

# AIDS, Power, and Reason

RONALD BAYER

*The Hastings Center*

**A**T THE CONCLUSION OF HIS MAGISTERIAL HISTORY, *Plagues and People*, William McNeill (1976, 291) asserted:

Ingenuity, knowledge and organization alter but cannot cancel humanity's vulnerability to invasion by parasitic forms of life. Infectious disease, which antedates the emergence of humankind, will last as long as humanity itself, and will surely remain as it has been hitherto one of the fundamental parameters and determinants of human history.

Written ten years ago, these observations seemed, at the time, somewhat overdrawn, especially with reference to the advanced technological societies. Now, in the fifth year of the AIDS epidemic, as American political and social institutions seek to fashion a response to the HTLV-III retrovirus, McNeill's observations seem prescient.

Since 1981, when the Centers for Disease Control determined that a pattern of extraordinary illnesses had begun to appear among young gay men on the West Coast, America has been compelled to confront a challenge that is at once biological, social, and political. What

some had believed might be a short-lived episode, like toxic shock syndrome or Legionnaires' disease, has proved to be quite otherwise, and no end is in sight. Predictions as to the ultimate toll over the next decade range into the hundreds of thousands. However this modern epidemic is brought under control, it is clear that no critical dimension of American social and political life will remain untouched. AIDS has become a "fundamental parameter" of contemporary history.

Like the epidemics of prior eras, AIDS has the potential for generating social disruption, for challenging the fabric of social life, the more so since it has been identified with those whose sexual practices and use of drugs place them outside the mainstream. As the disease spreads more rapidly among heroin users, the color of those who fall victim will darken, thus adding another dimension to the perceived threat to society posed by the bearers of the HTLV-III retrovirus.

In the face of an extended microparasitic siege, will American social institutions respond on the basis of reason guided by a scientific understanding of how HTLV-III transmission occurs, or will anxieties overwhelm the capacity for measured responses? Will the threat posed by AIDS elicit Draconian measures, or will fear of such measures immobilize those charged with the responsibility of acting to protect the public health? Will our capacity for social reason allow us to traverse a course threatened by irrational appeals to power and by irrational dread of public health measures? Will reason, balance, and the search for modest interventions fall victim to a rancorous din? At stake is not only the question of how and whether it will be possible to weaken, if not extirpate, the viral antagonist responsible for AIDS, but the kind of society America will become in the process.

### Private Acts, Social Consequences

The central epidemiological and clinical feature of AIDS and the feature that makes the public health response to its spread so troubling for a liberal society, is that the transmission of HTLV-III occurs in the context of the most intimate social relationships, or in those contexts that have for nearly three-quarters of a century proven refractory to effective social controls. The transmission of AIDS occurs in the course of sexual relationships and in the course of intravenous drug use. In both realms, and fueled by struggles on the part of women, gays, and racial minorities, the evolution of our constitutional law

tradition as well as our social ethos over the past two decades has increasingly underscored the importance of privacy and of limiting state authority—at times for reasons of practicality, at times for reasons of political philosophy.

It is no accident that the Supreme Court discovered the “penumbral rights of privacy” in a landmark case overturning Connecticut’s efforts to prohibit the use of birth control devices<sup>1</sup>; that issues of privacy loomed so large in the early abortion decisions; that so many of the procedural rights of criminal suspects enunciated by the Warren court emerged out of drug control cases. In each instance, attempts to enforce the law required the intrusive reliance upon the police in ways that offended the liberal understanding of the appropriate limits of state authority. Furthermore, the very effort to enforce the criminal law in such private realms was held to be inherently corrupting of law enforcement agencies, the result a “crisis of overcriminalization” (Kadish 1968).

An ideology of tolerance emerged to reflect the new perspective on the limits of the criminal law (Packer 1968) and on the capacity of all agencies of social control to compel adherence to standards of personal behavior where no complainants existed. When framed in the diction of sociology, the ideology of tolerance focused on the impact of “labeling” upon deviants (Schur 1971); when framed by concerns of law enforcement, it centered upon “victimless crimes” (Schur 1965).

This was the legal-social context within which AIDS intruded upon America, forcing a consideration of how profoundly private acts, with dire implications for the commonweal, might be controlled.

The only effective public health strategy for limiting or slowing the further spread of HTLV-III infection is one that will produce dramatic, perhaps unprecedented changes in the behavior of millions of men and women in this country. Such changes will demand alterations in behaviors that are linked to deep biological and psychological drives and desires. They will demand acts of restraint and even deprivation for extended periods, if not for the lifetimes of those infected and those most at risk for becoming infected.

The transmission of HTLV-III has as its first and most obvious consequence a private tragedy: the infection of another human being.

---

<sup>1</sup> *Griswold v. Connecticut*, 381 U.S. 479 (1965).

But to conceive of such transmission between "consenting adults" as belonging to the private realm alone is a profound mistake (Mohr 1985). Each new carrier of HTLV-III infection is the potential locus of further social contamination. When few individuals in a community are infected the prospect of undertaking individual and collective measures designed to prevent the spread of AIDS is enhanced. When, however, the levels of infection begin to approach a critical mass, when a level of saturation is approached, the prospect for adopting programs of prophylaxis is diminished. At stake here is a matter of extraordinary social moment. It has been estimated, we cannot be sure with what degree of accuracy, that the levels of HTLV-III infection by mid-1986 among gay men in San Francisco were something over 50 percent. Similar levels of infection have been cited for New York City. (Among intravenous drug users in New York and New Jersey the figures are, if anything, more grim.) Therefore, in New York and San Francisco, the likelihood of a gay or bisexual man avoiding an encounter with an infected male partner has virtually disappeared (Kuller and Kingsley 1986). Only the practice of great care in the conduct of one's sexual behavior is left as a mode of protection against infection or reinfection. That is not now the case in many cities across the country, particularly in America's midsection. As a clinical intervention would seek to block viral replication, the public health challenge is to prevent the replication of New York and San Francisco.

In some important respects the problem posed by AIDS is like those problems posed by a host of behavior-related diseases, e.g., lung cancer, emphysema, cirrhosis, with which health policy has had to deal explicitly since the surgeon general issued his first report on smoking (U.S. Department of Health, Education, and Welfare 1964). Ironically, at the very moment that an ethos of privacy was being enunciated, founded on philosophical individualism, the collective significance of every individual's acts began to attain public recognition. Both in the Lalonde report issued in Canada and *Healthy People* (U.S. Department of Health, Education, and Welfare 1979), public officials have argued that many private acts have indisputably social consequences, and that public intervention to limit social costs—characterized by economists as negative externalities—was a matter of the highest priority.

In the debate that has raged over the past two decades about measures to promote health—particularly over mandatory seatbelt and helmet laws—the specter of "Big Brother" has been evoked in an

effort to thwart public health regulations designed to limit morbidity through the modification of personal behavior (Moreno and Bayer 1985). But, in contrast to the difficulties that would be posed by efforts to limit the transmission of HTLV-III infection, those presented by attempts to modify smoking, alcohol consumption, and vehicular behavior are simple. In each of these cases we could, if we chose to, affect behavior through product design, through pricing and taxation mechanisms, through the regulation and control of essentially public acts. Invasions of privacy would be largely unnecessary. With the transmission of HTLV-III the public dimension of the acts that are critical for public health is exceedingly limited. Closing gay bathhouses in San Francisco or New York, the subject of acrimonious debate on both coasts—to the dismay of some traditional advocates of public health, who viewed such settings simply as “nuisances”—may have important symbolic meaning. But the bathhouse is not the Broad Street pump, so crucial in the history of the effort to control cholera in Great Britain. Attempts to control the public dimension of HTLV-III transmission, whether through bathhouse closings or the repression of male and female prostitution, even if successful, will have only the most limited impact on the spread of AIDS.

### Public Policy, Civil Liberties, and the Modification of Behavior

The central public problem before us is how to alter behavior that occurs in the most private of settings. Can that be done? Can it be done in a way that will not involve levels of intrusion into privacy that are morally repugnant? Can it be done in ways that do not require surveillance of Orwellian proportions? Can it be done in ways that acknowledge the importance of civil liberties to the structure and fabric of American social life?

It is important to underscore at this point a matter of direct relevance to these questions. The ethos of public health and that of civil liberties are radically distinct. At the most fundamental level, the ethos of public health takes the well-being of the community as its highest good, and in the face of uncertainty, especially where the risks are high, would limit freedom or restrict, to the extent possible, the realm of privacy in order to prevent morbidity from taking its

toll. The burden of proof against proceeding, from this perspective, rests upon those who assert that the harms to liberty would, from a social point of view, outweigh the health benefits to be obtained from a proposed course of action.

From the point of view of civil liberties the situation is quite the reverse. No civil libertarian denies the importance of protecting others from injury. The "harm principle," enunciated by John Stuart Mill, is in fact the universally acknowledged limiting standard circumscribing individual freedom. For twentieth-century liberals and civil libertarians, that principle has typically accorded considerable latitude to measures taken in the name of public health. But since the freedom of the individual is viewed as the highest good of a liberal society, from a libertarian point of view, measures designed to restrict personal freedom must be justified by a strong showing that no other path exists to protect the public health. The least-restrictive alternative, to use a term of great currency, is the standard against which any course of action must be measured. When there are doubts, the burden of proof is upon those who would impose restrictions.

These two great abstractions, liberty and communal welfare, are always in a state of tension in the realm of public health policy. How the balance is struck in a particular instance is, in part, a function of empirical matters—how virulent is a particular viral agent, with what degree of ease can it be transmitted, can therapeutic interventions blunt the consequence of infection—and in part a function of philosophical and political commitments. In the case of AIDS, the capacity of American culture to tolerate, over an extended period, the social stress engendered by the pattern of morbidity and mortality will determine how such empirical matters and philosophical concerns are brought to bear on the making of public health policy.

## The Appeals and Limits of Power

Faced with the presence of a new infectious and deadly disease, one whose etiological agent has already infected one to two million individuals, there is an understandable tendency to believe that the public health response ought to reflect the gravity of the situation. A deadly disease demands a forceful and even a Draconian response. In fact, however, the public health departments in the two cities

most affected by AIDS, New York and San Francisco, have responded over the past five years with considerable restraint. What better indication is there of the effort to balance a commitment to public health with an appreciation of the importance of civil liberties than the lengthy, perhaps tortured, discussion of whether or not to shut the gay bathhouses? At the federal level, the recommendations of the Centers for Disease Control (1985a, 1985b, 1985c) throughout the epidemic have been designed to limit the impulse toward rash and scientifically unfounded interventions. But to those who are alarmed, restraint appears as an apparent failure on the part of public health officials. The unwillingness to put forth "tough" policies on AIDS has provoked charges of timidity (Starr 1986), an unconscionable capitulation to gay political pressure, and the subversion of the ethos of public health by that of civil liberties (Restak 1985).

Accusations against public health officials for their failure to move aggressively against disease and for their capitulation to special interests are not new. Charles Rosenberg has noted that, in the nineteenth century, physicians who were too quick to discover the presence in their communities of epidemic diseases were often the targets of censure (Rosenberg 1962, 27). Since such diagnoses could well produce financial disaster for local commercial interests, public health officers sometimes sought to silence those who warned of the imminence of epidemics and to restrain the overzealous. A contemporary critic said of the New York Board of Health that "it was more afraid of merchants than of lying" (Rosenberg 1962, 19). In the case of AIDS—despite the professionalization in the twentieth century of those responsible for public health—*anxiety* has surfaced over whether political motivations have colored not only the willingness to press for forceful measures, but also prevailing official antialarmist pronouncements about the threats posed by HTLV-III. Have public health officials been too reassuring about the modes of transmission? Have they underplayed the potential role of female-to-male transmission? Have they failed to adopt standard venereal disease control measures like sexual contact tracing because of an unbalanced concern for civil liberties? Has a commitment to privacy and confidentiality thwarted sound public health practice, thus placing the community at risk?

Such AIDS-specific fears have merged with an undercurrent of populist distrust for scientific authority that has been amplified in recent years by the politically charged debates among scientists over

environmental and occupational health policy. These factors have contributed to the volatility of public opinion polls regarding matters like quarantine and isolation. Eleanor Singer and Theresa Rogers (1986) have found that as many as one-third of surveyed Americans favor the use of quarantine against those with AIDS or those who "carry AIDS," though they know a great deal about the modes of HTLV-III transmission and appear to accept the findings of the Centers for Disease Control on such matters.

Because of the potential abuse of power and authority that could well attend the implementation of public policies designed to halt the spread of HTLV-III infection, less attention has been given to the ways in which a failure to take appropriate public health measures could produce the popular basis for more drastic action. Writing about the Black Death, McNeill (1976, 172) noted:

In Northern Europe, the absence of well-defined public quarantine regulations and administrative routines—religious as well as medical—with which to deal with plagues and rumors of plagues gave scope for violent expression of popular hates and fears provoked by the disease. In particular, long-standing grievances of poor against rich often boiled to the surface.

We have, thus far, not experienced the kind of anomic outbursts described by McNeill, though reported increases of assaults on gay men (*New York Times* 1985) and strikes by parents seeking to keep school children with AIDS from the classroom may be viewed as functional (but pale) equivalents (Nelkin and Hilgartner 1986). More to the point, however, have been the calls in the press, in state legislatures, and from insurgent candidates for elective office—all still restricted to the most extreme political right—for the quarantine of all antibody-positive individuals (Intergovernmental Health Policy Project 1985). The most recent of such proposals is to be found in the March 1986 issue of the *American Spectator*:

There are only three ways that the spread of lethal infectious disease stops: it may be too rapidly fatal, killing off all its victims before the disease can spread; the population affected may develop natural or medically applied immunity; it may not be able to spread because uninfected individuals are separated sufficiently well from those infected. [At this point the only way] to prevent the spread of the



disease is by making it physically impossible. This implies strict quarantine, as has always been used in the past when serious—not necessarily lethal—infections have been spreading. Quarantine in turn implies accurate testing.

The authors then lament the failure of nerve on the part of Americans:

Neither quarantine nor universal testing is palatable to the American public where AIDS is concerned, yet both have been used without hesitation in the past (Grutsch and Robertson 1986, 12).

What is so striking about such proposals is that they would enforce a deprivation of liberty upon vast numbers for an indefinite period (the duration of HTLV-III infection) because of how infected individuals might behave in the future. Unlike the transmission of some infections, where one's mere presence in public represents a social threat, the transmission of HTLV-III infection requires specific, well-defined acts. Hence, the quarantine of all HTLV-III-infected persons would rest upon a willingness to predict or assume future dangerousness and would be the medical equivalent of mass preventive detention. Even were such a vast and thoroughgoing rejection of our fundamental constitutional and moral values tolerable, and even if it were possible to gather broad-based political support for such measures, the prospects for so enormous and burdensome a disruption of social life make mass quarantine utterly unlikely.

Rarely do those who propose quarantines suggest how all antibody-positive individuals would be identified, how they would be removed to quarantine centers, how they would be fed and housed, how they would be forcibly contained. Indeed, it is one of the remarkable features of proposals for mass quarantine as a public health response to AIDS, and an indication of the profound irrationality of such suggestions, that they treat with abandon both matters of practicality and history. Because proponents of quarantine speak of mass removal as if it were an antiseptic surgical excision, they can assume that their ends could be achieved without grave social disruption. A vision of benign quarantine measures is informed by recent memories of health officers imposing isolation on those who suffered from diseases such as scarlet fever. But when quarantine has been imposed upon those who viewed themselves as unfairly targeted by the state's agents, the

story has sometimes been quite different. Judith Leavitt's (1976, 559) description of how German immigrants in Milwaukee responded to efforts at the forced removal and isolation of those with smallpox provides ample evidence of what might be expected were even local and confined efforts to isolate large numbers of HTLV-III-infected individuals undertaken: "Daily crowds of people took to the streets, seeking out health officials to harass."

But the irrationality and potentially disruptive dimensions of quarantine are no guarantee against future impulsive efforts to move in such a direction were social anxiety over AIDS to continue to mount in the next several years. During the drug scares of the 1960s, both New York and California sought to meet that crisis by the establishment of mass civil commitment programs for addicts (Kittrie 1973). Such efforts failed to stop the spread of drug use, though many were incarcerated in the process. Folly by great states is not reserved to the international arena.

Apparently more tolerable and more practicable are calls for the mandatory screening and identification of all high-risk individuals so that they might be compelled to face their antibody status, adjusting their behavior accordingly. Since it is impossible to know who is, in fact, a member of a high-risk group, calls for mandatory screening of risk-group members would require universal screening. Such a program would, in turn, require the registration of the entire population to assure that none escaped the testing net. Finally, since one-time screening would be insufficient to detect new cases of infection, it would be necessary to track the movements of all individuals so that they might be repeatedly tested. The sheer magnitude of such an undertaking makes its adoption implausible. Modified versions of universal mass screening might take the form of governmentally mandated work-place testing. Though such efforts would eliminate the need for geographical dragnets, they would still pose enormous problems. To suggest that such mass screening might be undertaken, with the sole purpose of education and counseling, is inconceivable. The logic of universal mandatory screening for an infectious disease without cure leads ineluctably to mass quarantine.

Of a very different order are proposals for the quarantine of individuals—male and female prostitutes, for example—who though seropositive continue to behave publicly in a way that exposes others to the possibility of HTLV-III infection. Both criminal and health law

provide ample authority for the control of such individuals. Though the moral, legal, and constitutional impediments to the imposition of state control over all antibody-positive individuals does not arise in such cases, it is abundantly clear that the strategy of isolating such persons could have very little impact on the spread of HTLV-III infection.

Though there is an historical precedent for such measures in the efforts to control venereal disease by the mass roundups of prostitutes during World War I in the United States (Brandt 1985), anyone who has examined the more finely tuned attempts to impose isolation or quarantine upon "recalcitrants" or "careless consumptives" (Musto 1986), for example, will attest to the administrative difficulties that are entailed when even a modicum of procedural fairness is employed. More important, such efforts, directed as they are at the most obvious sources of infection, would fail to identify and restrict the many hundreds of thousands of infected individuals who in the privacy of their bedrooms might be engaged in acts that involve the spread of HTLV-III infection. If the quarantine of all antibody-positive individuals is overinclusive, the quarantine of public recalcitrants is underinclusive. That is the price of living in a constitutional society committed to the rudimentary principles of law, privacy, and civil liberties. It is also a restriction placed upon us by reality.

### The Appeals and Limits of Education

Confronted by the legal, moral, and practical costs of mass quarantine and the limited possibilities of selective quarantine, there has been an understandable embrace of education as the way of seeking to meet the social threat posed by AIDS. Teaching members of high-risk groups about how to reduce the prospect of infecting others, or of becoming infected, is viewed as the appropriate social strategy, one that is compatible with our legal, moral, and political institutions. Education must produce the critical and dramatic alteration in the sexual and drug-using practices of individuals, it is argued. That has been the program of gay rights and self-help groups, as well as of local and federal agencies (Silverman and Silverman 1985). What well-funded and aggressively pursued education might attain it is still too soon to know. Despite the paeans to education, governmental efforts have been limited by profound moralism. To speak directly and explicitly about "safe" or "safer" sexual practices would require a tacit toleration

of homosexuality (Washington Report on Medicine and Health 1986). For those committed to a conservative social agenda, such a public stance is intolerable.

The turn to education is, of course, compatible with the liberal commitment to privacy, to voluntarism, and to the reluctance to employ coercive measures in the face of behavior that occurs in the private realm. But the commitment to education in the case of AIDS occurs against a background of controversy about the efficacy of efforts to achieve the modification of personal behavior by health-promotion campaigns. Attempts to encourage changes in vehicular behavior, smoking, and alcohol consumption by education alone have had only the most limited success. Campaigns to encourage seatbelt use in automobiles in the United States, Canada, Great Britain, and France all faltered, and ultimately necessitated the enactment of statutes mandating their use (Warner 1983). More to the point is the failure of sex education to affect demonstrably the levels of teenage pregnancy in many urban centers. Finally, the historical legacy of efforts to control venereal disease through moral education in the period prior to penicillin provides little basis for optimism (Brandt 1985). So skeptical are some about the prospects of health education, that they charge that such campaigns represent a diversion from the more complex and difficult choices that need to be made (Faden 1986).

Nevertheless, the shock wave sent through the gay community by the rising toll of AIDS cases, coupled with the extraordinary and inventive efforts by gay groups at reaching large numbers with information about "safer sex" and the transmission of HTLV-III have apparently had a dramatic effect, at least in the short run. Anecdotal reports, quasi-systematic surveys, and, most important, the declining incidence of rectal gonorrhea, all have suggested to some that in the face of AIDS an unprecedented change has occurred in sexual behavior in a relatively brief period. Not only have gay men reduced the extent to which they engage in sexual activity with strangers, but so, too, have they reduced the extent to which they engage in anal receptive intercourse, the most "risky" of risky behaviors.

A longitudinal study conducted at the New York Blood Center, however, provides a sobering antidote to such educational enthusiasm and is compatible with what we have come to expect from health promotion campaigns (Stevens et al. 1986). Though it, like other studies, found a dramatic change in the extent to which gay men engage in anal receptive intercourse, just less than half of those in

the study population continued to engage in that practice. Needless to say, we know almost nothing about how education might affect the behavior of intravenous drug users, even were such efforts to be undertaken. In the absence of a natural social support constituency, the provision of education might well be utterly ineffective.

## Conclusion

Faced with a fatal illness that has the potential for grave social disruption, the appeal of coercive state power as an approach to the interruption of the spread of HTLV-III infection is understandable. But to yield to its seduction would be socially catastrophic. Confronted with the unacceptable specter of gross violations of privacy and civil liberties, many have embraced the promise of education. Here, the risk is that the politically attractive will be confused with the socially efficacious. The illusions of both power and voluntarism must be rejected. Instead of the grand vision of stopping AIDS, we must settle for the more modest goal of slowing its spread. As we attempt to fashion policies directed at that goal it will be important, at each juncture, to acknowledge the fundamental limits of our capacity to fight an infectious disease like AIDS.

We are hostage to the advances of virology and immunology, and will be so for many years. As the AIDS-associated toll mounts, so, too, will the level of social distress. In this protracted encounter with a microparasitic threat, it will be critical to preserve a social capacity for reasoned analysis and public discourse. That is a capacity that may be subverted by those who would generate hysteria and repressive moves as well as by those whose fears of such a turn result in irrational charges of "totalitarianism" at the very mention of public health (Ortleb 1985, 1986). A failure to defend reason in the face of AIDS may not only hinder our efforts to limit the exactions taken by this epidemic, but will leave a dreadful imprint upon the social fabric. The history of earlier epidemics should serve as a warning.

## References

- Brandt, A. 1985. *No Magic Bullet: A Social History of Venereal Disease in the United States since 1880*. New York: Oxford University Press.

- Centers for Disease Control. 1985a. Education and Foster Care of Children Infected with Human T-Lymphotropic Virus Type III/Lymphadenopathy-associated Virus. *Morbidity and Mortality Weekly Reports* 34 (August 30):517-21.
- . 1985b. Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-associated Virus in the Workplace. *Morbidity and Mortality Weekly Reports* 34 (November):681-6.
- . 1985c. Recommendations for Assisting in the Prevention and Perinatal Transmission of HTLV-III/LAV and Acquired Immunodeficiency Syndrome. *Morbidity and Mortality Weekly Reports* 34 (December):721-6.
- Faden, R. 1986. Ethical Issues in Government-Sponsored Public Health Campaigns. *Health Education Quarterly* 13(4). (In press.)
- Grutsch, J. F., and A. D. J. Robertson. 1986. The Coming of AIDS: It Didn't Start with Homosexuals and It Won't End with Them. *American Spectator* (March):12.
- Intergovernmental Health Policy Project. 1985. *A Review of State and Local Government Initiatives Affecting AIDS*. Washington: George Washington University, Intergovernmental Health Policy Project.
- Kadish, S. 1968. The Crisis of Overcriminalization. *American Criminal Law Quarterly* 7:17-34.
- Kittrie, N. 1973. *The Right to Be Different*. Baltimore: Penguin Books.
- Kuller, L., and L. Kingsley. 1986. The Epidemic of AIDS: A Failure of Public Health Policy. *Milbank Quarterly* 64 (Suppl. 1): 56-78.
- Lalonde, M. 1975. *A New Perspective on the Health of Canadians*. Ottawa: Government of Canada.
- Leavitt, J. 1976. Politics and Public Health: Smallpox in Milwaukee, 1894-5. *Bulletin of the History of Medicine* 50(4):553-68.
- McNeill, W. 1976. *Plagues and People*. Garden City, N.Y.: Anchor Press.
- Mohr, R. 1985. AIDS: What to Do—and What Not to Do. *Philosophy and Public Policy* 5(4):6-9.
- Moreno, J., and R. Bayer. 1985. The Limits of the Ledger in Health Promotion. *Hastings Center Report* 15(6):37-41.
- Musto, D. 1986. Quarantine and the Problem of AIDS. *Milbank Quarterly* 64 (Suppl. 1): 97-117.
- Nelkin, D., and S. Hilgartner. 1986. Disputed Dimensions of Risk: A Public School Controversy over AIDS. *Milbank Quarterly* 64 (Suppl. 1): 118-142.
- New York Times*. 1985. New York City Gay and Lesbian Antiviolence Project. November 16.

- Ortleb, C. 1985. The AIDS Prophet of Doom. *New York Native* (October 14–20):20.
- . 1986. Heil Bayer!! *New York Native* (June 2):4.
- Packer, H. 1968. *The Limits of the Criminal Sanction*. Stanford: Stanford University Press.
- Restak, C. 1985. Worry About Survival of Society First: AIDS Victims' Rights. *Washington Post*, September 8.
- Rosenberg, C. 1962. *The Cholera Years*. Chicago: University of Chicago Press.
- Schur, E. 1965. *Crimes without Victims*. Englewood Cliffs, N.J.: Prentice-Hall.
- . 1971. *Labeling Deviant Behavior*. New York: Harper and Row.
- Silverman, M. F., and D. B. Silverman. 1985. AIDS and the Threat to Public Health. *Hastings Center Report* 15(4):19–22.
- Singer, E. and T.F. Rogers. 1986. Public Opinion about AIDS. *AIDS and Public Policy Journal* 1(1):8–13.
- Starr, P. 1986. Possible Social Consequences of the AIDS Epidemic. Paper presented at the American Association for the Advancement of Science meetings, Philadelphia, May.
- Stevens, C., P. Taylor, E. Zang, J. M. Morrison, E. J. Harley, S. Rodriguez de Cordoba, C. Bacino, R. C. Y. Ting, A. J. Bodner, M. G. Sarngadharan, R. C. Gallo, and P. Rubenstein. 1986. Human T-Cell Lymphotropic Virus Type III Infection in a Cohort of Homosexual Men in New York City. *Journal of the American Medical Association* 255(16):2167–72.
- U.S. Department of Health, Education, and Welfare. 1964. *Smoking and Health*. Washington.
- . 1979. *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*. Washington.
- Warner, K. 1983. Bags, Buckles, Belts: The Debate over Mandatory Personal Restraints in Automobiles. *Journal of Health Policy, Politics and Law* 8(1):44–75.
- Washington Report on Medicine and Health*. 1986. No "Show & Tell" for AIDS Education, CDC Says. January 13.

---

*Acknowledgments:* The preparation of this paper was made possible by support to the Hastings Center Project on AIDS, Public Health, and Civil Liberties by the Field Foundation, the AIDS Medical Foundation, and the Pettus Crowe Foundation.

*Address correspondence to:* Ronald Bayer, Associate for Policy Studies, The Hastings Center, 360 Broadway, Hastings-on-Hudson, NY 10706.