BE IT RESOLVED, That the American Bar Association urges that federal, state, and local law, and the policies of private entities concerning the Human Immunodeficiency Virus (HIV) should be consistent with the following principles.

A. ACCESS TO THE LEGAL SYSTEM AND THE

A.1. The judiciary and the organized bar should encourage attorneys and judges to become knowledgeable about HIV and related legal issues, and should provide appropriate education and training in these areas.

A.2. The judiciary and the organized bar should support the allocation of additional private and public resources, including the further development of pro bono activities, for the delivery of legal services to individuals affected by HIV.

A.3. An attorney should not refuse to represent or limit or modify representation, because of an individual's known or perceived HIV status.

A.4. A judicial or administrative proceeding involving a participant known or perceived to be HIV-infected should be conducted in the same fashion as any other such proceeding. Extraordinary safety or security precautions should not be undertaken based solely upon the participant's known or perceived HIV status.

B. CONFIDENTIALITY

B.1. Specific confidentiality protections should be afforded to HIV-related information under state and federal statutes and judicial and administrative procedures.

C. PUBLIC HEALTH LAW

C.1. HIV reporting to public health agencies for epidemiological purposes should be limited to that information which is necessary for such purposes. If state law requires HIV reporting with identifier to public health agencies for preventive purposes, including partner notification, confidentiality protections should be afforded to such identifying information under state and federal law.
C.2. HIV-related disease reports made to public agencies should be exempt from public record laws and should be afforded statutory confidentiality protections under state and federal law, including protection from disclosure without court order.

C.3. If partner notification is undertaken, state and local law should require the following:

Counseling. Partner notification should include counseling protocols that encourage HIV-infected individuals to notify their partners that they may have been exposed to HIV.

Voluntary Participation. An HIV-infected individual's disclosure of the names of partners should be voluntary. An HIV-infected individual's access to counseling, referral and support services should not depend on disclosure of the names of partners.

Notice. Before ordering or performing a test for HIV or an antibody to HIV, a health care provider shall inform the test subject that in the event of a positive result, the subject will be asked to notify all known present partners, and, if the test subject fails to do so, the health care provider shall notify all present partners known to the provider either personally or by providing the information necessary to the public health department.

Confidentiality. Identifying information regarding notified partners should otherwise be afforded confidentiality protections.

Disclosure. Health care providers and public health officials shall disclose confidential HIV-related information, to known partners if they reasonably believe that: - After reasonable opportunity, an HIV-infected individual has refused to notify partner(s) or the individual's agreement to notify is considered unreliable; and - An identifiable third party is at significant risk of HIV infection and is unaware of the risk.

Immunity. Health care providers and public health officials who are authorized by law to decide whether to disclose confidential HIV-related information should be immune from liability for such decisions made in good faith.

C.4. Personal control measures necessarily implicate the most fundamental constitutionally protected liberty interests and should never be imposed based on status or group characteristics.

C.5. Isolation for public health purposes is a particularly serious infringement of liberty and is not generally appropriate for controlling the spread of HIV infection. However, if such isolation of an individual is sought, it should be ordered by a court only if it has found by clear and convincing evidence that: - The individual is HIV-infected; poses a direct threat to public health as evidenced by a recent overt act endangering another person; and after notice, counseling and appropriate training will not restrict his/her own behavior to avoid a direct threat to public health; and - The proposed isolation is necessary to protect public health and is the least restrictive alternative. In any proceeding in which the isolation of an individual is proposed or under review, stringent procedural protections should be afforded, including the rights to: - Notice, representation by counsel, subpoena and present evidence, cross-examination, a verbatim transcript, and appeal; - Judicial review after 30 days and thereafter no less frequently than every six months; and - Appropriate treatment, habilitation and education directed toward changing the
behavior that resulted in isolation.

C.6. A court may grant an emergency non-renewable isolation order for a period of 72 hours or less upon application of a public health official who has filed with the appropriate court an affidavit establishing reasonable cause to believe that the facts and circumstances necessary for the imposition of isolation exist (see Recommendation C.5 above), and that there is an imminent, direct threat to public health.

D. ACCESS TO HEALTH CARE

D.1. Health care providers should not refuse to treat or limit treatment of an individual, because of the individual's actual or perceived HIV status.

D.2. Access to outpatient facilities should not be limited by zoning or other governmental actions that discriminate based on an individual's actual or perceived HIV status.

D.3. Government programs that cover HIV-related health care should incorporate flexible mechanisms for payment, including expediting the Medicaid waiver review process, to allow more treatment alternative for HIV. D.4. Public and private entities should expeditiously develop and implement HIV-related programs targeted to serve minority communities.

E. HIV TESTING AND COUNSELING

E.1. States should provide for accessible anonymous or confidential testing and counseling sites, coupled with confidentiality and non-discrimination protections, in order to promote voluntary testing for HIV.

E.2. A voluntary HIV test should be conducted only after informed consent, specific to the HIV test, has been obtained and documented.

E.3. Health care facilities should not routinely require an HIV test as a condition for admission or treatment.

F. INSURANCE

F.1. An insurer should not base an adverse underwriting decision solely on information derived from data banks such as the Medical Information Bureau (MIB).

F.2. State laws should prohibit insurance discrimination based on sexual orientation.

F.3. Insurers should not use information about an applicant's lifestyle to attempt to determine an applicant's sexual orientation.

F.4. Consistent with the National Association of Insurance Commissioners Guidelines on Medical / Lifestyle Questions, state insurance regulatory authorities should prohibit underwriting
based on sexual orientation of lifestyle.

F.5. Any HIV test required by an insurer that may be the basis for an adverse underwriting action should conform to generally accepted public health protocols.

F.6. An insurer should be prohibited from asking applicants whether they have taken a HIV test or sought counseling regarding HIV.

F.7. An insurer may disclose positive HIV results to a health care provider named by the applicant for the purpose, or to the applicant upon specific request. Disclosure to the applicant should be accompanied by appropriate counseling or referral for counseling.

F.8. States should adopt confidentiality statutes or regulations consistent with the National Association of Insurance Commissioners' Insurance Information and Privacy Protection Model Act.

F.9 All health insurance policies and health plans that cover a comprehensive range of medical conditions should cover AIDS, ARC and HIV to the same extent as other serious medical conditions.

F.10. Insurers should be encouraged to cover care in the home, nursing homes, hospices, or outpatient facilities to the extent that such alternatives are cost-effective.

F.11. Insurers should be encouraged to apply case management techniques to HIV-related care.

F.12. Insurers should be encouraged to include coverage of drugs which have been approved by the FDA under a "Treatment IND" mechanism.

F.13. The period of exclusion for HIV-related conditions should be no longer than for other pre-existing conditions.

F.14. Insurers should not cancel or refuse to renew or increase premiums on an individual insurance policy because of the individual's HIV-related claims or a change in health status.

F.15. Public and private entities should share responsibility for financing health care for medically uninsured individuals, including individuals with HIV-related conditions.

G. DRUG DEVELOPMENT

G.1. The Food and Drug Administration should continue its efforts to accelerate review, approval and dissemination of HIV-related drugs, vaccines and medical devices.

G.2. Public and private entities should support forms of "community-based" drug trials as
a mechanism to make experimental therapies available to the widest range of individuals with HIV.

G.3 The Food and Drug Administration should continue to require a demonstration of drug efficacy by well-controlled studies so long as potentially effective drugs are available for clinical studies among the widest range of individuals with HIV.

G.4. The Secretary of Health and Human Services should require all state Medicaid programs to reimburse for HIV-related drugs that have been approved by the Food and Drug Administration for marketing or made available under a "Treatment IND" mechanism.

G.5 The federal government should evaluate and address the financial, legal and other obstacles limiting access to HIV-related drugs.

H. EMPLOYMENT

H.1. Employers should not test employees for HIV except in those extraordinarily rare instances in which an employee's HIV status is relevant to his or her job performance.

H.2. Consistent with existing standards governing refusals to work, and after appropriate HIV education and notice regarding possible sanctions, employers may discipline any employee or group of employees who refuse to have work-related contact with an individual who is known or perceived to have HIV.

H.3. Employees should retain the right to refuse to work if: - An employer fails to comply with CDC recommendation or other governmental require HIV safeguards, and such failure results in an unsafe work environment; or - Consistent with OSHA protections, the employee's refusal to work is based on reasonable belief that: there is an imminent danger of HIV infection in the workplace; and alternatives to a refusal to work are inadequate to eliminate the imminent danger.

I. DISCRIMINATION

I.1. State and local governments should enact and enforce legislation which prohibits discrimination against "an otherwise qualified individual" as defined by such legislation in employment, housing, public accommodations, or governmental services solely by reason of the fact that such individual is, or is regarded as being, infected with HIV or having AIDS or an AIDS-related condition.

I.2. Public and private entities should take appropriate steps to ensure that people in minority communities receive equal access to HIV-related treatment, prevention and research programs.

I.3. The Fair Housing Amendments Act prohibiting discrimination because of disability, including actual or perceived HIV status, should be effectively and speedily implemented and enforced.
J. PUBLIC SCHOOL EDUCATION

J.1. A student should not be excluded from school because of known or perceived HIV status.

J.2. A student should not be separated from his or her classmates because of known or perceived HIV status unless: - The student has presented behaviors which unde current medical knowledge present a substantial and genuine risk of HIV transmission; - School authorities have made reasonable effort to provide counseling and training directed toward preventing risk behaviors or have determined that such efforts are unlikely to succeed; - Appropriate consideration has been given to the psychological and educational effects of the separation on the individual student; - The particular form of separation is the least restrictive means of effectively reducing the risk of HIV transmission; - School authorities periodically evaluate all relevant factors regarding the continuing need for separating the student from his/her classmates; and - A program is designed to train the student to join the general school population.

J.3 All school systems should adopt appropriate policies and curricula regarding the education of all students, staff and parents regarding HIV.

J.4. School authorities should afford maximum confidentiality to a student's HIV status.

K. CHILD WELFARE

K.1. Foster care and adopting agencies should not routinely test children for HIV. Agency decision to test a child should be made on a case - by - case basis and should be governed by written criteria that are consistent with generally accepted public health recommendations.

K.2. The HIV status of adoptive or foster children should be afforded maximum confidentiality protection, but should be disclosed to foster care or adoptive parents.

K.3. Foster care and adoption agencies should provide HIV-related services to children under their jurisdiction consistent with the goal of providing appropriate services in the least restrictive setting.

K.4. Foster care and adoption agencies shall consider the HIV status of foster care or adoptive parents only to the same extent as other medical conditions are considered.

L. FAMILY LAW

L.1. HIV status generally should be not deemed admissible evidence in a family law proceeding. Such evidence may be considered only if: - There is a preliminary independent showing which supports the relevancy of such evidence; and - HIV status is probative of the issue in question.
L.2. HIV status should be considered only in the same manner as other medical conditions in: - Awarding alimony where a party's health is at issue; or - Determining child custody and visitation.

L.3. HIV status should not be deemed admissible evidence for the purpose of proving a party's sexual orientation.

M. DRUG ABUSE

M.1. States and localities should address the HIV epidemic among drug abusers and their partners as a significant public health problem and should support appropriate public health education and medical interventions.

N. IMMIGRATION

N.1. Legalization pursuant to the Immigration Reform and Control Act should not be denied to otherwise-qualified aliens solely because of HIV status. N.2. Non-immigrant visitors to the United States should not be barred solely because of HIV status.

N.3. Otherwise-qualified political asylees and refugees should not be barred from the United States solely because of HIV status.

N.4. The Attorney General should have the authority to waive exclusions based on HIV status for immigrants on a case-by-case basis.

O. EDUCATING THE PUBLIC

O.1. Accurate, effective education of the public regarding HIV, consistent with generally accepted public health recommendations, should be supported by public and private entities as essential to any informed response to legal issues arising from the HIV epidemic.
# REPORT

## TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>ACCESS TO THE LEGAL SYSTEM</td>
<td>8</td>
</tr>
<tr>
<td>CONFIDENTIALITY</td>
<td>15</td>
</tr>
<tr>
<td>PUBLIC HEALTH LAW</td>
<td>21</td>
</tr>
<tr>
<td>ACCESS TO HEALTH CARE</td>
<td>32</td>
</tr>
<tr>
<td>TESTING AND COUNSELING</td>
<td>39</td>
</tr>
<tr>
<td>INSURANCE</td>
<td>44</td>
</tr>
<tr>
<td>DRUG DEVELOPMENT</td>
<td>53</td>
</tr>
<tr>
<td>EMPLOYMENT</td>
<td>59</td>
</tr>
<tr>
<td>DISCRIMINATION</td>
<td>66</td>
</tr>
<tr>
<td>PUBLIC SCHOOL EDUCATION</td>
<td>76</td>
</tr>
<tr>
<td>CHILD WELFARE SYSTEM</td>
<td>88</td>
</tr>
<tr>
<td>FAMILY LAW</td>
<td>98</td>
</tr>
<tr>
<td>DRUG ABUSE</td>
<td>104</td>
</tr>
<tr>
<td>IMMIGRATION</td>
<td>109</td>
</tr>
<tr>
<td>EDUCATING THE PUBLIC</td>
<td>113</td>
</tr>
<tr>
<td>CONCLUSION</td>
<td>117</td>
</tr>
</tbody>
</table>
INTRODUCTION

The HIV epidemic, which has claimed the lives of 54,402 Americans since 1981,1/ has significantly affected virtually every major institution in this country, including the legal system. Over the past 18 months, the American Bar Association AIDS Coordinating Committee, with the assistance of many ABA entities and outside organizations, has analyzed the impact of HIV on the law. The Coordinating Committee has concluded that the legal profession must become more actively involved in shaping public policy in this critical area. The recommendations we have made to the Association are the product of that analysis and concern.

The Coordinating Committee was established by the Board of Governors, at the request of the Section of Individual Rights and Responsibilities, in August 1987. Recognizing that AIDS and HIV-related legal issues impact on virtually every area of the law, representatives of thirteen ABA entities and two outside organizations were invited to serve on the Committee. Current members include:

Mr. Barry Sullivan
Jenner & Block
CHAIR

Mr. William A. Bradford, Jr.
Hogan & Hartson
VICE-CHAIR

Honorable Richard T. Andrias
CRIMINAL JUSTICE SECTION

Mr. C. Rick Chamberlin
FAMILY LAW SECTION

Mr. Philip Corboy, Sr.
LITIGATION SECTION

Mr. Theodore C. Falk
FORUM COMMITTEE ON HEALTH LAW

Mr. Alan J. Hoff
YOUNG LAWYERS DIVISION

Mr. Alan J. Hoff
YOUNG LAWYERS DIVISION

Professor Ruth Luckasson
COMMISSION ON THE MENTALLY DISABLED

Professor Frank Merritt
URBAN STATE & LOCAL GOVERNMENT SECTION

Professor James T. O'Reilly
ADMINISTRATIVE LAW SECTION

Ms. Abby R. Rubenfeld
INDIVIDUAL RIGHTS AND RESPONSIBILITIES SECTION

Mr. Salvatore J. Russo
NEW YORK BAR ASSOCIATION

1/ Centers for Disease Control, telephone communication (May 23, 1989). Over 94,280 AIDS cases in adults, adolescents and children have been reported in the United States, as of May 23, 1989. Id.
The Coordinating Committee began its work in January 1988 by focusing upon the fifteen legal issue areas that are the subject of this package of recommendations. Three of those issues -- the impact of the HIV epidemic in the employment, health care, and public school contexts -- were the subject of fact-finding hearings which the Coordinating Committee held in Washington, D.C. on March 4-6, 1988. During the 1988 Annual Meeting in Toronto, the Coordinating Committee (together with ten other ABA entities) sponsored a Presidential Showcase Program, which included presentations on the subjects of HIV testing, employment, public education, insurance, and health care. Moreover, hearings on access to the legal system and HIV education were held in Washington, D.C. on September 23, 1988, and a hearing on financing issues was conducted in Chicago, Illinois on November 21, 1988. Many organizations and individuals with first-hand experience in these areas gave generously of their time by presenting live testimony and written submissions to the Coordinating Committee.

In preparing these recommendations, the Coordinating Committee has drawn upon the testimony presented at these hearings, which is cited, where appropriate, in relevant sections of this report. Virtually all members of the Coordinating Committee also have undertaken extensive research with respect to those areas which, because of time, staff and budget constraints, have not been the subject of oral hearings. In conducting this research, members of the Coordinating Committee have received valuable assistance and advice, both from members of the sections and entities they represent, and from other interested and knowledgeable persons. This research also has been shared with other members of the Coordinating Committee, who extensively discussed and debated these recommendations at the March 1988 hearings, and at drafting sessions held on January 28-29, April 30, and May 1, 1989.

The Committee would like to thank the witnesses who presented testimony: Dr. C. Ross Anthony, Associate Administrator for Program Development of the Health Care Financing Administration; Mr. Jordan Barab of AFSCME; Mr. David Chavkin, Director of Legal Advocacy, Epilepsy Foundation of America; Ms. Karen Clifford, Legal Counsel,
Health Insurance Association of America; Mr. Charles Cooper, Assistant Attorney General, Office of Legal Counsel, United States Department of Justice; Mr. Larry Ellis of Lifelink; Ms. Elizabeth Esty and Dr. David Orentlicher of Sidley & Austin, on behalf of the American Medical Association; Mr. Robert Greenwald, Legal Counsel, AIDS Action Committee; Ms. Katherine Fraser of the National Association of State Boards of Education; Mr. Kenneth Labowitz of Fagelson, Schonberger, Payne & Arthur; Mr. Arthur Leonard of Lambda Legal Defense Fund; Dr. Woodrow Meyers of the Association of State and Territorial Health Officials; Ms. Donna Richardson of the American Nurses Association; Mr. Frederick P. Shaffer of the Corporation Counsel's Office of the City of New York; Mr. Tom Sheridan, Director of Public Policy, AIDS Action Council; Mr. Mark Scherzer of Scherzer & Palella; Mr. Michael Simpson and Mr. James Williams of the National Education Association; Mr. James Monroe Smith of the AIDS Legal Council of Chicago; Mr. Peter Spanos of Hendricks, Spanos & Phillips; Mr. August Steinhilber of the National School Boards Association; Hon. David Thornberry, member of the Texas Board of Insurance and the National Association of Insurance Commissioners; Dr. Reed Tuckson, Commissioner of Public Health for the District of Columbia; and Dr. Patricia Wright, Director of Governmental Affairs, Disability Rights Education and Defense Fund.

The Coordinating Committee also would like to thank Ms. Janet Cook of Gibson, Dunn & Crutcher; Mr. Orvin Kacprzyk of Corboy & Demetrio; Judge Edward Terhane Miller of the Office of Administrative Law Judges, U.S. Department of Labor; Ms. Marjorie O'Connell of O'Connell & Kittrell; Dean William L. Robinson of the District of Columbia School of Law; Judge David Shields of the Circuit Court of Cook County, Illinois; and Mr. Clifford Stromberg of Hogan & Hartson, for their participation in various hearings and deliberations of the Coordinating Committee. In addition, we would like to thank Mr. William T. Carlson, Jr., Mr. Robert J. Pleasure, and Ms. Suzanne N. Saunders, all of whom contributed greatly to our work as members of the Coordinating Committee during the first year of its existence.

The Coordinating Committee has been fortunate to have the assistance of two outstanding staff members, Ms. Patricia Davidson and Ms. Michele Zavos, both of whom have contributed immeasurably to all aspects of our work. Ms. Davidson, who has served as Project Consultant since the beginning, has been indispensable throughout. Ms. Zavos, who joined us this year, has quickly attained the same status. Both of them have contributed greatly, despite much personal inconvenience, to the timely preparation of this report. We are grateful to them, and to Mr. Steven G. Raikin, our Program Director, for much support, advice, and encouragement. We are also grateful to Mr. Daniel S.
Goldman, Ms. Ellen R. Kordik, and Mr. Jeffrey T. Shaw, all of whom are associates with Jenner & Block. All have provided exceptional research and drafting assistance to the Coordinating Committee. Ms. Donna Dennis of Jenner & Block typed and retyped countless drafts of the report and recommendations, and we are particularly grateful to her for her patient and unstinting dedication to this project. We are also grateful to Jenner & Block for providing many other support services to this project.

Many of the hearing witnesses also contributed to the Coordinating Committee’s 1988 publication, ABA AIDS: The Legal Issues, which objectively analyzed HIV-related issues in 15 substantive areas of the law. This discussion paper was an important step in the development of ABA policy, and the Coordinating Committee is proud to report that requests for the discussion paper continue to pour in from lawyers, judges, individuals, and organizations across the country and abroad. The Coordinating Committee released AIDS: The Legal Issues during the Presidential Showcase Program it presented in Toronto, Ontario, during the 1988 ABA Annual Meeting. Our program, "The AIDS Crisis: The Legal System Begins to Meet the Challenge," was co-sponsored by the Administrative Law Section, the Commission on the Mentally Disabled, the Criminal Justice Section, the Family Law Section, the Forum Committee on Health Law, the General Practice Section, the Individual Rights and Responsibilities Section, the Labor and Employment Law Section, the Litigation Section, the Tort and Insurance Practice Section, and the Young Lawyers Division. We were fortunate to have a number of deservedly well-recognized authorities participate in that program, and we would like to take this opportunity to express our gratitude to them: Ms. Karen Clifford, Legal Counsel, Health Insurance Association of America; Prof. Harlon Dalton of the Yale Law School; Dr. Walter Dowdle, Deputy Director of the Centers for Disease Control; Mr. Larry Gostin, Executive Director, American Society of Law and Medicine; Ms. Karen Ignagni of the AFL-CIO; Mr. Kirk Johnson, General Counsel, American Medical Association; Mr. Jeff Levi, Executive Director, National Gay and Lesbian Task Force; Dean June Osborn of the University of Michigan School of Public Health; Mr. Glen Reed of King and Spalding; and Mr. Stephen Tallent of Gibson, Dunn & Crutcher.

Moreover, we are pleased to note that the ABA already has adopted policy in some areas identified in the report, including recommendations pertaining to criminal law

and the administration of justice, as well as recommendations concerning voluntary testing and counseling, confidentiality, and nondiscrimination. The Coordinating Committee strongly supports these policy statements and has relied upon them in developing the complementary recommendations that are the subject of this report. It is abundantly clear, however, that many significant legal issues remain to be addressed by the nation’s lawyers and judges. This package of recommendations, which has been carefully developed after a year and a half of research and hearings, will, if adopted, provide necessary guidance from the legal profession.

Several principles shaped the Coordinating Committee’s work and should similarly guide consideration of our recommendations. First, all of our recommendations are based on the current state of medical and scientific knowledge concerning HIV and AIDS. Thus, our recommendations are necessarily subject to review and revision in the event that new information significantly alters the basic scientific facts upon which they are based. We hasten to add, however, that we have no reason whatever to believe that those basic scientific facts will change, and we believe that it is necessary for us to take action based on what we now know about such matters as the transmission of the HIV virus. Indeed, given the epidemic proportions of this disease, and the intensive study which it already has received in the medical and scientific communities, it is safe to say that we know far more about this disease and its transmission than we do about many other diseases with which our society has been plagued for a far longer time. Second, the Coordinating Committee limited its deliberations to issues that directly affect the legal profession and the development of legal policy related to AIDS and HIV. Therefore, based on jurisdictional considerations, we did not attempt to address other issues relating to AIDS. Nor did we extend our recommendations to include other diseases. The principles which inform our recommendations might well be applicable to other areas, but such applications are beyond the scope of our mandate. We therefore leave that work, if it is thought desirable, to other hands and another day.


The intensive study which we have undertaken has persuaded the Coordinating Committee that the ABA must join the many professional organizations which already have stepped forward to help educate their members and the public about HIV, and to participate in the formulation of public policy in this critical area. As lawyers and judges, we are uniquely positioned, and, indeed, have a unique responsibility, for participating in the development of legal standards which further the protection of the public health, while also securing adherence to the traditional rights and responsibilities which all of us share as participants in a free society. Indeed, the Coordinating Committee has concluded, together with the Presidential Commission, that these interests are largely compatible, and that appropriate laws governing discrimination, confidentiality and control measures, will, if consistently and fairly applied, advance the public health as well as the principles of individual autonomy and responsibility that animate the social, political, and legal arrangements of a free people. Like the Presidential Commission, the Coordinating Committee believes that those who see a wide gulf between the needs of public health and individual rights in this area are handicapped by unfounded fears, which must be dispelled if rational policy is to be developed.

Indeed, the Coordinating Committee is deeply concerned that basic facts about HIV, particularly the fact that the virus is not transmitted by "casual" contact, are still not understood and accepted by far too many people in our society. As the Presidential Commission has aptly concluded:

Education about transmission of the virus and about laws banning HIV-related discrimination is insufficient. This results in ignorance, misinformation, acts of discrimination, and in some persons, an irrational fear of association with those who are HIV-infected.


6/ Report of the Presidential Commission on the Human (Footnote Continued)
The Coordinating Committee offers this package of recommendations with pride in its work and in that of the many lawyers and judges who already have contributed professionally and personally to the fight against HIV. Our work, as we have said before, must begin "by substituting fact for fear and reason for prejudice, and by providing a forum in which all parties may be heard and judged on the merit of their positions." The Coordinating Committee believes that these recommendations constitute a significant step in that process.

(Footnote Continued)

Immunodeficiency Virus 120 (June 1988) ("Report of the Presidential Commission").

BACKGROUND

People affected by HIV experience legal problems in a number of areas, including employment, housing, education, the provision of medical and social services, and public accommodations, specifically because of their condition. Moreover, people with HIV-related disease, like all people with a catastrophic illness, need attorneys to provide routine legal services, such as preparing wills and documents conferring medical and financial powers of attorneys.

In AIDS: The Legal Issues, the Coordinating Committee noted that "[p]roblems in all of these areas require the assistance of competent counsel who are willing to make available their professional services," and that providing such services is consistent with ethical obligations under Canon 2 of the ABA Model Code of Professional Responsibility.

In the course of its research, particularly during fact finding hearings held in March and September 1988, the Coordinating Committee found that the availability of effective and affordable representation is one of the most critical needs faced by people affected by HIV.

8/ "Persons affected by HIV" refers to the following: people with full blown AIDS as defined by CDC; people with other symptoms of HIV infection; people who test positive for HIV antibodies, but who have no clinical illness; family, friends and associates of people in any of the preceding categories; and people mistakenly perceived to fall into any of the above categories. See AIDS: The Legal Issues 5 (August 1988).

9/ Id. at 13.

10/ Id. at 14. See also, Testimony of Robert Greenwald, Legal Counsel, AIDS Action Committee, September 23, 1988 at 6; Written Testimony of David Chavkin, Director of Legal Advocacy, Epilepsy Foundation, September 23, 1988 at 2, 4.


Consistent with the ABA's Goals of improving the delivery of legal services13/ and increasing the public's understanding of the law and the role of the legal profession,14/ the adoption of ABA policy in this area will assist the legal profession, both in providing appropriate leadership in this area and in rendering the professional services sought by the many people and organizations affected by the HIV epidemic.

The Growing Need for Affordable Representation

The number of HIV-related discrimination complaints is rising and can be expected to increase along with the growing number of AIDS cases and HIV infections. The Presidential Commission reported that "HIV-related cases handled by the New York City Commission on Human Rights have risen from three in 1983 to more than 300 in 1986, to almost 600 in 1987."15/ In 1988, the Commission on Human Rights handled 700 cases.16/

It seems clear, however, that there are not enough trained attorneys currently willing to make their services available to HIV affected clients.17/ Moreover, incidents of outright refusal to represent have been reported. One witness before the Coordinating Committee testified about an attorney who refused to represent a child with AIDS in a


17/ Testimony of Mr. Kenneth Labowitz, private practitioner, March 5, 1988 at 327. Mr. Labowitz stated "There is no lawyer closer to Northern Virginia than me, 150 miles [away] that will even talk to a person with AIDS... I have been referred clients from North Carolina, West Virginia, and Maryland, as well as throughout Virginia. There isn't anybody else to do it." Id.
foster care proceeding and about a public defender who refused to represent an incarcerated client with AIDS.19/

The cost of legal services is also a formidable barrier for most people with HIV-related illnesses who face staggering medical bills, and perhaps, ultimately the loss of a job and insurance coverage.20/ Some established legal clinics serving people affected by HIV are currently providing free services, and all of the witnesses before the Coordinating Committee testified in support of expanding such services on a no fee or sliding fee basis.21/

Education and Training for Attorneys and Judges

Attorneys

Education and training about AIDS and HIV infection clearly are needed to assist attorneys in representing HIV affected people.22/ Effective programs should include the dissemination of medical information about AIDS and HIV, and should feature sessions designed to assist attorneys in working effectively and empathetically with HIV affected clients. Building trust, particularly in view of the privacy concerns of HIV affected clients, is essential. Thus, the Coordinating Committee recommends that HIV education and training programs include a confidentiality component.23/

18/ Testimony of David Chavkin, Director of Legal Advocacy, Epilepsy Foundation, September 23, 1988, at 4.
19/ Id.
20/ Coleman, Representing AIDS Affected Clients, Los Angeles Lawyer (September 1988).
21/ Testimony of Robert Greenwald, Legal Counsel, AIDS Action Committee, September 23, 1988, at 9-12; 17; See also Testimony of Dr. Patrisha Wright, Disability Rights Education and Defense Fund, September 23, 1988, at 42; Written Testimony of David Chavkin, at 6.
23/ Training for support staff in the area of confidentiality is also desirable. Testimony of Robert Greenwald at 9-10, 30.
A number of substantive areas should be covered in education and training programs, including, for example, disability law, employment law, financial planning, estate planning, housing and real estate law, public benefits law, insurance law, health law, credit, collection and bankruptcy law, immigration law, family law, and criminal law. Such training also should link attorneys interested in taking AIDS/HIV-related cases with attorneys currently practicing in these areas. The Coordinating Committee is aware that successful attorney training programs have been conducted in numerous jurisdictions (i.e., Minnesota, Washington, D.C., and San Francisco) and the Coordinating Committee is currently working with state and local bar associations and AIDS service providers to promote and expand such programs.

Judges

The Coordinating Committee supports the ongoing efforts of the judicial community to provide updated legal and medical information about AIDS and HIV education to all judges, recognizing that "[j]udges have special responsibilities and obligations when dealing with issues, such as HIV, which are often not fully understood, and which can cause confusion and fear among litigants, jurors, court officers and anyone else involved in the judicial process."24/ Currently, two major judicial education efforts are underway. The State Justice Institute (SJI) and the National Institute of Justice (NIJ) recently co-sponsored the first national conference for judges on "AIDS and the Courts" on April 1-5, 1989 in Miami, Florida. In addition, the ABA Section of Individual Rights and Responsibilities is working with the National Judicial College (NJC) on a judicial education program designed to complement the national conference. This program, funded in part by an SJI grant, will feature an NJC course on "AIDS and Other Tough Medical Issues," a pilot training module for state judges, and the publication of an AIDS benchbook.

These two programs are important first steps towards ensuring that judges have access to HIV-related educational materials and appropriate training.

24/ AIDS: The Legal Issues 3 (August 1988). An example of such fear and confusion recently appeared in a news article published by the Ft. Myers News Press (Florida) which reported that a Lee County Judge banished a defendant from her courtroom after he confided to her that he had AIDS, because of fear of being spat on or touched by him. Ft. Myers News Press, p. 1A (March 31, 1989).
Delivery of HIV-Related Legal Services

Largely through the initiative of gay and lesbian organizations and community-based AIDS service providers, several metropolitan areas have established AIDS/HIV legal clinics. These programs have served thousands of HIV affected clients. However, these programs are overloaded relative to their staffing levels and budgets, and they cannot be expected to continue to handle the growing caseload without assistance. The Coordinating Committee believes that the organized bar should support the allocation of additional resources for the delivery of legal services to persons affected by HIV, including expanded pro bono publico activities. The Coordinating Committee notes that the ABA recently adopted a policy calling for all attorneys to devote at least 50 hours of time per year to pro bono publico and public service activities. The Coordinating Committee applauds this action, and strongly encourages attorneys to donate their time to programs assisting HIV affected individuals.

A recent ABA survey revealed that state and local bar associations are greatly interested in establishing pro bono programs to assist people affected by HIV. Further, a witness who appeared before the Coordinating Committee testified that the number of private firms interested in participating in pro bono AIDS work is increasing. That witness, the Legal Counsel of the AIDS Action Committee, testified that: "Two years ago when I started contacting the law firms, most of them said we already have our set pro bono work and we're not interested. I would say over the past six months I have received 25 phone calls from the major law firms saying we're interested in setting up an AIDS law clinic one afternoon a week."

The Coordinating Committee believes that the active participation of local AIDS service providers will be required if private attorneys are to be linked effectively to HIV affected clients. Most existing legal clinics are

26/ AIDS: The Legal Issues 14 (August 1988); See also Testimony of Robert Greenwald, at 10.
27/ ABA AIDS Coordination Project Pro Bono Survey (April-July 1988).
28/ Testimony of Robert Greenwald, at 29.
conducted on the premises of community based service providers, where clients already feel comfortable.29/ At the same time, however, it is unlikely that a single model will meet the need for HIV-related legal services in every community.30/ Legal problems experienced by children with HIV, for example, relate primarily to access to appropriate medical services, entitlement programs, education, and foster care placement.31/ These service needs differ from those of adults with HIV, who have both generic legal services needs and legal problems specifically related to their HIV status. Moreover, people affected by HIV who are minorities, gay, IV drug users, incarcerated, institutionalized or disabled, also may have other legal problems requiring special expertise.

Finally, several witnesses emphasized the importance of making legal services available to people who are affected by -- but not infected with -- HIV. For example, one witness observed:

There are thousands of people who are not infected by this disease who spend hours volunteering to help people who are infected. Many of these individuals experience discrimination as well. They have been threatened with evictions, termination of their employment, etcetera ... The last thing I would want is for (sic) a member of the private bar doing an HIV case or a young teenager delivering meals on wheels to a PWA or a buddy visiting a PWA not do their part because they are afraid they might get fired.32/

Mechanisms to facilitate communication between attorneys who are involved in HIV-specific litigation and attorneys who have been working on disability rights cases over the past decade should also be built into HIV-related legal services programs. As one witness before the


30/ Testimony of Robert Greenwald, at 8; see also Testimony of Dr. Patrisha Wright, at 43-44; Testimony of David Chavkin, at 6-7.

31/ Testimony of David Chavkin, at 8-9.

32/ Testimony of Dr. Patrisha Wright, at 49-50.
Coordinating Committee pointed out, litigation in HIV discrimination cases necessarily will have an impact on the development of Section 504 and disability law because the same statutes apply to all disabilities. Thus, it is important that the organized bar support cooperation and coordination between attorneys involved in HIV-related cases and the disability legal community. Indeed, in light of the extensive experience that those involved in disability rights litigation have had in cases involving Section 504 and related statutes, and the specific expertise that attorneys involved in HIV-related litigation bring to certain disability issues, such cooperation and coordination will be fruitful for both communities of lawyers and their clients.

In short, the mix of resources in the community, as well as the needs of the local client population, should shape the HIV-related legal services model adopted in a given community.

Key resources and participants might include:

- Community-based AIDS service providers;
- Bar association sponsored pro bono panels;
- Legal services components of gay and lesbian organizations;
- Private attorneys;
- Protection and Advocacy Systems;
- Legal Services Corporation funded programs and other legal aid programs;
- National, regional, state and municipal Offices of Civil Rights;
- Law school clinical programs; and
- Judicial colleges and institutions.

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33/ Id. at 47-50.

34/ Id. at 44-45; see also Written Testimony of David Chavkin, at 2-3.

35/ Written Testimony of David Chavkin, at 2-3; Testimony of Dr. Patrisha Wright, at 45.
CONFIDENTIALITY

Background

The Presidential Commission concluded that "[r]igorous maintenance of confidentiality is considered critical to the success of the public health endeavor to prevent the transmission and spread of HIV infection."36/ The Coordinating Committee concurs in this judgment and therefore recommends that specific confidentiality protections should be afforded to HIV-related information under state and federal law.

Current Law

In AIDS: The Legal Issues, the Coordinating Committee discussed the constitutional, common law, statutory and regulatory basis of privacy and confidentiality protections for medical information.37/ The Coordinating Committee noted that the health care provider's duty to preserve the confidentiality of medical information is both an ethical and a legal obligation.38/ Since 1828, when New York first enacted legislation to make privileged the communications between a patient and his or her physician,39/ virtually every American jurisdiction has recognized the privilege through legislation or case law.40/ State statutes and accrediting agencies have imposed parallel obligations of confidentiality upon health care facilities,41/ and state

39/ Id. at 19-15.
professional licensing laws have extended the duty to maintain the confidentiality of medical information to other health care professionals.42/

The general rationale for requiring confidentiality is the public interest in encouraging patients to furnish the information needed by their health care providers to diagnose and care for them.

Rationale For Special Rules for HIV

In addition to safeguarding medical information, confidentiality laws traditionally have protected information about treatment for drug dependency and sexually transmitted diseases (STDs).43/ Special confidentiality protections have been developed in these contexts because of the particularly strong public interest in encouraging individuals to seek and receive treatment for these diseases, a rationale which also applies to persons infected with HIV.

Although no cure has yet been found for HIV-related disease, confidentiality protections encourage individuals to come forward for voluntary testing, counseling and research.44/ Furthermore, the development of palliative treatment, experimental drugs, and future therapies or vaccines depends upon a population willing to step forward and submit to testing and research. Currently, nearly half of the states have enacted confidentiality statutes specifically addressing HIV-related information.45/ However, these statutes vary greatly with respect to the categories of information, people, and organizations covered, and the

42/ Id.


types of disclosures permitted. Moreover, some jurisdictions rely on the Uniform Health Care Information Act, while others utilize licensure statutes or regulations, accreditation statutes or regulations, or evidentiary privileges, to limit the disclosure of medical information.

The Need for Uniformity

The Presidential Commission has identified the lack of uniform confidentiality protections as a significant obstacle to HIV prevention efforts, and has called both for the enactment of a federal law and for the development of model state confidentiality legislation which would enunciate a general confidentiality rule with specific, limited exceptions. The Coordinating Committee agrees with the Presidential Commission and therefore recommends that state and federal statutes and judicial and administrative procedural rules and regulations specifically protect the confidentiality of HIV-related information. The Coordinating Committee's recommendation states a general principle that applies to the entire package of recommendations. Moreover, this principle is elaborated upon in a number of specific areas, including HIV reporting and partner notification, HIV testing and counseling, insurance, education, and child welfare.

The Coordinating Committee believes that confidentiality statutes are important, not only to protect the privacy of persons with HIV, but also to provide clear standards for health care workers and others who have access to HIV-related information. Moreover, the Coordinating

46/ Id. at 1626-1627.
48/ See Public Health Law section.
49/ See HIV Testing and Counseling section.
50/ See Insurance section.
51/ See Education section.
52/ See Child Welfare section.
53/ Gostin, Public Health Strategies for Confronting AIDS (Footnote Continued)
Committee is aware of several efforts to develop uniform confidentiality legislation including:

- Published Models, particularly the "Comprehensive AIDS Confidentiality Act" published in the Harvard Journal of Legislation.\footnote{54/}

- The Intergovernmental Health Policy Project, which has published a compilation of AIDS-related state legislation from 1983-1988\footnote{55/} and is currently preparing a report analyzing state confidentiality and informed consent laws.

- The Harvard Model AIDS Legislation Project, which recently received a grant to develop model AIDS-related legislation.

- The University of Michigan Public Health Legislation Project, which has drafted a proposal to develop guidelines and model legislation on communicable diseases.

The Coordinating Committee expects to work with these groups and others to develop a model confidentiality law that clearly defines the classes of information, and the classes of people and organizations, subject to its provisions; delineates a general rule of confidentiality for HIV-related information with appropriate exceptions; and provides remedies for breach of the duties established.

Confidentiality and the Attorney Client Relationship

As the Presidential Commission has noted, protecting the confidentiality of HIV-related information is particularly important because, apart from the illness itself, it is discrimination which is most feared by

\footnote{(Footnote Continued)}


\footnote{55/} Intergovernmental Health Policy Project, AIDS: Communicable and Sexually Transmitted Disease, Public Health Record and AIDS-Specific Laws, George Washington University (1988).
individuals with HIV. The Coordinating Committee believes that, consistent with the ABA Code of Professional Responsibility, attorneys should maintain the confidentiality of information regarding a client’s HIV status. Moreover, attorneys should also take appropriate steps to ensure that their employees do not disclose confidential information. (See Access to the Legal System and the Administration of Justice section of this report for further discussion).

Under Disciplinary Rule 4-101 of the ABA Code of Professional Responsibility, which has been adopted in most jurisdictions, an attorney may not reveal two types of information about a client. First, an attorney may not reveal client confidences, which are defined as "information protected by the attorney-client privilege." Second, an attorney may not reveal client "secrets," which are defined as information that the client has requested to be kept secret, or information which would be embarrassing or detrimental to the client if disclosed. Moreover, an attorney must exercise reasonable care to prevent his or her employees and associates from disclosing this information.

The only exceptions to this duty of confidentiality are when:

* the client consents;
* the attorney is compelled to disclose the information by court order;
* the information is necessary to prevent the commission of a crime; or
* the attorney needs to use the information to defend an accusation that he or she engaged in wrongful conduct, or to collect his or her fee.

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58/ Id.
59/ Id. at 82.
60/ Id.
The Coordinating Committee concludes that information regarding an individual's HIV status, including information obtained from a third party, should also be protected as a client secret, since it is clearly information that could be detrimental to the client if disclosed.
Background

The application of traditional public health reporting and intervention strategies to AIDS and HIV cases has been the focus of considerable debate among health lawyers and medical professionals. The Coordinating Committee has examined these issues and made a series of recommendations regarding reporting, partner notification, and control measures. In general, the Committee agrees with the Presidential Commission that "[t]he perception that confidentiality may be breached is keeping people who believe that they may have been exposed to the virus from seeking testing and counseling services". This perception must be dissipated if effective public health strategies are to be implemented.

Reporting

Communicable disease reporting generally has two purposes: (1) to gather epidemiologic data regarding the incidence of a disease, and (2) to take appropriate public health action regarding a specific case, that is, to prevent further transmission. While anonymous reporting is consistent with the first purpose, reporting with names or other identifiers traditionally has been relied upon for the latter purpose. In all 50 states, AIDS cases currently must be reported to the health department, which in turn reports these cases anonymously to CDC. Reporting of HIV-related disease or HIV infection, on the other hand, is not required in a majority of jurisdictions. However, the Presidential Commission has recommended that all states require HIV reporting for the purpose of gathering epidemiological data, and a growing number of states have enacted HIV

63/ Lewis, Acquired Immuno Deficiency Syndrome: State Legislative Activity, 258 J.A.M.A. 2410, 2413 (Nov. 6, 1987).
reporting laws.66/ Currently, twenty-two states have anonymous testing or reporting statutes, eight states require confidential reporting, and twenty-one jurisdictions combine the two approaches.67/

The Coordinating Committee believes that all HIV reporting conducted for epidemiological purposes should be limited solely to that information necessary for the particular purpose. In practice, such studies are often anonymous with no identifiable links to the subjects.68/ However, the Coordinating Committee recognizes that some HIV epidemiological studies and prevention activities, such as partner notification, do include identifying information. In these contexts, the Coordinating Committee agrees with the Presidential Commission's recommendation calling for statutory confidentiality protections.69/ Otherwise, given the climate of fear and discrimination which currently surrounds HIV, people may avoid testing and counseling, thereby undermining efforts to curb the spread of infection.70/


70/ A recent South Carolina study concluded that "[t]he current policy of mandatory reporting of HIV seropositive persons in South Carolina is associated with decreased attendance and testing by those individuals most at risk for exposure to HIV. Government health policy makers should take this factor into account when considering similar policies." Johnson, Francisco and Jackson, The Impact of Mandatory Reporting of HIV Seropositive Persons in South Carolina (unpublished paper presented at the IV International Conference on AIDS, June 12-16, 1988, Stockholm, Sweden). This study is consistent with the results of an Oregon survey which found that initiating (Footnote Continued)
Moreover, the Coordinating Committee is convinced that maintaining the confidentiality of HIV-related information in disease reports will require specific statutory protections, and the Coordinating Committee is particularly concerned about breaches of confidentiality during the course of litigation. The Association of State and Territorial Health Officers (ASTHO) recommends that states enact statutes prohibiting the release of HIV-related information and reports under subpoena or court order. Further, in states currently lacking such protections, ASTHO recommends that:

- Public health agencies should respond to subpoenas seeking HIV-related information with motions to quash or for a protective order.
- Court orders for disclosure of identifying HIV-related information should not be issued absent a finding of compelling need.
- Court proceedings concerning identifiable HIV-related information should be conducted in camera and records should not be open to the public.

Partner Notification

Public health agencies traditionally have relied on voluntary partner notification to curb the spread of

(Footnote Continued) anonymous testing led to a 50% increase in the number of people seeking HIV testing. The Oregon study also reported a 125% increase in the number of gay men seeking HIV testing. Fehrs, Foster, Fox, et al., Trial of Anonymous Versus Confidential Human Immunodeficiency Virus Testing, The Lancet 379-381 (August 13, 1988).


73/ Id.
communicable diseases and to identify people in need of available treatment. The goal of partner notification is to encourage a person with HIV, through compassionate counseling, to notify directly all sex and needle sharing partners of their possible exposure. However, after counseling, some individuals with HIV may decide that they would prefer to have public health officials notify their partners. In such cases, a health care provider under some partner notification programs will, with the patient's permission, contact identified partners and inform them that they may have been exposed to HIV.

The application of this strategy to HIV has sparked considerable debate in the public health and legal communities, largely because of the stigma associated with HIV and the lack of either a cure or vaccine for the infection. Indeed, the World Health Organization (WHO) Global Programme on AIDS recently released a consensus statement on partner notification programs, emphasizing that localities should consider implementing such programs only as part of a comprehensive AIDS (HIV) education and prevention program. WHO has expressed particular concern about confidentiality, discrimination, and the availability of support services.

The Coordinating Committee also believes that state and local health departments should not be required to establish partner notification programs, and its recommendations in this area should not be interpreted as an endorsement of such programs. However, the Coordinating Committee urges jurisdictions offering partner notification services to adhere to the guidelines recently issued by ASTHO and WHO.

Current ABA policy recognizes the importance of confidentiality protections to effective partner notification programs and, consistent with the position of public


75/ Id.

76/ See ASTHO Report at 3, note 72, supra.

77/ See WHO Consensus Statement, note 74, supra.
health authorities and the Presidential Commission, provides that an index patient's identity should not be disclosed to partners. Moreover, the Coordinating Committee believes that all identifying information pertaining to both index patients and identified partners must be afforded the most stringent confidentiality protections. The Coordinating Committee agrees with ASTHO that "[i]f confidentiality is not fully protected by law, written records on index patients and their partners should be destroyed after partners have been notified." Of course, in some cases (e.g., a monogamous spouse), the notified partner may be able to determine the identity of the index patient. Clearly, these situations cannot be avoided.

"Duty to Warn" Or Protect

The debate about partner notification has raised questions about the so-called "duty to warn" or protect third parties from possible exposure to HIV. In general, health care providers have a legal and ethical duty to preserve the confidentiality of medical information about their patients. However, case law also has established that a physician has a duty to protect a known potential victim from a dangerous patient by warning the third party.

78/ See ASTHO Report at 11, note 72, supra.


81/ See ASTHO Report at 11, note 72, supra.


In the landmark Tarasoff case, the California Supreme Court established the precedent that psychiatrists have a duty to warn identifiable third parties when a patient threatens harm. Moreover, it is equally well established that a physician faces tort liability for failure to warn family members, or others in close proximity to a patient, that the patient has a communicable disease.

Some commentators have suggested that health care providers may have a similar "duty to warn" or protect the known partners of HIV-infected patients. The American Psychiatric Association has analyzed the applicability of the Tarasoff line of cases to patients with HIV and recently adopted the following policy:

If a patient infected with human immunodeficiency virus (HIV) refuses to change his or her behavior or to notify the person(s) at risk, or the physician has good reason to believe that the

(Footnote Continued)


patient has failed to or he is unable to comply with this agreement, it is ethically permissible for the physician to notify an identifiable person who the physician believes is in danger of contracting the virus.87/

Similarly, the American Medical Association (AMA) and ASTHO88/ have adopted policies permitting, but not requiring, health care providers to disclose otherwise confidential information to identifiable third parties at significant risk of HIV infection. The Coordinating Committee joins the APA, AMA and ASTHO in recognizing this narrow exception to confidentiality in the health care context, emphasizing that the disclosure permitted by the exception is distinct from a "duty to warn" or protect. Such a duty, in the opinion of the Coordinating Committee, would inappropriately subject health care providers to an affirmative obligation and accompanying liability.

Moreover, the Coordinating Committee emphasizes that both of the disclosure criteria set forth in its recommendation must be met and should be carefully documented. In particular, the requirement of a specific identifiable third party should limit the applicability of the exception. The ASTHO report's discussion of the confidentiality exception (which it calls a "privilege to disclose") states:

Privilege to disclose does not imply that providers should, against the wishes of the index patient, actively seek out the identities of the index patient's partners. In fact, the perception that this occurs may discourage persons from seeking counseling and testing. A privilege to disclose situation occurs only when the provider learns of at-risk partners through the provider's ordinary activities.89/


89/ ASTHO Report at 14, note 72, supra. (Emphasis added).
Consistent with existing case law, however, a provider may make a reasonable inquiry to determine the specific identity of a third party at risk.90/

Direct and Indirect Notification

The Coordinating Committee recognizes that private health care providers may be more likely than public providers to be aware of an identifiable third party at risk because they are often involved in a continuing relationship with their patients. Assuming the disclosure standard is met, however, the Coordinating Committee believes that many private providers may prefer to notify the public health department about a third party at risk, instead of directly notifying the individual. ASTHO has noted that public health agencies generally have the expertise and resources to notify partners and that they are usually better able to maintain the confidentiality of all concerned.91/ The Coordinating Committee agrees with ASTHO that a private provider should directly notify partners only if the provider is "qualified to counsel the partner appropriately and maintain the index patient's confidentiality."92/

Immunity

Finally, the AIDS Coordinating Committee agrees with ASTHO93/ that health care providers and public health officials who are authorized by law to disclose confidential HIV-related information should have immunity from liability for disclosure decisions made in good faith. Since disclosure is discretionary, immunity should apply both to decisions to disclose and decisions to maintain confidentiality, provided that those decisions are made in good faith.

90/ See Tarasoff, note 84, supra.
91/ See ASTHO Report at 14, note 72, supra.
92/ Id. at 15.
93/ Id.
Personal Control Measures and Isolation

Recognizing that personal control measures necessarily implicate the most fundamental constitutionally protected liberty interests, the AIDS Coordinating Committee joins the Presidential Commission in opposing the application of any such measure based on status or group characteristics. Public health officials and legal commentators consistently have opposed disease-based isolation or quarantine because

AIDS does not display the paradigmatic conditions that call for isolation. HIV is not transmitted by casual contact with others; it is not an airborne disease which is spread by coughing or sneezing; and it is not transmissible by touching, kissing or other social activities.

Moreover, under the modern view, disease-based isolation would probably be held unconstitutional.

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94/ The Committee uses the term isolation instead of quarantine because "[a]lthough the terms "isolation" and "quarantine" are often used interchangeably, both in public health statutes and in common parlance, there is a technical distinction between them. 'Isolation' is the separation of infected persons from others during the period of communicability so as to prevent transmission of the infectious agent; 'quarantine' is the detention of persons who are healthy, but have been exposed to a communicable disease, to prevent contact with persons not exposed." Gostin, The Politics of AIDS: Compulsory State Powers, Public Health and Civil Liberties, 49 Ohio St. L.J. 1027, 1017-1058 (1989) ("The Politics of AIDS"). Currently, 15 states have isolation or quarantine statutes. Gostin, Public Health Strategies for Confronting AIDS: Legislative and Regulatory Policy in the United States, J.A.M.A. 1622-1623, 1621-1630 (March 17, 1989). ("Public Health Strategies for Confronting AIDS").


97/ See The Politics of AIDS at 1027, note 94, supra.

98/ Id. at 1033.
However, many commentators believe that a narrowly
drawn behavior-based isolation statute would probably be
held constitutional. The Coordinating Committee is aware
of reported cases of individuals with HIV who refuse, after
counseling and repeated warnings from public health offi­
cials, to modify their behavior to avoid infecting others.
In such rare cases, the Coordinating Committee recognizes
that public health authorities and the courts may be forced
to consider isolating the recalcitrant individual.

However, the Coordinating Committee, like the
Presidential Commission, has concluded that the funda­
mental liberty interests presented in such cases require the
application of stringent substantive and procedural due
process standards. As one commentator has stated, isolation
is a uniquely serious form of deprevation of liberty because it deprives a
person of liberty without criminal
conviction, based on what he or she
might do in the future. Even more
telling is that isolation has no
temporal limitation; in as much as
HIV-positive persons are presumed to be
chronically infectious, isolation
amounts to a kind of civil life
sentence.

Therefore, the Coordinating Committee's recommended substan­
tive standard for public health isolation requires a judi­
cial finding, based on clear and convincing evidence that the individual:

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99/ Id. at 1036.
100/ Report of the Presidential Commission 77 (June 1988).
101/ See, Public Health Strategies for Confronting AIDS at
1627, note 94, supra.
102/ Although the Coordinating Committee's recommendation
distinguishes public health isolation cases from civil
commitment cases, equal protection and equity considerations
may require states with civil commitment laws requiring
proof beyond a reasonable doubt to apply that higher
standard to HIV-related isolation cases. Moreover, although
there may be cases where an individual with HIV falls under
the jurisdiction of civil commitment laws, the Committee
believes that in most cases mental health facilities are not
(Footnote Continued)
is HIV infected;
• poses a direct threat to public health as evidenced by a recent overt act endangering another person; and
• will not, after notice, counseling and appropriate training, restrict his behavior to avoid a direct threat to public health.

Moreover, the Coordinating Committee’s substantive due process standard requires a judge to find by clear and convincing evidence that the isolation order being proposed or under review is necessary to protect public health and that it is the least restrictive alternative.

The Coordinating Committee’s recommendation regarding procedural due process is intended to ensure that the proceedings are constitutional, and that, in the event that isolation is imposed it is not necessarily a permanent status. Since HIV infection is considered a life-long condition at this point, it is particularly important to provide the confined individual with opportunities to change his behavior, as well as regular judicial review of the isolation order.103/

Finally, the Coordinating Committee recognizes that there may be HIV-related cases necessitating temporary emergency isolation and has recommended an appropriate standard. The Coordinating Committee emphasizes, however, that the public official’s affidavit state facts establishing reasonable cause for isolation, and any such court order would not be subject to renewal.

(Footnote Continued)

(103) Upon judicial review, the substantive standard for the initial isolation order would apply, and the state would have the burden of proof.
ACCESS TO HEALTH CARE

Background

The varied and complex health care needs of persons infected with HIV require that they have contact with a number of health care providers (physicians, surgeons, dentists, nurses, aides, social workers, psychiatric workers, paramedical professionals, home health care workers, community health program workers, and volunteers) in a variety of health care settings (acute care hospitals, outpatient clinics, minimal care residential facilities, chronic care nursing homes, homes, and hospices). Although most providers of health-related services have responded to the challenge of AIDS and HIV infection with skill and dedication, some HIV-infected individuals have nonetheless experienced discrimination within the health care system, both individual and systemic, and have had trouble obtaining and financing medical care on the same terms and conditions as other persons.104/

Nondiscrimination

HIV affected individuals should not be denied access to necessary health care services because of the unfounded fears or prejudices of individual health care providers or institutions. The Coordinating Committee strongly believes that health care providers should not refuse to treat an individual solely on the basis of the individual’s actual or perceived HIV status. Moreover, once accepted for treatment, HIV infected patients should receive the same respect, dignity, and decision-making autonomy as other patients.105/

The Presidential Commission has similarly concluded that health care providers should not refuse to provide care, within the limits of their competency, to persons who

104/ See AIDS: The Legal Issues 63 (August 1988). For example, one hospital in Maryland will not treat or employ individuals who test positive for HIV. Centers for Disease Control, AIDS Weekly Surveillance Report 18 (July 4, 1988). Thirty-five percent of physicians recently surveyed in Sacramento, California, stated that they would not treat HIV positive individuals. Id.

are affected by HIV.106/ This position is echoed in the ethical guidelines promulgated by the American Nurses’ Association107/ and by the Council on Ethical and Judicial Affairs of the American Medical Association.108/

As the Presidential Commission has noted, discrimination within the health care system against persons affected by HIV is unlikely to be remedied until health care providers are adequately educated about the risks of HIV and about how they can protect themselves from contracting the virus.109/ The Coordinating Committee believes, therefore, that in order to provide access to health care for persons affected by HIV, health professional organizations, hospitals, and other providers of health care to HIV-infected patients need to establish education programs for all their members, affiliates, and employees.110/ Any educational programs regarding HIV should include education about the legal rights of HIV patients, the ethical obligations and responsibilities of health care providers, the social context of HIV infection, and the need for confidentiality and the protection of private medical information.111/

As the Presidential Commission has aptly observed:

106/ Id. at 137.

107/ The ethical guidelines of the American Nurses’ Association state: "The nurse provides services with respect for human dignity and the uniqueness of the client, unrestricted by considerations of social or economic status, personal attributes, the nature of the health problem." See Report of the Presidential Commission 137 (June 1988); see also AIDS: The Legal Issues 71 (August 1988).

108/ "Those persons who are afflicted with the disease or who are seropositive have the right to be free from discrimination. A physician may not ethically refuse to treat a patient whose condition is within the physician’s current realm of competence solely because the patient is seropositive." AMA Council on Ethical and Judicial Affairs, Ethical Issues Involved in the Growing AIDS Crisis, 259 J.A.M.A. 1360 (Mar. 4, 1988).


111/ Id.
A well-educated, skilled, and concerned health care community is not only vital to the task of caring for those who are ill, but during this critical time when fear and misunderstanding about the HIV epidemic exist within our population, the leadership established by providers of health care to persons with HIV infection is crucial to fostering a sense of compassion and rationality among our citizens. When health care professionals care for all patients who need their help, regardless of HIV infection status, and do so without reservation or trepidation using time-tested infection control measures, they communicate to all people that calmness and reason can prevail over panic and anxiety as we confront this epidemic.112/

Availability of Services for HIV Patients

The health care delivery system must be able to respond to the diverse needs of HIV infected individuals and develop services and treatment alternatives that best meet the needs of their HIV affected clients. To date, in-patient hospitals have been the primary providers of care for persons infected with HIV.113/ However, the needs of HIV patients can often be served better, and more economically, by hospice and home- and community-based care.114/ For example, the average annual cost for hospital care is approximately $40,000; in contrast, the average cost of home care is only $15,000 per year.115/ Yet, as the Presidential Commission has found, numerous legal and social

112/ Id. at 23.
113/ Id. at 17.
115/ See Report of the Presidential Commission 18, 142 (June 1988).
obstacles often prevent the development of innovative and cost effective community-based services for persons with HIV infection.116/ These obstacles must be identified and eliminated.

In many areas, for example, zoning restrictions prevent the development or use of out-patient facilities which might otherwise provide cost-effective care for persons with HIV infection.117/ Zoning ordinances can also limit the development of group home or residential care facilities.118/ The Coordinating Committee believes that access to out-of-hospital services should not be limited by zoning or other governmental restrictions that discriminate on the basis of individuals' actual or perceived HIV status. Local governments should provide reasonable zoning variances to permit alternative care sites and should ensure that other local restrictions do not unreasonably limit the availability or development of community-based services.119/ In addition, state and local governments and health care providers should develop long-range plans to anticipate the future need for community-based health care facilities; they also should develop strategies to educate community members to accept facilities and to prevent discrimination against HIV-infected individuals.120/

Another obstacle to the development of cost-effective health services tailored to the needs of HIV patients is the current structure of the Medicaid program, which is the primary public payor for most individuals infected with HIV.121/ At the present time state Medicaid plans are required to cover only in-patient hospital care, out-patient care, physician services, laboratory and x-ray services, and

116/ Id. at 18-19, 141-45.

117/ Id. at 19.


119/ See also Report of the Presidential Commission 20 (June 1988). Zoning laws that, on their face or in their application, discriminate against people with HIV infection, would, in all likelihood, violate the recently enacted Fair Housing Amendments Act of 1988. See, Discrimination section of this report.

120/ Id. at 126.

skilled nursing and home health care services for certain qualified individuals. 122/ States have the option of providing certain additional services, 123/ many of which are those most relevant to the care of persons with HIV infection, 124/ such as individual case management, hospice services, home-based drug abuse treatment services, psychotherapy, private duty nursing, respite care, medical day care, personal care assistance, and increased reimbursement for foster parents of children with AIDS or ARC. 125/ To provide such home- and community-based services, however, states first must obtain a waiver from the Health Care Financing Administration, as authorized under section 2176 of the Omnibus Budget Reconciliation Act of 1981. 126/

To date, few states have sought Section 2176 waivers, in part because the application and waiver review process is slow and fraught with administrative obstacles. 127/ Consequently, the Coordinating Committee recommends, as does the Presidential Commission, that the Health Care Financing Administration should take steps to streamline the Medicaid waiver review process and expand the waiver program to allow more flexible and cost-effective treatments and services for HIV infected individuals. 128/

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123/ Id.


128/ Report of the Presidential Commission 144 (June 1988). The Presidential Commission also made a number of other recommendations relating to restructuring of the Medicaid system to allow alternative treatments for HIV-infected individuals. See id. at 27 (direct reimbursement to nurses); id. at 144 (encouraging states to take full...
Access to Health Care in Minority Communities

The HIV epidemic adds a new dimension to the longstanding problems which many minority communities have faced in obtaining adequate health care. The Presidential Commission noted that "[t]he basic health care needs, including education and prevention programs, of minority populations have not been met in the past, a situation that is being compounded by the HIV epidemic,"129/ and the Presidential Commission has therefore recommended that the Centers for Disease Control and the Public Health Service Office of Minority Health should dramatically increase HIV education programs targeting minority communities.130/ The Coordinating Committee is aware that a number of Requests for Proposals (RFPs) have recently been issued by these and other agencies, and urges rapid review and expedited funding for as many proposals as possible.

In addition, the Coordinating Committee urges the private sector to increase its efforts to fund and, where appropriate, to participate in delivering HIV education, health care, and support services to minority communities. Community groups, including religious organizations, can be particularly effective forces for ensuring that culturally sensitive HIV educational messages are heard; and in building public support for, and confidence in, HIV-related services.131/

(Footnote Continued)

advantage of options available under the Medicaid program); id. (demonstration projects of reimbursement mechanisms); id. (HIV-related Diagnostic Related Group (DRG) reimbursement); id. at 144-45 (demonstration projects with higher federal matching rates for states that reimburse providers at higher rates for HIV-related special services).

129/ Id. at 7.
130/ Id. at 86-87.
131/ The National Minority Council on AIDS has noted that "[i]n addition to the lack of established AIDS education and prevention programs with the expertise to reach minority communities, language, culture and stigmas associated with certain behaviors and practices have operated to slow the development of programs within minority communities. As a result of cultural or religious prohibitions on issues of sexuality and other personal behaviors, the delivery of AIDS education and prevention programs in minority communities (Footnote Continued)
Health care and support service needs for minority people with HIV are particularly acute, in part because of the historically poor health care available to them and in part because of the disproportionate number of poor women and children represented. \(^{132}\) (See the Child Welfare section of this report). Moreover, many of these cases are directly or indirectly related to IV drug use \(^{133}\) with all of the related medical, social and legal complications associated with that status. (See the Drug Abuse section of this report for further discussion).

The Coordinating Committee joins the Presidential Commission in calling with a special sense of urgency for increased HIV-related services targeted for minority communities. In the absence of such services, HIV almost certainly will be linked for decades to come with communities already struggling to overcome economic disadvantages and discrimination.

\(^{132}\) Currently, minority women account for 70% of all female AIDS cases and minority children represent 75% of all pediatric cases. Centers for Disease Control Surveillance Summaries, Distribution of AIDS Cases by Racial/Ethnic Group and Exposure Category, United States June 1, 1981–July 4, 1988 (July 1988). (CDC Surveillance Summaries). In noting the disproportionate number of minority women and children with AIDS, the Coordinating Committee does not intend to minimize the significant number of cases among Black and Hispanic men.

\(^{133}\) See CDC Surveillance Summaries note 132, supra.
Testing and Counseling

Background

Existing ABA policy134/ supports federal legislation which promotes voluntary HIV testing and counseling, provides confidentiality protection for information obtained through testing and counseling, and prohibits discrimination against an individual (because of actual or perceived, HIV status) in employment, housing, public accommodations or governmental services. Moreover, the Presidential Commission essentially has endorsed the three elements of the ABA's policy -- voluntary testing and counseling, confidentiality, and non-discrimination -- as critical to the success of public health efforts aimed at curbing the spread of HIV.135/ In view of the public health community's strong support for these principles, the Coordinating Committee recommends their adoption by states and localities, as well as by the federal government.

HIV Testing and Counseling

The ABA's current policy recognizes the value of voluntary counseling and testing as "a vital component of an overall prevention strategy to promote behavior change in order to stem the spread of HIV infection."136/ However, it appears that not enough facilities currently exist to meet the demand for voluntary HIV testing and counseling.137/ Although recently enacted federal legislation138/ should help states and municipalities increase anonymous testing and counseling services, the Coordinating Committee expects that the need to expand such facilities will continue to grow. Therefore, the Coordinating Committee believes that it is vitally important to ensure that states and localities considering such an expansion adhere to generally accepted


136/ Id. at 73.

137/ Id. at 74.

testing and counseling protocols, including the provision of providing pre- and post test counseling for all individuals taking the test, irrespective of the results.139/

Confidentiality

The ABA has described confidentiality as "a sine qua non for testing," and has noted that virtually all federal and state public health officials agree that strict confidentiality protections are essential to encourage individuals to seek voluntary HIV testing.140/ Moreover, the Presidential Commission found that "[t]he perception that confidentiality may be breached is keeping people who believe that they may have been exposed to the virus from seeking testing and counseling services."141/ Thus, the Coordinating Committee, along with the Presidential Commission,142/ urges all states to enact and enforce statutes ensuring the confidentiality of information obtained as a result of HIV testing or counseling. (See the Confidentiality and Public Health Law sections of this report for further discussion).

Discrimination

The Coordinating Committee, together with the Presidential Commission,143/ is convinced that discrimination against people affected by HIV is a major obstacle to public health efforts to halt the epidemic and recommends extending the ABA's current nondiscrimination policy to the states and municipalities. (See Discrimination section for discussion).

Informed Consent

In addition to ensuring that confidentiality and discrimination protections are linked to voluntary HIV testing and counseling programs, the Coordinating Committee

139/ Id. at 73-74; AIDS: The Legal Issues 97-98 (August 1988).
140/ ABA Report No. 115A 4 (February 8-9, 1988).
142/ Id.
143/ Id. at 3, 120-126.
believes that informed consent should be required. The Coordinating Committee also believes that such consent should be specific to the HIV test. In AIDS: The Legal Issues, the Coordinating Committee noted that specific informed consent is not routinely obtained by health care providers prior to performing blood tests or other low risk diagnostic procedures. In such cases, consent traditionally has been inferred from the patient's conduct, such as submitting to the test without objection or signing a general release.

However, the Coordinating Committee agrees with the Centers for Disease Control, the American Hospital Association, and the American Medical Association, that neither implied consent nor general releases should be deemed sufficient to conduct a voluntary HIV test. Unlike routine tests and diagnostic procedures, HIV testing constitutes a major intrusion into the life of the person tested and can have a profound impact on the individual, his family, friends, and associates.


As the Coordinating Committee previously has noted, "[o]btaining informed consent is a process, which includes an exchange of information between a health care provider and a patient, culminating in the patient's agreement to a specific medical procedure."\textsuperscript{150} Therefore, documentation of informed consent should reflect that such an exchange has occurred, and that the patient has clearly communicated his understanding of the meaning of the HIV test and his willingness to be tested.

In the view of the Coordinating Committee, requiring documented informed consent specific to the HIV test is necessary to ensure the validity of the consent and to foreclose the possibility of surreptitious testing in the health care, insurance and employment contexts. The Coordinating Committee is particularly troubled by reports that some health care facilities routinely administer HIV tests, without obtaining informed consent or providing appropriate counseling. The Coordinating Committee therefore joins the American Hospital Association in opposing HIV testing as a condition for admission or treatment.\textsuperscript{151}

Moreover, the Committee believes that informed consent laws should include provisions for adults who lack decisional capacity and for minors. Such provisions are particularly important in view of the fact that some people with HIV develop dementia and may wish to consider executing a health care durable power of attorney, a health care proxy instrument, or a living will.\textsuperscript{152} Furthermore, although parental consent is generally necessary in order to provide medical treatment to a minor,\textsuperscript{153} there are exceptions that apply to both emancipated and unemancipated minors.\textsuperscript{154} The Coordinating Committee has noted that the exceptions for unemancipated minors may have a sufficient nexus with HIV

\textsuperscript{150} Id. at 94.

\textsuperscript{151} American Hospital Association, AIDS and the Law: Responding to the Special Concerns of Hospitals 29 (Nov. 1987). The Committee is aware, however, that there are circumstances under which an HIV test may be indicated in order to provide appropriate care to patient. In such cases informed consent must be obtained and documented. Id. at 27-28.

\textsuperscript{152} AIDS: The Legal Issues 99 (August 1988).

\textsuperscript{153} Id. at 100.

\textsuperscript{154} Id. at 100-101.
testing or counseling to permit a minor to provide informed consent for HIV testing and counseling without parental involvement.155/

155/ Id. at 101.
INSURANCE

Background

Because financial solvency and access to medical care often depend on the availability of insurance coverage, insurance is a critical concern for all people facing a potentially catastrophic illness. This problem has become particularly acute for persons with AIDS, not only because of the high cost of health care associated with AIDS, but also because persons with AIDS are more likely than the general public to be uninsured (20%) or on Medicaid (40%). Moreover, as the Presidential Commission has suggested, the percentage of HIV infected individuals without adequate insurance coverage can be expected to rise further as the number of IV drug users with HIV escalates, and if private insurance companies limit coverage for persons with AIDS.

The Coordinating Committee believes that the staggering health care costs attendant upon the treatment of AIDS and AIDS-related illnesses can be borne only by a mixture of public and private sources. Towards this end, the Coordinating Committee's proposed resolutions seek solutions to these difficult issues primarily within the existing public and private framework for financing health care.

Underwriting

Underwriting is the process by which insurance companies determine the risk classification of groups and individuals for use in making insurance application decisions. The goal of this process is to predict accurately the life expectancy and morbidity costs of particular


157/ Id.

158/ Various studies have placed the costs anywhere from $50,000 to $150,000 over the lifetime of a person with AIDS. See Scitovsky, et al., "Medical Care Costs of Patients with AIDS in San Francisco," 256 J.A.M.A. no. 22 (December 12, 1986).
groups, and to use this information to create risk classifications for those groups. Ordinarily, a risk classification is lawful if it is based on actuarially supportable data or reasonably anticipated experiences.

Because gay men have been identified as being at higher risk for HIV infection, however, a number of insurance companies have used sexual orientation as an underwriting factor. In a recent survey, 30% of the commercial insurers reported using sexual orientation in underwriting decisions. Further, because of the difficulty in obtaining information about sexual orientation, some insurers have begun to question applicants about perceived indicia of sexual orientation, employing such proxies as residence in a gay neighborhood, working in occupations thought to be populated by gay men; marital status, and so forth.

The Coordinating Committee believes that insurance discrimination based on an applicant's lifestyle or sexual orientation should be prohibited by state statutes and state insurance regulations. As one commentator has noted, the withdrawal of coverage for an entire social class, such as gay men, because a small percentage of its members is expected to develop a disease, represents an invidious and unacceptable form of stereotyping. Such stereotyping is dangerous because it can lead to employment discrimination, and to the denial of credit or home mortgages. While such stereotyping may also reinforce negative public perceptions of gay and bisexual men, it is socially undesirable for the additional reason that it fosters discrimination against persons who do not even belong to the class at which the stereotyping is directed. In other words, persons may be

159/ Hammond & Shapiro, AIDS and the Limits of Insurability, 64 Milbank Quarterly 143 (Suppl. 1986); Clifford & Inculane, AIDS and Insurance: The Rationale for AIDS-Related Testing, 100 Harv. Law Rev. 1806 (1987).


161/ U.S. Congress, Office of Technology Assessment, AIDS and Health Insurance; an OTA Survey 1 (Feb. 1988).


163/ Schatz, note 160, supra.
discriminated against because they have a "gay zip code," rather than a "gay lifestyle."

A ban on on sexual orientation-based underwriting has been endorsed by two leading insurance trade organiz­ations, the Health Insurance Association of America (HIAA) and the American Council of Life Insurance (ACLI). Further, both groups have supported a model bulletin produced by the National Association of Insurance Commissioner­s, which bulletin prohibits inquiry into sexual orienta­tion or lifestyle. This bulletin forbids the use of questions "designed to establish the sex orientation of the applicant." The bulletin also mandates that an appli­cant's marital status, living arrangements, occupation, gender, medical history, beneficiary designation and zip code may not be used to establish an insurance applicant’s sexual orientation. The Coordinating Committee urges all insurers to abide by these guidelines.

Testing

In 1988, over forty jurisdictions permitted insurers to use blood tests in order to determine the presence of HIV infection for underwriting purposes. The ELISA test, which is commonly used to determine seropositivity, is highly sensitive and therefore subject to false positive results. It is estimated that one-half to two-thirds of those who test positive on a single ELISA test may be false positives. Thus, in order to insure accurate classifi­cation, positive ELISA tests must be confirmed by a Western

164/ Id.
165/ Id. at 1788.
166/ NAIC Medical/Lifestyle Questions and Underwriting Guidelines, 1 NAIC Model Laws 162-1.
167/ Id.
Blot Analysis or by an Immunoflorescale Assay, both of which are less prone to false-positive results. For this reason the Coordinating Committee believes that those jurisdictions which do not prohibit insurers from performing HIV testing should mandate that these tests be performed according to generally accepted public health protocols.\textsuperscript{171} Further, because of the lack of uniformity of practice among those who perform HIV tests, and the consequent unreliability of those test results, insurers should not base an adverse underwriting decision solely on information gained second-hand from the Medical Information Bureau (MIB) or from the applicant.

**Coverage**

Policies which purport to provide coverage for a comprehensive range of medical conditions typically contain exclusions for suicide, for experimental treatment, and for other unusual circumstances. Recently, a number of insurance companies have begun to exclude coverage for AIDS, or to place dollar limits on AIDS coverage, in their new policies.\textsuperscript{172} Since an expansion of this practice will only lead to an increase in the number of AIDS patients who are unable to afford adequate medical care, the Coordinating Committee supports legislation prohibiting the writing of policies which purport to be comprehensive, but exclude coverage for AIDS. By 1988, 17 states had passed legislation which bans the exclusion of AIDS in comprehensive medical policies.\textsuperscript{173}

Similarly, most insurance policies are non-cancelable by their terms, but a number of states do allow insurance companies to cancel or fail to renew policies because of a change in the health status of the individual. The Coordinating Committee supports the move by a number of states to prohibit this "post-claim underwriting." People who have been diagnosed with AIDS or HIV-related conditions, and have had their policies cancelled, probably will not be able to find coverage with other companies because of pre-existing condition limitations. This would vastly increase the number of individuals without coverage, who may then be unable to afford adequate health care.

\textsuperscript{171} The standard CDC protocol mandates two ELISA tests followed by a confirmatory Western Blot or IFA.

\textsuperscript{172} AIDS: The Legal Issues 130 (August 1988).

\textsuperscript{173} See Faden & Kass, note 168, supra.
A similar situation might exist if an individual's policy premium could be raised without limit after the discovery of an HIV-related illness. The likely result is that coverage, and thus health care, might quickly become unaffordable. The Coordinating Committee therefore urges insurers to adopt standards which prohibit premium increases on an individual policy based on an HIV-related claim or change in health status. However, it should be emphasized that this recommendation is aimed at preventing unaffordable increases to the holder of an individual policy, and it should not be taken as a call to prohibit increases to group policies based on actual experience.

Most insurance policies exclude coverage of conditions which existed prior to the effective date of the policy, if the excluded condition is discovered within a pre-determined period of time. In an effort to reduce the cost of AIDS coverage, some insurers have lengthened the exclusion period, and refuse to provide coverage for AIDS if the disease is diagnosed within 24 months after the issuance of the policy. The Coordinating Committee believes that such a policy is detrimental to the goal of ensuring adequate access to health care for people with HIV because those individuals who are denied coverage after being diagnosed with AIDS will be unable to obtain coverage from other carriers. For this reason, the Coordinating Committee urges insurers to adopt policies which ensure that the period of exclusion for HIV-related conditions is no longer than that for other pre-existing conditions. Moreover, the Coordinating Committee's recommendation should not be interpreted as support for the proposition that asymptomatic HIV infection alone should be treated as a pre-existing condition.

Confidentiality

The Coordinating Committee believes that the need for maintaining the confidentiality of information regarding the HIV status of individuals is critical. People who have been perceived to be at risk for AIDS have been subject to discrimination in jobs, housing, and the provision of other essential services. Because of this problem, the Coordinating Committee believes that it is essential that

175/ Id.
176/ Schatz at 1787-1788, note 160, supra.
insurers take steps to ensure the confidentiality of information regarding the HIV status of applicants for insurance. Moreover, states should adopt confidentiality statutes or regulations consistent with the NAIC Insurance Information and Privacy Protection Model Act. This Model Act prevents disclosure of "personal or privileged information" collected about an individual in connection with an insurance transaction, without the written consent of the applicant. 177/

Further, under the NAIC Insurance Information and Privacy Protection Model Act, insurers must explain the medical reasons for rejecting an application, if requested by the applicant. 178/ This disclosure may be made either to a health care provider designated by the applicant, or directly to the applicant. 179/ Generally, insurance companies prefer to notify health care providers, and they usually do so by means of a letter which explains that the applicant has an unspecified medical condition which requires the advice of a physician. Should an insurance company notify the individual directly, the notification should be accompanied by appropriate referral for counseling, both for the benefit of the individual and the public at large. 180/ The goal of this counseling is to inform people with HIV about how to protect their own health, and the health of others; and to provide them with information about the availability of support and health services. As the Presidential Commission has noted, counseling and education which encourage behavior modification and currently the most effective methods of halting the spread of AIDS. 181/ Moreover, it is only by halting the spread of HIV that our society will truly resolve all of the legal and social problems which have accompanied the HIV epidemic, including those relating to insurance.

177/ NAIC Insurance Information and Privacy Protection Model Act, 1 NAIC Model Laws 625-12.

178/ Id. at 625-11.

179/ Id. at 625-13.

180/ A number of states already require referral for such post-test counseling. See Calif. A. 3305, Section 799.03, Ch. 1279, Laws 1988; N.Y.S. 9265-A, Section 3, Ch. 584 (1988); and Fla. H. 1519, Section 47, Ch. 88-380, Laws 1988).

Although the NAIC Model Act is a step in the right direction, it should not be viewed as a panacea for all confidentiality-related issues. A number of commentators have raised confidentiality concerns regarding the use of the Medical Information Bureau (MIB).\textsuperscript{182} Insurance companies which subscribe to the system report their rating or rejection of insurance applicants to the MIB.\textsuperscript{183} This information is then available to other insurers for the important purpose of detecting and deterring fraud in the insurance application process.\textsuperscript{184} Although HIV status is assigned a generic blood code within the MIB, the Coordinating Committee is concerned that an individual’s HIV status could be deduced under the coding system.\textsuperscript{185} In addition, the Coordinating Committee is concerned that other individuals, who have not tested positive for HIV infection, may become subject to discrimination because they have been included, by virtue of unrelated diseases, within the generic blood code that is used for persons with HIV positive tests.

Moreover, commentators have called attention to the confidentiality implications of the system by pointing to the fact that MIB files have been successfully subpoenaed.\textsuperscript{186} The Coordinating Committee recognizes these concerns, and urges that all insurers adopt guidelines for the use of MIB information which minimize the potential for disclosure of HIV-related information.

Another area which is not covered by the Model Act concerns confidentiality issues regarding self-insured employers. Since ERISA, a federal law, preempts state law relating to employee benefit plans, state insurance departments lack authority to regulate a self-insurer’s insurance plan.\textsuperscript{187} Similarly, self-insurers do not fall under the purview of the NAIC Model Act unless they affirmatively elect to be governed by its provisions. The Coordinating

\begin{itemize}
  \item \textsuperscript{182} AIDS: The Legal Issues 132 (August 1988).
  \item \textsuperscript{183} Id.
  \item \textsuperscript{184} Id.
  \item \textsuperscript{185} Transcript, Examination of Committee member Salvatore Russo, November 21, 1988 at 40.
  \item \textsuperscript{186} Id.
\end{itemize}
Committee necessarily is troubled by the fact that self-insured employers are not subject to any of the confidentiality requirements placed upon the insurance industry. As more employers resort to self-insurance, the magnitude of this problem will grow. The Coordinating Committee strongly encourages all self-insurers to adhere to the confidentiality requirements contained in the NAIC model guidelines.

Alternative Methods of Financing Health Care

The Public Health Service estimates that by 1991 the nationwide cost of medical care for AIDS patients will be between $8 billion and $16 billion annually, based on its projected number of AIDS cases (174,000 persons with AIDS alive in 1991).188/ The Coordinating Committee encourages insurers to continue to explore creative methods for lowering the cost of providing medical services to patients with HIV-related illness, while maintaining or increasing the quality of care.

The Coordinating Committee specifically endorses the expansion of case management services, which have been shown to save an average of $112 in medical costs for every one dollar spent on case management.189/ Further, the Coordinating Committee encourages insurers to provide flexible coverage for in-home nursing home and hospice care for patients with HIV-related illnesses. HIV-related care costs can be significantly lowered in non-hospital settings, and such treatment is often more effective and humane to the patient.

Finally, the Coordinating Committee believes that the insurance industry should continue to work together with governmental entities to resolve the long standing problem of the medically uninsured, including individuals with HIV. For example, the Presidential Commission has recommended the creation of public and privately funded risk pools.190/


189/ Id.

190/ Report of the Presidential Commission 147 (June 1988). At present, ten states have health insurance pools for the (Footnote Continued)
the institution of tax incentives for insurers to provide community rated, open enrollment policies. Changes in ERISA may also need to be considered in order to spread costs among self-insurers, as well as throughout the insurance industry.

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(Footnote Continued)

medically uninsurable: Connecticut, Florida, Indiana, Iowa, Minnesota, Montana, Nebraska, North Dakota, Tennessee and Wisconsin.

191/ Id. at 147.

192/ See Testimony of Hon. David Thornberry, member of the Texas Board of Insurance, November 21, 1988, at 196.
Background

Since the beginning of the HIV epidemic, the legal, policy, and scientific issues relating to drug development have been a source of both hope and frustration to the thousands of people affected by HIV. A congressional committee charged with overseeing the operations of the Department of Health and Human Services, recently concluded that:

[0]ver the past few years there has been a deluge of criticism of the Federal drug development and testing process from persons infected with HIV, their advocates and clinical researchers. NIAID's clinical trials program has been characterized as bureaucratic - moving too slowly to develop protocols and get drugs into trials. Patient advocates and leading researchers have argued that people with AIDS are languishing and dying, lacking access to experimental drugs and having few options among approved therapies.193/

The Coordinating Committee has carefully examined this criticism, and its recommendations in this area are intended not only to address continuing problems, but also to recognize that significant steps that have been taken.

Expedited Approval

In AIDS: The Legal Issues,194/ the Coordinating Committee summarized the drug testing and approval process and discussed its application to HIV-related drugs, vaccines, and medical devices. The Coordinating Committee noted that the Food and Drug Administration (FDA), as part of its review of new drugs, recently made an adjustment in its rating system which moves all HIV-related drugs ahead of


other products. This "fast-track" classification system is commendable and the Coordinating Committee urges the FDA to establish a parallel system for reviewing vaccines and medical devices. Moreover, the Coordinating Committee supports the additional steps called for by the Presidential Commission and the Institute of Medicine/National Academy of Sciences, including the increasing of personnel necessary to expedite FDA review of HIV-related therapies, vaccines, and products.

Access to Drug Trials

Clinical drug trials are conducted for the purpose of scientifically testing the safety and efficacy of experimental drugs before they are marketed. Traditionally, these trials have involved the fewest number of people necessary to obtain reliable data, thus minimizing the impact of any harmful side effects. Recognizing the need to scientifically evaluate experimental drugs, the Coordinating Committee supports the continued application of FDA safety and efficacy requirements to the testing of HIV-related drugs. However, the Coordinating Committee, along with the Presidential Commission, also believes that access to drug trials must be expanded in order to determine more rapidly the value of particular drugs and to provide hope and the possibility of treatment to the thousands of people with HIV. The Coordinating Committee is particularly concerned about the underrepresentation of people with disabilities, children, minorities, women and IV drug users in existing clinical trials, since some of "these

195/ Id. at 140.
199/ Id. at 54-58.
populations may represent the future of the epidemic,"\textsuperscript{201} and experimental drugs may have varying therapeutic and toxic side effects in each group.

The Coordinating Committee also supports the development and implementation of other mechanisms to increase the availability of HIV-related drugs, including treatment INDs and "community-based" trials. Treatment INDs, which permit physicians to prescribe an experimental drug while it is being tested in a clinical trial,\textsuperscript{202} are a vital tool for moving HIV-related drugs to larger patient populations. AZT (also known as zidovudine), the only approved antiviral therapy for HIV infection, initially was made available under a treatment IND. More recently, aerosol pentamadine, a drug which may prevent an HIV-related, life-threatening form of pneumonia, also was released under a treatment IND. The Coordinating Committee applauds these steps.

However, the Coordinating Committee also notes that both the Presidential Commission\textsuperscript{203} and a congressional oversight committee\textsuperscript{204} concluded that private drug companies have not been eager to use treatment INDs to market HIV-related drugs. Major pharmaceutical companies have testified before Congress that there are several factors contributing to the underutilization of treatment INDs, including:

\begin{itemize}
  \item the potential loss of volunteers for more rigorous clinical drug trials;
  \item the complex process and paperwork requirements applied to physicians seeking permission to prescribe drugs under a treatment IND; and
\end{itemize}

\textsuperscript{201} Id. at 58-59.

\textsuperscript{202} 40 C.F.R. §312.34.

\textsuperscript{203} Report of the Presidential Commission 50-51 (June 1988).

liability concerns of both pharmaceutical companies and physicians.\textsuperscript{205/}

The Coordinating Committee believes that the government and the private sector should work together to resolve these problems.

"Community-based" trials are another relatively new method for getting experimental HIV-related drugs out to people who are not currently participating in traditional clinical drug trials. The Community Research Institute (CRI) in New York City, a private organization registered with the New York State Health Department, is regarded as a prototype, linking researchers with private physicians and their patients.\textsuperscript{206/} The Presidential Commission noted that CRI:

combines the technical expertise of the research community with the outreach potential of community health clinics and physicians in community practice. This outreach effort to minority populations, drug users, and women may increase the access of these populations to experimental treatment.\textsuperscript{207/}

A similar organization, Community Research Alliance (CRA) was recently established in San Francisco,\textsuperscript{208/} and the Coordinating Committee hopes that other such community-based organizations will be funded and become operational in the near future.

Finally, the Coordinating Committee believes that the federal government should develop and implement a comprehensive plan to assess and address the financial, legal, and other factors which now inhibit access to HIV-related drugs. The cost of HIV-related drugs is an issue of

\textsuperscript{205/} Id. at 30-31.


\textsuperscript{207/} Report of the Presidential Commission 56 (June 1988).

\textsuperscript{208/} Community-based Research, 72 AIDS Treatment News 2 (January 13, 1989).
particular concern. The Committee on Government Operations reported that when AZT was initially approved, it cost each patient $8,000-10,000 per year, making it the most expensive drug ever marketed. Moreover, the congressional committee noted that although the drug was developed with considerable government assistance, the government is not in a position, under existing law, to influence the cost of this drug to the public. This fact particularly troubled the Committee on Government Operations since "[t]he cost of AZT to Federal and State governments under the Medicaid Program was $20 million in FY 1987 and is estimated to grow to $155 million in FY 1990." Currently, states have the option, but not the duty, to provide prescription drugs under state Medicaid plans. Although to date all states have opted to cover prescription drugs as a Medicaid service, some state programs specifically do not cover AZT (also known as zidovudine). The Coordinating Committee believes that all HIV infected individuals, regardless of their residence, should have ready access to AZT or other drugs found by the Food and Drug Administration to extend the lives of persons with HIV. The Coordinating Committee is aware that AIDS patients in some states have successfully challenged their state's refusal to cover AZT on the ground that it is a "medically necessary" treatment and urges the Secretary of Health and Human Services to require all state Medicaid programs to reimburse for HIV-related drugs approved by the FDA for marketing or treatment IND status.

Moreover, the Coordinating Committee believes that private insurers could help reduce Medicaid expenditures for HIV-related treatment by providing coverage for experimental


210/ Id. at 32.

211/ See 42 U.S.C. §§ 1396(a)(10(A), 1396d(a).


drugs under insurance policies and health plans. Providing such coverage might also permit people with HIV who are able to work to continue to do so, instead of "spending down" in order to become eligible for Medicaid. (See Access to Health Care Section of this report for further discussion).

Another major difficulty faced by people with HIV and their physicians is a lack of information about drugs that are currently available, particularly insofar as openings in clinical trials are concerned. 215/ The Coordinating Committee is aware that some private non-profit organizations, such as the American Foundation for AIDS Research (AMFAR), and community-based groups, such as CRI, Gay Men's Health Crisis in New York, and Project Inform in San Francisco, publish and distribute materials on HIV-related drugs.

More recently, the National Institute of Health established a national toll free telephone service to provide callers with up-to-date information on all government sponsored HIV-related research and experimental drug trials. 216/ The Coordinating Committee applauds this step and urges the government to expedite the planned expansion of the hotline to include information about privately sponsored drug trials.

215/ Id. at 15; see also Report of The Presidential Commission 57 (June 1988).

EMPLOYMENT

Background

Because of the central importance of employment in our society, the resolution of HIV-related issues in the workplace will in part determine the nature and extent of the impact which the HIV epidemic will have in other settings. The Coordinating Committee's recommendations in this area are informed by its agreement with the Presidential Commission's conclusion that "HIV infected individuals, including those with symptomatic HIV infection, should continue their self-sufficiency through employment as long as possible. Every effort should be made to keep disabled individuals, including those with HIV infection, gainfully employed."217/

Employment Discrimination

The ABA already has adopted policy supporting federal legislation that prohibits HIV-related employment discrimination.218/ The Presidential Commission also has recommended that federal anti-discrimination legislation be expanded to prohibit HIV-related discrimination in the private as well as the public sector.219/ Currently, individuals with HIV infection are protected under Section 504 of the federal Rehabilitation Act of 1973, which prohibits discrimination against an "otherwise qualified individual with handicaps."220/ However, the Act applies only to the


219/ Recommendation 9-4 of the Presidential Commission states: "Comprehensive federal anti-discrimination legislation which prohibits discrimination against persons with disabilities in the public and private sectors, including employment, housing, public accommodations, and participation in government programs, should be enacted. All persons with symptomatic or asymptomatic HIV infection should be clearly included as persons with disabilities who are covered by the anti-discrimination protections of this legislation." Report of the Presidential Commission 123 (June 1988).

federal government, to federal contractors, and to entities receiving federal financial assistance. Although a number of states have enacted laws prohibiting private employers from discriminating against persons based on a handicap, including HIV infection, the enactment of federal legislation is nonetheless necessary to ensure that all persons with disabilities, regardless of residence or place of employment, are free from discrimination in employment, or public accommodations. The Coordinating Committee reiterates the ABA's support for the enactment of federal legislation to prohibit private and public handicap discrimination, and strongly encourages the prompt enactment and enforcement of such legislation. Moreover, the Coordinating Committee believes that the ABA's current non-discrimination policy should be extended to include support for the enactment and enforcement of such legislation at the state and local levels. (See Discrimination section for further discussion).

HIV Testing

The ABA previously has adopted policy encouraging voluntary HIV testing. The ABA's position on voluntary testing is consistent with "the almost unanimous view of federal and state public health officials that mandatory testing, except for very limited situations, would be counter-productive, would waste significant amounts of taxpayer dollars, and would raise serious questions of civil rights violations." These same considerations apply to

(Footnote Continued)


222/ See ABA Report 115A.

223/ Id.
mandatory HIV testing in public and private employment settings.

The constitutionality of mandatory HIV testing of employees recently was considered for the first time by a federal appellate court. In Glover v. Eastern Nebraska Community Office of Retardation (ENCOR), the Eighth Circuit held that the Fourth Amendment was violated by a Nebraska state agency, which had a policy requiring certain employees in a community-based mental health facility to undergo mandatory HIV and hepatitis testing.224/ The district court had found that the risk of viral transmission was "minuscule, trivial, extremely low, extraordinarily low, theoretical, and approaches zero."225/ Based on this and other findings the district court concluded that the state agency could not require such testing because, while "pursuit of a safe work environment for employees and a safe training and living environment for all clients is a worthy one, the policy does not reasonably serve that purpose. There is simply no real basis to be concerned that clients are at risk of contracting the AIDS virus at the workplace."226/ The Eighth Circuit agreed, holding that the Nebraska policy was unreasonable because of the low risk of transmission of the HIV virus in the workplace. According to the Eighth Circuit, the theoretical risk could not justify a policy which interfered with the constitutional rights of the staff members.227/

Because HIV testing in the workplace will rarely, if ever, be justified based upon the risk of transmission, the Coordinating Committee recommends that employers should not test employees for HIV except in those extraordinarily rare instances in which an employee's HIV status is related to his or her job performance. This recommendation is based upon currently available scientific evidence and is consistent with the CDC's conclusion that there is "no known risk" of transmission of the virus from HIV infected employees to co-workers, clients, or consumers in most circumstances.228/

224/ Glover v. ENCOR, 867 F.2d 461 (8th Cir. 1989).


226/ Id.

227/ 867 F.2d at 464.

228/ CDC, Recommendations for Preventing Transmission of Infection in the Workplace (Nov. 15, 1985).
Finally, some employers have suggested that employee HIV testing can be justified on the ground that the central nervous system impairment experienced by some HIV infected persons may adversely affect their work performance.229/ According to the World Health Organization, however, there is no scientific evidence to show that an employee's HIV status is itself useful in ascertaining whether the employee exhibits, or may exhibit, functional impairment.230/ Obviously, employers should conduct performance testing and evaluation to detect functional impairment, where such testing and evaluation is appropriate and indicated to protect the safety of the public.231/ However, the Coordinating Committee, like the Presidential Commission, does not believe that a positive HIV test is an accurate indicator or proxy of an employee's physical or mental skills and does not recommend that HIV blood screening be conducted for this purpose.232/

**Labor-Management Relations**

The Coordinating Committee recognizes that sound policy in this area cannot be limited solely to a consideration of the rights of HIV infected employees. Effective HIV employment policies must also take into account the rights and concerns of the infected employee's co-workers. In this respect, the Coordinating Committee believes that employers should strive to implement HIV-related employment policies that meet the four objectives articulated by the personnel guidelines of the General Accounting Office (GAO): (1) to maintain a safe and healthy work environment for all employees; (2) to treat HIV affected employees as fairly and humanely as possible; (3) to avoid or minimize disruptions to worker productivity; and (4) to help managers deal efficiently and sensitively with HIV-related illness in the workplace.233/

Like the Presidential Commission, the Coordinating Committee believes that employee education will be a necessary and critical component of any employer’s HIV

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230/ See id. at 113.

231/ See id. at 114.

232/ See id. at 113-114.

233/ See id. at 111-112.
As the Presidential Commission has noted, fear and misunderstanding about HIV have been the underlying causes of much of the anxiety, hostility, and discrimination which HIV infected individuals have faced in the workplace. The Committee agrees with the Presidential Commission that an effective HIV education program is an effective tool for reducing fear and eliminating discrimination, and thereby maintaining a productive and harmonious work environment.

An employer confronted by employees who refuse to work with a co-worker who has AIDS, or who is HIV-positive, faces a potentially difficult dilemma. The HIV infected employee may be protected from any adverse employment action by handicap discrimination laws, while the protesting employees may be protected against adverse employment action by federal labor laws recognizing the employees' right to refuse to work in unsafe or unhealthy work environments. For example, section 7 of the National Labor Relations Act (NLRA) protects concerted activities to protest a health or safety hazard when the employees have a "genuine concern" over safety. Section 502 of the Labor Management Relations Act (LMRA) protects the "quitting of labor by an employee or employees in good faith because of abnormally dangerous condition for work at the place of employment of such employee or employees." Under federal regulations implementing section 11(c) of the Occupational Safety and Health Act (OSHA), an employee may refuse to work in certain circumstances if performance would subject the employee to "serious injury or death arising from a hazardous condition at the workplace."

The Coordinating Committee recognizes and supports an employee's right to refuse to work in an unsafe working environment. At the same time, however, it must be recognized that there are few circumstances in which a work

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234/ See id. at 111, 112, 114.
235/ Id. at 114.
236/ Id.
environment legitimately could be considered unsafe because of the presence of an employee infected with HIV. Moreover, the question whether a workplace is unsafe is, as a matter of law, one that must be decided under an objective standard, and unfounded employee fears about casual transmission clearly would be insufficient to justify a refusal to work.

Thus, it is the position of the Coordinating Committee that employers should first provide appropriate HIV education and notice regarding possible sanctions to any employees who, singly or together, refuse to have contact with an individual who is known or perceived to have HIV. In the event that such educational and counseling efforts are unavailing, however, such employees may be disciplined for their refusal to work. This recommendation is consistent with existing law.

The United States Supreme Court has interpreted the regulations implementing Section 11(c) of OSHA to protect an employee's good faith refusal to work if "(1) a reasonable person would conclude that there is a real danger of death or serious injury in the situation, and (2) there is insufficient time to eliminate the danger through resort to regulatory enforcement channels (i.e., an OSHA complaint)."241/ Thus, the test under section 11(c) of OSHA is an objective reasonableness standard.242/ Cases interpreting Section 502 of the LMRA similarly apply an objective standard and require that a party seeking protection present "ascertainable, objective evidence supporting its conclusion that an abnormally dangerous condition for work exists."243/ Although an employee's subjective good faith belief that a dangerous condition exists may be sufficient to invoke the

243/ Gateway Goal Co. v. United Mine Workers, 414 U.S. 368, 387 (1974). See also Redwing Carriers, Inc., 130 N.L.R.B. 1208, 1209 (1961), enforced as modified sub nom. Teamsters, Chauffeurs & Helpers Union No. 79 v. NLRB, 325 F.2d 1011 (D.C. Cir. 1963), cert. denied, 377 U.S. 905 (1964) (holding that the language of the statute "contemplates, and is intended to ensure, an objective, as opposed to a subjective, test. What controls is not the state of mind of the employee or employers concerned, but whether the actual working conditions shown to exist by competent evidence might in the circumstances reasonably be considered 'abnormally dangerous.'"). See also AIDS: The Legal Issues 175 (August 1988).
protections of Section 7 of the NLRA. Section 7 protection does not extend to employee pressure designed to induce the employer to violate the law. Thus, if exclusion of an HIV infected employee would violate applicable federal, state, or local handicap discrimination provisions, employees who refused to work for the purpose of forcing such an exclusion probably would not be protected under Section 7. Moreover, replacement of the protesting workers may be lawful even if the refusal to work was determined to be protected by Section 7 of the NLRA.

The Coordinating Committee does recognize, however, that an employer’s failure to establish and implement adequate infection control measures may justify an employee’s refusal to work in certain specialized occupational settings, such as those involving health care and emergency response. In these areas, employers should strive not only to educate employees about HIV infection, but also to provide employees with the specific HIV infection control training and equipment necessary to establish and maintain a safe working environment.


245/ See NLRB v. Indiana Desk Co., 149 F.2d 987, 989-95 (7th Cir. 1945); ABC Prestress & Concrete, 201 N.L.R.B. 820, 825-26 (1973); American News Co., 55 N.L.R.B. 1302, 1307-1314 (1944).


247/ See NLRB v. McKay Radio & Tel. Co., 304 U.S. 333, 345-346 (1938). See also Butterworth-Manning-Ashmore Mortuary, 270 N.L.R.B. 1014 (1984), aff’d sub nom. Public Professional & Office Clerical Employees Local 763 v. NLRB, 120 LRRM 2632 (9th Cir. 1985) (contract clause forbidding discharge or other discipline of sympathy strikers did not constitute waiver of employer’s right to replace them with others). See also D. Nohlgren, K. Lopatka & W. Snapp, AIDS In The Workplace IV-27.
Background

Since the AIDS epidemic began, people with AIDS and HIV infection have experienced discrimination in many areas of life, including employment, housing, public accommodations and government services. Often such discrimination against people with HIV is based on fears of casual transmission which have been shown to be unfounded.248/ The ABA recognized these problems and adopted policy in February 1988, calling for the enactment of federal legislation to prohibit such discrimination.249/

The Presidential Commission has recommended enactment of federal and state laws to prohibit


249/ ABA Report No. 115A:

BE IT RESOLVED, That the American Bar Association supports the enactment of federal legislation such as S. 1575 and H.R. 3071 which:

1) promotes an increased level of voluntary counseling and testing for AIDS;

2) mandates that identifying information obtained as a result of such counseling or testing may not be disclosed without the consent of the individual except where such information is required to be provided by state or federal law and such law provides for the protection of the confidentiality of the identity of the individual; notwithstanding the foregoing, any contact tracing of sexual contacts provided by law must be conducted without disclosing information identifying the infected individual; and

3) prohibits discrimination against an "otherwise qualified individual" as defined by such legislation in employment, housing, public accommodations, or governmental services, solely by reason of the fact that such individual is, or is regarded as being, infected by the HIV virus or having AIDS or an AIDS-related condition.
discrimination against persons with disabilities, including people with HIV infection.250/ The Coordinating Committee agrees with the Presidential Commission that both state and federal laws are necessary, and recommends extending the ABA's present policy to states and municipalities.

State and Local Legislation

At present, 15 states have enacted AIDS-specific legislation prohibiting discrimination in housing and/or employment, or both.251/ In addition, all 50 states and the District of Columbia have enacted handicap statutes patterned on Section 504 of the Rehabilitation Act of 1973, which prohibits discrimination against "an otherwise qualified individual" (see the Public School Education section of this report).252/ In thirty-four states, AIDS or HIV infection has been formally or informally determined to be covered by existing handicap laws.253/ Moreover, in most jurisdictions, such statutes prohibit discrimination in the public and private sectors.254/

The Presidential Commission has observed that "discrimination against persons with HIV infection in the workplace setting, or in the areas of housing, schools, and public accommodations is unwarranted because it has no public health basis."255/ The Presidential Commission has


254/ Gostin, note 251, supra. The exceptions are Alabama, Alaska, Delaware, Idaho and Michigan.

further noted that such discrimination impairs this country's ability to limit the spread of the HIV virus by interfering with educational testing, counseling and health care efforts.\textsuperscript{256/} Individuals who, because of discrimination based on their actual or perceived HIV status, may lose their jobs, housing, insurance, or access to medical and support services will understandably be reluctant to cooperate with public health officials.\textsuperscript{257/} Consequently, the Presidential Commission has recommended that:

Comprehensive federal anti-discrimination legislation which prohibits discrimination against persons with disabilities in the public and private sectors, including employment, housing, public accommodations, and participation in government programs, should be enacted. All persons with symptomatic or asymptomatic HIV infection should be clearly included as persons with disabilities who are covered by the anti-discrimination protections of this legislation.\textsuperscript{258/}

As noted, the ABA had adopted policy consistent with the Presidential Commission's call for federal legislation.\textsuperscript{259/}

However, the Presidential Commission also has recognized that the present patchwork of federal, state and local laws is ineffective in "preventing discrimination or providing remedies" for such discrimination.\textsuperscript{260/} The Presidential Commission further recommended that:

If not now the case, states should amend their disability laws to prohibit discrimination against persons with disabilities, including persons with HIV infection who are asymptomatic or symptomatic, and persons with AIDS, in public and private settings including

\textsuperscript{256/} Id.  
\textsuperscript{257/} Id.  
\textsuperscript{258/} Id. at Recommendation 9-4 at 123.  
\textsuperscript{259/} See ABA Report 115A, note 249, \textit{supra}.  
\textsuperscript{260/} Report of the Presidential Commission 120 (June 1988).
employment, housing, public accommodations, and governmental services.261/

The Coordinating Committee agrees with the Presidential Commission's conclusion and therefore recommends extending the ABA's policy calling for federal protection against discrimination to the states and local governments.

Minorities

Black and Hispanic minority communities have been particularly hit hard by the HIV epidemic. The Centers for Disease Control reported in 1988 that "U.S. AIDS patients were disproportionately black (26%) and Hispanic (13%), compared with the proportions of blacks and Hispanics (6%) in the U.S. population."262/ This disparity is even greater for women and children, with minority women accounting for 70% of all female AIDS cases,263/ and minority children representing over 75% of all pediatric cases.264/ A number of factors appear to be responsible for this startling difference, including the types of opportunistic diseases which strike minority people with AIDS, the relationship between IV drug use and HIV in minority communities, and the economic conditions which presently place health care services beyond the reach of many minority people.265/ In addition, basic health care needs of the minority population have not been adequately met in the past, which has exacerbated the spread of the HIV virus in minority communities.266/ (See Access to Health Care section for further discussion).

261/ Id. at 124.


263/ Id.

264/ AIDS and People of Color: The Discriminatory Impact, the AIDS Discrimination Unit of the New York City Commission on Human Rights Updated Report, 6-7 (August 1987).

265/ CDC Surveillance Summaries, 7 note 262, supra.

266/ Report of the Presidential Commission, 86 (June 1988).
To date, adequate HIV-related services, including education, counseling and medical care, have not been made available to these communities. The Coordinating Committee is deeply concerned about these critical gaps and recommends that both private and public entities immediately take steps to address the HIV-related needs of minority communities. Intensive outreach is particularly critical to HIV prevention programs. The Committee also stresses that such efforts must have significant input from members of minority communities in order to be successful.267/

Fair Housing Amendments Act

The original Fair Housing Act (FHA) was passed in 1968268/ and prohibited discrimination on the basis of race, religion and national origin.269/ However, it became clear over the years that the Act lacked effective enforcement provisions, and in 1988 the Fair Housing Amendments Act270/ (FHAA) was enacted in an effort to correct some of these problems. In addition to establishing a new system of administrative enforcement, the Amendments Act extends protection against discrimination in housing to individuals with handicaps and families with children. It is this inclusion of individuals with handicaps that the Coordinating Committee has focused on in recommending that the ABA support the effective and speedy enforcement of the FHAA. Moreover, the Coordinating Committee believes that its recommendation is consistent with current ABA policy which endorses the enactment of federal legislation to prohibit

267/ Id.


269/ The original Act was amended in 1974 to prohibit discrimination on the basis of sex. Pub. L. 93-383. The Fair Housing Act, including the revisions made by the Fair Housing Amendments Act, applies generally to all residential housing, whether or not subsidized or insured by the federal government or any other public body, except certain owner-sold (i.e. without a broker) or owner-rented single-family homes and units covered by the so-called "Mrs. Murphy" exemption (units in a one- to four-family home where one of the units is occupied by the owner).

270/ Pub. L. 100-430.
discrimination against "an otherwise qualified individual" in housing.271/

Coverage of AIDS and HIV Infection

Coverage of people with AIDS or HIV was one of the major issues considered during Congressional debate about FHAA.272/ During that debate, numerous Members of Congress noted that people with AIDS and HIV infection often face discrimination in housing, and that AIDS and HIV infection are among the disabilities covered under the FHAA's definition of "handicap."273/ Statements by various Members of

271/ See ABA Report 115A.

272/ Section 802(h) defines "handicap," with respect to a person, as

1) a physical or mental impairment which substantially limits one or more of such person's major life activities,

2) a record of having such an impairment, or

3) being regarded as having such an impairment, but the term does not include current, illegal use of or addiction to a substance (as defined in section 102 of the Controlled Substances Act (21 U.S.C. § 802).

273/ "The Fair Housing Amendments Act ... is a clear pronouncement of a national commitment to and the unnecessary exclusion of persons with handicaps from the American mainstream ... People with Acquired Immune Deficiency Syndrome (AIDS) and people who test positive for the AIDS virus have been evicted because of an erroneous belief that they pose a health risk to others." House Committee Report, at 22. "This bill defines handicapped individuals consistent with the definition Congress established fifteen years ago in the Rehabilitation Act of 1973 .... This broad definition has been particularly important in protecting individuals who are often subject to the most irrational and virulent discrimination. For example, in our day and age, people with AIDS and people infected with the human immunodeficiency virus (HIV-commonly known as "the AIDS virus") are often subject to irrational discrimination in their attempts to obtain and maintain private housing." Statement of Rep. Ted Weiss, 134 Cong. Rec. H4601 (June 22, 1988).
Congress also make clear that AIDS and HIV infection are included in the definition of handicap under the FHAA.274/

A number of Members of Congress explained in detail that HIV-infection was covered under the FHAA, either as a physical impairment that actually substantially limits the major life activity of reproduction or as a physical impairment that is perceived by others to limit

274/ "Handicapped. Provides a definition of handicap to be used under this Act. This language is substantially similar to the definition under the primary federal law prohibiting discrimination against the handicapped, the Rehabilitation Act of 1973 .... (Footnote omitted.) The Committee intends that the definition be interpreted consistent with regulations clarifying the meaning of a similar provision found in Section 504 of the Rehabilitation Act. /Footnote 55/ Footnote 55: "See, e.g., 45 C.F.R. Sec. 84.3; 45 C.F.R. Part 84, App. A, subpart A. As the regulations note, the definition of handicap does not include a list of specific diseases and conditions that constitute physical or mental impairments because of the difficulty of ensuring the comprehensiveness of any such list and because some conditions covered under the definition of handicap may not even have been discovered or prevalent in the population at the time of passage of legislation. For example, AIDS and infection with the Human Immunodeficiency Virus (HIV) are covered under this Act, although such conditions were not even discovered when Section 504 was passed in 1973. See, e.g., Local 1812, AFGE v. U.S. Department of State, 662 F. Supp. 50, 54 (D.D.C. 1987). Ray v. School District of DeSoto County, 666 F. Supp. 1524 (M.D. Fla. 1987)." House Committee Report, at 22 and n.55. "I rise to support the Fair Housing Amendments Act of 1988, H.R. 1158. The House Committee on the Judiciary, on which I am privileged to serve, responsibly decided that this important legislation extends fair housing protection to all handicapped individuals, including those with such conditions as epilepsy, cancer, AIDS or the human immunodeficiency virus (HIV) which causes AIDS, unless there is a direct threat to the health or safety of other persons." Statement of Rep. John Bryant, 134 Cong. Rec. H4900 (June 29, 1988).
substantially a major life activity.\footnote{People infected with HIV are covered under both Acts [the FHA and Section 504] .... Such individuals are covered under the definition of handicap because they are regarded as having a physical condition that substantially limits one or more of their major life activities -- and are thus subjected to discrimination. \textsuperscript{275}} This analysis is identical to that offered by the Department of Justice.\footnote{Department of Justice Legal Memorandum, "Application of Section 504 of the Rehabilitation Act to HIV-Infected Individuals," 7-13 (September 27, 1988).} Congress also was careful to make clear that the provisions of the FHA would not require the sale or lease of a dwelling if a real threat to the health or safety of individuals existed.\footnote{Section 804(f)(9) of the FHA provides that: \footnote{(9) Nothing in this subsection requires that a dwelling be made available to an individual whose tenancy would constitute a direct threat to the health or safety of other individuals or whose tenancy would result in substantial physical damage to the property of others.}} Nonetheless, the Congressional intent, as expressed by Congressman Henry Waxman, a sponsor of the FHA, appears to be that "no discrimination will be permitted against persons who pose no direct threat to the health or safety of others because they pose no significant risk of transmitting the AIDS virus in the kind of normal social interactions which form the context for housing decisions."\footnote{Statement of Rep. Henry Waxman, 134 Cong. Rec. H4921 (June 29, 1988).}

The FHA prohibits several specific categories of actions with regard to people with disabilities.\footnote{Section 804(f)(1)-(2) provides:}

\footnote{\[T\]here is from HIV infection alone, a clear 'physical impairment' to at least one major bodily system. Moreover, this impairment does substantially limit what is undisputably a major life activity -- procreation and childbirth ...". Statement of Rep. Henry Waxman, 134 Cong. Rec. H4921-4922 (June 29, 1988).}
example, a landlord cannot refuse to rent to an individual, and an owner cannot refuse to sell to an individual, because (1) the individual is HIV infected, (2) because the individual has a roommate or lover who is HIV-infected and who would live in the dwelling, or (3) because the individual is associated with HIV-infected people who would probably visit the dwelling. In addition, a landlord or owner cannot refuse to rent or sell to physicians or other health care providers because they would be providing care to people with AIDS or HIV infection.

The FHAA also includes an explicit "reasonable accommodation" provision. While such a provision is

(Footnote Continued)

A. Disability

(A) A person may not discriminate in the sale or rental of a dwelling, or otherwise make a dwelling unavailable, and:

a person may not discriminate in the terms, conditions, or privileges of sale or rental of a dwelling, or in the provision of services or facilities in connection with such a dwelling because of:

1. The handicap of a buyer or renter;

2. The handicap of a person who is residing in, or intends to reside in, that dwelling after it is so sold, rented, or made available; or

3. The handicap of any person associated with the buyer or renter.

Section 804(f)(3) provides:

(B) It constitutes discrimination on the basis of disability:

1. To not allow a person with a handicap to make reasonable modifications to existing premises;

2. To refuse to make reasonable accommodations in rules, policies, practices, or services, when such accommodations may be necessary to afford such a person equal opportunity to use a dwelling; and

3. To fail to design and construct new multifamily
often of critical importance for people with AIDS in the employment context, it would probably be rare for a reasonable accommodation to be necessary for a person with AIDS or HIV infection in the housing context. Nevertheless, to the extent that such a situation might arise, the statute explicitly establishes such a requirement.

The FHAA also prohibits any entity engaging in residential real estate transactions to discriminate in making such transactions available, or to discriminate in the terms or conditions of such a transaction, because of an individual's handicap. To date, there have not been any publicized incidents of people with AIDS or HIV-infection being discriminated against in transactions such as loans or appraisals because of their disabilities. However, to the extent that such discrimination may arise because of a perceived shortened life-span of the individual or because of a perceived effect on property value due to the person's infection, it would be prohibited. The statute does not, however, prohibit an entity from taking into account factors other than handicap (e.g., financial status) in making loans.

(Footnote Continued)

281/ Section 805(a)-(b) defines residential real estate transactions as (1) the making or purchasing of loans or providing other financial assistance for purchasing, constructing or maintaining a dwelling, or loans secured by residential real estate and (2) selling, brokering, or appraising of residential real property.

282/ Section 805(c) specifically states that nothing in the Act "prohibits a person engaged in the business of furnishing appraisals of real property to take into consideration factors other than race, color, religion, national origin, sex, handicap, or familial status."
Background

In modern America, school attendance is an experience shared by virtually all children. Almost without exception, children aged five to eighteen spend six hours per day, nine months per year, in school with their peers. Compulsory school attendance is required by state law in all but one state.\footnote{M. Yudof, D. Kirp., T. Van Geel, & B. Leven, Kirp & Yudof's Educational Policy and the Law: Cases and Materials (2d ed. 1987).} Although the courts have not recognized any fundamental constitutional right to education, it is not incorrect to view school attendance as a right protected by various federal constitutional and statutory provisions, which directly affect children with handicaps and children of minority groups and illegal aliens. In any event, it is beyond dispute that the public schools play a singularly important role in our modern society.

In the landmark case of \textbf{Brown v. Board of Education},\footnote{347 U.S. 483 (1954).} a unanimous Supreme Court well described that role:

\begin{quote}
Today, education is perhaps the most important function of state and local governments. Compulsory school attendance laws and the great expenditures for education both demonstrate our recognition of the importance of education to our democratic society. It is required in our performance of our most basic public responsibilities, even service in the armed forces. It is the very foundation of good citizenship. Today it is a principal instrument in awakening the child to cultural values, in preparing him for later professional training, and in helping him to adjust normally to his environment. In these days, it is doubtful that any child may reasonably be expected to succeed in life if he is denied the opportunity of an education. Such an opportunity, where the state has undertaken to
\end{quote}
provide it, is a right which must be
made available to all on equal
terms.285/

It is within this framework that the Coordinating
Committee recommends that the ABA adopt HIV-related public
school education policies. The need for these policy
recommendations arises not only from the important role
which public education plays in our society, but also from
the special problems which the HIV epidemic has created in
this context, as the Coordinating Committee has explained in
AIDS: The Legal Issues:

Children with AIDS and HIV experience
many of the legal problems common to
their adult counterparts. In addition,
they experience compelling legal prob-
lems unique to their age and status.
Indeed, the public controversy surround­
ing HIV often has been most sharply
focused on the attempts of affected
children to stay in school, despite
school or community opposition. The
underlying themes in this controversy
touch deeply held values: our nation's
commitment to education for all chil-
dren, our concern for health and safety
in the school environment, and compas­
sion for children and families affected
by HIV: In practical terms, the conflu-
ence of these basic values has resulted
in conflict over demands for public
identification of school children with
HIV, calls for mandatory HIV-testing as
a condition for school attendance, and
efforts to provide school-based HIV
education.286/

285/ Id. at 493.

286/ AIDS: The Legal Issues 188 (August 1988). These
controversies will only increase in number in the future as
the number of infants and children with HIV increases. As
of February 15, 1988, the CDC had reported 1,065 cases of
pediatric AIDS in the United States. (The CDC
classification system for children affected by AIDS differs
from the classification system for adults. See Current
Trends: Classification System for Human Immunodeficiency
Virus (HIV) Infection in Children Under 13 Years of Age, 36
(Footnote Continued)
The Coordinating Committee believes that its recommendations reflect the current state of the law and medical knowledge as applied in the public school setting.

**Exclusion**

While there is no fundamental right to education triggering strict scrutiny under the Fourteenth Amendment, the Supreme Court has held that the total exclusion from public school is inappropriate.287/ Lower court cases have prohibited the exclusion from public schools of children with handicaps,288/ and Congress has enacted federal statutes such as Section 504 of the Rehabilitation Act of 1973,289/ and the Education of the Handicapped Act of

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(Footnote Continued)

Morb. & Mort. Weekly Rep. 225 (April 24, 1987)). Of those reported, 838 were infants and 226 were adolescents. Children with AIDS currently represent less than two percent of the total number of people with AIDS in the United States. AIDS Weekly Surveillance Report, U.S. AIDS Program, Center for Infectious Diseases, Centers for Disease Control, November 16, 1987). However, the Surgeon General estimates that perhaps two to three times that number of children actually are infected with HIV, but do not meet the CDC reporting criteria; he predicts 3,000 cases of pediatric AIDS by 1991. U.S. Department of Health and Human Services, Public Health Service, Report of the Surgeon General’s Workshop on Children with HIV Infection and Their Families 1 (1987). Other experts, including the Presidential Commission, predict as many as 10,000 to 20,000 cases of pediatric AIDS by 1991. Oleske, Natural History of HIV Infection II in U.S. Department of Health and Human Services, Public Health Service, Report of the Surgeon General’s Workshop on Children with HIV Infection and Their Families 24 (1987); Report of the Presidential Commission 108 (June 24, 1988).


to ensure that handicapped children receive the benefit of a public school education whenever possible.

Recognition that school-age children would be affected by HIV led the Centers for Disease Control (CDC) to formulate guidelines for treatment of these children in educational and foster care settings. The CDC analyzed existing information, including the risk factors for acquiring HIV infection, the risk of transmission in the school, day care, or foster care settings, and the risk to the child who has the infection.

For most school children, the CDC recommended an unrestricted educational setting. These recommendations have been widely accepted, and the CDC's position has been

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290/ 20 U.S.C. §§ 1400 et seq. The Education of the Handicapped Act (EHA) was enacted by Congress in 1975 to assure a free appropriate public education for all handicapped children. Certain advantages accrue to children who come within EHA's coverage. Such students are entitled to individually designed special education programs and any necessary related services such as physical therapy, periodic reviews, and many procedural and substantive protections. The statute's requirement for mainstreaming, that is, education with children who are not handicapped, also indicates that children should not normally be excluded or segregated in school settings.


293/ For a full discussion of the transmission of HIV, concluding that casual contact is not a factor but that transmission occurs only through blood, sexual activity, and perinatal events, see Lifson, Do Alternate Modes for Transmission of Human Immunodeficiency Virus Exist: A Review, 259 J.A.M.A. 1353 (March 4, 1988); Friedland & Klein, Transmission of the Human Immunodeficiency Virus, 317 New Eng. J. Med. 1125 (Oct. 29, 1987).

294/ Current Trends, note 291, supra.
further supported by numerous studies showing that casual contact is not a factor in HIV transmission.295/

Despite the recommendations of the CDC, the Surgeon General, other public health officials,296/ and major professional groups,297/ a number of individual school districts have attempted to exclude children affected by HIV.298/ Lawsuits have been filed in at least five states over attempted exclusion from school of children with AIDS, and actions to exclude such children have occurred in at least ten states.299/

Section 504 has been invoked successfully in cases involving the exclusion of children with HIV from school settings. The Eleventh Circuit recently has held that an HIV-infected child may be "otherwise qualified" under

295/ Id.


297/ The American Academy of Pediatrics has adopted guidelines similar to the CDC recommendations (American Academy of Pediatrics, Committee on School Health, Committee on Infectious Disease, School Attendance of Children and Adolescents with Human T-Lymphotropic Virus III/Lymphadenopathy-Associated Virus Infection, 77 Pediatrics 430 (Mar. 1986). The guidelines are frequently cited with approval by courts (see, e.g., Ray v. School Dist. of DeSoto County, 666 F. Supp. 1524 (M.D. Fla. 1987); Thomas v. Atascadero Unified School Dist., 662 F. Supp. 376 (C.D. Cal. 1987); and state policy guidelines based on these recommendations have been upheld (see, e.g., Board of Educ. of Plainfield v. Cooperman, 105 N.J. 587, 523 A.2d 655 (N.J. 1987).

298/ Reed, Children with AIDS: How Schools are Handling the Crisis, Phi Delta Kappa, Special Report K1 (Jan. 1988).

Section 504 to attend public school, if reasonable medical judgments are used to determine (a) the nature of the risk (how the disease is transmitted); (b) the duration of the risk (how long the carrier is infectious); (c) the severity of the risk (what the potential harm is to third parties); and (d) the probabilities that the disease will be transmitted and will cause varying degrees of harm, which indicate that public school attendance is appropriate.300/

In Thomas v. Atascadero Unified School District,301/ another recent case which involved a kindergarten student who was infected with HIV during transfusions for complications arising from his premature birth, a federal court enjoined the school district from barring the student from placement in a regular class, based on the mainstreaming regulation of Section 504. Similarly, a federal court in Florida granted a preliminary injunction under Section 504 to prevent the exclusion of three brothers with hemophilia who tested HIV positive.302/ More recently, the same federal court ordered that a mentally handicapped child be integrated into a regular trainable mentally handicapped classroom.303/

Although schools have the right to exclude children who create a peril for other students and their teachers, wholly unsubstantiated fears cannot justify exclusion. The CDC reports that none of the identified cases of HIV infection in the United States are known to have been transmitted in school settings.304/ Thus, it may

300/ Martinez v. School Board of Hillsborough County, Florida, 861 F.2d 1502 (11th Cir. 1988).


302/ "Unless and until it can be established that these boys pose a real and valid threat to the school population of DeSoto County, they shall be admitted to the normal and regular classroom settings, to which they are respectively educationally entitled." Ray v. School Dist. of DeSoto County, 666 F. Supp. 1524 (M.D. Fla. 1987) at 1535. (Emphasis in original).

303/ Martinez, note 254, supra, on remand, ____ F. Sup. ____ (April 26, 1989).

304/ Current Trends, note 291, supra.
be expected that the medical facts about HIV will rarely support the exclusion of children affected by HIV from school.

Although attempts at exclusion have been largely unsuccessful, these attempts have been recurrent, and needlessly litigation over these attempts have diverted public and private resources. Thus, the Coordinating Committee believes that the ABA should affirm that a student with AIDS or HIV should not be separated from his or her classmates, except in the rare instance when a particular child presents a substantial risk of transmitting the virus in a school setting. The Coordinating Committee's recommendation prohibiting exclusion also applies to a child who has not been admitted to school, and therefore is not a student, because of the child's actual or perceived HIV status.

Separation or Restriction

In its 1985 recommendations, the CDC also advised a "more restricted environment" for pre-school aged children and "some neurologically handicapped children who lack control of their body secretions or who display behavior, such as biting, and those children who have uncovered, oozing lesions."305/ Doubts have been raised, however, concerning the medical support for those 1985 cautions relating to biting and body secretions.306/ In addition, the CDC more recently reported that "[s]aliva has not been implicated in HIV transmission."307/

While generally giving great deference to the CDC guidelines, courts have resisted excluding from school children who bite.308/ In testimony before the Coordinating Committee, the General Counsel of the National School Boards Association well summarized the state of medical knowledge when he observed that the virus is transmitted only by blood

305/ Current Trends, note 291, supra, at recommendation 3.

306/ Id.


308/ One federal district court reasoned: "The overwhelming weight of medical evidence is that the AIDS virus is not transmitted by human bites, even bites that break the skin." Thomas, note 301, supra at 380.
or in semen: "No other body fluids -- tears, saliva, or perspiration, for example -- have a concentration that the virus seems to require."309/ Accordingly, the Coordinating Committee urges that very strict standards should be adopted for determining when a student may be separated from other students in the normal school setting. Moreover, HIV-infected students should not be prevented from attending such courses as biology, physical education or shop because of unfounded fears of cuts and scrapes transmitting the HIV virus.310/

To separate a student from his regular classmates, or otherwise restrict his activities, the student's behavior must present a substantial and genuine risk of HIV transmission under current medical knowledge. School authorities in such a case must then attempt to make any reasonable accommodation which might reduce the risk of HIV transmission. Reasonable accommodation is a flexible concept which may include counseling and training, although these types of accommodations may be more appropriate for older children. Reasonable accommodation for a child with HIV also should include attempts to change behavior that risks infection. Attempts to make a reasonable accommodation must be unsuccessful, or a determination made that such attempts will be unsuccessful, before the child may be restricted. Moreover, the Coordinating Committee believes that the psychological and educational effects of the separation or restriction also must be considered because the possible damage to a student is no less severe when it is based on fear of HIV than when it is based on fears and prejudice founded.

309/ Testimony of August Steinhilber, Associate Executive Director and General Counsel, National School Boards Association, March 5, 1988, at 359.

310/ The Committee understands that the National Association of State Boards of Education (NSBE) currently is in the process of developing policies for HIV-infected students and school staff, under a CDC contract. The NSBE report is expected to reflect the most up-to-date medical information and should be issued in July 1989.

311/ Emotional distress related to isolation attending fear of HIV in young people has been noted by health care teams working with young men with hemophilia. "The young men often become recluses. They are afraid to establish friendships with girls and even avoid other boys because of fears of peer pressure and uncertainty about their disease." Kolata, Perplexed Counselors and the Facts of Life, N.Y. (Footnote Continued)
on race or handicap.\footnote{312}{The Coordinating Committee further believes that consideration must be given to the psychological and educational impact which separating a student will have on the children who would otherwise be his classmates.}

The Coordinating Committee also urges the ABA to adopt policy requiring that the particular form of separation be the least restrictive setting, consistent with the requirements of Section 504 and the "mainstreaming" regulations of the Education of the Handicapped Act.\footnote{313}{Moreover, in keeping with the requirements of the Education of the Handicapped Act, school authorities should periodically review the need for continued separation or restriction.}

The Coordinating Committee notes that the CDC has recommended that placement decisions concerning HIV infected children should be made by a team comprised of the child's physician, public health personnel, the child's parent or guardian, and personnel associated with the proposed setting.\footnote{314}{The Coordinating Committee stresses again, however, that separating or restricting students with HIV will almost never be appropriate, given current medical knowledge as to methods of transmission.}

Education Respecting HIV

In 1986 the Surgeon General called for HIV education in the public schools.\footnote{315}{Although that recommendation created substantial controversy at the time, there appears to be increasing acceptance of the proposition that}

(Footnote Continued)

\footnotetext{312}{See \textit{Brown v. Board of Education}, at 494 and n. 11, note 284, \textit{supra}.}
\footnotetext{313}{20 U.S.C. § 1412(5)(B); 45 C.F.R. Part 84.34.}
\footnotetext{314}{Current Trends, note 291, \textit{supra}.}
\footnotetext{315}{Surgeon General's Report on Acquired Immune Deficiency U.S. Department of Health and Human Services 31 (1986).}
HIV education in the schools is essential to fighting the disease.316/ Indeed, the Presidential Commission recommended that "State boards of education should mandate that an HIV education curriculum with appropriate content for age be offered to all students at each schooling level (e.g. elementary, middle, and high school) throughout the state."317/

Eighteen states now mandate HIV education in the schools, and most other states have some initiatives concerning education on the disease.318/ The National PTA has called for comprehensive school health education programs that include instruction concerning HIV,319/ and the CDC recently promulgated guidelines for effective school health education to prevent the spread of HIV.320/ Many educators are developing curricula and teaching materials for implementation of school HIV education.321/

316/ A survey by Louis Harris and Associates found that 94% of the parents polled said school officials should take special steps to educate teachers and students about AIDS, even if no student is suspected of carrying it. Children (March 1988), Parents' Poll: Yes to AIDS Courses, No to Boycotts Over the Disease, Education Week, Mar. 2, 1988, at 2, col. 4. Every school superintendent surveyed in one study said that education about AIDS should be part of the regular school curriculum. Keough & Seaton, Superintendents' Views on AIDS: A National Survey, Phi Delta Kappa 358, 359 (January 1988). For an excellent general discussion of education in the prevention of AIDS, see Fineberg, Education to Prevent AIDS: Prospects and Obstacles, 239 Science 592 (Feb. 5, 1988).


320/ Center for Disease Control, Guidelines for Effective School Health Education to Prevent the Spread of AIDS, 37 MMWR No. S2 (Jan. 29, 1988).

321/ See, e.g., Centers for Disease Control, Center for (Footnote Continued)
Although HIV education in the schools remains controversial, the Coordinating Committee believes that such education is essential to control the spread of the disease, to combat the dissemination of misinformation about the disease and its transmission, to allay unfounded fears based on such misinformation, and to prevent invidious discrimination against people with AIDS and HIV. By calling for "appropriate" HIV education, however, the Coordinating Committee acknowledges that different localities may well wish to adopt differing approaches to such education, and that such differing approaches should be encouraged. Accordingly, the ABA should call on school systems to adopt local policies regarding the education of all students (including special education students), staff and parents respecting HIV.

Confidentiality

The privacy interests of children with respect to their HIV status are similar to those of adults. Without confidentiality, children with AIDS or HIV infection and their families may suffer discrimination, harassment and ostracism in school and in employment. The Centers for Disease Control has recognized that social isolation in school can be especially damaging for children. The CDC recommends respect for the child's right to confidentiality: "Persons involved in the care and education of HTLV-III/LAV-infected children should respect the child's right to privacy, including maintaining confidential records. The number of personnel who are aware of the child's condition should be kept at a minimum needed to assure proper care of the child and to detect situations where the potential for transmission may increase (e.g.,

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(Footnote Continued)

Health Promotion and Education, Division of Health Education, Combined Health Information Database (CHID): AIDS School Health Education Subfile. (Computerized descriptions of education programs, curricula, guidelines, policies, regulations, and materials.)


323/ "Parents of HTLV III/LAV-infected children should be aware of the potential for social isolation should the child's condition become known to others in the care or educational setting." Current Trends, note 291, supra.
bleeding injury)."324/ Furthermore, the Presidential Commission has recommended that school children and staff should be afforded confidentiality protections in the school setting.325/ The Coordinating Committee joins the CDC and the Presidential Commission in recommending that school authorities protect the confidentiality of a student’s HIV status.

324/ Id. at recommendation 12.

325/ "In any communications about specific HIV-infected individuals, the confidentiality of the schoolchild or staff member should be maintained to minimize the opportunity for discriminatory behavior." Report of The Presidential Commission 125 (June 1988).
Background

Given the recent and alarming increase in pediatric AIDS cases,326/ the special needs of children infected with HIV will become an increasing public concern in the years to come. Nonetheless, the public policy debate surrounding the HIV epidemic has focused almost exclusively on the problem of HIV infection in adults; the number of children affected by HIV, and the difficult medical, legal, educational, and social service problems faced by these children and their families, have not been adequately addressed by policy makers and community leaders.327/ The Coordinating Committee recognizes that ongoing public policy discussions concerning AIDS must begin to address the needs of the youngest and most vulnerable in our society, many of whom necessarily will lead very short lives due to the AIDS epidemic.328/

Approximately 83% of children with AIDS acquire the infection in the womb or at birth from mothers who are intravenous drug users or sexual partners of intravenous drug users.329/ A disproportionate percentage of these

326/ Of the total of 64,506 cases of AIDS reported to the CDC through June 6, 1988, 1,013 were infants and children under the age of 13 at the time of diagnosis. Predictions as to the number of pediatric AIDS cases in 1991 range from 3,000 cases estimated by the Public Health service to 10,000 to 20,000 cases predicted by the National Commission to Prevent Infant Mortality. See Report of the Presidential Commission 108 (June 1988).


328/ Most children with HIV-related diseases die before the age of three years. Report of the Presidential Commission 12 (June 1988). With increased development of treatments for HIV infection, however, children with HIV disease can be expected to live longer lives. See White, "Treating Pediatric AIDS," AIDS Patient Care (September 1987).

mothers come from minority and low income populations. As a result, most children with AIDS are infants whose parents are unable, due to their own medical or financial status, to provide adequate care for them. For the most part, these children are dependent upon the state for their care and protection, and they must rely on an already overburdened and underfinanced public child welfare system to meet their most basic needs.

As the Presidential Commission has noted, the all-too-often, and unfortunate consequence of these demographic realities is that babies with AIDS tend to become "boarder" babies -- living their brief and tragic lives in hospital wards, rather than experiencing the stimulation, constant attention, and care of home environments. These abandoned infants, who are difficult to place in foster care homes, not only suffer on a human level from experiencing life only in an institutional setting, but often unnecessarily occupy costly hospital beds, when less expensive, community-based services would better meet their needs. Recent federal legislation providing incentives to foster care families and community-based organizations to care for infants abandoned in hospitals may help to alleviate this heartrending problem.

Infants and young children with AIDS or HIV in the child welfare system have the same legal rights as other HIV-affected persons, including the rights to privacy and non-discrimination, and access to appropriate services. At the same time, however, these children also share the legal problems of all youths committed to the care of the child.

330/ Over 75% of the reported pediatric AIDS cases are black or Hispanic children. AIDS Weekly Surveillance Report, U.S. AIDS Program, Center for Infectious Diseases, Centers for Disease Control, September 26, 1988.


welfare system: the imprecise fit of discrimination laws geared towards the needs of adults or older children (e.g., employment, insurance, and schooling); the natural proclivity towards assuming that the state, acting as parens patriae, is acting in the child's best interest; and the limited access which young children have to legal representation. The Coordinating Committee's recommendations in this area attempt to address the legal rights and special needs of HIV infected children in the child welfare system, while recognizing the additional burdens that these children place upon public foster care and adoption agencies.

Testing

The responsible provision of appropriate care to children within the child welfare system requires knowledge of the physical condition of the child. Therefore, the Coordinating Committee recognizes that foster care and adoption agencies, in appropriate circumstances, should be able to request or conduct HIV testing of children within their jurisdiction. The Coordinating Committee strongly believes, however, that mandatory or routine testing of all children within the system is neither warranted, desirable, nor cost-effective. Instead, an agency's decision to test a particular child for HIV should be made on a case-by-case basis and should be governed by clearly established written criteria that are consistent with generally accepted public health recommendations. A decision to test should be based solely on the medical necessity for testing, such as when the child's clinical status indicates the appropriateness of the test, or when the medical history of the child or the child's family indicates that the child or the child's parent is, or was, at high risk of contracting the virus. A child should never be tested based upon factors such as a prospective foster parent's unfounded fear that a child may be HIV positive.


336/ "Foster care" refers to any out-of-home care in which the child has been placed voluntarily by the parent or by court order within the public child welfare system.

As in all cases of HIV testing, any HIV testing within the child welfare system should be voluntary, and it should be predicated upon the specific, written informed consent of either the child or a person legally entitled to give informed consent for the child. In most cases of children committed to the child welfare system, of course, "consent" will come from the state itself. The clearly established written criteria called for in the Coordinating Committee's recommendation are necessary to protect the child's rights and to insure that testing is not imposed arbitrarily by the public agency.

The Coordinating Committee's recommendation in this respect is consistent with the position of major medical and professional groups, all of which also favor a selective case-by-case approach to HIV testing. Such an approach is based on the strong medical evidence that HIV is not transmitted through routine contact of family members.

Finally, public child welfare agencies that conduct HIV testing should also provide age-appropriate pre- and post-test counseling. An agency should not institute HIV testing unless the agency has the ability to formulate a service plan for seropositive children and their families; has up-to-date knowledge regarding HIV test results and reliability, and a plan for HIV retesting, as necessary; has educated its staff about the implications of

339/ Id.
340/ See, e.g., Report of the Child Welfare League of America Task Force on Children and HIV Infections, Initial Guidelines (March 1988). Although the CDC suggested in 1985 that foster care and adoption agencies consider mandatory HIV testing as part of their routine initial health assessment, the CDC approach has not been widely accepted by public child welfare agencies, and no jurisdiction has, as a matter of public policy, adopted the CDC's position. See Education and Foster Care of Children Infected With HIV, MMWR 34 (Aug. 30, 1985). See also AIDS: The Legal Issues 208 (August 1988).
Confidentiality

An agency's decision to test a child for HIV necessarily implicates the privacy rights of the child and the child's family. As with all cases of HIV testing, the test results should be afforded maximum confidentiality protections. Child welfare agencies conducting or requesting HIV testing should have strong policies and procedures in place to ensure confidentiality before any testing is requested or conducted.

HIV testing also raises questions as to who within the agency should have access to information about the child's HIV status. The Coordinating Committee believes that such information should be available only on a case-by-case basis, considering such factors as the child's age, the child's needs, the risk of exposure to other health hazards, and any behaviors exhibited by the child or others that would put the child or others at risk of contracting the infection. Moreover, the information should be available only to those persons with a need to know the child's HIV status, including health care providers and any person directly responsible for the primary care of the child.

The Coordinating Committee agrees with the Child Welfare League of America that a child's HIV status should be disclosed to foster care or adoptive parents before the child is placed within their care. Several factors support this conclusion. First, the child's HIV status is relevant to the foster or adoptive parent's ability to care adequately for the child. Second, the prospective

342/ Id.
343/ Id. at 16-17.
344/ Id.
345/ Id. at 16.
346/ Id. at 18-20.
adoptive parents need to know the child’s HIV status in order to negotiate an adequate adoption subsidy with the state.348/ In all such cases, the agency should counsel and educate the prospective foster or adoptive parents and should remind them of the importance of confidentiality.349/

Third, disclosure of a child’s HIV status to prospective foster care or adoptive parents may be necessary to protect the agency from liability for either misrepresentation or negligent placement of a child with an infectious disease.350/ Some non-HIV-related legal precedent suggests that an agency could be found liable for failure to advise foster or adoptive parents of a child’s HIV status if another family member contracted a disease or infection related to HIV from the child.351/ Other non-HIV-related precedent suggests that an agency may be liable for medical and other expenses incurred by adoptive parents when the agency places a child whom it knew, or should have known, to be infected with HIV, without advising the adoptive parents.352/ Finally, in some jurisdictions, adoptive parents may be entitled to annul the adoption on the ground that medical information was withheld.353/

Although agencies may disclose a child’s HIV status to prospective foster or adoptive parents, the Coordinating Committee believes that disclosure should be accomplished in a way that best protects the privacy concerns of the child and the child’s natural family. Thus, the Coordinating Committee recommends that disclosure to


352/ See e.g., Burr v. Stark County Board of Commissioners, 491 N.E.2d 1101 (Ohio 1986).

353/ See e.g., In re Lisa Diane G., 537 A.2d 131 (R.I. 1988). See also Cal. Civ. Code § 227b (West 1982) (annulment allowed based on certain mental illnesses or deficiencies resulting from conditions existing prior to the adoption, but unknown to the adopters).
foster care or adoptive parents be limited to the child's medical reports, and that disclosure occur prior to the time the child is placed in the care of the prospective foster or adoptive parents. To protect privacy rights, a child should generally be identified to those who are merely prospective foster or adoptive parents as having a "serious medical problem" rather than HIV infection. Only when a serious inquiry about the placement of a particular child is made by a prospective foster or adoptive parent should the agency explain the child's specific medical problem.354/

Least Restrictive Placement

In serving the needs of HIV affected children and their families, the goal of a child welfare agency should be the same as that for all children within the agency's jurisdiction: to preserve the family unit, whether biological, foster, adoptive, or extended family.355/ The agency should make all reasonable efforts to allow the HIV infected child to remain with his or her family, so long as the family affords a safe, healthy, and productive environment. Should it become necessary to remove a child with HIV from his or her home, the child's case plan should provide for placement in the least restrictive setting and should provide for services to the family which would allow the child to return to the family as soon as possible.356/

The Coordinating Committee's recommendation is consistent with the requirements of the Federal Adoption Assistance and Child Welfare Act357/ and the developing case law under the Act.358/ The Act promotes permanency planning


for each child in the child welfare system and conditions receipt of federal foster care funding upon the state's provision of "preventive services," which are defined as services enabling a child to remain with his or her natural family and as services to the family and child while the child is in foster care.359/ The Act has been interpreted to grant foster children an enforceable right to adequate health care, adequate services, and case plans which assure their placement in the least restrictive setting available.360/

To ensure least restrictive placement, child welfare agencies will be required either to call upon a variety of already established community-based services, or to provide, on their own, appropriate services to HIV affected families. Necessary and appropriate services may include individual or family counseling; support groups; respite care; transportation; baby sitting; homemaker services; visiting nurse services; day-care; home visitor or buddy services; housing; homebound education; dental care; and, of course, medical services.361/

Providing the services necessary to ensure that HIV infected children will remain in their family homes or be placed in least restrictive settings undoubtedly will require additional public programs and funding. As the Presidential Commission has noted, however, providing support services to HIV affected families and appropriate foster care not only will improve the overall well-being of HIV infected children, but also will be cost effective.362/ According to an informal survey conducted by the Child Welfare League of America and the National Association of Children's Hospitals and Related Institutions, the cost of hospital care for HIV infected children is approximately

359/ Id. at 213.


$1,200 per day, while specialized foster care averages only about $100 per day.363/

Non-discrimination

The Coordinating Committee believes that foster care and adoption agencies should consider the HIV status of foster or adoptive parents only in the same way that other medical conditions are considered. This recommendation is consistent with current medical evidence that HIV is not transmitted through casual family contact. The Coordinating Committee nonetheless recognizes that the long-term health of a prospective foster or adoptive parent is a relevant factor in foster or adoptive placements.

The Committee's recommendation is in keeping with the requirements imposed on most public child welfare agencies by federal law. Most public agencies, and indeed most private agencies, receive some form of federal funding,364/ usually passed through by a state agency pursuant to legislation such as the federal Adoption Assistance and Welfare Act.365/ As a result, the anti-discrimination provisions of Section 504 of the Rehabilitation Act366/ prohibit these agencies from discriminating against otherwise qualified handicapped individuals, including individuals infected with HIV.367/

However, HIV infected foster or adoptive parents whose health status precludes them from physically providing adequate care for a child would not be "otherwise qualified" to serve as foster or adoptive caregivers, unless a "reasonable accommodation" can be made for their handicap. In the context of foster care or adoption placement, "reasonable accommodation" might include the provision of services to enable the individual to care for the foster or adopted child. The Coordinating Committee notes that the concept of non-discrimination also requires that any inquiry as to the

363/ Id.
health status of an HIV positive foster or adoptive parent be conducted in exactly the same manner as inquiries into the health status of applicants with other diseases.
Background

Issues relating to divorce and custody are among the most problematic and emotionally charged issues with which the legal system is required to deal. The subject of AIDS and HIV infection is one that also engenders emotional reactions, largely because of fear and misinformation. When AIDS and HIV infection become intertwined with divorce and custody issues, the combination can be volatile. The Coordinating Committee has attempted to address some of these problems in its recommendations on family law.

Essentially, the Coordinating Committee recommends that HIV status should be treated in a family law proceeding in the same manner as any other medical condition. The Coordinating Committee believes that this is a particularly important principle since HIV infection, which may be asymptomatic, and AIDS are not synonymous.

Furthermore, HIV is communicable, but, contrary to wide public perception, the virus is transmitted only through sexual contact, the sharing of blood and blood products through transfusion and IV drug use, and from mother to child in utero or at birth. To date, there has been no evidence of transmission through everyday household contact, even though thousands of such contacts have been studied. These facts are particularly important to determining the relevancy of HIV status in family law cases, where emotional reactions to the dissolution of a marriage and custody disputes may drive the proceedings.

Admissibility

While HIV status generally should not be deemed admissible evidence in a family law proceeding, the Coordinating Committee recognizes that HIV status may be admissible where a specific showing of relevance and probativeness can be made. In many jurisdictions in this country, for


369/ Id.
example, no fault grounds are the primary bases for divorce actions.370/ Where fault grounds are still in use, however, the Coordinating Committee notes that a positive HIV result may support an allegation of adultery since one of the primary modes of transmission for the HIV virus is through sexual contact. Nonetheless, the Coordinating Committee believes that independent evidence of adultery must be presented before a party to a divorce can request an HIV test.371/

If such other evidence exists, and a positive HIV result could help establish that adultery was committed, the Coordinating Committee's recommendation provides that HIV status may be considered relevant evidence in a divorce proceeding based on adultery. Absent such independent reason to believe that adultery has been committed, however, HIV testing should not be permitted as part of a mere fishing expedition. The Coordinating Committee believes that this same type of analysis should be applied to any question as to whether an individual's HIV status should be admitted as evidence.

Alimony

There are currently no reported cases dealing with HIV testing and spousal support.372/ However, an attorney has a general duty to inquire as to a party's health status in cases where alimony is at issue, which duty of inquiry extends to the health status of an individual who may test positive for HIV. Clearly, the health status of a party is relevant evidence in an alimony proceeding, to determine the amount and duration of alimony. The Coordinating


371/ See, for example, Anne D. v. Raymond D., 528 N.Y. Supp. 2d 775 (S. Ct. Nassau County 1988).

372/ The term spousal support includes alimony, maintenance and any other term used to mean financial support of a present or former spouse.
Committee’s proposed recommendation in this area recognizes and confirms this principle.

In states permitting an award of alimony, a dependent spouse may want to maintain the option of seeking support in the future if he or she is HIV positive or has AIDS. On the other hand, the ability of an HIV positive paying spouse to make alimony payments may be subject to modification in the event that disease develops and restricts his or her ability to work. Both of these scenarios would be dependent on the spouse voluntarily revealing his or her positive HIV status.

Child Abuse

Child abuse allegations in a child custody case are always troubling, whether the lawyer represents the accusing or the accused parent. Because HIV infection is spread by unprotected sexual contact involving the exchange of bodily fluids, and is not transmitted by non-sexual, casual household contact, the test for HIV may arguably be relevant in child abuse cases where the accused party and the alleged victim are HIV positive. A court, for example, could be asked to consider HIV status as evidence of sexual contact between an accused party and child. The Coordinating Committee is mindful of concerns that unfounded abuse allegations are sometimes raised in child custody and visitation cases. The Coordinating Committee therefore believes, that before the accused party’s HIV status may be considered relevant, the child victim must be shown to be HIV positive, and there must be a threshold showing by substantial evidence of acts on the part of the alleged perpetrator which could result in transmission of the virus.


If the child is HIV negative, the accused party’s HIV status would clearly be irrelevant.

Child Custody and Visitation

Child custody and visitation matters are often among the most demanding and challenging aspects of the family lawyer’s practice. The attorney must deal with the emotional trauma suffered by the parents and the children, while also managing the presentation of the custody or visitation case within the legal system, which is often ill-equipped to deal with the emotional and social problems raised by such cases. The problems are increased exponentially when a case involves an HIV positive or AIDS diagnosed parent. Even mere allegations of such conditions can have a devastating impact.

Although such allegations may be motivated by health and safety concerns, they also may be raised because of conflicts over a parent’s sexual orientation or “lifestyle.” The Coordinating Committee believes that HIV status should not be deemed admissible evidence in a custody or other type of other case for the purpose of establishing sexual orientation.

To date, relatively few reported custody or visitation cases include HIV issues in the context of blood transfusion or drug use-induced infections. The routinely reported HIV-related custody or visitation case involves the linkage of HIV to gay men. In some cases, the AIDS or HIV allegation may not be a good faith attempt to protect the

children from infection, but rather an attempt to restrict a parent’s contact with his or her children. For this reason, the Coordinating Committee believes that a party’s HIV status may constitute very sensitive information in the context of a custody case, and should be considered relevant evidence in such a proceeding only to the same extent as other medical conditions which might impact on parenting ability.

A number of courts have given effect to this principle. In a New York case, for example, a mother sought to prevent a father with AIDS from having contact with the couple’s daughter pendente lite on the ground that the father could not properly care for the child. Her request was denied because no evidence, other than the fact of the father’s AIDS diagnosis, was presented to the court.376/ More recently, the Indiana Court of Appeals overturned a lower court’s termination of a father’s visitation rights based on his positive HIV status.377/ The Indiana Court of Appeals based its holding in part on the fact that "AIDS is not transmitted through everyday household contact."378/

These judicial decisions are consistent with the present state of medical knowledge regarding HIV transmission.379/ In proposing its family law recommendations, the Coordinating Committee recognizes that custody and visitation disputes are measured against the "best interests of the child." Although custody decisions involve a balancing of many factors, including a party’s general health status, visitation is usually permitted except in extreme circumstances.

The Coordinating Committee believes that it should emphasize again the fact that medical studies have shown no cases of household transmission other than through sexual contact or the sharing of needles in households where HIV positive individuals have lived with HIV negative individuals over long periods of time.380/ Clearly, this

376/ Jane W. v. John W., 137 Misc.2d 24, 519 N.Y.S.2d 603.
378/ Id. at 980.
379/ See note 368, supra.
medical evidence rebuts the premise, in a custody or visitation proceeding, that an HIV positive individual should be denied or have restricted custody or visitation based solely on his or her HIV status. The Coordinating Committee therefore concludes that an individual’s HIV status should be considered relevant evidence in a custody or visitation proceeding only to the same extent as other medical conditions, and that HIV status should not be admissible as general evidence of a parent’s sexual orientation or "lifestyle."
DRUG ABUSE

Background

The Presidential Commission has concluded that "[o]ur nation's ability to control the course of the HIV epidemic depends greatly on our ability to control the problem of intravenous drug abuse."381/ By January 1989, 24% of the AIDS cases reported to the CDC were men and women with histories of IV drug use, a 5% increase over the cumulative number of IV drug-related cases reported since the beginning of the epidemic.382/ Moreover, IV drug-related cases comprise an even larger and growing share of total AIDS cases in certain geographic locations, including metropolitan New York, northern New Jersey and Connecticut.383/ The statistics for the New York City area, where 55-60% of all IV drug users are estimated to be infected with HIV,384/ are cause for particular concern. Although seroprevalence rates are significantly lower in other regions, the spread of HIV among the estimated 1.2 million IV drug users in the United States presents an enormous challenge to the legal and public health systems.

Furthermore, IV drug users are a major link for transmission of HIV to their heterosexual partners and children. The Presidential Commission noted that 70% of all heterosexually transmitted AIDS cases in native-born citizens involve the sex partners of IV drug users, many of whom are women who do not inject drugs.385/ More recently, the

Centers for Disease Control reported that 83% of all perinatal AIDS cases are the infants of IV drug users or their partners.386/

Education and Services

Entire families are being decimated by the devastating link between HIV and IV drug use,387/ and a disproportionate share of these families come from minority communities.388/ Many of them also are members of poor, inner-city communities with all of the other disadvantages that status entails.389/ (See Discrimination section for further discussion). These communities urgently need a variety of targeted HIV-related services, including education, testing, counseling, drug treatment, and medical care. The Coordinating Committee agrees with the Presidential Commission that community-based programs are essential to reach IV drug users, their partners, and children.390/

The Coordinating Committee is aware that some of these services are being provided by existing drug treatment facilities, and supports such efforts to the extent that they are undertaken in a manner consistent with our other recommendations. However, additional steps are necessary. First, drug treatment facilities must be expanded. There are long waiting lists for treatment in some cities391/ and many smaller communities lack adequate facilities. The Presidential Commission has recommended that traditional approaches to the treatment of IV drug abuse (i.e., methadone programs) should be augmented by more flexible, extended program hours, mobile units, and "storefront"

391/ Id. at 96.
facilities. Moreover, the role that IV injection of cocaine appears to be playing in the spread of HIV in some cities raises special concerns about the effectiveness of current drug treatment methods, since methadone maintenance does not treat addiction to cocaine and IV-cocaine users apparently engage in more frequent injection and needle sharing behavior than do other IV drug users.

Second, communities should consider innovative education and intervention strategies to reach IV drug users who are not currently seeking treatment for their drug dependency. The City of San Francisco has implemented a highly regarded program to educate IV drug users about the risks of sharing needles. That program includes instructions on how to clean needles. Other options include pilot needle exchange programs and the removal of legal barriers to the purchase and sale of needles, syringes and drug paraphernalia. Although these programs are controversial, the Coordinating Committee is aware that pilot needle exchange programs are currently underway in New York City and in Seattle, Washington. Moreover, Secretary of Health and Human Services Louis W. Sullivan recently expressed his support for local needle exchange programs.

Finally, targeted HIV education and related services must be made available to the partners and children of IV drug users, many of whom may not be aware that they

392/ Id. at 97.
393/ HIV Infection and AIDS, Recommendations for President-Elect George Bush, Institute of Medicine, National Academy of Sciences (1988).
are at risk of HIV infection. Community health clinics, particularly, maternal/child and family planning clinics, are among the possible sites. The Presidential Commission has recommended that outreach be targeted to both female IV drug users and female sexual partners of IV drug users noting that

All providers of women's health care should be enlisted in efforts to prevent sexual transmission of HIV. Most women who visit a women's health care provider, whether it be for family planning or a routine checkup, have no other health contact annually.

More recently, the National Research Council of the National Academy of Sciences released a major study of HIV and IV drug use, recommending that:

- Drug treatment programs should be made available to all who desire treatment.
- Programs to reach IV drug users who are not in treatment must be expanded and should inform users about how to reduce the risk of acquiring or transmitting HIV through injection practices.
- Data collection systems should be established to monitor and evaluate HIV prevention programs for IV drug users.

Although the National Research Council identified a number of significant obstacles to the design and implementation of effective HIV-related programs for IV drug users, the Council concluded that "opportunities remain to


401/ The Council reports that "[n]one of the current studies on safer injection programs has shown increased IV drug use. Indeed, it appears that safer injection programs may indirectly encourage IV drug users to seek treatment." Id. at 17.
halt the spread of HIV among IV drug users."402/ In addition, the Council observed that sufficient data is currently available to "formulate rational plans for preventive action."403/

The Coordinating Committee shares the Council's perspective. However, the Committee also agrees with the Presidential Commission that "[t]he dangers and costs of drug abuse have taken on a new dimension, a greater horror, because of the relationship between HIV infection and drug use,"404/ and urges that all levels of government take prompt and appropriate public health steps to halt both epidemics.

402/ Id. at 240.
403/ Id. at 240.

-108-
Background

In AIDS: The Legal Issues, the Coordinating Committee noted that standards of admission to the United States for aliens with AIDS or HIV depend upon whether the alien is seeking entry as a permanent resident (immigrant), a temporary visitor (non-immigrant), a refugee, or an applicant for regularized status under the Immigration Reform and Control Act of 1986 (IRCA). The Coordinating Committee’s policy recommendations are directed towards these classes of aliens.

The first policy recommendation addresses those aliens who have become eligible for legalization, or "amnesty," under IRCA by having resided continuously in this country in an unlawful status since January 1982. The second is directed to persons coming to the United States temporarily for a specific purpose: tourism, attending a conference or meeting, studying, or working in a specific job category. The entry of these persons -- non-immigrants -- is controlled by the issuance of visas. The Coordinating Committee’s third and fourth recommendations are directed to persons who enter the United States with the intention of residing here permanently, or until conditions in their home countries change. These persons include refugees and political asylees.

To be admitted into the United States, an alien must not be covered by one or more of the thirty-three excludable categories, as set forth in Section 212 of the Immigration and Nationality Act. One of the classes of aliens excluded is those "who are afflicted with any dangerous contagious disease." In 1987, in legislation sponsored by Senator Helms, Congress made HIV disease a basis for exclusion by adding HIV infection to the list of "dangerous contagious diseases."

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407/ § 212(a)(6).
Under certain conditions and circumstances, an alien who would otherwise be excluded under Section 212 may be granted a waiver by the Attorney General, allowing the alien's admission to the United States. Among those conditions and circumstances are humanitarian reasons (such as the reuniting of families), need for medical treatment in this country, emergencies, and a host of other reasons left largely to the discretion of the Attorney General.

Legalization Applicants

The Coordinating Committee believes that barring legalization applicants with HIV is inconsistent with the purpose of IRCA. Congress, in enacting IRCA, indicated that humanitarian concerns are paramount in order to give lawful status to

...people [who] have been here for a number of years and have become part of their communities. Many have strong family ties here which include U.S. citizens and lawful residents. They have built social networks in this country. They have contributed to this country in myriad ways, including providing their talents, labor and tax dollars.408/

Consistent with that humanitarian intent, HIV status alone should not bar legalization, particularly since virtually all HIV infected legalization applicants acquired the infection in the United States. Moreover, if HIV status did bar legalization, contrary to the public interest, rejected applicants would probably be driven underground with their disease and would continue to live in fear of seeking help from public authorities.

Non-Immigrants

The Coordinating Committee also believes that entry to the United States should not be denied to travelers, students, and other non-immigrant visitors solely on the basis of HIV infection. The Coordinating Committee has reached this conclusion for two reasons. First, such a bar would invite retaliation by other countries. Second, restrictions based on HIV status would be virtually

impossible to enforce, especially in the case of travelers. The Presidential Commission made the following comment on the inefficacy of travel restrictions based on HIV infection:

the Commission concurs with the World Health Organization that the screening of international travelers for HIV infection would require an unjustified, immense diversion of resources from other critical programs of education, protection of the blood supply, and care. At best, border screening programs would only briefly retard the spread of HIV.409/

Refugees and Asylees

With respect to political refugees and asylees seeking to enter the United States, the Coordinating Committee believes that HIV infection alone should not be a bar to permanent residency.410/ This conclusion is particularly compelling because the law has already determined that refugees and political asylees are fleeing their home countries because of well-founded fears of persecution or natural disasters. To return those aliens to their home countries, or to bar them from entering the United States, because of HIV infection alone, is inconsistent with the rationale of our refugee and political asylum laws.

Waiver of Exclusion for Immigrants

Under present law, HIV positive aliens seeking permanent residency visas face absolute exclusion from the United States solely on the basis of their HIV status. Although the Attorney General may "parole" an alien into the United States for emergency reasons "deemed strictly in the


410/ Public Law No. 99-603, 100 Stat. 3359 (1986). H.R. 1280, sponsored by Rep. Barney Frank and 56 other representatives, now pending before the 101st Congress, which would permit the Attorney General, in his or her discretion, to issue a permanent residency visa to an alien who has certain familial relationships with a United States citizen, an alien lawfully admitted for permanent residence, or an alien who has been issued an immigrant visa, notwithstanding the applicant alien's HIV status.
public interest,"411/ such discretionary power is rarely used and can be withdrawn at any time.

The Coordinating Committee believes that absolute exclusion from the United States of HIV positive aliens seeking permanent residency is inappropriate, and that each application should be evaluated on its own merits. For example, a hemophiliac from Iran, who had resided in the United States legally for more than ten years married a U.S. citizen two years ago and recently completed his Ph.D.412/ He applied for permanent residency, but discovered he was HIV positive when he received the INS-required medical exam. The origin of his infection is almost certainly contaminated blood which he received in the United States. At present, he is excludable from the United States, and subject to deportation solely on the basis of his HIV status.

The above case is only one poignant example of aliens who face exclusion or deportation because they are HIV positive.413/ In fact, many such aliens contracted the HIV virus within the borders of the United States, and have extended family or employment here. Often such aliens are also financially secure, ameliorating the concern that immigrants with HIV who enter the United States will drain our medical and social services resources. Allowing the Attorney General the discretion to waive the HIV exclusion in individual cases, would permit aliens with particularly compelling circumstances to enter or remain in the United States.

412/ Communication from the National Hemophiliac Society to the American Bar Association, Coordinating Committee on Immigration Law, Washington, D.C.
413/ For further information, contact the ABA Coordinating Committee on Immigration Law, Washington, D.C.
Background

Virtually every organization that has adopted HIV-related policies has recognized the critical need for all people to be educated about AIDS and HIV infection. In its report, the Presidential Commission stated:

In a national response to an epidemic, there is some information which every citizen should receive regardless of race, sex, age, geographic location, literacy level, or degree of risk for infection. This information sets the tone for more specific education and prevention programs and helps sustain our community effort as a whole.414/

The primary purpose of HIV education is to reduce the risk of transmission. Moreover, successful educational programs will enable individuals and organizations to respond to the epidemic in a rational and compassionate way.415/ Indeed, the Presidential Commission explicitly recognized the link between HIV education and the incidence of legal problems, particularly the discrimination and breaches of confidentiality experienced by people affected by HIV. As the Presidential Commission stated, "Education about transmission of the virus and about the laws banning HIV-related discrimination is insufficient. This results in ignorance, misinformation, acts of discrimination, and, in some persons, an irrational fear of association with those who are HIV-infected."416/

Furthermore, the Coordinating Committee believes that HIV education can significantly reduce HIV-related problems in the workplace, particularly if it takes place before an HIV-related dispute occurs.417/ Community

415/ Testimony of Tom Sheridan, Director of Public Policy, AIDS Action Council, September 23, 1988, at 12, 14.
417/ Testimony of Peter Spanos, March 4, 1988, at 22-24. (Footnote Continued)
education and policy discussions about HIV also have been cited as critical factors in avoiding or defusing litigation over HIV public school admissions.418/

Moreover, a strong ABA policy supporting HIV education for all citizens is consistent with ABA Goal IV,419/ particularly Summary Objective 1, which calls upon the ABA to "[p]rovide factual information to the public to help it understand major legal issues"420/ and Summary Objective 4, which "[s]upport[s] through public education appropriate restraint in legislation, regulation and litigation."421/

Targeted Education Without Government Restrictions

General education of the public about HIV infection must be accompanied by targeted efforts specific to particular populations.422/ The Coordinating Committee, like the Presidential Commission, recognizes that it is behavior, not membership in any particular group or population, that places a person at greater risk for HIV infection. However, the educational response to the epidemic needs to acknowledge the eclectic nature of our society and effectively match the proper

(Footnote Continued)
The Committee also supports targeted HIV education for certain occupations, including health care workers and emergency personnel.

418/ Testimony of Mr. Richard Schaffer, March 4, 1988 at 199-200; see also Testimony of Mr. Labowitz, March 5, 1988, at 314-318; Testimony of Mr. Steinhilber, March 5, 1988, at 362.


420/ Id.

421/ Id.

422/ Report of the Presidential Commission 86 (June 1988); see also AIDS Education: Reaching Populations at Higher Risk, Government Accounting Office (September 1988), ("AIDS Education: Reaching Populations at Higher Risk"), at 19-25; Testimony of Tom Sheridan at 23.
Targeted educational efforts are effective only if a risk reduction message is clearly communicated by a credible source to the intended audience in a language or vocabulary which the audience will understand. The Presidential Commission correctly observed that "[t]he design and implementation of educational programs must have significant input from members of the targeted population so that each program will be relevant, appropriate in language and effectively reach the intended audience." Such targeted, explicit educational programs have successfully reduced transmission in the gay community. However, the continued success of these programs, and the development and implementation of outreach programs for other specific populations has been threatened by legislative efforts to restrict the content of AIDS (HIV) education.

One witness testified before the Coordinating Committee about the "chilling effect" of a congressional amendment to the Fiscal Year 87/88 appropriations bill that restricted explicit AIDS (HIV) education. He observed: "What happened as a result of the Helms amendment was

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424/ Testimony of Tom Sheridan, at 23-24; See also AIDS Education: Reaching Populations at Higher Risk, at 3; See also AIDS Sexual Behavior and Intravenous Drug Use National Research Council 19 (1988).


426/ Fineburg, Education to Prevent AIDS: Prospects and Obstacles, 239 Science 594 (February 5, 1988); see also Testimony of Tom Sheridan, at 9-10.

427/ The "Helms amendment" provided that no AIDS educational materials should "promote or encourage, directly, homosexual sexual activity," and that all such materials and activities would be required to stress abstinence from any sexual activity outside of a monogamous marriage, including abstinence from all homosexual activity. This language was ultimately rejected by Congress and an alternative amendment prohibiting the use of federal funds for materials and activities that are designed to promote or encourage (Footnote Continued)
that a number of AIDS educators everywhere, from people that were educating children to people who were educating dis­abled people to people who were educating in the gay commu­nity, all found themselves [faced] with basically a chilling effect coming down from the United States Senate. The witness further testified that "[s]uddenly we found that places like San Francisco AIDS Foundation who had been doing a tremendous AIDS education campaign [suddenly] were not getting grants to do public education." Moreover, in its recent report, Confronting AIDS - Update 1988, the National Academy of Sciences also concluded that restrictions on AIDS-related educational messages, such as the Helms amendment, are counter-productive to efforts to protect public health. The Surgeon General also has been an outspoken proponent of appropriately explicit HIV education and information as a primary tool for halting the spread of a virus for which there is no cure or vaccine.

Finally, the Coordinating Committee believes that, in addition to providing basic information about transmis­sion, HIV educational messages should encourage responsible individual behavior. Preventing the spread of HIV is primarily dependent on individual behavior, and individuals whose actions risk transmission must take responsibility for changing that behavior. In this respect, the Coordinating Committee agrees with the Presidential Commission that "[all] HIV programs should emphasize personal responsibility for one's actions."

(Footnote Continued)

homosexual or heterosexual sexual activity was accepted. Section 514 of the FY 1988 Labor, Health and Human Services Appropriation bill, P.L. 100-202.

428/ Testimony of Tom Sheridan, at 4-5.

429/ Id. at 10.


CONCLUSION

The Coordinating Committee, which was established by the Board of Governors in 1987 to guide and coordinate the development of ABA policy on AIDS, urges the House of Delegates to adopt this carefully crafted and coordinated package of policy recommendations. The Coordinating Committee’s intensive study of the issues discussed in this report has convinced us that the problems are large and the need for action is great. To meet the challenge that faces our society, the public and private sectors must work together. To that end, the leadership of each profession is called upon to contribute its share. As lawyers, we are trained to think clearly and act decisively, no matter how vexing or nettlesome the problem may be. We have much to contribute, and much is therefore asked of us. As Justice Frankfurter has reminded us, "The bar has not enjoyed prerogatives; it has been entrusted with anxious responsibilities."433/ We must confront and discharge those "anxious responsibilities" in our times, as our predecessors at the bar have done for centuries. It is time for the legal profession to bring its leadership and expertise to bear upon the HIV crisis. The challenge that circumstances have thrust upon us will not be met if all we can say is that "The law hath not been dead, though it hath slept."434/

Respectfully submitted,

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Chairperson
Litigation Section

Christopher L. Griffin
Chairperson
Young Lawyers Division

Andrew C. Hecker, Jr.
Chairperson
Tort and Insurance Practice Section


434/ W. Shakespeare, Measure for Measure, act II, sc. 20.
Clifford D. Stromberg
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Barry Sullivan
Chairperson
AIDS Coordinating Committee

David B. Wexler
Chairperson
Commission on the Mentally Disabled

August 1989
GENERAL INFORMATION FORM

No. __________________________

Submitting Entities: Litigation Section, Young Lawyers Division, Tort and Insurance Practice Section, Section of Individual Rights and Responsibilities, Commission on the Mentally Disabled

Submitted By: Clifford D. Stromberg, Chairperson, Section of Individual Rights and Responsibilities

1. **Summary of Recommendation(s).**


2. **Approval by Submitting Entity.**

This package of recommendations was approved by the Commission on the Mentally Disabled at its April 27-28, 1989 meeting, the Litigation Section on April 27, 1989, the Section of Individual Rights and Responsibilities at its Council meeting on May 12-13, 1989, the Tort and Insurance Practice Section at its Council meeting on May 13-14, 1989, and the Young Lawyers Division at its meeting on April 27, 1989.

3. **Previous submission to the House or relevant Association position.**

The Association adopted related recommendations pertaining to voluntary HIV testing and counseling, confidentiality and non-discrimination at its February 1988 Mid-Year Meeting, and recommendations concerning criminal law and the administration of justice at its February 1989 Mid-Year Meeting.

4. **Need for Action at This Meeting.**

This package of recommendations was developed by the ABA AIDS Coordinating Committee which has analyzed the impact of the HIV epidemic on the law for over a year and a half. The Coordinating Committee represents thirteen ABA entities and
two outside organizations and is charged by the Board of Governors with developing a comprehensive set of AIDS-related policy recommendations. In 1988 the Committee published AIDS: the Legal Issues, a discussion document that analyzed fifteen areas of the law affected by HIV. This package of recommendations evolved from that analysis and reflects hours of testimony gathered in a series of hearings, intensive research, and multi-disciplinary collaboration.

The HIV epidemic, which has claimed the lives of 54,402 Americans since 1981, has significantly affected virtually every major institution in this country, including the legal system. Although the Association has adopted policy in some important areas, many significant legal issues have not been addressed by the nation’s lawyers and judges. The Coordinating Committee has concluded that the ABA must join the many professional organizations which have stepped forward to help educate their members and the public about HIV.

5. Status of Legislation. (If applicable.)
None.

6. Cost to the Association. (Both direct and indirect costs.)
None.

7. Disclosure of Interest. (If applicable.)
N/A

8. Referrals.
The Forum Committee on Health Law has reviewed and approved the Coordinating Committee’s recommendations pertaining to health care (i.e., Access to the Legal System and the Administration of Justice, Confidentiality, Public Health Law, Access to Health Care, Testing and Counseling, Insurance, Educating the Public).

9. Contact Person. (Prior to meeting.)
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10. **Contact Person.** (Who will present the report to the House.)

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