FROM THE BLACK DEATH TO AIDS

BY

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I. A HISTORICAL OUTLINE

1.1. *The Spanish Influenza of 1918*

A ten-year-old girl and her sister are in bed, seriously ill. They go to the window to see what is going on outside. The farm's three horses are harnessed to different carriages, each carrying a coffin. In the coffins are the girls' mother and two brothers. The Spanish influenza of 1918 has taken their lives.

The ten-year-old subsequently became my mother. In my childhood I heard so often about the Spanish influenza that I could frequently imagine the three coffins as part of my own childhood.

This was not a unique incident. In Norway some 12,000 people died from the Spanish influenza. The total fatalities for the whole world have been put at about 20 million—more than twice the numbers killed during the First World War.

1.2. *The Black Death*

Cholera, smallpox, plague and other epidemics have raged throughout history, claiming many millions of lives. In Norway the Black Death has been the worst epidemic. It arrived in 1349 and quickly spread throughout the country, bringing fear, privation, sorrow and distress. It is estimated that only one-third or one-half of the population survived. The Black Death also ravaged in Denmark, Sweden and many other countries: of the Nordic countries, Norway was the hardest struck.

A lively history of the disease is given by Reichborn-Kjennerud in *Vår Gamle Trolldomsmedisin* (Our Old Witchcraft Medicine).[1] He says that the Black Death rushed like wildfire through all classes of the population. People lived no more than a couple of days after falling ill. In most places the epidemic passed after a few months.

Many of the kingdom's highest-ranking men died and new men took their offices in the higher posts. In many rural districts there were few survivors:

[1] I. Reichborn-Kjennerud, *Vår gamle trolldomsmedisin III* (Our Old Witchcraft Medicine), *Skrifter utgitt av Det Norske Videnskaps-Akademi* (Publications by the Norwegian Academy of Science), Oslo 1940, pp. 76–143.

legend has it that one woman survived in Kvinesdal (Valley of the woman) and one man in Mandal (Valley of the man)—and that they got married. Many fled to the mountains to save themselves; in my native district there is a mountain called Kvinnfjellet (Woman's mountain), and according to legend this is because a woman stayed there to avoid the pestilence.

The Black Death was ruinous for commercial life. Many farms were deserted, and the forests closed in on cultivated land. Most domestic animals died, either of the disease or of neglect. The Church did not get its legal tithes, and the bishop of Oslo complained to the King. Those who did take their grain to town were more addicted to drink than ever before, and therefore forgot the ecclesiastical right to a tenth of the grain that legally belonged to the Church.

The Black Death was followed by cultural and moral decline and a time of lawlessness. Few clergymen survived the epidemic, most likely because of their self-sacrificing work for the sick and dying. With many teachers dead, the young grew up under conditions that have been called "atrocious". Drunkenness and fighting were rife: people lived in a whirl of pleasure, as if every day were their last. Jungle law prevailed, and the administration was paralyzed.

During the Black Death almost all writing in the country ceased, so we do not know quite what happened. The details might not be so important, however, and historians describe the Black Death less dramatically.[2] Yet it is clear that apart from the innumerable deaths, the disease set in train radical changes in living and in society in the Middle Ages.

1.3. *From Witchcraft to Contagion*

A Swedish tuberculosis researcher named the history of epidemics a "Via Dolorosa".[3] Why has mankind had to suffer the scourges of these epidemics?

In ancient times people thought that epidemics were results of witchcraft, that the dead fought against the living and dragged them to the realms of Lethe. Ominous signs of the zodiac, comets, black clouds and dense fogs foretold the imminent onslaught of an epidemic. In legends, the disease was personified as a man with a scythe, a woman with a rake or a broom, often as a figure with a book in which the names of those picked to die were written. It was unknown that disease could be transferred by "contagion":[4] it was thought to be the revenge of the gods—a penalty for human sin. In Exodus the

[2] See, for example, Jørn Sandnes, "Mannedauen og de overlevende", in *Norges historie* (The Black Death and the Survivors, in The History of Norway), vol. 4 (Mykland, ed.), Oslo 1977.

[3] Britt-Inger Puranen, "Via Dolorosa", in *Helse- og sosialmagasinet Liv* (Journal on health and social matters) 1987, no. 1, p. 11.

[4] I. Reichborn-Kjennerud, *loc.cit.*, *supra* note 1.

Lord uses the plague as a scourge to force Pharaoh to let Moses and the Children of Isreal leave Egypt.

Medical science and health workers have concentrated on bacteria, bacilli, viruses and other infectious substances transferred from individual to individual either directly or through animals, drinking water, or other objects. Medical science made important progress in the fight against infectious diseases and epidemics. Research on infectious substances has been successful and vaccines have been developed. During the last half-century antibiotics have revolutionized the treatment of infectious diseases.

1.4. *Eradicating the Diseases*

Until well into this century, tuberculosis and other infectious diseases dominated the death statistics of the Nordic countries. Now these diseases have been nearly eradicated in the western world, though still causing serious problems in many other countries.

Medical research and the health services usually get the credit for the eradication of the traditional "mass murderers". Yet it is also maintained that the so-called progress within medicine has been of no significance in this respect. The Mexican theologian and health researcher Ivan Illich argues that, during the last hundred years, the doctors have not influenced the control of epidemics any more than the priests did before them. The rituals being followed in our medical temples do not control epidemics any more efficiently than exorcism or other magic did. Tuberculosis had culminated before Robert Koch discovered the tubercle bacillus; the death rate had declined dramatically by the time tuberculosis sanatoriums were built in our century; and the disease had to a great extent already been defeated when antibiotics came into use after the Second World War. Cholera, dysentery and typhoid fever have shown a corresponding culmination and decline without being under medical control. Illich attributes the decline in mortality to better housing and nutrition.[5] Better sanitary conditions have also been an important social factor in the near-eradication of tuberculoses and other infectious diseases.

A third explanation for the near-defeat of the diseases has been ambitious and efficient health legislation. Jørgen H. Berner's treatise on infectious diseases, which received the King's gold medal for medical research in 1922, pointed out that the Norwegian government had responded readily to the

[5] Ivan Illich, *Medisinsk nemesis* (Medical Nemesis), Oslo 1975, pp. 13–15.

Ministry was the famous legal scholar, lawyer and politician Fredrik Stang senior. It was a time of liberal ideas; Stang opposed state control, including restrictions on steamship traffic. Stang is often remembered for his energetic work in developing trade and communications, and for his valuable contributions as head of the Ministry of the Interior to Norway's economic growth.

The "side effects" of Stang's policies have been illustrated in a recent medical thesis on the 1853 cholera epidemic in Oslo. The author stresses that economic and commercial interests accorded with the then current medical view of cholera as a non-infectious or only slightly infectious disease. She further emphasizes that the better-informed worked for general economic growth and that medical authorities considered it a social duty to counteract any quarantine regulations that might cause unemployment, food shortages, famine and starvation. The situation was the same in Denmark in 1853. The steamships sailed from Copenhagen to the provinces "belching forth" cholera, while the county doctors joined in a vigorous protest against the government in the capital.[11]

Leprosy was widespread in the nineteenth century. Should lepers be committed to institutions and forbidden to marry? The general understanding was that leprosy was not infectious but hereditary. In the debate concerning leprosy legislation, encroachment on individual freedom was set against the efficient prevention of dissemination of the disease. The outstanding professor of law and conservative politician Anton Martin Schweigaard defended the marriage prohibition as "a moral call to the lepers to really understand their position and duties towards the rest of society". The well-being of society was the overriding political norm. The party leader of the Left, Johan Sverdrup, attacked the proposal because it would violate principles society was intended to secure: personal freedom and general legal protection. The ban was adopted. In 1873 Armauer Hansen discovered the lepra bacillus, and the Leprosy Act of 1885 authorized health boards to prescribe isolation or hospitalization, if necessary with police help.[12]

Regarding a more recent issue, discussion in Parliament leading to the Vaccination Act of 1954 showed a consensus that certain vaccinations could be made mandatory, but there was disagreement over how extensive the authorization could be. The majority in the Parliamentary Social Affairs Committee concluded that the circumstances of epidemics vary, and that the health authorities should therefore receive "relatively wide powers to stop epidemics

[11] Lizzie Irene Knarberg Hansen, "Koleraen i Christiania i 1853" (The Cholera in Christiania in 1853), Section for Medical History, University of Oslo (mimeogr.), 1986, especially pp. 32–53.

[12] See Anne-Lise Seip, *Sosialhjelpstaten blir til. Norsk sosialpolitikk* 1740–1920 (The Emergence of the Social Welfare State. Norwegian Social Policy 1740–1920), Oslo 1984, pp. 236 f.

representatives were also a political corrective to the doctor. People tend to accept strict measures more easily when decided by their own elected representatives.

Chief Medical Officer Fredrik Mellbye—who is among those in Norway with the greatest experience of epidemic diseases—has stressed that the Health Act "gives considerable emphasis to human forms of contact and patterns of behaviour as contributory causal factors in the occurrence and spread of epidemic and infectious diseases. The understanding of such factors seems to have been greater than it appears to be today, even in what are presumably better-informed circles."[9] The Health Act of 1860 was visionary in its understanding of the influence of the environment and behaviour on the general state of health. Mellbye has also said that the drafters of the Health Act "possessed the qualifications essential for making a law in such a dynamic area as medical administration. They had wide understanding of the country's political traditions."[10] The legislative committee included the country's leading men in medicine, law, politics and social debate. Chairman Ulrik Anton Motzfeldt became a law professor, county court judge, Supreme Court justice, chairman of Oslo City Council and a member of parliament before reaching his mid-forties.

1.6. *Conflicts of Interest Underlying the Legislation*

Norwegian legislation relating to infectious and epidemic diseases includes many regulations intended to prevent the spread of disease. Thus doctors and others are obliged to report infectious and epidemic diseases, and citizens to undergo medical examinations and treatment. There are provisions on mandatory vaccination, isolation of dangerous carriers of infection, work prohibitions, the location of infection sources and other infected persons, and the sterilization of rooms and clothes used by infected persons.

These regulations came about after thorough consideration, and not without political struggle. Individual freedom stood in opposition to society's interest in confining a disease. The following three important examples illustrate how patients' rights were in direct conflict with society's interests.

When cholera devastated Oslo in 1853, the Health Commission in Kristiansand asked the Ministry of the Interior to stop or restrict the steamship traffic between the two cities, but the request was not complied with. The head of the

[9] Fredrik Mellbye, "Praktiseringen av smittelovgivningen" (Application of the Law on Infectious Diseases) in the book *AIDS og JUSS* (see footnote 14 below), p. 38.

[10] Fredrik Mellbye, "Sunnhetsloven av 1860 og de menn som skapte den", (The Health Act of 1860 and its authors), *Liv og helse* 1960, pp. 104–110.

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efficiently". The minority regarded "the right to personal integrity as a superior principle in all states ruled by law". While it should be possible to set aside this principle in the interests of society, it should be "paramount that the Vaccination Act does not interfere more with the individual's right to self-determination regarding his/her own body than is necessary for the purpose". The minority further suggested that a person be exempted from vaccination "if the person can demonstrate that he/she through firm conviction does not wish to be vaccinated, and if the acute infectious disease viewed in the light of its dissemination, its nature and the situation in general cannot be regarded as a danger to public health".[13] As with conscientious objection, individual conviction is an acceptable reason for exemption, but should not apply if public health is at risk.

The views mentioned above indicate that discord and argument about coercive measures against infectious and epidemic diseases are old phenomena. They simply occur with a new variant in today's feared epidemic—HIV infection and AIDS. The earlier debates were however more open: moral and political arguments were presented straightforwardly.

II. BASIC PRINCIPLES IN EXISTING LEGISLATION

2.1. *Some Important Distinctions*

Before today's epidemic—AIDS—is dealt with, existing Norwegian legislation will be reviewed. This is comprehensive but heterogeneous, and spans the period from the 1860 Health Act until the present. To indicate its outlines it will be necessary to paint with bold strokes of the brush.

There has so far been no Scandinavian legal writing dealing with infectious and epidemic diseases.[14] In Danish and Swedish criminology, however, the AIDS issue has been discussed by several writers.[15]

First, a distinction must be made between regular health legislation and legislation dealing with infectious and epidemic diseases. The legislation states

[13] *Innst. O.* XI for 1984 *Innstilling fra Sosialkomitéen om lov om vaksinasjon* (Recommendation by the Committee on Social Affairs on the Vaccination Act), pp. 3–5.

[14] After this paper was written two more books have appeared: Asbjørn Kjønstad and Fredrik Mellbye, *AIDS og JUSS* (Aids and the Law), Oslo 1987, and Viggo Hagstrøm, *AIDS som et juridisk problem* (AIDS as a Legal Problem), Oslo 1988.

[15] Vagn Greve and Annika Snare, "AIDS—Nogle retspolitiske spørgsmål" (AIDS—Some Issues of Legal Policy), *Kriminalistisk instituts stensilserie* no. 35, (Publication Series of the Department of Criminology), Copenhagen 1986, Vagn Greve and Annika Snare, "Retssystemet v. AIDS" (The Legal System vs. AIDS), *Retfærd* 1986, pp. 4–18, and Hans Ytterberg and Bo Widgren, "Strid om lagstiftningen kring AIDS i Sverige" (Controversies on the legislation relating to AIDS in Sweden), *Retfærd* 1986, pp. 19–22.

that these diseases are objects of the state's special attention. This means that the state has a particular responsibility regarding them.

The regular health legislation includes the Hospital Act, the Municipal Health Service Act, the National Insurance Act on medical benefits, public health legislation and the Acts on the medical professions. This legislation governs administrative and economic relations between public authorities and people working in the health sector. Under the regular health legislation, patients have few and poorly-defined rights and duties.

Those who contract infectious and epidemic diseases, however, have extensive duties. They also have important economic rights in addition to those enjoyed under regular health and social security legislation.

Within the legislation dealing with infection there are two distinct levels. On the first, we find the provisions governing all infectious and epidemic diseases, mainly the provisions of the 1860 Health Act, of the 1952 Quarantine Act and of the 1954 Vaccination Act. The second level contains special legislation for venereal diseases and those of tubercular origin. Here, the individual's duties and rights are more extensive than in other infectious-disease legislation.

A main principle in Norwegian health legislation is that an individual can decide whether to seek health services, to undergo examination, to receive treatment or to be hospitalized. The main rule is that citizens have no legal right to treatment.[16] However, those who achieve status as a patient despite long waiting periods do have certain rights. Patients have a right to information about their state of health and their treatment, and to access to their own medical records. Health and medical personnel have a duty to maintain confidentiality about a patient's disease and other personal information.[17] Several of these principles may be overridden in cases of infectious and epidemic disease, as will be discussed in the following sections.

2.2. *The Individual's Duty to Report a Disease and to Seek Medical Care*

Under sec. 2 of the Venereal Diseases Act (VD Act), any person who knows, or has reason to believe, that he has a venereal disease, has a duty to seek a doctor. In the case of a minor or an incompetent, a parent or guardian must ensure that the necessary medical care is obtained. There is no similar regulation within the tuberculosis legislation.

According to sec. 14 of the Health Act, a householder must report to the Chairman of the Health Board any member of his household suffering from a disease dignosed as infectious and malignant. It is somewhat doubtful whether

[16] See further Asbjørn Kjønstad, *Helserett* (Health Law), Oslo 1987, pp. 45–72.
[17] *Lov om leger* (Act on Medical Practitioners) of June 13, 1980, no. 42, secs. 25, 31–37 and 46.

an individual has the same duty. It can be argued that the householder rule is antiquated; but it can also be argued that, since most adults can now be classified as householders, anyone who has contracted an infectious and epidemic disease has an individual duty to report this condition to the Health Board or to seek medical help.

2.3. *The Duty to Undergo Medical Examination and Treatment*

Sec. 2 of the VD Act clearly states that the diseased individual has a duty to undergo necessary treatment and subsequent check-ups. Diagnostic examinations are considered as included in the concept "treatment".

Under the tuberculosis legislation, all citizens have a duty to undergo tuberculin tests and subsequent verification with X-ray screening.[18] According to the TB Act of 1900, sec. 5(a), para. 2, there is a duty for those suffering from tubercular diseases to undergo health supervision; but apart from this the extent of the duty to undergo medical examination and treatment is unclear.

The Health Act also lacks clear provisions regarding the duty to undergo medical examination and treatment. It is possible that the duty arises from the general statement in sec. 15 that the Health Board may "take such steps as the nature of the disease demands", cf. section 2.5 below.

It follows from this that anyone contracting an infectious and epidemic disease will have a general obligation to undergo examination and treatment. Even without legal obligation, except in the case of venereal diseases, most people will follow the doctor's advice since the alternative may be compulsory hospitalization.

2.4. *Non-voluntary Hospitalization*

Under sec. 21 of the Health Act, the Health Board may enjoin individuals suffering from dangerous diseases that could be infectious to undergo hospital treatment, unless they can, without delay, get proper treatment at home or elsewhere, privately. Corresponding provisions are found in the VD Act, sec. 2, subsec. 3.

Other provisions empowering Health Boards to require hospitalization are found in the VD Act, sec. 8, para. 3, and the TB Act, sec. 6, para. 2. These paragraphs do not expressly provide a duty to undergo treatment, but such duty follows from other provisions in those two Acts.

[18] *Lov om røntgenundersøkelse ved skjermbildefotografering* (Act on Mass Radiography) of December 12, 1947, no. 15, and *Lov om tuberkulinprøving og vaksinasjon mot tuberkulose* (Act on Tuberculine Test and Vaccination against Tuberculosis) of December 12, 1947, no. 16.

Consequently, those who contract an infectious and epidemic disease may be compulsorily hospitalized and treated. For many, this represents serious encroachment on individual freedom.

Examination, treatment and hospitalization may be for the protection of the sick, or to prevent others from being infected. This follows from the wording of several provisions (e.g. the VD Act, sec. 8, and the TB Act, sec. 6) and from the *travaux préparatoires*. Where obligations are laid upon a patient solely to protect the interests of others, conflicts may occur. A need thus arises for certain guarantees for the legal protection of individual rights. Injunctions requiring compulsory hospitalization or other isolation may be brought before the ordinary courts according to a special provision in ch. 33 of the Code of Civil Procedure, which provides for review of administrative decisions concerning detention and other compulsory measures.

2.5. *House Detention. Confinement*

When a person can be legally detained in hospital to avoid infection of others, could he not also be isolated at home or elsewhere? We lack clear legislative authority for this, but the general "such steps" provision of the Health Act mentioned in 2.3 above presumes that the Health Board is to act when infectious and epidemic diseases approach or break out. The question then arises whether this provision implies duties for the Health Board only, or whether it also confers authority to impose duties on citizens.

This question has come before the Appeals Committee of the Supreme Court.[19] It was possible that a person who worked at a health spa had been infected with smallpox. The Health Board decided that all employees at the spa and their families should be isolated. The persons isolated were required to stay either at home or at their place of work, and could not use public transport between the two places. A physiotherapist disregarded the Health Board's injunction by driving a car on errands to several places. She was punished for this violation. The Appeals Committee found that the Health Act, sec. 15, supplied the necessary authority for a short-term injunction requiring an individual to remain at home.

A much greater encroachment would be to isolate an individual in a specific institution for a longer period of time. It is doubtful whether the Health Act, sec. 15, authorizes this. The wording of the statute and the Supreme Court decision mentioned above do not, however, indicate any fixed limit for more extended isolation.

[19] 1971 NRt 854.

2.6. *The Doctor's Obligation to Report*

The health worker is bound to professional secrecy; the purpose of this is to protect patients. This protection is reduced in cases of infectious and epidemic disease.

According to sec. 20 of the Health Act and sec. 39 of the Medical Practitioners' Act, doctors are obliged to report to the Health Board any infectious and epidemic diseases they come into contact with in the course of their work. Irrespective of confidentiality, information may also be given when it is necessary for stopping the spread of diseases that are objects of special state attention.[20]

Doctors are also obliged to report to the Health Board under the TB Act, sec. 2. In sec. 6 of the VD Act, the duty to report is somewhat different. Only those patients who fail to comply with the VD Act and the administrative regulations need be reported to the Health Board chairman.

The provisions concerning the doctor's obligation to report show that the struggle against infectious and epidemic diseases has been regarded as more important than the patient's right to seek assistance with the assurance that the doctor is bound by professional secrecy.

2.7. *Dangers of Infection at Public Gatherings*

During epidemics it is important to avoid gatherings where infection can spread. Sec. 15, para. 4, of the Health Act authorizes the Director-General of Public Health to ban meetings, performances, exhibitions and other arrangements that gather a considerable number of people. This provision can also be used to prevent the spread of venereal diseases, since these are covered by the Act. Sec. 11 of the TB Act confers wide powers on the Government to issue general regulations on the use of assembly rooms and work premises frequented by many people. Thus it is possible to restrict the exercise of trade and commerce, the right of association and the freedom of assembly.

2.8. *Disinfection of Rooms and Clothes*

Sec. 24 of the Health Act contains a provision governing objects that may be infectious. The Health Board may order the disinfection of rooms and clothing used by a person with an infectious and epidemic disease. This also applies to venereal diseases. Secs. 7 and 8 of the TB Act establish a duty to disinfect

[20] See further *Forskrifter om melding av infeksjonssykdommer* (Regulations on the reporting of infectious diseases), issued by the Ministry of Health and Social Affairs), December 12, 1974.

rooms and clothes that have been used by infected people. Such rooms or clothing must not be given to any other person before disinfection has taken place.

2.9. *Funerals*

By authority of the Health Act, sec. 25, the Health Board may issue regulations concerning funerals to avoid the spread of a disease. Commemorative services and funeral processions may be banned. It can be required that funerals take place immediately after death has occurred.[21]

2.10. *Other General Legislation Concerning Infectious and Epidemic Diseases*

In addition to the Health Act, Norway has three general Acts that relate to infectious and epidemic diseases. These are the Quarantine Act of 1952, the Vaccination Act of 1954 and the Criminal Code of 1902. Also of great importance, though not covered in this paper, is our foodstuffs, building and working-environment legislation.

The quarantine legislation has changed character during the two-to-three hundred years of its existence. It started with a prohibition against contact with other countries where there might be a risk of infection. This was followed by quarantine regulations, which were subsequently replaced by an inspection system. International conventions have influenced national measures during the last hundred years. The Norwegian Act of 1952 gives the Government wide authority to take measures to prevent infectious and epidemic diseases from being brought to or carried from Norway. The use of this authority has been limited since Norway ratified the international quarantine regulations, which place great importance on free passage and trade between countries.

Under the Vaccination Act of 1954, vaccination against smallpox and other dangerous acute infectious diseases may be ordered. There are no regulations authorizing compulsory vaccination against chronic diseases. There is, however, a provision regarding compulsory vaccination in the TB legislation.[22]

The vaccination legislation applies to all members of society, especially to those not yet infected.

According to secs. 154, 155, 156, 357 and 358 of the Criminal Code, a person may be punished for wilfully or negligently causing the spread of an infectious

[21] Such procedures have also been described by Albert Camus in his novel *La peste*.

[22] *Lov om tuberkulinprøving og vaksinasjon mot tuberkulose* (Act on Tuberculine Test and Vaccination against Tuberculosis) of December 12, 1947, no. 16.

disease. In cases of transmitted infection, provisions on assault and battery and manslaughter may become applicable.[23]

Having covered general principles concerning infectious and epidemic diseases, we shall now examine the special provisions concerning venereal diseases and diseases of tubercular origin.

2.11. *Tracing Sources of Infection and Infected Individuals*

The VD Act stresses the importance of tracing the sources of infectious disease and finding those infected. The doctor is required to ask the patient who the infection may have been contracted from, and to whom the patient may have transmitted it. The doctor must either examine these individuals personally or make a report to the chairman of the Health Board (sec. 5). If the infected individual refuses to reveal the identity of the source of infection, or of others possibly infected, the chairman of the Health Board may summon that individual for further questioning. The chairman shall then use his authorized powers to obtain information.[24]

The TB Act also has a provision (sec. 5(a)) aimed at identifying the source of the infection and whether others have been infected. Examination of the infected individual's home, the people living or staying there, fellow workers and others with whom the individual has frequent contact may be undertaken.[25] No-one may oppose such examination of their surroundings, and there is an obligation to cooperate with the examination procedure.

The Health Act lacks corresponding regulations concerning the tracing of the source of infection and those possibly infected. Here again, however, the "necessary steps" provision in sec. 15 (see 2.3 and 2.5 above) may apply.

2.12. *Work Prohibition*

The concept of "work prohibition"—*Berufsverbot*—is nowadays linked to adverse conditions in the labour market. But prohibitions against participation in working life have also been used to combat infectious diseases.

[23] *Brev av 1. oktober 1985 fra Justisdepartementet til Helsedirektoratet om straffansvar for personer som overfører AIDS-smitte* (Letter of October 1, 1985, from the Ministry of Justice to the Directorate of Public Health dealing with penalty for persons transferring AIDS infection).

[24] *Ot.prp.* no. 5 for 1947 *om lov om åtgjerder mot kjønnssykdommer* (Draft act on measures against venereal diseases), p. 7.

[25] *Ot.prp.* no. 94 for 1947 *om lov om endring i lov av 8. mai 1900 angående særegne foranstaltninger mot tuberkuløse sykdommer* (Draft act on amendments in the Act of May 8, 1900, relating to special measures against tubercular diseases) and *Innst. O.* no. 222 for 1947 *om endring av lov av 8. mai 1900 angående særegne foranstaltninger mot tuberkuløse sykdommer* (Recommendation by the Health Committee on the Act on amendments in the Act of May 8, 1900, relating to special measures against tubercular diseases).

To avoid passing on the infection, a tuberculous individual may be forbidden to work in food processing or to be a nanny or a teacher. The Health Board may ban the sale of milk from dairies or processing centres where tuberculous persons are working (TB Act, sec. 10). In sec. 10 of the VD Act the Health Board is given general authority to ban an individual suffering from a venereal disease from participating in work or other activity where the infection could be transmitted.

The Health Act has no regulations that deal with work prohibition but the general regulation in sec. 15 can possibly be used as authority to ban participation in certain occupations.

2.13. *Police Assistance*

The restrictive character of the VD Act appears, among other places, in sec. 11. The section provides that the police shall assist in implementing directives when required by the Director-General of Public Health, the County Medical Officer, or the Chairman of the Health Board. The police must report to the Health Board chairman any information they have obtained about venereal diseases. If the police suspect that a detainee or a prisoner is suffering from a venereal disease, that person must undergo medical examination.

2.14. *Marriage Prohibition*

The Marriage Act of 1918, sec. 6, prohibits the marriage of anyone who has a venereal disease and still has the possibility of infecting others with the disease, unless the other party is informed about the disease and both have had counselling from a doctor regarding its dangers.

This provision may seem old-fashioned today when pre-marital sex and extra-marital sex relations and non-marital cohabitation are common. The legislative committee on matrimony has proposed that the marriage prohibition in cases of venereal disease be abolished.[26]

2.15. *Economic Privileges*

Certain special economic privileges are linked to the treatment of tuberculosis and venereal diseases. These privileges were more important prior to the

[26] *NOU* 1986:2 (*Instilling til ny ekteskapslov, del 1)* (Recommendation on a new Marriage Act, Part 1), p. 35.

development of the present National insurance system and the public health service. But some of the older provisions continue to be significant.

National insurance benefits usually cover the major part of medical care and drug expenses, but the patient is required to pay the initial costs. However, these costs do not have to be paid by those afflicted by tuberculosis or venereal diseases, since in their case treatment is obligatory.[27]

The National Insurance Act, ch. 3 on sickness benefit, includes a favourable provision for those who are afflicted by an infectious disease. Sec. 3-2 contains important exceptions from the Act's main principle that the right to sickness benefit depends on the individual's inability to work. Sickness benefit can be allowed where a doctor declares that the treatment requires the diseased individual not to work. This may be the case when a diseased but able-bodied person is hospitalized for treatment. Benefit may also be allowed where the Health Board declares that the danger of infection makes it necessary for an infected individual, for instance a food industry employee, to stay away from work. Sickness benefit may also be granted when necessary medical control influences a person's ability to work, for instance if it is necessary to travel far to get radiation therapy.

2.16. *What Diseases Are Covered by the Health Act?*

Ch. 2 of the Health Act is limited to "special measures against epidemic and infectious diseases". Therefore the terms "epidemic", "infectious" and "disease" are decisive for the scope of this chapter, which also contains the regulations for compulsory committal. For these regulations to apply, the condition must fulfil all three definitional requirements.

Many sicknesses easily do so, for example cholera, smallpox and plague. Venereal diseases are also infectious and epidemic, so ch. 2 of the Health Act was applied to these before the passage of the VD Act, and it may still be used where precautions against venereal disease are not specifically authorized in the VD Act; see sections 2.7, 2.8 and 2.9 above.[28] Ch. 2 may also be used in cases of sexually transferrable diseases not covered under the VD Act. The VD Act refers only to syphilis, gonorrhea and other diseases mentioned in its sec. 1, while new diseases such as herpes 2 and AIDS are not covered.

The end of the last century saw the passage of special Acts regarding

[27] *NOU* 1986:11 (*Folketrygdens forhold til helsetjenestene og andre ordninger*) (the Relationship between the National Insurance and the health services and other systems), pp. 60 and 70.

[28] *Ot.prp.* no. 5 for 1947 *om lov om åtgjerder mot kjønnssykdommer* (Draft act on measures against venereal diseases), p. 1.

leprosy. This was because leprosy was not then regarded as infectious, and was therefore not covered by the Health Act.[29]

Nor has tuberculosis been presumed to be covered by the Health Act, ch. 2. This is clear from the *travaux préparatoires* of the Act,[30] from legal writing[31] and from its compatibility with other Acts.[32] Even though the infectious nature of tuberculosis was known at the turn of the century, the disease may not have been considered epidemic. "Epidemic" may be defined as "the occurrence of a disease in a large number of individuals within a short period".[33] Tuberculosis has shown a constant and continuing spread throughout the last century, but a rapid decline during the present one. It is believed that even well into this century most of the population was infected. Tuberculosis is, therefore, not a disease that has suddenly appeared, raged for some months and then disappeared again.

An important question is whether HIV and AIDS may be considered epidemic diseases in the meaning of ch. 2 of the Health Act. HIV and AIDS appeared quite suddenly, and have quickly spread. It is, however, unlikely that the diseases will disappear of their own accord, as did the old and typical epidemics. Thus HIV and AIDS have more in common with tuberculosis than with the typical epidemics such as plague, smallpox and cholera.

On the other hand, HIV and AIDS could probably be classified as similar to the venereal diseases, which undoubtedly *are* subject to ch. 2. Stig Frøland's "AIDS—A Challenge to Us All" is the most comprehensive medical work on HIV infection and AIDS in Norway.[34] The book states several times that HIV and AIDS are epidemics, and they are described chiefly as venereal diseases. Such statements also appear in the anti-HIV action plan of the Director-General of Public Health.[35] In practice, the provisions in ch. 2 of the Health Act have been used in AIDS cases, i.e. as authority for compulsory hospitalization. This could be a tenable interpretation of the Health Act. Thus the whole range of coercive measures found in ch. 2 of the Health Act may, in principle, be used with respect to AIDS.

AIDS undoubtedly *is* a disease; but the case of HIV is more uncertain, since the infected person often shows no symptoms of sickness. It must, however, be

[29] Jørgen H. Berner, *op.cit.* (footnote 6 above), p. 524.

[30] *Ot.prp.* no. 10 for 1898 *om udfærdigelse af en lov angaænde særegne foranstaltninger mod tuberkuløse sygdomme* (Draft act on special measures against tubercular diseases), p. 6.

[31] Jørgen H. Berner, *op.cit.*, p. 565.

[32] *Ot.prp.* no. 45 for 1947 *om lov om tuberkulinprøving og vaksinasjon mot tuberkulose* (Draft act on tuberculine test and vaccination against tuberculosis) of December 12, 1947, no. 16, p. 1.

[33] Sigvard Tschudi Madsen, in *Aschehougs konversasjonsleksikon*, Oslo 1969, vol. 5, p. 731.

[34] Stig Frøland, *AIDS—en utfordring til oss alle* (AIDS—A Challenge to Us All). Oslo 1986.

[35] *Helsedirektørens tiltaksplan for bekjempelse av HIV-infeksjonen* (the Action Plan of the Director of Public Health for combating the HIV Infection), issued by the Directorate of Public Health, October 15, 1986.

quite clear that the Act is applicable once complications such as LAS, ARC and related conditions occur. There is, however, a presumption that ch. 2 of the Health Act may be applied to persons in the first stage of immune deficiency.

2.17. *Are the Governing Provisions Antiquated?*

Many of the epidemic provisions dealt with above have not been used for decades. Can these be awakened and put to work? Or, in legal terms: have not the provisions fallen into desuetude?

The answer is a definite No! The provisions may still be applied when epidemics occur, as for example in 1971, when they were used by the Supreme Court's appeal division. The epidemic laws constitute stand-by legislation ready for use when epidemics threaten or break out.

The Health Act of 1860 and the TB Act of 1900 are prime examples of a restrictive nineteenth-century attitude towards health questions and social problems. In the modern welfare state it is not the restrictions, but what can be offered that should be at the centre of legislation. In our society the public has, through the taxes and duties it pays, gained control of half the national product. The chief strategy is to influence life-styles and behaviour through the allotment of resources such as information activities, public health services and social security benefits. The important question is whether we need the old restrictive provisions as a supplement to, or a replacement for, the modern measures.

III. VIEWPOINTS: PROPOSALS FOR LEGISLATION

3.1. *Introduction*

How should legislation concerning infectious and epidemic diseases be developed?

This is not merely a legal problem, or even primarily a question of law. It is a general problem for society, and medical, psychological, ethical, legal, economic and other viewpoints are of importance. The medical expertise seems to be in agreement regarding the medical bases of the measures; but opinions diverge regarding what measures should be taken against HIV-infected persons and AIDS sufferers. The following will stress legal aspects and will consist largely of personal opinions and viewpoints.

One opinion of little controversy is that Norway may need new legislation in this area. Problems associated with epidemics have not been closely examined

since the passing of the Health Act of 1860 and the TB Act of 1900. Our society is quite different, and the Acts are obsolete and unclear at many points. The other Nordic countries have initiated new legislation for epidemic diseases. Study of foreign legislation is important both for what we can learn from it and for keeping abreast of the rest of the world: epidemics know no frontiers.

Another central opinion is that new legislation must be supplemented by health services and information. Those infected or wanting to know whether they are infected should be given the opportunity to undergo diagnostic medical examination and medical treatment and care when possible. Psychological treatment is also important when the situation is connected to serious and life-threatening diseases.[36] Infected individuals should be given information so that they can more easily cope with their disease, and also to prevent its further spread.

The controversial issue is whether to introduce additional regulations for compulsory action. This will be dealt with in more detail below, but a general view is given here. The approach or outbreak of an epidemic creates a serious danger to public health and to society in general. In such a situation, Government alone should not bear all the responsibility: some rests with individual citizens. Most people feel a responsibility toward fellow citizens, and that they must show this when the situation so requires. But experience shows that there are a few who do not, and the consequences for the lives and health of others may be disastrous. Society must then be entitled to use compulsory means of protecting fundamental community interests. But such means should be used only as a last resort, where milder means have not worked. To avoid injustice, compulsion should be offset by guarantees of legal protection.

Not only in the health laws do we have regulations involving compulsory means of protecting citizens' health, but also in the foodstuffs, building and work environment legislation, as mentioned in section 2.10 above. These regulations are aimed primarily at trade, industry and other groups with large resources. An example of the use of the Labour Environment Act was the closing of the Norcem sheet asbestos factory in Slemmestad. Close to 1,000 employees worked at the factory during the 40 years of its operation. Up to September 1983, sixteen had died and seven were seriously affected through exposure to asbestos. Predominant was the cancerous disease mesothelioma, which, like AIDS, is 100 % fatal.[37] When such severe sanctions as closing down industries are used to prevent occupational health injuries in working time, one

[36] Mona Duckert, "Testen din er positiv—Om krisereaksjoner hos stoffmisbrukere" (Your Test Is Positive—on Drug Addicts' Reactions), in the magazine *Stoffmisbruk* 1986, no. 3–4, pp. 37 ff.

[37] Gunnar Mowé, *Malignant Mesothelioma in Norway. Epidemiological, Aetiological and Medico-legal Aspects*, Institute of Occupational Health, Oslo 1986.

should not reject out of hand the idea of coercion in connection with health injuries that can be traced to our leisure time.

3.2. *HIV Infection and AIDS*

Work on a new Act for epidemic and infectious diseases will no doubt be marked by today's epidemic—HIV infection and AIDS—just as the Health Act of 1860 was influenced by the cholera epidemics of the last century. The following will deal mostly with HIV infection and AIDS.

In the Nordic countries, AIDS is most prevalent in Denmark; thereafter Iceland, Sweden, Norway and Finland. Up to June 21, 1988, 81 Norwegians had been diagnosed as infected with AIDS.[38] It is assumed that all who are diagnosed as having AIDS will die within months or possibly a few years. Of those tested for HIV in Norway up to June 21, 1988, 697 were infected—eight times more than those with AIDS. Yet the hidden number is even greater: there are presumably 50–100 HIV-infected individuals to every AIDS victim. Consequently, there may be between 4,000 and 6,000 undiagnosed but infected individuals. It is estimated that 30 to 40% of HIV-infected persons will develop AIDS within 5 to 10 years, and since the number of AIDS cases diagnosed has so far doubled every twelve months, there will probably be several thousand people with AIDS by the middle of the 1990s.

Health service expenditure for the treatment and care of each AIDS patient has been estimated at one million NOK. National insurance costs in the form of sickness benefit, rehabilitation aid and benefit, disability pension, widows' and children's pensions and other social benefits can add up to several hundred thousand NOK. Add to this the enormous loss to commerce, industry and society in general when young people die. Yet more important is the human suffering of the afflicted and their families and friends.

The accuracy of these figures is less important than the fact that if the HIV infection continues to spread as it has done in Norway and in other countries—especially Central Africa, Haiti and the USA—it could possibly represent the most serious threat to public health, living conditions and social economy that we have known in modern times.

The epidemics of the past appeared suddenly and spread quickly in an unknown way throughout whole populations. Victims died within a few days while others remained free of infection and immune. The whole epidemic was usually over within a few months.

[38] Statens Institutt for Folkehelse: *Meldesystem for infeksjonssykdommer* (Reporting System for Infectious Diseases) 1987; 15(3).

The HIV virus has now been discovered. The infectiousness is small, blood and semen are the chief infection carriers, and normal social contact is not considered to be dangerous. Many years elapse from the first infection in a country until significant parts of the population have been affected. Health authorities have therefore had good time to consider the situation and plan steps to stop this epidemic, whereas in earlier cases they were required to act quickly and had to improvise. On the other hand these epidemics, after raging for a while, died out largely of their own accord. Those who are infected with HIV will be carriers for the rest of their lives.

3.3. *Precautions against the HIV Epidemic*

The authorities have tried to limit the extent of the HIV epidemic. This was last described in the action plan of the Director-General of Public Health of October 15, 1986. This plan is characterized by reliance on voluntary cooperation and information activities. Great stress is placed upon preserving the relationship of trust between the patient and the health workers, confidentiality, privacy and protection from stigmatization. Restrictive measures are almost never mentioned, because this would weaken patients' trust in the public health service.

The authors of the plan do not have much faith in the chances of stopping the spread of the disease. The main problem may be that the plan lays the chief responsibility upon the welfare state, and that no additional duties are imposed on the individual. A group led by the Professor of Social Medicine Per Sundby has drawn up an alternative viewpoint for an AIDS plan.[39]

Most important is to stop the spread of the HIV infection. To achieve this, infected persons—if necessary the whole population—must radically change their sexual habits from widespread promiscuity to sex only within steady relationships. With modern contraceptives and abortion, the health service has created the basis for free sexuality: now the health service, faced with the AIDS threat, must lead the promotion of a radical change in sexual habits. Addressing the Norwegian Medical Society on January 21, 1987, the advisor on AIDS for the Director-General of Public Health said that the health service would now become the focus of a new sexual morality. But the health service should not have greater influence in moral questions than other groups.

[39] Per Sundby, "Bekjempelse av AIDS-epidemien" (Combating the AIDS Epidemic), lecture in Det Norske Medicinske Selskap (the Norwegian Medical Society), January 21, 1987, and letter to the Parliamentary Committee of Social Affairs concerning alternative views of the fight against AIDS regarding the Director of Public Health's action plan for the HIV epidemic of August 1, 1986.

To change people's habits, it is important to supply general information and individual guidance regarding the HIV infection. But it is also important to be aware of the limitations of these measures. To meet the goal the message must be correct and easy to understand; it must attract the individual's interest so he may grasp it, understand it, be convinced and act on it, not merely as a guiding principle but as an absolute norm. There are many barriers between transmission of information and its reception, and reception is often poorest among those who need the information most.

Many people who are responsible for giving information become more or less disillusioned. The present author's experience is derived mainly from work on the State Council for Smoking and Health. Despite our 15 to 20 years of energetic information activities, a third of the adult Norwegian population are still slaves to nicotine. HIV is much more dangerous than tobacco, but as late as 1980 General Director Mahler of the World Health Organization said: "Smoking is probably the largest single preventable cause of ill health in the world".[40]

The limitations in information activities have led many to suggest more draconian measures. Doctors have suggested that the whole population be HIV tested and all HIV-infected placed in detention camps. A professor of biology has suggested that the infected be marked with a little blue heart in the groin, so potential sexual partners may know the risk they are taking. Such suggestions should be rejected as grossly offensive, discriminating and unsuitable.

Some less restrictive steps should, however, be considered. They could include authorized supervision, HIV testing and detention of persistent spreaders of the disease. On the other hand one might consider easing restrictions that were established prior to the AIDS threat. For instance it may be considered to allow intravenous drug users easier access to hypodermic syringes and needles, see section 3.9 below.

There is not room here to go into detail about all the possible steps. The next section will consider the connection between the HIV epidemic and the principles governing current infection legislation and questions arising from the action plan of the Director-General of Public Health.

3.4. *Collaboration with Voluntary Organizations*

The Directorate of Public Health has stressed the importance of collaboration with the Homosexuals' Health Association and other voluntary organizations

[40] H. Mahler, "Smoking or Health, the Choice Is Yours", World Health Organization, Geneva 1980.

better equipped to present information and help persons in the high-risk groups than are the public authorities.

One condition for collaboration between public authorities and voluntary organizations is that the public authority to a large degree must accept the organization's basic principles. If the organization opposes compulsory measures, the Directorate of Public Health must in the interests of collaboration refrain from suggesting such measures. Thus suggestions for using compulsory measures have in Norway come from levels above and below the Directorate of Public Health—from the Ministry of Health and Social Affairs down to a number of individual doctors through the mass media.

Collaboration with voluntary organizations is of special importance, and the Directorate of Public Health deserves credit for its efforts in this area. Collaboration may be dearly bought, but should be eagerly sought because it is here that the great gains may be made. To avoid the risks involved, however, the parties would have to give a clear undertaking to do all in their power to stop the HIV epidemic.

3.5. *The Individual's Duty to Report a Disease and Seek a Doctor*

Sec. 14 of the Health Act enjoins the householder to report diseases that are "malignant" and are spreading to others. As stated above (section 2.2), a duty may obtain for those who suspect they are HIV infected to report to the Health Board, or to seek a doctor. The provision has not been applied in this manner however, and there is no general understanding that citizens have such an obligation.

The introduction of a duty to report suspected HIV infection should be considered. Most people would obey such a provision, and the health authorities would get a much better impression of the HIV epidemic's possible dimensions. This would be the case even though some individuals disregarded the provision, and though violations could not be followed up or sanctioned efficiently.

3.6. *Duty to Undergo Medical Examination*

Today HIV testing is generally voluntary. As mentioned above (section 3.2), probably only one-eighth of the HIV-infected in Norway have been tested. This shows that voluntariness and cooperation have not led to major results.

To donate blood, it is a condition that one undergoes such a test. In other situations it is doubtful whether HIV testing can take place without the patient's express consent.

If a person goes to a doctor for help with health problems and symptoms, the doctor will carry out examinations and tests to be able to give the right diagnosis. It may be admissible to examine a blood sample to check whether the patient is HIV-infected. Consent to examination for diagnostic purposes is usually considerred to be a part of the decision to seek a doctor, and there is little reason to differentiate between HIV testing and other examinations.

A more difficult question is whether hospitals and health centres may HIV-test all comers as routine. The answer to this should be No. Such testing would appear as an unfair condition: you want treatment, you must have a HIV test! It should, however, be allowed to test patients before starting certain forms of treatment where the risk of infecting health workers or other patients is significant. For instance this could be necessary in operations where blood is released and where protection with gloves and other means is impossible. Health workers cannot be expected to treat all patients as if they were HIV-infected.

Some doctors have suggested in the media that the whole population should be HIV-tested. Mass testing could give an overview of the dimensions and development of the epidemic. And the health service would be able to trace many of the infection carriers and give help and guidance to prevent further development of the infection. There are, however, many arguments against such mass examination. Many would refuse, many would react negatively to compulsion, and serious mental strain may result from the knowledge that one is HIV-infected. The test is not 100 % reliable, and some infected individuals with negative test results could develop a false sense of security and become efficient spreaders of the infection if they continue or expand their manifold sexual life.

Under current Norwegian legislation compulsory testing is not allowed, and a general authorization of this should in any case not be given at this time. Nor should compulsory testing of certain groups, e.g. all pregnant women, military service personnel, foreign visitors and/or Norwegians who have been abroad, be enforced. Compulsory testing should be used sparingly, and only in the most strategic areas.

It is obviously important for planning medical resources and the expansion of health services that potential patients obtain better knowledge of the extent of the epidemic. In particular, we know too little about whether the epidemic is spreading from the so-called high-risk groups of homosexuals, bisexual men and intravenous drug addicts to their sexual partners and to the rest of the population. This knowledge could be obtained from a representative population survey. This could probably be done as a research project with voluntary participants and with blood samples already obtained. Since this is research, individual information need not appear in medical records.

3.7. *Trust and Confidentiality*

As mentioned earlier, the action plan drawn up by the Director-General of Public Health stresses the importance of the individual's trust in the health services. People should be able to seek a doctor and obtain a blood test without risking that others could be informed of the result, or later being subjected to restrictive means. Absolute confidentiality is therefore considered important in this area.

This can be explained by the very sensitive nature of the information in question and by the fact that many will avoid seeking a doctor if there is a risk that information will leak out or that restrictive means can be used against them.

It is not common elsewhere for the Norwegian health service to stress the importance of confidentiality and trust. Our legislation contains more than fifty important and extensive exceptions to professional secrecy. Legally and illegally there is a very comprehensive exchange of health information inside and outside the health service. The welfare state's professional secrecy is so shot with exceptions that it is more ideology than reality.

Apart from the sensitive nature of the information, another reason why confidentiality and trust are so important in HIV infection and AIDS is that the health service has not much to offer as long as there is no treatment for the basic disease. In cases of other diseases, where effective treatment is available, confidentiality is not taken so seriously. To encourage people to undergo HIV tests voluntarily, confidentiality should certainly be offered. This shows that professional secrecy is not an absolute rule, but primarily an item of exchange, used pragmatically.

Health workers exalt professional secrecy as holy and inviolable when it suits them. Legally, however, it must yield to serious considerations of public health. This is clear from the Medical Practitioners' Act, sec. 31, para. 2. If a doctor knows that a HIV patient is spreading the disease to others he may inform such persons about the risk these are exposed to. There may even be a duty under sec. 139 of the Criminal Code to report the diseased person if he/she is a malicious spreader.

3.8. *AIDS and the HIV Register*

Most countries keep a number of health registers, for instance for cancer and infectious and epidemic diseases.[41] The Norwegian Data Inspectorate has

[41] *Rapport fra arbeidsgruppe nedsatt for å gjennomgå statens epidemiologiske registre* (Report from a working group set up to study the state epidemiological registers), Oslo, February 15, 1985.

authorized the establishment of such registers. Irrespective of professional secrecy,[42] the doctor has a duty to report to the register regarding diseases treated, see section 2.6 above.

Doctors are now required to report all AIDS cases, but HIV cases are merely reported without giving the patient's name. This latter is for reasons of confidentiality and trust.

Both the Medical Practitioners' Act and the Health Act empower the authorities to require nominative reports in HIV cases as well as in others. Many are in favour of using these powers. Nominative reports are required for smallpox, cholera, polio, tuberculosis, leprosy, diphteria, malaria and other serious infectious diseases.[43]

A comprehensive HIV register could provide valuable information about the extent and development of the infection, and health authorities would have the possibility of following up the diseased. A HIV register should be just as important as a register for other infectious diseases or a cancer register. Strict professional secrecy would be required, and only a small number of people would be allowed access to information in the registers. These would of course not include employers, insurance companies, the military or others outside the health area.

3.9. *Distribution of Hypodermic Syringes and Needles*

As mentioned above, the restrictions on the access of drug addicts to syringes and needles should be eased. The HIV epidemic is spreading quickly, especially among intravenous drug users because many share syringes. A large number of intravenous drug users are prostitutes, which may mean that the epidemic spreads to their customers and to the customers' sexual partners. Much of the spread from this group could be prevented if the drug users could obtain sterile syringes and if the police did not confiscate syringes.

It could be argued that this would involve a legalization of drug use, such that if syringes were distributed without restriction, the AIDS threat would lose its function as an important motive for drug users to mend their ways. But the eradication of HIV is more important than this. Intravenous drug users are a difficult group to reach with information and guidance, since their dependence usually dominates their behaviour patterns.

Drug dealers in New York have started giving free syringes when selling

[42] Asbjørn Kjønstad, "Taushetspslikt og bruk av EDB i helsesektoren" (Secrecy and the Use of EDB in the Health Sector), *Lov og Rett* 1985, pp. 483–506.

[43] *Forskrifter om melding av infeksjonssykdommer* (Regulations on the reporting of infectious diseases), issued by the Ministry of Health and Social Affairs, December 12, 1974.

narcotics. In this way they get the customers to buy and use drugs without the risk of becoming HIV infected, and their circle of customers does not die out. It is not like the tobacco industry, which kills off its best customers.

The rules regarding the availability of syringes differ among the Nordic countries, and have been discussed by the Danish criminologist Vagn Greve.[44] One idea would be to allow free syringes and needles when the old "tools" are traded in. The trade-in is necessary to prevent children and others from being infected from carelessly discarded syringes and needles.

3.10. *Tracing the Sources of Infection and Infected Individuals*

According to the VD Act the doctor shall ask the patient from whom the infection was transferred, and to whom the patient might have transferred it. The TB Act includes a corresponding provision, but the Health Act does not contain any clear rule, see section 2.11 above.

A question of interpretation is whether the principles in the VD Act should be applied to HIV. On the affirmative side, it would be possible to reach a large number of those infected and to provide them individual guidance to stop the further spread of the disease. On the other hand, the duty to reveal the source of the infection and the identity of others possibly infected involves disclosing clearly intimate relationships and becoming an "informer". Many HIV-infected persons will avoid seeking a doctor if they are required to reveal the source of their infection and persons that they may have infected.

3.11. *Restrictions on Sexuality*

In cases of both leprosy and venereal diseases there has been a marriage prohibition. In our time such prohibitions cannot stop the spread of a disease transferred by sexual contact or from parents to children. There is much to indicate that sexual activity is just as prevalent outside marriage as within. In his book mentioned earlier Stig Frøland notes that it was not unusual for the first homosexual and bisexual patients in the USA to have had 500–1000 sexual partners.[45]

The banning of pre- and extra-marital sex, sexual relationships between

[44] Vagn Greve, "Narkomaners ret til deres 'værktøj'" (The Right of Drug Addicts to Their 'Tools'), *Nordisk Tidsskrift for Kriminalvidenskab* 1986, pp. 428–435.
[45] Stig Frøland, *op.cit.*, p. 11.

men and atypical sexual activities such as anal sex is not unknown.[46] If the old principle of lifelong monogamous marriages were restored, the HIV infection could be stopped.

Not all members of society may be willing to do this. Free sexuality, which has grown especially in the last twenty years, is regarded as a liberation, and has become a natural way of life for many. It is possible that the fear of AIDS will stop this promiscuity.

Criminal legislation in this area will hardly influence people's sexual habits; and laws that cannot be enforced will impair the general respect for legislation. There is also some doubt as to the advisability of regulating the most intimate relationships between people.

It should be considered whether a person who is HIV infected or has reason to believe this, ought to have a duty, when engaging in sex, to use a condom, which is regarded as adequate protection against HIV infection. When it is mandatory to use a seat belt to protect life and limb, then it should also be possible to demand some protection in cases of sexual intercourse.

3.12. *Work Prohibiton and Job Security*

As mentioned in section 2.12, a work prohibition is authorized both in the TB Act and in the VD Act, but there is no such clear regulation in the Health Act. HIV does not usually spread during the normal course of work—with the exception of prostitution. A work prohibition is therefore out of the question.

There may however be some functions within certain professions that the HIV-infected person should not carry out. A HIV-infected surgeon should not perform operations if there is a risk of his/her blood coming in contact with the patient. Employers must apportion work so that HIV-infected employees do not spread their infection by doing tasks involving risk.

If this is impossible, the question arises whether there is reasonable cause for dismissal under sec. 60 of the Labour Environment Act. There must be a considerable risk of infection for dismissal to take place. In Norway there have been several incidents where HIV-infected persons have been dismissed. A male nurse at an institution for the mentally retarded lost his job when patients' relatives feared that he might infect potentially violent patients who might bite or beat until bleeding was caused. A barman was fired because of the risk that he might cut himself on a glass and infect the guests; in any case the restaurant might lose guests because of fear of infection. In both cases the

[46] Ola Viken, "Via homofile mot abort" (Through Homosexuals against Abortion), *Stud.Jur.* (Law students' publication) no. 6/86, p. 30 (dealing with laws banning anal and oral sex in American states).

risk was so little that the dismissals were hardly reasonable. In the second example the court agreed with the barman that the dismissal was unreasonable, but did not give him the right to return to his former position.

3.13. *Compulsory Treatment of the HIV-infected and AIDS patients*

Under sec. 21 of the Health Act, the Health Board may require persons with dangerous diseases to be treated in hospital, see section 2.4 above.

It is somewhat doubtful whether HIV may be considered a disease, but with complications (LAS, ARC and related conditions and AIDS) it clearly becomes a disease within the meaning of the Act. The term "treat" may cause greater problems, since there is no treatment for the basic disease. Infections and cancer diseases that are present in the HIV-infected individual can, however, to some extent, be treated. It is possible that this is a sufficient basis upon which to use sec. 21 for the HIV-infected.

It is also possible that the term "treat" could be understood in a broader sense than pure curative therapy. Sec. 21 states that hospitalization can be ordered if "such treatment in the home or other private home" is not possible. This indicates that compulsory hospitalization can take place when the patient's need of care justifies this.

3.14. *Detention/Confinement*

Can the risk of infecting others justify the detention of HIV-infected persons? According to the Supreme Court's 1971 ruling the Health Act can be used at least for some isolation of persons who might be infectious, see section 2.5 above.

The Ministry of Health and Social Affairs proposed legislation for special measures against HIV infection. The proposal included a provision authorizing the hospitalization of a HIV-infected person whose behaviour exposes others to a serious risk of infection. Authority to invoke the provision should rest with the county medical officer. A person should not be compulsorily hospitalized for more than 30 consecutive days or for more than a total of 90 days a year. This provision could be used even where there was no hope of cure for the infected. It could thus be used to hinder the spread of the disease, for instance against HIV-infected persons who use blood-filled syringes as a weapon, against prostitutes who continue their occupation, and against others who have a large number of sexual partners without informing them of the risk of infection or without taking the necessary precautions.

Doctor juris Viggo Hagstrøm has stated that such a provision regarding

detention, decided administratively, would violate constitutional ideals of the Rule of Law.[47] He regards such dentention as a punishment which, according to art. 96 of the Constitution, can be ordered only by the courts.

It is clear that such dentention may be experienced as a punishment: it would be a consequence of earlier behaviour. But in order to be a punishment within the meaning of art. 96 of the Constitution it must, according to the eminent Norwegian scholar in criminal and constitutional law—Johs. Andenaes—be an "intended evil".[48] The purpose of dentention is here not to cause pain for the infected, even though pain may be a side effect.

Administrative deprivation of liberty has been used extensively in our society under the Act on Mental Health Care, the Temperance Act and the legislation covering infectious and epidemic diseases. Loss of liberty under these Acts is usually justified by the need for treatment, but the legislation also authorizes detention in the public interest, see section 2.4 above. According to the European Convention on Human Rights of 1948, "lawful detention of persons for the prevention and the spreading of infectious diseases" is permitted.[49]

Even if a court hearing may not be a constitutional requirement for hospitalization of the HIV-infected according to art. 96, many people consider that such a decision should be a matter for the courts. The hospitalization would be a question of evaluating behaviour, something that the courts are especially fitted to do. Because there are so many conflicts of interest, the principles of justice applicable to the work of the courts should be taken into consideration.

Another weakness of the legislation proposed by the Ministry of Health and Social Affairs is that detention would take place in a hospital. Since we are here dealing with fractious persons, there might be a necessity for security on a level similar to prisons. This the hospitals are not equipped to do, nor should they assume the character of penal institutions.

A special institution for this purpose could be considered. Life at such an institution must be made as pleasant as possible for the inmates, so that their stay will resemble a punishment as little as possible. The detainees must be taught how they can prevent the spread of the disease, and these norms must be learned.

The number of detainees must be as low as possible. Only persistent HIV

[47] Viggo Hagstrøm, "AIDS og rettssikkerhet" (AIDS and Legal Protection), feature article in *Dagbladet*, January 14, 1987.

[48] Johs. Andenæs, *Alminnelig strafferett* (General Criminal Law), Oslo 1974, pp. 8–15, and Johs. Andenæs, *Statsforfatningen i Norge* (The Norwegian Constitutional Law), Oslo 1981, pp. 395–401.

[49] Convention on the Protection of Human Rights and Fundamental Freedoms of November 4, 1948, art. 5(1)e.

spreaders should lose their liberty. And the detention must be accompanied by legal guarantees.

Such provisions regarding detention will probably not go further than what is currently authorized in the Health Act. But since the scope of the Health Act is unclear, a new provision is needed that describes the cases where detention can take place and that contains clear legal guarantees for the HIV-infected. Thus, HIV-infected persons who take necessary precautions against spreading the infection themselves may be assured of their liberty.

If no new institution is established for persistent spreaders of HIV infection, the Criminal Code could probably be used against them. Today a significant number of prison inmates are HIV-infected. Imprisonment should not be used for the sick and the dying. According to the guidelines and practice of prison authorities, AIDS sufferers should be pardoned.[50] There have been serious problems in prisons with a few HIV-infected prisoners who have threatened officers with blood-filled syringes. The prison administration is hardly equipped to teach the infected how not to spread their infection.

3.15. *Final Remarks*

Previous sections have dealt with the main questions that should be resolved in a new Act covering infectious and epidemic diseases. Regarding HIV infection and AIDS, it is probably not necessary to make provisions corresponding to the current prohibition against public gatherings, instructions for disinfection of rooms and clothes, or special regulations for funerals, see sections 2.7, 2.8 and 2.9 above.

The new epidemic has given rise to a number of issues that did not need regulation when the existing health legislation was framed. Thus dentists have refused to treat HIV-infected persons or persons they suspect are infected; hairdressers have refused to cut the hair of such persons; restaurants have refused to admit them; insurance companies have refused to sell them insurance; and landlords have refused to rent to them.

The main rule is that people in the liberal professions have no obligation to contract: they can refuse clients, customers, guests and other potential contract parties without giving any special reason. This does not, however, apply to a restaurant, which is open to the public. Hospitals and other public institutions cannot in principle treat the HIV-infected differently from other people.

In our private lives we choose our acquaintances freely. One might very well ask for a HIV test from a girlfriend or a boyfriend before entering into a sexual

[50] *Fengselsstyrets brev av 12. desember 1986 til Fengselsdirektøren og fengselsinspektøren* (The Prison Authorities' Letter of December 12, 1986, to the Prison Governor and the Prison Inspectors).

relationship. There are stories about American young people who start their relationship by going hand-in-hand to medical laboratories to get a HIV test.

If the public authorities do not make sufficient efforts to control the epidemic, demands for private testing may increase. Employers, insurance companies, house-owners, and other important groups and institutions in society could start requiring HIV testing of those applying for jobs, buying insurance, renting rooms, etc. Requiring a HIV certificate for admission to important institutions in society would be a much more regrettable development than the introduction of limited mandatory reporting of HIV infection and detention of only the most malicious spreaders of the infection, along the lines mentioned above.

If the HIV infection is to be eradicated, it is necessary that not only society assume certain duties, but that HIV-infected persons and the rest of us are willing to accommodate to the serious new dangers that have arisen. History has shown that force has been necessary to eradicate the great epidemics. Despite its limitations, the welfare state is better equipped than former societies to solve problems through the offer of its services rather than through coercion.