Legal Rights and Communicable Disease: AIDS, the Police Power, and Individual Liberty

Wendy E. Parmet, Northeastern University

Abstract. The policy debate over AIDS has focused on how to balance the rights of individuals who have the disease against the rights of the public. This paper examines the nature of both sets of rights by analyzing the development of public health law and its dominant visions today. The article argues that while once public health rights implied a vast reserve of community authority and obligation to prevent illness, today the rights of the public and those of individuals are seen as being in opposition. Public health jurisprudence now presupposes that illness is primarily a matter of individual concern. In this view, the science of medicine mediates the relationship between the individual and the public. This understanding of rights protects some of the interests of infected individuals, but is inadequate for addressing many of the major problems raised by the AIDS epidemic particularly the spread of infection among the uninfected.

Since the advent of the AIDS epidemic, policy debates have focused on how to balance the rights of individuals infected with the disease against the rights of the public at large. The prevailing perception has been that these two sets of rights are in conflict. Efforts by the community to stem the tide of the disease are seen as threats to the liberty of individuals infected with the virus which causes AIDS (Merritt 1986; Orland and Wise 1985). The legal and policy challenges, therefore, have been to chart a path respectful of both sets of rights, recognizing the importance of the public's health while not unduly restricting the rights of the infected (Presidential Commission 1988; Gostin 1986).

Whether this perception of a clash of rights is accurate is questionable. Certainly many public health experts argue that effective disease prevention programs depend on respect for individual rights, that indeed, the rights of the public and the individual are not in conflict, but rather in harmony (Gostin, Curran, and Clark

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An earlier version of this paper was delivered at the 1988 annual meeting of the American Political Science Association. The author wishes to thank Deborah Stone for her support and encouragement; Judith Olans Brown, Daniel Givelber, and Mary O'Connell for their critical insights; and Karen McCloskey, Karen Jacobsen, Peggy Pahl, Karen Rosenberg, Laurie Woog, and Kathy Gabriel, without whose assistance this article could not have been written.

Journal of Health Politics, Policy and Law, Vol. 14, No. 4, Winter 1989.

1987). But regardless of whether this "happy coincidence" is true, the perception of conflict has fueled the policy discussion and will continue to influence the nation's response to AIDS (Bayer 1989; Shilts 1987).

It is therefore worth considering what is meant by the "rights of the public" and the "rights of the individual." What is the nature of these legal rights that we seek to balance, and what is the relationship between the individual and the public that we presume when we balance them?

This article explores the legal treatment of these relationships. It argues that while once the interests of the public and society were perceived as unified in an effort to prevent illness, today's assumptions are vastly different. The decline of communicable diseases, the rise of the medical profession, and the development of an individualistic, rights-based jurisprudence have all helped to create a new vision of public health law. It is a highly adversarial vision, in which individuals are seen as primarily responsible for their own health and are perceived as having interests that conflict with those of the public. But in this vision, the interest of the public itself is little more than an aggregation of individual interests. The role of public health law then becomes to demarcate or balance the conflict between the interests of an individual rights-bearer on the one hand and the interests, as expressed through the state, of the aggregate, or majority, on the other. In this legal regime, medicine plays a special role: it provides the neutral or expert principle by which law attempts to make the demarcation. And law, in return, serves to mediate the relationship between individuals and medicine.

This adversarial model of public health law has much to commend it. In the case of AIDS, it has served to protect many of the concerns of AIDS patients and to thwart restrictive and invidious policies. But it has also failed to provide a vision capable of addressing many of the major problems raised by the epidemic.

The rights of the public: The police power

The adversarial conception of health law predominant today assumes a conflict between the interests of the public and those of the individual. In the typical case of the competent adult, the individual's interests are taken to be self-generated.[1]

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1. In this paradigm, the especially difficult cases are those in which the individual at issue is not legally competent to express his or her own self-interest. In such circumstances, courts differ as to whether they should apply "the best interest" of the individual—in other words, what the law believes is in the individual's own best interest—or the "substituted judgment" of the individual, in which case they attempt to determine what that individual would desire if he or she were competent. Courts use these two "tests" in cases concerning forced medical treatment of terminally ill incompetents, e.g., Rasmussen v. Fleming, 154 Ariz. 207, 741 P.2d 674 (1987) (en banc) (best interests); Brophy v. New England Sinai Hosp., Inc., 398 Mass. 417, 497 N.E.2d 626 (1986) (substituted judgment); mentally ill incompetents, e.g., Wentzel v. Montgomery General Hosp., Inc., 293 Md. 685, 447 A.2d 1244 (1982) (best interests), cert. denied, 459 U.S. 1147 (1983); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977) (substituted judgment), minofs seeking abortions, e.g., In the Matter of T.H., 484 N.E. 2d 568 (Ind. S.Ct. 1985) (best interests); In the Matter of Moe,

The public's interest, however, is harder to locate. What is the interest of the public in whether AIDS testing should be mandatory or whether infected food workers should be allowed to stay on the job? Is it the declared policy of the government, or is it the policy suggested by public health experts? Where does this interest come from? And how does that interest convert into a "right"?

The answers to these questions are more problematic than is first apparent. Indeed, any complete answer would require a lengthy detour into political theory far beyond the scope of this article.[2] But even a narrower view, focusing on legal doctrine, suggests that the answers have not always remained the same. When we speak today of the "public's right" with respect to health, we use terms derivative from a different era, whose basic meanings are at worst lost, and are at best unclear.[3] Thus to see why it is so hard to define the public's right, it is useful to survey briefly the different meanings of that concept, some of which were held not so long ago.

Although today we tend to think of government's involvement in the preservation of health as a relatively recent development, historically, many governments have considered both the prevention of illness and the treatment of the ill as being among their core functions. For example, the Italian city-states developed sophisticated responses aimed at preventing plague and providing care for the afflicted (Cipolla 1973). Similarly, in the nineteenth century many American states had statutory provisions for quarantine and medical care (Parmet 1985). And some states had far-reaching regulatory programs for disease reporting and sanitary engineering (Rosenkrantz 1972).

In American jurisprudence the public's interest in preserving health was embodied in the concept of the "police power," a term that has lost much of its early meaning. The concept of the police power appears to have its roots in the law of nuisance and the common law principle that property rights are limited to the extent that they injure others (Schwartz 1974).[4] Thus the public, acting through the state, could regulate the rights of real property or contract to protect the public health and safety. More importantly, basic rights of property were limited by the needs of the public.

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18 Mass. App. Ct. 727, 469 N.E.2d 1312 (1984) (substituted judgment), and the medical treatment of minors, e.g., In the Interest of Bryan Karwath, 199 N.W.2d 147 (Iowa S.Ct. 1972) (best interests); Custody of a Minor, 385 Mass. 697, 484 N.E.2d 601 (1982) (substituted judgment).

2. Beauchamp (1988) attempts to derive a political theory of public health. Influenced by Michael Walzer's *Spheres of Justice* (1983), he seeks a complex, republican understanding of public health, based on an expanded notion of community.

3. Tushnet (1988) has made a similar point about other aspects of constitutional discourse. Indeed, his notion of a lost republican discourse of the public good is in many ways similar to the discussion that follows pertaining to the idea of public health. Beauchamp (1988) argues that a republican discourse of public health is not lost, although it is on the defensive. He sees it reflected in many of the regulatory programs of the Great Society, and hopes it will emerge as the silver lining to the AIDS debate.

4. Thus early boards of health were often limited by the courts to abating hazards that could have been considered public nuisances under the common law. E.g., People ex rel. Copcutt v. Board of Health, 140 N.Y. 1, 7–8 (1893); Coe v. Schultz, 47 Barb. 64, 69 (N.Y. Sup. Ct. 1866).

As a constitutional principle, the police power developed along with American federalism and became critical to the concept of state sovereignty. In the nineteenth century an important constitutional question was the extent to which states or the federal government could regulate commerce without intruding on the other's constitutional domain. Although the Supreme Court continually modified its doctrinal approach to the issue (Tribe 1988), it consistently adhered to the concept, first enunciated by Chief Justice Marshall in *Gibbons v. Ogden*, that certain state regulatory powers predated the Constitution and continued to reside with the states as an essential attribute of their sovereignty.[5] Regulations which fell within this police power were permissible even if they otherwise violated limitations on state regulation of interstate commerce.[6]

The enactment of the fourteenth amendment after the Civil War altered the relationship between the federal government, individuals, and the states by making the federal government a protector of individual rights against the states.[7] Although initially designed to protect the newly freed slaves, the Supreme Court quickly negated that purpose of the amendment.[8] Instead, in a series of cases beginning in the last decades of the nineteenth century, the court developed an individualistic, contractarian approach that used the due process clause of the fourteenth amendment[9] to restrain governmental regulations that, in the court's opinion, unreasonably impeded individual rights of contract and property.[10]

Yet despite the so-called *Lochner* court's clear antipathy to economic and social regulation, the court continued to affirm the states' right to protect public health pursuant to the police power.[11] In other words, public health regulations provided a significant exception to the restraints on governmental power that the court read into the due process clause of the fourteenth amendment. Indeed, the key to the court's substantive due process inquiry became whether a particular state regulation did or did not fit within the police power.[12] According to the court, public health measures clearly did (Beauchamp 1988).

Indeed, what is striking to modern eyes is how the court, through shifting ideological coalitions and doctrinal expositions, continued to assume that public

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5. 22 U.S. (9 Wheat.) 1, 207–8 (1824). See also The License Cases, 46 U.S. (5 How.) 504, 582–84 (1847); Mayor of New York v. Miln, 36 U.S. (11 Pet.) 102, 109, 131–33 (1837).

6. Brown v. Maryland, 25 U.S. (12 Wheat.) 419, 438 (1827). See also cases cited by Tribe (1988).

7. Ex parte Virginia, 100 U.S (Otto) 339, 345, 347 (1880).

8. Plessy v. Ferguson, 163 U.S. 537 (1896); Civil Rights Cases, 109 U.S. 3 (1883).

9. ". . . nor shall any State deprive any person of life, liberty, or property, without due process of law . . . " U.S. Constitution Amendment XIV, Sec. 1.

10. E.g., Lochner v. New York, 198 U.S. 45, 53 (1905). For a discussion of this substantive due process doctrine, see Tribe (1988).

11. See Miller v. Standard Nut Margarine Co., 284 U.S. 498 (1932); Muller v. Oregon, 208 U.S. 412 (1908); Barbier v. Connolly, 113 U.S. 27 (1885).

12. Dobbins v. Los Angeles, 195 U.S. 223, 236 (1904); Barbier v. Connolly, 113 U.S. 27 (1885).

health was a clearly knowable interest that was at the core of the police power and thus was always within the government's legitimate scope. For example, in the 1824 case of *Gibbons v. Ogden*, Chief Justice Marshall referred to "inspection laws, quarantine laws, [and] health laws of every description" as the essential regulatory powers of the state.[13] More than 75 years later, in the same year that the court denied the states' power to enact maximum working hours laws in *Lochner v. New York*,[14] the court in *Jacobson v. Massachusetts*[15] upheld the power of Massachusetts to require vaccination. The court stated:

> Although this court has refrained from any attempt to define the limits of [the police] power, yet it has distinctly recognized the authority of a State to enact quarantine laws and "health laws of every description;" indeed, all laws that relate to matters completely within its territory and which do not by their necessary operation affect the people of other States. According to settled principles the police power of a State must be held to embrace, at least, such reasonable regulations established directly by legislative enactment as will protect the public health and the public safety.[16]

That health regulations were within the core of the police power should not be surprising. In a time of smallpox, yellow fever, cholera, diphtheria, and a host of other deadly epidemic diseases, public health policies were inevitably a central part of the public's concern. Even in the midst of today's AIDS epidemic, it is difficult to recall the urgency that must have been felt in an era when epidemics could easily destroy large portions of a population (Presidential Commission 1988). With the threat of disease omnipresent, it is not surprising that cases such as *Jacobson* weighed the interests of the public in preventing epidemics as superior to that of the individual rejecting vaccination. The court stated:

> . . . the liberty secured by the Constitution of the United States to every person within its jurisdiction does not import an absolute right in each person to be, at all times and in all circumstances, wholly freed from restraint. There are manifold restraints to which every person is necessarily subject for the common good. On any other basis organized society could not exist with safety to its members. Society based on the rule that each one is a law unto himself would soon be confronted with disorder and anarchy.[17]

Thus, in *Jacobson* and many other cases, courts upheld the broad power of government officials to enact measures to protect the public health. Quarantine (Parmet

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13. 22 U.S. (9 Wheat.) at 203. See also Compagnie Française de Navigation à Vapeur v. Louisiana State Board of Health, 186 U.S. 380 (1902); Brown v. Maryland, 25 U.S. (12 Wheat.) 419 (1827).
14. 198 U.S. 45 (1905).
15. 197 U.S. 11 (1905).
16. Id. at 25.
17. 197 U.S. at 26.

1985), restrictions on commerce,[18] and mandatory vaccination (including the exclusion of unvaccinated students from the public schools[19]) were routinely affirmed as legitimate exercises of state sovereignty. As the Maine Supreme Court stated in *Seavey v. Preble*,[20] "When the small-pox or any other contagious disease exists . . . the law demands the utmost vigilance to prevent its spread. . . . *Salus populi suprema lex*—the safety of the people is the supreme law."[21] The police power was, in short, the public's right to self-survival.

But it is misleading to stress only the importance and breadth given to the police power. Although the courts usually upheld broad exercises of governmental power in the face of disease,[22] the most striking feature about communicable disease cases prior to the 1920s is how seldom the need for public action was questioned.[23] And those cases that were decided usually raised issues pertaining to the regulation of commerce or the allocation of treatment costs (Parmet 1985). Very few cases concerned the rights of the community to restrict the liberty of an individual.

The reasons for the paucity of litigation concerning individual rights in opposition to those of the public are probably numerous.[24] One possible explanation, however, is that the issue was not litigated because the perception of conflict was dim. Courts recognized that "the individual right sinks in the necessity to provide for the public good,"[25] but the concept of an interest of the individual apart from that of the public was not firmly established.[26] As one court stated when discussing the procedural rights of smallpox victims, "We do not perceive how it could be of importance to the sick man."[27]

Many factors explain the lack of perceived conflict. The philosopher John Arras (1988) uses the term "democratic epidemics" to describe communicable illnesses

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18. E.g., Morgan's La. and Tex. R.R. and Steamship Co. v. Louisiana Board of Health, 118 U.S. 455, 456 (1886); Brown v. Maryland, 25 U.S. (12 Wheat.) 419, 443–44 (1827).

19. E.g., Zucht v. King, 260 U.S. 174 (1922); Abeel v. Clark, 84 Cal. 226, 24 P. 383 (1890).

20. 64 Me. 120 (1874).

21. Id. at 121.

22. Courts consistently held that states have the power to take restrictive actions designed to prevent the spread of epidemics. Courts nevertheless reviewed and sometimes invalidated particular actions taken by public health authorities. The most common ground for invalidating governmental action was that the public officials acted in excess of their statutory authority. E.g., In re Smith, 146 N.Y. 68, 40 N.E. 497 (1895).

23. See Morris v. City of Oklahoma, 102 Ga. 792, 30 S.E. 850 (1898) ("Danger to public health has always been regarded as a sufficient ground for the exercise of police power in restraint of a person's liberty").

24. I have speculated on other reasons elsewhere (Parmet 1985).

25. Haverty v. Bass, 66 Me. 71, 74 (1876).

26. Courts did recognize the possibility that health officials would take actions that impinged upon common law property rights. The New York courts, for example, resolved this dilemma by restricting health officials to destroying property which at common law formed a public nuisance, and thus was not a protected property interest at common law. E.g., Coe v. Schultz, 47 Barb. 64 (N.Y. Sup. Ct. 1866). What is rare in nineteenth-century cases is a judicial recognition of a personal interest apart from property interests. In re Smith, 146 N.Y. 68, 40 N.E. 497 (1895), is one of the few such cases in which the court recognized that a health order could violate an individual's liberty.

27. 66 Me. at 73.

which cut across class, racial, and ethnic lines and threaten the community at large. Faced with such diseases, the community may well feel that each individual's fate is dependent on the well-being of the other, and that all are mutually vulnerable. Therefore, the community cannot afford to stigmatize and relegate the infirm to outcast status, since every individual may be the next to be ill. Given this mutual vulnerability, the interests of public and individual are intertwined, and the need for public action becomes linked to the need to provide care for the afflicted. Smallpox, which was known to be contagious before the germ theory was widely accepted, is probably the best example of such a disease (Rosenkrantz 1972). Thus it should not be surprising that early public health statutes aimed at smallpox consistently provided a mechanism for providing care for the indigent (Parmet 1985).[28] Similarly, Fox (1988) has shown that throughout history, civic authorities have responded to epidemics by making provisions for care of the indigent.

This linkage of the interests of the afflicted with the nonafflicted is consistent with a moralistic conception of disease and health care. Mid-nineteenth-century disease theory linked disease to filth and moral decay; thus health care policies were inextricably tied to the cleansing and moral betterment of the community (Rosenkrantz 1972).

Understanding disease through a religious or moral lens always had an equivocal effect on public health policy. On the one hand, because disease could be seen as a sign of a community's moral failing, epidemics provoked movements for communal improvement, charity, and reform (Rosenberg 1962). Moreover, as long as the ill and the community shared a moral outlook, both the public and the afflicted were seen as benefiting from the moral prescriptions that constituted much of disease prevention.

But communitarian visions of public health always had their flip side. To the extent that disease was considered a sign of spiritual failing, it was easy to assume that illness was the fault of, if not the moral retribution for, the victim's sins (Rosenberg 1962).[29] The possibility for castigating those who became ill as apart and inferior always existed. Some diseases, such as leprosy, were never democratic: its victims were always subject to oppressive treatment and excluded from the community (McNeil 1976).[30] Other diseases provoked a more ambiguous effect. Rosenberg (1962), for example, has shown how mid-nineteenth-century medical opinion blamed cholera on the "predisposing" tendencies of its victims. Never-

28. Early vaccination statutes sometimes provided public financing for the indigent. See Abeel v. Clark, 84 Cal. 226, 288, 24 P. 383 (1890); Bissell v. Davison, 65 Conn. 183, 188, 32 A. 348 (1894).

29. As Rosenberg (1962) has shown, people simultaneously hold inconsistent views about disease. Thus nineteenth-century Americans believed that cholera only struck the sinful and impoverished; yet at the same time, they did all they could do to escape from epidemics.

30. Susan Sontag (1978) has shown how different illnesses acquire different social and metaphorical meanings.

theless, the public continued to believe in its contagiousness and therefore the need for a civic response to the epidemic. Indeed, even while believing that the afflicted were at fault for their own disease, the public believed that its own fate was intertwined with the fallen, and responded by attempting to reform the community through public prayer, cleansing the cities, and providing charity to the poor and medical care to the afflicted (Rosenberg 1962).

Of course, as the moral and social homogeneity of the community is reduced, it becomes easier to cast the afflicted in the role of the outsider who is at fault for disease. Thus throughout the Middle Ages, Jews were often blamed for bubonic plague (McNeil 1976). Similarly, the mid-nineteenth-century public was less apt to engage in concerted action to ameliorate poor health conditions among Irish immigrants than among "natives" (Rosenkrantz 1972).

The decline of the police power and the rise of medical authority

Although in one sense there never was an indivisible consensus and unity as to the public's interest in health, that lack became more evident as the nineteenth century ended and this one began. Immigration (Rosenkrantz 1962), industrialization, and the adoption of a highly individualistic constitutional jurisprudence (Tushnet 1988) made suspect views about shared interests around public health. In addition, the decline of epidemics may have diminished assumptions about shared vulnerability that once seemed plausible.

The breakdown of a moral consensus concerning disease became evident in case law by the turn of the century. In 1902 the Supreme Court denied a commerce clause and due process challenge to a Louisiana law barring even healthy and noncontagious immigrants from southern European and West Indian ports on the theory that their arrival would exacerbate the state's yellow fever epidemics.[31] Although the majority saw no problem with the statute, Justice Brown in dissent saw Louisiana's justification as a sham for oppressing immigrants. He wrote that Louisiana was barring immigrants on the theory they would "add fuel to the flame."[32] In other words, the arrival of outsiders assumed to be morally suspect would contaminate the community with individuals vulnerable to disease.[33] Similarly, in 1900 San Francisco attempted to impose a quarantine on the Asian community on the scientifically unsupported fear that they carried bubonic plague. A lower court took the rare step of seeing through the city's racism and prohibiting the quarantine as a violation of the equal protection clause.[34]

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31. Compagnie Française de Navigation à Vapeur v. Louisiana State Board of Health, 186 U.S. 380, 397 (1902).

32. Id. at 399 (Brown, J., dissenting).

33. At the turn of the century syphilis was also widely believed to be spread by immigrants, which led to calls for immigration restrictions (Brandt 1988).

34. See Jew Ho v. Williamson, 103 F. 10 (C.C. Cal. 1900).

The recognition that disease control could be used to oppress social or racial minorities increasingly led to challenges of public health restrictions and judicial scrutiny of police power actions. The widespread use of quarantine against prostitutes during the 1910s and 1920s (Brandt 1988) prompted courts to recognize the abusive potential of public health measures and to increase judicial scrutiny of actions taken in the name of public health protection (Parmet 1985). This is not to say that courts disapproved of the campaign against prostitutes. On the contrary, the judiciary collaborated with public health officials for the most part. However, the use of the public health power against prostitutes was so clearly punitive that the adversity of interests between the disease victim and the public was all too apparent. Moreover, the stigmatization inherent in being forced to submit to an examination for venereal disease led courts increasingly to overturn actions of public health officials taken against individuals other than prostitutes (Parmet 1985).

It is not surprising that courts, albeit slowly and inconsistently, responded to this use of the public health authority to single out the outsiders. It is here, after all, where the role of rights, as traditionally conceptualized, emerges. Once the public interest is perceived of as being apart from the interest of some individuals who may be assumed to share a different vision of moral betterment, the role of law becomes one of delineating boundaries. Rights are then given to the individual, to define a space in which the public is disabled from imposing its will on the outsider (Mill 1859). Under this liberal vision, rights are protective and necessary given a breakdown in public consensus. And the role of courts, especially constitutional courts, becomes one of enforcing those rights. The problem, however, becomes how to determine the boundaries between public and private, a task that becomes increasingly difficult and increasingly necessary as common notions of public health recede.[35]

By the early years of this century, the public's interest in health was no longer perceived as being unified. As a result, courts needed a principle by which to sort illegitimate public interests from legitimate ones. The increasing medicalization of health appeared to provide that principle. It also reinforced the perception that the public interest was not uniform.

By the turn of the century, disease was increasingly being considered in medical terms, and control over the ill and health policy was increasingly delegated to the medical profession (Rosenberg 1988; Starr 1982). The rapid advances in bacteriology and antisepsis that occurred in the latter part of the nineteenth century gave the medical profession a new prestige and prompted the optimism that disease could be conquered by a scientific approach (Rosenberg 1962). And indeed, as this century progressed, the mortality and morbidity associated with communicable diseases declined dramatically (McNeil 1976).

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35. Tushnet (1988) makes a similar point about constitutional jurisprudence. Judicial review is made necessary by the loss of a shared republican vision of the public good. But judicial review is also made impossible to justify as a truly neutral system by that very same loss.

The law's initial response to these developments was an increased willingness to delegate public power to health officials. After all, contagion was now confirmed by science, and more importantly, preventive steps, from quarantine to disinfection, now received "scientific" approval. Thus after the contagiousness of cholera was accepted by the scientific community, New York passed a strong public health law giving broad powers to the metropolitan board of health (Rosenberg 1962). Its success in limiting the epidemic of 1866 proved popular, and other jurisdictions quickly followed suit (ibid.).

But the vast new delegation of powers to public officials was shortly followed in the courts by the recognition that public action might injure individual rights, especially property rights. The sweeping, almost unlimited power granted to the metropolitan board, for example, met with resistance in the courts (ibid.).[36] Moreover, the acceptance of the germ theory ironically meant that individuals were increasingly seen as responsible for their own health. Although this was always true to some extent, the nature of individual responsibility for disease, at least as perceived by the law, changed in subtle ways. The original contributions of science to health in the nineteenth century primarily involved public sanitation (Rosenkrantz 1972; Beauchamp 1988). After the turn of the century, however, medical science replaced public health, and the focus of public health policy shifted towards ensuring that individuals followed the advice prescribed by medical experts (Rosenkrantz 1972).[37]

Once science could prescribe ways of preventing disease, the law could more clearly see the interests of the community as endangered by the actions of particular individuals, such as those who refused vaccination.[38] The belief that an individual could threaten the community perhaps reached its high point in *Buck v. Bell*, where the Supreme Court, relying on vaccination cases, upheld a state's right to involuntarily sterilize the "feeble-minded" on the theory that their offspring would be a drain on the community.[39] But once the individual interest was seen as adversarial to that of the public,[40] courts began to recognize that there were two sets of interests, and that the individual might also have a legitimate interest in opposition to that of the public. After all, the public was composed of individuals who were also capable of protecting themselves from disease.

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36. See Coe v. Schultz, 47 Barb. 67 (N.Y. Sup. Ct. 1866) (act is constitutional, but board's authority is limited to abating nuisances which could have been declared as such at common law).

37. Stone (1986) has shown how this lifestyle view of disease has continued in recent years.

38. E.g., Prince v. Massachusetts, 321 U.S. 158, 166–67 (1944) (dicta); 197 U.S. at 26. Thus many courts in the early part of the century upheld compulsory vaccination laws. See, e.g., Board of Trustees v. McMurtry, 169 Ky. 457, 184 S.W. 390 (1916); Zucht v. King, 225 S.W. 267 (Tex. Civ. App. 1920), appeal dismissed, 260 U.S. 174 (1922).

39. 274 U.S. 200, 207–8 (1927).

40. E.g., In re Smith, 146 N.Y. 68, 40 N.E. 497 (1895) (strict judicial review of quarantines imposed for refusing vaccination); see also Davis v. Wyeth Labs, Inc., 399 F.2d 121, 129–30 (9th Cir. 1968) (individual faces risks in taking vaccinations).

Jacobson v. Massachusetts reflects the changing outlook. The defendant challenged a Massachusetts mandatory vaccination statute as violating the fourteenth amendment. The court upheld the statute, stressing that "in every well-ordered society charged with the duty of conserving the safety of its members the rights of the individual in respect of his liberty may at times, under the pressure of great dangers, be subjected to such restraint, to be enforced by reasonable regulations, as the safety of the general public may demand."[41] Yet although the court affirmed the power of the public to act, its opinion did not assume a unity of interests in the face of disease. The court recognized that public action could require sacrifices from the individual.[42] Moreover, this individual interest could at times act as a restraint on the police power, which was no longer conceptualized as the indivisible, inherent public right. The court recognized that the police power may be limited in order to respect the interests of the individual. The court stated:

> . . . we deem it appropriate, in order to prevent misapprehension as to our views, to observe . . . that the police power of a State . . . may be exerted in such circumstances or by regulations so arbitrary and oppressive in particular cases as to justify the interference of the courts to prevent wrong and oppression. . . . We are not inclined to hold that the statute establishes the absolute rule that an adult must be vaccinated if it be apparent or can be shown with reasonable certainty that he is not at the time a fit subject of vaccination or that vaccination, by reason of his condition, would seriously impair his health or probably cause his death.[43]

Thus, the court recognized that individual and community interests may clash, and seemed to open the door to judicial review of the police power and ultimately the interest balancing that we see today.

Medical science appeared, and still appears, to provide the means for that balancing. Prior to the 1880s, public health cases rarely relied on the opinions of physicians. By the 1890s courts deciding vaccination cases noted that medical opinion was divided on the efficacy of vaccination, but that it was the duty of the courts to enforce laws that much of the public and the medical profession thought reasonable.[44] And in *Jacobson*, the court looked to the newly prestigious medical profession for support, as well as to community morals and beliefs (Burris 1985).[45] Later decisions, however, gave less weight to community knowledge and far more

41. 197 U.S. at 29.
42. Id. at 26–27.
43. 197 U.S. at 38–39.
44. E.g., Bissell v. Davison, 65 Conn. 183, 192, 32 A. 348, 350 (1894); Duffield v. Williamsport School Dist., 162 Pa. 476, 484, 29 A. 742, 743 (1894). Luker (1984) argues that at in the mid- to late 1800s abortion law came under the influence of medical opinion.
45. 197 U.S. at 34-5.

deference to medical expertise.[46] Generally, this reliance on expertise gave the government a rationale for imposing individual restraints.[47]

But medical justifications also potentially provided a limit on public power. Once the legitimating rationale for public health action was severed from the community which exercised the power and posited in a supposedly objective, external source—medical expertise—courts found a guidepost against which to measure public health actions. The most obvious example of this is Justice Blackmun's opinion in *Roe v. Wade*, in which he relied on medical knowledge and the patient's discussion with her physician to delineate a constitutional right to abortion.[48] Some commentators read this reliance on medicine as the court's search for a supposedly neutral justification for limiting the public's or majority's reach (Ely 1973; Tribe 1973). It was as if the court said, "Legislators don't know the public interest here—doctors do." Thus the science of medicine formed the boundary in which the court separated out the legitimate public interest, as defined by medicine, from the illegitimate interest, or mere imposition of majority morality.

This deference on medical expertise to displace public authority appears throughout the abortion cases, in opinions both furthering and limiting abortion rights. In *City of Akron v. Akron Center for Reproductive Health, Inc.*,[49] for example, one of the issues was the legality of the state's requirement that second-trimester abortions be performed in a hospital. The majority acknowledged that such a requirement might have been reasonable at the time of *Roe* because in the early 1970s both the American Public Health Association (APHA) and the American College of Obstetricians and Gynecologists (ACOG) recommended hospitalization.[50] However, the state statute was no longer reasonable, and therefore no longer constitutional according to the court, because of advances in abortion technology that undermined the need for hospitalization. In support of its conclusion, the court quoted at length the new APHA and ACOG guidelines.[51] Justice O'Connor criticized the court's approach, which necessitated changing constitutional standards to conform to technological changes. But she, too, relied on medical knowledge. Her argument that *Roe*'s viability standard was heading for a breakdown was essentially a claim that the majority misread the direction of medical science and failed to realize the advancing age of viability.[52]

This reliance on medical opinion was more recently evident in *Webster v. Reproductive Health Services*.[53] Although the court there increased the extent to

46. See, e.g., 169 Ky. at 465, 184 S.W. at 394; State ex rel. McBride v. Superior Court, 103 Wash. 409, 426, 174 P. 973, 978–79 (1918).

47. See, e.g., People ex rel. Barmore v. Robertson, 302 Ill. 422, 432, 134 N.E. 815, 819 (1922); 169 Ky. at 465, 184 S.W. at 394.

48. 410 U.S. 113 (1973).

49. 462 U.S. 416, 435–39 (1983).

50. Id. at 435.

51. Id. at 436–37.

52. 462 U.S. at 459 (O'Connor, J., dissenting).

53. 109 S. Ct. 3040 (1989).

which legislatures could regulate abortion, thereby effectively overruling parts of *Akron*, the key opinions were careful to reconcile the state's regulation with medical judgment. Chief Justice Rehnquist, writing for a plurality that included himself and Justices White and Kennedy, construed the Missouri statute at issue to require certain fetal viability tests at 20 weeks of gestation only when the testing accorded with the physician's reasonable professional skill and judgment.[54] In her pivotal separate opinion, Justice O'Connor agreed with the plurality, and further stated that as construed the Missouri statute did not "impose a degree of state regulation on the medical determination of viability that in any way conflicts with prior decisions of this Court."[55] In other words, because the state relied on medical judgment to determine when testing is required, and thus when the state may prohibit abortion, no individual right of the woman as recognized in *Roe* was violated.

A similar use of medical judgments to delineate the public from the private appears in the Supreme Court's only recent case concerning a communicable disease. In *School Board v. Arline*,[56] the court considered whether the discharge of a teacher with tuberculosis violated Section 504 of the Rehabilitation Act of 1973.[57] The court held that in order to determine whether the discharge was lawful, lower courts should look to a set of criteria postulated by the American Medical Association. Following *Arline*, courts that have considered cases concerning discrimination against individuals with AIDS have consistently relied on medical evidence in order to determine whether the exclusion is valid.[58]

The growing reliance on science—and, more particularly, the medical profession—for developing and controlling health policy thus interacted with the developing recognition of conflicting interests to provide the contours of the public's

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54. 109 S. Ct. 3054–55 (1989). Justice Scalia would have overruled *Roe* completely and therefore did not have to discuss the role of medical judgment. Justices Blackmun, Brennan, Marshall, and Stevens dissented and would have upheld *Akron*. Justice O'Connor's separate opinion, in which she argued that neither *Roe's* holding nor its reasoning were at issue, is thus critical for determining the future of *Roe*.

55. 109 S Ct. 3058, 3062 (1989) (O'Connor, J., concurring).

56. 480 U.S. 273 (1987).

57. Pub. L. No. 93-112, 87 Stat. 357 (1973), codified as amended at 29 U.S.C.A. 794 (West Supp. 1989).

58. Cases include Martinez v. School Bd., 861 F.2d 1502, 1506 (11th Cir. 1988); Muhammad v. Carlson, 845 F.2d 175, 178 (8th Cir. 1988), cert. denied, 109 S.Ct. 1346 (1989); Chalk v. U.S. Dist. Ct., Cent. Dist., 840 F.2d 701, 706–9 (9th Cir. 1988); Leckelt v. Board of Comm'ns, 499 F.E.P. Cas. (BNA) 541, 550 (E.D. La. 1989); Doe v. Centinela Hosp., No. Cv. 87-2514 Par (Px), 1988 U.S. Dist. Lexis 8401, 27 (C.D. Cal. 30 July 1988); Doe v. Dolton Elementary School Bd. Dist. No. 148, 694 F. Supp. 440, 444 (N.D. Ill. 1988); Robertson v. Granite City Community Unit School Dist. No. 9, 684 F. Supp. 1002, 1006 (S.D. Ill. 1988); Doe v. Belleville Pub. School Dist. No. 118, 672 F. Supp. 342, 343 (D. Md. 1987); Ray v. School Dist., 666 F. Supp. 1524, 1529 (M.D. Fla. 1987); Dist. 27 Comm. School Bd. v. Bd. of Education, 502 N.Y.S.2d 325, 334–35, 130 Misc.2d 398, 410–13 (1986). But see Doe v. Coughlin, 509 N.Y.S.2d 209, 211–12 (upholding restriction on conjugal visits of HIV-infected prisoners despite weight of medical evidence), aff'd., 71 N.Y.2d 48, 523 N.Y.S.2d 782, 518 N.E. 2d 536, 533 N.Y.S.2d (1988). For a further discussion of this issue, see text accompanying notes 124–27, infra.

rights. No longer were the rights of the public an inherent aspect of sovereignty that entailed the power to prevent disease and improve the morals of a community while at the same time creating an obligation of care and benevolence. Instead, the rights of the public became defined as the right to take certain measures against individuals when such measures were scientifically justified by medical evidence presented in a court. Thus medicine provided the courts with a mechanism for protecting the newly recognized individual interests that medicine helped to make visible.[59]

But the courts' reliance on medicine turned out to be as equivocal as its earlier assumption of a unity of public interest. Reliance on medicine could expand individual rights, as it did in *Roe* and *Arline*. But courts also relied on the knowledge of health experts in approving the quarantine of prostitutes, who were presumed by health authorities to be spreaders of venereal disease.[60] More recently, a district court has relied on deference to hospital officials in upholding the discharge of a nurse who refused to disclose the results of an HIV antibody test.[61]

Indeed, the irony of judicial reliance on medical knowledge as a benchmark for delineating the public from the private is that it has led to a further problem: the need to delineate the professional from the private. To explore how courts have struggled with this dilemma, the concepts of individual rights and professional interest require further exploration.

Individual rights to health care

When communicable disease was widespread and the utility of medical treatment less established, the rights of an individual to health care were more intertwined with the rights of the community than they are today. "Care" was more a matter of comfort and support than scientific therapy. It could be given as well by, if not better by, family and friends than by practitioners. The community provided it in various degrees to its members, including the indigent. Other actions taken in the name of disease prevention, such as isolation, were interconnected with the provision of care and charity.

In the late nineteenth and early twentieth centuries, public health remained primarily communal in its outlook (Beauchamp 1988). Sanitation is the best example of measures taken to prevent illness on behalf of the public. But, with the checking of epidemics, control of illness was delegated increasingly to the medical profession, and the needs of the individual were seen in a different light.[62] Today two

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59. Beauchamp (1988) applauds this development. He argues that a republican equality of public health would limit the impact of moralism and increase spheres of individual privacy.

60. E.g., Ex parte Dayton, 52 Cal. App. 635, 199 P. 548 (1921) (per curiam). Interestingly, physicians in the 1910s and 1920s seemed to ignore the role that men played in spreading venereal disease (Brandt 1985).

61. Leckelt v. Board of Comm'ns, 49 F.E.P. Cas. (BNA) 541 (E.D. La. 14 March 1989).

62. The contemporary environmental and occupational safety movements may be seen, as Beauchamp (1988) sees them, as the heirs to the nineteenth-century public health movement.

factors are seen as essential to the achievement of individual health. First, disease is seen as a function of an individual's behavioral choices—i.e., whether the individual practices a healthy lifestyle (Stone 1986; Beauchamp 1988). However, such choices are dependent not only on a proper moral outlook, but also on access to information provided by professionals. Thus many argue that prenatal care is critical to the birth of healthy babies, because it provides expectant mothers with information about the lifestyle they should lead while pregnant (New York Times 1988). Similarly, many advocate that the most critical factor in controlling the AIDS epidemic is education about behavioral risks, and that access to the health care system is critical for ensuring individual understanding of safe behaviors (Presidential Commission 1988).

The second essential ingredient of individual wellness is access to the scientific therapeutics of modern medicine. Thus many argue that there is a critical need to provide individuals with the means for obtaining medical services. A central public health policy dilemma has become how to improve public access to health care professionals, especially physicians (Callahan 1988).

Access to professionals can be seen as the sine qua non of an individual's interest with respect to health care. Yet despite the importance of access to medical care, only in a very limited way can individuals be said to have a right to professional care. At common law, a physician/patient relationship was conceived of as primarily a private, voluntary relationship. A physician had no obligation to render care.[63] That remains generally true today, except for physicians in emergency rooms.[64] Thus, although access to professionals has developed into the primary mode of protecting public health, the physician/patient relationship remains largely private. Of course, widespread public medical insurance programs exist, but none are universal. Wide gaps exist (Enthoven and Kronick 1989). Moreover, federal programs usually do not provide care; they merely help subsidize its private provision (Beauchamp 1988).[65]

The assumption that professional care is largely a private matter is reflected in Supreme Court doctrine. According to the court, the Constitution sets limits on governmental power. It does not require government to provide "positive" rights, or entitlements to services to those who cannot otherwise afford them (Brown, Parmet, and Baumann 1987).[66] Thus the government has no obligation to provide health care for the poor.[67] Indeed, according to the court, an individual's inability

63. Hurley v. Eddingfield, 156 Ind. 416, 59 N.E. 1058 (1901).

64. Brennan (1988) describes the variety of legal obligations required of emergency room physicians.

65. Of course, local governments do provide significant direct services through their public hospital systems, which recently have faced severe stress (Bovbjerg and Kopit 1986).

66. See DeShaney v. Winnebago County Dept. of Social Services, 109 S.Ct. 998 (1989); San Antonio Indep. School Dist. v. Rodriguez, 411 U.S. 1, 36 (1973).

67. See Harris v. McRae, 448 U.S. 297, 315–18 (1980). For a discussion of present laws, and an argument that the equal protection clause should be read as creating a right to health care, see Mariner (1986).

to obtain care is a purely personal matter, since the public did not "cause" the poverty which impedes or prevents access to care.[68]

Although the reasons for denying universal health care rights are obviously complex and multifaceted, the dissociation of individual and community interests is striking. As disease changes from communicable epidemics to the chronic problems of old age and as health becomes less a matter of community and more a matter of an individual concern, the provision of care to others may be increasingly seen as something done for the indigent, not for the community as a whole.

Thus in some ways public health today has deteriorated from an integral function of the community to the provision of mere charity. Indeed, the very power given to the medical profession and the equation of public health with medical treatment has facilitated the perception that treatment cannot be provided to everyone. The increasing tendency to equate health policy with access to the medical profession has helped shape access-expanding policies that have contributed to the rise in health care costs (Starr 1982). But the very cost of care and the recognition that access comes with a price tag helps to further decimate the public commitment to access (Beauchamp 1988). In the late 1970s and early 1980s, the policy debate changed from questions of greater access to questions of cost-cutting. Building on the individualistic assumptions that health is primarily a private matter, legislation was aimed at increasing competition in the health sphere[69] and commentators urged the introduction of consumer decisionmaking and market discipline (Havighurst 1986).

Although today we may be witnessing some renewal of interest in access expansion,[70] the market prism remains (Beauchamp 1988). The adversarial relationship once perceived only in some unique questions of public health restrictions is now seen everywhere (Callahan 1988; Havighurst 1986). Thus, if more money is available for one diagnostic-related group,[71] we assume there is less for another. The phenomenon of experience rating of health insurance is a prime example. If insurance is the socialization of health risk and government support of private health insurance is the public's underwriting of that risk,[72] the decline of community rating demonstrates the erosion of the public interest in health. Experience rating makes each group pay dearly for its high-risk members and leads inexorably to a situation in which those most at risk—those most in need of health care—

68. Maher v. Roe, 432 U.S. 464, 474 (1977).

69. E.g., The Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914, codified as amended in scattered sections of 42 U.S.C. (1982 and 1986 Supp. III).

70. For example, in 1988 Congress expanded the Medicare program to provide catastrophic coverage. Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, 102 Stat. 683, codified at 42 U.S.C.A. Sec. 1305 note (West Supp. 1988).

71. Diagnostic-related groups (DRGs) form the disease classification system used by the Medicare prospective payment system to determine hospital reimbursement (Spiegel and Kavaler 1986).

72. For example, certain employer-provided health insurance premiums do not qualify as income for federal income tax purposes. 26 U.S.C. Sec. 106 (1982 and 1987 Supp. V).

are no longer able to afford it (Starr 1982). For some of these groups, such as the elderly and patients with end-stage renal disease, government has stepped in and provided some, albeit far from complete, support.[73] For others, such as AIDS patients, this has not yet happened. But the very hodgepodge nature of public insurance programs demonstrates that they are not seen as clearly supporting public health. They are merely programs of charity, or the spoils obtained by powerful "special interest" groups (Beauchamp 1988). Not surprisingly, the courts see such programs not as providing fundamental rights, but as mere discretionary programs, over which the legislature is entitled to almost total deference.[74]

What, then, are the individual rights that courts balance against the public interest? They are not rights to care or rights against society. Rather, these rights set limits on the community's and, to a lesser degree, the medical profession's ability to impose its priorities on individuals. As a result, these rights protect the individual as an isolated decisionmaker, and indirectly serve to counterbalance the deference that public health law traditionally accords to the medical profession. Thus, ironically, the rights that are recognized are not rights to health, but rights to limit the control that medical practitioners may exercise over those who have access to care.

Autonomy rights

Rights of autonomy are classical negative rights; they limit the authority of the state to constrain individual actions. In the health care area, they also serve to restrain the power wielded by physicians.

Generally, the law is extremely deferential to medical science. It supports physician monopoly over health practice, and it gives the medical profession the primary responsibility for developing standards of practice and policing physicians (King 1986).[75]

Not surprisingly, however, the decline in community authority and the perception that health is primarily a matter of individual concern has rebounded on the medical profession. Once health is seen primarily as a matter of individual choice, which is perhaps the inevitable result of the decline of communicable disease and the adoption of a medical model for disease, the right of the patient to choose his or her own form of therapy becomes valued. In the seminal case of *Canterbury v.*

73. See generally the Medicare program for the elderly, 42 U.S.C. Sec. 1395 et seq. (1982 and 1986 Supp. IV), and the end-stage renal disease program, 42 U.S.C. Sec. 426-1 (1982 and 1986 Supp. IV).

74. See Alexander v. Choate, 469 U.S. 287, 308 (1985); Schweiker v. Gray Panthers, 453 U.S. 34, 48 (1981). Only constitutional rights can serve as true rights recognized against the majority. There are no such rights to health care. This is not to say that courts do not enforce rights to statutory programs, but these are rights against administrative officials who are not seen as complying with majority, legislative decisions.

75. E.g., 42 U.S.C. Sec. 1320C et seq. (1982 and 1986 Supp. IV) (establishing peer review).

Spence,[76] the court took tentative steps toward recognizing that patients, not physicians, should control treatment decisions. Modifying prior law, which had held that the physician's duty to disclose information is governed by professional custom, the court held that physicians should inform patients about the risks of a procedure based upon the information's materiality to a reasonable patient.[77] The court stated, "The duty to disclose . . arises from phenomena apart from medical custom and practice. The latter, we think, should no more establish the scope of the duty than its existence. Any definition of scope in terms purely of a professional standard is at odds with the patient's prerogative to decide on projected therapy himself."[78] In recent years many jurisdictions have adopted the *Canterbury* standard.[79]

A similar recognition of patient autonomy has evolved on the constitutional level. At the time of *Jacobson v. Massachusetts*, the court employed its doctrine of substantive due process to protect individual rights of contract and property.[80] But the court had not yet developed a fulsome vision of personal rights apart from common law rights, and there was no concept of individual autonomy or personhood that was balanced against the police power.[81] Thus when public health measures infringed solely on personal liberties, there was no firm recognition of a countervailing interest to the state's well-established authority to fight disease.

The changes wrought by a government increasingly involved in regulation, however, ultimately made the court's substantive due process review of economic regulation unworkable and helped lead to its abandonment of the doctrine as applied by the *Lochner*-era court.[82] This development, along with comparable changes in the court's construction of the equal protection and interstate commerce clauses,[83] seemingly opened the path for an expansion of government's role in promoting health. In many ways that happened, as the huge Medicare and Medicaid programs attest. The unquestioned constitutionality of federal involvement in drug, workplace, and environmental safety are also testaments to the post–New Deal court's acceptance of a broad federal regulatory role.

In other ways, however, new constitutional limits have appeared, some of which limit public health authority to a far greater degree than did the pre–New Deal

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76. 464 F.2d 772 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972).

77. Id. at 786–88.

78. Id. at 786.

79. See Largey v. Rothman, 110 N.J. 204, 212 (1988).

80. E.g., Adkins v. Children's Hosp., 261 U.S. 525 (1923); Lochner v. New York, 198 U.S. 45 (1905).

81. Personal rights, such as the right to privacy, were recognized to a limited extent in other areas. See Boyd v. United States, 116 U.S. 616 (1886) (fourth and fifth amendments protect against required production of documents).

82. See Williamson v. Lee Optical, 348 U.S. 483 (1955); L. Tribe (1988). For a discussion of the abandonment of the doctrine, and its relationship to health law, see Parmet (forthcoming).

83. E.g., 348 U.S. at 488–89 (equal protection); N.L.R.B. v. Jones & Laughlin Steel Corp., 301 U.S. 1, 29–32, 34–41 (1937) (interstate commerce).

court's substantive due process doctrine. The reason for this is clear. Under the pre–New Deal substantive due process doctrine, the police power was the exception legitimating governmental action. Thus, the inquiry was whether an action was truly a public health measure.[84] Under the new constitutional doctrine of autonomy, public health has no special status. Indeed, these new individual liberties have been given special force in the area of public health, and can be seen in some ways as the outgrowth of a judicial perception that medical issues are more personal than public.

The roots of the constitutional recognition of autonomy go back to early in this century,[85] but the concept crystallized only in the middle of the century, after communicable disease had begun to decline. In the 1942 case of *Skinner v. Oklahoma*,[86] the Supreme Court invalidated a statute providing for the involuntary sterilization of certain felons. The court's opinion is striking for its vision of the personal, private nature of the decision to reproduce. The belief that certain questions of health and reproduction are somehow too intimately connected to an individual's "personhood" was furthered in *Roe v. Wade*[87] and the other Supreme Court cases establishing a constitutional right to privacy pertaining to reproduction.[88] In establishing this personal right, the court was in effect recognizing that the social consensus that had underpinned and intertwined issues of morality and health had broken down. In numerous cases involving reproduction and abortion, the court made short shrift of the supposed moral justifications for bans on abortion and contraceptives.[89] Public morality could not take precedence over an individual's right to decide his or her own biological destiny.[90] Nor was the public perception of public health a sufficient justification. In *Roe* the court conceded that protecting a woman's health was a legitimate state goal, but found that it was not furthered by prohibitions on abortion, since "medical science" showed abortion to be a relatively safe procedure.[91] In other words, the state's goals did not coincide with prevailing medical standards.

Roe and its progeny are often read as examples of the court's great deference to the medical profession (Appleton 1985). Certainly the *Roe* court in particular

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84. Dobbins v. Los Angeles, 195 U.S. 223, 236 (1904).

85. See, e.g., Meyer v. Nebraska, 262 U.S. 390 (1923).

86. 316 U.S. 535 (1942).

87. 410 U.S. 113 (1973).

88. E.g., Thornburgh v. Amer. Coll. of Obstetricians and Gynecologists, 476 U.S. 747 (1986); Doe v. Bolton, 410 U.S. 179 (1973); Eisenstadt v. Baird, 405 U.S. 438 (1972); Griswold v. Conn., 381 U.S. 479 (1965).

89. 410 U.S. at 148; 405 U.S. at 442–43, 448–50. But see Bowers v. Hardwick, 478 U.S. 186 (1986).

90. In Webster v. Reproductive Health Services, 109 S.Ct. 3040 (1989), the court found a greater role for legislative action, but stopped far short of finding that the legislature could either prohibit or indeed actually place severe restrictions on the individual's personal right. For a further discussion of *Webster*, see text accompanying notes 104–105 infra.

91. 410 U.S. at 149.

spoke often about the rights of a woman and her physician.[92] Recent cases have continued the tendency to "medicalize" constitutional law.[93] Nevertheless, the court has made it clear that the right to an abortion is not really a physician's right, but the right of the patient.[94] Although the contours of this right are bounded by prevailing medical standards,[95] the right itself resides within the patient and is an exercise of her autonomy. It is she, not the physician, who decides whether to have the abortion. Indeed, the court has recognized that she may make that decision without consulting a physician.[96]

The theory that individual patients have the right to decide certain fundamental matters affecting their own health and biological destiny and that their choices may restrict the majority is even more evident in cases affirming a constitutional right to terminate treatment. Several state courts have decided that individuals facing severe (although not necessarily terminal) illnesses have a constitutional right to refuse treatment suggested by physicians.[97] These cases recognize the state interests in preserving life[98] and the integrity of the medical profession.[99] Nevertheless, seeing that individuals must ultimately bear the consequences, the courts are increasingly finding that individual rights outweigh all of these other interests.[100] This is not surprising. In the absence of a clear moral consensus, each individual's medical treatment is seen as promoting only the health of that individual. Therefore, the denial of autonomy becomes an unjustified assertion of professional authority or community taste. There is no strong reason to counter the compelling claims of the individual suffering from technology's intrusion.

This does not mean that the courts have completely abandoned their traditional deference to the medical profession. In abortion and right-to-die cases, the courts have taken pains to demonstrate that their decisions accord with prevailing medical standards,[101] even if individual physicians may disagree. And even *Canterbury* recognized a therapeutic exception to the principle of patient decisionmaking.[102]

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92. Id. at 153, 163, 164.

93. See City of Akron v. Akron Ctr. for Reproductive Health, Inc., 462 U.S. 416, 435–39 (1983); 462 U.S. at 454–58 (O'Connor, J., dissenting); text accompanying notes 49–60, supra.

94. E.g., 476 U.S. at 772; Whalen v. Roe, 429 U.S. 589, 604 (1977).

95. E.g., 462 U.S. at 434–37.

96. Id. at 448–49.

97. E.g., Bartling v. Superior Ct., 163 Cal. App.3d 186, 195, 209 Cal. Rptr. 220, 225 (1984); Brophy v. New England Sinai Hosp., Inc., 398 Mass. 417, 497 N.E.2d 626, 633 (1986); In re Quinlan, 70 N.J. 10, 40, 355 A.2d 647, 663 (1976). The Supreme Court has recently decided to hear a case raising this issue. Cruzan v. Harmon, 760 S.W.2d 408 (Mo. Sup. Ct. 19088) (en banc) (woman in vegetative coma who is not terminally ill has no right to refuse treatment), cert. granted sub nom Cruzan v. Director Missouri Dept. of Health, 109 S.Ct. 3240 (1989) (No. 88-1503).

98. See note 97, supra.

99. E.g., 163 Cal. App. 3d at 195; 209 Cal. Rptr. at 225; 398 Mass. at 432, 497 N.E.2d at 634.

100. E.g., 163 Cal. App. 3d at 195; 209 Cal. Rptr. at 225; 398 Mass. at 434, 497 N.E. 2d at 635; 70 N.J. at 41, 355 A.2d at 664.

101. E.g., 462 U.S. at 434–37; 398 Mass. at 439, 497 N.E. 2d at 638.

102. 464 F.2d at 788–89.

Indeed, the principle of patient autonomy appears most clearly entrenched where prevailing medical standards support individual decisionmaking, as they often do (Blake 1989). What the autonomy principle does do, however, is provide a perspective of individual concerns. The fulfillment of these concerns becomes the overriding goal of both medical science and health policy. As long as medical science and ethics are seen as furthering these goals, their own prestige is legitimated.

The view that health policy aims at implementing individual patient choices does not mean that courts will always find that individual interests outweigh those of the public. Where the public interest is considered sufficiently compelling, even an individual's fundamental rights may be overridden (Merritt 1986). Indeed, in recent years the court has begun to move away from the civil libertarian stance of the Warren and early Burger courts. This can be seen in the recent cases in which the court upheld mandatory drug testing.[103] And in *Webster v. Reproductive Health Services* a deeply divided court cut back on the broad civil libertarian thrust of *Roe*.[104] Justice Rehnquist, writing for the plurality, not only questioned and modified *Roe*'s reasoning, but injected a new strain of majoritarianism into the court's health jurisprudence:

> . . . the goal of constitutional adjudication is to hold true the balance between that which the Constitution puts beyond the reach of the democratic process and that which it does not. We think we have done that today. The dissent's suggestion . . . that legislative bodies, in a Nation where more than half of our population is women, will treat our decision today as an invitation to enact abortion regulation reminiscent of the dark ages not only misreads our views but does scant justice to those who serve in such bodies and the people who elect them.[105]

The *Webster* plurality's willingness to limit the scope of constitutional protection for individual autonomy was foreshadowed by *Bowers v. Hardwick*, which upheld a state statute criminalizing homosexual sodomy.[106] There the Supreme Court made it clear that the constitutional right to privacy was no longer favored and would not be expanded into a generalized right to make lifestyle choices.[107] Taken together with *Webster*, *Bowers* suggests that many behaviors that government might restrict in order to protect public health, such as unprotected sex, may not be constitu-

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103. Skinner v. Railway Labor Execs. Ass'n., 109 S.Ct. 1402 (1989); National Treas. Employees Union v. Von Raab, 109 S.Ct. 1385 (1989).

104. 109 S.Ct. 3040.

105. Id. at 3058.

106. 478 U.S. 186, 190–92 (1986) (upholding statute criminalizing homosexual sodomy).

107. Nor do autonomy rights extend to commercial enterprises. City of New York v. New St. Marks Baths, 130 Misc.2d 911, 916, 497 N.Y.S.2d 979, 983 (1986). In People v. Privitera, 23 Cal. 3d 697, 703, 153 Cal. Rptr. 431, 434, 591 P.2d 919, 922 (1979), the court rejected the claim that *Roe* created a constitutional right to make one's own decisions concerning cancer treatment.

tionally protected. Majoritarian restrictions imposed in the name of public health may be given greater force than they would have only a few years ago.

Despite the newly developing restrictions on autonomy rights, public health law remains far different than it was at the turn of the century. Public health itself has lost its preeminent place and is no longer the special justification for state action. It remains subject to, in Justice Rehnquist's words, "the balance between that which the Constitution puts beyond the reach of the democratic process and that which it does not."[108] Further, the recent cases limiting autonomy rely upon a simple positivism. They display no developed vision of a public interest in health care; they merely limit the scope of individual rights in light of majority preferences.

More importantly, the recent cases do not alter the basic landscape. The generalized legal vision of patient autonomy, of which the constitutional right is but a part, ensures that public health decisions today continue to be made in an atmosphere dramatically different from the one that existed in prior epidemics. Despite the court's recent cases—indeed, especially in them—interests of the individual and the public are seen as being in opposition. This adversarial perspective inevitably changes the equation, even when the interests of the individual do not ultimately prevail. The power of the public is not seen as plenary; more importantly, public health itself is seen as but the aggregation of individual decisions.

Rights against discrimination

The second major category of rights that health law accords individuals is rights against discrimination. These rights, which have had a major influence on AIDS policy, have their roots in the development of legal rights against racism (Parmet 1987). That heritage might suggest that rights against discrimination are less individualistic than autonomy rights are. After all, racism is the prime example of group oppression, and equal protection might be said to imply equal treatment under law. Although theoretically plausible, such a view of discrimination has been substantially rejected in recent years.

In the area of race discrimination itself, the court has adopted an individualistic fault-centered framework for analyzing claims under the equal protection clause (Brown, Parmet, and Baumann 1987). Instead of analyzing cases in light of historical group injuries, the court has moved to a far narrower perspective which requires discrimination plaintiffs to prove particularized injuries caused by the invidious intent of defendants.[109] Group or affirmative remedies are prohibited in all but the most limited of circumstances.[110] This same restrictive reading of an-

108. *Webster*, 109 S.Ct. at 3058.
109. E.g., Washington v. Davis, 426 U.S. 229 (1976).
110. E.g., Richmond v. J.A. Croson Co., 488 U.S.109 S.Ct. 706 (1989).

tidiscrimination rights also applies to claims arising under Title VII of the Civil Rights Act,[111] which was designed to prevent discrimination in employment against minorities and women.[112] Today, rights against race discrimination are at most individual rights against particularized wrongs that impede an individual's opportunity to compete equally.

The same vision of discrimination law applies to public health cases.[113] The Supreme Court has emphatically rejected the argument that the denial of even minimal health care constitutes a violation of the equal protection clause.[114] Moreover, the Constitution itself affords little protection against any type of discrimination on account of illness, since the Supreme Court has held that the handicapped do not constitute a suspect class entitled to special judicial protection.[115] Thus the antidiscrimination rights which do apply in this context are exclusively statutory.

The antidiscrimination principle has been applied in the health care context primarily under the Rehabilitation Act of 1973,[116] which forbids federally funded programs or federal contractors from discriminating against "otherwise qualified" handicapped individuals.[117] In construing this statute, however, the court has made clear that it does not mandate equality of treatment. Although the Rehabilitation Act requires covered programs to make "reasonable accommodations" for the handicapped, these need not entail "substantial adjustments in existing programs."[118]

As a result, individuals who are too ill to work or attend school, or those who require substantial modifications in a position to carry out their job, are not at all protected by the act. Thus as a statement that individuals with handicaps will be treated as full members of the community, discrimination law is extremely limited. It only welcomes such individuals into the community as long as they can meet the preexisting criteria.

Discrimination law also parallels autonomy rights in its relationship to health care. It does not provide any affirmative obligation to provide health care to the

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111. 42 U.S.C. 2000 et seq. (1982 ed. and 1986 Supp. IV).

112. E.g., Wards Cove Packing Co., Inc. v. Atonio, 109 S.Ct. 2115 (1989).

113. Beauchamp (1988) relies on the environmental and safety regulatory programs of the Great Society as expressions of a different kind of equality—a more communal, republican equality.

114. Harris v. McRae, 448 U.S. 297, 317–18 (1980).

115. Cleburne v. Cleburne Living Ctr., 473 U.S. 432, 442 (1985). Under prevailing equal protection doctrine, unless an individual belongs to a so-called suspect or semi-suspect class, state action discriminating against that individual, unless it affects a fundamental right, is upheld as long as the state can demonstrate a rational basis for its action. Not surprisingly, state action tested under this standard is usually, although not always, upheld (Tribe 1988). *Cleburne*, which held that the mentally handicapped do not constitute a suspect class, is one of the rare cases striking down state action under the rational basis test.

116. Pub. L. No. 93-112, 87 Stat. 357 (1973), codified as amended at 29 U.S.C. 701 et seq. (1986). The Americans with Disabilities Act of 1989, S. 933, 101 Cong., 1st Sess., which is currently before Congress, would greatly expand the antidiscrimination protections available to the ill and disabled, especially with respect to access to public accommodation by the physically disabled.

117. Gostin (1989) compiles state antidiscrimination laws.

118. Southwestern Community College v. Davis, 442 U.S. 397, 410 (1979).

ill.[119] For example, in *Alexander v. Choate*[120] the court held that the act was not violated by a state's decision to limit Medicaid benefits to only fourteen days of inpatient hospitalization, even though the most ill would be harmed the most by the cutback. The court held that the goal of the Medicaid program is not to provide "adequate health care" but merely a particular package of services. The court then said that Section 504 does not require states to alter their package of services

> . . . simply to meet the reality that the handicapped have greater medical needs. To conclude otherwise would be to find that the Rehabilitation Act requires States to view certain illnesses, *i.e.*, those particularly affecting the handicapped, as more important than others and more worthy of cure through government subsidization.[121]

Thus the act only ensures an equal opportunity to health care services otherwise provided by public or private means. It does not require legislators or private insurers[122] to consider the impact that the services provided would have on the ill.

The major impact of discrimination law is strikingly similar to that of autonomy law. It is a highly individualistic doctrine. It does not provide for public obligation in the face of illness. Rather, like rights of autonomy, discrimination rights provide shields against particular public actions taken in the face of illness. In *School Board v. Arline* the Supreme Court stated that the Rehabilitation Act was designed to protect people against "irrational fears or prejudice."[123] In other words, discrimination rights only provide the outsider or minority with protection against differential or harmful actions that might be taken in the name of health.

But how are courts to determine which actions are legitimate? In *Arline* the court noted that in order to determine whether someone was "otherwise qualified" for the position at issue, courts should defer to the "reasonable medical judgments" of health officials.[124] Where medical professionals determine that an individual poses a health risk to others, the individual is not entitled to protection under Section 504.[125] What is remarkable about this formulation is that it assumes not only an adversarial relationship between the individual and the community, but also that medical expertise can mediate the relationship. Yet the issue in cases such as *Arline*, which concerned whether a teacher with tuberculosis could be discharged, is not only the risk posed by an illness, but the risk that society should tolerate (Parmet 1987). The court, seeing only the opposition between an ill plaintiff and

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119. Bowen v. American Hosp. Assoc., 476 U.S. 610, 640–41 (1986); Alexander v. Choate, 469 U.S. 287 (1985).

120. 469 U.S. 287 (1985).

121. Id. at 303–4.

122. B. v. Blue Cross & Blue Shield, 528 F.Supp. 125 (S.D.N.Y. 1981), aff'd, 679 F.2d 7 (2d Cir. 1982).

123. 480 U.S. 273, 284 n.13 (1987), quoting Sen. Humphrey, 123 Cong. Rec. 1355k (1977).

124. 480 U.S. at 288.

125. Id.

a possibly prejudiced defendant, lacks the means for determining the mutual responsibilities and obligations between the handicapped individual and society. In other words, the court has no way of determining what is in the public interest. All it can do is defer to the medical profession's assessment of interests.

Thus in discrimination law, as in other areas of public health law, courts rely on medical assessments to delineate the boundaries between the public and individuals. So far, in the case of AIDS, this has generally worked to the advantage of infected individuals.[126] Medical judgment has tended to support their claim that they pose no substantial risk of communicating the disease in the typical workplace or classroom setting.[127] Medical judgment has thus provided the courts with the expert authority against which to judge prejudicial acts.

But the import of that protection should not be overstated. In several recent cases, courts have begun to uphold discriminatory actions taken with the support of the medical profession. Where a hospital has articulated a health-based justification for denying drug or alcohol treatment to individuals infected with HIV[128] or employment to nurses who refuse to be tested for the virus,[129] courts have been less sympathetic to individuals claiming discrimination.

Indeed, because of the courts' reliance on medical expertise to resolve these disputes, courts become particularly helpless when the issue is discrimination by the medical profession itself. In contrast to informed consent and autonomy cases, the courts here have not yet developed a means of limiting the scope of professional expertise. In *United States v. University Hospital*,[130] for example, the Second Circuit considered the applicability of Section 504 to severely ill newborns. The court held that "where the handicapping condition is related to the condition[s] to be treated, it will rarely, if ever, be possible to say with certainty that a particular decision was 'discriminatory.'" In other words, because discrimination law relies on medical authority to determine the legitimacy of particular actions, the law has difficulty when the case before it relates to medical treatment decisions. In such

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126. See cases cited in note 58, supra.

127. Thus far most plaintiffs have prevailed, at least preliminarily, in AIDS discrimination cases. See, e.g., Martinez v. School Bd., 861 F.2d 1502 (11th Cir. 1988); Chalk v. U.S. Dist. Ct., 840 F.2d 701 (9th Cir. 1988); Doe v. Dolton Elementary School Dist. No. 148, 694 F.Supp. 440 (N.D. Ill. 1988); Robertson v. Granite City Community Unit School Dist. No. 9, 684 F.Supp. 1002 (S.D. Ill. 1988); Doe v. Belleville Pub. School Dist. No. 118, 672 F.Supp. 342 (S.D. Ill. 1988); Ray v. School Dist., 666 F.Supp. 1524 (M.D.Fla. 1987); Thomas v. Atascadero Unified School Dist., 662 F.Supp. 376 (C.D.Cal. 1986); Shuttleworth v. Broward Cty, 639 F.Supp. (S.D.Fla. 1986); Cronan v. New England Tel. Co. (Mass. Sup. Ct. No. 80332, Aug. 15, 1986). But see Local 1812, Amer. Fed. of Gov't Employees v. United States Dept. of State, 662 F.Supp. 50 (D.D.C. 1987) (denying preliminary injunction against antibody testing of foreign service employees).

128. Doe v. Centinela Hosp., W.L. 81776 (C.D. Cal. 1988).

129. Leckelt v. Board of Commissioners, 49 F.E.P. Cas. (BNA) 541 (E.D. La. 1989). See also Kohl v. Woodhaven Learning Ctr., 865 F.2d 930 (8th Cir., 1989) (residential school for the mentally retarded can deny admission to individual infected with hepatitis B).

130. 729 F.2d 144, 155 (2d Cir. 1984).

The implications of this vision of rights for AIDS policy—and, indeed, for all questions of public health—are profound. Individual concerns are generally given great weight. Despite the egregious discrimination and bigotry which accompany the AIDS epidemic, a consensus has developed in the legal community that discrimination against individuals with AIDS is both wrong and often unlawful (Leonard 1985; Shumaker 1986). That this view quickly became accepted doctrine,[132] even over the protests of the Reagan administration,[133] is testament to how compatible it was with prevailing social norms and constitutional jurisprudence.

Similarly, the respect for individual liberties reflected in modern health law has meant that restrictive actions against individuals who are HIV positive have been surprisingly few. Although there have been many calls for quarantine and mandatory testing, there has been no mass adoption of any restrictive measure. Certainly the legal consensus that many restrictive measures are of questionable constitutionality (Merritt 1986) does not alone explain the paucity of action taken given the concern over AIDS. Far more likely is the fact that the legal view which cherishes individual rights is reflective of societal norms that abhor restrictive actions in matters as personal as disease.

But the picture is not all rosy. For one thing, as the recent autonomy cases suggest, the courts, led by the United States Supreme Court, are moving away from their broad protection of individual rights. The right of privacy is under attack, while rights against discrimination are being eviscerated. Thus legal protections for individuals with AIDS are increasingly precarious.

This reduction in individual rights might not be as alarming if it were accompanied by a decline of the adversarial assumptions beneath public law. This has not happened. Instead, we see today a jurisprudence that remains individualistic and adversarial. It continues to assume that the individual and public are in opposition. It is merely moving towards giving less weight to the individual's interest.

This view of public health law poses significant problems for AIDS policy, for the flip side of a well-developed sense of individual rights is a weakened vision of public goals. Eight years into the AIDS epidemic astonishingly little action has been taken towards establishing a coherent public prevention policy (Beauchamp 1988; Presidential Commission 1988). For example, little thought, and far less action, has been given to devising ways to stem the spread of the disease in the inner cities. After all, if the disease can be thought of as "their" problem, there is no public good at stake.

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132. See cases cited in note 127, supra.

133. U.S. Dept. of Justice, Office of Legal Counsel, memorandum for Ronald E. Robertson; Re: Application of Section 504 of the Rehabilitation Act to persons with AIDS, AIDS-related complex, or infection with the AIDS virus (23 June 1986). The administration later changed its opinion following the *Arline* case. U.S. Dept. of Justice, Office of Legal Counsel, memorandum for Arthur B. Culvahouse, Jr., Re: Application of Section 504 of the Rehabilitation Act to HIV-infected individuals (7 October 1988).

Indeed, much of the policy debate has been over ways to extend or limit individual rights (Bayer 1989). But both individual and majority rights that exist apart from a conceptualization of the public nature of a communicable disease are of limited worth. The law of autonomy gives the individual the right to control certain treatment decisions and perhaps to defend against certain restrictive measures that could otherwise be imposed by the state. However, the law offers neither the individual nor the majority protection against the virus, because it provides no mechanism for formulating a policy that can actually diminish its spread.

Similarly, the law against discrimination protects the individual against invidious discrimination, and enables an individual to hold on to his or her job or schooling for as long as physically possible. But the law only protects those who are "otherwise qualified." It does not help those who are too sick to work or those without a job.

Most importantly, the individual rights that are recognized today provide no adequate assurance of care. There is no legal right for an individual with AIDS to obtain AZT or any other drug. Nor is there any universal right to any form of care. For many AIDS patients, impoverishment is a prerequisite to government assistance (Presidential Commission 1988). And for AIDS patients as a group, there is no legal right that adequate resources be applied to developing new forms of treatment. There may be the hope that lobbying will lead to increases in spending, but there is no entitlement.

These visions of rights, in which rights of prevention are divorced from rights of care, are most understandable as reflections of the brief period of human history in which communicable disease seemed to have been conquered and illness became primarily associated with the chronic diseases of old age. Only in an era when one person's health does not depend on another's does this sharp severing of the public's interest from the individual's interest make sense. This raises two questions: Will the emergence of a new deadly infectious disease change the law's perspective? Will it lead to a reappraisal of the weights and nature given to public and private interests?

It is still too early to tell. Thus far, the courts, at least, have continued to follow the highly individualistic model described above. The restricted epidemiology and the limited communicability of AIDS may make the epidemic compatible with prevailing visions of health law. Alternatively, the threat posed by the epidemic may remind the public of the mutual vulnerabilities that exist in the time of disease.

But even if that happens, its effect may be unclear. If we are very lucky, perhaps we can discover the public realm without losing the respect for individual dignity that we have gained in the years between plagues. On the other hand, there are ominous signs on the horizon. AIDS may not be a democratic epidemic. If its epidemiology continues to be confined primarily to homosexuals, intravenous drug users, and inner-city minorities, then perhaps it will be too easy to think of it as a disease of those outside the community. In such circumstances, the individualistic view of disease that has reigned recently may unite with the court's emerging

majoritarianism to permit the scapegoating of some individuals. In such circumstances, our vision of individual rights and the limited protections it affords may be all we have to thwart the oppressions and bigotry that have accompanied prior, undemocratic diseases.

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