not end the discussion of this interaction, but it does insure that such a discussion will be an important part of the quest for the common good of this pluralistic society.

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THE MORAL DIMENSIONS OF AIDS

The emergence of Acquired Immune Deficiency Syndrome (AIDS) as an epidemic raises profound moral questions for every institution of American society, including the churches. A review of the literature on AIDS gives the impression that a disaster is relentlessly unfolding. We

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Bibliographical Guide (2 vols.; New York: Greenwood, 1986 and 1987). Among the recent articles on the subject are the following: Cardinal Joseph Bernardin, "The Consistent Ethic: What Sort of Framework?" *Origins* 16 (1986) 345–50; Robert H. Bork, "Law, Morality, and Thomas More," *Catholic Lawyer* 31 (1987) 1–6; Eugene Borowitz, "Between Anarchy and Fanaticism: Religious Freedom's Challenge," *Christian Century* 104 (1987) 619–22; James R. Brockman, "Oscar Romero on Faith and Politics," *Thought* 62 (1987) 190–204; Glenn R. Bucher, "Christian Political Realism after Niebuhr: The Case of John C. Bennett," *Union Seminary Quarterly Review* 41 (1986) 43–58; Harry J. Byrne, "Thou Shalt Not Speak," *America* 155 (1986) 356–62; Charles E. Curran, "The Difference between Personal Morality and Public Policy," in *Toward an American Catholic Moral Theology* (Notre Dame: Univ. of Notre Dame, 1987) 194–202; Harold H. Ditmanson, "Christian Faith and Public Morality," *Dialog* 26 (1987) 87–97; Frederick L. Downing, "Martin Luther King, Jr. as Public Theologian," *Theology Today* 44, no. 1 (April 1987) 15–31; Robert F. Drinan, "Religion and the Future of Human Rights," *Christian Century* 104 (1987) 683–87; Philip Gleason, "Pluralism, Democracy and Catholicism in the Era of World War II," *Review of Politics* 49 (1987) 208–30; Vigen Guroian, "Between Secularism and Christendom: Orthodox Reflections on the American Order," *This World* 18 (Summer 1987) 12–22; Jeffrey K. Hadden and Anson Shupe, "Televangelism in America," *Social Compass* 34 (1987) 61–75; John J. Haldane, "Christianity and Politics: Another View," *Scottish Journal of Theology* 40 (1987) 259–86; Carl F. H. Henry, "Where Will Evangelicals Cast Their Lot?" *This World* 18 (Summer 1987) 3–11; Bill Kellermann, "Apologist of Power: The Long Shadow of Reinhold Niebuhr's Christian Realism," *Sojourners* 16, no. 3 (March 1987) 15–20; Richard P. McBrien, "Religion and Politics in America," *America* 155 (1986) 254–56, 272; Allen O. Miller, "What a Calvinist Has Learned from a Lutheran about Calvin's Political Theology," *Currents in Theology and Mission* 14 (1987) 133–39; Thomas Molnar, "Morality, the State, and America," *This World* 16 (Winter 1987) 70–76; Will Morrisey, "Public Morality and Public Moralism," *This World* 16 (Winter 1987) 77–87; Mark Noll, "The Constitution at 200: Should Christians Join the Celebration?" *Christianity Today* 31, no. 9 (July 10, 1987) 18–23; Cardinal John O'Connor, "From Theory to Practice in the Public-Policy Realm," *Origins* 16 (1986) 105–12; Joseph B. Tamney and Stephen D. Johnson, "Church-State Relations in the Eighties: Public Opinion in Middletown," *Sociological Analysis* 48 (1987) 1–16; Martin R. Tripole, "Religion and the First Amendment," *Crisis* 5, no. 6 (June 1987) 12–20; Rembert G. Weakland, "The Church in Worldly Affairs: Tensions between Clergy and Laity," *America* 155 (1986) 201–5, 215–16; William H. Willemon, "The Chains of Religious Freedom," *Christianity Today* 31, no. 13 (Sept. 18, 1987) 28–30; James P. Wind, "Two Kingdoms in America," *Currents in Theology and Mission* 14 (1987) 165–76.

seem to be like spectators in a steep canyon looking up at the beginnings of an avalanche in slow motion. A force of nature has been unleashed that we are helpless to turn back. Its full effects are a few years away and the toll in human suffering and death will be enormous.

AIDS is already having a severe impact on every major institution in our society. I will focus on the crises in health-care systems, politics and the legal system, and the churches. A single statistic may bring home its scope: it is estimated that in 1991 more Americans will die of AIDS than died in the entire Vietnam War—over 54,000.[64] And 1992 will probably be worse.

The epidemic and the human anguish it generates raise a host of difficult moral questions: How protect the privacy of those with AIDS while safeguarding the rest of the population? Who should be tested for exposure to the Human Immunodeficiency Virus (HIV)? Should testing be mandatory, voluntary, or "routine" (as a requirement for a marriage license, certain forms of employment, military service, immigration, etc.)? Who should pay for the cost of the disease, which may range up to 16 billion dollars by 1991?[65] In the absence of any other effective means, can education prevent the further spread of the epidemic? Can persons in high-risk groups (93% of persons in the U.S. with AIDS are either homosexual or bisexual men or intravenous drug users) be persuaded to alter behavior which spreads the lethal contagion? How will the churches respond to those dying of AIDS when most of them come from groups stigmatized by the general population? What responsibility does the Church have to counteract the primitive moralism which some of its spokespersons manifest in blaming the victims as "getting what they deserve from God"?

These are issues of social justice rather than sexual ethics. Assessing individual accountability will not halt an epidemic once it has broken out, although individuals are morally responsible for not infecting others with this lethal contagion. Most of these issues present the classic conflict between the rights of the individual and the protection of the common good. No absolute norm enables one to decide for one side or the other in advance of close study of the situation and judicious weighing of competing claims. Measures which purport to serve the common good but undermine individual dignity frustrate the basic good which public order strives to protect: the human dignity of that society's members.

[64] *New York Times*, March 16, 1987, 11.

[65] The Surgeon General estimates that by 1991 "an estimated 145,000 patients with AIDS will need health and supportive services at a total cost of between $8 and $16 billion" (C. Everett Koop, *Surgeon General's Report on Acquired Immune Deficiency Syndrome* [Washington, D.C.: U.S. Dept. of Health and Human Services, 1987] 6).

The Factual Picture on AIDS

Who would have thought that the most technologically advanced society in history would face a plague in the late-20th century?[66] "An entirely new, transmissible, always fatal and, thus far, medically uncontrollable pathological condition has suddenly appeared" since 1981.[67] That year Kaposi's sarcoma, a rare form of cancer, appeared in a number of previously healthy young homosexual males who had been very sexually active. This medical curio started researchers on the trail which would lead in 1984 to the discovery of its cause, variously termed lymphadenopathy-associated virus (LAV) or Human T-cell Lymphotropic Virus Type III (HTLV-III). This particular virus, now called Human Immunodeficiency Virus (HIV), "preferentially multiplied in, and killed, human T4 lymphocytes *in vitro*, a property that immediately pointed to its possible implication in the immunodeficiency characteristic of AIDS."[68] These varieties of HTLV are the first ones known to attack

[66] Cf. E. D. Acheson, "AIDS: A Challenge for Public Health," *Lancet* 1, no. 8482 (March 22, 1986) 662–66; Gail Henderson Baumgartner, *AIDS: Psychosocial Factors in the Acquired Immune Deficiency Syndrome* (Springfield, Ill.: Charles C. Thomas, 1985); Morton J. Cowan et al., "Maternal Transmission of Acquired Immune Syndrome," *Pediatrics* 73, no. 3 (March 1984) 382–86; Peter Ebbesen, Mads Melbye, and Jorn Beckman, "Fear of AIDS," *Scandinavian Journal of Social Medicine* 14 (1986) 113–18; Daniel M. Fox, "The Cost of AIDS: From Conjecture to Research," *AIDS and Public Policy* 2, no. 1 (Winter 1987) 25–27; Javier Gafo, "EL SIDA, ?un azote de Dios?," *SIC* 50, no. 494 (April 1987) 186–90; Philip M. Kayal, " 'Morals,' Medicine, and the AIDS Epidemic," *Journal of Religion and Health* 24, no. 3 (Fall 1985) 218–38; Lisa M. Krieger, "Battling AIDS: A Report from the Front Lines," *Image Magazine (San Francisco Examiner-Chronicle)*, May 31, 1987, 12–19; Mathilde Krim, "AIDS: The Challenge to Science and Medicine," *Hastings Center Report*, Special Supplement, "AIDS: The Emerging Ethical Dilemmas," August 1985, 2–7; Richard G. Marlink et al., "Low Sensitivity of ELISA Testing in Early HIV Infection," *New England Journal of Medicine* 315, no. 24 (Dec. 11, 1986) 1549; Kenneth H. Mayer, "The Epidemiological Investigation of AIDS," *Hastings Center Report*, Special Supplement, August 1985, 12–15; Michael J. Mills, Constance B. Wolfsy, and John Mills, "Special Report: The Acquired Immunodeficiency Syndrome," *New England Journal of Medicine* 314, no. 14 (April 3, 1986) 931–36; Nancy Padian and John Pickering, "Female-to-Male Transmission of AIDS: A Reexamination of the African Sex Ratio of Cases," *JAMA* 256, no. 5 (Aug. 1, 1986) 590–91; William S. Palmer, "AIDS: Riddles and Paradoxes," *ANA-GRAM* (Anatomic Pathology Institute, Berkeley, Calif.) 1, no. 21 (February 1987) 1–4; G. B. Scott et al., "Mothers of Infants with Acquired Immunodeficiency Syndrome," *JAMA* 253, no. 3 (Jan. 18, 1985) 363–66; Earl E. Shelp, Ronald H. Sunderland, and Peter W. A. Mansell, *AIDS: Personal Stories in a Pastoral Perspective* (New York: Pilgrim, 1986); Carol A. Tauer, "AIDS and Human Rights: An Intercontinental Perspective," *AIDS: Ethics and Public Policy* (Belmont, Calif.: Wadsworth, 1988) 154–69; U.S. Dept. of Health and Human Services, *AIDS Bibliography: 1986–1987* (Washington, D.C.: Public Health Service, NIH, June 1987).

[67] Krim, "AIDS: The Challenge" 2. Up to 15% of AIDS patients have lived five years; a few seem to have reverted to negative status, although scientists cannot yet determine why.

[68] Ibid. 4.

the body's elemental defense system, which should ward off infections. This virus has properties which make it extremely resistant to treatment or elimination.

1) It is a retrovirus, i.e., one which is reverse-transcribed into the patient's basic cell-formation pattern, DNA. The viral RNA becomes DNA and then incorporates itself permanently into the human genetic material, enabling it to reproduce itself rapidly, thus creating large numbers of infectious viral particles. "Once it occurs, the phenomenon of retroviral integration into host genetic material precludes the elimination of the viral blueprint through therapeutic means."[69] If treatment to protect the cells which remain uninfected is developed, it would have to be used for the rest of the patient's life unless some way of altering DNA is discovered.

2) Like most viruses, HIV stimulates the body's immune system to produce antibodies; unlike most other viruses, however, these antibodies do not neutralize HIV effectively because it remains intranuclear. This feature rules out the standard approach of producing a vaccine from antibodies. It means that

> viral multiplication and its consequences—such as gradual loss of T4 cells and immune deficiency—can progress virtually unimpeded, ushering in CDC-defined [Centers for Disease Control, the federal agency which traces and attempts to eliminate communicable diseases] AIDS. Second, infected people remain infectious who can continue to transmit the infection to others, whether through sexual contact or blood transmission.[70]

3) The production of a general vaccine against AIDS is complicated immeasurably by the fact that an antibody which would be effective against one strain of the virus could be ineffective against genetic variants. Like influenza viruses, HIV mutates easily as it spreads from person to person, modifying its protective coat. As a result, HIV may be a series of viruses which mutate many times more rapidly than influenza viruses. Researchers are seeking stable elements in the HIV core to target for a vaccine. However, despite enormous commercial investment, scientists have yet to develop a general vaccine against the common cold; AIDS may be even more difficult to counteract.[71] Nevertheless, a general

[69] Ibid. 5.

[70] Ibid. 5.

[71] A UPI story states that scientists working at the Los Alamos National Laboratory believe that AIDS viruses are "thousands of slightly differing forms, some perhaps with new abilities to be transmitted.... The AIDS virus ... is mutating its genetic code as much as five times as fast as the influenza virus, and is changing one million to 10 million times faster than the genes of human beings" (*San Francisco Examiner*, Sept. 6, 1987, A-3).

vaccine is necessary:

> The development of an effective vaccine that can be administered to the whole population is the only hope of effectively controlling the spread of LAV/HTLV-III infection. Unfortunately, it is already clear that it will be a difficult and time-consuming undertaking. Even if the effort succeeds, the availability of a vaccine for general use is several years away.[72]

4) Testing presents its own challenges. Techniques to detect infection by HIV have been developed, the most common being an "enzyme-linked immunosorbent assay" (ELISA) and the Western blot test. These detect the presence of antibodies formed against HIV in the blood. When used in combination, they are an increasingly reliable indicator of exposure to HIV. Unfortunately, ELISA can register both "false positives" and "false negatives." Reliance on ELISA alone can result in accidental diagnoses which can be false and devastating or provide an illusion of immunity for those tested.[73]

Because the body does not produce a measurable amount of antibody immediately upon exposure to the virus, a "window" of up to four weeks may occur before the antibody appears. (This obviously complicates testing measures close to the time of exposure.) HIV may remain dormant for anywhere from a few months to ten years. When cells of the immune system respond to an unrelated infection, the viruses which have been incorporated into the host genes come to life and burst forth from the cell, destroying the T4 cell in the process.[74]

5) The body is then susceptible to a variety of infections which eventually prove fatal. With its immune defenses exhausted by this process, the body produces fewer and fewer infection-fighting T-cells and falls prey to a number of diseases which ordinarily would have been resisted. Such "opportunistic infections" include *Pneumocystis carinii* pneumonia, tuberculosis, and forms of cancer such as Kaposi's sarcoma. While some patients die within weeks of being diagnosed with AIDS, the average male lives 14 to 18 months after diagnosis and the average woman lives six to eight months. "Cofactors" which seem to hasten the onset of AIDS are parasite infections, hepatitis A, previous exposure to

[72] Ibid.

[73] "Among those with a known risk of exposure to AIDS—homosexual men and intravenous drug users, for example—detection of antibody to human T-cell lymphotropic virus Type III (HTLV-III), using the recently licensed enzyme-linked immunosorbent assay, is 99% predictive of prior AIDS retrovirus infection. Among other groups, the predictive value of the test is much lower; positive results must be confirmed by Western blot or another reliable confirmatory test. The presence of antibody definitely directed against AIDS retroviruses appears virtually 100 percent predictive of prior infection and potential infectiousness" (Mills et al., "Special Report: The Acquired Immunodeficiency Syndrome" 931).

[74] Krieger, "Battling AIDS" 14.

sexually transmitted diseases, and the use of "recreational drugs" and stimulants such as amyl nitrate "poppers" inhaled to enhance sexual performance. The gradual debilitation of the body often leads to a slow and painful death, tragically accompanied by forms of dementia in up to 65% of AIDS patients in whom the virus attacks the central nervous system.[75]

6) The origins of AIDS remain unclear. Some speculate that the virus came from Central Africa, but recent evidence shows it to have been present in the U.S. as far back as 1969. In Central Africa it has reached pandemic proportions. As many as 10% of the population of Zaire is estimated to be infected with HIV, leading to fears of massive depopulation. In Africa the host population appears to be largely heterosexual, with the ratio of men to women nearing 1:1.[76] The World Health Organization estimates that ten million people have been infected world-wide by HIV. "Unless powerful preventive measures are enacted, according to the international agency, as many as 100 million people could be infected within five years. 'We're running scared,' said Dr. Haldan Mahler, director of the WHO.[77]

The Surgeon General estimates that about 1.5 million people in the U.S. have been infected with the AIDS virus. Almost all are asymptomatic, most are probably unaware of their status, yet are infectious to others through intimate contact. Over 25,000 people have died from it in the U.S. alone.[78] 70% of those infected with AIDS are homosexual and bisexual men and 25% are IV drug users (with some overlap among the three categories). The remaining groups are female partners of infected IV drug users, their newborn infants (one third of whom are born with AIDS), hemophiliacs, and other recipients of contaminated blood products.[79]

Although not even one per 50,000 units of blood is now contaminated, prior to the development of adequate testing mechanisms in 1985 "Federal officials estimate that 12,000 transfusion recipients may have been

[75] David G. Ostrow and Terence C. Gayle, "Psychosocial and Ethical Issues of AIDS Health Care Programs," *Quality Review Bulletin* 12, no. 8 (August 1985) 284.

[76] The nearly equal ratio need not mean that women transmit HIV to men as frequently as men do to women: see Padian and Pickering, "Female-to-Male Transmission" 590.

[77] *New York Times*, March 16, 1987, 11.

[78] Koop, *Surgeon General's Report* 12.

[79] Some studies place the rate of eventual AIDS infection for such infants at between 65% and 91%: see G. B. Scott et al., "Mothers of Infants with the Acquired Immunodeficiency Syndrome: Evidence for Both Symptomatic and Asymptomatic Carriers," *JAMA* 253 (1985) 363–66; G. Luzi, B. Ensoli, et al., "Transmission of HTLV-III Infection by Heterosexual Contact," *Lancet* 2 (1985) 1018.

infected. . . ."[80] Hospitals waited until the fall of 1987 to notify recipients of donated blood from the years 1981 to 1985 that they should be tested for exposure to HIV. One wonders how many of them have unwittingly infected sexual partners in the interim.

It seems a historical accident that HIV landed in homosexual and IV-drug-user populations in the U.S. rather than in the sexually-active heterosexual population. It is, therefore, highly misleading to refer to AIDS as "the gay plague."[81] In the high-risk groups in the U.S. the virus found practices which were opportune conditions for its rapid transmission: sexual practices which involve exchange of bodily fluids; anal intercourse, which frequently causes tears in the rectal tissue that expose blood vessels; multiple partners; and, for IV drug users, the practice of sharing needles while "shooting up." The highest concentrations of AIDS cases have occurred in those areas where the host populations are most represented, the New York City–Newark areas (New York has 31% of the 42,353 cases reported by the CDC nationwide) and the San Francisco Bay area (which has about 11%, almost exclusively homosexual men).[82]

Since an estimated 95% of the IV drug users in this country are heterosexually active, the crossover of HIV into the heterosexual population seems likely to occur at that point, either through their partners or drug-using prostitutes (both male and female). At present the rate of heterosexual transmission in groups that do not practice high-risk behaviors remains very low—less than 1%—but sexually-transmitted diseases are notorious for spreading to new populations.[83]

Because the incubation period from exposure to the virus to develop-

[80] *New York Times*, March 17, 1987. In the San Francisco Bay area one major blood source, the Irwin Memorial Blood Bank, has admitted that during 1981–83 one percent of its units were contaminated by HIV, and half of one percent in 1984. Area hospitals are only now notifying some 30,000 recipients of blood from Irwin that they should be tested for HIV antibodies. The hospitals and blood bank covered up the problem lest they cause panic and because they maintained that notification and testing would be too expensive. A political note with enormous moral import: when officials at Irwin wanted to inquire of potential donors in 1981 whether they were sexually-active homosexuals, considerable pressure from gay-community activists and local politicians made them retract their screening plans. Protecting the rights of one group has had and will have lethal consequences for hundreds of blood recipients. See Randy Schilts, *And the Band Played On: Politics, People and the AIDS Epidemic* (New York: St. Martin's, 1987).

[81] Using the standard, if conservative, estimate of Kinsey that 5% of the U.S. male population is homosexual, one can estimate that no more that one sixth of that population has been exposed to HIV. In addition, almost no lesbians have been exposed to HIV.

[82] Recent redefinitions of AIDS lead New York public-health officials to judge that deaths of IV drug users are 150% higher than previously estimated (*New York Times*, Oct. 22, 1987, 13).

[83] See Katie Leishman, "Heterosexuals and AIDS: The Second Stage of the Epidemic," *Atlantic Monthly*, February 1987, 39–58.

ment of AIDS symptoms can be as long as ten years, anyone having unprotected sex with a person who has engaged in high-risk behavior since 1977 runs the risk of having been infected. The odds of infection are one in 100 for a single act of unprotected intercourse (i.e., without effective use of a condom). Homosexual men and female sex partners of infected drug users run a far higher risk: a 66% to 75% chance of becoming infected themselves.[84] Men seem more likely to transmit HIV to women than they are to receive it from an infected woman.

What proportion of those who are "seropositive" (i.e., show presence of HIV antibody in their blood serum) will eventually develop "full-blown" AIDS? This question may be the most hotly debated of all. Early estimates set the figure at 10% to 20%, but they have been steadily revised upwards. Even a year ago, most reports described three distinct plateaus of exposure in decreasing amounts: at the base of the pyramid were the 1.5 million who are seropositive; midway up were the 30% or so who developed some but not all of the symptoms of AIDS (the "Aids-Related Complex" or ARC); finally, the 10% to 20% who developed full-blown AIDS. The Surgeon General now states: "With our present knowledge, scientists predict that 20 to 30 percent of those infected with the AIDS virus will develop an illness that fits an accepted definition of AIDS within five years."[85] Note Koop's two provisos: he does not speculate beyond five years and he limits the definition of AIDS to those "presently accepted." More recent estimates are far more alarming: Berkeley's Anatomical Pathology Institute's Dr. William S. Palmer writes:

> A researcher at Walter Reed has classified clinical AIDS into a more gradual series of six stages (not the usual one of: positive antibody test followed by ARC followed by AIDS) and has followed those people for 36 months. He found that when he used these finer gradations, about 90 percent of the people progressed to higher stage within three years. Terrible fact.[86]

Even if there were no additional American exposed to HIV, 90% of the 1.5 million already exposed means that 1,350,000 people may have begun the fatal progression to AIDS. Worldwide, this would be nine million who will likely die. The dimensions of the crisis begin to come home when we consider an epidemic of this magnitude. It raises the central moral question: Can the threat to the common good justify curtailment of rights, such as confidentiality and privacy, which are generally observed?

[84] Krieger, "Battling AIDS" 16.

[85] Koop, *Surgeon General's Report* 12.

[86] Palmer, *Anagram* 2.

Health-Care Institutions

The conflict between individual rights and the common good arises quite sharply in health-care and research programs.[87] I will concentrate on two issues: How should the patient's right to privacy and confidentiality be balanced against the need to inform others (caregivers, epidemiological investigators, public-health officials) of the presence of AIDS or exposure to HIV? What obligation do physicians and other health-care providers have to treat AIDS patients? Problems of reluctant caregivers will only intensify with the increasing burden placed on the health-care system. By 1991, when it is estimated that there will be 270,000 cases of AIDS, hospitals will have to provide various forms of care for 170,000 people with AIDS.[88]

First, confidentiality, an important right derived from the dignity of the patient, as we shall see in the discussion of mandatory screening below. Patients have a legitimate interest in seeking to keep their sexual orientation and/or medical status confidential when disclosure could lead to termination of employment, loss of health insurance, eviction from housing, and social isolation. For IV drug users, disclosure of their addiction could have direct legal consequences. The right of confidentiality, however, is not absolute. It can conflict with the rights of others who have a right to protect themselves against contagion from diseases, especially one which is predictably fatal.

A debate in the *Hastings Center Report* states both sides of the dilemma. The case concerns a young man who tests positive but refuses to let his physician inform his fiancée. Morton Winston, a philosopher, cites the 1984 ethical manual of the American College of Physicians: "the physician shall keep secret all that he knows about the patient and release no information without the patient's consent, unless required by the law or unless resulting harm to others outweighs his duty to his

[87] Molly Cooke, "Commentary: Ethical Issues in the Care of Patients with AIDS," *Quality Review Bulletin* 12, no. 10 (October 1986) 343–46; Irwin S. Davison, "The HIV-Positive Patient Who Won't Tell the Spouse," *Medical Aspects of Human Sexuality*, March 1987, 16; Terence C. Gayle and David G. Ostrow, "The Question of Confidentiality of a Patient's HIV Antibody Test in a Psychiatric Treatment Unit," *Quality Review Bulletin* 12, no. 8 (August 1986) 290–91; Michael A. Grodin, Paula V. Kaminow, and Raphael Sassower, "Ethical Issues in AIDS Research," ibid. 12, no. 10 (October 1986) 247–352; Robert Steinbrook et al., "Ethical Dilemmas in Caring for Patients with Acquired Immunodeficiency Syndrome," *Annals of Internal Medicine* 103, no. 5 (November 1985) 787–90; Paul Volberding and Donald Abrams, "Clinical Care and Research in AIDS," *Hastings Center Report*, Special Supplement on AIDS, August 1986, 16–18; Abigail Zuger, "AIDS on the Wards: A Residency in Medical Ethics," *Hastings Center Report* 17, no. 3 (June 1987) 16–20.

[88] Zuger, "AIDS on the Wards" 20.

patient." Most states require that cases of sexually-transmitted diseases, as well as gunshot wounds and incidents of child abuse, be reported to public-health authorities. While AIDS is a reportable disease in all states, "only a few states, Colorado and Montana among them, presently require confidential reporting of persons who test positive for antibodies to HIV."[89] Winston recommends against mandatory tracing of sexual contacts for all who test seropositive, but holds that an exception may be made for patients who refuse voluntarily to disclose such information to their sexual partners.

A recent California Supreme Court decision in the case of *Tasaroff v. Regents of the University of California* held that "a doctor is liable to persons infected by his patient if he negligently fails to diagnose a contagious disease, or having diagnosed the illness, fails to warn members of the patient's family." Winston writes that this obligation must be met without extreme measures: "In general, the duty to protect should be discharged in the way that is least invasive of the patient's rights while still effectively serving to protect potential victims."[90] Although legal statutes do not always dictate moral duty, they should guide the physician. If efforts to persuade the seropositive patient to inform his partner are unsuccessful, then the physician must contact her either directly or through public-health authorities.

Sheldon H. Landesman, professor of medicine and director of the AIDS Study Group at SUNY Health Services Center in Brooklyn, counters with some broader considerations. "Any legally or socially sanctioned act that breaches confidentiality or imposes additional burdens (such as job loss or cancellation of insurance) acts as a disincentive to voluntary testing." A legal requirement to report seropositive persons would drive people away from testing. He frames the question differently from Winston: "the difficult ethical dilemma is one of balancing long-term societal benefits against short-term benefit to an individual." If the physician decides that breaching confidentiality would discourage others from coming forward to be tested, he may say nothing, even at great personal cost. "But his discomfort and the woman's infection may be the cost that society pays if it wishes to implement public health measures to minimize the spread of the virus."[91]

This position exposes the pitfalls of utilitarian thinking, in which social benefit is presumed to override justice of equal treatment. It hardly seems responsible to trade off the life of an actual innocent against the

[89] Morton Winston, "AIDS and a Duty to Protect," *Hastings Center Report*, February 1987, 22.

[90] Ibid. 23.

[91] Ibid.

potential good envisioned by a social policy.

Confidentiality is also at issue in collecting epidemiological data and attempting to safeguard the supply of donated blood. Certain epidemiological projects have experienced a backlash from members of high-risk groups concerned about unwarranted disclosure. An inability to collect data on the epidemic threatens to undermine attempts to control the spread of AIDS. However, when the infecting behavior is forbidden by criminal statute (as sodomy is in almost half the states, while controlled-substance use and injection is illegal in all), that reluctance is understandable. Would government or private researchers share such information with the police?

One historical study of the history of disease reporting concluded:

> I have found no accusations that public health officials violated the confidentiality of particular case reports. Perhaps because they realized that organized medicine would gleefully have publicized any betrayals of privacy, public health professionals guarded case reports, especially of venereal disease, "at risk of life," as one veteran epidemiologist told me.... There is no instance on record in which a public health agency has released to an unauthorized person the name of someone reported to have a sexually transmitted disease.[92]

Even in the more than two million cases a year when state and local health officials trace the sexual contacts of those infected with venereal diseases, the name of the source patient has never been revealed to the sexual contact (though presumably some accurate guessing could occur).

Would a hostile society threatened by a fatal disease destroy this protection of anonymity? Many gay spokesmen fear that it would. However, where the purposes of research are to chart the patterns of disease rather than identify those who are infected, anonymity could be preserved by strict coding procedures in reporting, as it now is done in reporting AIDS cases to the CDC. Names of blood donors who test positive for HIV have been kept in a confidential, national deferral registry by the American Red Cross since July 1, 1985. However, since the blood banks do not want to enter into a clinical relationship with their donors, they do not inform the seropositive of their status.[93]

Nursing and house staff of wards containing AIDS patients or workers in hemodialysis units present a different case. Does their right to be informed of the risk involved in treating particular patients outweigh the patients' insistence on anonymity? They are less at risk than either sex

[92] Daniel M. Fox, "From TB to AIDS: Value Conflicts in Reporting Disease," *Hastings Center Report*, December 1986, 11.

[93] Carol Levine and Ronald Bayer, "Screening Blood: Public Health and Medical Uncertainty," *Hastings Center Report*, August 1985, 9.

partners of HIV patients or blood recipients. They have assumed professional responsibility to treat the sick and have considerable institutional control over exposure.

Some of the fears of caregivers can be dispelled by adequate education about the impossibility of becoming infected by casual contact. On the other hand, since to this date at least four health-care workers in the U.S. have been exposed to HIV by contact with blood or accidental deep puncture from infected needles, the danger is not negligible. Many facilities are treating all possible AIDS patients under the restrictions specified for hepatitis B, an infectious disease which demands stringent precautions. While this practice preserves patient confidentiality, it gives house staff greater protection.[94]

There are few instances in which public-health concerns would justify overriding the confidentiality obligation: e.g., a hospital should notify a blood bank that a donor had tested seropositive. However, one principle should be observed: "Whenever disclosure is to occur, individuals must be informed that a breach of confidentiality will take place and why it is necessary."[95]

Second, are health-care workers obliged to treat patients with AIDS? A recent anonymous sampling of 258 residents at New York City hospitals revealed that a fourth of them judged that it was not unethical to refuse treatment to AIDS patients. The American Medical Association has insisted on the right of each physician "to choose whom to serve...."[96] On the other hand, the A.M.A.'s Council on Ethical and Judicial Affairs stated recently: "A physician may not ethically refuse to treat a patient whose condition is within the physician's current range of competence" solely because the patient has been exposed to HIV. It also cited a traditional principle of medical ethics: "When an epidemic prevails, a physician must continue his labors without regard to the risk to his own health."[97] The American College of Physicians and the Infectious Disease Society of America declared jointly in 1986: "Denying appropriate care to sick and dying patients is unethical."[98] While legal statutes rarely demand that a person put himself or herself at risk for

[94] The large number of people in a hospital who routinely have access to the records of patients—estimated as high as 150—raises further problems of confidentiality.

[95] Ronald Bayer, Carol Levine, and Susan Wolf, "HIV Antibody Screening: An Ethical Framework for Evaluating Proposed Programs," *JAMA* 256, no. 13 (Oct 3, 1986) 1768–74, at 1770. This is the best single treatment I have come across.

[96] Section VI of the A.M.A.'s Principles of Medical Ethics, cited in Zuger, "AIDS on the Wards" 19.

[97] Robert Pear, "A.M.A. Rules That Doctors Are Obligated to Treat AIDS," *New York Times*, Nov. 13, 1987, 10.

[98] Zuger, "AIDS on the Wards" 19.

the benefit of another, professional responsibilities go beyond the legal minimum.

The care of terminal AIDS patients can be severely taxing on physicians and house staff even when they do not fear contracting the disease. When caring for homosexual AIDS patients, they face a set of conditions rare in their experience: the slow and inevitable death of an articulate population whose average age is mid-thirties, the increasingly severe symptoms (painful open lesions, fevers, pulmonary complications), the emotional trauma, depression and incipient dementia often suffered by patients lead to "burn-out" for staff. Caring for IV drug users is often draining because of hostile and irrational reactions of people combining withdrawal and hospitalization for a fatal disease. In addition, the negative moral value attached by many caregivers to risk behaviors such as drug addiction and anal intercourse compounds their alienation from many AIDS patients.

Dr. Molly Cooke of San Francisco General Hospital, where extensive work is done on AIDS, cites another factor in the resistance of young physicians in particular to treating AIDS patients:

> We have, as individual practitioners and as members of institutions, a clear obligation to care for AIDS patients. Epidemic illness has been a central part of physicians' experience from the beginning of medicine; only in the last 30 years—in which we have seen the development of efficacious antibiotics, universal poliomyelitis immunization, and the eradication of smallpox—have we begun to feel that we have conquered contagion. Now we confront the same moral choice our predecessors faced.[99]

Other issues which this crisis raises for the health-care system are: research protocols where informed consent could be a problem (patient autonomy), allocation of resources in hospitals which could fill their intensive-care-unit beds with AIDS patients leaving others without care (distributive justice), the need to care adequately when there is no hope for cure, the problems of diminished competency to decide about treatment in dementia-affected patients.[100]

[99] Cooke, "Ethical Issues" 344.

[100] See Lawrence J. Nelson, "Law, Ethics and Advance Directives regarding the Medical Care of AIDS Patients," in *AIDS and the Medical Humanities*, eds. Eric T. Juengst and Barbara Koenig (forthcoming from Praeger Publishers, a division of Greenwood Press, New York, N.Y.). Important essays in the same volume: Ray E. Moseley, "AIDS and the Allocation of ICU Beds"; Paul C. Carrick, "AIDS: Ethical, Legal and Public Policy Implications"; Carol Tauer, "The Concept of Discrimination and the Treatment of AIDS." See also *Medical Anthropology*, November 1987.

Government: The Politics of Public Health

The politics of AIDS has been a credit to no one.[101] The Reagan Administration's response to the crisis was both slow and grudging. The President did not even mention the disease in public until over 22,000 people had died from it. Never before have public officials had to contend in an epidemic with at-risk populations which were politically organized. The trade-offs which are the ordinary business of political compromise assume an ominous character in AIDS funding. The *Hastings Center Report* noted that "The Reagan administration's most recent budget request to Congress asks for $126.3 million in AIDS funding, 47 percent more than the original request for fiscal 1986 and $15.3 million above the current spending level.... The increase in AIDS funding has not affected the space program, however; the money has been taken from rural and Indian health programs."[102]

The central issue of the debate on national public-health policy is blood testing. The Reagan Administration has proposed a testing program which would include 57 million Americans at a cost of $306 million for the laboratory work alone. It would mandate "routine" (i.e., compulsory) testing for all people applying for marriage licenses, hospital patients, and prisoners, as well as immigrants to the U.S. "Education Secretary William Bennett is among the leading advocates in the administration for widespread AIDS testing and for a morally conservative approach to AIDS education."[103]

In so doing, the Administration takes the opposite tack from that advocated by most public-health officials and physicians involved in the question. They oppose any form of mandatory testing as counterproductive because it would discourage people at risk from being tested; it would also result in a relatively high number of false negatives. In addition, they advocate widespread public education as the only effective defense against the epidemic. Federal efforts to mount a massive distribution of

[101] See Bayer et al., "HIV Antibody Screening" 1768–74; James F. Childress, "An Ethical Framework for Assessing Policies to Screen for Antibodies to HIV," *AIDS and Public Policy Journal* 2, no. 1 (Winter 1987) 28–31. Also William J. Curran, Mary E. Clark, and Larry Gostin, "AIDS: Legal and Policy Implications of Traditional Disease Control Measures" 27–35; Wendy E. Parmet, "AIDS and the Limits of Discrimination Law" 61–72; Arnold J. Rosoff, "The AIDS Crisis: Constitutional Turning Point?" (book review) 80–85: all in *Law, Medicine and Health Care* 15, nos. 1–2 (Summer 1987). Cf. *Milbank Quarterly* 64, Supplement 1 (1986) on "AIDS: The Public Context of an Epidemic." Also Sandra Panem, "AIDS: Public Policy and Biomedical Research" 23–26; Mervyn F. Silverman and Deborah B. Silverman, "AIDS and the Threat to Public Health" 19–22: both in *Hasting Center Report* (Special Supplement) 15, no. 4 (August 1985).

[102] Panem, "AIDS: Public Policy" 26.

[103] *San Francisco Chronicle*, Oct. 18, 1987, 9.

Surgeon General Koop's report have been recently countermanded by White House political advisors, who seem more willing to protect the sensibilities of conservative supporters than to inform the general public of this lethal threat.

The relevant moral principles for the testing issue are outlined in two excellent articles, one by James F. Childress of the University of Virginia at Charlottesville and the Kennedy Institute at Georgetown, the other by Bayer, Levine, and Wolf of the Hastings Center (cited n. 95 above). They set deontological limits to policy reflections which might trample individual rights. Both articles come to a negative conclusion on mandatory screening for HIV. Bayer et al. mention four relevant moral principles:

1. *Respect for persons* requires that individuals be treated as autonomous agents who have the right to control their own destinies.... The right to privacy and informed consent flow from this principle.
2. The *harm* principle permits limitations on an individual's liberty to pursue personal goals and choices when others will be harmed by those activities.
3. *Beneficence* requires that we act on behalf of the interests and welfare of others.... The justification for public health authority derives from both the harm principle and beneficence.
4. *Justice* requires that the benefits and burdens of particular actions be distributed fairly. It also prohibits invidious discrimination.[104]

While these principles may at times conflict, they indicate a prima-facie obligation since they bind us, other things being equal. However, they may be overridden by more pressing considerations. "For example, the principle of beneficence and the harm principle may outweigh the need to obtain consent in some situations, but they never outweigh the obligation to treat persons with respect for their intrinsic worth and dignity." Clearly, human dignity is the primary obligation which should not be overridden.

Childress specifies four conditions for testing programs which would override rules of liberty, including freedom of association, privacy, and confidentiality:

1) A policy infringing on these rules must be *effective and proportional.* It must be shown that such a policy "will probably realize the goal of protecting public health and that the probable benefits will outweigh the probable harms, costs and burdens."

2) Infringing these rules should be a matter of *last resort* where no feasible alternative remains. Policies which would protect the public health without violating these rules should be preferred.

[104] Bayer et al., "HIV Antibody Screening" 1769.

3) The *least infringement* possible should be sought in all cases. "For example, when society infringes liberty, it should seek the least restrictive alternative, when it infringes privacy, it should seek the least intrusive option, and when it infringes confidentiality it should disclose only what is essential for effectiveness."

4) "Respect for persons may require that the society inform people whose liberty, privacy and confidential relations have been infringed." A duty to disclose and even justify such policies to the person may arise, as well as the obligation "in some contexts to undertake compensatory measures."[105]

Childress describes four types of screening, which vary according to the extent of screening (universal or selective) and the degree of voluntariness (voluntary or compulsory). He judges that *voluntary universal screening* is not justified at this time because "It is not necessary; the virus does not appear widespread outside high risk groups; there would be many false positives outside such groups; such screening would be costly and would not be cost effective; and its potential 'discriminatory impact' would far outweigh any potential benefit." *Compulsory screening* has been proposed on the grounds that voluntary screening would not be universal. This strategy is morally objectionable because it would violate the four conditions stated above. "If it is proposed in order to inform people of their antibody status so that they will change their behavior, the goals of changing behavior can probably be realized by other means that will less infringe on the rules of liberty and privacy."

Voluntary selective screening would be morally justified, but still raises difficult questions. Public financing of such tests would encourage those at risk to test and would be justified because the policy would protect others in society. Would the risks to privacy and of subsequent discrimination be countered by the advantage of knowing one's antibody status? This question becomes the more pressing in jurisdictions such as Colorado where reporting of test results to public-health departments is required. What advantage does testing have when no cure is known for the condition? Some may prefer to remain ignorant rather than being burdened with knowledge which cannot be made personally useful and would likely be traumatic and depressing. Since the same recommendations for avoiding high-risk behaviors hold in any case, would the knowledge of a positive status provide significant additional motivation?

Compulsory selective screening has already been adopted for some populations. Childress holds that mandatory screening is justified when "people are engaged in actions that impose risks on others without their

[105] Childress, "An Ethical Framework" 29.

consent. Examples include blood donation, sperm donation, and organ donation."[106] Mandatory screening for marriage licenses would not likely affect the population most likely to produce infected infants, namely, IV drug users, and runs the risk of "false positives" for many couples who have never engaged in high-risk behaviors. The Pentagon is screening all military recruits under the rationale that the policy would protect battlefield transfusions and provides a consistent base for epidemiological data. However, if the policy is a device to exclude homosexuals from the military, it is morally dubious. Inmates of federal prisons who are sexually active or are prison rapists are being screened for segregation, which may be a reasonable way to protect the rest of the prison population. Patients in mental-health facilities should also be protected from sexually-active incompetents who are antibody positive. Wherever mandatory screening is in effect, the institution should also provide counseling and other health services to those who are seropositive.

Advocates of mandatory testing, such as Senator Jesse Helms of North Carolina, may not have considered the implications of such programs, as Ronald Bayer writes:

> 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.[107]

Bayer raises the more ominous question: Would universal (hence mandatory) testing have education as its aim or the eventual isolation of those who are seropositive? With HIV seropositivity, such a policy would require lifelong isolation for a million and a half (or more) individuals. Such preventive detention on the mere possibility of dangerous action would represent such an assault on constitutional liberties that it is virtually impossible under our present legal system.[108]

[106] Ibid. 30.

[107] Ronald Bayer "AIDS, Power and Reason," *Milbank Quarterly* 64, Supplement 1 (1986) 177.

[108] Kenneth R. Howe, "Why Mandatory Screening for AIDS Is a Bad Idea," and David J. Mayo, "AIDS, Quarantines, and Noncompliant Positives," in *AIDS: Ethics and Public Policy*, eds. Christine Pierce and Donald VanDeVeer (Belmont, Calif.: Wadsworth, 1988) 140–49 and 113–23 respectively.

The Christian Response to AIDS

What position and what actions should the Church take on AIDS?[109] Three areas of special challenge arise. The first is the religious framework for defining the issue; the second is the educational strategy appropriate to the crisis; the third is the practical response in ministering to persons with AIDS.

What religious perspective should this crisis be placed within? Often the horizon of meaning within which a moral question is placed points to an appropriate response. What does AIDS have to do with God? Plagues have a way of bringing primal fears and primal religious instincts into play. Certain religious leaders today are piously proclaiming that God is the direct agent of the disaster. Rev. Jerry Falwell has called AIDS divine retribution on homosexuals, a judgment shared by not a few mainstream Christians. In a time of crisis it is all the easier to blame the victims when they belong to groups already stigmatized in American society.

Hate becomes the offspring of fear, and the Almighty can be conveniently enlisted to justify righteous rejection and discrimination. If the plague can be attributed to God, believers can let the victims languish in their well-merited suffering. This moralism reinforces the image of a punitive God, which is alien to the New Testament. It also undermines any compassionate response of churches to the enormous human suffering caused by this epidemic.

Responsible church leaders are calling for a different perspective or horizon for grasping the meaning of AIDS. Rev. Donald Morlan, a New York American Baptist leader, writes: "God does not send men and women and children cancer, and God does not send AIDS." Rejecting any simplistic theodicy, he adds: "Part of the task of faith is abiding the unknown while being in solidarity with those who suffer and those who search."[110]

[109] Cardinal Joseph Bernardin, "The Church's Response to the AIDS Crisis," *Origins* 16, no. 22 (Nov. 13, 1986) 383–85; "Call to Compassion: Pastoral Letter on AIDS to the Catholic Community of California," *Origins* 16, no. 45 (April 23, 1987) 785–90; *Health Progress* (Special Section, "AIDS: Responding to the Crisis") 67, no. 4 (May 1986) 30–56; Michael G. Meyer, "The Catholic Church and AIDS," *America*, June 28, 1986, 512–14; National Conference of Catholic Bishops, forthcoming statement on AIDS (Washington, D.C.: U.S.C.C.); Robert Pawell, O.F.M., "AIDS: Crisis and Compassion," *Blueprint for Social Justice* 39, no. 10 (June 1986) 1–7; Archbishop John R. Quinn, "The AIDS Crisis: A Pastoral Response," *America*, June 28, 1986, 505–11; Judith Wilson Ross, "Ethics and Language of AIDS," *AIDS and the Medical Humanities*, eds. Eric T. Juengst and Barbara Koenig (New York: Praeger, forthcoming).

[110] Donald Morlan, "Churches and AIDS: Responsibilities in Mission," *Christianity and Crisis* 45 (1985) 483–84, at 483.

Cardinal Joseph Bernardin wrote a pastoral letter on the subject which extends to AIDS what he has called the Church's "consistent life ethic."

God is loving and compassionate, not vengeful. Made in God's image, every human being is of inestimable worth, and the life of all persons, whatever their sexual orientation, is sacred and their dignity must be respected.... The Gospel reveals that while Jesus did not hesitate to proclaim a radical ethic of life grounded in the promise of God's kingdom, he never ceased to reach out to the lowly, to the outcasts, of his time—even if they did not live up to the full demands of his teaching.[111]

Bernardin notes the alienation from the institutional Church experienced by some in the gay community. "At times this is due to a certain bias which exists among some members of the church." Although this alienation also stems from rejection of church teaching on sexual behavior, the attitude of the Catholic community contributes to it. "Unfortunately, in our efforts to teach the wrongness of homosexual acts, at times all that has been heard is the sound of condemnation and rejection."[112]

It may be helpful to recall the words of Pope John Paul to AIDS patients in San Francisco, when he emphasized that God loves us "without distinction, without limit.... He loves those of you who are sick, those who are suffering from AIDS and from AIDS related complex."[113]

St. Louis University Hospital chaplain Richard Dunphy, S.J., writes that the punitive image of God figures in the minds of some patients.

In many gay people this sense of religious guilt is really internalized homophobia, the irrational fear of same-sex orientation that has been expressed in personal, social, and religious nonacceptance of and discrimination against homosexuals. Given the phenomenon of regression that can accompany AIDS, the religious homophobia a person may have internalized at an earlier age can reassert itself as religious guilt.[114]

He distinguishes this from a healthy sense of guilt which AIDS patients may also experience. "When realizations such as these surface, with accompanying guilt, these persons need to take responsibility for their harmful attitudes and behaviors. In other words, they need forgiveness and reconciliation...."[115]

While Christians should not attribute any causal link between God

[111] Bernardin, "The Church's Response" 384.

[112] Ibid. 383.

[113] *San Francisco Chronicle*, Sept. 18, 1987. 1.

[114] Richard Dunphy, S.J., "Helping Persons with AIDS Find Meaning and Hope," *Health Progress* 68, no. 4 (May 1987) 58–63, at 62.

[115] Ibid. 63.

and AIDS, some lessons may be drawn from a natural-law perspective. Natural-law theories have attempted to place the human species in the context of the rest of nature by insisting that human conduct needs to observe certain natural finalities and limitations. Human identity is not a blank slate which can be filled in by whatever an individual or culture might desire. AIDS reminds us of this much at least: evolution has not equipped the human species for multiple, indiscriminate sexual partnering. The human immune system has no efficient defense against the assaults of promiscuity, whether in heterosexual relations (witness the high rate of cervical cancer among female prostitutes) or homosexual ones. Furthermore, certain forms of sexual practice are not protected against transmission of infections—in this instance, anal intercourse and oral-anal contact. The injection of drugs into the body can be either therapeutic or dangerously invasive. However one links these biological limits to divine intention in the process of creation and evolution, they are realistic limits that must be respected in sexual expression and use of chemicals.

What stance should the Church take on AIDS education, especially when the most commonly recommended means of prevention, using a condom, is expressly forbidden by Church teaching? Archbishop Roger Mahony of Los Angeles withdrew permission to use church facilities for an AIDS education program after learning that the program would promote the use of condoms. *Origins* reports: "A statement by Mahony said Catholic doctrine forbids the use of contraceptives and forbids sexual activity outside of marriage. He said that 'in the issue of AIDS,' use of condoms 'implies either heterosexual promiscuity or homosexual activity. The church approves of neither.'"[116]

Bishop Anthony M. Pilla of Cleveland has recommended a set of guidelines for counseling and teaching on AIDS which takes a different tack. After explaining the meaning of human sexuality in the context of marriage and Catholic teaching, "the normative value of premarital abstinence [and] marital chastity" is discussed. The second step acknowledges that "many people who are not Catholic would not share these teaching values about sexuality and marriage" and are unable or unwilling to practice chastity. Specific forms of genital sexual behavior are mentioned. Third, the medical facts about AIDS are presented explicitly with the recommendation, "be graphic in describing forms of sexual behavior," while adapting it to the age of the audience. Fourth, in discussing those who disagree with Church teaching on sexual behavior, "You are to inform them of a fact, from medical science, that condoms are recom-

[116] *Origins* 16, no. 28 (Dec. 25, 1986) 506.

mended to protect against AIDS. This is information 'about' condoms; it is not a recommendation 'for' condoms." Finally, Bishop Pilla urges that the initial step be repeated.[117]

Although numerous dioceses have initiated task forces and educational programs, the practical response at the local level has been slow.[118] As the crisis worsens, local parishes can make a needed contribution by establishing and staffing hospices. Medical analysts say that the most appropriate care for AIDS patients in their terminal condition is in a hospice rather than a hospital. When curing is out of the question, then caring in the most humane setting is called for. Until now, however, hospices for AIDS patients have been almost exclusively staffed by volunteers from the gay communities in cities such as San Francisco and New York. Heterosexuals are conspicuously absent from programs which train people to work with people with AIDS. The extent of the crisis will soon swamp the resources of the gay community in urban areas. In rural and suburban areas discrimination in hospital care and avoidance by the majority seem even more likely for homosexual AIDS patients and IV drug users.

The local church needs to respond in concrete ways to people with AIDS, however they contracted the disease. Lobbying efforts at all levels of government are needed to meet this crisis. The strains on our institutional fabric which this epidemic will inevitably bring present a special challenge to the local church. Archbishop John Quinn of San Francisco has described this challenge in words that soon will apply to many, if not all, of the dioceses in the United States:

> It would be a great mistake if we were to see in this massive epidemic only an occasion to speak about the moral principles of sexual behavior.... Each day, as the numbers of dead mount and we come to realize that these are people whom we have known and loved, distant and close members of our families, the call to an active compassion becomes clearer and clearer. It is not just a homosexual disease. It is a human disease. It affects everyone and it tests the quality of our faith and of our family and community relationships.[119]

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[117] Most Rev. Anthony M. Pilla, Bishop of Cleveland, letter of April 3, 1987.

[118] See Meyer, "The Catholic Church and AIDS" 512.

[119] Quinn, "The AIDS Crisis" 506. Two further areas of social justice remain which space does not permit to be treated. One is the crisis in financing the costs of AIDS through insurance and/or public means. See American Council of Life Insurance, "White Paper: The Acquired Immunodeficiency Syndrome and HTLV-II Testing," 32-33; Jack H. Blaine, "AIDS: Regulatory Issues for Life and Health Insurers" 2-10; Robert F. Hummel, "AIDS, Public Policy, and Insurance" 1; Russell P. Iuculano, "D.C. Act 6-170: The Five Year Ban on Risk Based Pricing for AIDS" 15-18; Mark Scherzer, "AIDS and Insurance: The Case