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TOBACCO, HIV, AND THE COURTROOM: THE ROLE OF AFFIRMATIVE LITIGATION IN THE FORMATION OF PUBLIC HEALTH POLICY

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* Professor of Law, Northeastern University School of Law. Support for this paper was provided by Grant Award No. RO1 CA 67805-01 from the National Institutes of Health/National Cancer Institute. The author wishes to thank Judith Olans Brown, Patricia Davidson, Richard Daynard, Peter Enrich, and Bennett Klein for their helpful criticism; Jennifer Kaplan, Glen Matheson and Eleanor Morton for their research assistance; and Elsie Chan for her secretarial support.

I. INTRODUCTION

Tobacco and HIV are among the most critical public health threats of this era.[1] They are also among the most litigated matters of our time.[2] To a remarkable degree, issues pertaining to both tobacco and HIV have found their way into the courtroom.

Litigation of public health issues is not new. In the past, however, courts generally played a reactive role. They usually became involved in public health issues either when they were asked to review public health regulations or enforcement actions,[3] or when they were asked to provide compensation for individuals injured by the actions of others.[4] But in the cases of tobacco and HIV, advocates have often gone to court hoping to develop new policies that might promote public health.[5] The courts, in other words, have become central sites of movements to affect the shape of public health policy.

This Article uses the experiences of tobacco and HIV to explore litigation's potential to advance the cause of public health. Part II reviews briefly the role that courts have

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1. *See Reduce the Spread of HIV, in* AIDS LAW TODAY: A NEW GUIDE FOR THE PUBLIC 82, 88 (Scott Burris et al. eds., 2d ed. 1993) [hereinafter *Reduce the Spread of HIV*] (noting that between 1982 and 1991, the Public Health Service spent over $1.6 billion on AIDS prevention efforts); *see also* Graham E. Kelder, Jr. & Richard A. Daynard, *The Role of Litigation in the Effective Control of the Sale and Use of Tobacco*, 8 STAN. L. & POL'Y REV. 63, 63-66 (1997) (discussing the public health threats posed by tobacco).

2. *See* Kelder & Daynard, *supra* note 1, at 70-87 (discussing the use of litigation as an effective means of tobacco regulation); *see generally* LARRY GOSTIN ET AL., PUBLIC HEALTH SERVICE, AIDS LITIGATION PROJECT: OBJECTIVE DESCRIPTION OF TRENDS IN AIDS LITIGATION (1990) (discussing the modern trends in AIDS litigation).

3. *See* Wendy E. Parmet, *Legal Rights and Communicable Disease: AIDS, the Police Power, and Individual Liberty*, 14 J. HEALTH POL. POL'Y & L. 741, 745-46 (1989) [hereinafter Parmet, *Legal Rights*] (discussing the police power and the courts' willingness to uphold legislative and administrative measures to protect the public health).

4. *See, e.g.*, PAUL WEILER, MEDICAL MALPRACTICE ON TRIAL 17 (1991) (discussing traditional tort liability in the malpractice context, in which doctors are held responsible for harms attributable to their negligent actions).

5. This does not mean that the development of new public health principles is the sole or even primary motivation of plaintiffs. Plaintiffs, of course, may have multiple motivations. However, the development of public health policy is one motivating factor in much of tobacco and HIV litigation, and even when it is not, public health issues often become an integral part of the claim. *See, e.g.*, Bragdon v. Abbott, 524 U.S. 624, 628-30, 655 (1998) (making policy by holding that HIV infection is a disability under the Americans with Disabilities Act of 1990); Giboy v. American Tobacco Co., 582 So. 2d 1263, 1264-66 (La. 1991) (making policy by holding that the assumption of the risk of smoking is not adequate to entitle manufacturers to summary judgment).

historically played in the development of public health policy. Part II surveys the recent history of tobacco litigation and HIV litigation, pointing out some of the differences and similarities between the two domains. This Article suggests that in contrast to most earlier forms of public health litigation, the tobacco cases and many of the HIV cases have been brought by those who have become ill due to public health threats, for the purpose of using courts to affirmatively advance the interest of others who are ill or will become ill without the intervention of new public health policy.[6]

Part IV considers some of the questions that can be raised about the use of litigation as a means for developing public health policy. In so doing, this Article focuses particularly on litigation's ability to influence the public discourse and alter the political agenda, the relationship between public health professionals and lay citizens who bring public health cases,[7] and how legal rights may enrich, yet also threaten, attempts to promote the health of a community. The Conclusion suggests that although litigation offers no panacea for public health, and cannot be trusted to develop public health policy alone, it nevertheless has an important role to play in the political struggle to protect the rights of the community and its more vulnerable members. Indeed, litigation is one means by which we can come to understand what we mean by public health and what its relationship should be to the individuals who form our body politic.

II. COURTS AND THE PUBLIC HEALTH

"[P]ublic health is 'what we, as a society, do collectively to assure the conditions in which people can be healthy.'"[8] Courts have always played a role in formulating policies pertaining to that endeavor. After all, when the first common law court determined that an individual was liable for an action endangering another, public health policy was made.[9] A standard

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6. Refer to text accompanying notes 137-39 *infra*.

7. Refer to Part IV.B-C *infra*.

8. Barry S. Levy, *Twenty-First Century Challenges for Law and Public Health*, 32 IND. L. REV. 1149, 1150 (1999) [hereinafter Levy, *Twenty-First Century*] (quoting INSTITUTE OF MED., REPORT BY THE COMM. FOR THE STUDY OF THE FUTURE OF PUB. HEALTH (1988)). As will be evident from the discussion below, what we do to assure our collective health is in part contingent upon the outcome of the public health advocacy described below. Refer to Part IV.A *infra* (describing the different types of public health advocacy).

9. For a brief discussion of the historical roots of tort law, see W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 6 (5th ed. 1984)

of care was enunciated that could affect, positively or negatively, the public's rate of injury.[10]

This type of common law formation of public health policy continues today. The most obvious example arises in the area of medical malpractice. In the course of determining the liability of physicians or health care providers to individuals who have been injured, courts are applying and often refining common law public health policy.[11] In most such cases, when the legal issues appear to be settled, the public policy impact of the litigation lies very much in the background. Still, to the extent that malpractice litigation has a deterrent impact, it has the capacity to affect the public health,[12] and when courts establish a "new rule," their policymaking potential is even more evident.[13]

Other common forms of tort litigation also create public health policy. Most obviously, so-called "toxic tort" cases (such as those pertaining to asbestos or DES) affect the price and manufacture of products that have potentially wide-ranging public health impacts.[14] Cases concerning more common

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(describing the early common law torts system and the transition to the "public health policy" of holding people liable for intentionally or negligently injuring others).

10. *See* WEILER, *supra* note 4, at 70-73 (evaluating the deterrent effect of tort liability).

11. *See* Randall R. Bovbjerg, *Medical Malpractice on Trial: Quality of Care Is the Important Standard*, 49 LAW & CONTEMP. PROBS. 321, 335-36 (1986) (discussing the malpractice system as the price society pays to control the quality of health care).

12. There is a debate about the magnitude of the deterrent effect of malpractice litigation. *See, e.g.*, PATRICIA DANZON, MEDICAL MALPRACTICE THEORY EVIDENCE AND PUBLIC POLICY (1985); WEILER, *supra* note 4, at 70-73 (noting that although the deterrent effect of tort law is plausible, it is difficult to determine how much deterrent effect is created and whether the behavior of potential defendants materially reduces the injuries to potential victims); Bovbjerg, *supra* note 11, at 328-35 (commenting on the lack of evidence of a deterrent effect, but arguing that economic theory and common sense are reasons to believe that the deterrence factor does exist).

13. For cases that explicitly made such "new rules," see *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334, 347 (Cal. 1976) (holding that the public policy favoring protection of the doctor-patient relationship must yield to the extent necessary to protect third persons from danger) and *Helling v. Carey*, 519 P.2d 981, 983 (Wash. 1974) (requiring Washington ophthalmologists to alter their customary standard of care and administer routine diagnostic tests for glaucoma to patients under the age of 40). The actual impact of these cases has been the study of important empirical analysis. *See generally* Daniel J. Givelber et al., Tarasoff, *Myth and Reality: An Empirical Study of Private Law in Action*, 1984 WIS. L. REV. 443 (1984) (analyzing the impact of *Tarasoff*); Jerry Wiley, *The Impact of Judicial Decisions on Professional Conduct: An Empirical Study*, 55 S. CAL. L. REV. 345 (1982) (analyzing the impact of *Helling v. Carey*).

14. For a discussion of the development and nature of toxic tort litigation, as well as some of its public health implications, see Robert F. Blomquist, *An Introduction to American Toxic Tort Law: Three Overarching Metaphors and Three*

products, such as automobiles or even children's toys, have a similar potential for developing public health policy.[15] This potential may be particularly apparent when tort cases are brought as class actions involving large numbers of individuals.[16] Still, tort cases are usually brought to obtain compensation for injured individuals; the development of public health policy remains secondary and incidental.[17]

Issues of public health are even more prominent under the "classic model of public health litigation." In this model, cases involve the enforcement of a statute or regulation purporting to protect the public health.[18] In subject matter, they may be

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Sources of Law, 26 VAL. U. L. REV. 795, 799 (1992) (describing toxic tort litigation as a "logical exposition of . . . policy issues") and Ann Taylor, *Public Health Funds: The Next Step in the Evolution of Tort Law*, 21 B.C. ENVTL. AFF. L. REV. 753, 795-96 (1994) (describing how toxic tort liability promotes pre-production testing of products by manufacturers).

15. There is substantial disagreement in the literature on the extent of the deterrent impact of products litigation and whether or not litigation leads to an efficient degree of injury reduction. *See, e.g.*, Peter W. Huber & Robert E. Litan, *Overview*, *in* THE LIABILITY MAZE: THE IMPACT OF LIABILITY LAW ON SAFETY AND INNOVATION 1, 12 (Peter W. Huber & Robert E. Litan eds., 1991) (asserting that most of the essays contained in this collection generally argue that there is not a strong causal connection between product liability litigation and the creation of safer products); Gary T. Schwartz, *Reality in the Economic Analysis of Tort Law: Does Tort Law Really Deter?*, 42 UCLA L. REV. 377, 443 (1994) (arguing that tort law can achieve significant but not perfect deterrence).

16. Litigation surrounding DES and asbestos stand out as examples of mass torts that also had a major public health impact. *See* Taylor, *supra* note 14, at 755-62 (discussing toxic tort class actions such as DES and asbestos and the adoption of the "discovery rule" in order to further the public health policy of compensating those who are injured by the wrongful conduct of others). The suggestion that HIV and tobacco cases are distinguishable from many prior tort cases because of the centrality of public health issues should not be read to suggest that public health issues were not as prominent in other civil cases. Indeed, many of the characteristics of HIV and tobacco litigation discussed below are likely shared by other cases. However, this Article focuses on tobacco and HIV because of their prominence as the preeminent health threats of our time, as well as their surprising similarities. *See* Kelder & Daynard, *supra* note 1, at 64-66 (discussing the public health threat posed by tobacco); *Reduce the Spread of HIV*, *supra* note 1, at 88 (noting the financial costs associated with AIDS prevention education).

17. *See, e.g.*, Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 347 (Cal. 1976) (holding that the public policy favoring protection of the doctor-patient relationship must yield to the extent necessary to protect third persons from danger); Helling v. Carey, 519 P.2d 981, 983 (Wash. 1974).

18. We often think of cases pertaining to infectious disease regulations as "core" public health cases. *See, e.g.*, Jacobson v. Massachusetts, 197 U.S. 11, 12, 24-25, 38 (1905) (opining that the states' police power includes the authority to enact "health laws of every description," and upholding a Cambridge, Massachusetts regulation requiring people to undergo small pox vaccination). In fact, an astounding number and assortment of both administrative law and constitutional law cases concern the authority of the government to regulate in the name of public health. *See* Wendy E. Parmet, *From* Slaughter-House *to* Lochner: *The Rise and Fall of the Constitutionalization of Public Health*, 40 AM. J. LEGAL HIST. 476, 493-501 (1996)

extraordinarily wide-ranging. For example, cases may concern the ability of the government to detain individuals with active tuberculosis who fail to take their medications,[19] the constitutionality of state laws prohibiting physician-assisted suicide,[20] or the power of a federal agency to rescind a regulation that requires automobiles to have passive occupant restraint systems such as automatic seatbelts and air bags.[21] Although the exact issues, both scientific and legal, vary greatly in these cases, they are all similar in that the initial determination of public health policy was made by a nonjudicial governmental body, either an administrative agency entrusted to protect the public's health or a legislative body.[22] Hence the governmental entity made (at least initially) the public health policy that the private entity is challenging, often in the name of some individual right.[23] Undoubtedly, in the course of reviewing the government's authority to enforce the policy at issue, and in considering the validity of the individual's right to limit that policy, the court is asked to review and possibly alter a public health policy. Most often in such cases, courts uphold the policy at issue.[24]

[hereinafter Parmet, *Slaughter-House*] (analyzing the use of the police power when the alleged goal was to protect public health, but when the effect of the use was questionable in the years following the *Slaughter-House* cases). Indeed, a great number of constitutional law cases pertain to whether a particular regulation, purportedly designed to protect the public health, actually has such a purpose or effect. *See, e.g.*, Kassel v. Consolidated Freightways Corp., 450 U.S. 662, 667, 678-79 (1981) (holding that an Iowa truck regulation, ostensibly enacted to help highway safety, violated the Commerce Clause because it imposed burdens on interstate commerce without a significant countervailing state interest).

19. *See* Lawrence O. Gostin, *The Resurgent Tuberculosis Epidemic in the Era of AIDS: Reflections on Public Health, Law, and Society*, 54 MD. L. REV. 1, 117 (1995) [hereinafter Gostin, *The Resurgent Tuberculosis*] (discussing the modern standard for long-term detention of tuberculosis patients who do not take their medication).

20. *See* Washington v. Glucksberg, 521 U.S. 702, 705-06, 734-35 (1997) (holding that Washington's prohibition against causing or aiding a suicide does not violate the Fourteenth Amendment).

21. *See* Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29, 34-35, 42 (1983).

22. *See, e.g.*, *Washington*, 521 U.S. at 705-06, 734-35; *Motor Vehicle Mfrs. Ass'n*, 463 U.S. at 29, 34-40, 46; *Jacobson*, 197 U.S. at 25 (validating a Cambridge, Massachusetts law that required vaccination).

23. *See Washington*, 521 U.S. at 705-06, 734-35 (containing a claim brought by physicians, patients, and a nonprofit organization, that the State of Washington's ban on physician assisted-suicide violates a liberty interest protected by the Fourteenth Amendment's Due Process Clause, namely the right of mentally competent, terminally ill patients to commit physician-assisted suicide); *Jacobson*, 197 U.S. at 12-14 (containing a challenge to the constitutionality of a Cambridge, Massachusetts law requiring small pox vaccination, brought by a person who refused to be vaccinated).

24. *See* Parmet, *Legal Rights*, *supra* note 3, at 744-46 (noting that public health measures are routinely upheld under the police power).

Sometimes, the court agrees with the private party, and vacates or modifies the public health policy, thereby effectively creating a new public health policy.[25]

Still, although issues of public health are critical under this classical model of public health litigation, and important public health policies may derive from such cases, the judicial role is generally secondary in that it is limited to reviewing and interpreting health policies initiated by other decisionmakers, particularly state legislatures and local boards of health.[26] What is interesting about the tobacco litigation, and much of HIV litigation, is the extent to which advocates and activists have used the courts affirmatively in an attempt to influence and develop (rather than merely review or limit) policies directly affecting the public's health.[27] There are many critical differences between the two fields of litigation, but there are also surprising similarities.[28] A consideration of both suggests some of the potential uses and problems with a reliance upon courts to develop public health policies.

III. TWO FIELDS OF PUBLIC HEALTH LITIGATION

At first glance, it is difficult to see the similarities between the tobacco and HIV litigation. Other than the fact that they both concern matters which threaten the public health—and therefore fall within the broad parameters of this symposium—the

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25. Undoubtedly the most famous instance of this was *Roe v. Wade*, 410 U.S. 113 (1973), which held that the Due Process Clause of the Fourteenth Amendment precludes states from prohibiting abortions except in situations in which the mother's life is in jeopardy, and announced the trimester standard to determine when, and to what extent, the states may regulate abortions. *See id.* at 147-54, 164-65.

26. Refer to notes 18-25 *supra* and accompanying text (citing cases in which courts have reviewed health policy initiated by legislatures and public agencies).

27. *See* Hubert H. "Skip" Humphrey, III, *The Decision to Reject the June, 1997 National Settlement Proposal and Proceed to Trial*, 25 WM. MITCHELL L. REV. 397, 397 (1999) (stating that the goal of Minnesota's tobacco litigation was "better public health"). Not all HIV litigation shares these characteristics; however, key advocates did see their litigation as promoting public health and working to further the goals of public health officials. *See* Telephone Interview with Matthew Coles, A.C.L.U. AIDS Law Project (Aug. 24, 1999). Refer to text accompanying notes 92-103 *infra* (explaining and illustrating the goals of HIV litigation). Moreover, litigation over other public health issues may also share these characteristics. For example, critics of lax gun regulations have recently begun to bring lawsuits against gun manufacturers. *See* Lawrie Mifflin, *N.A.A.C.P. Plans to Press for More Diverse TV Shows*, N.Y. TIMES, July 13, 1999, at A10 (announcing "that the N.A.A.C.P. would file a federal class action suit against handgun manufacturers and distributors, seeking injunctions that would increase restrictions on the sale of guns").

28. Refer to text accompanying notes 39-41 *infra* (listing three major similarities).

commonalties seem few. Tobacco, after all, is a legal, highly profitable product.[29] Individuals choose to consume tobacco and thereafter become ill and die in horrifying numbers,[30] but generally decades after they begin to use the product.[31] HIV, in contrast, is a retrovirus, neither owned nor purposefully manufactured by anyone.[32] Unlike tobacco, HIV is neither marketed nor willingly consumed.[33] And until recently, when advances in medicine have reduced the virus's lethality in developed nations,[34] HIV killed its victims relatively quickly (compared to tobacco) and usually while they were still young.[35]

Given these significant differences, it is not surprising that there are many distinctions between HIV and tobacco litigation. Because tobacco is sold to consumers as a manufactured good, tobacco litigation has focused, to a large degree, upon cigarette manufacturers.[36] The tobacco industry provides a sharp focal point for tobacco litigation, where none exists in the case of HIV. After all, a virus cannot be sued, and generally no single party or

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29. In 1995, the estimated profits from U.S. cigarette sales were $7.6 billion. *See* Jeffrey E. Harris, *American Cigarette Manufacturers' Ability to Pay Damages: Overview and a Rough Calculation*, 5 TOBACCO CONTROL 292, 292 (1996).

30. It has been estimated that cigarette smoking alone causes over 430,000 deaths in the United States each year, making cigarettes the single greatest preventable cause of death. *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., SMOKING AND HEALTH IN THE AMERICAS 106 (1992) (chart itemizing various causes of death related to smoking); AMERICAN CANCER SOC'Y, *Cancer Facts & Figures—1997* (visited Oct. 11, 1999) <http://www.cancer.org/statistics/97cff/97tabp4.html>.

31. *See* Robert L. Rabin & Stephen D. Sugarman, *Overview, in* SMOKING POLICY, LAW, POLITICS AND CULTURE 3, 11-12 (Robert L. Rabin & Stephen D. Sugarman eds., 1993) (noting that smoking does not cause immediate consequences).

32. HIV is believed to have derived from a related virus infecting some African primates. *See Scientists Discover Origin of HIV-1*, AIDS WKLY. PLUS, Feb. 15, 1999, *available in* 1999 WL 10040714.

33. However, as with tobacco, people willingly engage in behavior that they know increases their risk for disease. *See* Helena Brett-Smith & Gerald H. Friedland, *Transmission and Treatment, in* AIDS LAW TODAY, *supra* note 1, at 18, 23-27 (discussing transmission of HIV through voluntary actions such as sexual activity and needle sharing among drug users).

34. For an account of the reduction in HIV deaths in this country, see National Ctr. for Health Statistics, *Latest Final Mortality Statistics* (visited Aug. 12, 1999) <http://www.cdc.gov/ncnswww/releases/99facts/99sheets/97morta.htm>.

35. *See* INSTITUTE OF MED., NATIONAL ACADEMY OF SCIENCES, CONFRONTING AIDS 72-73 (1986) [hereinafter, CONFRONTING AIDS] (documenting that 90% of AIDS patients are between 20 and 49 and that the reported two year mortality rate is 75%).

36. In the discussion below, this Article focuses on litigation against cigarette manufacturers. Refer to text accompanying Part III.A *infra* (discussing the tobacco litigation). For a discussion of the legal issues surrounding cigars and other tobacco products, see Patricia Davidson, *Tobacco Ingredients and Smoke Constituent Reporting and Disclosure Laws: The Case for Expansion*, 77 DENV. U. L. REV. (forthcoming 2000).

group of parties control its entree into the community.[37] Thus, HIV litigation has been more diffused and has been brought against more parties than has tobacco litigation.[38]

Nevertheless, although there are immense differences between tobacco and HIV, and tobacco and HIV litigation, there are also significant similarities. First, both tobacco and HIV are public health threats to which governmental responses were initially inadequate.[39] Second, public education aimed at influencing individual behavior has been the dominant public health policy with respect to both epidemics.[40] And third, a

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37. This is generally true, although some entities may be seen as playing a unique role in spreading the virus, and some of them have been sued in that regard. The clearest example is the blood industry, which can be thought of as responsible for the wide-spread dissemination of the virus to recipients of transfusions and blood products in the early 1980s. For a discussion of cases concerning the blood industry, refer to text accompanying notes 129-34 *infra*. Another industry that may be considered "responsible" is the so-called "sex industry," however, actions against sex clubs and others in that industry have generally been taken by public authorities. *See, e.g.*, City of New York v. New St. Marks Baths, 562 N.Y.S. 2d 642 (N.Y. App. Div. 1990) (holding that the right to privacy does not prevent the city of New York from prohibiting gay sexual activity in the private rooms of businesses). Finally, it is possible to suggest that sellers of drugs that are injected intravenously are responsible for the high infection rates among intravenous drug abusers. However, because that is an illegal industry, *see* 21 U.S.C. § 841(a) (1994) (making it a federal crime to manufacture, distribute, or dispense a controlled substance); TEX. HEALTH & SAFETY CODE ANN. §§ 481.102, 481.112 (Vernon 1992) (making it illegal to sell controlled substances in Texas), the type of lawsuits brought against the tobacco industry clearly are not feasible. *See Recent Legislation*, 109 HARV. L. REV. 699, 699-702 (1996) (noting that, although an Illinois statute authorizes suit against a drug dealer for civil damages, the statute is unlikely to provide adequate compensation).

38. *See generally* GOSTIN ET AL., *supra* note 2, at 1-21 (describing the large variety of AIDS-related litigation).

39. For a discussion of the lack of effective laws and regulations aimed at reducing tobacco-related morbidity, see Kelder & Daynard, *supra* note 1, at 66-70. For a discussion of the lack of evidence that tobacco controls have been effective at the state and local levels, see Peter D. Jacobson & Jeffrey Wasserman, *The Implementation and Enforcement of Tobacco Control Laws: Policy Implications for Activists and the Industry*, 24 J. HEALTH POL. POL'Y & LAW 567, 568 (1999). The response to the HIV epidemic was initially slow and inadequate. For the definitive history of the early years of the HIV epidemic, see RANDY SHILTS, AND THE BAND PLAYED ON (1987). In more recent years, the picture has become more mixed. There is substantial government support for HIV-related research and a wide-range of HIV-related legislation, particularly at the state and local levels. *See, e.g.*, CONFRONTING AIDS, *supra* note 35, at 28 (noting the amount spent by the U.S. Department of Health and Human Services on AIDS research); Scott Burris, *Fear Itself: AIDS, Herpes, and Public Health Decisions*, 3 YALE L. & POL'Y REV. 479, 504-16 (1985) (documenting San Francisco's efforts to close gay bathhouses). However, the response to several aspects of the epidemic, such as the spread of infection among IV drug users, remains inadequate. *See* CONFRONTING AIDS, *supra* note 35, at 106 (noting the difficulties in educating intravenous drug users).

40. Much of what regulation does exist vis-a-vis tobacco assumes that consumers should be educated or informed about tobacco's dangers. *See* 15 U.S.C. §§ 1331-1340 (mandating cigarette labeling so that "the public may be adequately

critical question with respect to both tobacco and HIV is whether the public is responsible for, or should be concerned about, an illness that an individual can in most cases prevent by changing his or her own behavior.[41] To help see these common points, and what they suggest about affirmative public health litigation, this Article first provides a brief survey of the litigation.[42]

A. *Tobacco in the Courts*

For much of this century, tobacco was the subject of little regulation and even less litigation.[43] That began to change in the 1950s as information appeared in the national press about the health risks associated with smoking.[44] For example, in 1952 *Reader's Digest* published a series of articles about the dangers of smoking.[45] Moreover, in 1953 news of scientific findings that

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informed about any adverse health effects of cigarette smoking"); 15 U.S.C. §§ 4401-4408 (instructing the Secretary of Health and Human Services to "establish and carry out a program to inform the public of any dangers . . . resulting from the use of smokeless tobacco products"). For a discussion of the role of education in HIV prevention, see *Reduce the Spread of HIV*, *supra* note 1, at 82.

41. Refer to text accompanying notes 268-90 *infra*. Of course, the earliest victims of both HIV and tobacco can in no way be said to have any responsibility for their illnesses. Only after individuals are informed about how to avoid these hazards can any responsibility be assigned. Even then the idea of finding individuals to be personally responsible for their illnesses is deeply troubling. Refer to text accompanying notes 269-90 *infra*.

42. The overview that follows is necessarily incomplete and is intended merely to provide a starting point for an analysis of the strengths and limitations of affirmative public health litigation. For a more complete review of the history of tobacco litigation, see Michael V. Ciresi et al., *Decades of Deceit: Document Discovery in the Minnesota Tobacco Litigation*, 25 WM. MITCHELL L. REV. 478, 482-89 (1999); Kelder & Daynard, *supra* note 1, at 71-75; Robert L. Rabin, *A Sociolegal History of the Tobacco Tort Litigation*, 44 STAN. L. REV. 853, 855-76 (1992). For a more complete discussion of HIV litigation, see LAWRENCE O. GOSTIN, THE HENRY J. KAISER FAMILY FOUNDATION: THE AIDS LITIGATION PROJECT III (1996) [hereinafter AIDS LITIGATION PROJECT] (copies of the report can be obtained by calling the Kaiser Family Foundation at (800)-656-4533, publication No. 1164) and GOSTIN ET AL., *supra* note 2, at 1-21 (examining HIV and AIDS cases litigated in the state and federal courts from January 1991 through June 1996).

43. Federal regulation of tobacco was not seriously considered until the 1960s despite the fact that federal regulatory agencies, such as the FDA, have regulated other consumer products since early this century. *See* Kelder & Daynard, *supra* note 1, at 67 (discussing that it was not until 1964 that the Federal Trade Commission began proceedings that would ultimately lead to health warnings on cigarette packaging and advertising). Robert Rabin notes that the initial lawsuits against tobacco manufacturers were brought in the 1950s. *See* Rabin, *supra* note 42, at 857 (noting that the first wave of tobacco litigation was launched in 1954).

44. *See* Rabin, *supra* note 42, at 856 (citing several articles that discuss the health risks associated with smoking).

45. *See id.* (explaining that the widely read *Reader's Digest* described the risks associated with smoking in easily understandable terms).

linked smoking to lung cancer was published.[46] Not surprisingly, as the negative publicity increased, lawsuits began to follow as individuals attempted to sue tobacco companies for injuries they believed were caused by smoking.[47]

This so-called "first wave" of tobacco litigation began in 1954 with the filing of *Lowe v. R.J. Reynolds*[48] in St. Louis.[49] Over the course of the next few years, over one hundred cases were filed.[50] The rise of private litigation was accompanied by the commencement of public law actions. The increasing prominence given to courts as agents of social change in the wake of the civil rights movement[51] helped spur a movement to use litigation to achieve regulatory actions relating to tobacco.[52] For example, in 1968 John F. Banzhaf III intervened in litigation between the FCC and tobacco companies, arguing that anti-smoking forces should be given air time to respond to cigarette advertising.[53]

Despite these developments, the first wave of litigation is generally considered to have been unsuccessful. No tobacco tort plaintiff prevailed in court,[54] even though in 1964 the report to the Surgeon General was made public, providing more authoritative support for the plaintiffs' contention that cigarettes harmed their health.[55]

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46. *See id.* (noting that these findings generated an assault on tobacco use); *see also* Peter Pringle, *The Chronicle of Tobacco: An Account of the Forces that Brought the Industry to the Negotiating Table*, 25 WM. MITCHELL L. REV. 387, 389 (1999) (explaining that the first wave of tobacco litigation began after research linked smoking to cancer in mice).

47. *See* Rabin, *supra* note 42, at 857.

48. No. 9673(C) (E.D. Mo. Filed Mar. 10, 1954). This case was subsequently dropped.

49. *See* Rabin, *supra* note 42, at 857 (explaining that *Lowe* was the first of a succession of lawsuits filed against the tobacco industry).

50. *See id.* (noting that at least 11 judicial opinions were written and an estimated 100 to 150 other filings were dropped without formal disposition).

51. *See* Katherine L. Caldwell, *Not Ozzie and Harriet: Postwar Divorce and the American Liberal Welfare State*, 23 LAW & SOC. INQUIRY 1, 1 n.7 (noting that the courts were viewed as agents of social change during the civil rights movement).

52. *See* Constance A. Nathanson, *Social Movements as a Catalyst for Policy Change, The Case of Smoking and Guns*, 24 J. HEALTH POL. POL'Y & L. 421, 449 (discussing that the tobacco activists framed their movement in language similar to that of the civil rights and environmental movements).

53. *See* Banzhaf v. FCC, 405 F.2d 1082, 1085 (D.C. Cir. 1968) (affirming a ruling of the Federal Communications Commission requiring television stations carrying cigarette advertisements to devote a significant amount of broadcast time to advertising against smoking).

54. *See* Rabin, *supra* note 42, at 859 (noting that none of the first wave of cases that went to trial resulted in a victory for the plaintiff).

55. *See* RICHARD KLUGGER, ASHES TO ASHES, 258-59 (1997) (discussing the 1964 report to the Surgeon General that rebuked the tobacco industry's contention that cigarettes did not contain carcinogenic substances).

Many explanations can and have been given for the lack of success experienced by tort plaintiffs in the first wave of tobacco litigation. For example, much has been made about the industry's scorched earth defense strategy.[56] In contrast to most tort defendants, the tobacco industry simply refused to settle.[57] It bombarded plaintiffs' lawyers, many of whom were simply overmatched, with barrages of procedural motions, discovery requests, and every expensive and time-consuming device known to the defense bar.[58] In addition, significant doctrinal problems, especially pertaining to the forseeability of injury, prevented plaintiffs from achieving success.[59]

Despite these problems, and the lack of a liability verdict against the tobacco companies, the initial wave of litigation should not be seen as a complete failure from a public health perspective. By helping to raise the specter of liability, the litigation likely worked in harmony with the publicity surrounding the 1964 report to the Surgeon General to spur federal legislation pertaining to the packaging and advertising of tobacco.[60] In 1965, Congress enacted the Federal Cigarette Labeling and Advertising Act, which required warning labels to appear on cigarette packages.[61] A few years later, the Public Health Cigarette Smoking Act strengthened the warning labels and prohibited the advertising of cigarettes on electronic media.[62]

Several other developments in the 1960s and 1970s paved the way for a "second wave" of litigation that commenced in the 1980s.[63] One development was doctrinal. The courts' increasing

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56. *See* Jon D. Hanson & Kyle D. Logue, *The Costs of Cigarettes: The Economic Case for Ex Post Incentive Based Regulation*, 107 YALE L.J. 1163, 1169 (1998) (discussing the aggressive legal tactics the tobacco industry used to combat lawsuits).

57. *See* Rabin, *supra* note 42, at 857-58 (explaining that over a period of 35 years, the tobacco industry had not settled a single case).

58. *See id.* at 857-59.

59. *See id.* at 863-64 (noting that the *Restatement* provision defining "unreasonably dangerous" products in the context of strict liability ended the first wave of tobacco litigation because it explicitly advised that even if the effects of smoking are harmful, that alone is not "unreasonably dangerous"); *see also* Ciresi et al., *supra* note 42, at 482 (discussing how the early tobacco cases dealt with foreseeability issues and whether the tobacco industry could foresee the potential health risks of smoking).

60. For a discussion of how litigation helps to spur legislation, refer to notes 197-212 *infra* and accompanying text.

61. *See* 15 U.S.C. §§ 1331-1340 (1994).

62. *See id.* §§ 1333, 1335 (requiring warning labels on packages, advertisements, and billboards and making it unlawful to advertise tobacco products on "any medium of electronic communication subject to the jurisdiction of the Federal Communications Commission").

63. *See* Ciresi et al., *supra* note 42, at 485 (noting that the second wave of

acceptance of strict liability as the dominant standard of care in products liability litigation made it easier for plaintiffs to prevail.[64] At the same time, public attitudes toward risk and responsibility changed, and consumers were more likely to hold manufacturers responsible for risks associated with products in the marketplace.[65]

These developments induced lawyers to bring better financed and better coordinated civil liability cases.[66] These cases benefited from the increased scientific knowledge about the health effects of cigarettes,[67] as well as changes in the application of tort doctrine.[68] However, significant doctrinal challenges remained. Of particular importance was the assumption, expressed explicitly in the commentary to the *Restatement (Second) of Torts*, that because cigarettes were dangerous even when used properly, strict liability should not be the governing legal standard.[69]

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cigarette litigation was also composed of personal injury suits).

64. *See* KEETON ET AL., *supra* note 9, at 690-94 (discussing the development of strict liability for warranty and for physical harm to persons and tangible items); Rabin, *supra* note 42, at 863-66 (explaining that the plaintiffs' lawyers hoped the courts would apply the comparative fault principle to tobacco cases as they had done with the strict liability defective product cases in hopes of a retreat from the *Restatement*'s total bar to recovery). However, some of these developments, particularly the use of strict liability for defective products, were not applied to cigarettes. *See* Daniel Givelber, *Cigarette Law*, 73 IND. L. REV. 867, 872-75 (1998) (discussing the *Restatement*'s exemption of tobacco products from strict liability).

65. *See* Samuel Jan Brakel, *Using What We Know About Our Civil Litigation System: A Critique of "Base-Rate" Analysis and Other Apologist Diversions*, 31 GA. L. REV. 77, 157 (1996) (finding that in the 1960s, consumer advocates such as Ralph Nader helped shift public attitude of risk and responsibility away from their perception as private problems and toward their perception as public wrongs).

66. For example, in 1984 my colleague at Northeastern University, Richard Daynard, founded the Tobacco Products Liability Project that seeks to utilize litigation as a public health strategy. *See* Richard A. Daynard, *Tobacco Liability Litigation as a Cancer Control Strategy*, J. NAT'L CANCER INST., Mar. 2, 1988, at 9, 12 (explaining that attorneys were driven to press forward with tobacco products liability cases by a combination of a desire to be recognized, to succeed where others failed, and to bring justice to victims). The Project has had annual conferences in which advocates have shared their ideas and strategies, enabling a previously nonexistent level of coordination. *See id.* (explaining that the project holds annual meetings, works closely with a reference service for lawyers, and publishes a newsletter for nonlawyers).

67. *But see* Kelder & Daynard, *supra* note 1, at 71 (noting that the tobacco industries successfully argued in court that the plaintiffs had chosen to smoke and thereby assumed the risk despite medical studies establishing a direct link between smoking and disease).

68. *See* Rabin, *supra* note 42, at 864-65, 867 (noting that the increase in toxic tort litigation and the application of comparative fault principles to product liability cases gave new hope to plaintiffs' attorneys).

69. *See* RESTATEMENT (SECOND) OF TORTS § 402A cmt. i. (1965) (explaining that the article sold must be dangerous to an extent beyond that contemplated by

Moreover, some of the gains that had been made since the early 1960s in public awareness about tobacco's dangers and regulation of cigarette marketing seemed to boomerang against plaintiffs in the courtroom. Because the hazards of smoking were becoming well known,[70] the tobacco industry was able to argue, with great success in court, that individual plaintiffs had known of the risk of smoking and should not be able to hold others accountable for the consequences of the plaintiffs' own choices.[71] In addition, the federal statutes that were enacted were claimed by defendants to preempt state law actions, a position that the Supreme Court adopted in part and rejected in part in the *Cippolone* case.[72] Finally, the industry was able to continue its policy of outspending and out-motioning plaintiffs, a policy that ultimately led to the plaintiffs' lawyers in *Cipollone* withdrawing their case before the retrial.[73]

The so-called "third wave" of tobacco litigation began in 1994.[74] It engaged an extraordinary number of lawyers and law firms in a "battle for the hearts and lungs of millions of Americans."[75] These cases placed increasing emphasis on litigation's potential as a "public health" strategy.[76] This new emphasis on public, rather than private, goals is apparent in the third wave's focus on the addictiveness of tobacco to demonstrate that individual plaintiffs should not be held solely responsible for their disease.[77] Once smoking is recognized as an addiction that

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the ordinary consumer); Givelber, *supra* note 64, at 872-75 (discussing the *Restatement*'s exemption of tobacco from strict liability).

70. This does not mean that the public fully appreciated the extent of the risk posed by tobacco. *See* Hanson & Logue, *supra* note 56, at 1181-86 (arguing that even though consumers are generally aware of some of the risks associated with smoking, they may not be fully informed of those risks).

71. *See* Rabin, *supra* note 42, at 870-71 (discussing the jury's apportionment of fault in favor of the tobacco companies based on the plaintiff's freedom of choice and awareness of the risks associated with smoking).

72. *See* Cipollone v. Ligget Group, Inc., 505 U.S. 504, 530-31 (1994) (holding that the Cigarette Labeling and Advertising Act preempts failure to warn actions against cigarette makers, but not claims based on express warranty, intentional fraud and misrepresentation, or conspiracy).

73. *See* Kelder & Daynard, *supra* note 1, at 72 (noting that the plaintiff's attorneys faced a loss of hundreds of thousands of dollars and withdrew from the case); *see also* Pringle, *supra* note 46, at 389 (discussing the tobacco companies' use of a sophisticated legal defense to outspend and outlast their opponents).

74. *See* Ciresi et al., *supra* note 42, at 487 (explaining that the third wave involved not only individual claims, but state claims seeking injunctive relief and costs for medical care for injured smokers).

75. Pringle, *supra* note 46, at 389.

76. *See* Ciresi et al., *supra* note 42, at 487-88.

77. *See* Richard L. Cupp, Jr., *A Morality Play's Third Act: Revisiting Addiction, Fraud and Consumer Choice in "Third Wave" Tobacco Litigation*, 46 KAN. L. REV. 465, 473 (1998) (explaining that in the third wave of litigation the plaintiffs'

usually begins while the smoker is a minor, it can more readily be perceived as a public health matter, rather than a question of individual choice.[78] In addition, the third wave featured an increased reliance upon class actions,[79] as well as the public actions brought by state attorney generals.[80] Actions brought by nonsmokers harmed by environmental tobacco smoke (ETS) also serve to demonstrate that the issues at stake are not simply private matters between a knowing consumer and a manufacturer, but rather matters that affect the health of everyone who may potentially come in contact with tobacco smoke.[81]

Another essential characteristic of the third wave is the critical use of discovery. Initially, discovery benefited defense counsel who used it to burden plaintiffs.[82] However, documents revealed in litigation (often after many lengthy court battles) eventually shed new light on the industry's knowledge of the addictiveness of tobacco, as well as its intentional manipulation of nicotine levels and marketing to minors.[83] These revelations

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attorneys focused on the injuries of becoming addicted to smoking as a result of the tobacco industry's manipulation of nicotine levels).

78. *See id.* at 471 (noting that becoming addicted to smoking while a minor should be a mitigating factor in failing to quit after learning of the dangers). Refer to notes 276-77 *infra* and accompanying text (discussing the emphasis on public health in the third wave of tobacco litigation).

79. *See* Kelder & Daynard, *supra* note 1, at 72 (noting that class actions had become increasingly common during the third wave of tobacco litigation). The largest class action was decertified by the United States Court of Appeals for the Fifth Circuit. *See* Castano v. American Tobacco Co., 84 F.3d. 734, 740-41 (5th Cir. 1996). However, smaller "son of Castano" actions continued in state courts. *See* Pringle, *supra* note 46, at 395 (describing the uphill battle that the smaller classes of plaintiffs faced in the state courts).

80. *See* Ciresi et al., *supra* note 42, at 487 (discussing that states sued the tobacco industry to recover medical costs for injured smokers). For a partial listing of these cases, see Givelber, *supra* note 64, at 867 n.3.

81. For a discussion of tort cases concerning ETS, see Cupp, *supra* note 77, at 474-76. For a discussion of civil rights cases concerning ETS, see Wendy E. Parmet et al., *Accommodating Vulnerabilities to Environmental Tobacco Smoke: A Prism For Understanding the ADA*, J.L. & HEALTH 1997-98, at 1, 11-21 [hereinafter Parmet et al., *Accommodating Vulnerabilities*].

82. *See* Rabin, *supra* note 42, at 857-59 (discussing the deposition strategy employed by the tobacco companies to burden plaintiffs in the first two waves of tobacco cases).

83. *See* Kelder & Daynard, *supra* note 1, at 76 (discussing the documents indicating that the tobacco industry knew of the addictive properties of nicotine and took efforts to manipulate nicotine levels in order to addict smokers). Many of these documents derive from the *Cipollone* case. *See id.* (noting that the FDA Commissioner relied on a document from the *Cipollone* case as evidence of nicotine manipulation). Sections of the documents are collated in STANTON GLANTZ, THE CIGARETTE PAPERS 447-93 (1996). For a discussion of other documents uncovered from litigation, see Richard D. Hurt & Channing R. Robertson, *Prying Open the Door to the Tobacco Industry's Secrets About Nicotine*, 280 JAMA 1173 (1998) (explaining

have helped to change the politics of tobacco and have made public officials feel more comfortable in suggesting its regulation.[84]

The final characteristic of the third wave that derives from the other features noted is its potential to influence tobacco policy. For the first time, the tobacco companies entered into settlements. The 1998 multi-state settlement between the tobacco companies and the states calls for significant changes in the marketing and advertising of tobacco, plus the payment of over a billion dollars to the states.[85] At the same time, individual actions, class actions, and other third party reimbursement cases continue to be brought, further threatening the financial viability of the tobacco industry.[86]

Of course, these developments in themselves do not ensure a change in tobacco consumption or the ill effects it causes.[87] However, it can no longer be doubted that tobacco litigation has come to play a major role in the development of public health policy. The meaning and nature of that role will be considered further in Part IV.

B. HIV Litigation

In contrast to the tobacco litigation, the cases concerning HIV appear diffused, disorganized, and difficult to describe. Whereas most tobacco cases shared a common set of defendants (the manufacturers), the defendants in the HIV cases have been

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that the uncovered documents revealed the tobacco companies' knowledge of nicotine addiction, delivery, and manipulation). For a discussion of the legal battles pertaining to document production, see Ciresi et al., *supra* note 42, at 499-557.

84. *See* Lynn Mather, *Theorizing About Trial Courts: Lawyers, Policymaking and Tobacco Litigation,* 23 L. & SOC. INQUIRY 897, 929-31 (1998) (discussing the effect the damaging documents had on politics); Tucker S. Player, Note, 49 S.C. L. REV. 311, 331 (1998) (discussing documents that show conclusively that the Liggett Group targeted underage smokers through advertising and intentionally manipulated nicotine levels).

85. For an analysis of the settlement, see *The Multistate Master Settlement Agreement and the Future of Tobacco Control: An Analysis of Selected Topics and Provisions of the Multistate Master Settlement Agreement of November 23, 1998* (visited Aug. 12, 1999) <http://www.tobacco.neu.edu.MSA/index.html>.

86. For a list of on-going trials, see *Recent Major Tobacco Trials* (visited Aug. 12, 1999) <http://www.tobacco.neu.edu.upcoming.html>.

87. There are few empirical studies about the ability of litigation to change health outcomes. Analysts of products liability law disagree about the degree of deterrence it creates and its efficiency. Refer to note 15 *supra*. However, they generally do find some deterrent effect. *See* Huber & Litan, *supra* note 15, at 5-16 (discussing the deterrent effect of products liability litigation and the impact of this litigation on injury reduction). Scholars have also disagreed about the health impact of malpractice litigation.

extraordinarily diverse, consisting of local school boards,[88] employers,[89] business-creating high risk environments,[90] and blood suppliers.[91] Moreover, although infected individuals have brought most cases, actions have also been instigated by individuals who fear exposure to HIV, as well as states exercising their criminal law authority.[92] The vast majority of tobacco cases have been products liability cases,[93] but HIV cases are far more evenly dispersed across doctrines.[94]

Despite this wide dispersion, some very general observations can be made. The initial wave of HIV litigation began in the mid-1980s as the virus was identified and discrimination and hysteria were rampant; children were barred from schools, individuals were evicted from their apartments, patients were denied health care, and punitive policies were widely debated.[95] Although private attorneys brought many of the cases, public interest law organizations, particularly those concerned about the rights of gays and lesbians, quickly became involved in much of the litigation.[96] As in the tobacco litigation, many of the advocates involved in HIV litigation attempted to share information and coordinate their efforts. Since the mid-1980s, many of them have

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88. For a list of cases involving school boards, see Wendy E. Parmet & Daniel J. Jackson, *No Longer Disabled: The Legal Impact of the New Social Construction of HIV*, 23 AMER. J.L. & MED. 7, 17 n.79 (1997).

89. *See, e.g.*, Runnebaum v. NationsBank, 123 F.3d 156, 176 (4th Cir. 1998) (ruling in favor of the employer in an ADA suit in which an HIV-positive employee had sued for wrongful termination).

90. *See, e.g.*, City of New York v. New St. Mark's Baths, 562 N.Y.S.2d 642, 643 (N.Y. App. Div. 1990) (holding that the right to privacy does not extend to sexual activity occuring on commercial property).

91. *See, e.g.*, United States Blood Servs. v. Quintana, 827 P.2d 509, 527 (Col. 1992) (allowing expert opinion evidence that established that the national blood banking community used a negligent standard of care when supplying blood).

92. Refer to notes 135-39 *infra* and accompanying text (describing the wide variety of HIV cases filed in the last two decades).

93. *See* Kenneth L. Polin, *Agrument for the Ban of Tobacco Advertising: A First Amendment Analysis*, 17 HOFSTRA L. REV. 99, 103 (1988) (noting that tobacco was the subject of approximately 125 product liability suits). *But see* Brown & Williamson Tobacco Corp. v. FDA, 153 F.3d 155, 176 (4th Cir. 1998) (holding that Congress did not intend to grant the FDA jurisdiction over tobacco products), *cert. granted*, 1999 U.S. App. LEXIS 298 (Apr. 26, 1999).

94. For a fuller survey, see AIDS LITIGATION PROJECT, *supra* note 42, at vii-xviii (examining over 300 cases involving HIV and AIDS).

95. Telephone Interview with Kevin Cathcart (Aug. 30, 1999) (discussing discrimination that led to early litigation); Telephone Interview with Coles, *supra* note 27 (dating the commencement of litigation efforts to the 1984 discovery of the virus). For a discussion of the discrimination and hysteria of the mid-1980s, see Parmet & Jackson, *supra* note 88, at 9-12.

96. Telephone Interview with Coles, *supra* note 27.

met twice per year during a "roundtable" of lesbian and gay legal organizations.[97]

Many of the early HIV cases were brought by individuals who were either denied health care or barred from school because they had or were thought to have AIDS.[98] The most famous of these cases was brought by Ryan White, a child with AIDS, who was kept from school because of his condition.[99] In contrast to the early tobacco cases, plaintiffs, such as White, primarily sought injunctive relief rather than monetary damages.[100]

Like the tobacco cases, these early HIV cases undoubtedly concerned and affected public health policy. However, the plaintiffs and advocates also perceived the issues as pertaining to the plaintiffs' civil rights.[101] Not surprisingly, these cases were brought generally under disability discrimination laws, particularly the Rehabilitation Act of 1973.[102]

In further contrast to the tobacco cases, the "public health" position in the HIV cases was at times subject to dispute. For example, in the school cases the school committee generally

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97. Telephone Interview with Bennett Klein (Aug. 26, 1999). In 1989 the Ford Foundation sponsored a forum for HIV advocates to discuss forthcoming legal issues and strategies. *See generally* Nan D. Hunter & William B. Rubenstein, *Introduction, in* AIDS AGENDA: EMERGING ISSUES IN CIVIL RIGHTS (Nan D. Hunter & William B. Rubenstein eds., 1992).

98. *See, e.g.*, Chalk v. United States Dist. Ct. Cent. Dist. of Cal., 840 F.2d 701, 712 (9th Cir. 1988) (granting injunctive relief and ordering the school district to restore a teacher infected with AIDS to his former position as an instructor of hearing-impaired children); Ray v. School Dist., 666 F. Supp. 1524, 1538 (M.D. Fla. 1987) (granting a motion for a preliminary injunction enjoining and restraining a school district from excluding HIV-infected children from the classroom); Martinez v. School Bd., 675 F. Supp. 1574, 1583 (M.D. Fla. 1987) (denying a motion for a preliminary injunction to reinstate a child diagnosed with AIDS into a mentally handicapped class); Mark H. Jackson, *Health Insurance: The Battle over Limits on Coverage, in* AIDS AGENDA: EMERGING ISSUES IN CIVIL RIGHTS, *supra* note 97, at 147-49 (discussing instances of discrimination in health care treatment and administration against HIV and AIDS infected individuals).

99. *See* White v. Western Sch. Corp., 1985 U.S. Dist. LEXIS 16540, at *1 (S.D. Ind. Aug. 23, 1985) (involving a student who was denied access to school by the superintendent because he had AIDS).

100. Refer to note 98 *supra* (listing examples of cases brought by plaintiffs seeking injunctive relief).

101. *See* Parmet & Jackson, *supra* note 88, at 17 (noting that the overwhelming judicial consensus found that HIV and AIDS were diseases protected by existing disability discrimination statutes).

102. *See* 29 U.S.C. § 794 (1994) (protecting individuals from discrimination by any program receiving federal funds, including local school systems); Parmet & Jackson, *supra* note 88, at 16-17 (noting that every reported decision in the 1980s determined that AIDS and asympomatic HIV constituted disabilities within the meaning of the Rehabilitation Act). Refer to note 98 *supra* (listing cases brought under the Rehabilitation Act of 1973).

claimed to be acting to protect the public's health.[103] The plaintiff, sometimes aided by public health experts, would contest that position, arguing that AIDS was not casually transmitted and did not create a public health threat in a classroom setting.[104] Although the major question in the early tobacco cases was whether the cigarette companies could foresee the risks of smoking,[105] the difficult issue for the courts in the early HIV cases was weighing the interest of the general public against the interest of protecting infected individuals from discrimination.[106] Thus, to a degree, these cases could be viewed as traditional public health cases in which individuals sought to limit the power of government to protect the public health.[107]

However, upon closer inspection, the HIV cases appear more similar to the tobacco cases than is initially evident. First, like tobacco cases, most HIV cases differed from the classical model of public health litigation in that the plaintiffs did not seek to limit an action undertaken by a public health department.[108] Rather, individuals asked courts to limit the action of governmental entities that were not expert in matters of health (such as schools, and later public employers and prisons).[109] Second, in contrast to the school boards' claims of acting in the name of

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103. *See, e.g., Ray*, 666 F. Supp. at 1535 (discussing the school district's assertion that the school population may be harmed by the transmission of the disease).

104. *See, e.g.*, Chalk v. United States Dist. Court Cent. Dist. of Cal., 840 F.2d 701, 706 (9th Cir. 1988) (discussing the evidence presented by the plaintiff and numerous public health experts that AIDS was not a threat for casual transmission in the classroom).

105. As Professor Rabin notes, even in the 1950s, courts and juries had little trouble accepting the idea that tobacco caused health injuries. *See* Rabin, *supra* note 42, at 860-61 (noting that foreseeability emerged as the central theme in early tobacco cases).

106. *See* Parmet & Jackson, *supra* note 88, at 16 (explaining that many of the individuals in the early cases were schoolchildren worthy of protection from discrimination).

107. Refer to notes 18-25 *supra* and accompanying text (discussing the wide-ranging subject matter of cases involving the enforcement of a statute or regulation purporting to protect the public health).

108. *See generally* AIDS LITIGATION PROJECT, *supra* note 42 (discussing the various types of litigation involving HIV and AIDS). *But see* City of New York v. New St. Mark's Bath, 562 N.Y.S.2d 642, 643 (N.Y. App. Div. 1990) (upholding an action brought by New York to prohibit owners of a gay bathhouse from maintaining private rooms not continuously open for visual inspection).

109. *See, e.g.*, Anderson v. Romero, 72 F.3d 518, 520 (7th Cir. 1995) (noting that a complaining inmate had alleged that prison officials violated his constitutional rights because he was diagnosed with AIDS); *Chalk*, 840 F.2d at 703 (addressing the Orange County Department of Education's ability to remove a teacher from the classroom because he was diagnosed with AIDS); Ray v. School Dist., 666 F. Supp. 1524, 1538 (M.D. Fla. 1987) (granting an injunction requiring school officials to admit three HIV-positive children back into school).

public health, most public health authorities believed that the plaintiffs, like tobacco plaintiffs, were asserting positions that would further the public health.[110] In effect, anti-discrimination claims became part of the public health agenda. By the mid-1980s, public health experts had begun to realize that discrimination against individuals with HIV was detrimental to efforts to stem the epidemic's tide.[111] Given the absence of a vaccine or any medical silver bullet, the best hope for stopping the virus' spread rested with educating the public about how HIV was transmitted and how individuals could reduce their chances of becoming infected.[112] However, in a climate filled with fear, homophobia, and misinformation, that public health message would be difficult to convey, and public health authorities feared they would have little success in working with communities to reduce the spread of the virus.[113] As a result, not only did public health officials support the work of HIV legal advocates, but some were even willing to be plaintiffs in cases challenging discriminatory practices.[114] Thus, as in the tobacco cases, individuals sought to use the courts not to limit the reach of public health agencies, but in order to enforce the policies endorsed either officially or unofficially by public health officials.

The public health ramifications were even clearer in the cases brought to secure health care for infected persons. One of the earliest cases, for example, was brought by the Lambda Legal

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110. *See* Telephone Interview with Coles, *supra* note 27. This alliance of HIV activists and public health authorities is analyzed and criticized by Ronald Bayer, *An End to AIDS Exceptionalism?* 324 NEW ENG. J. MED. 1500 (1991) (discussing public health policy issues concerning the AIDS virus and the views of public health authorities and social activists concerning these issues).

111. *See* H.R. REP. NO. 101-485, pt. 2, at 31 (1990) (stating that "discrimination against individuals with HIV infection is widespread and has serious repercussions for both the individual who experiences it and this nation's efforts to control the epidemic"). The basic argument was that if individuals with HIV were subject to discrimination, those at risk for contracting the virus would refuse to be tested or treated, and would not inform their sexual partners about their disease. *See* S. REP. NO. 101-116, at 8 (1989). Of course, the rationale was also partially the result of a political recognition that public health workers required the cooperation and trust of the communities affected in order to reach people at risk in those communities. *Cf.* Donald H.J. Hermann & Rosalind D. Gaylians, *AIDS, Therapeutic Confidentiality, and Warning Third Parties*, 48 MD. L. REV. 55, 56 (1989) (discussing the need for confidentiality to encourage voluntary participation of HIV-infected persons in AIDS treatment programs).

112. *See* Sylvia Mayer Baker, Comment, *HIV: Reasons to Apply Traditional Methods of Disease Control to the Spread of HIV*, 29 HOUS. L. REV. 891, 909 (1992).

113. *See* Hermann & Gaylians, *supra* note 111, at 59 (discussing the need to collect medical information of HIV-infected persons to help curb the spread of the disease and the concern of high risk individuals over the negative effects of a positive entry into their medical record).

114. *See* Telephone Interview with Coles, *supra* note 27.

Defense and Education Fund on behalf of a physician who was being evicted because he treated AIDS patients.[115] In that case litigation was used not only to assure an individual's civil right but also to protect the public health by ensuring that health care providers could continue to provide care to those who were infected.[116]

Similar issues were at stake last year in *Bragdon v. Abbott*,[117] a case brought under the Americans with Disabilities Act,[118] by an infected individual who was refused dental care because of her infection.[119] The Supreme Court held in that case that an individual with HIV was entitled to the anti-discrimination protections of the ADA.[120] Remanding the case to the court of appeals to determine whether the dentist could prevail under a "direct threat" defense, the Court noted that deference should be given to the opinions of public health authorities.[121] The court of appeals subsequently found that those authorities, including the Centers for Disease Control and Prevention (CDC), had determined that the denial of routine dental treatment was unwarranted because such treatment did not indeed pose a direct threat to the health of the dentist, as long as "universal precautions" were followed.[122] Importantly, as with the tobacco litigation, the *Bragdon* case evidenced not only a synchrony between the opinions of public health officials and the positions of the plaintiffs, but also considerable coordination among advocates. For example, numerous public health, civil rights, and AIDS advocacy groups collaborated during the

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115. *See* Telephone Interview with Cathcart, *supra* note 95; *AIDS Physician Blocks Ouster in Settling Suit*, N.Y. TIMES, Oct. 18, 1984, at B28 (indicating that the co-op board informed the doctor that his lease would not be renewed because residents feared that the doctor's patients would infect them and reduce apartment values).

116. *See* Telephone Interview with Cathcart, *supra* note 95. The doctor agreed to a settlement in which he received $10,000 and a new lease. *See AIDS Physician Blocks Ouster in Settling Suit*, *supra* note 115, at B28.

117. 524 U.S. 624 (1998).

118. 42 U.S.C. §§ 12101-12213 (1994).

119. *See Bragdon*, 524 U.S. at 628-29 (noting that the dentist was willing to treat the infected individual's cavity at a hospital, but that the individual would be responsible for the increased costs associated with the use of the hospital facilities).

120. *See id.* at 655 (affirming the circuit court's holding).

121. *See id.* at 648, 650, 655 (stressing that the opinions of public health authorities, such as the National Institutes of Health, the Centers for Disease Control and Prevention, and the U.S. Public Health Service, are of "special weight and authority").

122. *See* Abbott v. Bragdon, 163 F.3d 87, 88 (1st Cir. 1998).

litigation, leading to the filing of briefs by several joint amici groups.[123]

HIV and public health advocates have also been united, albeit less successful, in cases against health insurers that seek to limit HIV-related claims.[124] Although the Equal Employment Opportunity Commission (EEOC) has asserted that such practices violate the ADA,[125] some courts have reached the opposite conclusion, relying again upon a variety of technical, quasi-jurisdictional defenses proffered by industry.[126]

The harmony between public health agencies, medical officials, and HIV advocates has been less secure in cases brought by medical workers who are infected with HIV and have been removed from their positions on that account.[127] For the most part, the courts in these cases have upheld the right of health-care institutions to discriminate against infected workers, finding that such workers pose a "direct threat" to the health or safety of patients.[128] In other words, courts in these cases have viewed public health as warranting discrimination.

On their face, the many tort claims brought against the blood industry bear a greater resemblance to the tobacco cases than do the antidiscrimination cases discussed thus far. In the early years of the epidemic, many transfusion recipients and

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123. *See* Brief of Amicus Curiae of Infectious Diseases Society of America et al., Bradgon v. Abbott, 524 U.S. 624 (1998) (No. 97-156); Brief of Amicus Curiae of the American Medical Association, Bragdon v. Abbott, 524 U.S. 624 (1998) (No. 97-156); Brief of Amicus Curiae of the AIDS Action Council et al., Bragdon v. Abbott, 524 U.S. 624 (1998) (No. 97-156).

124. *See, e.g.*, Gonzales v. Garner Food Servs., Inc., 89 F.3d 1523, 1524, 1531 (11th Cir. 1996) (holding that an HIV-infected former employee, who was suing his employer for discrimination because the employer imposed a cap for AIDS-related treatment, was not a "qualified individual with a disability" within the meaning of the ADA). Amici curiae briefs were filed by the American Civil Liberties Union, the American Association of Retired Persons, and the EEOC. *See id.* at 1524.

125. *See* Consent Judgment in EEOC v. Mason Tenders Local 23, 1995 Daily Lab. Rep. (BNA) 241, 241 (1995).

126. *See* Doe v. Mutual of Omaha Ins. Co., 179 F.3d 557, 561, 563-64 (7th Cir. 1999) (finding that the ADA does not prohibit HIV insurance policy caps). *But see* Carpart Distribution Ctr., Inc. v. Automotive Wholesalers Ass'n, 37 F.3d 12, 18, 20 (1st Cir. 1994) (finding a similar claim actionable under the ADA).

127. The Centers for Disease Control and Prevention, for example, recommended in the 1980s that health-care institutions determine on an individual basis whether infected personnel should continue to engage in certain invasive procedures. *See* Centers for Disease Control and Prevention, *Recommendations for Prevention of HIV Transmission in Health Care Settings*, 36 MORBIDITY & MORTALITY WKLY. REP. SUPP. 2S, 16S (1987).

128. *See, e.g.*, Doe v. University of Md. Med. Sys. Corp., 50 F.3d 1261, 1266 (4th Cir. 1995) (recognizing that the worker in this case posed a "significant risk" because he was a neurosurgical resident and because the risk of percutaneous injury could "never be eliminated through reasonable accommodation").

recipients of other blood products became infected with HIV through contaminated blood.[129] Not surprisingly, lawsuits were brought.[130] Interestingly, as with the cases against tobacco, plaintiffs faced numerous procedural and technical hurdles. Just as the *Restatement (Second) of Torts* had the effect of denying tobacco plaintiffs the advantages of strict liability,[131] so-called "blood shield" laws served to deny HIV-infected plaintiffs the benefits of that same doctrine.[132] As a result, plaintiffs have had to show negligence or a deviation from the industry-wide standard of care in order to prevail.[133] The statute of limitations has also proven difficult for plaintiffs in these cases.[134]

A wide variety of other types of HIV litigation has also been brought in the last two decades. Many cases arise under the criminal law and concern the ability of the state to sanction behavior that may potentially transmit the virus.[135] In some sense, these cases are the least similar to the tobacco cases, for they are not brought by individuals who are ill nor by those who represent these people. Instead, these cases harken back to the classical model of public health litigation, in which the state attempts to regulate or sanction an individual in the name of public health, and the job of the court is to review the state's authority and to assess the individual's rights.[136] Although critical for determining the relationship between the individual

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129. *See* Centers for Disease Control and Prevention, *Update: Acquired Immunodeficiency Syndrome—United States*, 35 MORBIDITY & MORTALITY WKLY. REP. 17, 19 (1986) (noting the increasing incidence of HIV infection caused by blood transfusions in the mid-1980s).

130. *See* Joseph Kelly, *The Liability of Blood Banks and Manufacturers of Clotting Products to Recipients of HIV-Infected Blood: A Comparison of the Law and Reaction in the United States, Canada, Great Britain, Ireland, and Australia*, 27 J. MARSHALL L. REV. 465, 465 (1994) (noting the large number of HIV-related lawsuits stemming from blood transfusions).

131. Refer to text accompanying note 69 *supra*.

132. *See* Gostin et al., *The Resurgent Tuberculosis*, *supra* note 19, at 1-2 (noting that some courts had interpreted state "blood shield" statutes broadly to prohibit strict liability).

133. *See id.* at 2 (recognizing that once a negligence standard is adopted, the plaintiff has the burden of establishing that the defendant's conduct fell below the industry standard of care). *But see* KEETON ET AL., *supra* note 9, § 33, at 194 ("Even an entire industry, by adopting such careless methods to save time, effort or money, cannot be permitted to set its own uncontrolled standard.").

134. *See* Gostin et al., *The Resurgent Tuberculosis*, *supra* note 19, at 6.

135. *See id.* at 4-5 (noting four principal criminal issues: whether the risk of transmitting HIV is a crime itself or merely relevant to the charge, whether the defendant's knowledge of his or her serologic status will prejudice the defendant at trial, whether HIV testing of the defendants involved in violent sex or drug crimes is permissible, and whether HIV status can be used as an aggravating or mitigating factor at trial).

136. Refer to text accompanying notes 18-25 *supra*.

and the state when the health of the public is at issue, such cases differ from the tobacco cases and the HIV antidiscrimination and tort cases because the mantle of public health is being worn by the state, not the individual plaintiff.[137] In most of the tobacco and many of the HIV antidiscrimination cases, in contrast, individuals are using the court not to limit the power of the state but to advance the interests of those at risk for a major health threat.[138] In many cases, these plaintiffs are using this litigation explicitly and consciously to change the legal landscape, to engage in law reform.[139] But even when the parties do not subjectively share a law reform goal, even if their primary goal is personal compensation or the advancement or protection of an individual right, their litigation is different from the classic model of public health litigation because they are not seeking to limit the state's power to protect the public, rather they are seeking the creation or advancement of policies to protect the interests of those at risk for (or already striken by) public health threats. Whether this use of the courts can serve effectively to promote public health is examined below.

IV. AFFIRMATIVE PUBLIC HEALTH LITIGATION AND THE FORMULATION OF PUBLIC HEALTH POLICY

In their recent comprehensive analysis of infectious disease law, Professors Gostin, Burris, and Lazarrini remind us that "[l]aw is an essential part of public health practice. Law defines the jurisdiction of public health officials and specifies the manner in which they may exercise their authority."[140] This vision of law as both the enabler and restrainer of public health is illustrated

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137. *See, e.g.*, State v. Sherouse, 536 So. 2d 1194, 1194 (Fla. Dist. Ct. App. 1989) (reciting facts in the attempted murder prosecution of an HIV-infected woman for offering to engage in sexual intercourse for money); State v. Haines, 545 N.E.2d 835, 835-36 (Ind. Ct. App. 1989) (describing facts in the attempted murder prosecution of an HIV-infected man who deliberately exposed others to his body fluids). Of course in the attorney general suits, the states brought the actions to recover the costs of treating individuals with tobacco-related diseases. *See* Robert A. Levy, *Tobacco Wars: Will the Rule of Law Survive?*, 2 J. HEALTH CARE L. & POL'Y 45, 45 (1998) [hereinafter Levy, *Tobacco Wars*].

138. *See* Daynard, *supra* note 66, at 9, 12 (noting that the tobacco litigation will likely have the effect of reducing future cigarette consumption).

139. This is clearly the objective, for example, of the Tobacco Litigation Project. *See id.* at 10-11 (discussing the application of various legal theories to tobacco cases). This is also the objective of the AIDS Law Project of Gay and Lesbian Advocates and Defenders, which brought the *Bragdon* case. *See* Telephone Interview with Klein, *supra* note 97.

140. Lawrence O. Gostin et al., *The Law and the Public's Health: A Study of Infectious Disease Law in the United States*, 99 COLUM. L. REV. 59, 61 (1999) [hereinafter Gostin et al., *The Law and the Public's Health*].

by such classic public health cases as *Jacobson v. Massachusetts*.[141] In these cases, the state legislature responds to a public health threat (be it smallpox or contaminated drinking water) by entrusting a public health agency to take the actions necessary to ameliorate the problem.[142] The agency, in turn, uses that authority to initiate an action (in *Jacobson*, it was mandatory vaccination),[143] guided by its expert understanding of the scientific foundations for public health.[144] An individual or industry whose interests are infringed upon by the agency's actions (such as Mr. Jacobson) then seeks judicial review, calling upon the court to determine if the agency has acted properly.[145] In so doing, the court must consider the agency's jurisdiction (whether it has acted within the scope of its delegated authority),[146] the factual and scientific circumstances necessitating the action,[147] and the nature and extent of the individual interest threatened.[148]

Fundamental to this classical model of public health law is the integration of democratic decisionmaking, scientific and bureaucratic rationality, and the protection of individual rights.[149]

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141. 197 U.S. 11, 12-13, 39 (1905) (upholding a Massachusetts statute prescribing a mandatory vaccination against smallpox).

142. *See* Marshall B. Kapp, *Tobacco Litigation, Round Three: It's the Money and the Principle*, 24 J. HEALTH POL. POL'Y & L. 811, 813 (1999) (arguing that traditionally the police power to protect the health, safety, and welfare of the community was the tool of public health officers operating under agency regulations pursuant to legislative enactments); *see also* Burris, *supra* note 39, at 481-84 (discussing how courts generally review actions of public health agencies).

143. *See Jacobson*, 197 U.S. at 12-13.

144. *See* Sanford E. Gaines, *Science, Politics, and the Management of Toxic Risks Through Law*, 30 JURIMETRICS J. L. SCI. & TECH. 271, 273 (1990) (crediting agencies with successfully implementing policy when the scientific information is not in dispute).

145. *See Jacobson*, 197 U.S. at 1; *see also* Gaines, *supra* note 144, at 279 (noting that the tenuousness of the scientific basis used by agencies often invites controversy).

146. *See* Wendy E. Parmet, *AIDS and Quarantine: The Revival of an Archaic Doctrine*, 14 HOFSTRA L. REV. 53, 88 (1985) (recognizing that courts must review administrative actions to determine whether they are authorized by statute and describing the "hard look" approach wherein the courts rigorously examine agency regulations); *see also* Gostin et al., *The Law and the Public's Health*, *supra* note 140, at 91 (characterizing a public health department as having two types of jurisdiction: actual jurisdiction and "persuasive" jurisdiction).

147. *See* Burris, *supra* note 39, at 482-83 (noting that an objective assessment, including medical and epidemiological data as well as comprehensive cost-benefit analysis, is appropriate).

148. *See* Parmet, *Legal Rights*, *supra* note 3, at 758-66 (surveying the scope of constitutional protection afforded to personal autonomy in the context of public health regulation).

149. As described, the model largely resembles the theoretical model provided for the administrative state developed in the wake of the New Deal. *See* Daniel B.

Democratic decisionmaking is respected because the foundational public health policy derives from the legislature, and the public health agency is expected to follow the policies set forth by the legislation.[150] Bureaucratic rationality and scientific guidance are ensured because public health experts supposedly utilize their scientific understanding to elaborate upon and implement the general policy set forth by the legislature.[151] Moreover, courts stand ready to ensure that at least some scientific basis does indeed exist to justify the actions undertaken.[152] Finally, individual rights are protected by that same process of judicial review, which ensures that claims of private constitutional and statutory rights can be made and used to limit the actions of public health authorities.[153]

The history of much of HIV and tobacco litigation stands this model on its head. In the private tobacco court cases and the HIV antidiscrimination cases, litigants ask the courts not simply to review policies of public health authorities, but in essence to make policies (or determine liabilities) where no clear regulatory

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Rodriguez, *Jaffe's Law: An Essay on the Intellectual Underpinnings of Modern Administrative Law Theory*, 72 CHI.-KENT L. REV. 1159, 1159 (1997) (recognizing that despite the intent of the architects of the New Deal regulatory programs, the courts perform a "very significant and independent role" reviewing agency actions). This similarity should not be surprising as public health law is to a large degree administrative law, and it has developed and matured along with the administrative state. *See* James G. Hodge, *Implementing Modern Public Health Goals Through Government: An Examination of New Federalism and Public Health Law*, 14 J. CONTEMP. HEALTH L. & POL'Y 93, 93-95 (1997).

150. In federal law, the question of whether or not the policy must actually be specified by legislation is the subject of the much-mooted nondelegation doctrine. *See* George Bunn et al., *No Regulation Without Representation: Would Judicial Enforcement of a Stricter Nondelegation Doctrine Limit Administrative Lawmaking?*, 1983 WIS. L. REV. 341, 342 (1983) (describing the nondelegation doctrine as "a prohibition on congressional delegations of legislative power to agencies"). The doctrine has recently been revived by the D.C. Court of Appeals. *See* American Trucking Ass'ns v. EPA, 175 F.3d 1027, 1034 (D.C. Cir. 1999) (examining whether the EPA has construed two provisions from the Clean Air Act so loosely as to invoke the nondelegation doctrine). As Professors Gostin, Burris, and Lazzarini report, most state public health laws have historically been extremely broad and provided extensive discretion for state and local public health agencies. *See* Gostin et al., *The Law and the Public's Health*, *supra* note 140, at 104-05. This broad delegation suggests that in reality public health policy is more often the product of agency action than legislative enactment. Thus, democratic decisionmaking is more often a myth than a reality.

151. *See* Gaines, *supra* note 144, at 273 (characterizing the agencies as being adept at implementing policy, even under ambiguous statutes, when scientific information is undisputed).

152. *See* Burris, *supra* note 39, at 496 (noting that "rational relations" and "least restrictive means" are determined by medical criteria).

153. *See* Parmet, *Legal Rights*, *supra* note 3, at 758-66 (describing an array of constitutional limits on the exercise of public health authority).

policies exist.[154] Thus, tobacco plaintiffs do not seek to hold the manufacturers liable for their failure to follow regulations specified by public health authorities. To the contrary, tobacco plaintiffs seek to hold manufacturers liable in the absence of any such regulation.[155] Indeed, in the tobacco cases it has been the manufacturers who have pointed to legislation, arguing that it not only does not hold them liable, but that it instead immunizes them from common law liability.[156]

Likewise, in many HIV cases, plaintiffs have neither challenged nor relied upon public health regulations.[157] Instead, they have gone to court utilizing civil rights law and tort theories to advocate for the interests of individuals infected, thereby making public health policy.[158]

This reliance upon courts to formulate public health policy in the absence of either public health legislation or bureaucratic intervention can be criticized, as can other forms of court-centered law reform, as undemocratic.[159] Affirmative public health litigation may also be condemned as anti-scientific and detrimental to the population perspective at the core of public

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154. Refer to note 5 *supra* and accompanying text.

155. *See id.* at 12 (describing the failure of attempts to implement tobacco legislation and recognizing that litigation does not rely on such legislation).

156. *See* Cipollone v. Liggett Group, Inc., 505 U.S. 504, 510-11 (1992) (reciting respondent's contention that the Federal Cigarette Labeling and Advertising Act preempted common-law actions).

157. *But see* New York State Soc'y of Surgeons v. Axelrod, 572 N.E.2d 605, 606 (N.Y. 1991) (challenging the health department's decision not to designate HIV as a communicable and sexually transmitted disease under the prevailing state statute).

158. Of course, as the discussion below should make clear, there can be no clear division between a public health law and a civil rights law. To the extent that the latter promotes or thwarts public health, it can rightly be labeled a public health policy. Still, the laws relied upon by the HIV anti-discrimination plaintiffs differed from traditional public health laws not only because they were not labeled as such but also because they were primarily designed to address a different issue—civil rights deprivations. Moreover, in contrast to traditional public health laws, public health agencies were not entrusted with their enforcement. *See* Robert L. Burgdorf, Jr., *The Americans with Disabilities Act: Analysis and Implications of a Second-Generation Civil Rights Statute*, 26 HARV. C.R.-C.L. L. REV. 413, 463-64 (1991) (noting that the EEOC was charged with the implementation of the ADA). However, in *Bragdon*, the Supreme Court compensated for that omission by granting deference to the opinions of public health agencies in the application of the ADA to cases concerning infections diseases. *See* Bragdon v. Abbott, 524 U.S. 624, 650 (1998) (acknowledging the "special weight and authority" of public health authorities in determining the reasonableness of the dentist's actions).

159. *See* Antonin Scalia, *Common-Law Courts in a Civil-Law System: The Role of United States Federal Courts in Interpeting the Constitution and Laws*, *in* A MATTER OF INTERPRETATION: FEDERAL COURTS AND THE LAW 3, 10-12 (1997) (acknowledging and agreeing that policy implementations accomplished through the courts is undemocratic, but still the best way to develop the law in many fields).

health.[160] The anti-democratic charge notes that such litigation evades the legislative process, relying upon judges and juries to determine public health policy.[161] And, a critic may argue, such litigation is anti-scientific in that it relies upon the emotional and largely unlearned judgments of judges and juries rather than the expert opinions of public health professionals.[162] Finally, a critic may claim that to the extent that such litigation seeks to advance the individual rights of the plaintiff, it is inimical to the population perspective fundamental to public health, obscuring the commonality of health threats and the public perspective that is needed to address them.[163]

These criticisms are powerful and worthy of consideration. But, the experiences of the tobacco and HIV litigation also suggest several responses. First, the happy marriage of democracy and science predicated by the classic model does not always work.[164] Even when it does, litigation's intervention is not always disruptive to that alliance. Often litigation supports it.[165] Moreover, litigation's focus on rights does not always conflict with the public interest and undermine a public health perspective. Depending upon the rights at issue, their advancement may complement both public health and a public

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160. *See* Jonathan M. Mann, *Medicine and Public Health, Ethics and Human Rights,* HASTINGS CTR. RPT., May 15, 1997 at 6 ("The fundamental difference [between medicine and public health] involves the population emphasis of public health . . . .").

161. *See* Peter D. Jacobson & Kenneth E. Warner, *Litigation and Public Health Policy Making: The Case of Tobacco Control,* 24 J. HEALTH POL. POL'Y & L. 769, 770 (1999) (noting that those who believe in a limited judicial role see litigation as appropriate only to resolve disputes between particular parties, not to establish general policy).

162. *See id.* at 796 (recognizing several inherent limitations in judicial policy making).

163. *See id.* (recognizing the argument that the courts are ill-equipped to select cases whose parties and particular issues allow for assessment of the conflicting policy choices). A different set of arguments derives from a laissez faire perspective and questions the appropriateness of any or most government regulations aimed at protecting health. For an example of such a critique as applied to tobacco, see Levy, *Tobacco Wars, supra* note 137, at 70-73 (arguing that the Constitution does not confer on Congress a national police power to regulate health, morality, education, or welfare). This Article does not meet such objections but assumes that public health is an appropriate area for governmental action and that regulation to that effect may at times (although certainly not always) be justified.

164. *See* Jacobson & Warner, *supra* note 161, at 793 (noting the failure of attempts to enact tobacco control legislation despite strong support for this legislation).

165. *See id.* (reciting the view that tobacco control litigation could serve to initiate policy development).

health perspective.[166] Each of these points, and the criticisms to which they respond, are elaborated upon below.

A. *Setting Public Health Policy*

In the classical model of public health litigation, legislators and regulators establish the policy and courts simply review its implementation.[167] From this perspective, litigants in the tobacco and HIV cases have sought an end-run around the "normal" process, turning to the courts to establish policies when neither legislatures nor public health agencies have acted.[168]

Descriptively this criticism is partially correct, especially in the case of tobacco because there is no statute or regulatory policy specifically establishing the liability of cigarette makers to individuals harmed by the product.[169] However, there certainly are affirmative public health cases in which the plaintiffs can point to legislation and legislative history to support their position. For example, in *Bragdon v. Abbott*, the Court cited extensive legislative history to bolster its conclusion that the ADA applies to individuals infected with HIV.[170] Thus, even though there was no regulatory action by public health officials at issue in the case, there was not a complete absence of legislative involvement. Indeed, it may be fair to say that the plaintiffs used the courts to implement a legislative policy rather than to usurp that policy.

But clearly, litigants have also gone to court because of the absence of enacted policies responding to tobacco and HIV.[171] To be fair, litigants have asked the courts to develop policy.[172] The question then arises: Is this an appropriate role for courts to

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166. *See id.* at 769 (suggesting litigation as a complement to a "broader, comprehensive approach to tobacco control policymaking").

167. Refer to notes 18-25 *supra* and accompanying text (describing the classical model of public health litigation).

168. Refer to note 5 *supra* and accompanying text (explaining that many tobacco and HIV plaintiffs go to court to develop new policy).

169. *See* Daynard, *supra* note 66, at 12 (noting that the tobacco industry has successfully deflected most anti-smoking legislative efforts). Some states, however, did enact laws paving the way for holding manufacturers liable for the state-insured medical costs of tobacco related illnesses. *See, e.g.*, Florida Medicaid Third-Party Liability Act, FLA. STAT. ANN. § 409.910 (West 1998).

170. *See* Bragdon v. Abbott, 524 U.S. 624, 642-45 (1993) (discussing not only legislative history, but also prior statutory interpretation by agencies and courts).

171. Refer to note 39 *supra* and accompanying text (citing sources that discuss the lack of legislation and regulation for tobacco and HIV).

172. *See* Jacobson & Warner, *supra* note 161, at 769-70 ("Many tobacco control advocates, believing that legislators and regulators have failed to enact and implement sufficiently stringent tobacco control laws, have supported litigation as a means of achieving public health policy goals.").

play? Is it contradictory, not only to democratic principles in general, but to the communitarianism inherent in public health for courts to make public health policy?

Many answers can be given to those questions. Some would respond to the general anti-democratic critiques that have been leveled at the use of courts to develop policies.[173] Such responses might note the inherent impossibility of distinguishing between the interpretative task, which all critics would concede is rightfully the job of the courts, and lawmaking.[174] Additional responses might note that in our common-law system, the development of law through litigation is at least as old and established in our political system as is democratic representation.[175] The interactive process between courts and legislatures has always been a basic part of the way laws have been established.[176] Moreover, as long as legislatures can alter or negate judge-made law (which is true for all rulings that are not based upon the Constitution) democratic control is not totally negated by the development of judge-made law.[177]

But with respect to public health litigation, some particular observations are in order. The first is that the so-called democratic system is often neither responsive nor representative when it comes to public health.[178] As Professors Gostin, Burris, and Lazarrini have demonstrated, there are significant endemic stumbling blocks to the political enactment of public health

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173. *See* Scalia, *supra* note 159, at 12 (arguing that although it may be undemocratic, the common law is the best method by which to develop the law in many fields).

174. *See* Lawrence H. Tribe, *Comment*, *in* A MATTER OF INTERPRETATION: FEDERAL COURTS AND THE LAW, *supra* note 159, at 71-72 (1997) (noting the inherent difficulty in distinguishing between interpretation of objective meaning and imposition of personal values).

175. *See* Benjamin N. Cardozo, THE NATURE OF THE JUDICIAL PROCESS 9-10 (1921) (recognizing judge-made law as one of the "existing realities of life").

176. *See id.* at 14-15 (suggesting an interactive approach).

177. *See id.* at 14 (noting that statutes, if constitutional, override judge-made law).

178. The entire discussion that follows may be subject to the criticism that it fails to accept the appropriateness of inaction or a laissez faire approach when it comes to matters of public health. However, although inaction may well be correct in many instances, this Article proceeds upon the assumption that there is a valid public interest in protecting and promoting public health. *See* DANIEL BEAUCHAMP, THE HEALTH OF THE REPUBLIC 119 (1988) (discussing Justice Harlan's recognition in *Jacobson* that the legislature is properly vested with the right to promote the public health through appropriate laws). Democratic outcomes should be respected with regard to matters of health; however, they need not be accepted at face value. When they result in significant unnecessary morbidity and mortality, they should at least be open to question.

legislation.[179] One problem is public apathy.[180] While most people care about threats to health, they rarely focus on factors that constitute the major risks to the population as a whole.[181] Instead, people tend to focus on risks that they perceive to be significant to their own near-term well being.[182] From a population perspective, however, such personal risks may be relatively insignificant and not worthy of public health's devoted attention.[183] But because of this discrepancy between the threats that people worry about, and those that are major causes of morbidity and mortality to the population as a whole, it may be difficult to arouse the public and their political representatives to address significant public health issues. The fact that many public health threats, such as HIV or lead-paint poisoning, disproportionately affect communities subject to widespread discrimination compounds the problem.[184] Clearly in the case of HIV, homophobia initially delayed the enactment of beneficial legislation.[185] Even today, the wide-spread antipathy that exists for intravenous (IV) drug users has continued to make it politically difficult to establish programs such as needle-exchange programs that could reduce the spread of the epidemic among drug abusers and their sex partners.[186]

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179. *See* Gostin et al., *The Law and the Public's Health*, *supra* note 140, at 64 (recognizing that the practice of public health entails judgements that "challenge deeply ingrained social attitudes and practices").

180. *See id.* at 65 (naming apathy as one of the significant political difficulties inherent in modern public health practice).

181. *See id.* at 89 (suggesting that people are typically concerned with their personal health, but do not worry about specific health problems unless they are at high risk).

182. *See id.* at 90 (contrasting the concern over immediate threats to personal health with the general apathy towards longer terms risks).

183. *See id.* at 89-90 (recognizing that from a population perspective, relative risk is not necessarily a helpful statistic).

184. *See id.* (noting that political and public support of public health programs are linked to a threat to the "general population," not special groups).

185. *See* SHILTS, *supra* note 39, at xxii (lamenting that because AIDS was considered a homosexual affliction, the political and scientific communities were slow to act).

186. *See* Linda C. Fentiman, *AIDS as a Chronic Illness: A Cautionary Tale for the End of the Twentieth Century*, 61 ALB. L. REV. 989, 995-96 (1998) (characterizing state regulations limiting hypodermic needles as short-sighted, because although such approaches might discourage drug use, they also increase transmission of hepatitis, HIV, and other blood borne pathogens). A similar pattern may be emerging with respect to tobacco. The public health measures that are being applied in this country in the wake of the litigation do not apply overseas, where sales are brisk, and where the United States government has been willing to assist the industry in forcing other nations to accept U.S. tobacco. *See* Levy, *Twenty-First Century*, *supra* note 8, at 1155 (noting the increasing tendeucy of United States tobacco companies to seek profits overseas amid United States government efforts to coerce other countries to import U.S. tobacco products).

The significant political influence that may be wielded by industries subject to public health regulation also makes it difficult at times for legislatures to respond to public health threats.[187] In most situations, public health legislation provides a low level of benefit to a diverse group of citizens.[188] At the same time, the costs of the regulation may be borne disproportionately by an identified economic interest.[189] As a result, it should not be surprising that the targeted industry often becomes especially vociferous in its opposition to suggested public health laws.[190] This was true in earlier times when many businesses opposed the imposition of health measures,[191] and it remains true today as the politics of tobacco make clear. In recent years the tobacco industry has invested enormously in political campaigns, lobbying, and advertising, for the clear purpose of preventing strict public health regulations.[192] To a large degree, this strategy has worked. Both the Congress and most state legislatures have been remarkably sympathetic to the industry's interests and have failed to enact the type of strict public health regulations that the product's health risks would seem to justify.[193] Indeed, much of the tobacco legislation that exists has served to protect the industry rather than the public health.[194]

Given these political realities, it is not surprising that individuals concerned about public health threats have turned to the courts. For example, in the absence of any nation-wide law

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187. *See* KLUGGER, *supra* note 55, at 685-86 (detailing efforts by Philip Morris to influence legislation).

188. *See* Kelder & Daynard, *supra* note 1, at 69 (explaining the limited impact of regulation).

189. *See* Parmet, *Slaughter-House*, *supra* note 18, at 48 (stating that the costs of a slaughter-house regulation in the public health "were not being evenly imposed").

190. *See* Kelder & Daynard, *supra* note 1, at 63 (detailing the tobacco industry's intrusion into politics).

191. *See* Parmet, *Slaughter-House*, *supra* note 18, at 482 (noting that the challengers of health measures have characterized them as "a shackle on economic freedom").

192. *See* KLUGGER, *supra* note 55, at 685-86.

193. Of course, the strong libertarian streak in our political culture also helps explain the lack of regulation. Many people reject the public health perspective and believe that individuals should be able to choose whether or not to smoke. *See* Kelder & Daynard, *supra* note 1, at 70 (emphasizing the view that tobacco control infringes the personal "rights" of smokers). This free market ideology no doubt plays a major role in the politics of tobacco, but it cannot fully explain why our legislatures are far quicker to ban products that pose far less of a threat to the public's health. There can be no doubt, for example, that many illegal drugs are far less deadly than cigarettes, yet the free market ethos does not prevent their prohibition. *See id.* at 64 (stating "tobacco is responsible for more deaths than . . . illicit drug use").

194. *See id.* at 68-69 (explaining the tobacco industry's use of legislation to protect its advertising rights).

guaranteeing a tobacco-free workplace, individuals harmed by environmental tobacco smoke (ETS) have had little choice but to go to court, using civil rights statutes and common law theories.[195] If there was a legislatively-enacted public health policy pertaining to ETS in the workplace, such litigation might not be necessary.[196] Similarly, many of the early HIV cases may have been avoided if there had been a clear federal policy in the 1980s prohibiting discrimination on the basis of HIV.

But, litigation is more than simply the understudy for legislation. Litigation can also help lead to the enactment of legislation. This can occur in a variety of ways, as both the tobacco and HIV cases demonstrate.

Most obvious is the role that litigation can play in drawing public attention to a health problem.[197] In the history of HIV, for example, the story of Ryan White, a child who sued after he was barred from school because he had AIDS, clearly drew attention to the epidemic.[198] This new attention, in turn, helped the public

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195. *See* Parmet et al., *Accommodating Vulnerabilities*, *supra* note 81, at 16-31 (reviewing various causes of action). Many localities, however, have enacted ordinances to address these issues. *See* Kelder & Daynard, *supra* note 1, at 69. Such ordinances may face problems of preemption by state law. *See id.* at 69-70.

196. However, private litigation may still be necessary to ensure the statute's enforcement. Refer to notes 239-41 *infra* and accompanying text.

197. Some scholars question the impact litigation can have in changing public perceptions and policies. *See* GERALD N. ROSENBERG, THE HALLOW HOPE: CAN COURTS BRING ABOUT SOCIAL CHANGE? (1991) (discussing the ability of courts to influence public perceptions and policies). Others have noted, however, that even when judicial decisions themselves do not change the policy environment, they, as well as litigation, may help arouse attention to issues and mobilize individuals around a cause. *See* MICHAEL W. MCCANN, RIGHTS AT WORK: PAY EQUITY REFORM AND THE POLITICS OF LEGAL MOBILIZATION (1994) (discussing the impact of litigation on social movements). In addition, some scholars have noted the significant media attention given to notable court decisions. *See generally* Roy B. Flemming et al., *One Voice Among Many: The Supreme Court's Influence on Attentiveness to Issues in the United States, 1947-92*, 41 AM. J. POL. SCI. 1224 (1997) (discussing the impact of the media upon the public opinion of Supreme Court decisions).

198. *See* Mark C. Donovan, *The Problem with Making AIDS Comfortable: Federal Policy Making and the Rhetoric of Innocence*, *in* ACTIVISM AND MARGINALIZATION IN THE AIDS CRISIS (Michael A. Hallett ed., 1997); Beverly Beyette, *Ryan's Hope*, L.A. TIMES, Apr. 10, 1990, at E1. Of course, other events, including the death of Rock Hudson to AIDS and the disclosure that Magic Johnson was HIV-positive, also helped focus the public on the epidemic. *See* Bill Hendrick, *An AIDS Death Remembered 10 Years Later*, ATLANTA CONST., Oct. 1, 1995, at 1C (discussing the legacy of Rock Hudson); *see also* Lou Cannon & Anthony Cotton, *Lakers Answer Question That's on Minds of All: Magic Got Virus from Woman*, HOUS. CHRON., Nov. 9, 1991, at 24A (discussing Magic Johnson's announcement that he has HIV). The increase in attention may also be useful in another way. To the extent that public education about the dangers of tobacco or the ways in which HIV is transmitted remains the dominant public health policy, litigation may play a role in the process, helping individuals learn more about what does and does not

to appreciate that AIDS was a public health problem rather than a private threat to marginalized groups.[199] At least partially as a result of this shift in public understanding that the White litigation helped to create, the political dynamics of the epidemic changed, and in 1990 Congress finally addressed the issue, in a statute honored with White's name.[200] Thus, instead of evading the legislative process, Ryan White's litigation, like the other early HIV school cases, helped the process.[201]

Of course, litigation was not solely responsible for bringing public attention to the problems faced by individuals living with HIV. HIV advocates have relied upon a wide-range of devices, from traditional lobbying to civil disobedience, to draw attention to their issue.[202] Litigation has only been a part of the story. But given the media attention it can garner, as well as its ability to put a human face on an issue, litigation can work alongside other efforts at political mobilization to make public health issues more salient and public health legislation more probable.[203]

The tobacco litigation has demonstrated even more dramatically how litigation may alter the political calculus.[204] The litigation has done this not only by the substantial media attention the trials have received,[205] but also from publicity

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endanger their own health, presumably helping them to alter their own behaviors. Of course, the role that litigation plays in this health education process is hard to quantify, but given the significant publicity that litigation engenders, it seems likely that litigation has at least some role to play.

199. Some commentators have noted that attention focused on Ryan White and other children because they were treated by the media as the epidemic's innocent victims, in contrast to gay men and intravenous drug users, who were treated as if they were responsible for their plight. *See* Donovan, *supra* note 198, at 121-23. While this is troubling, and likely resulted in public policies that were less responsive to the needs of most HIV-infected individuals, it does not vitiate the point that the case of Ryan White helped bring HIV to the public and hence the legislative agenda. *See* Beyette, *supra* note 198, at E1 (discussing the publicity of Ryan White's case).

200. *See* Ryan White Comprehensive AIDS Research Emergency Act of 1990, 42 U.S.C. §§ 300ff to 300ff-90 (1994).

201. This litigation also helped lead to the enactment of the ADA in 1990. *See* 42 U.S.C. § 1201-12213 (1994). Antidiscrimination litigation led in the late 1980s and 1990s to a body of case law establishing that HIV was a disability and entitled to federal disability-discrimination protection. *See, e.g.*, Bragdon v. Abbott, 524 U.S. 624, 631 (1998). Those principles, in turn, were cited repeatedly by legislators during the ADA's debate. *See* H.R. REP. NO. 101-485, pt.2, at 50-53 (1990) (citing cases in support of the ADA). In essence, the litigation enabled legislatures to claim they were merely codifying already established legal principles. *See id.*

202. *See* Parmet & Jackson, *supra* note 88, at 9-16.

203. *See* Beyette, *supra* note 198, at E1 (dicussing the impact of Ryan White's case).

204. *See* Mather, *supra* note 84, at 930 (dicussing the modern trend of politicians shying away from the tobacco industry).

205. *See id.* at 922-23.

pertaining to the documents discovered during the litigation process.[206] The revelations about the industry's knowledge of nicotine's addictiveness[207] helped to alter public perceptions and make politicians more willing to consider regulating tobacco sales.[208]

In addition, the mere possibility of civil liability can induce industries to compromise and accept some form of public health regulation. For example, it is unlikely that the Federal Cigarette Labeling and Advertising Act of 1965[209] would have been enacted had the industry not feared regulation by the FTC as well as private lawsuits.[210] Likewise, the fear of massive liability in class action claims and state reimbursement suits led the industry in 1997 to accept more stringent regulations than it had previously contemplated, but only in return for significant limitations on the industry's civil liability.[211] When those limitations were removed from the proposal before Congress, the industry "withdrew" from the settlement, pulling its political weight with it.[212] Thus, only the threat of civil liability, and the inducement of immunity from it, made new federal tobacco regulation politically plausible.

In short, affirmative public health litigation is not necessarily antithetical to the democratic enactment of public health policies. At least in some situations, such litigation does not displace democratic decisionmaking. Rather, it serves as a participant in that process.

B. Litigation and the Role of Public Health Professionals

The classic model of public health litigation grants a special role to public health authorities. Historically, this is appropriate because the development of such agencies played a vital role in the dramatic improvements of public health that occurred within the last 150 years.[213] Clearly, common law actions alone were not able to

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206. *See id.* at 931.

207. *See* GLANTZ ET AL., *supra* note 83, at 58-107 (discussing the tobacco industry's knowledge of nicotine's effects).

208. *See* Mather, *supra* note 84, at 923-24, 930 (noting an increase in negative public opinion toward tobacco and a trend among politicians to distance themselves from the support of the tobacco industry).

209. 15 U.S.C. §§ 1331-1541 (1994).

210. *See* Kelder & Daynard, *supra* note 1, at 67 (reviewing the multiple influences on the "regulation of cigarette advertising").

211. *See* John M. Broder, *Major Concessions: Industry Would Pay for the Costs of Treating Smoking Diseases*, N.Y. TIMES, June 21, 1997, at 1 (reviewing the tobacco litigation settlement agreement and the compromises involved).

212. *See* David E. Rosenbaum, *Tobacco Strategy: When No Means Yes, and Vice Versa*, N.Y. TIMES, Apr. 19, 1998, at § 4 pg. 5.

213. *See* Parmet, *Slaughter-House*, *supra* note 18, at 489 (recalling the

remove contaminated meat, vaccinate children, or ensure a clean water supply. Moreover, today even more than in earlier eras, public health cases have the potential to raise complex epidemiological and biomedical issues, which courts and laypersons are seldom equipped to understand.[214] It makes sense in these cases to grant a primary role to public health authorities.[215]

To some degree the growth of affirmative public health litigation may be seen as a threat to the institutions of public health. In affirmative litigation, lay individuals and their advocates go to court and ask nonexpert judges and juries to issue judgments that will influence and create public health policy.[216] By so doing, these litigants may effectively deprive public health officials of control over the public health agenda as well as the particulars of public health policy.

Sometimes this lay policymaking may be harmful to public health. Critics of litigation aimed at the pharmaceutical industry, for example, have argued that courts have rendered scientifically questionable judgments that have made manufacturers reluctant to market potentially health-saving medications and vaccines.[217] More generally, critics have questioned the ability of courts to accurately assess complex scientific information, particularly the epidemiological analysis at the heart of so many toxic tort cases.[218] If judges and jurors are poor scientists, the argument may go, should not public health policy be left to public health agencies in which those trained and competent in scientific issues are employed?

Although a thorough discussion of the ability of courts to "do science" is beyond the scope of this Article, a review of the

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"blossoming" of the "public health movement").

214. *See, e.g.*, Barry Sullivan, *When the Environment Is Other People: An Essay on Science, Culture, and the Authoritative Allocation of Values*, 69 NOTRE DAME L. REV. 597, 602-03 (1994) (discussing circumstances in which judges must determine a degree of risk without any true scientific knowledge).

215. *See, e.g.*, Bragdon v. Abbott, 524 U.S. 624, 624 (1998) (noting the lower court's reliance upon public health authorities like the CDC and ADA).

216. *See, e.g.*, *id.* at 631 (indicating the Court's creation of public health policy by holding that HIV is a disability under the ADA).

217. *See* Huber & Litan, *supra* note 15, at 7 (discussing manufacturers' concerns over liability).

218. Criticism of judicial competence to assess issues of science is widespread. *See generally* MARCIA ANGELL, SCIENCE ON TRIAL: THE CLASH OF MEDICAL EVIDENCE AND THE LAW IN THE BREAST IMPLANT CASE 111-32 (1996); PETER W. HUBER, GALILEO'S REVENGE: JUNK SCIENCE IN THE COURTROOM (1991). For a somewhat different assessment, see Helene L. Kaplan, *Judicial Decision Making: Creating Opportunities and Meeting Challenges*, *in* SCIENCE, TECHNOLOGY, AND GOVERNMENT FOR A CHANGING WORLD 167, 168-69 (Carnegie Commission ed., 1993) (detailing efforts to increase the court system's ability to evaluate scientific issues).

tobacco and HIV cases suggests that affirmative public health litigation is not necessarily corrosive of strong public health authorities. First, while complex questions of science may play a major role in such cases, that has been rare. More often than not, the science is relatively clear. With respect to tobacco, for example, there is really little doubt about the negative health effects of cigarettes.[219] Courts in tobacco cases are seldom required to evaluate complex and subtle scientific issues.[220] Rather, the real questions before them are the social, political, and moral questions of responsibility, for which scientific training provides no special insight.[221] Likewise, in most of the HIV cases, the scientific questions were again relatively simple. Early on, for example, the evidence was quite clear that HIV was not casually transmitted and could not be easily spread in a classroom.[222] Again, in these cases the fundamental issues were the policy questions: What degree of risk should be borne and what policies regarding infected individuals accord with our moral edicts and maximized total public health?[223]

Moreover, private litigation has not undermined the centrality of public health authority because when scientific issues became prominent (and even when they did not), courts have relied heavily upon the opinions and support of public health officials. This reliance is especially obvious in the case of HIV.[224] Indeed, the early years of the epidemic saw a close collaboration between AIDS advocates and public health officials who recognized that nondiscrimination was vital to their efforts to stem the epidemic's spread.[225] Often this collaboration took place outside of the courtroom, as advocates worked with public health experts in drafting legislation and testifying before legislative bodies.[226] At times, however, the collaboration extended to the courtroom. For example, medical and public health experts served as named plaintiffs in an action brought by

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219. *See* Rabin, *supra* note 42, at 877 (discussing the wide reporting of smoking-related health risks).

220. *See id.*

221. *See id.* at 860, 876-78 (discussing several of the nonscientific issues courts face).

222. Refer to note 104 *supra* and accompanying text.

223. *See* Sullivan, *supra* note 214, at 597 (discussing efforts by courts to deal with the complex problems associated with AIDS).

224. *See, e.g.*, Bragdon v. Abbott, 524 U.S. 624, 624 (1998). For a further discussion of this point, see Wendy E. Parmet, *The Supreme Court Confronts HIV: Reflections on* Bragdon v. Abbott, 26 J.L. MED. & ETHICS 225, 231-32 (1998) (listing several amicus briefs filed by health associations and professionals).

225. *See* Telephone Interview with Coles, *supra* note 27.

226. *See id.*

the ACLU to oppose a California ballot initiative that would have imposed named HIV reporting.[227]

The alliance between HIV advocates and public health experts was also evident in *Bragdon v. Abbott.*[228] A large number of private public health agencies filed briefs in the case endorsing the plaintiff's position.[229] Moreover, although the federal government was not a party to the case, it too participated as an amicus, presenting the Centers for Disease Control's position that individuals with HIV may be safely treated in a dental office.[230] These representations were clearly important to both the Supreme Court[231] and the Court of Appeals.[232] In fact, the Supreme Court reaffirmed the individual plaintiff's position that courts are to give deference to the opinions of public health agencies in determining what constitutes a direct threat to the health and safety of others.[233] Thus, not only was the plaintiff supported by public health agencies, but her litigation served to reinforce their authority.

The opinions of public health agencies have also been important in the tobacco litigation. Indeed, the entire second wave of tobacco litigation was prompted, in part, by the release of the 1964 Report to the Surgeon General.[234] That Report changed the legal landscape and made it far easier for litigants to convince courts that smoking was in fact hazardous to one's health.[235]

Affirmative public health litigation may support public health authorities in other, less evident ways. As the Institute of Medicine has reported, public health agencies in this country are underfunded, overworked, and often struggling to gain political support for their agendas.[236] Often that agenda is consistent with the goals of private litigants.[237] To the extent that litigation helps

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227. *See id.*

228. *See generally Bragdon*, 524 U.S. 624.

229. Refer to note 123 *supra* (naming several amicus breifs filed).

230. Brief of Amicus Curiae of the United States, Bragdon v. Abbott, 524 U.S. 624 (1998) (No. 97-156).

231. *See Bragdon*, 524 U.S. at 650.

232. *See* Abbott v. Bragdon, 163 F.3d 87, 89-90 (1st Cir. 1998) (citing the opinions of several health agencies).

233. *See Bragdon*, 524 U.S. at 650.

234. Refer to notes 55-60 *supra* and accompanying text.

235. Refer to notes 55-60 *supra* and accompanying text.

236. *See* COMMITTEE FOR THE STUDY OF THE FUTURE OF PUBLIC HEALTH, THE FUTURE OF PUBLIC HEALTH (1988) (discussing the problems facing public health care agencies); Gostin et al., *The Law and the Public's Health*, *supra* note 140, at 95 (calling public health "inadequate" and under-funded).

237. Of course, this need not always be the case. Indeed, even when affirmative

put public health issues into the limelight and prompts the enactment of legislation,[238] it can advance the goals of public health authorities. Thus, to some degree, the affirmative tobacco litigation has been able to achieve some of the restrictions on tobacco advertising that the Food and Drug Administration had hoped to achieve by regulation, but has thus far been unable to institute (due to the court's finding of restrictions on the agency's jurisdiction).[239] At other times, affirmative public health litigation may help agencies enforce their regulations. Public health officials seldom have the resources to enforce fully all of their regulations.[240] Sometimes they must rely on private litigation to help them with that job.[241]

Litigation may also serve the interests of public health authorities directly by adding voice to the educational messages that are at the heart of so many public health efforts. In the cases of both tobacco and HIV, public educational efforts are critical to achieving public health goals.[242] By providing publicity about public health threats and sending clear messages about appropriate norms of behavior, litigation can complement the efforts of public health officials to inform the public of how they can and cannot protect themselves from public health threats.[243]

More fundamentally, the perception that litigation threatens public health authorities relies on a far-too static conception of

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litigation is brought by the state, public health agency goals may not always be fully accepted by the state's attorneys. For example, many in the public health community have criticized the multi-state tobacco settlement, believing that the attorneys general were too quick to accept industry funds rather than significant changes in the marketing and sale of tobacco products. *See* Barry Meier, ***Remaining States Approve the Pact on Tobacco Suits***, N.Y. TIMES, Nov. 21, 1998, at A1.

238. Refer to notes 197-205 *supra* and accompanying text.

239. *See* Brown & Williamson Tobacco Corp. v. FDA, 153 F.3d 155, 176 (4th Cir. 1998) (finding that "Congress did not intend to delegate jurisdiction over tobacco products to the FDA"), *cert. granted*, 119 S. Ct. 1495 (1999).

240. Refer to note 236 *supra* and accompanying text (discussing the problems public health agencies face).

241. This is not to say that litigation invariably or even often leads to the outcomes that public health authorities would desire. Individual litigants have their own personal goals and motivations in bringing lawsuits. The remedies they seek and the settlements to which they may agree may well weigh these more personal goals more heavily than public health goals. Moreover, even when litigants and their lawyers advocate for public health positions, their lack of expertise may show and the solutions they may advocate may not be identical to the ones that public health officials would seek.

242. Refer to note 40 *supra* and accompanying text.

243. Of course, this can be risky. Every litigation includes two sides, and opponents of the public health position may also use the litigation to try and get their story across. And if they prevail in the courtroom, they can then make claims such as "the jury does not find that smoking causes cancer," or "discrimination against workers with HIV is permissible."

public health and the mission of public health authorities. What constitutes the public health is not simply a question of science. It is "inherently political."[244] As a result, public health officials cannot simply be scientists, they must also be political actors.[245] Thus, by mobilizing constituents, influencing the agenda, and changing the distribution of political chips, litigation plays a role in the political process that is not apart or different from the task of public health officials.[246] Rather, it is part and parcel of the environment in which such officials must operate if they are to achieve meaningful advances in public health.[247]

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244. *See* Gostin et al., *The Law and the Public's Health*, *supra* note 140, at 68 (explaining that public health is political because it is "concerned with the allocation of resources in society").

245. *See id.* at 64 (discussing how public health is "rooted in the biomedical and social sciences," but that by taking a collective responsibility for the health of the community, public health "entails judgment that challenges deeply ingrained social attitudes and practices"). The recent controversy surrounding the confirmation of the Surgeon General demonstrates how highly politicized public health may be. *See* Sheryl Gay Stolberg, *After 3-Year Void, Surgeon General's Post Is Filled*, N.Y. TIMES, Feb. 14, 1998, at A7 (noting that the Surgeon General's job is highly politicized because it deals with hot issues like teenage sexuality and the distribution of clean needles for drug addicts).

246. Refer to text accompanying notes 209-12 *supra* (describing how the tobacco industry withdrew its political support from legislation after Congress removed limitations on its civil liability).

247. The history of HIV shows how important it is for public health officials to appreciate the politics of health and to work with affected communities. *See* RONALD BAYER, PRIVATE ACTS, PUBLIC CONSEQUENCES 232-44 (1989) (explaining how earlier reactions to the HIV epidemic were unsuccessful because they were based upon conventional methods of dealing with dangerous diseases, and explaining that public health officials must instead be proactive in a way that is responsive to the needs of the community as a political unit). Early in the epidemic, public health officials came to appreciate that HIV could not be stopped by any simple top-down command and control approach to public health regulation. *See id.* at 237-40. Rather, officials had to negotiate, ally, and work with communities at risk. *See id.* at 242. Some critics have suggested that this approach marks a departure from the more scientific, authoritarian approaches that public health officials have typically used in prior epidemics. *See* Bayer, *supra* note 110, at 1500 (discussing how compulsory examinations and screening, reporting of names to public health registries, and quarantine of those infected with dangerous diseases have been traditionally accepted and warranted methods of dealing with public health threats). That is questionable. Public health is invariably political and public health officials have always had to negotiate political waters. *See* Gostin et al., *The Law and the Public's Health*, *supra* note 140, at 68 (explaining that public health is political because it is concerned with the allocation of resources). What was different about HIV is that officials realized that they had to work with communities representing individuals at risk, not simply interests that would be financially harmed by public health protections. Refer to text accompanying notes 104-08 *supra* (discussing how public health authorities began working collaboratively with HIV plaintiffs once authorities realized that discrimination against individuals infected with HIV was "detrimental to efforts to stem the epidemic's tide" and that it would be more beneficial, for purposes of public health, to support plaintiffs in advancing their claims).

C. Public Health and Legal Rights

In the traditional model of public health litigation, individual rights are viewed as being in conflict with public health goals. For example, in the case of *Jacobson v. Massachusetts*[248] the individual's claim of liberty stood in conflict with the State's desire to stem a smallpox epidemic.[249] In such a case, it is a court's job to determine whose right should prevail—the individual's or the public's.

In the tobacco and HIV cases, the clear juxtaposition of individual and public rights has vanished. First, as discussed above, the individual plaintiffs in these cases are not necessarily opposing state action.[250] Often, the plaintiff is either seeking state action or is advancing a position consistent with state action.[251] Hence, the litigation does not conform to the classical case in which one party represents the state and the other party opposes its action.

Second, and more importantly, to the extent affirmative public health litigation influences the political debate, it also helps construct the perception and recognition of what constitutes the public interest.[252] In a world in which the risks to health and safety are untold, litigation is but one means by which we come to decide which of those risks are matters of public health and public concern.[253] In this sense, litigation is not antithetical to the public interest because it helps to form that interest.

Supporters of public health may still worry that litigation and legal rights, with their inherently individualist bias, will be corrosive to the promotion of public health.[254] After all, public

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248. 197 U.S. 11 (1905).

249. *See id.* at 26-28 (holding that Massachusetts's interest in preventing a smallpox epidemic by requiring mandatory vaccination outweighed the defendant's liberty right to care for his own body and health).

250. Refer to text accompanying notes 137-39 *supra* (explaining that in HIV and tobacco cases, plaintiffs often advance the interests of the state by advocating the interests of people who are at risk for a major health threat).

251. Refer to text accompanying notes 139-40 *supra* (noting that plaintiffs often use litigation to effect law reform and that in doing so, plaintiffs do not attempt to limit state action, but rather foster advancement of policies to "protect the interests of those at risk for public health threats").

252. *See* Mather, *supra* note 84, at 912-13 (explaining that litigation, through the media, increases public awareness and helps create a new public forum that in turn increases public discussion of political issues).

253. Refer to text accompanying notes 202-08 *supra* (listing lobbying and civil disobedience as alternative means by which we may determine public health policy).

254. The literature criticizing legal rights and litigation for their individualistic bias is voluminous. *See, e.g.*, AMITAI ETZIONI, THE SPIRIT OF THE COMMUNITY: RIGHT, RESPONSIBILITIES AND THE COMMUNITARIAN AGENDA 163-65 (1993) (suggesting that extreme emphasis on individualism pervades American society and that it creates suspicion of governmental action that inevitably frustrates

health focuses upon populations and the social conditions necessary for a healthy population.[255] Litigation, a critic may suggest, can undermine that perspective by accentuating the individualistic aspects of ill health and framing the causes of morbidity in an adversarial posture.

Such criticism cannot be readily dismissed. In many ways our legal system has accentuated individualistic concerns over the public or social aspects of health.[256] Additionally, our public law, at least our constitutional law, has not been receptive to the type of positive right claims that are inherent in the notion of a legal right to public health.[257] Individuals who bring actions against the government, demanding it to respond to a public health threat or to promote a healthy environment, are likely to see their claims dismissed on one of a variety of jurisdictional doctrines that emphasize the individualistic nature of public claims.[258] Even when those claims survive the jurisdictional stage, they are apt to be rejected on the grounds that the Constitution limits government but does not require it to act.[259] Public law, it would seem, has little room for rights to public health.

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government actions aimed at meeting social needs); MARY ANN GLENDON, RIGHTS TALK: THE IMPOVERISHMENT OF POLITICAL DISCOURSE x-xi (1991) (emphasizing that by regarding individual rights as superior to the rights of others, individualism impairs compromise and advancement of civic obligations and "core democratic values"); Thomas D. Barton, *Reclaiming Law Talk*, 81 CAL. L. REV. 803, 806 (1993) (noting that individualism draws attention away from solutions for the well being of the entire community by focusing on individual rights); Mark Tushnet, *The Critique of Rights,* 47 SMU L. REV. 23, 25-26 (1993) (explaining that by focusing on individual rights and individual victories in court, the community is sometimes led to believe that there has been a complete victory when in reality a victory in court is more ideological and can impede real change).

255. *See* Levy, *Twenty-First Century, supra* note 8, at 1150 (noting that the advancement of public health is dependent on public awareness and participation).

256. For a discussion of the law's focus on individualism and autonomy as they relate to matters of health, see Parmet, *Legal Rights, supra* note 3, at 757-62.

257. *See* Wendy E. Parmet, *Health Care and the Constitution: Public Health and the Role of the State in the Framing Era,* 20 HASTINGS CONST. L.Q. 267, 272-78 (1993) (explaining that the Constitution hinders the advancement of public health by limiting the government's intrusion upon individual liberty on one side and not imposing affirmative obligations on governments to provide public health protection on the other).

258. *See, e.g.*, Lujan v. Defenders of Wildlife, 504 U.S. 555, 561-63 (1992) (involving an action by private individuals against the government for increasing the potential extinction of endangered species in which the court explained that although the interest of the plaintiffs was a valid interest, the parties did not have standing because they were not able to show they were "'*directly*' *affected* apart from their 'special interest' in the subject" (emphasis added)).

259. *See* DeShaney v. Winnebago County Dep't of Soc. Serv., 489 U.S. 189, 195 (1989) (stating that nothing in the Constitution imposes an affirmative duty on states to protect those interests from harm through other means).

Moreover, through much of history, litigation has served to challenge the authority of public health agencies.[260] Recognized individual rights have often been framed as being in opposition to the interests of public health.[261] Many commentators have seen the legal issues surrounding HIV in such a light. Ronald Bayer, for example, has noted that concern for the "rights" of HIV patients initially precluded public health agencies from engaging in traditional, coercive measures designed to protect the public health.[262] Likewise, questions pertaining to HIV testing, confidentiality, or discrimination can all easily be framed as placing individual rights against the rights of the common good. As one commentator has suggested, a focus on rights overlooks "the more important analysis of whether a policy is effective."[263] This focus may also allow "policy-makers to ignore community and government denial of responsibility" for those who are ill.[264] From this perspective, litigation geared toward recognizing individual rights related to public health might well be thought of as potentially threatening to the promotion of public health.

These are difficult criticisms to answer and anyone concerned about the "public" in "public health" must wonder whether litigation may be more harmful than helpful to the public health goal of increasing the health of the community. Certainly, at times litigation has been counter-productive, and there is no reason to assume that it cannot be again.[265] However,

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260. Refer to text accompanying notes 19-23 *supra* (noting that often, litigation stems from an individual challenging a statute or regulation that was enacted to protect the public health by asserting that such legislation infringes on an individual right).

261. *See* Parmet, *Legal Rights*, *supra* note 3, at 741 (noting that now efforts are placed on balancing the rights of individuals against the rights of the public to avoid the continuing conflict within this set of rights).

262. *See* Bayer, *supra* note 110, at 1500-01 (explaining that when HIV and AIDS became an issue, the initial trend was not to treat the epidemic with conventional methods such as isolation and quarantine). Professor Bayer has more recently argued that the concern for rights has dwindled as medical interventions have become more effective. *See* Ronald Bayer, *Clinical Progress and the Future of HIV Exceptionalism*, 159 ARCHIVES INTERNAL MED. 1042, 1042-43 (1999). For a refutation of Bayer's initial theory, see Scott Burris, *Public Health, "AIDS Exceptionalism" and the Law*, 27 J. MARSHALL L. REV. 251, 252 (1994) (criticizing Bayer's article on the exceptionalism of AIDS and arguing that the political disputes associated with AIDS were no different than those inspired by all other major health measures).

263. *See* Jennifer Sinton, *Rights Discourse and Mandatory HIV Testing of Pregnant Women and Newborns*, 6 J.L. & POL'Y 187, 231 (1997) (explaining that our society concentrates on conferring rights on individuals, but that in doing so, society has overlooked the more important task of deciding whether or not a health policy is effective).

264. *See id.*

265. Refer to note 254 *supra* (explaining that litigation can often be corrosive to

the notion that litigation necessarily threatens the advancement of public health stems from the classical model of public health litigation in which the individual seeks to limit the authority of a public health agency.[266] But as we have seen in both tobacco and HIV cases, much recent litigation has taken a different form. In most cases, the individual concerned about a health threat is promoting a position similar, rather than contradictory, to the policies of a public health authority.[267] In such a case, recognition of the plaintiff's rights may serve to foster rather than hinder public health policies.

Affirmative public health litigation may also promote public health in more subtle ways. By stressing the rights of individuals who are ill against the interests of other parties who would forsake those needs, affirmative public health litigation may highlight interdependence and the social context in which ill health arises.[268] One of the chief insights of public health is the large role that social factors play in the prevalence of disease.[269] While medicine focuses on individual "risk factors," public health forces us to think about the social conditions that promote those factors.[270] Affirmative public health litigation has the capacity to highlight those conditions and demonstrate that an individual's

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the advancement of public health because it places an emphasis on individual rights and often overlooks the needs of the community as a whole). *See also* ROSENBERG, *supra* note 197, at 339-41 (suggesting that courts do not produce significant social reform and that by "luring" activists of social reform into litigation, precious resources are lost along with the funding for other better strategic options for bringing about reform).

266. Refer to text accompanying notes 18-25 *supra* (discussing the classical model of public health litigation and explaining that under this model, plaintiffs are usually challenging a health policy and are asking courts to change or review the policy, claiming their individual rights are being infringed).

267. Refer to text accompanying notes 252-64 *supra* (discussing how litigation often advances the interests of public health authorities by raising awareness of the issues, educating the public through its publicity, advancing agendas that an underfunded agency could not, and helping public health officials enforce regulations).

268. Refer to note 78 *supra* and accompanying text (illustrating how litigation in the tobacco context was able to demonstrate that smoking is an addiction that begins in childhood and is therefore a matter of public concern and not one of individual choice).

269. *See* Levy, *Twenty-First Century*, *supra* note 8, at 1158 (explaining that almost all public health problems are partially caused by social and cultural factors); Mann, *supra* note 160, at 19 (1997).

270. This is especially true to the extent that an "ecological" perspective to public health is adopted. *See* Gostin et al., *The Law and the Public's Health*, *supra* note 140, at 74-77 (noting that often the health measures are determined by taking into account social conditions that may lead to unhealthy behavior or hazards such as smoking).

illness is neither the individual's fault nor sole responsibility but rather a social, public problem.[271]

Tobacco litigation powerfully illustrates how litigation can attempt to foster a public health perspective and also how the individualism central to our legal system can defeat that perspective. At the core of most tobacco tort cases is a plaintiff claiming that he or she should not be solely responsible for the illnesses that have resulted from smoking.[272] Rather than seeing smoking as a question of individual choice, the plaintiff is asking the court to recognize the way in which the existence and marketing of a product endangers health.[273] In essence, the plaintiff's plea is the public health cry that individual health is not entirely an individual matter.[274]

In the initial waves of tobacco cases, plaintiffs had a great deal of difficulty convincing juries that they alone should not bear the consequences of smoking.[275] In the third wave of tobacco litigation, however, litigants have learned to structure their cases so that the focus is shifted from the plaintiff's action to the defendants', leading to a recognition that tobacco-related illness is not purely a private matter.[276] When plaintiffs prevail, the "right" they win is not an individual trump against the individual

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271. *See* Mather, *supra* note 84, at 908 (explaining that by disseminating information, litigation can help redefine issues and shift blame and responsibility from smokers to the tobacco industry).

272. *See* Cupp, *supra* note 77, at 471, 473 (noting that during the third wave of tobacco litigation, in an effort to shift blame, plaintiffs focused on the misrepresentation of the tobacco industry and its knowledge of tobacco's addictiveness).

273. *See id.*

274. Litigation's recognition of social responsibility does not negate recognition of individual responsibility. Thus, tobacco plaintiffs' claim for compensation may be appropriately offset in part for their individual negligence. *See id.* at 499 (explaining that many jurisdictions follow a form of comparative fault). Likewise, a position advocating nondiscrimination for HIV infected individuals does not preclude recognition that individuals who consciously or recklessly infect others should likewise be held accountable. *See* Lori A. David, *The Legal Ramifications in Criminal Law of Knowingly Transmitting AIDS*, 19 LAW & PSYCHOL. REV. 259, 259 (1995) (noting that individuals who knowingly expose others to HIV may face charges for attempted murder and assault). Indeed, the essence of a true public health vision may be that although individuals have a right to public health, no rights can be absolute against the public good.

275. *See* Cupp, *supra* note 77, at 467 (noting that in earlier cases of tobacco litigation, juries would rarely find in favor of plaintiffs due to the plaintiffs' presumed knowledge that smoking may be harmful).

276. *See id.* at 465 (discussing how defendants in earlier tobacco cases were often found not liable due to plaintiffs' knowledge that smoking is harmful, but that now, litigation focuses more on the actions of the tobacco industry and "new evidence regarding addiction and industry fraud").

rights of others, but rather a recognition of society's partial responsibility for disease.[277]

The public stake in health is presented even more starkly in state reimbursement cases. In these cases, states' attorneys general put forward claims to recoup the medical costs expended by the states due to tobacco-related illnesses.[278] The theory behind these cases is that smoking is not a matter of individual choice because it affects the public as a whole.[279] That theory appears to have helped shape the public perception of the issue. As Professor Mather has written:

> The litigation provided a new definition of tobacco liability issues by creating new analogies and new ways of thinking about responsibility for smoking. The problem was no longer a private problem of individual assumption of risk but was arguably a public problem of collective health and health care costs.[280]

In many ways the HIV cases are similar. Ryan White's case can be portrayed as a case in which an individual attempted to exercise a right against the interests of the community.[281] But equally accurate would be a description of the case as one in which an individual with a disease attempted to force the community to recognize that his illness is neither a private matter nor a reason to exclude him from the community.[282] The right White claimed, therefore, was not a right in conflict with the rights of the public, but a right to be a part of the public.[283] In essence, his case demonstrated that we cannot solve the problem of HIV by casting aside those who are infected.[284] They

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277. Even if we describe the plaintiffs' claim as one for a right against society, it should be remembered that this need not be corrosive of public health. The work of Mann and others shows us that individual rights, even when they are seen as negative limitations upon the government, may indeed serve to foster public health. *See* Mann, *supra* note 160, at 9-11.

278. *See* Jacobson & Warner, *supra* note 161, at 776-77.

279. *See id.*

280. Mather, *supra* note 84, at 934.

281. *See* White v. Western Sch. Corp., 1985 U.S. Dist. LEXIS 16540, at *1 (S.D. Ind. Aug. 23, 1985); Parmet & Jackson, *supra* note 88, at 10-11 (discussing how Ryan White was denied the right to go to school because of fears that he might infect other children).

282. *See* Parmet & Jackson, *supra* note 88, at 10-11 (explaining how cases like Ryan White's pointed out that discrimination against HIV individuals is not a private matter because it may create a barrier for public health strategies aimed at deterring the spread of AIDS).

283. *See id.*

284. *See id.* (noting that by discriminating against individuals infected with HIV, individuals can be deterred from being tested and counseled thereby threatening the health of the community as a whole).

are a part of the public and the public health requires their inclusion.[285]

Seen from this perspective, affirmative public health litigation uses the tools and forums of private civil litigation to foster an environment receptive to positive public rights. When cases are brought by those who are ill or who have suffered the effects of illness-causing conditions, their claims are claims for inclusion, recognition, social responsibility, and amelioration of the conditions that harmed them.[286] In essence, they are claims for positive, public rights.

Of course, these claims are not always successful. Indeed, the tobacco cases show just how strong the individualistic perspective is in our legal culture. Even when the law itself permits such claims, jurors often have trouble looking beyond individual choices and accepting that individuals should not be solely responsible for their own fates.[287] Likewise, HIV litigation may help to prevent an epidemic by protecting the rights of these infected against discrimination, but litigation does not ensure a right to prevention.[288] Moreover, although individual rights in this context generally promote public health, that need not always be the case. Clearly, recognizing the right of an HIV positive person to serve as a blood donor would harm the public health.

Still, the fact that individualistic perspectives may be dominant in some affirmative public health cases[289] does not

285. Of course, if Ryan White's inclusion in school had significantly threatened the health of other children, then the recognition of his right might well have jeopardized the public health. The argument here is not that plaintiffs are always correct, nor that all affirmative public health cases promote appreciation for public health. This Article merely suggests that sometimes such cases can promote the public health—depending upon their nature, rights can either limit or strengthen the public good.

286. *See White*, 1985 U.S. Dist LEXIS 16540, at *1 (addressing White's suit to defend his right to attend public school and his right to not be excluded from society because he was infected with HIV); Jacobson & Warner, *supra* note 161, at 776-77, 780 (explaining that the third wave of tobacco litigation is an attempt to have society recognize that much of the blame for tobacco-related illnesses rests on the tobacco industry and discussing how Attorneys General are getting involved in the tobacco litigation to recoup the costs the states have incurred due to tobacco and to ameliorate the problem of addiction by subjecting the tobacco industry to tougher regulations).

287. *See* Rabin, *supra* note 42, at 871 (discussing juries' negative reaction to claims brought by plaintiffs who were aware of the risks associated with smoking and juries' refusal to award damages even in cases when some fault was allocated to the defendants).

288. *See* Telephone Interview with Cathcart, *supra* note 95.

289. *See* Sinton, *supra* note 263, at 231 (explaining that emphasis on individualism can divert attention away from the more important task of analyzing whether or not a public health policy is effective).

mean that all such cases are destructive to the public health. In some instances, litigation may actually result in the recognition of a new public right or responsibility.[290] Moreover, even when litigation fails, it can help to articulate the social responsibility for health care that is at the root of public health. And by so framing the argument, and advancing the agenda, litigation can help keep the struggle for public health alive.

V. CONCLUSION

Professor Gerald Rosenberg compares courts to "fly-paper" that lures the hopes, talents, and resources of social reformers.[291] Litigation, he concludes after his exhaustive empirical analysis, often achieves reforms that are more illusory than real.[292] Rights can seldom "triumph" over politics.[293]

Those who are concerned about public health have reason to heed Professor Rosenberg's concern. The history of public health suggests that if rights play any role, that role has often been to limit the power of the community to protect the health of its members.[294] Rights to property,[295] contract,[296] freedom of speech,[297] and liberty[298] have more often disabled than invigorated actions

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290. Refer to notes 275-93 and accompanying text.

291. *See* ROSENBERG, *supra* note 197, at 341 (suggesting that litigation is not always the best route to take when social reform is sought due to courts' emphasis on legal issues rather than "substantive political battles" and due to the small impact of courts' decisions in the scheme of social reform).

292. *See id.*

293. *See id.*

294. *See* Parmet, *Legal Rights*, *supra* note 3, at 748-51 (noting that toward the end of the nineteenth century, the public's interest in health and the protection of individual rights were often in conflict, thus resulting in litigation by individuals challenging and curtailing the use of police power to regulate public health).

295. *See, e.g.*, Zahm v. Peare, 502 N.E.2d 490, 492, 495 (Ind. Ct. App. 1985) (renouncing plaintiff's claim that he should be allowed to install a sand filter system on his property even though the system contributed to the spread of contagious diseases and holding that the denial of the necessary permit did not amount to an unconstitutional taking).

296. *See, e.g.*, Lochner v. New York, 198 U.S. 45, 52, 58-59 (1905) (holding that a statute passed pursuant to New York's police power to limit the number of hours a baker could contract to work was unconstitutional because it was an unjustifiable interference with freedom of contract and the right to labor).

297. Shortly after they were first enacted, bans on tobacco advertising on television and radio were upheld. *See* Capital Broad. Co. v. Acting Attorney Gen., 405 U.S. 1000 (1972) (holding that a statute banning advertisement of cigarettes on electronic media was not a violation of plaintiff's First Amendment right). Recently, the constitutionality of advertising restrictions has been the subject of great debate. *See, e.g.*, Sylvia A. Law, *Addiction, Autonomy, and Advertising*, 77 IOWA L. REV. 909, 915 (1992) (finding restrictions constitutional); Martin H. Redish, *Tobacco Advertising and the First Amendment*, 81 IOWA L. REV. 589, 599 (1996) (same).

298. *See, e.g.*, North Carolina v. Anderson, 164 S.E.2d 48, 52 (1968) (holding

taken to advance the public health. Moreover, at least in public law, claims for public health protection have seldom been successful.[299]

There are other reasons for a public health advocate to be wary of the courtroom. Litigation requires resources that could perhaps be better spent on direct public health activities, such as community education or the provision of direct services. Litigation is also messy. It cannot be controlled by those knowledgeable about public health.[300] Bad science may prevail as often as good science. Litigation is adversarial;[301] it often adopts a perspective that may be inherently at odds with public health's emphasis on a common good.

Yet, although public health advocates would be wise to remember these warnings, the history of both tobacco and HIV litigation suggests that litigation may at times play a positive role in the advancement of a public health agenda. Rather than deflating political support for public health protection, litigation may put a human face on the importance of the interest, arousing public concern for issues that were previously not very salient.[302] Litigation may also help uncover information and documents that may change public perceptions and mobilize support for the regulation of hazardous goods.[303] In an era during which public health agencies, like much of the public sector, are underfunded and undersupported, litigation may help to enforce regulations and advance the agenda of those governmental agencies entrusted to protect our health. Finally, when claims are brought by those who have lost their health to threats that endanger us all, litigation's focus on rights need not be divisive or corrosive of public well-being. In such cases, the right requested is a right to inclusion and social responsibility—a right that

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that a state has the power to require motorcycle helmets to promote the safety and welfare of individuals traveling on streets and highways).

299. Refer to text accompanying notes 257-59 *supra* (explaining that individual claims for right to public health seldom succeed due to jurisdictional doctrines or because there is no affirmative duty on governments requiring them to provide certain services).

300. *See U.S. Needs Real Tobacco Policy*, ARIZONA REPUBLIC, July 14, 1999, *available in* 1999 WL 4185227 (noting that litigation is unpredictable).

301. *See* Paul J. Spiegelman, *Certifying Mediators: Using Selection Criteria to Include the Qualified—Lessons from the San Diego Experience*, 30 U.S.F.L. REV. 677, 678 (1996) (explaining that litigation is "adversarial, combative, and typically has winners and losers").

302. Refer to text accompanying note 204 *supra* (pointing out the importance of media attention spurred by litigation).

303. Refer to notes 82-84 *supra* and accompanying text (explaining how the use of discovery in tobacco litigation has led to an awareness of the industry's knowledge of tobacco's addictiveness, thus making it easier to enact legislation).

suggests that one's illness, be it lung cancer or AIDS, is not solely one's own concern.

Of course, this is not to say that litigation is a silver bullet. The state tobacco reimbursement cases have been settled, but children still smoke and smokers still die. The courts have proclaimed that individuals with HIV cannot be discriminated against, but stigma and discrimination continue, as does the epidemic.[304] Litigation alone cannot eradicate disease nor resolve the social conditions in which ill health is fostered. But litigation, at times, may play a useful role in the continuing political and social struggle for the protection of our common health.

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304. *See* Sonia Bhatnager, *HIV Name Reporting and Partner Notification in New York State*, 26 FORDHAM URB. L.J. 1457, 1477-78 (noting that discrimination against HIV-infected individuals is pervasive despite court holdings and regulations prohibiting discrimination).