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Health Law and Ethics

HIV Infection and AIDS in the Public Health and Health Care Systems

The Role of Law and Litigation

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The AIDS Litigation Project has reviewed nearly 600 reported cases involving individuals with human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS) in the federal and state courts in the United States between 1991 and 1997. Cases were identified through a federal and 50-state computer and library search. An important subset of litigation relates to HIV/AIDS in the public health and health care systems, since the law affects health care institutions and professionals, patients, and public health policy in America. This subset of HIV/AIDS litigation includes testing and reporting; privacy, the duty to warn, and the right to know; physician standards of care in prevention and treatment; and discrimination and access to health care. In broad terms, the review demonstrates a reliance on voluntary testing and protection of patient privacy through HIV-specific statutes and the common law. Negligence with potential civil and criminal liability has been alleged in cases of erroneous or missed diagnosis of HIV infection. In the first AIDS case to be considered by the Supreme Court, the Court will decide whether patients with asymptomatic HIV infection are protected under the Americans With Disabilities Act. Considerable progress has been made, both socially and legally, during the first 2 decades of the epidemic, but much still needs to be accomplished to protect privacy, prevent discrimination, and promote tolerance.

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THE EPIDEMIC of human immunodeficiency virus (HIV) infection and the acquired immunodeficiency syndrome (AIDS) has had powerful personal, social, and economic effects throughout America—in employment, housing, insurance, education, prisons, and many other aspects of life.[1] Yet, perhaps the most profound effects of the epidemic have been in the public health and health care systems.[2] Public health and medicine have responsibilities to monitor, prevent, and treat HIV infection. At the same time, the nation has struggled with the task of reconciling patients' rights to privacy and nondiscrimination with collective rights to public health protection.

Given the high degree of ongoing social conflict caused by the epidemic, it is not surprising that, unlike past infectious disease outbreaks, attempts to resolve contentious issues consistently involve the courts and legislatures at all levels. Furthermore, because of the high level of patient activism and advocacy, as well as immediate public access to new developments in scientific and medical information, including that available via the Internet, law and policymaking have not been the exclusive preserve of medical experts or other professional specialists. The resulting democratization of policymaking processes has heightened the impact that legislatures and courts have had on the public health and health care systems.

Deeply divisive questions have emerged relating to informed consent for HIV testing, named HIV reporting, confidentiality vs the duty to warn, and an HIV-infected physician's right to practice. These and many other questions have come to be decided by legislatures and courts. The results are by no means uniform or consistent. Court decisions in similar cases sometimes conflict, and legislatures in different jurisdictions at times take markedly different approaches. Nevertheless, legislation and litigation provide a window through which the HIV epidemic's troubling questions, arising in relation to the delivery of health care services and the formulation of complex public health policy, can be examined.

This article is part of the AIDS Litigation Project,[3,4] which has reviewed nearly 600 cases reported in the federal and state courts in the United States between 1991 and 1997. The methods involved a federal and 50-state computer and library search of all reported cases involving HIV infection or AIDS. This article discusses an important subset of litigation relating to HIV/AIDS in the public health and health care systems. (The complete AIDS Litigation Project report can be found in the Library section of the HIV/AIDS Information Center at http://www.ama-assn.org.)

IDENTIFYING CASES OF HIV INFECTION: TESTING AND REPORTING

Issues of law and public policy take on new urgency as the HIV/AIDS epidemic experiences a paradigm shift. Combination antiviral therapies and clinical prophylaxes provide for the first time an opportunity for a longer, higher quality of life for persons living with HIV.[5] Combination therapies have markedly reduced the incidence of AIDS,[6] have lowered rates of perinatal transmission,[7,8] and potentially may diminish infectiousness by decreasing viral load. With these new treat-

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ment opportunities, it becomes critically important to identify persons at the earliest stages of HIV infection and to ensure full and fair access to the health care system.

Testing, since the approval of an HIV antibody test in early 1985,[9] has been considered essential for HIV prevention. With more recent advances in antiviral and prophylactic treatments, testing has also become important as an entrée into the health care system. Public health and medical authorities recommend that all persons at risk should know their serologic status, and many want to see the "routinization" of HIV testing. A broad range of testing services are desirable, such as testing by primary care clinicians and hospitals, public clinics, "alternative" (anonymous) test sites, and home testing. The technological development of "rapid" tests and analyses of saliva and urine will make testing easier for the public.

Despite the manifest clinical and public health benefits, testing may result in loss of privacy, increased social stigma, and discrimination. As a result, many state legislatures have enacted special requirements for HIV testing. State legislation requires informed consent, often in writing, as well as pretest and posttest counseling. While counseling and consent are thought to be important to enhance patient autonomy, ironically, they do make it more burdensome for health care professionals to "routinize" HIV testing and bring it into the mainstream of medicine.

Voluntary testing is almost universally recommended, and most states have abided by an ethic of voluntarism. Compulsory, nonconsensual testing has been undertaken only in limited circumstances and principally for nonmedical purposes. Thus, mandatory tests are imposed, for example, on US military[10] and foreign service personnel,[11] immigrants,[12] and certain sex offenders.[13,14] In the health care setting, however, compulsory testing violates statutory and common law requirements for informed consent and may violate nondiscrimination statutes[15] or constitutional prohibitions against unreasonable searches and seizures.[16] Although a Pennsylvania court held that HIV testing without patient consent or knowledge did not violate state common law doctrines of informed consent or invasion of privacy,[17] that ruling was subsequently overturned by statute.[18]

Some states permit nonconsensual HIV testing of patients in limited circumstances. An Alabama statute, for example, allows testing without consent if (1) the patient is at "high risk" of infection; (2) knowledge of the patient's serologic status is necessary for medical care; or (3) knowledge of HIV status is needed for the protection of health care personnel. A federal district court found the high-risk classification to be unconstitutional because a patient could be arbitrarily classified, but upheld the other 2 classifications.[19] Many states allow compulsory testing to determine the HIV status of a patient in the event of an injury to a health care worker, emergency response employee, or corrections officer that poses a risk of HIV transmission.

Scientific evidence that anti-HIV therapy could significantly reduce perinatal transmission, together with new treatment opportunities for newborns, has led legislatures to consider mandatory testing of pregnant women and newborn infants. Under federal law, states must at a minimum follow Centers for Disease Control and Prevention (CDC) guidelines recommending counseling and voluntary testing for all pregnant women. If federally set targets for reduction of perinatal HIV transmission are not met, mandatory measures ensue.[20] At the state level, several legislatures have enacted laws that mandate counseling and make voluntary testing available. These federal and state statutes may set a standard of care in tort, so that failure to counsel and offer testing to pregnant women may result in physician liability for wrongful life or wrongful birth in the event that the infant is born with HIV infection.[21] New York has enacted a law requiring mandatory testing of newborns, even though a positive antibody test reveals the serologic status of the mother. New York's law also requires disclosure to the mother and protects confidentiality.[22] That law is currently under court challenge on constitutional grounds.[23]

Since the earliest moments of the epidemic, all states have required named reporting of CDC-defined AIDS. By contrast, 28 states require HIV reporting,[24] and 3 additional states conduct HIV surveillance for pediatric cases only.[25] All HIV reporting states except Maryland and Texas are name based.[26] The CDC recently recommended that all states move to a system of HIV surveillance.[6] The CDC also recommends that states (unless otherwise required by state law) provide alternative test sites where names of persons with HIV infection are not reportable. Ten states proscribe nonreportable, anonymous testing.[27] North Carolina's closure of publicly funded anonymous HIV test sites was upheld as a valid exercise of the state's public health powers.[28]

The predominantly voluntary approach to HIV testing and the absence of a national HIV surveillance system has resulted in concerns that HIV/AIDS has acquired a special or "exceptional" status.[29] In New York State, prominent medical organizations sued to compel the health commissioner to include HIV in the official list of sexually transmitted diseases (STDs). By failing to classify HIV as an STD, the commissioner declined to trigger his powers for compulsory testing, reporting, and contact tracing. New York's highest court held that the classification of diseases was within the commissioner's discretion and affirmed the reasonableness of his belief that the exercise of mandatory powers would not serve an important public health purpose.[30]

PRIVACY, DUTY TO WARN, AND THE RIGHT TO KNOW

Privacy of HIV data has been thought to be necessary for both patient autonomy and public health.[31] Privacy safeguards against social stigma and discrimination and allows each person to make decisions for herself concerning disclosure. Privacy also supports trusting clinical relationships and participation in public health services such as testing, counseling, and partner notification. Most states have HIV-specific statutes requiring confidentiality of HIV data.[32] Litigation claiming wrongful disclosure of HIV-related information has been commenced against numerous individual and institutional providers during the course of the epidemic, including hospitals,[33] physicians,[34] and health departments.[35]

Guided by the mandates of the provider-patient privilege and state HIV confidentiality laws, health care professionals are generally prohibited from revealing a patient's HIV-related information.[36] In fact, some state privacy statutes specifically protect HIV information within the health care or social service setting.[37] Intentional disclosure is only 1 way to breach confidentiality. A health care facility's negligent failure to protect a medical record from disclosure may also violate privacy.[38] However, not all disclosures result in liability. If the health care provider can present a compelling reason for disclosure, a court may allow it. The courts balance the need for the disclosure against the harm done to both the individual's privacy and the public interest and often have little difficulty finding against the individual's privacy right. Using such a test, a Pennsylvania

court authorized a hospital to disclose a physician's HIV status to 280 patients who had received invasive procedures.[39] In another case, a court held that a public health agency's disclosure of confidential HIV information to aid in a criminal prosecution was permissible; the criminal activity was deemed a waiver of confidentiality.[40] In contrast, another court prohibited law enforcement access to public health records.[41]

A major tension exists between confidentiality and the "right to know." Health care workers and others who perceive themselves to be at risk for HIV infection in the workplace claim the right to know the HIV status of patients or others. Generally, because infection control precautions in the health care setting are both the standard of practice and highly effective, right-to-know claims are difficult to maintain. For example, a surgeon's lawsuit alleging emotional distress caused by learning, after the fact, that his surgical patient was HIV positive was rejected.[42] Similarly, if morticians and emergency response employees use universal infection control precautions, the risk of HIV transmission is negligible. Nevertheless, federal law authorizes, under certain circumstances, disclosure of HIV information to morticians and emergency response workers upon their request.[43] But whether right-to-know claims will be successful in generating damage awards seems questionable. In a West Virginia case, a mortician filed a tort action against a hospital for failing to inform him that a corpse he had handled was contaminated with HIV. The court found no liability in the absence of actual exposure.[44]

Fear of HIV Exposure in the Health Care Setting

Many cases have been filed by patients claiming that individual or institutional health care providers are liable for exposing them to the risk of HIV transmission without their knowledge. Patients argue that health care professionals negligently caused them emotional distress by failing to warn or failing to prevent some contact that is perceived to pose a risk of transmission. These plaintiffs seek compensation for their mental distress and anguish. Recognizing the litigious nature of American society, many courts limit fear of HIV claims by requiring proof that the plaintiff's mental distress is a result of circumstances posing an actual risk of HIV transmission. Plaintiffs who fear an objectively nonexistent or unprovable risk generally will not be compensated.[45,46] Furthermore, many courts limit compensation to distress occurring during the "window of anxiety," the period between learning of possible exposure and obtaining a reliable HIV-negative test result.[47] In 1 case, a surgical patient provided her own blood for transfusion, but the surgeon transfused another donor's blood. This negligence caused emotional distress that, in light of plaintiff's precautions, was in the court's view both reasonable and foreseeable.[48]

HIV-Infected Health Care Professional's Duty to Disclose

Several courts have held that health care professionals have a duty to disclose their HIV status to patients or health authorities, assuming that their professional activities pose a risk of transmission to patients. The Maryland Court of Appeals ruled that a surgeon has a duty to inform his patients of his infection; even if the patient has not actually been exposed and tests HIV negative, the contact with the surgeon may subsequently give rise to a claim for the infliction of mental distress due to fear of transmission.[49] Courts justify orders to disclose based on a duty to protect patients and on the doctrine of informed consent.[39] Requiring disclosure to patients, of course, can severely jeopardize a health care professional's career. To avoid this result, some states allow the professional to continue practicing, with appropriate restrictions and supervision, but without disclosing his or her HIV status.

The Duty to Warn Third Parties at Risk

Many state laws permit, but do not require, disclosure by physicians to third parties known to be at significant future risk of HIV transmission from patients known to be infected.[50] Thus, if a physician reasonably believes that a patient will share drug injection equipment or have unprotected sex without informing a partner of the risk, the physician has discretion to inform the partner. Under some disclosure laws, the physician is required to first counsel the patient to refrain from the risk behavior, and, in providing the third-party warning, the physician is prohibited from disclosing the patient's identity. In the absence of state laws permitting such disclosure, physicians may be held liable for breach of confidentiality for disclosing patient information to sex partners.[51]

The "duty to warn" may extend to nonpatient third parties in other contexts, based on the provider's primary duty to the patient. Thus, health care professionals have a duty to inform patients that they have been transfused with HIV-contaminated blood, and this duty may extend to third parties. A physician in 1 case failed to inform a teenager or her parents that she had been transfused with HIV-contaminated blood. When the young woman's sexual partner tested positive for HIV, the court upheld his claim against the physician based on the physician's failure to inform the patient.[52] Similarly, courts have held that a health care professional's duty to inform a patient of his or her HIV infection may extend to those the patient foreseeably puts at risk such as a spouse[53] or family member caregiver.[54] On the other hand, courts have ruled that disclosure is wrongful in cases in which the third party, such as a family member, is not at actual risk of infection, or the physician has no knowledge that the patient has failed to disclose to the partner.[55]

PREVENTION AND TREATMENT: PHYSICIAN STANDARDS OF CARE

Negligent Diagnosis of HIV/AIDS

Patients who have been erroneously informed that they are HIV-infected, when in fact they are not, have filed suit against their health care providers for negligent infliction of emotional distress. Some of these plaintiffs have argued that an HIV-positive diagnosis is a "death sentence" that inflicts extreme psychological harm. To limit recovery to only those cases involving a significant claim for compensation, some courts have refused to award damages unless the mental distress arose from or led to physical injury. For example, courts have held that increased blood pressure is not an adequate injury, but that adverse effects of AIDS treatments or a patient's attempt at suicide would suffice to justify liability.[56] Other courts have not imposed a physical injury requirement.[57]

Providers may also be liable for negligently failing to diagnose HIV infection. In 1 case, a jury awarded more than $1 million in a case in which an earlier diagnosis would have delayed by 1 year the onset of symptoms, disability, and death.[58] A physician may also be liable for unnecessary delay in notifying a patient of exposure to HIV[59] and may be liable to the patient's sexual partner who is subsequently infected.[52] How-

ever, providers have not been held liable for failure to diagnose and effectively treat HIV unless the plaintiff has shown a causal connection between their failure and the injury suffered.[60] In the early years of the epidemic, failure to diagnose HIV infection did not expose the provider to significant liability, since treatment options and likelihood of success in treatment were limited. But as treatments for HIV illness develop to higher levels of efficacy, failure to render a prompt diagnosis or failure to initiate prompt and appropriate treatment may expose providers to increasing liability.

Distribution of Drug Injection Equipment

Public health[61] and medical[62] authorities recommend that physicians counsel drug users to use a new syringe and needle for every injection. Syringe exchanges have been established at the state and local levels to prevent transmission of HIV and other blood-borne pathogens.[63] Nevertheless, a web of state statutes create criminal offenses for the sale, distribution, or possession of syringes and needles.[64,65] These laws pose the threat of prosecution to public health officials and community activists who distribute sterile needles and syringes, and, in some cases, prosecutions have resulted. The Washington Supreme Court, however, upheld syringe exchange as a valid public health measure. The court reasoned that the health department had acted in pursuance of an AIDS statute that granted the department the general power to implement prevention strategies.[66] Federal law prohibits use of federal funds for syringe exchange until the secretary of health and human services certifies that exchanges are effective in preventing HIV infection and do not encourage drug use.[67]

DISCRIMINATION AND ACCESS TO CARE

The HIV epidemic has been characterized by a high level of social opprobrium against those infected or suspected of being infected. As a result, individuals with HIV infection routinely encounter discrimination in many aspects of their lives. Discrimination in the health care setting, however, is especially pernicious, depriving patients of necessary services and undermining their trust in the system's commitment to provide them with the care they need. If individuals fear discrimination in health care, they may forgo testing or fail to discuss their health and risk behaviors. Furthermore, because health care professionals are viewed by the general public as being well informed, their actions set a poor example for others attempting to respond to the epidemic in a nondiscriminatory fashion.

Institutional health care providers and other employers have a duty to provide a reasonably safe workplace. The use of barrier techniques on a universal basis has been the officially sanctioned approach to workplace safety. As a result, discrimination against patients is rarely, if ever, justified by a provider's fear of transmission. The Occupational Safety and Health Administration's (OSHA's) blood-borne pathogen safety standard[68] has been challenged as overly broad,[69] but remains the primary safety standard. Although employer noncompliance with infection control standards may give rise to a justifiable refusal to work, the underlying fear must have an objective basis.[70] Employee claims of occupational transmission (or fear of occupational transmission) are generally covered by worker compensation statutes,[71] which provide exclusive remedies for work-related claims against employers.[72]

Definition of "Disability" Under the ADA: The Supreme Court's First AIDS Case

An array of laws at the federal, state, and local levels prohibit discrimination on the basis of a person's disability or health status.[1] The primary federal nondiscrimination statute is the Americans With Disabilities Act (ADA) of 1990,[73,74] although the laws of many states and localities also specifically prohibit discrimination against individuals living with HIV/AIDS.

The ADA provides that no individual "shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation."[75] The ADA's definition of "public accommodation" specifically includes hospitals and professional offices of health care providers.[76] Similarly, New York's highest court ruled that the offices of private dentists are considered places of public accommodation under New York law.[77]

A critically important issue under the ADA is whether persons with asymptomatic HIV infection have a "disability" and thus are protected under the ADA.[78] Disability is defined as a physical or mental impairment that substantially limits 1 or more of the major life activities of the individual, a record of such impairment, or being regarded as having such an impairment.[79] In the past, many courts have ruled or assumed as undisputed that HIV infection, as the underlying cause of a life-threatening illness, is a disability. However, several recent court decisions have held that HIV does not automatically qualify as a disability, and in each case there must be an individualized determination as to whether the infection actually limits, in a substantial way, a major life activity. Given the advent of new combination therapies that significantly delay the onset of disabling symptoms, this judicial view could markedly undermine legal protection against discrimination for persons with asymptomatic or mildly symptomatic HIV infection. The ADA's legislative history, however, indicates that Congress intended to include HIV infection within the definition of disability, and the Equal Employment Opportunity Commission's regulations embody that view.[80] In its first AIDS case ever, the Supreme Court will decide whether and to what extent persons with HIV infection are protected under the ADA.

In *Abbott v Bragdon*,[81] a dentist refused to fill a dental cavity of an HIV-infected patient. The patient then brought suit alleging that the refusal violated the ADA. The dentist conceded that his professional office was covered by the ADA, but argued that providing services to the infected patient, because of the risk of HIV transmission, would pose a direct threat to his health. Additionally, he argued that the plaintiff, who did not have symptoms of HIV illness, was not an individual with a disability under the ADA. The lower courts rejected the dentist's defenses, concluding that the dentist was unable to show that in 1994, when the case arose, there was evidence that treating an infected patient posed a significant risk. The plaintiff's infection, which she testified resulted in her decision against becoming pregnant, was viewed as substantially limiting the major life activity of reproduction. The Supreme Court has agreed to consider 3 questions presented by the case: (1) whether reproduction is a major life activity; (2) whether asymptomatic HIV infection is a per se disability under the ADA; and (3) whether the courts should defer to a health care provider's reasonable professional judgment.

The ADA's coverage also extends to individuals merely regarded as having a disability. Thus, it is unlawful to discrimi-

nate against an individual based on the misperception that the person is infected with HIV under the ADA as well as under the laws of many states.[82] Persons discriminated against because of their association with a person with HIV infection are also protected,[83] as are persons retaliated against because of their opposition to discrimination.[84]

The Health Care Professional's Duty to Treat

Courts have consistently held that health care professionals have a legal duty to treat patients living with HIV/AIDS.[85] Health care professionals must, of course, exercise appropriate clinical judgment. If a professional lacks the skill appropriate to render competent care, she may legally refuse to treat the person and may lawfully refer him elsewhere.[86] A clinician cannot, however, simply reject or refer an HIV-infected patient solely because of his or her HIV status.

The courts have had to decide the difficult question whether and to what degree a health care professional can treat HIV-infected persons differently from other patients. Although CDC and OSHA standards require use of "universal" precautions applicable to all patients without regard to infection status, imposition of special precautions for HIV-infected patients has been upheld.[87] One court, finding that special precautions may be necessary for certain procedures, ruled that a dentist may lawfully refuse to treat a patient who refuses to reveal HIV-related information.[88] But another court ruled that the use of special precautions, which resulted in delay of services, beyond those recommended by the CDC constituted unlawful discrimination.[89]

Nondiscrimination In Health Insurance

Access to health care is often contingent on the ability to pay or the availability of insurance coverage. Federal and state law provides little or no protection from adverse coverage decisions provided the insurance company uses sound actuarial data. However, an employer's decision to place severe limits on coverage for HIV/AIDS, but not on comparable diseases, may be unlawful under the ADA.[90,91] A central question in determining the extent of health insurance coverage is whether certain services are "medically necessary." In an important case, the Eleventh Circuit Court of Appeals held that skilled nursing care was "medically necessary" and should be reimbursed under an employer's self-funded health benefits plan.[92]

HIV-Infected Health Care Professionals

Federal law[93] requires states to comply with CDC guidance[94] that recommends an individualized determination of whether HIV-infected physicians engaging in "exposure-prone" procedures can safely practice. At present the CDC and the American Medical Association are reevaluating their policies in light of epidemiologic evidence showing that the risk to patients, even from invasive procedures, is negligible. The judiciary has had to decide whether HIV-infected health care professionals pose a significant risk to their patients, and thus are not qualified to continue to practice. Several courts have upheld decisions to prohibit HIV-infected health care professionals who perform invasive procedures.[95,96] These courts have reasoned that the severity of harm if HIV infection were transmitted justifies practice restrictions. However, the Ninth Circuit Court of Appeals held that a physician's practice could not be restricted if he did not primarily perform invasive procedures. The physician, a general internist, was employed by the Federal Bureau of Investigation (FBI). The agency refused to refer patients to the physician after suspecting that he was HIV positive. The court ruled that the FBI had failed to make adequate inquiries about the physician's infection control procedures: "The record shows that Dr. Doe and the hospital were entirely forthcoming about these procedures, but that their explanations fell on deaf ears."[97]

Prisoner Health Care

Access to adequate health care for prison inmates living with HIV/AIDS has been a long-term problem.[98] Gross inadequacies in state prison health care systems may rise to a constitutional violation.[99] In New York, inmates living with HIV/AIDS challenged the state's delivery of medical, mental health, educational, and prevention services. The court ordered the state to release records enumerating the inmates, both living and deceased, who had been diagnosed as having AIDS or AIDS-related illnesses, in order to aid in the court's determination as to whether the prison authorities deliberately neglected the inmates' health care needs.[100] Inadequate medical care and lack of HIV education services resulted in a court-imposed remedial plan in another case.[101] But when a showing of deliberate indifference is lacking, federal constitutional claims against prison officials will fail.[102]

CONCLUSION

Considerable progress has been made—socially and legally—during the first 2 decades of the HIV/AIDS epidemic. Reductions in social stigma and new statutes to protect privacy and proscribe discrimination have emerged. The serious consequences of the epidemic, however, are not over. While instances of gross abuse are less frequent, intolerance and animus stubbornly persist. Even legal advances have been eroded with some courts denying antidiscrimination protection for persons with asymptomatic HIV infection, and upholding discrimination against HIV-infected health care professionals despite the extremely low risks.

Systematic efforts to confront the HIV/AIDS epidemic are needed: (1) expanded and nondiscriminatory access to health care; (2) expansion of counseling, testing, and other prevention services; (3) educational campaigns to promote tolerance and reduce social stigma; and (4) better laws to protect privacy and prohibit discrimination. The health care and public health systems need these and other kinds of new strategies to reduce the deep personal and social burdens of HIV disease in the United States.

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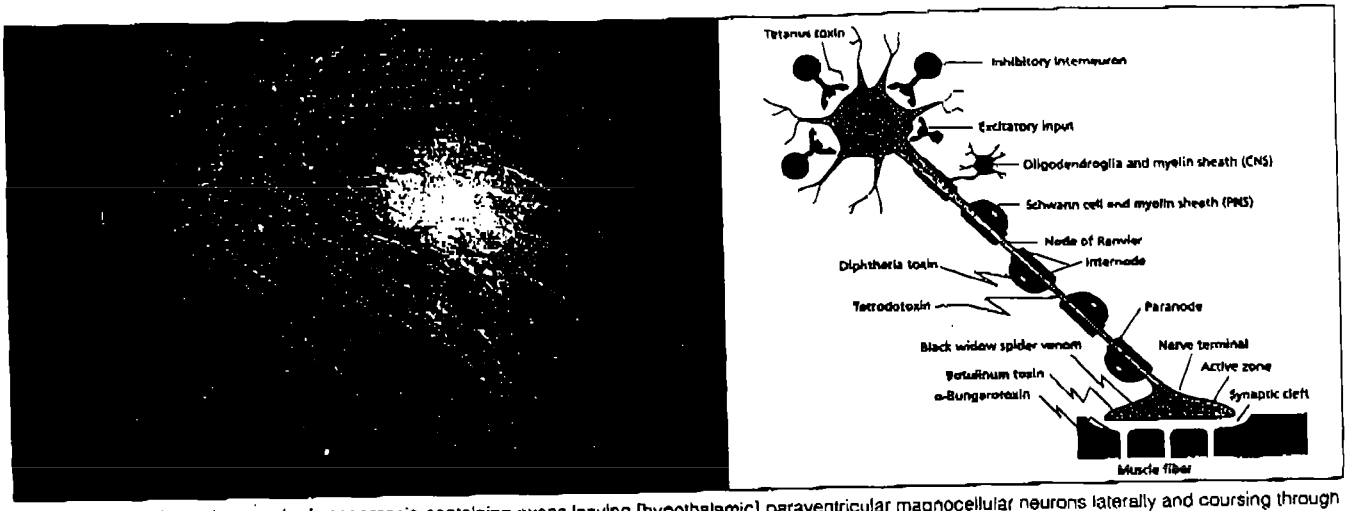

Left, "Dark field photomicrograph of vasopressin-containing axons leaving [hypothalamic] paraventricular magnocellular neurons laterally and coursing through and around the fornix on their ventral pathway to the pituitary stalk." Right, "Nuclear groups reflecting the cellular organization [of the hypothalamus]: some of these contain known releasing secretory systems." From **Atlas of Clinical Neurology,** edited by Roger N. Rosenberg, 504 pp, with illus, $165, ISBN 0-7506-9922-1, Philadelphia, Pa, Current Medicine, Woburn, Mass, Butterworth-Heinemann, 1998. Reprinted by permission.

AIDS and Rights

Human Rights and Public Health in the AIDS Pandemic, by Lawrence O. Gostin and Zita Lazzarini, 212 pp, $29.95, ISBN 0-19-511442-6, New York, NY, Oxford University Press, 1997.

The acquired immunodeficiency syndrome (AIDS) epidemic has occasioned frequent and varied debates about human rights, public health, and the sometimes difficult conflicts that arise between them. At times, these interests are complementary, at times, there is indeed an irreducible conflict between competing, legitimate agendas. It is not surprising, however, that such dilemmas arise in the setting of human immunodeficiency virus (HIV) infection and AIDS, given the basic dynamics of an epidemic in which private behavior has significant public consequences. This fundamental contradiction has engendered many debates, since early in the epidemic, over issues of confidentiality vs disclosure, voluntary vs mandatory HIV testing, and the limits and obligations of partner notification, epidemiologic surveillance, and risk reduction interventions in high-risk populations.

Fortunately, a new resource can help clinicians, public health officials, and policy makers think through the sometimes difficult and contradictory questions that arise in these sensitive areas. *Human Rights and Public Health in the AIDS Pandemic,* by Lawrence Gostin and Zita Lazzarini, is a carefully written, comprehensive guide to many of the ethical and philosophical issues generated by the tension between these two realms. It will be a valuable guide and reference both for people working in the field and for those seeking to acquaint themselves with the major themes.

The authors' basic premise is that the demands of human rights and of public health are in fact most often complementary—that, in a sense, the apparent conflict between them is often a false dichotomy—and that the best guarantee of public health is a strong societal commitment to human rights. For example, as has been strongly argued previously, particularly in developing countries, equality for women and the ability to exert control over one's sexual choices are critical elements in any public health strategy to decrease HIV transmission is such settings. As the authors also argue convincingly in this volume, policies such as quarantine and travel restrictions for HIV-infected individuals are not only unacceptable from a human rights standpoint but also unlikely to have any positive public health impact. Other contexts, such as partner notification, the rights and obligations of HIV-infected health care workers, and the implications of reproductive decisions for women with HIV, raise more difficult questions. In these areas, the authors provide useful guidance and a systematic way to assess the rationale for and consequences of different policy options.

The authors begin by outlining the broad framework of postwar human rights law and international agreements, which form the basis for the human rights agenda for the AIDS epidemic. Some of these principles are clear-cut and unambiguous in their implications, such as the right to life, freedom from inhumane treatment, freedom of movement, and the right not to be discriminated against. Others raise immediate tensions in the setting of AIDS, such as the right to found a family and have children, which may conflict with the concurrent responsibility to protect children from harm, as in the case of perinatal HIV transmission. (Indeed, both on a clinical and public health level, the decisions faced by HIV-infected individuals about reproduction are among the most difficult that must be made, complicated by the uncertainty of the actual risk of mother-infant transmission, the concept of "wrongful life" vs the belief that a life lived, however brief, is precious, and the social meaning of fertility for women in many societies. The last issue has been of key importance in strategies aimed at reducing perinatal HIV transmission in the developing world where the need has been articulated for virucides that are not also contraceptives.)

When conflicts arise between human rights and public health agendas, Gostin and Lazzarini suggest a logical and systematic approach to evaluate the issues and craft effective policies. The Human Rights Impact Assessment is a seven-step process that can be applied to virtually any real-world situation in which these issues arise: (1) find the facts; (2) determine if the public health purpose is compelling; (3) evaluate how effectively the policy would achieve the public health purpose; (4) determine whether a particular policy will be as effective as other policies; (5) determine whether the public

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health policy is well-targeted; (6) examine each policy for human rights burdens; and (7) determine whether the policy is the least restrictive alternative that can achieve the public health objective. If, after addressing all of these elements, a coercive measure is the one that is determined to be truly the most effective, least restrictive alternative, then it must be based on the "significant risk" standard—ie, the risk of *not* implementing the policy must be significant—and the policy must also guarantee fair procedures.

This approach is then applied in the book to a series of case studies, including a health care worker with HIV infection, a proposed public health policy regarding breastfeeding and transmission of HIV in a developing country, and a hospital policy requiring disclosure of patients' HIV-serologic status to known sexual and needle-sharing partners. These examples demonstrate the usefulness of the assessment process, which clearly results in these cases in logical, defensible policy decisions that best satisfy the potentially competing agendas.

The reader finishes this book with the feeling that the strategies outlined therein will be of practical benefit in trying to untangle the sometimes complex ethical issues that arise in the field of HIV prevention, policy, and practice. Yet, at the same time, one also has the feeling that, as often happens when one observes skilled practitioners performing their craft, the experts have made it seem a little easier than it really is.

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Cancer Follow-up

Cancer Patient Follow-up, edited by Frank E. Johnson and Katherine S. Virgo, 554 pp, with illus, $69, ISBN 0-8151-4925-5, St Louis, Mo, Mosby, 1997.

This comprehensive multiauthored textbook on follow-up of the patient with cancer fills an enormous gap in the published knowledge base for the oncology practitioner. The details of patient follow-up strategies in the care of the cancer patient remain largely determined by each practitioner and until recently have been poorly defined. As the editors point out in the preface, "There are currently few well-accepted standards for cancer patient follow-up." As the delivery of medical care becomes more focused on outcomes and cost-effectiveness, oncologists need more guidance on what constitutes an appropriate follow-up regimen.

The book comprises 25 chapters authored by 111 contributors from 16 different institutions, representing leading cancer centers in the United States, Japan, Great Britain, and the Netherlands. "Concepts," the first of three main sections, includes chapters that explain the goals of surveillance, as well as the economic principles of follow-up evaluation. These chapters are particularly useful and deserve careful reading. The entire issue of costs is largely ignored in much of the literature, and this primer is most helpful. In addition, a cost analysis of the follow-up strategies presented in the next section is set forth in a table. The ethical principles that guide follow-up are also discussed.

The second section, "Current Practice," contains 19 chapters on specific tumor types. Each begins with a discussion of the tumor, its recurrence patterns, and the staging system. Methods of surveillance and therapy of recurrent disease are also delineated. Following the presentation of the "standard" follow-up regimen, three to four "counterpoints" are presented from other institutions, including many outside the United States. This material highlights the similarities and differences between regimens used at different institutions. Following the last counterpoint, a table of follow-up strategies is given to allow quick comparison of all the regimens presented. It is incumbent on all of us who care for cancer patients to pursue follow-up strategies that are based on scientific evidence and careful studies of cost-effectiveness. Failure to do so may leave future decisions regarding follow-up in the hands of "bean counters" rather than oncologists. This book is an excellent step in the direction of practicing evidence-based follow-up, providing a wealth of data gleaned from the international literature.

The editors admit that a few tumors are omitted from this first edition, including thyroid, uterine cervix, eye, and brain. I sincerely hope that a second edition will be forthcoming to complete this excellent treatise. As an oncologist, I had also hoped for a standard table of follow-up for each tumor. However, upon reading the material, one quickly realizes that such standardization is extremely difficult, considering the broad scope of tools available to the oncologist today. The table at the end of each chapter is an excellent format for presenting otherwise disparate approaches. In fact, one should use this book for guidance to develop a follow-up strategy that is individualized yet based on scientific evidence—far more useful than a cookbook strategy.

The final section, "Horizons," provides a primer on two important areas, including "How Molecular Genetics Can Affect Cancer Surveillance Strategies" and "Decision Analysis of Cancer Patient Follow-Up." These are extremely well-written summaries of important topics, and I would expect that this portion of the book might expand in future editions.

This important text belongs in the personal collection of anyone who provides follow-up care to patients with cancer. It is well constructed and nicely arranged. It provides a storehouse of information in a single source that is otherwise difficult to acquire and is of use to surgeons, medical oncologists, and radiation oncologists alike. The focus on cost-effectiveness of follow-up strategies is most welcome in today's medical economic climate. *Cancer Patient Follow-Up* is an extremely useful book, which will hopefully progress through many editions providing guidance to oncologists for years to come.

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Imaging

Grainger and Allison's Diagnostic Radiology: A Textbook of Medical Imaging, vols 1-3, edited by R. G. Grainger and D. J. Allison, 3rd ed, 2626+ pp, with illus, $495, ISBN 0-443-05167-4, New York, NY, Churchill Livingstone, 1997.

It has been several years since I reviewed the second edition of this textbook of medical imaging. Since the last review there have been significant changes in radiology and in the way that radiology and medicine, in general, are practiced.

When the second edition came out, magnetic resonance imaging (MRI) was in its infancy, spiral computed tomography (CT) was just beginning to be used, and interventional radiology was a mere shadow of what it is today. Digital images were present but in no way as sophisticated or far reaching as is in many of today's radiology departments. Managed care was a term just becoming familiar to many radiologists and clinicians. Currently, for better or worse, managed care has considerable influence in how radiology studies are ordered and performed. In his foreword to the third edition, Dr Pochen has made the analogy of the primary care physician being asked to manage many of the clinical problems that formerly were referred to a specialist, just as the general radiologist is expected to provide expertise in multiple areas of radiological diagnosis. To aid the general radiologist in this challenge comes the third edition of this already popular textbook.

The text is in 12 sections divided among three volumes with 112 chapters. Specialists from the world over have contributed their expertise to making this textbook an excellent reference and atlas of imaging. Most authors are from the United States and England, but much of Europe and Asia is also represented.