are the key components.

A critical step is getting accurate information and encouragement to the people who can benefit from it about how the disease is transmitted, which activities are relatively safe, and which are not. These are the messages that enable everyone to assume personal responsibility to stop the spread of AIDS. Progress made so far seems primarily attributable to this sort of emphasis.

How and through which media those messages are sent is important. Public health and other governmental officials should rely heavily on organizations that already are in touch with population groups regarded as being at high risk for AIDS. If people don't trust the messenger, they are not likely to hear the message.

Further, government can begin to build a social environment that is supportive and encouraging, rather than one that is perceived to be discriminatory and unaccepting. Ensuring rights and protection against discrimination for populations most affected by AIDS is one important step. The already fragile cooperation that is indispensable to continued progress depends upon the guarantee of rights and protection.

Government's role should extend further only when infected individuals fail to take responsibility to avoid putting others at risk of infection, which some will do. But controlling or restrictive measures should be used only in those cases when an infected person is unable, due to mental or physical incapacity, or unwilling to avoid putting others at risk of infection.

This report endorses strategies that emphasize personal responsibility and community cooperation. It finds indirect strategies more effective than direct interventions. It acknowledges the difficulty of dealing with AIDS in a society that values individual liberties, when the most extreme proposed measures threaten to overwhelm those rights.

This report also seeks objectivity in the search for workable strategies and compassion for those whose lives already have been threatened by AIDS. But it concedes that failure to achieve success through personal responsibility invites consideration of more restrictively-oriented policies.

Finally, this report acknowledges that the factual situation may not be static. Its recommendations are based on the best present knowledge and would be open to review should circumstances change dramatically.

AIDS Committee Charge and Process

The AIDS Committee was charged by the Citizens League Board of Directors to analyze proposals to slow or stop the spread of the AIDS virus that might create a conflict between individual liberties and the public health. The committee was directed to find a balance between those two important interests.

The committee's study started with an analysis of the effectiveness and efficiency of each proposal. Any proposal that passed this first, important test then would be considered for its impact on individual liberties. The proposals that could not pass the first test would be rejected.

Most measures that tended to be coercive or restrictive could not pass the effectiveness and efficiency test. The committee found virtually no case in which steps to balance individual liberties and the public health needed to be taken. In fact, the only measures found that can be effective in the long run do not impinge strictly on individual liberties.

These findings led the committee directly to education as a key strategy to stopping AIDS, even though it was not directed to study education. This report discusses the importance of education and recommends some general directions and strategies. But it does not recommend specific education approaches and messages, since this was not part of the committee's charge.

Neither does this report discuss research efforts to develop treatments and a vaccine for AIDS. While such efforts are of obvious, vital importance, their review was outside the study committee's charge and could be the subject of a separate study.

II.

CONTEXT

AIDS, or "Acquired Immunodeficiency Syndrome," is a physical condition in which the body's immune system is unable to fight off infections and diseases, or in which the brain or gastrointestinal system is severely damaged. A virus called the "Human Immunodeficiency Virus" (HIV or, simply, the AIDS virus) attacks and kills the body's "Helper T" lymphocytes, whose job it is to control the body's immune system. The AIDS virus, in other words, attacks and kills the very system that usually attacks viruses.

Once the immune system is disabled by the virus, "opportunistic" diseases and infections are able to set in. AIDS is not technically a disease itself (although it will be referred to as a disease), but a condition in which the body cannot effectively fight diseases and infections.

The Centers for Disease Control (CDC) identifies AIDS by opportunistic infections, such as Pneumocystis carinii pneumonia; opportunistic cancers, such as Kaposi's Sarcoma; wasting, caused by an infection in the gastrointestinal tract that severely reduces or eliminates the body's intake of nutrients; and dementia, a deterioration in the brain [1].

A person can be infected with the AIDS virus for several years without developing AIDS. Noticeable symptoms of infection could be absent during that time, but transmission of the virus to other persons is possible.

AIDS is new to the list of known diseases affecting the world. The Centers for Disease Control started following AIDS cases only in 1981.

The scientific community has responded to this deadly disease with a frenzy of activity, although whether there has been enough support for research is hotly contested. While some significant advances have been made in such a short period of time, much remains unknown. The scientific community generally agrees on what AIDS is and how it is contracted. But it has not yet found an effective treatment or vaccine to stop or cure it.

Until medical science can progress further, policymakers must look to the social sciences of sociology, psychology, and politics for means to stop AIDS. The only "vaccine" available today is to change or control individual behavior. And, like medical advances, this solution will not be implemented easily. The nature of AIDS -- the way it is transmitted, the way it progresses, its almost certain result (death), and the populations most affected by it -- means there are no simple solutions.

A. AIDS is a fatal disease. Nearly all, if not all, persons who develop AIDS will die.

The Centers for Disease Control's surveillance report of April 8, 1988, shows that 92 percent of persons diagnosed in 1981 with AIDS have died. Already, approximately 20 percent of persons diagnosed in 1987 have died. Overall, the CDC reports a 56 percent fatality rate of all persons diagnosed with AIDS between 1981 and April 1988. Death becomes more likely as time passes since AIDS development: [2]

<u>Year of Diagnosis</u>	<u>Fatality Rate</u>
1981	91 %
1982	87 %
1983	86 %
1984	81 %
1985	72 %
1986	46 %
1987	20 %

Only more time will tell if all persons with AIDS will die.

Estimates of the fatality rates specific to the various opportunistic diseases and infections have been made. One study by the California Department of Health Services found that persons with AIDS diagnosed as having Pneumocystis carinii pneumonia die on average within 36 months; about half of such persons die within nine months. Persons with Kaposi's Sarcoma live an average of 60 months, although half die within 12 months [3].

B. It is unclear how many persons infected with the AIDS virus subsequently will develop AIDS, or when they will develop AIDS.

Time, again, is a factor in the lack of information; the AIDS virus simply has not been known and studied long enough. The CDC estimates that 5 to 20 percent of AIDS-infected persons will develop AIDS within two to five years [4], while an ongoing study of 288 homosexual, AIDS-infected men in San Francisco reports that about 50 percent of all persons infected with the AIDS virus will develop AIDS within nine years [5].

C. AIDS cannot be stopped or avoided medically, as effective treatments and vaccines have not yet been developed.

Research to develop treatments and vaccines for AIDS is underway, although it may be years before AIDS can be stopped medically.

In the meantime, drugs to prolong the lives of some persons who develop AIDS have been tested and licensed. Most well-known is a drug known as AZT (azidothymidine), which hampers the ability of the AIDS virus to reproduce. AZT is being given to patients both in the late stages of AIDS and in the asymptomatic stage of AIDS infection.

Another drug, Ampligen, is being tested on persons who are infected

with the AIDS virus, but who have not yet developed AIDS. The drug is expected to stabilize the immune systems of these people and increase the number of Helper T lymphocytes, which are key players in the body's system to fight diseases and infections. But, like AZT, it cannot eliminate the AIDS virus.

D. Only a small proportion of all people infected with the AIDS virus have been tested. Many people who have not been tested do not suspect they are infected and could be spreading the virus to others unknowingly.

The Minnesota Department of Health has estimated that 10,000 to 30,000 Minnesota residents currently are infected with the AIDS virus. This range is based upon the numbers of all homosexual and bisexual men and intravenous drug users estimated to reside in Minnesota and surveys of persons who have visited Minnesota testing and counseling sites [6].

Using those estimates, the Department predicts that a total of 1,300 to 1,900 cases of AIDS will be diagnosed through 1990, including all cases reported since the Department started keeping records in 1982.

But of the 10,000 to 30,000 Minnesotans estimated to be infected with the AIDS virus, only about 1,000 to 1,500 have been tested and know they are infected [7]. This means that many Minnesotans, unaware that they are infected, may be transmitting the AIDS virus to others.

<u>Infected</u>	<u>Tested</u>
10,000 - 30,000	1,000 - 1,500

Many reasons can be cited for this difference between the number of Minnesotans estimated to be infected and those who have been tested. Many people are unaware that they could be infected and do not even consider getting tested. Others simply do not want to know they are infected with the AIDS virus or avoid testing out of fear they will become targets of discrimination and violence if the test results are disclosed.

Perhaps most vexing of those reasons is that persons who are infected with AIDS can be asymptomatic for a very long time. Many people simply do not get tested because they have no signs of infection. One study of 51 homosexual men in San Francisco showed that 35 percent did not show symptoms of AIDS infection until five years after the onset of the infection [8].

Finally, even though tests commonly conducted to detect the AIDS virus are nearly 100 percent accurate, they cannot perfectly identify every person who is infected. The tests detect the antibodies to the AIDS virus, not the virus itself. If the test is conducted during the period between the onset of infection and the development of the antibodies (four to twelve weeks), the infection will not be detected.

Many persons, therefore, may be infected with the AIDS virus, but be completely unaware and unsuspecting. Moreover, their sexual and needle-sharing partners also are unaware and unsuspecting, meaning the virus is being spread without knowledge of infection.

E. The AIDS virus cannot be transmitted casually from one person to another. Transmission is possible only through specific means; one must engage in specific acts to become infected with the AIDS virus.

The only means of transmission of the AIDS virus from one person to another are sexual intercourse, injection or puncture with a contaminated intravenous needle, transfusion of contaminated blood and blood components, and from mother to fetus. The latter two have been the causes of relatively few cases of AIDS in Minnesota.

The AIDS virus has not been transmitted through any other means, including the air, saliva, or touching. One cannot become infected, for example, by using a toilet seat just used by an infected person. Theoretically, the virus could be transmitted by significant contact with an infected person's saliva, such as through "french" kissing. But there are no proven cases of transmission in this way; the dosage of the virus in saliva is too low [9]. In fact, one study reported preliminary findings that human saliva may contain a factor that blocks the AIDS virus from infecting cells [10].

A 1985 study of intra-familial transmission of the AIDS virus supports these facts. The study investigated the spouses and children of seven men infected with the AIDS virus. While four of the seven wives were found to be infected (likely through sexual intercourse with their infected husbands), only one of the 11 children was infected. And that one child was a 14-month baby who likely became infected via its mother while a fetus [11].

AIDS is, in other words, a behavior-related disease.

The Centers for Disease Control had recorded 59,628 adult and adolescent AIDS cases nationally by April 25, 1988. The cases were distributed as follows: [12]

Homosexual and bisexual men	37,805 -- 63 %
Intravenous drug users	11,014 -- 18 %
Homosexual/bisexual men and intravenous drug users	4,420 -- 7 %
Heterosexual contact	2,458 -- 4 %
Transfusion	1,456 -- 2 %
Hemophilia/coagulation disorder	589 -- 1 %
Undetermined *	1,886 -- 3 %

(does not total 100% due to rounding)

* More than half the "undetermined" cases died before determination could be made.

As of April 25, 1988, AIDS cases in children under 13 years of age totalled 955 nationally. They were distributed as follows:

Mother with AIDS or at risk	734 -- 77 %
Transfusion	132 -- 14 %
Hemophilia/coagulation disorder	53 -- 6 %
Other	36 -- 4 %

(does not total 100% due to rounding)

Minnesota's reported adult and adolescent AIDS cases, as of May 5, 1988, totalled 349: [13]

Homosexual and bisexual men	289 -- 83 %
Homosexual/bisexual men and intravenous drug users	21 -- 6 %
Intravenous drug users	12 -- 3 %
Hemophilia/coagulation disorder	10 -- 3 %
Heterosexual	9 -- 3 %
Transfusion	5 -- 1 %
Undetermined *	3 -- 1 %

* Two of the undetermined cases died before determination could be made; the third is still being analyzed.

The Minnesota Department of Health also recorded two cases of AIDS in children as of May 5, 1988. One case was the result of a blood or blood-components transfusion; the source of the other case was unknown.

If the AIDS virus could be transmitted casually, the profile of reported infection cases would be very different.

The population groups with the highest prevalence of AIDS infection are homosexual and bisexual men and intravenous drug users. Nationally, these population groups carry almost 90 percent of all adult and adolescent AIDS cases; in Minnesota, that figure is closer to 95 percent. This disproportionate impact relates directly to the activities in which many of these infected people have engaged (unprotected sexual intercourse and sharing of contaminated intravenous drug needles) and the frequency of those activities.

The following activities are the most common means of transmission of the AIDS virus:

1. Sexual intercourse. Transmission of the AIDS virus has been documented via sexual intercourse, both between homosexuals and heterosexuals and through vaginal and anal intercourse. Most cases of sexual transmission have occurred in homosexual men via anal intercourse. It is speculated that transmission has been highly prevalent in this population because a group of homosexual men who became infected was very sexually active, especially in the early 1980s before the virus was identified. These men spread the virus into the general homosexual population.

But the AIDS virus, when transmitted, is not selective about a person's sexual preference (e.g., homosexual or heterosexual). Rather, the risk of transmission increases as possible exposures to infected persons increases, through a greater number of sexual partners and greater frequency of sexual intercourse.

One study of 1,034 men in San Francisco has found that 18 percent of the men who had only one sex partner in the previous two years were infected with the AIDS virus, whereas 71 percent of the men who had more than 50 sex partners in the previous two years were infected [14].

Transmission also is documented from male to female and female to male. A study of 97 women who were sexual partners with AIDS-infected men within the previous year found that 22 of these women became infected as a result of their contact. The study also proved, though, that transmission of the AIDS virus does not occur with every act of heterosexual intercourse; 75 of the 97 women did not become infected. But, like the study of homosexual men, the women who tested positive were 4.6 times more likely than the uninfected women to have had more than 100 exposures to their infected partner [15].

The first case of a transmission from an infected female to a male sexual partner was documented in 1986. It is presumed that this transmission was enabled by vaginal secretions to the urethra or a break in the skin of the penis.

2. Needle-sharing. Transmission is documented when an infected person shares intravenous drug needles with another person. Drug users often "boot" during their self-injections of narcotics, meaning they withdraw blood into the syringe after injecting the drug to ensure that all the drug has been used.

The AIDS virus also can be transmitted through transfusions of contaminated blood and blood components and from mother to fetus.

1. Transfusions of blood and blood components. Although transmission through transfusions once was the cause of a high proportion of new AIDS infection cases, health officials stress there is little or no risk of this occurring today. The development of tests for AIDS antibodies has enabled all blood donations to be screened. The Red Cross estimates that the risk that a blood or blood-component donation is infected is 1 in 400,000 at most. Only one case of transmission of the AIDS virus through transfusion has been reported since testing of all donated blood began in 1985.

The antibodies test is largely responsible for this very low risk, but so is general awareness of what persons should not donate blood. Since 1985, only 16 of the 400,000 potential blood donors in Minnesota have tested positive for the AIDS virus. Generally, people who are infected with the AIDS virus are not attempting to donate blood [16].

2. Mother to fetus. Approximately 1.4 percent of all AIDS cases nationwide have been reported in children under the age of thirteen. Eighty percent of the parents of these children either have been diagnosed as having AIDS or acknowledge membership in groups documented to be at risk for AIDS; the majority of the parents give a history of drug use [17]. Only two cases of AIDS in children have been diagnosed in Minnesota, or 0.6 percent of all cases (2 of 351, as of May 5, 1988).

The probability that the AIDS virus will be transmitted from an infected mother to her fetus has been estimated in several studies at 20 to 60 percent [18].

One study, conducted in the first half of 1987, found that about 2.1 per 1,000 women giving birth in Massachusetts were infected with the AIDS virus. The rate was highest in inner-city hospitals, at 8.0 per 1,000, and lowest in suburban and rural hospitals, at 0.9 per 1,000. The high rate in the inner-city hospitals probably was related to the concentration of women who use drugs or have sexual partners who use drugs [19].

The average estimate of 2.1 per 1,000 gained from testing women giving birth in Massachusetts is higher than estimates gained from testing women in other settings. Testing of blood donors in Massachusetts found that 1 in 25,000 (or 0.04 per 1,000) female blood donors are infected with the AIDS virus, and testing of military recruits in Massachusetts found that 2 out of 2,029 (or 1 per 1,000) women were positive. The problem with these samples is that each is biased by some self-selection in the population [20].

As more women become infected with the AIDS virus, the number of AIDS infections in newborns is likely to increase.

Other modes of transmission are possible, although they present a significantly lower risk than those just discussed. They include:

1. Saliva. No cases of transmission of the AIDS virus through saliva have been confirmed. In fact, a study reports that a factor in saliva may block the AIDS virus from infecting cells [21].

2. Artificial insemination of semen. A study in Sydney, Australia, has reported that four of eight women became infected with the AIDS virus after receiving semen through artificial insemination from a donor who was infected [22].

These transmission cases occurred before testing of semen was routinized in the artificial insemination industry. No cases have been reported since then [23].

3. Needlestick and mucous membrane exposure. Many health care workers, especially those who come into contact with persons infected with AIDS through surgical and emergency procedures, are concerned about transmission. But, while transmission clearly is possible, the risk is extremely small. Transmission can occur only through exposure to AIDS-infected blood as a result of a puncture with an intravenous needle just used on a patient or through a break in the health care worker's skin. Even then, the risk of transmission is less than one percent.

A Centers for Disease Control study of 649 health care workers found that, as of June 30, 1987, only four (0.6 percent) had tested positive for the AIDS virus after percutaneous or mucous-membrane exposures to the blood or body fluids of AIDS-infected patients. A National Institutes of Health study found that none of 332 health care workers with 453 needlestick or mucous-membrane exposures had become infected with the AIDS virus as of April 1987 [24].

And, despite the high rate of AIDS infection, no emergency medical personnel in New York City or San Francisco has become infected with the AIDS virus as a result of contact with patients.

F. The activities that pose the greatest risk of AIDS virus transmission are not easily stopped or changed.

The two activities that are the principle modes of the spread of the AIDS virus -- sexual intercourse and drug use -- may be the most difficult activities to stop or change. In some cases, physical and mental addiction is involved.

Rather than trying to forbid the activities that are likely to spread AIDS, an option for controlling the spread of the AIDS virus through these activities is to persuade individuals to protect themselves and others to a large degree by avoiding semen exchange (e.g., using a condom can be up to 99 percent effective) and using clean intravenous needles (e.g., not sharing, or cleaning with bleach).

G. The population groups most affected by AIDS also historically feel stigmatized and have been oppressed by the rest of society.

The population groups most affected by AIDS, or in which there is the highest prevalence of AIDS infection, are homosexual and bisexual men and intravenous drug users. The latter disproportionately are people of color; 51 percent of all cases of AIDS infection in drug users have been Blacks and another 29 percent have been Hispanics [25].

Surveys across the nation have produced estimates of the rate of infection among homosexuals and drug users. Prevalence rates within the homosexual population range from 10 to 70 percent in various regions of the country. On average, 20-25 percent of men who are exclusively homosexual are estimated to be infected with the AIDS virus. The highest rates are documented in homosexuals in San Francisco. Prevalence rates among drug users range from 50 to 60 percent in New York City, northern New Jersey, and Puerto Rico, to below 5 percent in most areas of the country outside the East Coast. The average across the nation is estimated at 25 percent of regular intravenous drug users [26].

Much of the rest of society displays distaste and intolerance for these persons' lifestyles. Discrimination and physical and emotional violence are not foreign to these populations. In Minnesota, the Governor's Task Force on Prejudice and Violence found 169 incidences of "hate crime" against persons based on sexual preference since 1970 [27].

Comments such as, "AIDS is divine punishment" or "they brought it on themselves," when referring to homosexuals and drug users as the population groups most affected by the AIDS virus, are not uncommon.

And sodomy (anal and/or oral intercourse) is illegal in about half of the states and use of non-prescribed controlled substances (e.g., heroin) is illegal in all states. The people who fall into both population categories (e.g., homosexuals who also are drug users), or who are homosexuals or drug users and people of color, may feel even more disenfranchised than those who are identified by one category.

H. The outlook of AIDS is not promising. Because so many people already are infected with the AIDS virus, new cases of AIDS will continue to be diagnosed for many years.

Internationally, the World Health Organization predicts there will be 100 million people in the world infected with the AIDS virus by the mid-1990s. Currently, an estimated 5 to 10 million people are infected. In coming years, 500,000 to 3 million people will develop AIDS.

In the U.S., the Centers for Disease Control predicts there will be 270,000 cases by 1991, compared with about 60,000 cases today.

The Centers for Disease Control also estimates that 1 to 1.5 million Americans now are infected with the AIDS virus. If this is an accurate estimate, then at least 1 in every 250 Americans is infected. Applying the population distribution of AIDS against that estimate suggests that about 1 in 30 young and middle-aged American males are infected with the AIDS virus [28].

In Minnesota, 349 AIDS cases were diagnosed and reported to the Department of Health as of May 5, 1988. The number of cases doubled between January 1, 1987, and January 1, 1988, from 155 to 311. The Department estimates that between 10,000 and 30,000 Minnesotans currently are infected with the AIDS virus. By 1990, an estimated 1,300 to 1,900 persons will have developed AIDS in Minnesota.

While these figures are disheartening, the spread of the AIDS virus may be slowing, at least among homosexual men. The San Francisco Men's Health Study, conducted at the University of California at Berkeley's School of Public Health, has found that the rate of spread of the AIDS virus has slowed. It has moved from a high of new infections in 20 percent of the previously uninfected homosexual population each year in 1980-82 to about 2 percent in 1987 [29].

Similarly, the Multicenter AIDS Cohort Study, which is following nearly 5,000 homosexual and bisexual men, found a decrease in activities that risk transmission of the AIDS virus between 1984 and 1986. The proportion of men reporting celibacy or monogamy increased from 14 to 39 percent, and the proportion that reported avoiding receptive anal intercourse increased from 26 to 49 percent [30].

The same cannot be said, however, for the spread of the AIDS virus among intravenous drug users. While new infections among homosexual men now is at about 1 to 2 percent of the previously uninfected homosexual population per year, intravenous drug users are being infected nationally at an annual rate of 7 to 8 percent of the previously uninfected population. The infection rate in areas with the highest drug use, such as New York City and northern New Jersey, might be as high as 50 to 65 percent of the previously uninfected population [31].

III.

STRATEGY

A. Individual responsibility as Minnesota's central strategy to stop the spread of the AIDS virus

The spread of the AIDS virus will be stopped only when individuals take responsibility to stop it. Other options will be ineffective and are unnecessary. Coercive and restrictive measures would be nearly impossible to implement and enforce, in as much as sexual and drug use activities (the primary ways the virus is spread) are not easily monitored. And such measures might be counterproductive; the populations most affected by AIDS already feel stigmatized by the rest of society. Coercion is likely to result in greater division and less cooperation.

Fortunately, individual responsibility should be able to stop the spread of the AIDS virus. Infected persons can avoid transmitting the virus to others. And almost all persons can protect themselves against AIDS infection, making historical measures, such as quarantine, unnecessary. Almost nobody is at the mercy of the AIDS virus.

1. Individuals who are infected with the AIDS virus must take responsibility to protect others from infection. They should:

- * Refrain from sexual intercourse, or at least avoid having unprotected sexual intercourse, with the understanding that protective devices, such as prophylaxis (condoms) offer good protection, but do not eliminate risk.
- * Avoid sharing unclean intravenous needles with other drug users, by either using new needles or cleaning used needles with bleach. Again, they should know that cleaning with bleach may not completely eliminate risk.
- * Avoid getting pregnant.
- * Tell their partners of their infection, so that others can take the educated options of either not engaging in any activities that risk transmission or taking precautions that can reduce the risk.
- * Cooperate with the Minnesota Department of Health's program of notifying all contacts of infected persons of the possibility that they too may be infected.

2. Individuals who have engaged in activities that risk transmission and, therefore, may be infected with the AIDS virus must take responsibility to determine whether they are infected and avoid transmitting the virus to others. They should:

- * Get tested for the AIDS virus.
- * Avoid or change activities that risk transmission of the virus.

3. Individuals who are not infected with the AIDS virus must take responsibility to avoid putting themselves at risk of becoming infected. They should:

- * Insist on knowing their partners' AIDS status.
- * Avoid multiple sex partners.
- * Avoid unprotected sexual intercourse and sharing contaminated intravenous needles with people who may engage in activities that risk transmission.

B. Public health measures to enable and encourage individual responsibility

The most workable and effective option to stop the spread of the AIDS virus is to give individuals the right information, encouragement, and support so they take responsibility and avoid transmission. When this is done, the spread of the AIDS virus should be controllable. Minnesota's strategies should include providing education and counseling about AIDS and how to avoid infection, offering and encouraging voluntary testing, and notifying the contacts of persons known to be infected with the AIDS virus.

1. The state of Minnesota should maintain and expand its commitment to a strategy of AIDS education that reaches both the general population and specific populations in which AIDS is most prevalent.

Education and counseling are keys to getting individuals to take the responsibility to stop the spread of the AIDS virus. They certainly will not be completely successful, but if provided broadly and strategically, education and counseling may have enough impact so that other, more restrictive measures should be needed only rarely.

The Army's experience during World War II with the spread of venereal disease among the troops suggests that education and counseling can slow the spread of the AIDS virus. The Army aggressively educated troops about the dangers of venereal disease and promoted the use of condoms. During 1940 and 1943 (prior to penicillin), the venereal disease rate in the Army fell from 42.5 to 25 per thousand [32].

a) The state of Minnesota should design and deliver education about AIDS to the general population.

Education about AIDS and how to avoid infection should be delivered to all Minnesotans, even though most may not be at risk of infection. Not only can education give individuals information about how to protect themselves, but it can erase much of the misinformation and hysteria about AIDS. And education to the general population can reach those individuals who engage in activities that risk transmission and would not otherwise be reached.

Formal education through the schools is an obvious place to start; educating children in their formative years can reduce future AIDS cases that otherwise are likely. Many schools in Minnesota already are providing a curriculum on AIDS, and the Legislature has adopted a policy mandating AIDS education. Reaching adolescents, however, also might require creative uses of media that influence them, such as television and videos.

In addition, informational brochures and public speakers could be made available through churches, community groups, medical offices and facilities, and government agencies (e.g., distributed with tax statements or to marriage license applicants). Such efforts could have the double benefit of (1) providing essential information to individuals who need to know when they risk infection and how to protect themselves, and (2) reducing misinformed overreactions.

b) The state of Minnesota should ensure delivery of education to the populations in which the AIDS virus is most prevalent, including homosexual men and drug users. The content of the programs should be targeted and delivered in a way that fits the unique characteristics of those groups.

Education and counseling are most critical for the populations in which the AIDS virus already is most prevalent, including homosexual men and drug users. The efforts should be targeted to each population's specific needs and delivered by individuals, agencies, and media that already are trusted and used by those populations. Positive response is much more likely when the agent of delivery is trusted and familiar. Moreover, the individuals and agencies closest to the population to be served typically will have the best understanding of what education is needed and how it should be delivered.

It appears that education in the homosexual community, both through traditional mediums and the natural education that comes as friends and family become ill, may have caused the spread of the AIDS virus to slow. Officials in San Francisco have documented a slowing in the spread of AIDS among homosexual men in that city [33]. And Minnesota health officials have found a similar decrease in the rate of spread of other sexually-transmitted diseases among homosexual men, which suggests the spread of AIDS also is down [34].

But ongoing efforts still are needed. While immediate impact may be likely, the effects of educational efforts could be lost over time. A University of Massachusetts study of homosexual men found that education produced an immediate and significant decrease in activities that risk transmission of the AIDS virus. That impact, however, diminished after six months of the education campaign [35].

2. The state of Minnesota should expand and promote voluntary testing and counseling about AIDS.

Testing for AIDS is important to efforts to stop the spread of the AIDS virus. It is a vital step for many individuals toward taking responsibility to avoid transmission of the AIDS virus. Even though not everyone reacts the same way, several studies suggest that persons who elect to be tested are more likely than others to reduce activities that risk transmission.

For example, one 1984-86 study of 502 homosexual men in San Francisco reported a significant decrease in sexual behavior that risks transmission of the AIDS virus after testing. As of November 1986, 12 percent of the men who tested positive for the virus reported having unprotected anal intercourse, while 27 percent of the men who had not been tested reported the same. The study's analysis of the 99 men who tested positive found that 48 percent had reported having unprotected anal intercourse before being tested, compared with 12 percent after being tested [36].

While testing alone may be sufficient to persuade some people to change behavior, the central cause of this reduction in risk activity is the strong association between testing and the counseling that often goes along with it. Testing can get an individual's attention; counseling empowers the individual to make necessary changes.

The combination of testing and counseling persuades many individuals to protect themselves from that point on (if the test is negative) or to take care not to transmit the AIDS virus to others (when the test is positive).

And counseling can preclude some individuals from misinterpreting test results. Without it, some who test negative could assume they must be immune to the virus. And others, testing positive, might just give up, failing to care for themselves or to protect others from transmission.

a) Physicians offering testing should, as standard medical practice, provide counseling about the test results and how to avoid transmission of the AIDS virus, or they should provide a counselor. The Minnesota Medical Association, in keeping with the recommendations of the American Medical Association [37], should urge its members who do not provide counseling to refer patients for testing to physicians who do provide counseling.

The weakness in the present approach to testing in Minnesota is the failure to ensure appropriate counseling when the test is provided by a private physician or clinic. Much testing currently occurs at "alternative testing and counseling" sites which were established as accessible, confidential testing centers. Counseling is a regular part of testing at these sites.

But many private physicians, clinics, and hospitals are testing patients and not providing counseling along with the test results. Because counseling is a key element in stopping the spread of AIDS, the Minnesota approach should ensure that it consistently is associated with testing.

b) To be successful, testing should remain voluntary. Efforts to make testing mandatory, for all or certain segments of the population, generally are not practical and may be counterproductive.

If counseling, along with test results, is the key factor in changing attitudes and modifying behavior that risks giving or getting this virus, then personal motivation that comes in counseling is the primary determinant of success. Choosing to be tested implies a receptivity to information and counseling. That receptivity would be unlikely if testing were mandatory.

- Simply mandating that the entire population be tested -- even at only \$40 a test -- would be so expensive that it would be the most inefficient proposal of all.

- Nor should testing be mandated just for certain populations, such as homosexual men or intravenous drug users. For one, it simply is not a practical option. Identifying these persons would be very difficult, if not impossible. Even if that could be done, once the testing was completed, their sexual and drug-using activities could not be policed or monitored to any public benefit. Finally, requiring that a person or a particular segment of the population be tested once is not enough; mandatory testing would have to be repeated frequently to find all infected persons, because some may continue to have unprotected sexual intercourse or share needles.

And mandatory testing for those population groups in which the presence of the AIDS virus is disproportionately high (homosexual men and drug users) would likely be counterproductive. The suspicion and alienation these groups already feel could worsen. Instead of cooperation, there likely would be resistance and a bitter legal struggle over claims of discrimination. Any progress made toward getting individuals to take responsibility to stop the spread of the AIDS virus could be eliminated.

- Mandatory testing has been proposed for marriage license applicants and pregnant women. Such testing might be administered with relative ease, but it targets a population where AIDS is not likely to show up in serious numbers. The state of Illinois found only four persons infected with the AIDS virus out of 12,000 couples applying for marriage licenses in January through mid-April of 1988. And many people seeking marriage simply have opted to leave the state to avoid the cost of the test; marriage license applications were 40 percent lower in January 1988 than in January 1987 [38]. After only four

months in effect, the Illinois Legislature is considering a bill to repeal the law. Similarly, the Louisiana Legislature, which also enacted a mandatory testing law in 1987, is moving toward the law's repeal [39].

This nation's experience with mandatory premarital testing for syphilis (the Wassermann test) should serve as sufficient evidence that the effectiveness and efficiency of premarital testing for AIDS will be minimal. In 1978, premarital screening accounted for only 1.27 percent of all syphilis tests found positive nationally. And a 1984 study in California estimated the cost per identified syphilis case through premarital screening at \$240,000 [40]. These figures may not seem out of line as costs to avoid more cases, but the resources could better be spent targeted at communities in which the prevalence of AIDS is high and the risk of rapid transmission great.

Pregnant women present a similar, although perhaps more troubling, situation. A Massachusetts study has found that about 2.1 of every 1,000 women giving birth in that state are infected with the AIDS virus [41]. (See Appendix B on study to test newborns.) The fetus that becomes infected through its mother is truly an innocent victim of the AIDS virus; it could do nothing to protect itself.

The purposes of testing pregnant women would be to create the opportunity to abort the fetus and avoid future pregnancies. But mandatory testing of pregnant women to meet the former objective would be virtually impossible to implement, because identifying them during the early stages of pregnancy is not easy. Unfortunately, women need not apply to become pregnant (as do persons wishing to get married), they do not show physical signs of pregnancy for more than half the term, and many of the women who most likely would be infected with the AIDS virus also are the women who do not seek medical assistance until near or at the time of delivery.

A measure that would be more efficient than mandatory testing would be to make information and counselors routinely available and testing recommended to (1) all persons applying for marriage licenses, (2) all pregnant women, and (3) all other women of child-bearing age with identifiable risks for AIDS infection (e.g., drug users, women who have multiple sexual partners) through clinics, obstetricians offices, and all social service agencies. The Minnesota Department of Health should ensure that such a policy is implemented throughout the state.

c) There is only one exception to this general recommendation against mandatory testing: the Legislature should mandate testing of all persons convicted of criminal sexual conduct, for the purpose of notifying those persons contacts that they may be infected.

This testing order should be used only in cases in which the

criminal sexual offense involved coercion or force and penetration of the victim. In keeping with Minnesota law, coercive cases would include cases involving minors and other persons not considered capable of making informed choices (e.g., the mentally retarded). This recommendation in no way envisions testing persons who have engaged in a non-coercive sexual act that currently is deemed criminal, such as sodomy or prostitution.

Testing criminal sex offenders for the AIDS virus will be too late to help the victim, but it is not too late to determine if this person, who has engaged at least one person in an act that risks transmission of the AIDS virus, is infected. The offender may have past victims as well, who then could be notified of their risk of infection, should the offender tests positive for the AIDS virus. Mandatory testing is necessary in these cases because it is unlikely that a sex offender will voluntarily seek testing and counseling.

d) The Minnesota Department of Health should establish a task force to identify and design means to build incentives for individuals who may be infected with the AIDS virus to voluntarily receive testing and counseling.

Fear, altruism, or concern for one's health may not provide adequate encouragement for some individuals to get tested for the AIDS virus and receive counseling. A state task force, including experts in the area of incentives, should be assembled to look specifically at the question of how to create such encouragement.

3. The Minnesota Department of Health should continue its policy of notifying contacts of persons diagnosed as being infected with the AIDS virus (contact notification).

Currently, the Minnesota Department of Health attempts to conduct follow-up procedures with every individual who tests positive for the AIDS virus. Part of the follow-up is an interview to identify persons with whom that individual has engaged in activities that risk transmission of the virus. The identified contacts then are notified that they may be infected and advised to get tested and avoid transmitting the virus to others.

Contact notification can be costly, but it can be one of the most effective and efficient public health measures to stop the spread of the AIDS virus. It focuses on individuals who have engaged in some type of activity that risks transmission of the AIDS virus with persons known to be infected. Contact notification can break an otherwise undetectable chain of infection.

a) Only persons for whom there is a reasonable risk of infection, based upon the best medical evidence regarding acts that risk transmission, should be contacted.

The only situations in which contact notification would be

expected to be applicable today involve unprotected sexual intercourse, sharing of contaminated intravenous needles, and transfusion of infected blood and blood components. But, because the future is uncertain, authority to determine a reasonable risk should be left with the Department of Health.

b) Priority of contact notification should be given to persons who are unsuspecting contacts or who lack information to understand that they may be at risk of infection.

This prioritization especially would include spouses of bisexual men and drug users who share needles and are not aware of risk.

c) Contact notification should be anonymous in almost all cases, but should be left to the discretion of the Minnesota Department of Health.

When a person is notified of possible infection with the AIDS virus due to a past contact it is, in most cases, unnecessary to identify the infected contact. This policy is needed to protect the privacy, and maintain the confidence and cooperation, of the infected person.

4. The Minnesota Department of Health should continue its policy of requiring all sites that conduct tests for the AIDS virus to report positive test results (mandatory reporting). All physicians, clinics, hospitals, and alternative testing and counseling sites should attempt to obtain the names of persons who test positive for the AIDS virus and to include those names with test reports.

Mandatory reporting of AIDS infection cases to the Minnesota Department of Health is an important policy for all physicians and test sites to follow. For one, it provides the Minnesota Department of Health with data on which to track the spread of the disease and plan measures to combat its spread.

Perhaps more important, mandatory reporting enables the Department to follow up with every person tested as infected to (1) ensure adequate counseling about the nature of AIDS, and (2) interview the person to identify contacts who also may be infected. Most physicians and facilities conducting tests in Minnesota are not yet trained and committed to doing such follow up with patients, therefore the responsibility must rest with the Department.

No persons, however, should be denied testing for the AIDS virus if they refuse to give their names. Testing and counseling have been identified already as essential measures to stop the spread of the AIDS virus (Section III.B.2.) Anything that could create a disincentive to electing to get tested, therefore, should be avoided. Even if a person refuses to give his or her name, worthwhile results can accrue from the test and counseling that emphasizes how to avoid spreading AIDS and the importance of notifying any contacts who may be infected.

5. The Minnesota Legislature should require that the appropriate health agency regulate commercial establishments* where a primary purpose of operation is to facilitate activities that risk transmission of the AIDS virus.

This report neither sympathizes with nor sanctions the operations of these establishments. And law enforcement efforts to close establishments that facilitate activities on-site that are illegal doubtless will continue. But resources and efforts to stop the spread of the AIDS virus, the public health concern here, are better directed at disseminating information that can influence individual behavior.

One might argue that, even as a public health issue, the best approach would be to close these establishments through an order that they pose a public health threat by the Commissioner of Health. But a closer look at this option makes it less attractive, and regulation more viable.

First, similar establishments rarely are successfully closed by law enforcement or public health action. Houses of prostitution, for example, are frequent targets of law enforcement agencies, but are rarely closed; they move to new locations or re-open under new names. In keeping with the goal of encouraging individual responsibility, the resources and efforts to close these facilities could better be spent in other ways to stop the spread of the AIDS virus, such as by educating and counseling to the establishments' clients, many of whom otherwise might not be reached.

Moreover, merely closing the establishments will not necessarily stop the activities that risk transmission of the AIDS virus. It may reduce the frequency or the availability of multiple partners, but the activities will continue at different locations.

It could be more effective and simpler to use those establishments as sites to reach persons who may be putting themselves or others at risk of AIDS infection. Education and counseling, and perhaps even making protective devices available, could have more direct and broad effects.

Concern that government regulation of such establishments could

* Commercial establishments that might be affected by this action include facilities commonly known as bathhouses, adult bookstores, saunas, and shooting galleries. It is difficult to get accurate data regarding whether and how much risk activity occurs at these establishments. However, the characteristic that distinguishes them from other establishments at which activities that risk transmission also may be occurring (e.g. fitness centers, hotels, bars) is that a primary purpose of their operation is to provide space for people to engage in sexual or drug-using activities, many of which risk transmission of the AIDS virus.

Only one bathhouse is known to be operating, in Andover, Minnesota. The bathhouse in Minneapolis closed in early 1988.

imply sanctioning of the activities is real and understandable, especially if the impression given to some individuals is that the activities that occur at the establishments are safe. Strategic education and counseling efforts, however, should clarify that the message is a warning of danger, not an approval of activities.

Specifically, the appropriate public health agency should:

- a) Identify all commercial establishments where a primary purpose of operation is to facilitate activities that risk transmission of the AIDS virus. This would not include most hotels, motels, and health clubs.
- b) Establish a procedure for all establishments identified above, which should include:
 - a fee to cover costs to provide educational materials and services at the establishment as deemed necessary by the Department of Health, and
 - rules governing operating conditions of the establishment such as educational requirements, sanitary conditions, prohibitions against lockable or private cubicles, or other provisions deemed necessary by the health agency.
- c) Close any commercial establishment that has been identified as a place where activities that risk transmission of the AIDS virus are occurring or are likely to occur and one of whose primary purposes is to facilitate those activities, but that has not followed the procedures established under item (b). This option is necessary to provide incentive for compliance.

C. Measures of community support to encourage and remove barriers to individual responsibility

The recommendations in the previous section are aimed at providing individuals with information and encouragement to enable them to take responsibility and stop the spread of the AIDS virus. But because persons most affected by AIDS also are most likely to feel alienated and fear discrimination, the efforts recommended will reach their full effectiveness only when the social environment is reinforcing and supportive of behavior change. All barriers, both real and perceived, should be removed if legally possible.

The individuals at whom education, counseling, testing, and contact notification efforts should be most directly targeted must trust the delivery agents. Only then is their cooperation likely. Legal and real community support of individuals who may be or are infected is essential to stopping the spread of the AIDS virus.

A supportive, barrier-free atmosphere must be built in the community by ensuring (1) that the only people who can learn a person's AIDS infection status have a legitimate need to know, and that any of these people who disclose another's health data without authorization can be punished, (2) that adequate protection against discrimination on the basis of infection with the AIDS virus or affectional preference is available, and (3) that the sexual lifestyle of many homosexuals and heterosexuals (anal and oral sexual intercourse, known as sodomy) is recognized as legal.

While legislative acts such as those recommended in this section cannot be expected to have an immediate and direct impact on the spread of the AIDS virus, history confirms that they can make a significant difference in the long-run. The passage of the 1964 Civil Rights Act, for example, did not immediately bring about all the changes envisioned. But its passage did build a new atmosphere in which those changes were expected and possible.

1. Data on an individual's AIDS infection status should be treated as private information that can be disclosed only to authorized agencies and individuals (by persons other than the infected individual).

The assurance of confidentiality is a key to getting cooperation of persons who are infected or who should be tested. When a disease cannot be transmitted casually, very few people need to know anyone's AIDS status beyond the individual being tested: the health care worker conducting the test, the Minnesota Department of Health, and health and social service providers who should know in order to provide proper care.

a) Employers should ensure that all employees receive adequate education about AIDS and training to avoid transmission in the workplace. But almost no persons have a need or right to know that another employee or client is infected with the AIDS virus. The only exception to this would be persons who need to know in order to provide proper care for the infected individual.

Some employers may think they need to know which employees are infected with the AIDS virus. But no relevant basis for this can be found, since the AIDS virus cannot be transmitted casually. All persons in the work place easily can protect themselves if a co-worker is infected. Of course, if an employee is unable to continue to perform and has become too ill to work, then the employer may have the right to information; even then, though, such conditions are common to any illness that creates a work impairment.

The same is true for housing conditions; landlords may assert a claim to this information. But, again, it would serve no purpose other than curiosity. The sensitivities, even stigmas, surrounding this disease make confidentiality imperative to assure that persons who already are suffering from the AIDS virus are not subjected needlessly to discrimination and other forms of injustice.

Nor do school administrators and teachers need to know that a student is infected with the AIDS virus, except when that student may need special attention due to the illness.

The strongest claims to know a person's AIDS status come from health care workers. Certainly, where such knowledge is necessary as a condition to proper treatment, it is appropriate.

But in most cases, given the extremely low likelihood of an "accidental" transmission of the disease (see page 11), we find no basis for labeling persons who are infected with the AIDS virus. Recommendations for precautions developed at the Centers for Disease Control are based on the principle that health care workers should assume this risk in their environment regularly; their treatment of all patients should anticipate the possibility of infection. Gloves and other protective clothing, along with special care in handling and disposing of needles, should be routine and adequate under virtually all conditions of potential exposure [42].

The experience of health care workers with hepatitis patients in the 1970s underscores this policy. Patients first were labeled as having the infectious disease, in an effort to curb the spread of the infection to health care workers. But the labeling seemed to have the reverse effects; at least, the spread did not slow. Only when health care workers were trained to treat all patients as though they were infected did the spread slow.

Employers of health care workers have a responsibility to follow the recommendations of the Centers for Disease Control and provide their employees with training, articles to provide precautions against transmission, and voluntary, confidential testing for the AIDS virus. Health care workers are entitled to these standards of safety in their work environment, as established by federal occupational safety and health laws [43].

While these precautions will add financial burden to some health care providers, they likely are no greater than the costs of additional workers' compensation claims that can be avoided.

Finally, even if there is any suspicion of transmission, the important step is the testing of the health care worker, not the patient. Whether the patient tests negative or positive is not sufficient assurance -- (1) the test could be wrong or could have missed the virus if antibodies had not yet developed and (2) even if the patient tests positive, the risk that transmission to the health care worker occurred is less than one percent (see page 11). Breaching the confidentiality of the patient's AIDS status is of little or no value in determining the worker's exposure. Health care facilities should adhere to the policy of the American Medical Association, which rejects mandatory testing of patients [44].

b) The state of Minnesota should enforce its Data Practices Act (Minnesota Statutes 1987, Chapter 13), which establishes civil liability and penalties for public employees and agencies that disclose health data without authority.

The Minnesota Data Practices Act provides that health data, including data of a person's AIDS infection status, be considered "private data" that may be disclosed only to the test subject, the Department of Health, and the subject's physician (Minnesota 1987 Statutes 13.38). The subject of an unauthorized disclosure can bring an action to cover damages sustained, plus costs and reasonable attorney fees. In the case of a willful violation, the political subdivision, statewide system or agency can be liable for exemplary damages of \$100 to \$10,000 per violation (Minnesota 1987 Statutes 13.08).

c) Data on a person's AIDS infection should be considered private data in the private sector as well. The Legislature should affirm the right to sue an individual or agency for unauthorized disclosure of a person's AIDS status and remove the possible defense position that the data disclosed were true. This liability should be applicable to individuals who have legitimate reason to know that person's AIDS status (e.g., persons who know another's AIDS status for professional purposes or learn of it in a professional setting). It should not be applicable, however, when a physician or health official is fulfilling his or her professional duty to warn (e.g., spouse of the patient).

Recourse already may be available through common law, but the serious nature of unauthorized disclosure of such data should be clarified in Minnesota law. Persons, such as employees of private hospitals and nursing homes, should be aware that they do not have the right to disclose a patient's AIDS status to unauthorized persons. And persons who are infected, or who may be infected but fear getting tested, should be aware that they have recourse if their health data is shared.

This concept, however, should not be extended to cases in which a person's AIDS status is learned casually from the infected person or through hearsay. No liability should apply when a person discloses his or her infection to another person for reasons other than in an official or professional situation. That other person could not be held liable for passing the information to any other persons. Civil liability should be limited to situations in which a person gets information from an official source.

2. The Legislature should enact specific statutory protection against discrimination on the basis of infection with the AIDS virus or affectional preference involving education, employment, property, housing, and public accommodations and services.

Just as ensuring confidentiality of one's AIDS status may not have a direct impact on slowing the spread of the AIDS virus, giving adequate protection against discrimination cannot be expected alone to make inroads to the disease. But these steps are necessary to begin removing the barriers that keep some individuals from taking responsibility for their actions, especially being tested. Lack of community support, a feeling of alienation, a fear of discrimination and violence are very real barriers. The process of removing them can begin with these legal steps.

The Minnesota Department of Human Rights currently interprets Minnesota's discrimination statute to protect persons infected with the AIDS virus or whose affectional preference is their same sex, even though Minnesota law does not explicitly prescribe that interpretation (see Appendix C). But there is no guarantee the next administration will do the same. For that reason, the Legislature should give specific statutory protection to such persons.

Because the AIDS virus cannot be transmitted casually, no legitimate reason exists to deny a person access to a facility or service on the basis that the person is infected with the AIDS virus. Even in health care settings, the proper precautions as recommended by the Centers for Disease Control make the risk of transmission extremely small -- too small to warrant denying admission or care on the basis of AIDS infection.

a) The only exception to this general rule against discrimination concerns health care facilities that are unable to provide proper care to persons infected with the AIDS virus. Authority granted these facilities, under current Minnesota law, to deny services to that person (Minnesota Statutes 144.56) should be maintained.

A person infected with the AIDS virus should not be denied care by health care facilities, such as hospitals, health clinics, and nursing homes, solely on the basis that the person is infected with the AIDS virus. However, in accordance with current state law, no health care facility can be required to provide admission or care if it lacks the resources to provide proper care to a patient.

b) The state of Minnesota should analyze whether and how many health care facilities are unable to provide care to AIDS patients, and develop an appropriate plan for providing long-term health care and adequate resources.

It is conceivable that, because of the exception to health care facilities that cannot provide care, the demand of persons with AIDS for certain health care facilities, especially nursing homes, could exceed availability and resources.

c) While a health care facility that is certified to provide a certain level of care cannot deny that care, patients must be willing to accept alternative treatment procedures which, while safeguarding their care, can reduce the likelihood of accidental transmission of the AIDS virus to health care workers.

3. The Minnesota law that makes anal and oral sexual contact, legally known as sodomy, a criminal act should be repealed (Minnesota Statutes 609.293).

Repealing the anti-sodomy law cannot be expected to have a direct and significant impact on the spread of AIDS. But it can be a positive step to greater willingness of gay men who may be infected to seek testing and counseling.

The anti-sodomy law makes no reference to heterosexuality or homosexuality, and presumably was enacted for moral purposes. Although the common impression is that sodomy is predominantly a homosexual phenomenon, this is not true. One highly-regarded study of human sexual behavior reported in 1948 and 1953 that 54 and 49 percent of predominantly heterosexual men and women, respectively, engage frequently in anal and oral sexual contact [45].

The anti-sodomy law rarely is enforced. And as a device to stop the spread of the AIDS virus, it would be ineffective and unrealistic. Monitoring and enforcement of the law is nearly, if not completely, impossible. If the anti-sodomy law did not exist,

it certainly would not be proposed as a measure to stop the spread of the AIDS virus. Such a law would need to govern unprotected sexual intercourse of all kinds (anal and vaginal) with multiple partners.

The existence of the anti-sodomy law could be deterring some people who should be tested and counseled about AIDS from coming forward. A homosexual man might believe he is infected and desire to get tested, but by doing so he must admit to criminal conduct. The law may rarely be enforced, but its presence is enough to inhibit some persons from taking rational, healthy steps.

While there is no concrete evidence that this is the case, one physician who treats many of the Twin Cities metropolitan area's AIDS cases has testified before the Minnesota Senate Judiciary Committee that the existence of the anti-sodomy statute may "obstruct efforts to prevent transmission of the AIDS virus" [46]. The anti-sodomy law simply preys on the fears of many persons.

D. Restrictive public health measures to protect
the public when an infected individual
fails to take responsibility

Targeted and strategic efforts to get information and encouragement to individuals to take responsibility to stop the spread of the AIDS virus should have significant impact, but they will not be completely successful. Some infected individuals will be unwilling or unable to avoid transmitting the virus to others. In these rare cases, government has a responsibility to step in with coercive or restrictive measures to prevent further spreading of the AIDS virus.

The options available for restricting or punishing infected individuals who continue to put others at risk of transmission include both civil and criminal remedies, already established in Minnesota law. However, careful consideration must be given to the direct and indirect impact one or the other option may have in various situations.

The preferred strategies would focus on intervention and treatment, and punishment when necessary. The courts can decide what combination of remedies makes greatest sense under either a civil or criminal action.

But criminal actions, generally, will be much more difficult to prosecute successfully than civil actions. The burden of proof, while not necessarily different, is much heavier in criminal actions, making the chance that a criminal case could be decided in favor of the defendant much greater than in a civil case.

Regardless, it is important to remember that these types of actions can have only limited impact on stopping the spread of the AIDS virus. Very few people, once adequately educated, will persist in behavior that makes civil or criminal action necessary. And, as is the case in all other judicial actions, the necessity of proving guilt beyond a reasonable doubt will result in some individuals escaping punishment when they probably should not.

1. The Legislature should maintain and the Department of Health employ, when absolutely necessary, Minnesota's Non-Compliant Carrier Statute (1987 Statutes 144.4171-144.4186), which establishes interventions that may be used to direct or restrict the activity of infected persons who, although counseled and warned, persist in putting others at risk of becoming infected.

The Non-Compliant Carrier Statute may serve both to deter persons from putting others at risk of infection and restrict persons who continue to spread the AIDS virus even though they have been counseled and warned. It may be, therefore, an effective way to deal with the few individuals who will fail to accept responsibility to avoid transmitting the virus to others.

As passed by the 1987 Minnesota Legislature, the statute affirms and clarifies the Minnesota Commissioner of Health's authority to

take legal action against any infected person deemed to be a "health threat to others."

A "health threat" is defined as a person who demonstrates an inability or unwillingness to avoid placing others at risk of infection. The act, then, would apply to a person who:

- * engages in repeated behavior that puts others at risk of infection
- * displays a substantial likelihood that he or she will repeatedly transmit the disease based upon past behavior or statements that are indicators of his or her intentions, or
- * makes an "affirmative misrepresentation" of his or her infected status prior to engaging in an activity that may transmit the virus.

The act establishes due process proceedings, which include a health directive from the Commissioner of Health to the infected person to avoid certain activities a hearing process, and a requirement that "clear and convincing" standards of proof be presented to the court. The remedies available, in priority of accepted uses, are:

- * requiring the subject to undergo medical testing
- * requiring participation in education, counseling or treatment programs
- * orders to cease and desist
- * orders to live in a supervised setting, and
- * orders to be committed to an institutional facility not longer than six months.

After six months, the Commissioner of Health must review the case and identify next steps; another court hearing, with testimony from professionals who worked with the subject during his or her commitment, must be held for commitment of another six months to be possible. The subject may not be committed to a correctional facility.

2. Infected persons who engage others in activities that risk transmission of the AIDS virus with the intention of transmitting the virus should be subject to criminal prosecution, regardless of whether transmission actually occurred.

Given the likelihood of fatality, any attempt to transmit the AIDS virus is equivalent to an attempt to kill and should be regarded as such by the legal system. In such cases, the AIDS virus is a lethal threat to others.

Classifying the intent to transmit the AIDS virus as a criminal act can have a deterring effect. But its impact on the spread of the AIDS virus will be limited. The standards that must be applied to criminal cases make them difficult to prosecute successfully. The prosecutor must prove beyond reasonable doubt that the defendant

was infected and was aware of his or her infection at the time of the attempt to transmit the virus to another person.

Criminal prosecution should not be attempted for cases other than the intent to transmit the virus. Actual transmission of the AIDS virus, when a person knows or has reason to know he or she is infected but does not disclose that infection, logically should be considered a criminal act as well. But this could create a disincentive to testing, since successful prosecution would be dependent upon the individual knowing he or she was infected at the time of the act. Criminal prosecution would not be as effective as measures provided by the Non-Compliant Carrier Statute to restrict individuals who persist in putting others at risk of infection (see Recommendation D.1.).

The standards necessary to prosecute a criminal case would require proof that a person was aware of his or her infected status. Such standards could have effects exactly opposite the intended goal.

A person may not want to know his or her AIDS status, if such facts could be used in criminal prosecution cases. Some persons would avoid testing, as a result.

Moreover, such cases would be very expensive and difficult to prosecute successfully because of the necessary standards of proof. The end result could be no restrictions on the person who has put others at risk of infection. Restrictive remedies established by the Non-Compliant Carrier Statute, while still requiring certain standards be met, will not be so difficult to implement as criminal remedies.

There is an apparent contradiction in the recommendation to apply criminal sanctions in cases of the intent to transmit, but not in negligent transmission. Theoretically, either could create a disincentive to testing. But the intent of transmitting the AIDS virus is an act of such serious magnitude that criminal remedies must be applied. These would be cases of one person using a lethal weapon against another person.

IV.

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V.

APPENDICES

APPENDIX A

Testing for the AIDS Virus

Tests that actually detect the presence of the AIDS virus are available. But the significant cost of these tests and the fact that only a few laboratories in the nation have the ability to conduct them causes them to be used infrequently. The tests most commonly used detect the presence of the AIDS virus by looking for antibodies that develop as a result of the virus' presence.

Tests for AIDS antibodies usually are conducted in two stages. The first stage is the enzyme immunoassay (EIA) screening test, which is better than 99.0 percent accurate in finding all infected persons. But because it is so sensitive to the presence of antibodies, the test can be overly-aggressive, producing an unacceptable chance that a person whose risk of infection is very low could falsely test positive. Therefore, the Western Blot test is performed regularly to validate the results of the two EIA tests. The Western Blot is highly specific, meaning it correctly identifies nearly all test samples that falsely test positive by the EIA test.

Some laboratories have demonstrated that the false-positive rate of the sequentially-performed EIA and Western Blot tests can be less than 0.001 percent (less than 1/100,000 persons tested).

Source: Centers for Disease Control: Journal of the American Medical Association, February 5, 1988, Vol. 259, No. 5.

APPENDIX B

Testing of Newborns in the Twin Cities Area

The Minnesota Department of Health will be testing all newborn babies in the Twin Cities area, under a contract with a study being conducted by the Centers for Disease Control. Similar testing will be done in other areas around the nation simultaneously, in an effort to generate estimates of the prevalence of AIDS infection among pregnant women and the transmission of the virus to their fetuses.

The testing will be conducted over six months in 1988, beginning mid-summer. All hospitals in the Twin Cities area will participate. The test will be blind; all identification will be removed from the test, so that the identity of the newborns will be unknown. Only basic demographic information will be recorded with test results.

APPENDIX C

Interpretation of Discrimination Statutes Minnesota and Federal

Minnesota

The Minnesota Department of Human Rights currently interprets Minnesota Statutes Chapter 363 (the Minnesota Human Rights Act), which prohibits discrimination on the basis of disability, to protect persons infected with the AIDS virus. This includes discrimination with regard to employment, property, education, housing, and public accommodations and services (any accommodation that offers goods or services to the public). Although the statute does not refer specifically to AIDS or other infectious diseases, the Department interprets "disability" to include infection with the AIDS virus.

The Department of Human Rights' interpretation of "disability" under this Minnesota law has not been challenged or upheld in a court of law; the Department has settled every AIDS discrimination case brought to it. The cases in which discrimination clearly was based upon a person's infected status have been settled in favor of the plaintiff (the infected person).

Federal

The Federal Rehabilitation Act of 1973 prohibits disability discrimination in federal government employment, the practices of its large contractors (contracts in excess of \$2,500), and in programs receiving federal financial assistance. Disability is defined as having or being regarded as having a physical or mental impairment that substantially limits one or more major life activities.

The Department of Justice interpreted this federal law (June 23, 1986 memorandum) to mean persons who have developed AIDS are protected, but persons who are infected but have not yet developed AIDS are not protected. The Supreme Court, however, in School Board of Nassau County vs. Arline 107 S.Ct. 1123 (1987), suggested that infection with the AIDS virus may be protected under the federal law on the basis that such persons may be "regarded as impaired."

Congress then attempted to clarify this issue in the Civil Rights Restoration Act of 1987. An amendment to Section 7(8) of the Rehabilitation Act of 1973 stated that an individual who has a contagious disease or infection will not be protected by the act if that person presents a "direct threat to the health or safety of other individuals or who...is unable to perform the duties of the job."

MINORITY REPORT

April 28, 1988

INTRODUCTION

The following report sets forth a minority opinion regarding legal issues and AIDS. This report is drafted as a critical response to the majority report issued by a Citizens League Committee charged with studying AIDS and related legal issues. The purpose of this Committee is to make viable policy recommendations to policymakers which in substance or procedure would act to slow or stop the AIDS epidemic. The majority report claims to fulfill that purpose.

In light of this charge, this minority report concludes that the majority report lacks sufficient policy recommendations which could be adopted by policymakers to slow or stop the spread of AIDS. Instead, the majority report is more a reflection of the committee's fear of appearing to discriminate. Importantly, this minority report acknowledges, and is sensitive to discrimination suffered by certain populations and consequently endorses the majority's recommendation. While this concern for discrimination must be a major focus of any set of policy recommendations on AIDS, it should not be the only focus or be given inordinate weight. With this premise in mind, the minority report expresses the several views which indicate the need to balance the concern for discrimination with concerns for other key policy recommendations that will protect the uninfected, promote public health and ultimately contribute to slow or stop the spread of AIDS.

The minority report is divided into the following two sections: (i) Minority comments; and (ii) Minority recommendations. The Minority comments set forth the reasons why the majority report fails, in part, as a policy proposal; the minority recommendations offer corrective policy measures and their respective reasons for policymakers to consider if we, as a society, seriously intend to respond to the AIDS epidemic.

I. MINORITY COMMENTS

The majority report is flawed because it fails to recommend proactive interventions and actions that are necessary to limit the spread of AIDS. The majority report:

1. Fails to give the same weight to the rights of the uninfected as it gives to the rights of the infected.
2. Refuses to recommend certain AIDS containment efforts because of unsubstantiated fears that these efforts might infringe individual rights.
3. Overemphasizes the preservation of gay rights and practices and reflects the unfounded fear that certain AIDS containment efforts will increase discrimination against gays.

4. Fails to adequately project the enormous economic and social costs that will result if the AIDS epidemic continues as projected by the Department of Health. Therefore, the majority report strongly favors individual liberties, but does little to encourage individual responsibility.

II. MINORITY RECOMMENDATIONS

1. Blood tests should be a condition of receipt of a marriage license. The results of the tests should be confidential and only disclosed to applicants.

Minority Reasons

- (1) Protects the innocent and ignorant.
 - (2) Reduces number of children born with AIDS.
 - (3) Would at least warn of need for protected intercourse.
 - (4) The benefits of testing outweigh the costs.
 - (5) The testing requirement sends a strong message to the public.
2. All public bathhouses and other commercial sex establishments should be closed under existing law.

Minority Reasons

- (1) There is overwhelming evidence that gay bathhouses facilitate acts of unprotected intercourse by high risk individuals. Even when protected intercourse is the norm, research suggests that the practices of gay men change after 6-9 months (from protected to unprotected.)
 - (2) The argument to keep them open to foster education is specious and dangerous. If the majority is correct, neighborhood bathhouses should be opened as a measure to create opportunities for gays to gather in settings that facilitate education.
 - (3) Failure to close these establishments sends a message to the public that government condones high risk behavior and considers such activities safe.
3. It should be a criminal act for a person who knows or has reason to know that he/she is infected with AIDS to engage in high-risk behavior without disclosure to others. High-risk behavior includes unprotected anal, oral, vaginal intercourse and exchange of blood or blood parts.

Minority Reasons

- (1) The uninfected partner has a right to know if their sex partner is infected.
- (2) Criminal sanctions sends a clear and strong message to the public and the infected partner that such behavior will not be tolerated and will be punished.
- (3) Unacceptable behavior must be defined in order to constitutionally detain an individual under civil or criminal law.

4. All pregnant women should be required to have a diagnostic test for AIDS.

Minority Reasons

- (1) An individual can only take responsibility when given information.
 - (2) The unborn cannot exercise responsibility.
 - (3) Thirty to fifty percent of infants born to AIDS-infected women are infected.
5. A diagnostic test for AIDS of health care workers should be made when it has been independently verified that an exchange of bodily fluids has in fact occurred between a patient and health care worker. The results of the diagnostic test should be provided to the health care worker. Persons who know that they are infected with the AIDS virus should be required to disclose their status to health care workers.

Minority Reasons

- (1) Health care workers cannot maintain total alert at all times.
 - (2) The incidents of AIDS transmission is one in one hundred incidents of needle puncture.
 - (3) Emergency health care personnel may not have the requisite time to engage in precautionary measures to guard against contracting the AIDS virus.
 - (4) Failure to recommend that health care workers be provided with information may result in a shortage of health care workers.
6. Friends, families, physicians, and counselors should strongly urge persons infected with AIDS to voluntarily abstain from participating in high-risk behavior.

Minority Reasons

- (1) The risk of transmitting AIDS to an individual through sexual activity is one in ten without a condom; one in one thousand with a condom with increasing odds as sexual activity is coupled with multiple partners.
- (2) The risk of transmitting AIDS through blood exchange is one in one hundred or greater when using intravenous needles.

CONCLUSION

This minority report shares with the majority report a sensitivity to the rights and interests of those persons infected with the AIDS virus. The minority report distinguishes itself from the majority report by balancing interests rather than a statement which advocates or is more concerned with protection of the rights of the infected. Instead, this report offers clear policy proposals in several critical areas where, if implemented, the AIDS epidemic may be solved or stopped. It is to this end that we respectfully submit this report and urge its adoption in whole by the Citizens League Board.

Submitted by:

Robert Bonine
Elsa Carpenter
Carol Coffey

Patricia Comeford
O'Brien J. Doyle, Jr.
Robert Hopper
Craig Wildfang

MINORITY REPORT ON
CRIMINALIZATION OF AIDS TRANSMISSION

April 19, 1988

The undersigned respectfully dissent from the Legal Issues and AIDS Committee's recommendations which state:

- C.2. a) Infected persons who (1) engage other persons in activities that risk transmission of the AIDS virus with (2) the intention of transmitting the virus should be subject to criminal prosecution (3) regardless of whether actual transmission occurred.
- b) Actual transmission of the AIDS virus, when (1) a person knows or has reason to know he or she is infected but (2) does not disclose that infection, logically should be considered a criminal act as well. But this could create a disincentive to testing and would not be as effective as the measures to restrict individuals who persist in putting others at risk of infection, provided by the Non-Compliant Carrier Statute.

We propose that the above language be replaced with the following recommendation:

C.2. The passage of statutes that specifically criminalize AIDS virus transmission (intentional or otherwise) would undermine efforts to stop or slow the spread of AIDS. For that public health purpose, the civil commitment approach of the Non-Compliant Carrier Statute, while imperfect, is more effective.

The rationale for our dissenting position is centered upon a cost/benefit analysis. The benefit of criminalizing AIDS transmission would be dependent upon the effective prosecution of individuals under the law. Yet, rare is the case in which an individual's conduct would render him or her criminally prosecutable, much less convictible. In contrast, the cost would be substantial in terms of the potential harm to progress in stopping or slowing the spread of AIDS, which harm is discussed specifically below.

Both criminal statutes presented in the Committee's report would require proof that the accused knew he or she was infected, thus making ignorance of one's AIDS antibody status an absolute defense. The Committee report correctly concedes that this standard of proof...

"could have effects exactly opposite the intended goal. A person may not want to know his or her AIDS status, if such facts could be used in criminal prosecution cases. Some persons would avoid testing, as a result."

Although this principle applies equally to both criminal statutes discussed in the Committee's report, the report only concludes as to one of the statutes (b):

"But this could create a disincentive to testing and would not be as effective as the measures to restrict individuals who persist in putting others at risk of infection, provided by the Non-Compliant Carrier Statute."

In fact, either statute presented in the report could have the same effect of inhibiting AIDS antibody testing thereby hampering efforts to slow or stop the spread of AIDS.

In conclusion, this Committee was charged with the task of recommending government action for policies that slow or stop further spread of the AIDS virus, while balancing the conflict between individual rights and public health interests. Throughout our deliberative process, the Committee followed a method by which we first asked whether a proposed measure would be effective in stopping or slowing the spread of AIDS. That was the threshold question which, if answered in the negative, would result in not recommending the measure. Criminalization of AIDS transmission will be ineffective, indeed harmful to the process of slowing or stopping the spread of AIDS. Hence, it should not be adopted as recommended policy.

Submitted by:

Kenyari Bellfield
Kathryn Engdahl
Dulcie Hagedorn
Joan Higginbotham
Catherine Jordan

George Moore
David Piper
Helen Reed
Kimberly Roden
Wallace Swan

WORK OF THE COMMITTEE

Charge to the Committee:

The Legal Issues and AIDS Committee worked with the following charge from the Citizens League Board of Directors:

LEGAL ISSUES AND AIDS

"AIDS is spreading rapidly. While the human immunodeficiency virus (HIV) which causes "AIDS" was detected only a few years ago, the disease has doubled its impact several times.

"The number of AIDS cases in Minnesota is small today. But experts predict that number will grow substantially by 1990. By that time it will be one of the leading causes of shortened life for adults.

"No expert expects a cure, or a preventive vaccine, short of the turn of the century. In addition to the visible urging directed at the federal government to sponsor more research into vaccines, more work is needed on policy-preparation fronts. While national policies are possible, much will be left to state action. We are not ready.

"Public and private AIDS education programs are under way, but these policies and programs are outside the scope of this study. Other strategies for slowing or stopping the spread of AIDS are the context of this study.

"The committee should identify the legal issues surrounding AIDS that involve conflicts between individual rights and public health interests. The committee should recognize that changes in these issues are likely to occur as the incidence of the disease increases or diminishes. The committee should examine proposals and recommend government action for policies which balance these conflicts while slowing or stopping the further spread of the virus that causes AIDS.

"Each recommended action should be sensitive to issues of cost and administration.

"The committee should examine the following major issues:

- * testing, tracing, and notification
- * rights and responsibilities in access to and provision of public facilities, services, programs, and the workplace
- * changes in the criminal codes for willful and negligent transmission of the virus.

Committee Membership

A total of 42 committee members, led by Chair Ellen Brown and Vice Chair Jane Vanderpoel, took an active part in the work of the committee. They were:

Charles Backstrom	Catherine Jordan +
Joanne Barr	Ken Kistler
Kenyari Bellfield +	Warren Kleinsasser
Sandra Berthene	Charles Lutz
Robert Bonine *	Mark Lystig
Elsa Carpenter *	Charles Meyers
Carol Coffey *	Malcolm Mitchell
Patricia Comeford *	Dick Moberg
Susan Crawford	George Moore +
Albert de Leon	John Mullen
O'Brien Doyle, Jr. *	Burt Nygren
Janet Dudrow	Lorraine Palkert
William Dustin	David Piper +
Kathryn Engdahl +	Helen Reed +
Dulcie Hagedorn +	Kimberly Roden +
Jeffrey Hazen	Sandra Sandell
Joan Higginbotham +	Peter Sipkins
Thomas Hoch	Wallace Swan +
Randy Hopper *	Kathleen Welte
Marna Johnson	Craig Wildfang *

* These members dissented from the majority report and wrote a minority report. Their report was not accepted by the Board of Directors.

+ These members dissented from the majority position on criminal penalties and wrote a minority report. Their report was not accepted by the Board of Directors.

Committee Meetings/Resource Speakers

The committee met for the first time on November 9, 1987 and concluded its deliberations on April 11, 1988. During its 22 meetings, the committee studied a wide variety of printed materials and heard from the following resource speakers (titles reflect positions held by the resource persons at the time they met with the committee):

Arlene Ackerman, Pastor, All God's Children Metropolitan Community Church
JoAnne Barr, Indian Health Board
Stephen Befort, University of Minnesota Law School
Kenyari Bellfield, Urban Coalition of Minneapolis
Mark Christopherson, person with AIDS
Sharon Day, Minnesota Chemical Dependency Program
Albert de Leon, Executive Director, Council of Asian and Pacific Minnesotans
Dr. Blanca Rosa Egas, Central Cultural Chicano
Eric Engstrom, Executive Director, Minnesota AIDS Project
Eric Janus, Associate Professor of Law, William Mitchell College of Law

Resource guests (continued)

Daniel J. McInerney, Deputy Commissioner, Minnesota Department of Health
George Moore, Hennepin County, Community Health Department
Terry O'Brien, Minnesota Attorney General's Office
Wayne Olhoft, Executive Director, Berean League
Mark Orland, C.L.U.E.S.
Michael Osterholm, Epidemiologist, Minnesota Department of Health
Gary Rankila, Attorney
Helen Reed, Minneapolis Chapter of the American Red Cross
Dr. Frank Rhame, Director of Infection Control, University of Minnesota Hospitals and Clinics
Lee Staples, Indian Service Halfway House of America
Dr. Carol Tauer, Professor of Philosophy, College of St. Catherine

Staff Support

The committee was assisted in its work by Deborah Loon, Dawn Westerman, and Joann Latulippe of the Citizens League staff.