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## Symposium:

AIDS: AT THE LIMITS OF THE LAW

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### INTRODUCTION

AIDS is a tragedy of epic proportions. It is a tragedy first and foremost for those who contract it and must suffer its agonies and the early and excruciating death that it inevitably brings. It is a tragedy for those who test positive for the AIDS virus and who must live in terrible suspense. It is a tragedy for those who must watch helplessly as AIDS destroys the lives of their friends, family and loved ones.

But AIDS is much more than a personal tragedy for those who are immediately exposed to the disease. AIDS is a tragedy for those who must suffer discrimination, whether they have the disease or are merely perceived by others as being at risk of contracting it. AIDS threatens our society as it responds to the disease with hatred and discrimination fueled by ignorant fear and bigotry. It is tragic when police refuse to touch an injured victim of a mugging because of a fear that the victim might have AIDS; when parents withdraw their children from school based on a rumor about a child with AIDS; when landlords refuse to rent to a couple, both of whom happen to be male, simply because the landlords feel they might be gay and in a high-risk group; when employers fire or refuse to hire; when doctors refuse to treat; or when priests refuse to counsel. The examples are legion and nationwide and evidence an even more insidious disease than AIDS itself—the irrational fear of persons with AIDS or persons perceived to be at risk of contracting the disease. Because this fear eats away the underpinnings of our whole society, it potentially

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has an even greater impact than the actual disease itself. One example of how this irrational fear has manifested itself is in calls by legislators, health care providers and the general public for wholesale involuntary testing for the human immunodeficiency virus (HIV), which causes AIDS, with the implication that some penalty or other stigma would attach to those who tested positive. Another example is the deplorable increase in discrimination against homosexual persons. Such responses are contrary to modern notions of privacy, informed consent, individual autonomy and equality—values which our society exalts.

Thus, AIDS tests our commitment to these and other principles. Litigants and others are testing the limits of existing law as they urge courts to apply it in new contexts, and as they press legislators for additional law to deal with situations previously unenvisioned. Our society confronts extraordinary issues when it confronts AIDS; hopefully, it will do so creditably, with honor and compassion.

The articles in this Symposium issue address some of the ways in which AIDS tests existing law and creates the need for new law or changes in the old. The availability of experimental drugs is one area where AIDS tempts governmental agencies to abandon existing requirements that drugs be safe and effective before they are made available to the public. But when dealing with a disease that is inevitably fatal, do existing safeguards and policies make any sense, or should we move beyond their limits to a theory of complete access to unproven drugs?

Another dilemma arises from the health care needs of AIDS patients. What are the legal and ethical obligations of health care professionals when confronted by a disease, like AIDS, which is contagious, incurable and fatal? The need to explore the intersection of applicable ethical codes, professional responsibility and discrimination law puts this issue at the limits of prior thought.

Mandatory testing for exposure to the AIDS virus tests our commitment to privacy and pushes at the uncertain boundaries of this fundamental right. If mandatory, nonconsensual testing is adopted, it will constitute an erosion of existing individual rights and autonomy.

Concerns of confidentiality loom large when AIDS is at issue. Disclosure statutes threaten both the doctor-patient relationship and the effort to curtail the spread of AIDS. Individual and public needs must be balanced, but before this balancing can take place

the competing risks and benefits of certain courses of action must be ascertained.

Likewise, AIDS challenges existing discrimination law as litigants urge courts to develop new law, expand existing law to fit new situations, and recognize that new and unsavory forms of bigotry require both a judicial and a human response. Are we willing to pursue our societal goal of equality by expanding discrimination law to cover newly exposed biases?

Finally, AIDS tests notions of judicial decision making in the public health context. AIDS has elicited a panic-stricken response from legislators who have lost sight of the need for scientific decision making. Should courts abandon the rhetoric of deference—which has arguably never been anything but a veneer—and go behind public health decisions to analyze scientific data and to test the rationality of the decisions, invalidating those decisions which fail to make scientific sense? These are among the topics and questions considered in this Symposium.

In his article, Professor Annas focuses on the “death-denying” nature of our society and its concomitant belief—shared by the scientists themselves—that science will develop a technological fix that will magically “make the AIDS epidemic go away.” This has led to a blurring of the distinction between experimental and therapeutic AIDS drugs, and has caused confusion about the role of the Food and Drug Administration (FDA). The FDA was designed to protect consumers; in the case of AIDS patients, its role has become that of a supplier of insufficiently tested drugs to the patient population. Compelling humanitarian arguments have been allowed to eradicate many of the protections formerly offered by the FDA against untested and unproven drugs. Professor Annas argues that this is a mistake, and that compassion should not blind us to the need for adequate drug testing to protect those who, with the disease, are most at risk from quackery and false hope.

Professor Annas points out that what scientists regard as experimental, AIDS patients regard as therapeutic. The very fact that AIDS is a fatal disease makes the “rules regarding research seem less relevant.” The rules requiring that a patient give informed consent to treatment seem silly in a context where patients are pleading to be subjects of experiments. But it is just this concatenation of circumstances that persuades Professor Annas that the protections afforded by the FDA must be maintained. AIDS tests our commitment to those protections. It is in the face

of persons who could be easily exploited that these protections attain most of their importance. Desperate persons with AIDS need as much protection from unscrupulous experimenters and profit seekers as they do from the disease itself.

Professor Annas' position depends on the ability to draw a bright line between experimentation and treatment. He argues that the trials designed to test AIDS drugs are trials and not treatment protocols, and that the perception of the gay community that such trials are therapeutic is erroneous. He notes that the Reagan and Bush administrations and the drug companies themselves are enthusiastically endorsing this perception—an endorsement based on their commitment not to health, but rather to deregulation (in the case of Reagan and Bush) and reducing the burden of testing with a view to increasing profits (in the case of drug companies). Implicit in Professor Annas' analysis is the argument that such endorsements should make one suspicious of the position being advocated.

AIDS drugs do not present the first challenge to FDA regulations. Laetrile, in the 1970s, gave rise to some of the same issues raised by AIDS drugs now. In connection with laetrile, the United States Supreme Court adopted the FDA position that the safety and efficacy criteria of FDA testing applied even to drugs for the terminally ill. However, since 1979 the FDA position seems to have changed. Professor Annas instances the willingness of the FDA to approve the use of temporary artificial hearts in emergencies, despite the absence of reliable scientific information on their efficacy and safety. Furthermore, in 1987 the FDA changed its regulations to allow therapeutic use of drugs which have not yet passed the FDA criteria where, among other regulatory criteria, the diseases they are supposed to combat are fatal and where no alternatives exist. The FDA has also changed its policy to permit individuals to import drugs from abroad for their own personal use. Professor Annas introduces ample evidence to demonstrate that this change in policy is based presumably on the inferential ground rejected in the laetrile case: that where the patient is going to die anyway, some of the FDA requirements stop making sense, a sort of "what does the patient have to lose?" theory.

Unfortunately, the changes in FDA policy have opened the door to those who would prey on the desperate for their own profit. Professor Annas provides numerous examples of injury to individuals and to groups resulting from the use of untested

drugs and from the ungoverned and false hope to which they have given rise. The injuries range from the toxic effects of untested drugs on individuals to the inability of manufacturers to perform any reliable tests at all once the demand for the untested drug has arisen. Who, faced with a choice, would choose the uncertainty of a drug trial if offered the (false) hope of a widely hyped “cure”?

Professor Annas then focuses on the question of whether research rules should be changed when the disease is fatal. In other words, does the fact that the disease is fatal change the need for or value of randomized clinical trials? Professor Annas would answer this question in the negative. Drug manufacturers have the sale of their products as their goal, and consumers require protection against manufacturer enthusiasm. Thus far, with the exception of allowing the importing of completely untested substances for the treatment of AIDS, the FDA has adhered to its mandate: its rule revisions in response to AIDS have primarily been designed to speed the testing process, but have made no dent in the requirements that safety and efficacy be shown. It is these requirements that Professor Annas argues should remain in place and be fully enforced. AIDS should not cause us to lose sight of the need for consumer protection and controls over those who would use the epidemic to their own financial or political advantage. Dying persons are entitled to have their humanity respected; Professor Annas contends that eviscerating the FDA standards would reflect the horrific idea that dying persons have somehow lost their status as human beings. This idea has particular appeal for those who discriminate against the primary AIDS risk groups and for those who feel that death from AIDS represents some form of divine retribution. It is an idea that can only be sent to its own, deserved death if we accord all persons with fatal diseases their full status as human beings.

AIDS is at the limits of the law which governs the health care professions—both the laws set by the professions to govern themselves and the laws set by the courts and legislatures to govern the administration of health care. AIDS, because it is such a frightening disease and because it is contagious, challenges the health care professional’s commitment to provide care.

In his article, Dr. Forrester raises AIDS issues of particular concern to health care professionals. These issues, of necessity, have an impact upon the patients they treat.

From the point of view of an AIDS patient—or a patient who,

for discriminatory or other reasons, is perceived as possibly having AIDS—the availability of adequate health care is critical. While health care professionals want to provide care, concerns for their personal health may interfere with this care giving ideal. Given the nature of their work, health care professionals must accept some risk of exposure to contagious disease, but AIDS is exceptional. Furthermore, although one would hope that health care professionals are too medically well-educated to fall victim to irrational prejudice, it is likely that some at least will be ensnared by the terror that AIDS has inspired and the discrimination AIDS has fostered.

For health care professionals, the risk of contracting AIDS on the job, although minuscule where preventive techniques are competently used, may be perceived as an occupational hazard. This implicates the ethics of the affected professions. Just as lawyers have ethical obligations not to turn away clients for inappropriate reasons—including unpopularity of the client or cause—so also do health care professionals have obligations not to refuse to treat patients. Dr. Forrester discusses these obligations and concludes that prejudice is never a valid reason for withholding health care and that the ethical obligation to care for patients outweighs “some degree of risk” to the professional. Prejudice not only violates accepted canons of human behavior, it also violates the ethical code of the health care professional.

Health care professionals share another set of issues with attorneys in addition to the obligations to treat/represent all persons, and that is patient/client competence. Dr. Forrester points out that AIDS can (and often does) affect the ability of persons with AIDS to make decisions about themselves. Persons with AIDS face vital and difficult decisions concerning their lives, treatment preferences and deaths. Health care professionals and lawyers must be sensitive first and foremost to their patients'/clients' needs, but also must keep abreast of developments in the fledgling field of right-to-die and informed consent law.

Professor Furrow's article deals with the relationship among mandatory testing for HIV positivity, the rights of the persons being tested and the needs of health care professionals for protection from exposure to the disease. Health care professionals have demanded that all persons admitted to hospitals be tested upon admission as a standard practice or that any person be tested if a health care worker suspects that he or she might test positive for HIV. These tests would be performed without patient consent.

Today mandatory, nonconsensual HIV testing is performed apparently with the approval of the American Medical Association and the federal government. Professor Furrow argues that routine nonconsensual testing will not protect health care workers and is "neither legally nor morally defensible."

Professor Furrow first focuses on the risks to patients from mandatory testing. The risks, which are numerous, include disclosure of a positive result and its concomitant effects such as discrimination, prejudice and violence. The stigma alone attached to a person who tests positive is an enormous risk of mandatory testing, given the sizable possibility that the result will be disclosed. Thus, there are substantial risks weighing against mandatory testing.

Professor Furrow then examines the actual risk that a health care worker will contract AIDS. Statistics demonstrate that the actual risk that a health worker will contract the disease in the course of employment is extremely small. This already minor risk can be decreased by following proper procedures for handling needles, modifying equipment and using greater care in observing the universal anti-contagion procedures recommended by the Centers for Disease Control. Moreover, given the uncertainty of testing and the fact that a person may not test positive until some time after exposure, knowledge that a person has tested negative is simply not that helpful. Furthermore, uncertainty about the validity of a negative test result should lead to the maintenance of appropriate precautions in any event.

Professor Furrow then turns to a third set of risks: the risk from technology. The tests themselves have their weaknesses, in that they yield false positive and false negative results. Laboratories have their weaknesses in terms of competence and experience with AIDS tests. Health care professionals also suffer from a weakness in that the informational value of a test result in the hands of one poorly educated about the meaning of the result is minimal. In any event, contagion is avoidable by use of proper precautions, casting further doubt on the value of possessing test results.

Professor Furrow concludes that the risks to patients from mandatory testing outweigh the risks to health care workers generated by an absence of such testing. Thus, the balance weighs against mandatory testing. Only a compelling interest would be sufficient to limit the right to consent. Those who would abrogate it bear a heavy burden of proof.



Several legal principles support Professor Furrow's argument that only a compelling interest—which does not exist given the facts about AIDS—could warrant limiting the right of informed consent. The informed consent doctrine itself, designed to protect individual autonomy, would require a much stronger case than advocates of mandatory testing, which by definition requires no consent, can make before a patient's right to consent could be abrogated.

The right to privacy is likewise jeopardized given the risks of disclosure. The right to privacy is close to a constitutional right; health care professionals cannot claim any right to know the HIV status of their patients, particularly in light of the questionable value of such knowledge. There can thus be no basis for requiring that the right to privacy be subordinated to the claims of health care workers.

Professor Furrow then turns to an explicit balancing of the arguments he has developed. On the patients' side, the rights to informed consent and privacy weigh heavily. Furthermore, under the Constitution, mandatory testing might trigger both privacy and fourth amendment concerns where the testing institution is related to the government. In the private law arena, nonconsensual testing might trigger tort liability under negligence theories (*e.g.*, violation of informed consent rights, failure to test competently, failure to provide adequate counseling, failure to diagnose, failure to warn third parties). On the health care workers' side, the questionable value of test results and the availability of effective contagion control measures cannot outweigh the rights held by the patients.

A health care institution has obligations to its patients as well as to its staff. Mandatory testing violates the rights of patients while it provides little protection for health care employees. Professor Furrow argues that an institution can better fulfill its duties to both of its constituencies by employing alternative means of protecting health care workers which do not implicate patients' rights. The hospital can rotate staff to minimize risk to which any one employee is exposed. The hospital can ensure that its employees take appropriate precautions, in compliance with its obligation to provide a safe workplace. The hospital can educate its staff and reassure its workers that in the rare event that an employee is infected by the virus, employees' benefits will be generous.

Professor Furrow concludes by offering a principle to guide

courts and legislatures: "No HIV test should be ordered until physicians understand the appropriate use of and potential adverse consequences of the HIV-antibody tests, have provided complete counseling to their patients, and have obtained the patient's written informed consent to the test." This principle strikes a balance among all of the competing concerns, a balance that would effectuate as many rights and interests as possible.

Professor Turkington's article deals with the confidentiality concerns created by various governmental responses to AIDS. The article first examines confidentiality in the context of health care generally and then turns to AIDS specifically.

Confidentiality of health care information generally is based on two principles. One is the perception that confidentiality is necessary to the exchange of information within the doctor-patient relationship. The other is the right to privacy, the protection of which is a goal in itself. However, neither basis for confidentiality is an absolute; there are times when confidentiality must yield to other governmental and private interests. The fact that so many jurisdictions are enacting AIDS legislation requires an evaluation of the extent to which the confidentiality of AIDS-related information must remain inviolate.

Professor Turkington proposes an analytical framework for determining what confidentiality policies should be when AIDS-related information is at issue. He suggests that there are three sets of factors which should determine the required scope of confidentiality in any case involving health care information: first, the loss of privacy and the consequences if there is disclosure (the privacy concern); second, the threat to the doctor-patient relationship if there is disclosure (the medical concern); and third, the need for disclosure and the nature of the public and private interests which will be served by disclosure (the public concern).

Professor Turkington then examines AIDS issues in light of these three factors. With respect to the privacy concern, AIDS information is particularly sensitive on two counts: it is highly intimate information, and its disclosure may result in significant harm to the individual in the form of discrimination and social stigma. While a breach of the right of privacy may have little or no impact on the individual involved where the information is neither particularly intimate nor particularly threatening, a breach of privacy assumes an enormously threatening aspect where—as in the AIDS context—the information is both intimate and likely to produce a negative reaction in those who obtain it.

With respect to the medical concern, confidentiality is vital in protecting the diagnosis and treatment of any patient, but is particularly crucial when one is dealing with a disease like AIDS. There are two reasons for this. The first is that communication between doctor and patient in the AIDS context is vital, both as part of treatment and as part of the need to reduce the spread of the virus. The second is that a patient in the AIDS context will have an expectation of and concern for privacy. In other words, where the information is as sensitive as AIDS information is, even a small threat to confidentiality will lead to a drastic reduction in the information a patient is willing to share with his or her doctor.

With respect to the public concern, the public interest likewise supports a high level of protection of the confidentiality of AIDS-related information. Individuals concerned about confidentiality are unlikely to be willing to submit themselves to voluntary testing. Thus, asymptomatic individuals will be less likely to find out that they are HIV-positive, and will therefore be unable to take the precautions necessary to avoid further spreading the virus.

The arguments in favor of the confidentiality of health care information are weakest when disclosure will protect life. For example, physicians are required to disclose certain kinds of information, like syphilis and child abuse, to health departments. Professor Turkington thus turns to the question of whether AIDS-related information should be placed in the same category.

One question that must be answered before placing AIDS-related information in this category is whether doing so will benefit anyone sufficiently to justify the breach of confidentiality. Professor Turkington details the facts about the transmission of the AIDS virus and concludes that AIDS is simply not that contagious. Statutes requiring disclosure serve not to prevent the spread of the virus, but rather to protect the peace of mind of persons concerned about the possibility of exposure. Peace of mind has not, in the past, been an acceptable basis for breaching confidentiality.

Professor Turkington then applies the analytical model he developed to several specific confidentiality questions and to statutes that have been enacted in response to the AIDS epidemic. He argues that three basic policies are supported by his analytical model: "(1) that testing not occur without the informed consent of the subject; (2) that the subjects have the right to release testing information to whomever they choose; and (3) that the release

be contained in a written document specifically limiting the extent of disclosure and specifically precluding further disclosure.” Justifiable exceptions to these policies are extremely rare. In many situations, such as tort negligence litigation, disclosure can be sharply limited to serve the societal interest in having the information while still preserving the privacy rights of the HIV-infected person.

What about notification by the medical professional to known sexual partners of the HIV-infected person? A statutory requirement of such notification may do more harm than good. Such a requirement may lead to a greater reluctance to be tested or to provide accurate information about sexual partners. Furthermore, the infected individual is in a better position to inform the third party of his or her status. Requiring the doctor to do so may be tantamount to requiring the doctor to find out who the third parties are—a police activity ill-suited to the doctor-patient relationship, and one which may be virtually impossible for doctors to perform.

Professor Turkington concludes by finding most defensible those statutes which state that health care professionals should have limited discretion to disclose HIV information where the infected person has the opportunity to notify a contact who is at risk but the health care professional believes he or she will not do so. This disclosure should be made only to persons currently at high risk and should be accompanied by counseling. The risks of any broad abrogation of confidentiality simply do not outweigh the benefits.

Ms. Dunlap’s article focuses on discrimination and AIDS. Fear of AIDS has been transformed into fear of persons with AIDS. This fear has also metamorphosed perniciously into fear of and discrimination against persons who are perceived as being in so-called high-risk groups. Because the highest percentages of cases come from groups against whom there is a history of bias, AIDS has led to an increase in prejudice. This bigotry is all the more difficult to combat because it is already entrenched.

It is rational to be afraid of AIDS; it is irrational—and reprehensible—to be afraid of people with AIDS or biased against those who are perceived to be at risk of contracting the disease. Ms. Dunlap’s article focuses on this irrational fear and its impact on society’s ability to deal responsibly with AIDS as a disease.

Another focus of the article is the all too unattractive light the AIDS crisis casts on our society and its institutions. The true

test of any society comes in time of crisis, not in tranquility. Our commitment to free speech can only be tested when we are confronted by someone we would rather not hear. Judged by this standard, our society has not done itself much credit in its response to the AIDS crisis. For the most part the response to AIDS has not been sympathy for the victims; rather, it has been intolerant and prejudiced revulsion. This in turn has become a more generalized bigotry against anyone who is perceived as being at risk. This attitude manifests itself in anti-gay violence, refusals to treat or protect gay persons from discrimination and violence, and exclusions of HIV-positive children from school. The victims of AIDS are not treated with the sympathy with which victims of a fatal disease are usually regarded: they are blamed.

Not all reactions to AIDS have cast a negative light on our society, however. Ms. Dunlap points to the AIDS Memorial Quilt as the reification of efforts to combat the disease, to cooperate, to work together to protect and care for all persons affected by the disease and suffering from its effects, including discrimination.

AIDS presents our society with a choice, a choice that will test our society's commitment to fairness and equality. Is the disease going to be an excuse for bias or is it going to lead to an increased exposure of—and concomitant desire to eliminate—bigotry? Will our legal system fail the AIDS test by perpetuating discrimination, or will our legal system work toward eradicating the long-standing discrimination AIDS has exposed? So far, our government's response has been mixed, ranging from clear homophobia in the United States Senate to extending the protections of section 504 of the Rehabilitation Act<sup>1</sup> to HIV-positive persons. The courts' responses have likewise been mixed, ranging from complete failure to protect against HIV-related discrimination to the inclusion of HIV-positive persons within the protective mantle of laws prohibiting discrimination against the handicapped.

Our Constitution and our societal commitment to equality are meaningless if they are allowed to fall by the wayside when tested by challenges such as the one AIDS presents. They are only as strong as our collective commitment to uphold the principles upon which they rest, and our commitment is only as strong as our willingness to adhere to it when it is challenged.

The final article in the Symposium focuses on the impact of

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1. Rehabilitation Act of 1973, 29 U.S.C.A. § 794 (West 1985 & Supp. 1989).

AIDS on public health law. There are three basic models for the standard of review applied in court attacks on public health decisions: deferential, scientific and hybrid. Under the deferential model, the courts apply a standard of complete deference to public health decisions as manifestations of state police power un-touchable by the courts. Under the scientific model, the courts rigorously analyze and test the public health decision for its scientific validity. Under the hybrid model, while they may repeat the deferential rhetoric of the police power cases, the courts in fact examine the public health decision being challenged to see whether it makes medical sense. This last approach has a long history in Supreme Court decision making, and may be further fueled by the antidiscrimination mandate given to the courts under the Rehabilitation Act.

After examining these models in detail, Mr. Burriss examines the actual approaches taken by the courts to public health case review. Public health decision making is a product of science, and public health decisions should have an identifiable basis in medical fact. But public health decisions are also the end product of what is first and foremost a political process, in which choices are made based not on medicine but on politics. One of the hazards of such a process lies in the danger that the political response to a public health crisis may embody an ignorant hysteria. A completely deferential approach by the courts runs the risk of tolerating such hysteria.

It becomes clear in Mr. Burriss' analysis of several actual cases that the courts are unwilling to be so deferential as to allow the public health decision maker to indulge in an unscientific (albeit politically popular) response to a particular public health issue. He first details the approach taken in two modern cases, *School Board of Nassau County v. Arline*<sup>2</sup> and *Glover v. Eastern Nebraska Community Office of Retardation*.<sup>3</sup> In *Arline*, which involved the Rehabilitation Act, the approach comes close to the pure scientific model, requiring a scientific basis for public health decisions. This standard is arguably mandated by the Rehabilitation Act. In *Glover*, which involved the fourth amendment in a case involving blood testing, the court applied a similarly rigorous medical/factual standard for evaluating the state's action—this time by choice, because the fourth amendment reasonableness criterion does not itself require the adoption of a scientific measure.

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2. 480 U.S. 273 (1987).

3. 686 F. Supp. 243 (D. Neb. 1988), *aff'd*, 867 F.2d 461 (8th Cir. 1989).

*Arline* and *Glover* each employed a standard of review other than the constitutional rational relationship test. However, even under the rational relationship test, the deference paid by the courts to the public health decision may be more rhetorical than real. Mr. Burris convincingly demonstrates the truth of this hypothesis in his analysis of two cases, *Jacobson v. Massachusetts*<sup>4</sup> and *City of New York v. New Saint Mark's Baths*.<sup>5</sup> The *Jacobson* Court used all of the rhetoric of deference to the state police power. But was the Court as deferential as its rhetoric would suggest? It was not. Indeed, one of the reasons given by the Court for its decision upholding the state's action was the overwhelming scientific support for vaccination. If the Court had been applying a completely deferential standard, there would have been no need for it to consider the medical reasonableness of the public health decision before it. In short, in *Jacobson* the Court limited the state's political exercise of its public health power to those decisions which are medically justifiable.

Even though *Lochner*<sup>6</sup> is dead, the standards utilized in *Jacobson* are not, as is demonstrated in the *St. Mark's* decision. Again, as in *Jacobson*, the court used the rhetoric of total deference. Also as in *Jacobson*, however, the court closely scrutinized the scientific evidence—a scrutiny which would have been unnecessary under a truly deferential approach.

The standard of review that emerges from the cases discussed by Mr. Burris is far from deferential. Moreover, Mr. Burris points out, this standard has virtually received the Supreme Court's imprimatur in footnote 15 of the *Arline* opinion "with its suggestion that there is no conflict between statutory and constitutional review of health cases." It is this footnote that may set the tone for court analysis of public health AIDS decisions in the future.

Mr. Burris then develops a hypothetical AIDS case and analyzes it under footnote 15 of the *Arline* opinion. His analysis makes clear the import of that footnote: that the traditionally deferential rational basis test should embody the same goal of preventing irrational and discriminatory public health decisions as the Rehabilitation Act. There is no explanation for the footnote other than the official recognition of a requirement of medical rationality—a medical rational basis test. Arguably, this test

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4. 197 U.S. 11 (1905).

5. 130 Misc. 2d 911, 497 N.Y.S.2d 979 (Sup. Ct. 1986).

6. *Lochner v. New York*, 198 U.S. 45 (1905).

has existed all along, as Mr. Burris demonstrated in the earlier part of his article. What is new is its official recognition.

In the final portion of his article, Mr. Burris describes the actual content of the medical rational basis test. The public health decision must be medically justified and justifiable. The reasons given for the decision must themselves be reasonable; it is not enough that they exist. This does not, of course, give the courts a license to choose and enforce the choice most attractive to them. The only guarantee is that the public health decision must be based in medical and scientific fact. This guarantee has immense power and significance, however, given the societal panic in the face of the AIDS virus.



