HIV And The Law {Cover Title: HIV Law: Coercion, Protection and Empowerment}

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Introduction

HIV is a fatal virus. The only way of ensuring that one does not die from AIDS or related conditions is to prevent infection in the first place. The only way of limiting the toll on society of an HIV epidemic is to secure mass behaviour change. As one of a number of methods of influencing behaviour, law can contribute to this change. The problem is to know how best to use the law.

The current legislation can be classified according to three models (Hamblin, 1991). The first model emphasises coercion and criminalisation. Its premise is that the interests of public health require the sacrifice of the rights of those who have contracted the virus. Prevention takes the form of proscribing certain behaviour by which HIV positive people might infect HIV negative people. The second model uses law in a protective manner. People Living with HIV/AIDS (PLWHAs) are entitled to the full protection of the law except where their infection puts others at risk of infection. The third model employs law to empower people infected with HIV or at risk of infection. Laws may assist in empowering affected people, though other methods of empowerment are equally important. Particular laws may fit one model or another. Within an entire legal system it is common to find examples of all three.

This paper examines the history of epidemics of infectious disease to show why legislatures in previous epidemics have preferred the first model. It then reviews HIV law in Australia and other Western countries to show why the second model has been adopted. As for the third model, Australian HIV law conforms to it more than most countries but even in Australia there are many gaps. As a case study of how legislation of the third model can work, there is a survey of confidentiality law in New South Wales. Finally, since the legislative model of empowerment is supposed to work in conjunction with non-legal measures, there is an analysis of the relationship between PLWHAs and medical practitioners.

The History Of Legislative Approaches To Infectious Epidemics

Allan Brandt has compared the HIV epidemic to earlier epidemics, especially syphilis in the early twentieth century in the United States (Brandt, 1988; see also Legal
Working Party Inter-Governmental Committee on AIDS, 1991, pp.10-15). The common features of HIV and syphilis are that both are sexually transmissible, without vaccines, very difficult or impossible to treat, with severe or fatal consequences. For syphilis, doctors believed that modes of transmission were pens, toothbrushes, towels and bedding and medical procedures. We now know that syphilis is not transmitted by any of the means mentioned, yet the belief that it was justified massive incursions into the lives of the populous. On the level of the trivial and ridiculous, the US Navy removed the doorknobs from its battleships during World War I on the grounds that they were a major source of infection of many of its sailors.

Theories of casual transmission are indicative of broad social values in the Victorian English speaking world. Hygiene and purity of body and soul were highly prized. Sexuality was to be expressed only in monogamous relationships sanctified by marriage. Behind these norms were fears about teeming urban masses, the growth of cities and the changing nature of families. These norms and fears conditioned the responses to the new perils of syphilis.

Brandt cites as a lesson from syphilis that "compulsory public health measures will not control the epidemic" (p.369). The examples he provides ring familiarly. During the syphilis epidemic, virtually all states of America enacted legislation requiring pre-marital serologies. The rationale was that as syphilis was treatable, intending spouses could test, treat if necessary and so ensure each other's safety and the safety of their children. In practice, premarital serology tests made little difference to the epidemic. By 1978, only 1.27 per cent of all positive tests came from pre-marital serologies, as the sample population had a very low incidence of infection. Another statistical consequence of low incidence and a large test sample was that a quarter of those who tested positive probably were false positives, undergoing highly toxic treatment regimes and subject to discrimination and ostracism. Finally, the cost of testing by 1978 was $80 million annually, or $240,000 for each positive result.

This is an example of a small, though costly, encroachment on the rights of the many. Another measure exemplifies a huge encroachment applied quite more specifically. During World War I, as mass hysteria peaked, Congress provided for the quarantine of anyone suspected of being infected and spreading syphilis until they were proven non-infectious. Under the Act, 20,000 prostitutes were involuntarily incarcerated during World War I. This Act had no visible effect on the epidemic, whose rates of infection actually climbed during the War. The decision to quarantine was made with public health in mind, but with little regard
to any rights of prostitutes, whom the legislature clearly regarded as a "disposable constituency" (Watney, 1987, p.137).

Australia has its own history of epidemics. Peter Curson's Times of Crisis (1985) scans the history of six epidemics in Sydney, starting with smallpox in 1789 and finishing with bubonic plague which began in 1900. Similar themes run throughout: public hysteria incited by rumour and unsubstantiated media reports, quarantine, the prospect of compulsory vaccinations and scapegoating of already marginalised minorities, in particular the Chinese.

The history of legislation responding to epidemics establishes a pattern of criminalisation and proscription. The rights of individuals infected or perceived to be at risk of infection are extinguished if they conceivably threaten the interests of the uninfected majority. When this legislative policy has been challenged in the United States, the courts have always upheld the interests of public health. In _Ex parte Company_, 139 NE 2d 204 (Ohio 1922) the court affirmed the state's authority to quarantine prostitutes who tested positive for syphilis and gonorrhoea. Similarly, in _Ex parte Johnston_, 190 P. 644 (Cal Dist Ct App 1919) women were held validly quarantined for testing positive for gonococcus infection. (Parmet, 1985).

**Model 1: Criminalisation And Coercion**

The potential for coercion in this history of legislation for epidemics was amplified in the case of HIV because most of those it struck identified themselves as members of already stigmatised groups, that is, gay men and injecting drug users. At the advent of the epidemic, many activities associated with these groups were criminal. We now know that transmission depends on risk activities rather than the fact of membership of any "at risk group" (an inaccurate term which is still often used). This potential for coercion – born out of the history of epidemic legislation and the pre-epidemic social status of the most commonly affected groups – has been realised in many countries. The most coercive approach has been taken in Cuba, where there is mandatory quarantine upon infection, (Bayer and Healton, 1989), despite condemnation by World Health Assembly resolutions (Kirby, 1992). Common features of many Asian and Pacific countries' legislative approaches are actively enforced crimes of prostitution, drug use and vagrancy laws (Papers of the HIV Legal Network in Asia and the Pacific Conference, March 1993). Many countries authorise non-voluntary testing of persons suspected of being HIV positive, which in practice means testing of members of 'at risk' groups. Confidentiality may be legislatively protected but in practice is often breached
Testing may also be a pre-requisite of employment, with the offer of a job withheld if the applicant tests positive.

**Model 2: Protection**

By this time in most liberal Western democratic nations, many HIV laws are common and belong to the protective model of legislation (Bayer, 1992). Despite a contrary tradition in infectious disease epidemiology, diagnoses of HIV are not reportable with information which would allow identification of the positive person. The confidentiality of a positive person's health and other records is legally protected. Criminal law is used sparingly to effect behaviour change. This reticence applies even where a PLWHA, once diagnosed, continues to behave in ways that put the health of others at risk. After initial controversy, gay bathhouses, are generally permitted to remain open. Lastly, anti-discrimination laws protects PLWHAs who are treated differently because of their HIV status and the different treatment has no reasonable justification.

Comparison of the coercive and protective legislative models is illuminating. Coercive legislation is especially applied to criminal conduct, which C.R. Williams describes as having two features. First, it must have an element of "publicness". It is this element that makes it appropriate for the government to intervene and, upon breach, act as complainant. Second, the conduct "must involve moral wrongdoing" (Williams, 1983, p.3). Expressed at this level of simplicity, the definition is fairly uncontroversial. Applied in the context of an infectious epidemic, the concept of criminalisation must be broadened to coercion, that is, prohibition of certain conduct, in the name of public health, with a sanction of deprivation of rights for those who contravene.

The relationship coercion creates between the players in this piece is a state, with a monopoly on the legitimate exercise of power, controlling those whose actions the state deems warrant control. These people are not only denied any legitimate participation in determining the propriety of their conduct, they are treated as having done something wrong which justifies deprivation of their rights. The fact that those acts were often criminal before the advent of the epidemic is purely coincidental, however it contributes to the feeling that those acts must be proscribed and punished now.

Cast in the role of villain, given little support or education at a time when they are facing a fatal illness, it is not surprising that some PLWHAs continue to act in ways
that jeopardise the health of others. As has been found in countries in which the epidemic has exploded, criminalisation tends to drive risk activities and the people who do them underground, beyond the reach of public health authorities. It is essential to remark the dynamic between the government and affected groups which coercive legislation engenders.

The protective model of legislation is premised on a different relationship between the government and affected groups. This difference is expressed in the aims of either model. The coercive model asks what is necessary to ensure the greatest protection of public health. The answer invariably involves sacrifice of the rights of affected individuals. The question posed for the formulation of protective legislation is what is the minimum encroachment on the rights of those infected to ensure minimum infection of the majority uninfected, or, in the words of the Intergovernmental Committee on AIDS Legal Working Party, "laws specially created to deal with HIV/AIDS alone require particular justification" (1992a, p.2).

This accords a legitimate place to the interests of affected individuals. While the answer to either question must take into account the scientific data (virology, epidemiology, etc), there has been a 'shift in the onus'. Affected individuals are entitled to all the rights of non-affected individuals unless there is a sound scientifically based reason why the rights of affected individuals should be abridged.

The US Center for Disease Control states phlegmatically: "The kind of non-sexual person-to-person contact that generally occurs among workers and clients or consumers in the workplace does not pose a risk of transmission of" HIV (Tahmindjis, 1989, p.419). Preventing PLWHAs from donating blood or organs, with penalties for doing so knowingly, is a good example of justifiable abridgment of rights (Human Tissue Act 1983 (NSW), ss.21C(1) and 21D; for other states, see Godwin et al. 1993, pp.57-60). An unjustifiable abridgment of the rights of PLWHAs is contained in the Regulations to the Therapeutic Goods and Cosmetics Act 1972 (NSW). A person who knowingly suffers from any communicable disease shall not engage in the manufacture, distribution, conveyance, storage or handling of therapeutic goods or cosmetics for sale and shall not handle any equipment used in any such activity (reg 39(2)).
The penalty is $400 (reg 40). The only redeeming feature of this legislation is that 'communicable disease' is not defined and might be interpreted not to include HIV for most of the activities prohibited. There is no reason why a PLWHA could not do the majority of these activities just as hygienically as an HIV negative person.

Model 3: Empowerment

Unlike even many Western countries, much Australian epidemic legislation has gone beyond non-criminalisation and protection. The difference in the legislation and its role in the epidemic hinges on a difference in the political history of the epidemic. The first feature of this history is the early participation, at all levels of decision making, of the community most affected, the gay community (for the following, see Ballard, 1989 and 1992; Altman, 1992). Many other countries excluded gay participation, and its inclusion in Australia was due to a unique alliance between the government and community based organisations. The gay community existed as a community before the epidemic. It was used to asserting its claims to legitimacy in the face of stigmatisation. The AIDS Action Committee in Sydney, with majority gay membership, formed in response to the quickly evident political nature of the AIDS issue. This was to be the nucleus of the AIDS Council of New South Wales (ACON) and was soon followed by the formation of the Victorian AIDS Action Committee. Naturally, these community based organisations adopted the style of politics which the gay community had developed in the years of campaigning for gay rights.

The government's attitude was similarly proactive. While the epidemic started earlier in the United States than Australia, it took the Reagan administration until 1986 to allocate substantial funds and even to mention the word "AIDS" publicly. In contrast, the Federal Minister for Health, Dr Neil Blewett, made HIV a health priority in 1985. He unequivocally recognised HIV as "potentially the most serious and expensive public health problem to face Australia since Federation" (Wran, 1988, p.488). At the same time as the Federal Government began to frame a comprehensive response to HIV, it was having difficulties with the medical profession over Medicare and doctors' salaries. Dr Blewett sought out alternative sources of policy advice from the Public Health Association, the women's health movement, the Consumer Health Forum and the Australian Federation of AIDS Organisations (AFAO). By 1988, the Federal Government was funding AFAO as an umbrella organisation which included under its umbrella the Scarlett Alliance, a national organisations of sex workers, and the Australian IV League, a national organisation of injecting
drug users. This funding would have been unthinkable before HIV.

The history of epidemic legislation and the stigmatised status of affected people has led to a presumption of encroachment on affected people's rights. Under this presumption, the best strategy for PLWHAs is to demand minimum encroachment on their rights, that is, non-criminalisation. In Australia however, the politics of HIV has produced a legislative approach and governmental approach that has gone further than this minimum claim.

The premise upon which the classic conundrum of community versus individual rights is based is, of course, that the two sets of entitlements are opposed to each other.

The lesson of HIV/AIDS is that the interests of the wider community depend upon respect for the rights of the individual" (Buchanan, 1993, p.1).

This may seem counter-intuitive. It is definitely contrary to the received wisdom from the courts and legislatures of former epidemics. The message is that non-criminalisation is a first port of call for constructive legislative approaches to HIV and that law can play a proactive constructive role in empowering PLWHAs. Empowering PLWHAs advances the interests of the wider community by making it unlikely that they will engage in risk behaviour. Understanding this sophisticated paradox depends on appreciating the meaning of non-criminalisation within its political context:

- Out of context, non-criminalisation (or non-proscription or non-coercion) is a meaningless term, a double negative. If criminalisation declares that an activity is unacceptable, non-criminalisation declares that an activity is not unacceptable.

- In the historical context of criminalisation and coercion of people affected by epidemics and of pre-existing stigmatisation of the groups most affected by HIV, non-criminalisation acquires a meaning. It represents a decision not to criminalise when criminalisation would be expected. Many events in the United Kingdom and the United States can be described in this way.

- In Australia, the strength of the gay community and the leadership demonstrated by the government made criminalisation far less likely. In this political context, non-criminalisation through protection of affected individuals' rights left space for the participation of affected groups in formulating codes of risk-avoiding
behaviour. If affected groups participate in and consent to these codes of behaviour, they are much more likely to conform to them. Alternatively, prescribing codes of behaviour from above is unlikely to win consent and in matters so intimate, is impossible to enforce.

To go beyond non-criminalisation in the second sense discussed above has required the articulation of an equal relationship between affected groups and empowered institutions, such as the government and the medical establishment. This in turn has required that PLWHAs become empowered. Put otherwise, the fight against the virus in Australia has been synonymous with the empowerment of those affected by it. This is a radical development in the management of illness within our society.

**Case study: empowerment of PLWHAs through confidentiality laws**

The issue of confidentiality is a good example of the use of law among other methods to empower PLWHAs. Confidentiality is a linchpin in the overall response to the HIV epidemic. Even countries which pursue a more coercive approach recognise its central importance with protective legislation. Rights to confidentiality for PLWHAs are vital for two reasons. First, once a person is diagnosed HIV positive, if that information were available to the public, the PLWHA would likely be exposed to a large range of discrimination and ostracism, possibly affecting that person's family and personal relations, their job and accommodation. Second, on a public health scale, breaches of confidentiality of HIV information send signals to the wider community. People who believe they are at risk of infection will be loath to present for testing if they have doubts that their confidentiality will be preserved.

What is the effect of people not presenting for tests? Even if not infected, they will live with considerable anxiety at the unconfirmed prospect of infection. More serious still is if someone has become HIV positive and chooses not to be tested. They may continue to participate in risk activities and infect others, rather than receiving counselling and education about ways of minimising the chances of infecting others. They will certainly not obtain timely medical treatment and advice, which may prolong their health significantly. This is important for the individual, who loses valuable years of health, and for society which loses a person often contributing usefully to society.

There are various general legal duties of confidentiality under statute and common law which are applicable to HIV information. Section 17 of the Public Health Act 1991 (NSW) is the only statutory provision solely designed to protect the confidentiality of HIV information.
(as opposed to more broad confidentiality provisions). Along with other amendments, enactment of s.17 was the result of extensive consultation between the New South Wales Department of Health and interested parties, including the AIDS Council of New South Wales (ACON).

Under s.17, a medical practitioner or other service provider must take all reasonable steps to prevent the disclosure of information in relation to a person's HIV status. Breach of this duty is an offence. The information may only be disclosed:

- with the consent of the person; or
- in connection with the administration of the Act; or
- by court order; or
- as a normal duty as a consequence of providing the service in the course of which the information was obtained; or
- in prescribed circumstances.

The Regulations provide that information about a person's HIV status may be disclosed to the Director-General of Health where the service provider has reasonable grounds to believe that the person is behaving in such a way that "the health of the public is at risk" (Public Health (Scheduled Medical Conditions) Regulation 1991 reg.7(2)).

Section 17 is a more specific version of a general duty to maintain the confidentiality of any information connected with the Health Administration Act 1982 (NSW) or similar Acts (Health Administration Act 1982 (NSW), s.22) The effect of s.17 is to provide legislative guidelines on the nature and extent of HIV confidentiality and perhaps to signal the importance with which the legislature views the issue.

Unfortunately, while this new legislation enhanced confidentiality on the statute books, it was little known and so had little impact (Plum and Alexander, 1992, p.8). This in turn lead to further representations from ACON, which prompted the AIDS Bureau of the New South Wales Health Department to produce a circular - 'HIV/AIDS and confidentiality: a guide to legal requirements' - to inform people of the existence of the law and its application to particular medical procedures. The Circular was issued early in 1993 to employees of the Department of Health.

Another circular, on contact tracing, is soon to be released. Contract tracing is the process by which contacts of a PLWHA who may also have been infected, are informed of the possibility of infection. Normally, the index case participates voluntarily in contact tracing. Another product of joint work by the government, medical practitioners and consumer groups, the circular provides that the only time in
which the confidentiality of a PLWHA may be breached is if s/he continues to engage in risk activities without the knowledge of others at risk. In this case, a service provider may notify the Director-General. If the Director-General is satisfied that the health of a contact is threatened, s/he may inform that contact of the threat. Note that the Director-General does not disclose the identity of the index case, though this may be easy to guess in some situations. An example might be a man who has acquired the virus from unprotected sex with other men, unbeknownst to his wife. The practice of contact tracing is an excellent example of the greatest possible accommodation made to the rights of PLWHAs without putting the health of HIV negative people at risk.

Complementing these circulars are guidelines released by the Federal Working Party on Privacy and HIV/AIDS chaired by the Privacy Commissioner. These guidelines strengthen the application of general privacy duties when that privacy relates to HIV/AIDS information. The guidelines will be evaluated in September 1993, perhaps with a view to new legislation. Another initiative on HIV confidentiality is the confidentiality project of the Australian Federation of AIDS Organisations, begun in 1993, which is performing in-depth case studies on the practices of a Youth Refuge and the Hospice of St Vincent's Hospital in Sydney. The aim of the project is to gather information on confidentiality practices and to ascertain whether these practices conform to law.

Together, these projects exemplify the wide approach to behaviour change for HIV. First, they are the result of cooperation and negotiation between the government, affected groups and the medical profession. Second, no one medium of social change is sufficient. The measures adopted to achieve change mix legislation with education with grassroots research. Third, they eschew coercion of affected individuals. Fourth, they elicit support for public health aims (testing, early treatment) by empowering PLWHAs.

The relationship between PLWHAs and medical practitioners

Empowerment has not been limited to relations with the government, nor has empowerment always depended principally on legal rights. Empowerment of PLWHAs is relevant to all elements of society in a position to exercise authority over affected communities. Apart from the legislature, the most important element of society in this position is medical practitioners.

Relations between medical practitioners and their patients are often said to be paternalistic. Practitioners trained in medical schools before the advent of preventative
and community medicine in particular see themselves as holding a legitimate monopoly over medical issues such as HIV (Buchanan, 1993, p.1). This monopoly is asserted to continue even on topics like HIV, where medical knowledge has been quite incomplete (see Trietchler, 1988, for an excellent history of the conflation of politics with medical science in theories about HIV.). "Radical critiques" (Ehrenreich, 1978) from sociologists of medicine question the extent and nature of power which the medical profession exercises over its patients. Thomas Szasz contends that:

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\text{Therapeutic interventions have two faces: one is to heal the sick, the other is to control the wicked ...}
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Contemporary medicine practices - in all countries regardless of their makeup - often consist of complicated combinations of treatment and social control" (1974, p.69).

We may draw back from Szasz's dramatic language and yet it is difficult to discount Szasz's thesis totally. Sociologists of medicine continually find in the practice of medicine a cult of the expert and of monopolised knowledge (major examples are Armstrong, 1983; Ehrenreich, 1978; Foucault, 1972 and 1973; and Freidson, 1970). Traditionally, medical practitioners have held overwhelming authority in diagnosis and treatment, hence the characteristic phrase in the literature on the patient-physician relationship, "patient compliance". That is, a patient's participation in treatment is described in terms of how well s/he obeys orders.

An illness as politically and morally invested as HIV mobilises any potential for social control. Historically, at the same time the legislature defined homosexual sex as a crime, the medical profession defined homosexuality as illness (Bayer and Spitzer, 1986, chart the history of the intense 'contests for meaning' during the American Psychiatric Association's 1970 debates over the official classification of homosexuality). What greater form of disempowerment is there than to define someone's normal state as an illness? The struggle for the demedicalisation of homosexuality has been fought and largely won by gays (despite recent outlandish remarks by the then-President of the Australian Medical Association, Dr Bruce Shepherd, to the effect that no more money should be spent on the medical efforts towards HIV until we have discovered what causes homosexuality). The experience of this fight, alongside the legislative fight, left its mark on gay-medical relations.

In Canada, AIDS groups recommend, "If you know more about AIDS than your doctor, maybe you should change doctors." It is difficult to think of another patient group that would countenance such a slogan, both in its challenge
to medical power and the degree of information it assumes PLWHAs to possess. As a patient group, PLWHAs have challenged several medical monopolies. This challenge has been based on self-empowerment through self-education. The gay press and AIDS Councils regularly publicise medical information of a complexity rarely found in lay circles. One sphere of challenge has been the ongoing activist campaign over treatments by the AIDS Coalition To Unleash Power (ACTUP). Another has been the degree of knowledge which PLWHAs have brought with them to their medical consultations and their willingness to use alternative medicine.

The empowerment of PLWHAs in relation to the medical profession extends beyond the strictly medical setting. Community based organisations have claimed a right, equal to that of medical practitioners, to participate in the full gamut of decisions about HIV. This fact was strikingly highlighted in 1992, when the late Dr Fred Hollows accused the "gay lobby" of hijacking the AIDS debate. Community based organisations, which are strongly gay identified, had enough authority to stand their ground and assert their legitimate participation in the debate. Equally, the Australian Medical Association's conference, AIDS - how we got it right?, did little to displace the prominence of community based input.

Conclusions, or, where to from here?

It is now a truism that, in league with the government and the medical and health care professions, community based organisations have been able to achieve more effectively what coercive laws sought to achieve in terms of protection of the public health through behaviour change. Ironically, the very successes in managing the epidemic threaten the continued special treatment which HIV has so far received. These successes include substantially containing the HIV epidemic within the groups which it first affected. The result has been that the feared escape of the virus into the heterosexual community has so far been averted in Australia, in contrast to the vast majority of other countries. (For international comparisons, see Mann and ors, 1992). The initial projections on the future spread of the epidemic (for example, Life Institute Federation of Australia, 1987) have been revised substantially downwards (eg. Carroll, 1992).

Another success which has markedly changed the nature of the epidemic in Australia is the gradually improved therapeutic prospects for PLWHAs (see generally Bayer, 1992). It is now possible to better manage HIV-related opportunistic illnesses and to retard the progression of HIV by early clinical prophylaxis. While AIDS could not yet be
considered a chronic disease, HIV infection will increasingly require long-term medical care similar to chronic diseases.

Quite apart from these successes, an entirely different, more coercive approach to treating HIV might also be prompted by people who simultaneously contract HIV and the much more contagious Multi-Drug Resistant Tuberculosis. The above factors have ushered in much discussion about mainstreaming and HIV—the practice of treating HIV as just another disease. Commenting on the United States situation, Bayer foretells that the effort to treat HIV as fundamentally different from other public health threats may well be viewed as a relic of the epidemic's first years, when so little was understood and so little could be done for those who bore the burden of infection. Either AIDS will be treated in the way other STDs were treated historically, or those broader policies will change to reflect the important lessons learned from dealing with HIV. But the era of HIV exceptionalism that so marked the epidemic's first decade is coming to an end (1992, p.530).

Most commentators on the HIV epidemic have recognised its potential to bring systemic improvements to areas not directly related to HIV. For many it would be unthinkable to dispense with the valuable lessons about respect for minority rights and methods of self and governmentally-fostered empowerment, especially as its applies to consumers of the medical industry.

In the midst of these debates on whether HIV will move closer to the mainstream, or the mainstream closer to HIV, there is a terrible possibility that some parties in the epidemic will become complacent, that the attention span of the general public will wane. The effects of the epidemic in Australia in the next few years will be as or more severe than they have ever been. As a matter of the urgency demanded by this fatal disease, all jurisdictions must adopt a comprehensive legislative regime along the lines recommended in the Final Report of the Intergovernmental Committee on AIDS. There must be enough money and support services from governments to enable PLWHAs to enforce their legal rights.

Finally, Australia's significant achievements in responding to the HIV epidemic have two possible repercussions for our relationship with the world epidemic, and especially the terrifying regional epidemic in Asian and Pacific nations. Either Australia, so eager to form trading links with these nations, will become isolationist on the
subject of HIV, or more hopefully, we will share the lessons and expertise which we have acquired in the epidemic so far.

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