Standards of Conduct, Multiple Defendants, and Full Recovery of Damages in Tort Liability for the Transmission of Human Immunodeficiency Virus

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NOTES

STANDARDS OF CONDUCT, MULTIPLE DEFENDANTS, AND FULL RECOVERY OF DAMAGES IN TORT LIABILITY FOR THE TRANSMISSION OF HUMAN IMMUNODEFICIENCY VIRUS

I. INTRODUCTION

Despite the fact that Acquired Immune Deficiency Syndrome (AIDS) was only first identified in the early 1980s, 90,000 cases have already been reported in the United States, with at least an additional 50,000 cases documented in 114 other countries. Predictions were that AIDS would be limited to homosexual men. 

1. See New York State Dep't of Health, Acquired Immunodeficiency Syndrome: 100 Questions and Answers 7 (1987) [hereinafter 100 Questions] (reporting that the disease was first identified in the United States in 1981). Five cases of Pneumocystis carinii pneumonia were found among sexually active homosexual men and reported by the Centers for Disease Control (CDC) on June 5, 1981. Imperato, Acquired Immunodeficiency Syndrome—1987, 87 N.Y. St. J. Med. 251, 251 (1987). These cases were linked to a cellular-immune dysfunction which enhanced the chances of opportunistic infection. Id. Subsequently, the disease "was found among other 'at risk' groups, including intravenous (IV) drug users, recent Haitian immigrants, hemophiliacs, sexual partners of those who had the disease, recipients of blood transfusions, and infants of mothers with the disease or at risk for it." Id. By late 1982, the CDC had "promulgated a surveillance definition for AIDS. The epidemic was underway." Id. (footnote omitted).

2. See AIDS Still Increasing in U.S., But Rate Slows, N.Y. Times, Apr. 15, 1989, at A28, col. 1 [hereinafter AIDS Still Increasing] (reporting 90,990 cases of AIDS in the United States); see also Bureau of Census, U.S. Dep't of Commerce, Statistical Abstract of the United States 113 (109 ed. 1989) (indicating that as of September 1988, there were 73,394 cases of AIDS in the United States and of this amount, 66,951 were male and 6,442 were female); AIDS and Human Immunodeficiency Virus Infection in the United States: 1988 Update, 38 Morbidity and Mortality Weekly Rep. 2, 3 (Mar. 12, 1989) (No. s-4) [hereinafter 1988 Update] (indicating that as of December 31, 1988, there were 82,764 cases of AIDS in the United States which were reported to the CDC); cf. Swenson, Plagues, History, and AIDS, The American Scholar, Spring 1988, at 183, 183 (indicating that as of September 1987 there were 40,000 cases of AIDS in the United States and 50,000 cases in other countries).
itions about the future growth rate of AIDS infection vary, with the Centers for Disease Control in Atlanta predicting 270,000 cases in the United States by 1991 and other commentators suggesting as many as 500,000 cases by 1991. In fact, as many as 1.5 million Americans may be infected with human immunodeficiency virus (HIV), the virus that can ultimately lead to AIDS. AIDS is usually fatal—fifty-eight percent of those diagnosed with the disease have already died. The death rate increases to seventy percent, for victims diagnosed two years ago or more. Individuals presently diagnosed with AIDS include homosexual, heterosexual, and bisexual men; women; and children. Given the pervasive effect of AIDS, it is

countries). As of June 8, 1987, 33,500 men, 2,500 women, and 511 children had been diagnosed with AIDS in the United States. 100 QUESTIONS, supra note 1, at 7.


4. See W. Masters, V. Johnson & R. Kolodny, CRISIS: HETEROSEXUAL BEHAVIOR IN THE AGE OF AIDS 15 (1988) (predicting 500,000 American AIDS cases by the end of 1991, with more than 300,000 deaths); PRESIDENTIAL COMM’N ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC, REPORT OF THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC xvii (1988) [hereinafter PRESIDENTIAL COMM’N] (reporting that “[r]ecent estimates suggest that almost 500,000 Americans will have died or progressed to later stages of the disease by 1992.”); cf. Swenson, supra note 2, at 193 (citing estimates as high as 350,000 cases by 1991).

These estimates are staggering enough, but even more devastating figures have been projected: “By the year 2,000, unless astonishing progress is made in the development of a vaccine to prevent this infection, there will be a cumulative total of 5 million cases of AIDS in America alone. Worldwide there will be 25 million cases.” W. Masters, V. Johnson & R. Kolodny, supra, at 16.

5. See Presidential Comm’n, supra note 4, at xvii; Surgeon General’s Report, supra note 3, at 12; Quarterly Report of the Domestic Policy Council on the Prevalence and Rate of Spread of HIV and AIDS—United States, 260 J. A.M.A. 1845, 1851 (1988) (supporting the CDC estimate that 1.0 million to 1.5 million people are currently infected); see also infra notes 36-38 and accompanying text (explaining the progression of AIDS, including the implications of HIV).

6. See 1988 Update, supra note 2, at 3 (reporting that of the 82,764 known AIDS cases in the United States, more than 46,000 have been fatal, the equivalent of 56% and noting that 85% of those diagnosed before 1986 are reported to have died); 100 QUESTIONS, supra note 1, at 10 (citing a 58% death rate); AIDS Still Increasing, supra note 2, at A28, col. 1 (noting that 52,435 of the 90,990 known AIDS victims in the United States have died, the equivalent of 58%); cf. Surgeon General’s Report, supra note 3, at 12 (indicating that “[t]he number of persons known to have AIDS in the United States to date is over 25,000; of these, about half have died of the disease.”).

7. See 100 QUESTIONS, supra note 1, at 10; cf. Surgeon General’s Report, supra note 3, at 12 (concluding that those AIDS victims who have not yet died are expected to eventually die because there is no cure).

8. See Grady, Just How Does AIDS Spread?, TIME, Mar. 21, 1988, at 60 (noting that although anal sex among homosexual men and needle sharing by drug addicts still account for
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not surprising that the disease has been compared to the Black Death, the European epidemic of bubonic plague in the fourteenth century.8

The rapid spread and devastating effects of AIDS can be expected to have profound sociological impact in the United States,10 These effects will inevitably reach into many areas of judicial and legislative decision-making.11 The number of legal issues that will be affected by AIDS may be unlimited, but areas clearly implicated include: constitutional law,12 criminal law,13 educational opportuni-

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9. See Swenson, supra note 2, at 183.
10. See generally Swenson, supra note 2, at 183-200 (examining the AIDS crisis by reviewing previous epidemics and their sociological effects, analyzing the "sociological anatomy" of an epidemic and comparing the social responses to historical epidemics with responses to the AIDS crisis).

Part of this sociological effect is certain to be found in the tremendous economic costs of AIDS. In 1985, $630 million was spent in the United States on personal medical care costs for AIDS, and $3.9 billion was estimated to have been lost as a result of victims' decreased productivity. Imperato, supra note 1, at 253. It has also been estimated that by 1991, the personal medical care costs will rise to $8.5 billion, and productivity loss will rise to $55.6 billion. Id. Additionally, "[n]onpersonal costs for research, education, screening, and general support services are expected to rise from $542 million for 1986 to $2.3 billion in 1991." Id.


One example of the growth of legislative action centers on the increased funding for AIDS research. Congress first allocated funds to AIDS research in 1984. AIDS Research Gets the Grants, NEWSWEEK, Mar. 6, 1989, at 46. Since that time, federal spending has grown by 2,000%, from $61 million to $1.3 billion. Id. Additionally, $1.6 billion has been requested for 1990. Id.

Responses from state and local governments should also be anticipated. For example, New York Governor Mario Cuomo recently unveiled a five-year New York state plan to combat AIDS. See Lambert, Cuomo Sets AIDS Plan, Admitting It Falls Short, N.Y. Times, Feb. 16, 1989, at B1, col. 5. The plan contains 200 proposals including: drafting certain laws barring discrimination and providing for punitive damages, expanding drug treatment for addicts, approving 600 new hospital beds for AIDS patients, and providing additional funding for "preventive education, training for AIDS workers and epidemiological studies." Id. at B10, col. 6; see also Fontana, The Ramifications of the AIDS Crisis for Local Governments, 23 TORT & INS. L.J. 195 (1988) (discussing various issues local governments must face in dealing with the AIDS crisis).

ties,\textsuperscript{14} employment discrimination,\textsuperscript{15} medical malpractice,\textsuperscript{16} and tort liability for the transmission of HIV.\textsuperscript{17} The final category is particu-


17. \textit{See generally} Baruch, AIDS in the Courts: Tort Liability for the Sexual Transmission of Acquired Immune Deficiency Syndrome, 22 \textit{Tort \& Ins. L.J.} 165 (1987); Corboy,
larly expansive; commentators have already suggested potential
causes of action, including battery,¹⁸ fraud and deceit,¹⁹ misrepresen-
tation,²⁰ and negligence.²¹


¹⁸. See Baruch, supra note 17, at 176 (arguing that where a defendant was “substantially certain that the spread of the disease would result from his conduct” and sexually transmitted AIDS, the elements of intent and offensive contact would both be fulfilled); Hermann, supra note 16, at 89-91 (comparing battery for AIDS transmission to cases involving other sexually transmitted diseases); Note, You Never Told Me, supra note 17, at 535-37 (noting that the defendant who knew he had AIDS would be liable for battery, but distinguishing the situation where the defendant was not aware of his infection, and therefore could not be held liable); Note, Tort Liability for AIDS?, supra note 17, at 987-88 (predicting that a case of intentional AIDS transmission is unlikely to occur, and concluding that “unless the court chooses to infer the AIDS carrier defendant’s intent from the sexual act and resulting injury, this action may prove difficult to sustain.”); Note, Interspousal Transmission, supra note 17, at 897 (arguing that battery can be used as a cause of action where the defendant is married to the plaintiff); cf. Comment, Clean Hands Doctrine, supra note 17, at 792-93 (discussing battery claims for herpes transmission).

¹⁹. See Note, Tort Liability for AIDS?, supra note 17, at 984-87 (discussing the elements of fraud and deceit, and noting that “similar causes of action have been sustained for the concealment of a contagious disease.”); Note, Interspousal Transmission, supra note 17, at 894 (discussing fraudulent transmission of AIDS between married parties). But see Baruch, supra note 17, at 178-79 (arguing that a deceit or fraudulent misrepresentation claim presented exclusively would be “too risky” because the plaintiff would have to prove each element “by a clear and convincing evidence standard, rather than the normal and less burdensome preponderance of the evidence standard.”).

²⁰. See Baruch, supra note 17, at 176-79 (comparing and analyzing claims for negligent misrepresentation and claims for fraudulent misrepresentation); Hermann, supra note 16, at 91 (indicating one advantage of misrepresentation would be the possible imposition of punitive damages, whereas simple negligence would not support such recovery); Comment, Clean Hands Doctrine, supra note 17, at 793-94 (explaining that the misrepresentation might come about in “the form of a false statement in response to direct inquiry [or] through intentional concealment of the fact that one is infected.”).

²¹. See generally Baruch, supra note 17, at 173-75; Hermann, supra note 15, at 89;
This Note focuses on the issue of potential negligence suits against defendants who were unaware of their infection at the time they sexually transmitted HIV. Causes of action for negligence have traditionally been recognized for other sexually transmitted diseases, including gonorrhea and herpes. The negligence suit for HIV transmission, while similar in general concepts, presents interesting and critical questions about the application of traditional tort law. These questions stem from several unique characteristics of the disease itself. The road from HIV infection to the development of AIDS has an unknown, but potentially lengthy, incubation period during which the infected party may not know that he or she has the disease, although the virus can still be transmitted to other persons. The incubation period presents problems in tracing the source of the infection, demonstrating the source's negligence, and proving that the victim was not participating in high risk conduct.

Three distinct questions about tort liability for HIV transmission can be isolated. First, what should be the acceptable standard of conduct for a person who is not aware that he or she has HIV, but

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Note, You Never Told Me, supra note 17, at 542-49; Note, Tort Liability for AIDS?, supra note 17, at 967; Note, Interspousal Transmission, supra note 17 at 902-08; Note, Negligence, supra note 17, at 928-41; Comment, AIDS Liability, supra note 16, at 691; Comment, Clean Hands Doctrine, supra note 17, at 794-95.

For a discussion of the elements of a negligence claim and their application to an AIDS transmission case, see infra notes 61-99 and accompanying text.

22. See, e.g., Duke v. Housen, 589 P.2d 334, 340 (Wyo.), cert. denied, 444 U.S. 863 (1979) (restating the general rule that "[o]ne who negligently exposes another to an infectious or contagious disease, which such other person thereby contracts, can be held liable in damages for his actions."). See generally Annotation, Tort Liability for Infliction of Venereal Disease, 40 A.L.R. 4TH 1089, 1094 (1985) (discussing the negligence cause of action for venereal disease transmission).

23. See, e.g., Berner v. Caldwell, 543 So. 2d 686, 689 (Ala. 1989) (holding that "one who knows, or should know, that he or she is infected with genital herpes is under a duty to either abstain from sexual contact with others or, at least, to warn others of the infection prior to having contact with them."); B.N. v. K.K., 312 Md. 135, 143, 538 A.2d 1175, 1179 (1988) (holding that the defendant, who knew about his infection, had a "duty either to refrain from sexual contact with [the plaintiff] or to warn her of his condition."); R.A.P. v. B.J.P., 428 N.W.2d 103, 106 (Minn. Ct. App. 1988) (sustaining a cause of action against the plaintiff's former wife for negligent transmission of herpes); Maharam v. Maharam, 123 A.D.2d 165, 170-71, 510 N.Y.S.2d 104, 107 (1st Dept '86) (recognizing a cause of action in negligence where a husband did not disclose to his wife the fact that he was infected with herpes).

24. See infra note 38 and accompanying text.

25. Dickens, Legal Rights and Duties in the AIDS Epidemic, 239 SCIENCE 580, 583 (1988) (explaining that "[t]he long incubation period of AIDS may obstruct the tracing of an alleged source and make it difficult to establish that party's wrongful nondisclosure or failure to follow prudent sexual behavior, or the plaintiff's seronegativity prior to the sexual encounter and low-risk conduct thereafter.").
participates in activities (particularly intravenous drug use or sexual contact with multiple homosexual partners) that create a high risk of infection? The second issue, raised by the fact that many people who have AIDS engage or have engaged in sex with multiple partners and/or share or have shared needles with other intravenous drug users, is whether the theory of "alternative liability" can be used to shift the burden of proof to multiple defendants who are all possible sources of the HIV infection. Third, given the potentially long incubation period between infection and the outbreak of symptoms, how will statutes of limitations affect the plaintiff's ability to fully recover his or her damages?

This Note reviews the medical facts about AIDS and the structure of a "typical" negligence suit for sexual transmission of HIV, observing areas where the above issues appear, and analyzing them in detail. Finally, this Note examines defenses to the AIDS lawsuit and further complications involved with such a cause of action.

II. THE MEDICAL FACTS

AIDS is the final stage of an infection which is caused by HIV, an RNA containing retrovirus, which becomes incorporated

26. See infra notes 100-38 and accompanying text.
27. See 100 QUESTIONS, supra note 1, at 2-3 (citing needle sharing and increased promiscuous sexual conduct as increasing the risk of AIDS).
28. See infra notes 139-83 and accompanying text (discussing the alternative liability rule and how it would be applied in an AIDS transmission suit).
29. See infra note 38 and accompanying text.
30. See infra notes 184-203 and accompanying text.
31. See infra notes 35-60 and accompanying text.
32. See infra notes 61-99 and accompanying text.
33. See infra notes 100-203 and accompanying text.
34. See infra notes 204-60 and accompanying text.
36. HIV is a generic term used to denote the causative agent of AIDS. Imperato, supra note 1, at 251. The human retrovirus in question has been given a number of different names, "including LAV (lymphadenopathy-associated virus), HTLV-III (human T-cell lymphotropic virus type III), and ARV (AIDS-associated retrovirus)." Id. The focus of AIDS policy-making should be on HIV infection:

The term "AIDS" is obsolete. "HIV infection" more correctly defines the problem. The medical, public health, political, and community leadership must focus on the full course of HIV infection rather than concentrating on later stages of the disease
within the chromosome of an infected cell, multiplies, and impairs the immune system, ultimately allowing other infections to occur far more frequently than normal, with devastating effects.\textsuperscript{37} Although infected and capable of transmitting HIV, the victim may take years to develop AIDS because of the unusual incubation period involved, or he may never develop any symptoms.\textsuperscript{38} The virus is most com-

\begin{quote}
\text{(ARC and AIDS). Continual focus on AIDS rather than the entire spectrum of HIV disease has left our nation unable to deal adequately with the epidemic.}\textsuperscript{37} \textit{See W. Masters, V. Johnson & R. Kolodny, supra note 4, at 18-19 (discussing HIV infection); Swenson, supra note 2, at 190 (tracing the progression from HIV infection to AIDS). Symptoms that must be documented to support a diagnosis of AIDS include: opportunistic infections which occur by organisms that would not usually cause disease; Kaposi's sarcoma, a malignant skin lesion; and non-Hodgkin's lymphoma of high grade pathogenicity. Sicklick & Rubinstein, supra note 36, at 5.}
\end{quote}

One United States district court described the effect of the AIDS virus within its findings of fact:

\begin{quote}
When the virus enters the body it begins to attack certain white blood cells (T-lymphocytes), which are an integral part of the human immune system. Specifically, the disease destroys, and generates qualitative abnormalities, in the victim's T-helper/inducer cells, which enable other components of the immune system to function. The virus thereby weakens the victim's immune system. Ray v. School Dist., 666 F. Supp. 1524, 1529 (M.D. Fla. 1987).
\end{quote}

\begin{quote}
\text{38. The progression of the HIV infection is a difficult but vital component in the understanding of AIDS. Although infected with HIV, the victim may never develop AIDS or any symptoms. \textit{See 100 Questions, supra note 1, at 9 (reporting that \textquoteall about 20 percent of those infected by the virus have so far developed the severe and fatal form of the disease which is called AIDS.'}); Surgeon General's Report, supra note 3, at 12 (noting that \textquoteall the majority of infected antibody positive individuals who carry the AIDS virus show no disease symptoms and may not come down with the disease for many years, if ever.'}).}
\end{quote}

\begin{quote}
Because visible symptoms do not necessarily exist, the majority of those who are HIV infected are unaware that they carry the virus. \textit{See Presidential Comm'n, supra note 4, at xvii (predicting that \textquoteall 1.5 million Americans are believed to be infected with the human immunodeficiency virus but are not yet ill enough to realize it.'}). However, these victims can still transmit the disease. \textit{See 100 Questions, supra note 1, at 9 (noting that HIV carriers may be unaware of their infection, but capable of transmitting the virus); cf. Surgeon General's Report, supra note 3, at 12 (warning that of the estimated 1.5 million infected Americans, \textquoteall of these individuals are assumed to be capable of spreading the virus sexually (heterosexually or homosexually) or by sharing needles and syringes or other implements for intravenous drug use.'}).}
\end{quote}

\begin{quote}
Typically, the first visible symptoms to develop include "fatigue, malaise, recurrent fever, night sweats, diarrhea, anorexia, unexplained weight loss, generalized lymphadenopathy (swollen lymph glands) in the groin and neck, and an increased susceptibility to opportunistic infections with prolonged recovery." Corboy, supra note 17, at 40. These symptoms indicate that the victim has developed AIDS-related complex (ARC). \textit{See id.; see also 100 Questions, supra note 1, at 10 (explaining that the ARC victim may die from those symptoms "without ever developing full-blown AIDS.'}); Surgeon General's Report, supra note 3, at 12 (esti-
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monly transmitted through anal intercourse or intravenous drug use. The large majority of current AIDS victims are male. Thus far, infectious quantities of the virus have only been found to exist in mating that 100,000 to 200,000 of those currently infected with HIV will develop ARC).

Finally, the victim may progress to "[t]he later stage of AIDS, commonly known as 'full-blown AIDS,'" which is "evidenced by Kaposi's sarcoma, a cancer that causes pink or purple lesions and pneumocystis carinii, a pneumonia that may result in respiratory depression. Both of these complications occur when the immune system is severely suppressed." Corboy, supra note 17, at 40. Full-blown AIDS is not the most common result of HIV infection. See 100 QUESTIONS, supra note 1, at 10 (reporting that "ARC is three to five times more common than AIDS."). The incubation period between HIV infection and the development of symptoms may be quite long, with many varying estimates available. See PRESIDENTIAL COMM'N, supra note 4, at 2 (estimating an average of eight years between HIV infection and the diagnosis of AIDS); SURGEON GENERAL'S REPORT, supra note 3, at 12 (reporting that symptoms of ARC or AIDS can take "as long as nine years to show up."); Barnes, AIDS: Statistics But Few Answers, 236 SCIENCE 1423, 1424 (1987) (analyzing studies that show an increased risk of developing AIDS as time progresses); Fauci, supra note 35, at 621 (predicting a time frame of "up to 5 years or longer" between HIV infection and development of clinically detectable symptoms); Imperato, supra note 1, at 251 (submitting evidence that "[t]he incubation period varies from a minimum of a few months after exposure to several years."); Kolata, AIDS Incubation Time Often Exceeds 9 Years, N.Y. Times, Mar. 16, 1989, at B15, col. 5 (citing research in San Francisco, which has "determined that 9.8 years is the median incubation period, meaning half the men would develop the disease in less than that and half in a longer time."); Silberner, Unlocking the Key to AIDS, U.S. NEWS & WORLD REPORT, Feb. 29, 1988, at 57 (suggesting a variable rate of incubation where some succumb quickly, while in others the disease can remain dormant for years).

Even more startling than the length of time between infection and symptoms is the duration between infection and the ability to detect such infection. See Imagana, Lee, Wolinsky, Sano, Morales, Kwok, Sninsky, Nishanian, Giorgi, Fahey, Dudley, Visscher & Detels, Human Immunodeficiency Virus Type 1 Infection in Homosexual Men Who Remain Seronegative for Prolonged Periods, 320 NEW ENG. J. MED. 1458, 1458 (1989) (noting that "HIV-1 infection in homosexual men at high risk may occur at least 35 months before antibodies to HIV-1 can be detected."). For a discussion of AIDS testing, see infra notes 50-58 and accompanying text.

39. Grady, supra note 8, at 60; see also SURGEON GENERAL'S REPORT, supra note 3, at 13 (explaining that no known risk exists from casual contact with items such as "shared food, towels, cups, razors, even toothbrushes . . ."). But see G. ANTONIO, supra note 35, at 95-124 (arguing that the evidence presently available does not support the conclusion that AIDS cannot be transmitted through casual contact).

In addition, the virus may be transmitted from pregnant women to their unborn children. See Friedland & Klein, Transmission of the Human Immunodeficiency Virus, 317 NEW ENG. J. MED. 1125, 1130 (1987). The virus "may be transmitted from infected women to their offspring by three possible routes: [1] to the fetus in utero through the maternal circulation, [2] to the infant during labor and delivery by inoculation or ingestion of blood and other infected fluids, and [3] to the infant shortly after birth through infected breast milk." Id. Interestingly, there is also a connection between the drug crack and AIDS. See Kerr, Crack and Resurgence of Syphilis Spreading AIDS Among the Poor, N.Y. Times, Aug. 20, 1989, at 1, col. 1. This is true because "[c]rack appears to stimulate pathological levels of sexual activity." Id. Thus, heterosexual activity in crack houses "has become a significant avenue for the spread of AIDS." Id.

40. Grady, supra note 8, at 60 (concluding that males number 92% of American AIDS victims).
blood, semen, vaginal secretions, and breast milk. Accordingly, the disease is relatively difficult to transmit, requiring either the exchange of a large volume of blood, or repeated exposure to smaller volumes. Heterosexuals who do not associate with intravenous drug users face an extremely small risk of infection. Homosexual males and intravenous drug users have been designated as “high risk group” members because their practices involve semen-to-blood and blood-to-blood contact which creates an increased risk of HIV transmission. Blood donors in the United States are now screened for

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41. Swenson, supra note 2, at 192. The HIV presence in vaginal secretions and breast milk is “in smaller, but significant numbers.” Id; see also Friedland & Klein, supra note 39, at 1130 (noting that HIV may be transmitted after birth through infected breast milk). HIV has also been “found occasionally in small numbers in saliva, tears, urine, and amniotic fluid, although clearly in numbers too small to transmit infection.” Swanson, supra note 2, at 192.

42. Id. In a study of 97 female partners of 93 male AIDS victims, “[r]epetitive exposures to an infected partner represented a significant risk, whereas general sexual activity (as measured by number of sexual partners and number of sexually transmitted diseases) was not associated with HIV infection.” Padian, Male-to-Female Transmission of Human Immunodeficiency Virus, 258 J. A.M.A. 788, 790 (1987).

43. Goode, I Love You, But Can I Ask a Question?, U.S. NEWS & WORLD REPORT, Feb. 22, 1988, at 85; see also Padian, supra note 42, at 790 (concluding that only one documented case exists of a single exposure transmission of AIDS from a male to a female). But see W. Masters, Y. Johnson & R. Kolodny, supra note 4, at 62 (concluding that “AIDS infection is spreading beyond the original high-risk groups into the heterosexual population, and the risk of becoming infected with HIV is higher for people with more numerous sexual partners.”); Heterosexuals Slow to Face the Reality of AIDS, 87 N.Y. St. J. Med. 310 (1987) (noting that not only can heterosexual transmission of HIV occur, but that “[i]n some regions of the world, AIDS occurs with similar frequencies in both men and women.”).

Although heterosexuals comprise only a minority of those infected with AIDS, the number of such cases seems to be growing at a higher rate than homosexual or intravenous (IV) drug user cases. Id. (indicating a 200% growth rate in 1986 for heterosexuals, compared with an 80% growth rate for the other two groups). In New York City, more than one-third of AIDS victims deny homosexual activity. Des Jarlais, Intravenous Drug Use and the Heterosexual Transmission of the Human Immunodeficiency Virus, 87 N.Y. St. J. Med. 283, 283 (1987) (commenting that as of-1986, 3,929 of the 7,696 AIDS victims in New York City denied homosexual activity; more than half of these cases can be attributed to IV drug use). For a discussion of IV drug use and its implications for heterosexual transmission of AIDS, see Id.

Some attempts are being made to reduce the risk of IV transmitted AIDS. For example, the Food and Drug Administration recently proposed the expansion of access to methadone. Ingersoll, To Curb AIDS, U.S. Would Widen Methadone Access, Wall St. J., Mar. 2, 1989, at B5, col. 1. Methadone has been offered to addicts because it can relieve the craving for heroin. Id. Because methadone is taken orally, the use of needles would be reduced, as would the risk of AIDS. Id. Under current rules, only patients in comprehensive treatment can be given the drug. Id. The proposal would allow clinics to dispense methadone to addicts who were still on waiting lists for comprehensive drug treatment. Id.

44. 100 QUESTIONS, supra note 1, at 2. Persons with an increased risk of AIDS infection include:

1. homosexual and bisexual men; 2. present or past IV drug abusers; 3. persons
the AIDS virus and all blood is tested for AIDS antibodies. Therefore, the chances of a recipient contracting AIDS from a blood transfusion have been substantially reduced.

Government reports have stressed that the safest behavioral patterns, in terms of AIDS risks, consist of avoiding casual sexual relationships and multiple partners. The use of condoms has been advocated as a precautionary measure, despite the fact that estimates concerning their effectiveness vary. Combining care in one's choice with clinical or laboratory evidence of infection, such as those with signs or symptoms compatible with AIDS or AIDS-related complex (ARC); (4) persons born in countries where heterosexual transmission is thought to play a major role; (5) male or female prostitutes and their sex partners; (6) sex partners of infected persons or persons at increased risk; (7) all persons with hemophilia who have received clotting-factor products; and (8) newborn infants of high-risk or infected mothers.

One United States district court enunciated a slightly different list of high risk groups: "1) homosexuals or bisexual men (73%), 2) hemophiliacs (1%), 3) transfusion recipients (2%), 4) intravenous (IV) drug users (17%), 5) sexual partners of risk-group members (1%), and 6) infants born to infected mothers (1%)." Ray v. School Dist., 666 F. Supp. 1524, 1530 (M.D. Fla. 1987) (citation omitted). In addition "[a]pproximately five percent (5%) of the AIDS population does not fall into any of these groups ...." Id.

45. SURGEON GENERAL'S REPORT, supra note 3, at 22 (explaining that each donor is screened for AIDS, each blood donation is tested for AIDS antibodies, any blood that contains antibodies is eliminated from transfusion or blood product use, and concluding that "[b]lood banks are as safe as current technology can make them.").

46. See PUBLIC HEALTH SERV., U.S. DEP'T OF HEALTH AND HUMAN SERVS., UPDATE: MMWR ARTICLES ON AIDS 3 (1988) [hereinafter MMWR ARTICLES] (noting a significant reduction in new infections among transfusion recipients and hemophiliacs); SURGEON GENERAL'S REPORT, supra note 3, at 22 (estimating the chance of infected blood being utilized before it can be tested positive for AIDS as "less than once in 100,000 donations."); Imperato, supra note 1, at 252 (finding that "[t]ransmission from high-risk-behavior groups via blood transfusions will be minimal in the US given the relative safety of the blood supply.").

47. See 100 QUESTIONS, supra note 1, at 21 (recommending various precautions, including the avoidance of "sexual contact with multiple partners or with persons who have had multiple partners."); see also SURGEON GENERAL'S REPORT, supra note 3, at 16 (advocating "mutually faithful monogamous relationships").

In one study of the effect of sexual practices on the likelihood of HIV infection, only one of 400 subjects claiming strict monogamy for the previous five years tested positive for HIV antibodies. W. MASTERS, V. JOHNSON & R. KOLODNY, supra note 4, at 56. In contrast, 10 of 200 men claiming an average of 9.8 sex partners in the previous five years tested positive, as did 14 of the 200 women who claimed an average of 11.5 sex partners in the previous five years. Id. at 55-56

48. See RECOMMENDATIONS AND GUIDELINES, supra note 44, at 14 (advocating condoms, but noting that "their efficacy in reducing transmission has not yet been proven."); cf. SURGEON GENERAL'S REPORT, supra note 3, at 17 (recommending condom use despite the unknown efficacy). But see W. MASTERS, V. JOHNSON & R. KOLODNY, supra note 4, at 117 (concluding that "to think that condom use is perfect, or even near perfect, in eliminating the risk of HIV transmission is foolishness of the highest order."); Carey, Condoms May Not Stop...
of sexual partners with condom use significantly reduces the risk of AIDS infection.  

Two tests have been developed to indicate whether or not a person has become infected. The Enzymelinked Immunosorben Assay (ELISA) determines whether HIV antibodies are present in the blood stream, since the presence of antibodies is an indication that the person is infected with HIV. In practice, however, it has been estimated that as many as ninety percent of those who test positive for antibodies are not really infected with the virus. Such results are commonly referred to as "false positives." If antibodies are present in two ELISA tests, the Western blot, a more expensive test designed to "confirm or deny the presence of antibodies," will be performed. The Western blot test, however, is problematic for two reasons. First, a growing number of inexperienced commercial laboratories are performing the testing, which may reduce the accuracy. Second, confusion exists regarding the specific criteria that denote a positive test result. Despite these problems, use of the two tests in combination can achieve an accuracy level in excess of ninety-nine percent.

AIDS, U.S. NEWS & WORLD REPORT, Oct. 19, 1987, at 83 (commenting that a 10-15% failure rate may be more problematic with AIDS than it is in pregnancy because while a woman is only fertile 36 days a year, the AIDS carrier can transmit the disease every day).

Several recent studies have been done to determine the effectiveness of condom use as an AIDS prevention technique. In one study testing 12 varieties of latex and natural-membrane condoms, it was found that HIV could not pass through the latex, although occasional leaks occurred in natural condoms. Goldsmith, Sex in the Age of AIDS Calls for Common Sense and 'Condom Sense', 257 J. A.M.A. 2261, 2263 (1988).

49. Measured Danger, TIME, May 2, 1988, at 62 (indicating that "the chance of getting AIDS ranges from 1 in 500 for a single act of intercourse with an infected partner when no condom is used to 1 in 5 billion if a condom is used with a partner who has tested negative for AIDS antibodies.").


52. Barnes, supra note 50, at 884-85.

53. Id. at 885. But see MMWR ARTICLES, supra note 46, at 6 (noting that "[u]nder ideal circumstances, the probability that a testing sequence will be falsely positive in a population with a low rate of infection ranges from less than 1 in 100,000 . . . to an estimated 5 in 100,000," assuming that tests are repeated and that proper criteria are used for evaluation).

54. Barnes, supra note 50, at 885.

55. Id.; see also Proffitt, supra note 51, at 23-24 (discussing the Western blot test).

56. Barnes, supra note 50, at 885.

57. Id.

58. PRESIDENTIAL COMM'N, supra note 4, at 2 (stating that "experts agree that the cur-
Finally, it should be noted that there is no cure currently available for AIDS, and the disease is invariably fatal.

rent sequence of tests used to detect antibody against HIV, when performed under well controlled conditions in good laboratories, yield both a sensitivity and specificity of greater than 99.8 percent.

A growing number of organizations, formerly opposed to AIDS testing, have begun to advocate it. See Lambert, In Shift, Gay Men's Health Crisis Endorses Testing for AIDS Virus, N.Y. Times, Aug. 16, 1989, at A1, col. 1. This trend reflects a decrease in fears about testing accuracy, possible discrimination and emotional trauma. See id., col. 2.

The ultimate question from the AIDS litigants' standpoint will be whether courts accept the test results. This may prove to be important in determining both the plaintiff's injury and the fact that the defendant has AIDS. The Supreme Court of New York, in Albany County, recently considered the effectiveness of AIDS testing in a suit challenging the legality of a regulation that prohibited requiring AIDS testing in applications for health insurance. Health Ins. Ass'n of America v. Corcoran, 531 N.Y.S.2d 456, 140 Misc. 2d 255 (Sup. Ct. 1988). The court found that "testing for HIV sero positivity produces statistically valid basis for actuarial risk classification purposes as an accurate, significant and substantial predictor of morbidity, mortality and future medical expenses." Id. at 461, 140 Misc. 2d at 270.

The recent development of the drug AZT has managed to prolong the lives of some AIDS patients. See AZT Approved for Sale in Britain, 87 N.Y. Sr. J. Med. 309 (1987) (reporting that AZT has been approved for use in both the United States and Britain, but its long term effects are not known at present); Making Do Without a Magic Bullet, U.S. NEWS & WORLD REPORT, Feb. 20, 1989, at 12 (discussing AZT and noting that AIDS patients in San Francisco now survive an average of 15 months after being diagnosed AIDS-positive, an increase from an average of 10 months three years ago); cf. AIDS Patients Using AZT Usually Live Much Longer, Wall St. J., June 7, 1989, at B4, col. 4 (noting the existence of reports of longer survival for AIDS patients using AZT, but noting that some researchers have questioned whether AZT alone should receive credit for such improvement). But see Chase, AIDS Patients Develop Viruses Resistant to AZT, Wall St. J., Mar. 15, 1989, at B1, col. 3 (noting that some AIDS patients have apparently developed strains of the AIDS virus that are resistant to AZT); cf. Silberman, supra note 38, at 56 (stating that AZT is the only drug currently available to treat AIDS, but it has serious side effects and is far from being a cure).

Additionally, recent developments in AIDS research continue to spark optimism that new treatments might be found. See Silberman, supra note 24, at 56; see also New AIDS Drug to Be Tested, N.Y. Times, Apr. 28, 1989, at A14, col. 4 (noting the FDA has approved the testing of a new drug, called GLQ223, which has destroyed cells infected with the AIDS virus in laboratory tests); Schmeck, Structure of Enzyme in AIDS Virus is Identified, N.Y. Times, Feb. 16, 1989, at B10, col. 3 (suggesting some hope because "[s]cientists have determined the complete three-dimensional structure of an enzyme of the AIDS virus, opening new possibilities for designing 'drugs to combat the deadly disease.'"). But see Waldholz, Tracking a Killer: Merck Scientists Find a Chink in the Armor of the AIDS Virus, Wall St. J., Feb. 16, 1989, at A1, col. 1 (recognizing that "[r]esearchers are quick to say . . . that it will be some time before a drug that can inhibit the AIDS enzyme in humans is found—if, in fact, it ultimately is found.").
III. THE STANDARD AIDS NEGLIGENCE CASE

In order to sustain a suit in negligence, the plaintiff must show four elements: a duty, recognized by law, to conform to a certain standard of conduct; a failure on the defendant's part to conform to that standard of care (i.e. a breach of that duty); a reasonably close causal connection between the conduct and the injury (proximate cause and cause in fact); and an injury denoted by actual loss or damage to the victim.61 Because there has been little judicial evaluation of the AIDS negligence claim,62 the application of each element to such a lawsuit should be examined.

A. Duty

A duty is a legally recognized obligation to conform to a certain standard of conduct towards another person.63 Although a court may

62. The Minnesota Court of Appeals examined a negligent AIDS transmission case in the Spring of 1989. See C.A.U. v. R.L., 438 N.W.2d 441 (Minn. Ct. App. 1989). The court upheld the trial court's determination that the defendant "was under no duty to warn appellant he had the AIDS disease because at the time of the parties' relationship it was not reasonably foreseeable that he had the disease or could cause appellant harm through intimate sexual conduct." Id. at 444. This holding was reflective of the fact that at the time of the relationship there was little information available about AIDS, id. at 9, and because there was little evidence that the defendant "had a history of homosexual activity." Id.

In another recent decision, a California trial court awarded Marc Christian $14.5 million from the estate of his former lover, Rock Hudson. Rock Hudson's Lover Wins Suit, N.Y. Times, Feb. 16, 1989, at A22, col. 5. The jury decided that Rock Hudson and his former secretary, Mark Miller, had conspired to keep Hudson's AIDS infection a secret from Christian, and that this constituted "outrageous conduct." Id. The award was $3.5 million more than Christian had sought, despite the fact that he has yet to actually develop the disease. Id.; see also Lovers, Liars and Other Strangers, NEWSWEEK, Feb. 27, 1989, at 61 (describing Christian's claim that he had suffered "grave emotional distress"). Additionally, the jury awarded Christian another $7.25 million in punitive damages. Hudson's Lover Wins $7 Million More, N.Y. Times, Feb. 18, 1989, at A7, col. 3. Although the compensatory damages were assessed both to Hudson's estate and Miller, the punitive damages applied only to Miller. Id. These damages were based on the jury finding that Hudson and Miller "had acted 'with malice' and intended to cause injury to the plaintiff . . . . Id." The award was reduced to $5 million in compensatory damages and $500,000 in punitive damages because the trial judge "concluded that the award [was] based [in] part on passion . . . . " Jury Award Is Sharply Cut in Hudson AIDS Suit, N.Y. Times, Apr. 22, 1989, at A7, col. 4.

Although interesting in several respects (amount of damages and recovery despite the lack of an infection), the Hudson case does not directly address the issue examined by this Note—the unintentional transmission of AIDS.

63. See RESTATEMENT (SECOND) OF TORTS § 282 (1965). A finding of duty is actually a simple determination that liability should be imposed in a given fact pattern. See Tarasoff v. Regents of the Univ. of California, 17 Cal. 3d 425, 434, 551 P.2d 334, 342, 131 Cal. Rptr. 14, 22 (1976) (endorsing the view that "legal duties are not discoverable facts of nature, but
evaluate a variety of factors when considering the duty issue. The central focus will be on the foreseeability of harm. Under this analysis, a duty will only be found to exist where the defendant should have foreseen harm to someone. Several courts have recognized merely conclusory expressions that, in cases of a particular type, liability should be imposed for damage done.

64. For example, the courts of California have indicated that seven factors are determinative of the existence of a duty:

   (1) foreseeability of harm to the plaintiff;
   (2) degree of certainty that the plaintiff suffered injury;
   (3) closeness of connection between defendant's conduct and injury suffered;
   (4) moral blame attached to defendant's conduct;
   (5) policy of preventing future harm;
   (6) extent of burden to the defendant and the consequences to the community of imposing a duty to exercise care with resulting liability for breach; and
   (7) availability, cost, and prevalence of insurance for the risk involved.

Vu v. Singer Co., 538 F. Supp. 26, 29 (N.D. Cal. 1981), aff'd, 706 F.2d 1027 (9th Cir.), cert. denied, 464 U.S. 938 (1983); see also Tarasoff, 17 Cal. 3d at 434, 551 P.2d at 342, 131 Cal. Rptr. at 22 (citing the same list).

Although this Note focuses on the foreseeability issue, see infra notes 65-69 and accompanying text, the other determinative factors may be analyzed to add additional support to the imposition of a duty to avoid transmitting HIV. For example, it has been argued that the policy of preventing future harm weighs heavily in favor of imposing a duty. See Note, Negligence, supra note 17, at 932 (arguing that the future harm includes human fatalities and economic costs). Additionally, the extent of the burden to the defendant is minimal when compared to this potential harm. See id. at 933.

It has also been argued that the moral blame attached to the defendant's conduct weighs in favor of imposing a duty. See id. at 932. One commentator has suggested that the criminalization of sodomy and the immoral status of homosexuality support this conclusion. Id. Hopefully, this narrow minded and archaic type of analysis will not appear in AIDS litigation. Rather, as the same commentator also suggested, the moral blame attaches to the act of "knowingly or negligently infect[ing] an unknowing sexual partner . . . ." Id.

The unavailability of insurance, as well as problems of inadequate coverage, have also been cited as support for the imposition of a duty. See id. at 931. The argument on this issue suggests that the government ends up bearing the cost of AIDS transmission, a cost which should be shifted to the negligent party. See id. at 931-32. However, the fact that insurance is equally unavailable to the negligent party implies that this argument is tautological because the government would still bear the costs after they are shifted.

The remaining factors—degree of certainty that the plaintiff suffered harm and closeness of connection between the defendant's conduct and the injury suffered—appear to be better suited for argumentation in individual cases because they are subject to substantial variations. See infra notes 92-99 and accompanying text (discussing damages); infra notes 83-91, 139-83 and accompanying text (discussing causation).

65. See Tarasoff, 17 Cal. 3d at 434, 551 P.2d at 342, 131 Cal. Rptr. at 22 (indicating that "[t]he most important of these considerations in establishing duty is foreseeability."); Dillon v. Legg, 68 Cal. 2d 728, 739, 441 P.2d 912, 919, 69 Cal. Rptr. 72, 79 (1968) (stating that foreseeability has a "primary importance" in evaluating duty); Vu, 538 F. Supp. at 30-33 (focusing on foreseeability in the discussion of duty).

66. The foreseeability analysis essentially proceeds as follows:

   [T]he court will determine whether the accident and harm was reasonably foreseeable. Such reasonable foreseeability does not turn on whether the particular defendant as an individual would have in actuality foreseen the exact accident and loss; it contemplates that courts, on a case-by-case basis, analyzing all the circumstances,
that harm to the plaintiff is foreseeable when the defendant knows that he has a sexually transmitted disease. Where a defendant is not aware of his HIV infection, the assertion of foreseeability becomes more difficult. However, if the defendant was aware that his conduct had created a high risk of infection, the risk of transmitting the disease should be considered foreseeable. Furthermore, recognizing a duty in this situation is consistent with a policy that seeks to deter the transmission of HIV, and thus prevent future harm. Courts have already recognized a duty to take reasonable precautions to prevent transmitting venereal disease when awareness of the infection is present. Stated more generally, the duty owed by one sexually active person to another is "the same one that every individual . . . owes another: the duty to exercise ordinary care not to injure others." Extension of this duty to cases involving AIDS victims

will decide what the ordinary man under such circumstances should reasonably have foreseen. The courts thus mark out the areas of liability, excluding the remote and unexpected.

Dillon, 68 Cal. 2d at 741, 441 P.2d at 921, 69 Cal. Rptr. at 81 (emphasis in original).

67. See, e.g., B.N. v. K.K., 312 Md. 135, 142, 538 A.2d 1175, 1179 (1988) (finding that "[o]ne who knows he or she has a highly infectious disease can readily foresee the danger that the disease may be communicated to others with whom the infected person comes in contact."); R.A.P. v. B.J.P., 428 N.W.2d 103, 107-08 (Minn. Ct. App. 1988) (concluding that the risk of transmitting herpes was foreseeable where the defendant knew she had the disease, and where she should have known that transmission was possible). See generally Casenote, Tort Liability for the Transmission of Genital Herpes: A New Legal Duty? R.A.P. v. B.J.P. 428 N.W2d 103 (Minn. Ct. App. 1988), 12 Hamline L. Rev. 91 (1988) (authored by Marcia Braun).

68. See C.A.U. v. R.L., 438 N.W.2d 441, 444 (Minn. Ct. App. 1989) (holding that absent a demonstration that the respondent had actual or constructive knowledge that he had the AIDS virus, the defendant owed no legal duty to the plaintiff).

69. For a discussion of the risk involved and the defendant's ability to recognize that risk, see infra notes 105-108, 115-20 and accompanying text.

70. See, e.g., B.N., 312 Md. at 142, 538 A.2d at 1179 (finding a duty to "take reasonable precautions—whether by warning others or by avoiding contact with them—to avoid transmitting" herpes, when the defendant was aware of the infection); R.A.P., 428 N.W.2d at 106-07 (explaining that "[t]his rule is based on the simple principle that people who have dangerous contagious diseases have a duty to protect others who might be in danger of infection.").

71. Long v. Adams, 175 Ga. App. 538, 539, 333 S.E.2d 852, 854 (1985); cf. Smith v. Baker, 20 F. 709 (C.C.S.D.N.Y. 1884) (holding that the plaintiff could maintain a cause of action for negligent transmission of whooping-cough); Gilbert v. Hoffman, 66 Iowa 205, 210, 23 N.W. 632, 634 (1885) (allowing a negligence action against a hotel-keeper who kept his hotel open with knowledge of the prevalence of small-pox on the premises); Hendricks v. Butcher, 144 Mo. App. 671, 674, 129 S.W. 431, 432 (1910) (holding that any person afflicted with small-pox has the duty "to so conduct himself as not to communicate this disease to [other persons], after he becomes aware that he is afflicted with it.") Kliegel v. Aitken, 94 Wis. 432, 435, 69 N.W. 67, 68 (1896) (sustaining a cause of action for the negligent transmission of typhoid fever, and stating that "[t]he general principle is well established that one who negligently—that is, through want of ordinary care—exposes another to an infectious or conta-
who know that they have the disease has been anticipated by several commentators. Ultimately, however, the question will focus not upon whether a duty should be established, but rather upon what standard of conduct is sufficient to meet the established duty of reasonable care. Therefore, recognizing a duty of reasonable care in cases where knowledge of the HIV infection does not exist would not be overly intrusive if the acceptable standard of conduct is set at an appropriate and reasonable level.

B. Standard of Conduct

Given the general duty of reasonable care, an appropriate standard of conduct can be set through four different methods: direct establishment by legislative enactment or administrative regulation; adoption by a court from legislative enactments or administrative regulations which do not specifically provide the standard; establishment via judicial decision; or application to the facts by the trial judge or jury when none of the other methods are available. At least one court has applied a statute prohibiting the transmission of disease, which such other thereby contracts, is liable . . . in the absence of contributory negligence or assumption of the risk.

72. See, e.g., Baruch, supra note 17, at 174 (indicating that the lethal nature of AIDS increases the likelihood that such a duty would exist); Hermann, supra note 16, at 89 (concluding that the possibility of infecting one's sexual partner is "easily foreseeable" when HIV infection is known); Note, You Never Told Me, supra note 17, at 542-44 (examining the precedent supporting a duty to avoid transmission of AIDS); Note, Tort Liability for AIDS?, supra note 17, at 972 (arguing that the public policy to reduce the spread of AIDS would support finding such a duty); Note, Interspousal Transmission, supra note 17, at 904 (suggesting such a duty in the marital context); Note, Negligence, supra note 17, at 928-33 (analyzing the imposition of a duty in AIDS transmission cases).

73. In negligence cases the duty does not vary and the important focus is on what standard of conduct is necessary to fulfill this duty:

It is better to reserve "duty" for the problem of the relation between individuals which imposes upon one a legal obligation for the benefit of the other, and to deal with particular conduct in terms of a legal standard of what is required to meet the obligation. In other words, "duty" is a question of whether the defendant is under any obligation for the benefit of the particular plaintiff; and in negligence cases, the duty is always the same—to conform to the legal standard of reasonable conduct in the light of the apparent risk. What the defendant must do, or must not do, is a question of the standard of conduct required to satisfy the duty.

W. Prosser & W. Keeton, supra note 61, § 53, at 356.

74. For an evaluation of the potential standards of conduct, see infra notes 100-38 and accompanying text.

75. See RESTATEMENT (SECOND) OF TORTS § 285(a) (1965).

76. Id. § 285(b).

77. Id. § 285(c).

78. Id. § 285(d).
mission of a venereal disease to set an appropriate standard.79 The


HIV transmission has already been specified as a criminal offense in a number of states. The scope of conduct deemed to be criminal varies among these statutes. Florida finds criminal conduct where a person (1) has an HIV infection, (2) knows he is infected, (3) has been informed that the virus may be communicated through sexual intercourse, (4) has sexual intercourse with another person, and (5) does not inform that person of the presence of HIV and does not receive informed consent to sexual intercourse. FLA. STAT. ANN. § 384.24 (West 1989). This offense has been classified as a first degree misdemeanor, id. § 384.34, punishable by imprisonment for a period up to one year, id. § 775.082, and a fine of $1,000. Id. § 775.083.

Georgia finds criminal conduct in a broader range of sexual relations by declaring that a felony has been committed when any person who knows that they are infected with HIV:
knowingly engages in sexual intercourse or performs or submits to any sexual act involving the sex organs of one person and the mouth or anus of another person and the HIV infected person does not disclose to the other person the fact of that person's being an HIV infected person prior to that intercourse or sexual act... GA. CODE ANN. § 16-5-60(c)(1). The statue also forbids sharing needles or syringes without disclosure of the infection, id. § 16-5-60(c)(2); prostitution without disclosure, id. § 16-5-60(c)(3); solicitation of sodomy without disclosure, id. § 16-5-60(c)(4); and blood or organ donations without disclosure. Id. § 16-5-60(c)(5). The felony is subject to "imprisonment for not more than ten years." Id. § 16-5-60(c).

Idaho has adopted an even broader provision:

Any person who exposes another in any manner with the intent to infect or, knowing that he or she is or has been afflicted with acquired immunodeficiency syndrome (AIDS), AIDS related complexes (ARC), or other human immunodeficiency virus (HIV) infection, transfers or attempts to transfer any of his or her body fluid, body tissue or organs to another person is guilty of a felony and shall be punished by imprisonment... not to exceed fifteen (15) years, by fine not in excess of five thousand dollars ($5,000), or by both such imprisonment and fine.

IDAHO CODE § 39-608(1) (1988) (emphasis added); see also id. § 39-608(2) (defining "body fluid" and "transfer").

Several states have stricter mens rea requirements in their HIV transmission statutes. Louisiana has made it a crime to "intentionally expose another to any acquired immunodeficiency syndrome (AIDS) virus through sexual contact without knowing and lawful consent of the victim." LA. REV. STAT. ANN. § 14.43.5(a) (West Supp. 1989). This crime is subject to a $5,000 fine, ten years imprisonment, or both. Id. § 14.43.5(b). Oklahoma similarly has declared it a felony "for any person to engage in any activity with the intent to infect or cause to be infected any other person with the human immunodeficiency virus." OKLA. STAT. ANN. tit. 21, § 1192.1(a) (West Supp. 1989). The crime is subject to five years imprisonment. Id. § 1192.1(b).

Utah has taken a different approach, supplementing a statute prohibiting the willful and knowing introduction of "any communicable or infectious disease into any county, municipality, or community..." UTAH CODE ANN. § 26-6-5 (1984), with an additional statute declaring that AIDS and HIV "shall be considered communicable and infectious disease" for the purposes of that chapter. UTAH CODE ANN. § 26-6-5 (Supp. 1989). The statute declares such conduct to be a misdemeanor. UTAH CODE ANN. § 26-6-5 (1984).

Significantly, none of these statutes requires actual transmission of HIV as an element.
general standard that has been proclaimed is that a "reasonable person" who knows or should know that they have a venereal disease must communicate this knowledge to any sexual partner prior to sexual activities. The conduct of an AIDS victim who is aware of his or her infection is clearly subject to the application of such a standard. Where the defendant was unaware of his infection, however, the appropriate standard of conduct will be more difficult to set. The significant questions that remain are whether the courts will find that a "reasonable person" who is unaware that they can transmit HIV must take affirmative steps to prevent any possible transmission or to inform their sexual partner of any existing risk; in what situations such steps should be taken; and what conduct is then sufficient to meet such a standard.

C. Causal Connection

Proximate cause is a limitation that courts place on an actor's responsibility for the consequences of his conduct. Essentially, the determination of proximate cause is an examination of the nature and degree of the connection between the defendant's act and the plaintiff's injury. In practice there are two requirements: the defendant's conduct must be the factual cause (cause in fact) of the injury, and he must be found to be legally responsible for the injury (proximate cause).

A factual cause is demonstrated where it can be said that "but for" the defendant's conduct, the plaintiff would not have been injured. Assuming that the defendant can be isolated as the only potential source of the plaintiff's HIV infection, this requirement can be easily fulfilled. A more difficult situation arises where the plaintiff


81. See Note, Negligence, supra note 17, at 936 (concluding that the duty to disclose AIDS is supported by "social policy to prevent the spread of AIDS, the high medical costs, the emotional trauma, and high death rate . . . ." (footnotes omitted)).

82. See infra notes 100-38 and accompanying text.

83. See W. PROSSER & W. KEETON, supra note 61, § 41, at 264.

84. Id. at 264.

85. Id. at 264-65.

86. Id. § 42, at 272.

87. Id. § 41, at 265.
had multiple sexual partners who were all capable of transmitting the virus.\textsuperscript{88} One possible solution would be to sue under an “alternative liability” theory in an attempt to switch the burden of proof to the defendants.\textsuperscript{89}

The proximate cause issue appears to be less difficult to establish in cases involving direct transmission between a carrier and a victim. In determining whether or not the defendant should be legally responsible for the plaintiff’s injury, it will probably be sufficient to show that a duty has been established and breached.\textsuperscript{89} Proximate cause is only likely to play a significant role in litigation in cases of third party harm, where a plaintiff seeks to recover from a defendant who has transmitted HIV to the person who transmitted the infection to the plaintiff.\textsuperscript{90} Such a situation is beyond the scope of this Note.

D. Damages

To sustain a suit in negligence, the plaintiff must demonstrate that he suffered some form of actual loss.\textsuperscript{92} Because AIDS involves devastating symptoms and is usually fatal,\textsuperscript{93} such a requirement would seem capable of being fulfilled with relative ease.\textsuperscript{94} Given the varying periods of incubation,\textsuperscript{95} however, a plaintiff may be barred from claiming the totality of his damages by an applicable statute of limitations. Generally, statutes of limitations begin to run when some

\textsuperscript{88} See Corboy, supra note 17, at 42 (suggesting that “a plaintiff who has been sexually active with numerous partners . . . may have difficulty proving a particular party is the infector.”); Note, \textit{You Never Told Me}, supra note 17, at 547-48 (discussing various problems that will exist in identifying the specific cause of AIDS infection); Note, \textit{Negligence}, supra note 17, at 939 (explaining that non-sexual causes of AIDS and the long incubation period may create problems in proving actual causation); supra note 25 (indicating problems in AIDS litigation which may be caused by the incubation period).

\textsuperscript{89} See infra notes 139-83 and accompanying text (discussing the alternative liability rule and how it would be applied in an AIDS transmission suit).

\textsuperscript{90} Note, \textit{Tort Liability}, supra note 17, at 977-78 (arguing that the close resemblance of the two issues will allow a finding of duty to satisfy the requirement of proximate cause); see also Note, \textit{Negligence}, supra note 17, at 939 (concluding that the proximate cause issue will have “little impact” in cases involving a single plaintiff and a single defendant).

\textsuperscript{91} See id. (arguing that the third party should not be responsible to foresee the negligent act of his sexual partner, and therefore should not be held liable in this situation).

\textsuperscript{92} W. Prosser & W. Keeton, supra note 61, § 30, at 165.

\textsuperscript{93} See supra notes 6-7 and accompanying text (reporting the estimations of death rates for AIDS victims).

\textsuperscript{94} See Note, \textit{Negligence}, supra note 17, at 940 (noting the ease of proving damages if the plaintiff has AIDS, and suggesting the possibility of recovering for emotional distress).

\textsuperscript{95} See supra note 38 and accompanying text (describing the different stages of AIDS and the possible incubation period).
injury has occurred. If the time of infection with the virus is considered to be the time of injury, a plaintiff whose infection is known years before the effects of the disease fully manifest and develops may have difficulty recovering for all of his or her injuries.

96. See Klein v. Dow Corning Corp., 661 F.2d 998, 999 (2d Cir. 1981) (holding that the plaintiff's claim in negligence and strict liability accrued when her mammary prosthesis implant burst, not when it was implanted); Cannon v. Sears, Roebuck and Co., 374 Mass. 739, 742, 374 N.E.2d 582, 584 (1978) (holding that the statute of limitations in a products liability suit begins to run when injury occurs, not when the product was manufactured or sold); White v. Schneebelen, 91 N.H. 273, 276, 18 A.2d 185, 187 (1941) (holding that the statute began to run when the lightning rod in question caused a fire, and not when it was negligently installed six years earlier); Martín v. Edwards Laboratories, 112 Misc. 2d 93, 98, 446 N.Y.S.2d 182, 186 (Sup. Ct. 1982) (finding injury to have "occurred upon the breakage of the artificial heart valve," and holding that the statute of limitations began to run at that date).

Traditionally, statutes begin to run at the time the plaintiff was hurt:

97. It can be argued that the injury in an AIDS case occurred when HIV was transmitted, not when ARC or AIDS ultimately developed. This would be consistent with some available precedent concerning the injection or inhalation of hazardous substances. See, e.g., Thronton v. Roosevelt Hosp., 47 N.Y.2d 780, 781, 391 N.E.2d 1002, 1003, 417 N.Y.S.2d 920, 922 (1979) (endorsing the view "that when chemical compounds are injected into a person's body, the injury occurs upon the drugs [sic] introduction, not when the alleged deleterious effects of its component chemicals become apparent."); Schwartz v. Hayden Newport Chem. Corp., 12 N.Y.2d 212, 188 N.E.2d 142, 237 N.Y.S.2d 714 (barring an action in negligence and breach of warranty under a three year statute of limitations where plaintiff received an injection in 1944, lost an eye because of a carcinoma discovered in 1957, and commenced a cause of action in 1959), cert. denied, 374 U.S. 808 (1963); Schmidt v. Merchants Despatch Trans. Co., 270 N.Y. 287, 301, 200 N.E. 824, 827 (1936) (indicating that in a suit against an employer for negligent failure to protect employees from injury through dust inhalation, "[t]he injury to the plaintiff was complete when the alleged negligence of the defendant caused the plaintiff to inhale the deleterious dust.").

98. See Baruch, supra note 17, at 188 (arguing that such a rule even hurts plaintiffs who become aware of the risk of AIDS, because they would be forced to litigate based on conjecture, thus "compromis[ing] the amount of recovery he could receive."); Note, Negligence, supra note 17, at 943 (indicating that "inequitable results" would occur if the statute ran from the date the plaintiff was exposed to HIV).

The problem of recovery was overcome in the Rock Hudson case, where Marc Christian, who had never tested positive for AIDS, was awarded $14.5 million in compensatory damages for emotional distress and $7.25 million in punitive damages. Hudson's Lover Wins $7 Million More, N.Y. Times, Feb. 18, 1987, at A7, col. 3. The jury found that Hudson and his staff conspired to keep the fact that Hudson had AIDS from Christian. Id., col. 4; see also Jury Award Is Sharply Cut in Hudson AIDS Suit, N.Y. Times, Apr. 22, 1989, at A7, col. 4. It seems unlikely that a plaintiff would be this successful where such a conspiracy was not present, or where the defendant was not a wealthy celebrity.
Therefore, alternate methods of dealing with such statutes should be examined when considering AIDS litigation.99

IV. SPECIFIC PROBLEM AREAS

A. Standard of Care for Unaware AIDS Victims

Application of the available precedent in the area of tort liability for venereal disease transmission seems to be limited to cases where the defendant was aware of his infection.100 However, most persons who are HIV infected are not aware of their infection and do not demonstrate any recognizable symptoms, although they can still transmit the disease.101 Therefore, an application of negligence law that requires knowledge of the infection would not support an imposition of liability in most cases involving HIV transmission.

Given the apparent inapplicability of current rules, a new standard of conduct should be set for persons who have engaged in high risk conduct, but do not know whether they are infected with HIV. The acceptable standard of conduct should be viewed as an external imposition, based on societal demands rather than personal morality.102 The basic principles involve a balancing of the recognizable risk involved with a particular course of conduct and the social utility of that chosen conduct.103 This will necessarily involve an evaluation of alternate courses of action as compared with the risk and utility of the chosen conduct.104

The risk of contracting AIDS varies according to the type of

99. See infra notes 184-203 and accompanying text (analyzing potential rules to expand the plaintiff's ability to recover for injuries detected after the traditional statute of limitations has run).

100. See supra notes 67-70 and accompanying text (examining the available precedent concerning liability for the transmission of venereal disease).

101. See supra note 38 and accompanying text (explaining the different stages of AIDS and the incubation periods involved).

102. See W. PROSSER & W. KEETON, supra note 61, § 31, at 169 (arguing that "[t]he standard of conduct imposed by the law is an external one, based upon what society demands generally of its members, rather than upon the actor's personal morality or individual sense of right and wrong.").

103. Id. The Restatement (Second) of Torts states the following:

Where an act is one which a reasonable man would recognize as involving a risk of harm to another, the risk is unreasonable and the act is negligent if the risk is of such magnitude as to outweigh what the law regards as the utility of the act or of the particular manner in which it is done.

RESTATEMENT (SECOND) OF TORTS § 291 (1965).

104. See W. PROSSER & W. KEETON, supra note 61, § 31, at 172 (discussing the implications of alternative courses of conduct).
activities in which a person chooses to participate. People engaging in “high risk” activities face a significantly greater chance of becoming infected, and therefore a greater chance of transmitting HIV. Particularly dangerous activities include homosexual relations with multiple partners and sharing needles with other intravenous drug users. If a person’s conduct places him at a high risk of transmitting HIV, one might argue that he should be required to determine whether he actually carries the virus, use a condom during intercourse to protect his partner, and/or notify potential partners of his prior sexual conduct, drug use or other risky activities.

Although even an increased risk of HIV transmission may remain statistically low, the potential significance of the injury may be so great that failure to address the risk would still be considered negligence. With AIDS, the most frequent degree of injury is death. Thus, a low probability of transmission should not be prohibitive of a cause of action, especially where that probability is increased because of high risk activities.

An important factor used in evaluating the “risk” of particular conduct is the extent to which such a risk was recognizable to the defendant. Generally, a person is expected to recognize that his conduct involves the risk of causing the invasion of another’s interest, given the attention, perception of the circumstances, memory, knowledge.

105. See supra notes 38-49 and accompanying text (discussing the AIDS statistics and describing what constitutes high risk conduct).
106. See supra note 44 and accompanying text (listing groups of individuals considered to be at high risk).
107. See supra note 44 and accompanying text (indicating that the nature of an individual’s activities enhances the chance of transmission).
108. See Swenson, supra note 2, at 191 (reporting that in some areas of New York City as many as 80% of intravenous drug users are infected).
109. See infra notes 125-29 and accompanying text.
110. See infra notes 130-34 and accompanying text.
111. See infra notes 135-38 and accompanying text.
112. See supra note 49 (indicating a low rate of transmission, even for careless persons).
113. See Clark’s Adm'r v. Kentucky Utils. Co., 289 Ky. 225, 230-31, 158 S.W.2d 134, 137 (1942) (holding that despite the fact that lightning was an act of God and not a significant probability, failure to properly insulate an electric company meter box ground wire was still negligence); see also W. Prosser & W. Keeton, supra note 61, § 31, at 171 (analyzing situations where the chance of an occurrence is low but the potential damage is high).
114. See supra notes 6-7 and accompanying text (reviewing death rates for AIDS victims).
115. See W. Prosser & W. Keeton, supra note 61, § 31, at 170 (explaining that “[t]he idea of risk in this context necessarily involves a recognizable danger, based upon some knowledge of the existing facts, and some reasonable belief that harm may possibly follow.”).
edge, intelligence, and judgment of a reasonable man.\textsuperscript{116} More specifically, the person is presumed to know the qualities, characteristics and capacities of things and forces that are common knowledge in the community.\textsuperscript{117} An issue in AIDS negligence litigation may be whether the risk of HIV transmission is recognizable within the common knowledge of the community.\textsuperscript{118} Given the massive efforts undertaken to educate the public about the risk,\textsuperscript{119} the defendant's subjective lack of knowledge about AIDS seems unlikely to hamper litigation.\textsuperscript{120}

In determining the social utility of a given conduct, the court must evaluate the social value that the law attaches to the interest which is to be advanced or protected by the conduct, and the extent to which that interest can be protected by some other conduct.\textsuperscript{121}

The possibility that the interest protected is a personal right of pri-

\textsuperscript{116} Restatement (Second) of Torts § 289 (1965).
\textsuperscript{117} Id. § 290.
\textsuperscript{118} The lack of available information about AIDS in 1985 has prevented at least one plaintiff from recovering for negligent transmission. See C.A.U. v. R.L., 438 N.W.2d 441, 444 (Minn. Ct. App. 1989) (holding that "[b]ased on the affidavits submitted by respondent's physicians, and the information available to the general public [at the] time . . . it was not reasonable for respondent to have constructive knowledge that he might have AIDS, or that he was capable of transmitting the disease to appellant" where the parties were having sexual relations from May 1984 to May 1985).

Part of the common knowledge problem is likely to be found in the conflicting information available about AIDS. See generally Grady, supra note 8, at 60 (discussing some of the conflicting information about AIDS). Some of the informational problems can be blamed on certain groups of people who insist that AIDS is a vengeful act of God meant to punish homosexuals and drug users. Swenson, supra note 2, at 198 (asserting that "[t]hese attitudes are reminiscent of the nineteenth-century view that poverty was a moral failing and that cholera was God's wrath on the poor."). Because of such problems, "the fear of transmissibility of HIV infection is tremendously exaggerated in the public's psyche." Id. These fears may benefit potential AIDS plaintiffs if they raise the "common knowledge" view of transmission risk, thus raising the standard of conduct required to avoid such risk.

\textsuperscript{119} See 100 Questions, supra note 1, at 14 (noting that "[e]ducational campaigns are directed to the general public and those in risk groups for AIDS, encouraging them to discontinue any practices that have been linked with the possible spread of AIDS."); Surgeon General's Report, supra note 3, at 28 (stressing the importance of education and predicting that such information could save "as many as 12,000 to 14,00 people . . . in 1991 from death by AIDS.").

\textsuperscript{120} In fact, failure to know about the risks of AIDS may itself be sufficient to constitute negligence. Failure to investigate risks is sufficient to impose liability in some situations:

It is enough that [the defendant] should realize that his perception of the surrounding circumstances is so imperfect that the safety or danger of his act depends upon circumstances which at the moment he neither does nor can perceive. In such case it is negligent for him to act if a reasonable man would recognize the necessity of making further investigation.

Restatement (Second) of Torts § 289 comment j (1965).
\textsuperscript{121} Id. § 292.
vacy will be evaluated later in this Note.\textsuperscript{122} Beyond this, the evaluation of social utility can only be completed by considering the possible alternate courses of action.\textsuperscript{123} Three prevalently cited alternate courses of action which might logically be required are: submitting to tests for HIV infection, using condoms during sexual relations and informing potential sexual partners of current AIDS risk by describing previous sexual and drug related activities.\textsuperscript{124}

A defendant could arguably be found to have been negligent if he failed to be tested for HIV as a precaution for future sexual relations, after having participated in high risk activities. AIDS testing is often readily available at no cost.\textsuperscript{125} Assuming that it is not substantially difficult to obtain a test, and that testing is effective,\textsuperscript{126} the protective interest served by such testing would outweigh the interests preserved by not requiring testing.\textsuperscript{127} A rule which requires testing for all high risk individuals in order to avoid potential tort liability would, however, closely resemble mandatory testing schemes, which have not been widely supported.\textsuperscript{128} In fact, even the Surgeon

\begin{footnotes}
\item[122] See infra notes 240-50 and accompanying text.
\item[123] W. PROSSER & W. KEETON, supra note 61, § 31, at 172.
\item[124] See 100 QUESTIONS, supra note 1, at 21 (advocating these and other methods of reducing the risk of transmission); SURGEON GENERAL'S REPORT, supra note 3, at 16-17 (promoting mutually faithful monogamous relationships, blood tests for those who have been involved in high risk activities and condom use during vaginal and rectal intercourse).
\item[126] This may be an open question, since there is still much dispute over the accuracy of AIDS testing. See supra notes 50-57 and accompanying text (evaluating the process and accuracy of AIDS testing). Therefore, the reliability of AIDS testing would probably be an important issue of fact if a plaintiff argued that testing is the appropriate standard of conduct, or if the results of an AIDS test were used to show injury to the plaintiff.
\item[127] One possible interest to be preserved in not testing for AIDS is avoiding the emotional impact of a false positive test. Such test results do occur with relative frequency. See supra notes 53-54 and accompanying text.
\item[128] See Banks & McFadden, Rush to Judgment: HIV Test Reliability and Screening, 23 TULSA L.J. 1, 25-34 (1987) (evaluating mandatory screening, the potential discriminatory uses of such screening, and relevant privacy concerns); Howard, HIV Screening: Scientific, Ethical, and Legal Issues, 9 J. LEGAL MED. 601, 605 (1988) (suggesting that the "poor predictive value of HIV antibody" testing and the "adverse social consequences of mislabeling" make compulsory or voluntary universal screening undesirable); Rosoff, supra note 12, at 83 (arguing that "massive population screening" should not be instituted until test accuracy can be increased, confidentiality can be guaranteed, and education and counseling can be "integrated with the screening process . . . "); Note, Constitutional Rights, supra note 12, at
\end{footnotes}
General has opposed compulsory blood testing. Given the concerns of unmanageability and inadequate counseling, holding a high risk defendant negligent for failing to be tested for HIV appears to be an impracticable standard.

Alternatively, a person who frequently has sex, particularly anal intercourse, may be found negligent if he fails to wear a condom during subsequent sexual activities. Although estimates as to the effectiveness of condoms vary, condoms certainly reduce the risk of HIV transmission to some extent. Condoms lubricated with nooxynol 9 spermicide may contain the added advantage of being able to kill the virus that transmits AIDS, although that evidence is not conclusive. The most common "adverse interest" expressed concerning the use of condoms is simply that men do not like to use them. This interest is not persuasive in comparison to the potential consequences of unprotected sexual relations. However, condom use alone is an inadequate standard of conduct because the effectiveness of such a precaution is, at best, questionable.

Finally, a person who has engaged in high risk activity may simply be required to reveal his participation in such conduct to potential sexual partners. This is the most attractive theory because it is analogous to the available precedent dealing with venereal disease transmission and is supported by public policy. Courts have sup-

1287-89 (concluding that the psychological trauma produced by false positives and privacy concerns outweigh potential benefits from AIDS testing given the lack of casual contact transmission); Note, Characterization and Disease, supra note 12, at 250 (criticizing "[t]he current calls for mandatory AIDS testing" because they "have increased anxiety among gays who perceive such measures to be a surrogate marker for their homosexuality.").

129. Surgeon General's Report, supra note 3, at 33. In addition to citing administrative and cost-related problems, the Surgeon General noted that "many who test negatively might actually be positive due to recent exposure to the AIDS virus and [the test may] give a false sense of security to the individual and his/her sexual partners concerning necessary protective behavior." Id. (emphasis in original).

130. See supra note 48 and accompanying text (discussing the predictions and uncertainty concerning condom effectiveness, and endorsing their use as a precautionary measure).

131. See supra notes 48-49 (discussing the effectiveness of condoms).

132. See Carey, supra note 48, at 83 (noting that the spermicide has been shown to kill the virus in test-tube studies, and may be advantageous should the reservoir tip in the condom become torn during sexual activities). A recent study conducted by three medical professors found: "(1) latex condoms are impenetrable to HIV; (2) the spermicide nonoxynol 9, as proved earlier, kills HIV in vitro; and (3) when a condom containing non-oxynol 9 in the tip is torn, the spermicide kills the virus in two thirds of all cases." Goldsmith, supra note 48, at 2263.


134. See Note, Negligence, supra note 17, at 936 (arguing that "[a] duty to warn of possible transmission should exist even if a condom is worn since the possibility of transmission is present even when a condom is utilized.").
ported a duty to reveal an actual infection of venereal disease.\textsuperscript{135} If the courts require this type of disclosure when a typical venereal disease is present, it seems consistent to require disclosure of the heightened possibility of an infection. Moreover, accurate disclosure of sexual history has been widely promoted as a valuable weapon against the spread of AIDS.\textsuperscript{136} The preventive effect of such conduct appears to be much greater than whatever discomfort might be created.\textsuperscript{137} Although there may be equal protection arguments in response to any of these possible standards,\textsuperscript{138} this standard of conduct seems, on its face, to be the least intrusive, and to apply equally to all persons similarly situated.

B. \textit{Causation Among Multiple Defendants}

The medical facts about AIDS present several problems of identification that the potential AIDS plaintiff must overcome in order to be successful. Specifically, if the incubation period lasts several years or the victim engages in sexual relations with multiple partners of whom more than one turn out to be HIV infected, finding the spe-

\begin{itemize}
\item This was the issue in the Rock Hudson case, discussed supra note 62. The trial court found Hudson and his secretary to be liable because they kept Hudson's disease a secret in hopes of continuing the relationship between he and the plaintiff, Marc Christian. Rock Hudson's Lover Wins Suit, N.Y. Times, Feb. 16, 1989, at A22, col. 5; \textit{see also} Rock Hudson's Lover Wins, Nat'l L.J., Feb. 27, 1989, at 6, col. 3 (explaining that Hudson and his staff conspired to hide his AIDS infection from Christian, and that they had a duty to warn Christian about the disease).
\item \textsuperscript{136} See \textit{100 QUESTIONS,} supra note 1, at 21 (listing abstinence from sexual contact with persons with unknown past history and current health status first among methods to reduce the risk of AIDS); \textit{SURGEON GENERAL'S REPORT,} supra note 3, at 17 (urging that "[i]f your test is positive or if you engage in high risk activities and choose not to have a test, you should tell your sexual partner."); Goode, supra note 43, at 85 (examining the process for discussing such matters).
\item \textsuperscript{137} See Goode, supra note 43, at 85 (endorsing honest communication in sexual relationships despite any uneasiness which may exist); Note, \textit{Negligence,} supra note 17, at 936 (noting that "a duty to warn of the possibility of a deadly risk is a minimal burden on the individual.").
\item An analogous argument has been presented in the context of a negligence suit for herpes transmission:
[The] defendant's pursuit of personal gratification has no social utility whatsoever, and the resulting harm is affliction with an incurable, socially stigmatizing, and emotionally crippling disease. The interest that the herpetic seeks to protect—his own sexual satisfaction—is not legally cognizable. Thus, liability would almost certainly flow under the negligence balance.
Comment, \textit{Kathleen K.,} supra note 80, at 517 (footnote omitted).
\item \textsuperscript{138} See \textit{infra} notes 251-60 and accompanying text (discussing the equal protection ramifications of tort liability for AIDS transmission).
\end{itemize}
pecific tort-feasor responsible for the transmission may prove to be impossible. The most promising legal argument available to deal with this problem can be found in the recent development of group responsibility causation rules. The rule of "alternative liability," first developed in the landmark case of Summers v. Tice, should prove to be a valuable weapon in appropriate fact patterns. This rule, subsequently codified in the Restatement (Second) of Torts, provides that

[w]here the conduct of two or more actors is tortious, and it is proved that harm has been caused to the plaintiff by only one of them, but there is uncertainty as to which one has caused it, the burden is upon each such actor to prove that he has not caused the harm.

The nationwide status of the alternative liability rule is difficult to trace, with some states having clearly accepted the rule, several

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139. See supra note 25 and accompanying text (explaining the difficulties multiple partners and the incubation period present in litigation of AIDS cases).


141. 33 Cal. 2d 80, 199 P.2d 1 (1948). The plaintiff in Summers was injured while hunting quail with two other men, the defendants. Id. at 82, 199 P.2d at 2. The plaintiff was struck in his eye and in his lip by bird shot discharged from a shotgun. Id. The two defendants had both fired their weapons, identical 12 gauge shotguns both containing the same size shells. Id. Both defendants were found to have acted negligently, but it could not be determined which of them had fired the shot that injured the plaintiff. Id. at 83, 199 P.2d at 2. The court held that the burden of proof should be shifted to the defendants on the issue of causation. Id. at 88, 199 P.2d at 4. In justifying such a shift, the court said that the defendants were "both wrongdoers—both negligent toward plaintiff. They brought about a situation where the negligence of one of them injured the plaintiff, hence it should rest with them each to absolve himself if he can." Id.

142. Restatement (Second) of Torts § 433B (1965).

143. Id.

144. States that have accepted alternative liability in some form include: Alabama, see Nelson Bros., Inc. v. Bushby, 513 So. 2d 1015, 1018-19 (Ala. 1987) (citing Summers to uphold a jury instruction allowing recovery absent direct proof that one defendant proximately caused the injury); California, see Summers, 33 Cal. 2d at 87-88, 199 P.2d at 4-5; Michigan, see Abel v. Eli Lilly & Co., 418 Mich. 311, 331, 343 N.W.2d 164, 173 (formally approving the theory in Michigan, and "fashioning and approving a new DES-unique version of alternative liability."); cert. denied, 469 U.S. 833 (1984); New Jersey, see Shackil v. Lederle Laboratories, 219 N.J. Super. 601, 623, 530 A.2d 1287, 1298 (1987) (holding alternative liability applicable "where one of a group of tortfeasors is responsible, in which case the burden shifts to the other defendants to exculpate themselves."); Ohio, see Minnich v. Ashland Oil Co., 15 Ohio St. 3d 396, 397, 473 N.E.2d 1199, 1200 (1984) (finding alternative liability applicable in a case against two ethyl acetate suppliers following an explosion of the product, and adopting Restatement (Second) of Torts § 433(B)(3)); and Oklahoma, see Hood v. Hagler, 606
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states specifically rejecting the rule, and the majority of states having found its application to be unwarranted in the specific cases where it was offered. The policy justification behind alternative liability is that innocent plaintiffs should not suffer because the nature of the culpable defendants' conduct precludes discovery of the actual cause.

P.2d 548, 553 (Okla. 1980) (shifting the burden of proof to defendant dog owners who negligently allowed their dogs to run free, when it was not clear which dog had bitten the plaintiff).

145. States that have refused to judicially adopt alternative liability include: Florida, see Conley v. Boyle Drug Co., 477 So. 2d 600, 603 (Fla. Dist. Ct. App. 1985) (rejecting alternative liability because it imposes liability on innocent defendants "simply because they may not be able to establish their blamelessness.") and Oregon, see Senn v. Merrell-Dow Pharmaceuticals, Inc., 305 Or. 256, 271, 751 P.2d 215, 223 (1988) (refusing to judicially adopt alternative liability because such action "requires a profound change in fundamental tort principles of causation, an adjustment rife with public policy ramifications" and suggesting that the "legislature may study and adopt one or another such theory . . .").

146. Many states have considered alternative liability when applicable fact patterns have arisen, but have refused to fully accept the rule, or to apply it because of specific gaps in the cases. Such states include: Arizona, see Porterie v. Peters, 111 Ariz. 452, 456, 532 P.2d 514, 518 (1975) (finding that the negligence of all defendants was not proven); Illinois, see Smith v. Eli Lilly & Co., 173 Ill. App. 3d 1, 31-32, 527 N.E.2d 333, 352-53 (1988) (rejecting alternative liability in a DES case where obtaining evidence would be difficult for all parties, not all of the potential defendants were joined and where the theory would not allow apportionment of damages corresponding to the amount of DES each manufacturer produced); Iowa, see Mulcahy v. Eli Lilly & Co., 386 N.W.2d 67, 73-74 (Iowa 1986) (rejecting the alternative liability theory in a DES case because not all possible defendants were joined); Maryland, see Thodos v. Bland, 75 Md. App. 700, 715-16, 542 A.2d 1307, 1315 (1988) (rejecting the alternative liability theory in an automobile accident case where negligence of all defendants was not shown); Minnesota, see Bixler v. Avondale Milles, 405 N.W.2d 428, 430-31 (Minn. Ct. App. 1987) (rejecting the alternative liability theory where negligence was not proven for any defendants, and not all possible defendants were joined); Missouri, see Zafft v. Eli Lilly & Co., 676 S.W.2d 241, 244 (Mo. 1984) (holding that alternative liability "has not achieved full acceptance in Missouri."); Nevada, see Kleitz v. Raskin, 738 P.2d 508, 509-10 (Nev. 1987) (refusing to shift the burden of proof when injury to the plaintiff could have occurred in one of two automobile accidents that occurred one month apart from each other); New York, see Centrone v. C. Schmidt & Sons, Inc., 114 Misc. 2d 840, 842, 452 N.Y.S.2d 299, 301 (Sup. Ct. 1982) (holding that alternative liability could not be applied where only one of the defendants had been shown to have acted tortiously); Utah, see Weber v. Springville, 725 P.2d 1360, 1367-68 (Utah 1986) (declining to endorse alternative liability where the plaintiff failed to bring into the lawsuit all of the potential tortfeasors); Washington, see Foster v. Carter, 49 Wash. App. 940, 945, 742 P.2d 1257, 1261 (1987) (finding Summers to be inapplicable when only one negligent defendant exists); and Wisconsin, see Collins v. Eli Lilly & Co., 116 Wis. 2d 166, 183-84, 342 N.W.2d 37, 46 (rejecting alternative liability in a DES case where defendants were not in a better position to offer evidence, it was not guaranteed that all negligent defendants were joined and where the theory does not fairly apportion damages among the defendants), cert. denied, 469 U.S. 826 (1984).

147. See Summers v. Tice, 33 Cal. 2d 80, 86, 199 P.2d 1, 4 (1948). The same policy rationale is given in the Restatement (Second) of Torts:

[T]he reason for the exception is the injustice of permitting proved wrongdoers, who among them have inflicted an injury upon the entirely innocent plaintiff, to escape
The potential application of alternative liability is easily understood in terms of a hypothetical. Imagine a situation where an AIDS victim has had sexual relations with more than one HIV carrier during the time when he or she must have contracted the disease. If alternative liability was imposed, the burden would be shifted to the defendants to establish that they could not have transmitted the disease to the plaintiff. Those defendants failing to establish that they could not have transmitted the disease would be subject to joint and several liability for the plaintiff's damages. Given the apparent difficulty of providing such proof, shifting the burden will most likely guarantee the plaintiff's victory on the issue of causation. The policy justification in an AIDS case is that the plaintiff should not suffer a loss merely because the virus that causes AIDS has a unique incubation period that renders identification of the transmitter impossible. Despite the appeal of such an argument, several potential problems exist.

As a preliminary matter, the use of alternative liability has been limited to situations where all possible causes of the plaintiff's injury have been joined. Therefore, the AIDS plaintiff must determine liability merely because the nature of their conduct and the resulting harm has made it difficult or impossible to prove which of them has caused the harm.

Restatement (Second) of Torts § 433B comment f (1965); see infra notes 209-34 and accompanying text (discussing situations in which the AIDS plaintiff does not appear to be "entirely innocent").

148. See supra notes 18-20 (discussing potential causes of action in battery, fraud and deceit or misrepresentation). For the purposes of this Note, it is assumed that none of the HIV carriers knew that they had the infection.

The fact that the plaintiff had multiple partners may prove troublesome in establishing his innocence. See infra notes 209-34 and accompanying text (discussing the implications of the plaintiff's conduct).

149. See supra text accompanying note 143 (presenting the alternative liability rule and its effect).

150. See, e.g., In re "Agent Orange" Product Liability Litigation, 597 F.Supp. 740, 822 (E.D.N.Y. 1984) (explaining that those defendants who do not meet their burden are subject to joint and several liability), aff'd 818 F.2d 145 (2d Cir. 1988).

151. See, e.g., Weber v. Springville, 725 P.2d 1360, 1367-68 (Utah 1986) (refusing to apply Summers where the plaintiffs failed to join all of the potential tortfeasors—all of the land owners at points where the plaintiff's child may have fallen into a creek); see also Restatement (Second) of Torts § 433B comment h (1965) (reporting that "[t]he cases thus far decided in which the rule [of alternative liability] ... has been applied all have been cases in which all of the actors involved have been joined as defendants.").

Joining all potential causes has been a significant problem in attempts to impose alternative liability on DES manufacturers. See, e.g., Mulcahy v. Eli Lilly Co., 386 N.W.2d 67, 73-74 (Iowa 1986); Smith v. Eli Lilly Co., 173 Ill. App. 3d 1, 31-32, 527 N.E.2d 333, 352-53 (1988); Collins v. Eli Lilly Co., 116 Wis. 2d 166, 183-84, 342 N.W.2d 37, 46, cert. denied, 469 U.S. 826 (1984); But see Abel v. Eli Lilly & Co., 418 Mich. 311, 331, 343 N.W.2d 164, 172-73...
every possible cause of the infection, and must join them all in the lawsuit. This requirement may prove quite cumbersome given the number of potential causes, some of which do not involve sexual activities. The possibility that situations may arise which call for relaxing this rule has been noted by some commentators, as well as the courts. In the products liability field, the "market share liability" rule has been developed to deal with such a problem. However, since the rule is by definition a products liability doctrine, it would seem to be inapplicable in the AIDS hypothetical. Creating an exception to the general rule requiring all potential causes to be joined in the suit may well require a showing of more distinguishing characteristics than the facts provide. At the very least, there is a strong comparative negligence argument against a plaintiff whose conduct has been such that he does not even know all of the possible causes of his infection. Where it is the plaintiff's conduct that causes the lack of evidence on the causation issue, burden shifting seems both inappropriate and inequitable. Additionally, the de-


152. See supra notes 38-46 and accompanying cases using the alternative liability rule have "involved conduct of substantially the same character, creating substantially the same risk of harm, on the part of each actor." Restatement (Second) of Torts § 433B comment h (1965). Thus, as the differences between the potential causes grow, the viability of a lawsuit would be reduced.

153. The authors of the Restatement (Second) of Torts recognized the necessity of modifying this requirement:

   It is possible that cases may arise in which some modification of the rule stated may be necessary because of complications arising from the fact that one of the actors involved is not or cannot be joined as a defendant . . . . The rule stated in Subsection (3) is not intended to preclude possible modification if such situations call for it.

Restatement (Second) of Torts § 433B comment h (1965).

154. See, e.g., Martin v. Abbott Laboratories, 102 Wash. 2d 581, 595, 689 P.2d 368, 377 (1984) (noting that there may be an exception to this requirement "where not all of the defendants were joined but strong policy reasons and 'the single indivisible injury' or 'risk contribution' rules could be applied.").

155. See, e.g., Sindell v. Abbott Laboratories, 26 Cal. 3d 588, 611-12, 607 P.2d 924, 937, 163 Cal. Rptr. 132, 144-45 (finding Summers to be inappropriate in DES litigation and holding that "[e]ach defendant will be held liable for the proportion of the judgment represented by its share of that market unless it demonstrates that it could not have made the product which caused plaintiff's injuries"), cert. denied, 449 U.S. 912 (1980). For a more complete description of the rule, see Bush, supra note 140, at 1484-86.

156. See generally W. PROSSER & W. KEETON, supra note 61, § 41, at 271 (discussing the application of the market share liability rule).

157. See infra notes 222-35 and accompanying text (analyzing the contributory negligence and comparative negligence arguments in an HIV transmission suit).

158. Alternative liability is a rule developed to protect innocent plaintiffs when the conduct of the defendants has made identification of the real cause difficult or impossible. See supra note 147 and accompanying text (discussing the policy rationale of alternative liability).
fendants are no longer in a better position to offer proof of causation, because they would have no conceivable way to trace the plaintiff’s disease or to locate all of the potential causes. Therefore, alternative liability seems to be a viable theory only where the AIDS plaintiff can identify all of the potential sources of transmission and join them in the suit.

A second problem for potential AIDS litigants is the rule that limits the imposition of alternative liability to situations where all of the defendants can be shown to have acted negligently. Assuming that the standard of conduct has been set at the level suggested by this Note, it is certainly possible that not all defendants will be found to have acted negligently. If even one of the defendants was candid and honest about his or her high risk activities, the plaintiff would be unable to shift the burden of proof on causation. The result would be the same if any of the defendants had not participated in high risk activities, but had acquired HIV through non-negligent conduct. Because alternative liability is used in an effort to place the burden of proof of cause in fact on the wrongdoer rather than the innocent plaintiff, it is consistent to deny application of the rule.

The policy rationale would no longer be supported by shifting the burden of proof since the plaintiff who cannot even be sure he has found all of the potential causes of his infection would appear to have engaged in conduct that is far from “innocent.”

Alternative liability was created on the premise that “ordinarily defendants are in a far better position to offer evidence to determine which one caused the injury.” Summers v. Tice, 33 Cal. 2d 80, 86, 199 P.2d 1, 4 (1948). Where the plaintiff is in a better position to offer such evidence, the policy rationale has not been satisfied.

In order to justify the imposition of alternative liability, the plaintiff must prove that all of the defendants acted negligently:

The rule . . . applies only where it is proved that each of two or more actors has acted tortiously, and that the harm has resulted from the conduct of some one of them. On these issues the plaintiff has still the burden of proof. The rule stated has no application to cases of alternative liability, where there is no proof that the conduct of more than one actor has been tortious at all. In such a case the plaintiff has the burden of proof both as to the tortious conduct and as to the causal relation.


See supra notes 135-38 and accompanying text (arguing that the defendant should be held negligent for failure to disclose participation in high risk activities).

See supra note 147 and accompanying text (discussing the policy rationale for al-
when not all of the possible causes are, in fact, wrongdoers. Additionally, an individual should not be held responsible for an injury caused by members of a group, when the individual is not a member of that group.\textsuperscript{163} Thus, the use of alternative liability is further limited to situations where all of the defendants acted negligently.

The third, but less obvious, problem for AIDS litigants may be the fact that alternative liability has traditionally been applied only when defendants acted simultaneously.\textsuperscript{164} In the AIDS hypothetical, the time period during which the plaintiff may have contracted the disease could be quite lengthy.\textsuperscript{165} Even if an incubation period of several years or longer is possible, the plaintiff would be required to include all possible causes of his infection within that time period in his suit.\textsuperscript{166} There are situations where all of the possible HIV transmitters may have acted in unison,\textsuperscript{167} but it is more likely that the possible causes will be separated by some period of time. One possible answer to this argument is that for the purposes of determining who transmitted the virus, all of the acts in question should be considered to have occurred simultaneously.\textsuperscript{168} Additionally, the plaintiff...
may choose to argue that the requirement of simultaneous causes should be abandoned in this case. It has been suggested that particular fact patterns may require a modification of the rule. Assuming that the time involved does not affect the ability to identify the specific cause of injury, the exclusion of alternative liability would still render an innocent plaintiff helpless against culpable defendants. Judicial reaction to these arguments remains to be seen, but it would be inconsistent with the policy justification for alternative liability to allow defendants to be exculpated merely because their conduct was not simultaneous, when the rule would be imposed if the exact same conduct had been done simultaneously.

The final problem arises because AIDS may be contracted through multiple exposures. In the hypothetical situation described above, it may be possible that sexual contact with one of the defendants would not have been sufficient to cause the infection. Although it is unclear whether alternative liability can be utilized when more than one defendant is the actual cause of injury, it is consistent with the policy justification of the rule to shift the burden of proof in a case where it is possible that only one, several, or all of the defendants caused the harm. First, the nature of the injury (i.e. the possibility that multiple exposures were required for transmis-

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*See Black's Law Dictionary* 1241 (5th ed. 1979) (defining “simultaneous” as “[a] word of comparison meaning that two or more occurrences or happenings are identical in time.”). *But see* Webster's Third New International Dictionary 2122 (1976) (defining “simultaneous” as meaning “existing or occurring at the same time . . . .”). For comparative purposes, the separate acts may be identical in time, in that they each occurred during the time period where HIV transmission may have taken place.

169. The Restatement (Second) of Torts has once again left open the opportunity for expansion of the rule:

> It is possible that cases may arise in which some modification of the rule stated may be necessary because . . . of the effect of lapse of time . . . . Since such cases have not arisen, and the situations which may arise are difficult to forecast, no attempt is made to deal with such problems in this Section.

Restatement (Second) of Torts § 433B comment h (1965).

170. *See supra* text accompanying note 42 (recognizing that the large volumes of blood necessary to transmit AIDS may require multiple exposures).

171. *See, e.g.*, Padian, *supra* note 42, at 790 (finding that multiple exposure to infected sexual partners created a significant risk unlike general sexual activity).

172. The rule as stated seems to limit application of alternative liability to situations where only one defendant is the actual cause. See *supra* text accompanying note 142 (stating as part of the rule the requirement that “it is proved that harm has been caused to the plaintiff by only one of [the defendants] . . . .”); see also Restatement (Second) of Torts § 433B comment f (1965) (indicating that the rule “arises where the conduct of two or more actors has been proven to be negligent or otherwise tortious, and it is also proved that the harm to plaintiff has been caused by the conduct of only one of them, but there is uncertainty as to which one.” (emphasis added)).
HIV TRANSMISSION

sion) should not preclude recovery from culpable defendants.\textsuperscript{173} Second, this situation presents an answer to the major objection to alternative liability; defendants who did not actually cause the injury should not be made to share in the payment of the damages to the plaintiff.\textsuperscript{174} If it is possible that all of the defendants may have shared in causing the injury, it is rational to hold them jointly and severally liable.

Another option in the multiple exposure situation would be utilization of the “single indivisible result” rule.\textsuperscript{175} This rule provides relief in situations where the type of harm caused by the tortious actions of two or more defendants are “by their very nature . . . normally incapable of any logical, reasonable, or practical division.”\textsuperscript{176} In these cases, the burden of proof is not shifted, but no apportionment is made and each defendant can be held liable for the entire harm.\textsuperscript{177} This rule has been used in a variety of situations,\textsuperscript{178}

\textsuperscript{173} See supra note 147 and accompanying text (discussing the policy rationale for alternative liability).

\textsuperscript{174} See Conley v. Boyle Drug Co., 477 So. 2d 600, 603 (Fla. Dist. Ct. App. 1985) (articulating such an objection).

\textsuperscript{175} See generally W. PROSSER & W. KEETON, supra note 61, § 52, at 347 (discussing the “single indivisible result” rule).

\textsuperscript{176} RESTATEMENT (SECOND) OF TORTS § 433A comment i (1965). The comment continues to explain that “[d]eath is that kind of harm, since it is impossible, except upon a purely arbitrary basis for the purpose of accomplishing the result, to say that one man has caused half of it and another the rest.” Id.

\textsuperscript{177} Id.; see Bolick v. Gallagher, 268 Wis. 421, 427, 67 N.W.2d 860, 863 (1955) (holding that “where independent torts concur to inflict a single injury, each tort-feasor is liable for the entire damage.”), overruled on other grounds, Butzow v. Wausau Memorial Hosp., 51 Wis.2d 281, 187 N.W.2d 349 (1971).

\textsuperscript{178} Common situations for the application of this rule include: accidents involving multiple vehicles, see Hackworth v. Davis, 87 Idaho 98, 105-07, 390 P.2d 422, 426-27 (1964) (finding that the jury should have been instructed on the single indivisible injury theory where plaintiff’s car was struck head-on, and then struck from the rear by a truck); Arnst v. Estes, 136 Me. 272, 276, 8 A.2d 201, 203 (1939) (holding that the entire liability will only be incurred absent any logical basis for apportionment); Watts v. Smith, 375 Mich. 120, 125-26, 134 N.W.2d 194, 195-96 (1965) (applying the single indivisible injury rule to litigation stemming from two accidents in the same day); fires which merge and cause destruction, see Anderson v. Minneapolis, St. P. & S. Ste. M. Ry., 146 Minn. 430, 440-41, 179 N.W. 45, 49 (1920) (holding that “[i]f a fire set by the engine of one railroad company unites with a fire set by the engine of another company, there is joint and several liability, even though either fire would have destroyed plaintiff’s property.”) and medical injuries, see Blanton v. Sisters of Charity, 82 Ohio App. 20, 24-25, 79 N.E.2d 688, 691 (1948) (upholding the conclusion that both the hospital and the operating surgeon were negligent in causing the patient’s death); Brown v. Murdy, 78 S.D. 367, 374, 102 N.W.2d 664, 667 (1960) (allowing two physicians to be joined as defendants despite the fact that “the alleged negligence of the two tortfeasors took place at different times and at different places [with] each doctor follow[ing] his own course of treatment . . . .”).

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and can be imposed when any defendant alone could have caused the harm, or where the conduct of both was necessary to bring about the harm. This rule carries one more significant advantage for the AIDS plaintiff in that it does not require that the acts in question occur simultaneously. Thus, if an AIDS plaintiff can show through medical testimony that his injury was caused by multiple exposures to the defendants’ HIV infections over a period of time, joint and several liability could be imposed.

The most significant objection to the use of alternative liability in AIDS cases may be that the rule would serve to reduce, if not eliminate, the deterrent effect of such litigation. Assuming that liability for the negligent transmission of HIV is imposed as a method of encouraging safe sexual practices, it would seem inconsistent to allow a shift in the burden of proof where the plaintiff has himself engaged in high risk group activities. Additionally, there may be some hesitance on the part of the courts to allow any AIDS victim to recover damages, particularly given the apparent public fear of and disdain for AIDS victims. This general hesitance, along with the desire to encourage safe sexual practices on the part of all individuals, will most likely limit success in HIV transmission suits involving multiple defendants to situations that fit the rules analyzed above.

C. Statutes of Limitations

It has been suggested that the lengthy incubation period that AIDS victims experience between infection and symptoms may cause them to discover the disease only after the statute of limitations has run on any potential claim. There has been a tremendous increase in judicial acceptance of the discovery rule, which starts the statute running when the plaintiff knew or should have known of his

179. Restatement (Second) of Torts § 433A comment i (1965).
180. Id. (concluding that “[i]t is not necessary that the misconduct of two or more tortfeasors be simultaneous” and adding that “[n]one defendant may create a situation upon which the other may act later to cause the harm.”); see also Maddux v. Donaldson, 362 Mich. 425, 434-35, 108 N.W.2d 33, 38 (1961) (noting that “[t]he reason for the rule as to joint liability for damages was the indivisibility of the injuries, not the timing of the various blows.”).
181. The goal of alternative liability is to have the failure of proof fall upon culpable defendants, as opposed to the innocent plaintiff. See W. Prosser & W. Keeton, supra note 61, § 41, at 271.
182. See supra note 118 (discussing public misinformation and the exaggerated public fear concerning AIDS).
183. See supra notes 140-80 and accompanying text.
184. See supra note 98 and accompanying text.
Although the nature of the AIDS injury is analogous to the typical discovery rule situation, imposition of this rule may prove difficult because the traditional rule for venereal disease cases has been that the statute runs from the time of infection. The current discovery rule trend, accompanied by the difference in incubation periods between AIDS and other venereal diseases, mandates a move away from the traditional rule. In an HIV transmission case, the statute should begin to run at the time the plaintiff knew or should have known that he developed the HIV infection.


In the court's analysis of the New York statute of limitations, it concluded that the statute began to run "[a]t that time [the defendant] introduced into the body of the plaintiff infectious pus producing bacteria known as gonococci, which causes the disease of gonorrhea." Id. at 346; see also supra note 97 (analogizing to cases involving the injection or inhalation of hazardous substances).
Assuming that the statute does not begin to run until discovery has or should have occurred, the plaintiff who discovers his HIV infection may be precluded from recovering for damages manifested when or if he develops ARC or AIDS. This type of problem has had major significance in the area of toxic substance litigation.\textsuperscript{188} Courts have countered this problem by allowing claims for present damages and fear of future harm,\textsuperscript{189} allowing recovery for substantial chances of future harm,\textsuperscript{190} or permitting a claim for present damages and allowing a second suit if further damage develops.\textsuperscript{191}

Several courts have allowed recovery for the fear of future harm in addition to present injuries.\textsuperscript{192} Such recovery has been limited to

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\textsuperscript{188} Cf. W. PROSSER & W. KEETON, THE LAW OF TORTS § 30, at 26 (5th ed. Supp. 1988) (arguing that in cases where some injury has been discovered, such as asbestosis, but more serious injuries are still possible, such as cancer, the combined principles of the discovery rule and res judicata could eliminate any claim for the later injuries).
\textsuperscript{190} See, e.g., Herber v. Johns-Manville Corp., 785 F.2d 79 (3rd Cir. 1986); Jackson, 781 F.2d at 394.
\textsuperscript{191} See, e.g., Herber, 785 F.2d at 79; Hagerty, 788 F.2d at 320-21; Eagle-Picher Indus., 481 So. 2d at 520.
\textsuperscript{192} See, e.g., Hagerty, 788 F.2d at 318 (allowing recovery for reasonable and genuine fear of contracting cancer where the plaintiff had been exposed to dripolene); Jackson, 781 F.2d at 414 (permitting recovery for fear of developing cancer when asbestosis was already present); Eagle-Picher Indus., 481 So. 2d at 528-89 (allowing a cause of action for fear of cancer).

At least one court, however, has rejected a cause of action based on “AIDS-phobia.” See Doe v. Doe, 136 Misc. 2d 1015, 519 N.Y.S.2d 595 (Sup. Ct. 1987). In Doe the Supreme Court of Kings County, New York rejected an “AIDS-phobia” claim which had been added to a divorce action by the wife because the husband had admitted homosexual conduct. Id. at 1016, 519 N.Y.S.2d at 596. The Court had a number of objections to the cause of action. The Court felt that the claim was an attempt to “circumvent the dictates of equitable distribution . . . .” Id. at 1018-19, 519 N.Y.S.2d at 597-98. The claim was distinguished from “cancer-phobia” cases because no actual injury had occurred and because the plaintiff was not subjected to regular check-ups to track the potential for disease. Id. at 1019-20, N.Y.S.2d at 598. Additionally, the Court appeared hesitant to punish disclosure of homosexual conduct, which it felt was “a responsible action of preventing any potential spread of the AIDS virus.” Id. at 1021, N.Y.S.2d at 599. Finally, the Court rejected the proximate cause analysis, finding that “the claim in this matter is a possibility, based on a potential, based on a possibility.” Id.

Where the defendant actually has AIDS or and HIV infection, the case for “AIDS-phobia” may be much stronger. Surely the plaintiff in such a case could argue that HIV antibody testing is required and, therefore, there is a clear proximate cause to the fear. However, this rule would still create a disincentive to inform a partner of high risk activity or HIV infection. Such a rule is undesirable if the goal of litigation is to promote responsible sexual practices.

\end{quote}
situations where “the plaintiff’s mental suffering is accompanied by a physical injury, or when the plaintiff establishes the defendant’s misconduct to have been wilful, gross, or wanton.” This seems consistent with the general rule that even a slight impact and injury can warrant recovery for emotional distress caused by fear. In AIDS litigation, HIV infection itself should be sufficient to establish a reasonable fear of AIDS. The problem with these types of damages may well be that recovery for fear would be substantially less than recovery for symptoms, should they actually develop.

The second possible solution is to allow recovery for the increased probability that AIDS will be contracted. This would be analogous to medical malpractice decisions which have allowed recovery for the decreased chance of survival. The more similar cases, such as toxic exposure, have also resulted in such recovery at times. Since seventy percent of those infected with full-blown AIDS die within two years of diagnosis, and since there is only a two to five percent survival rate for those diagnosed between 1978 and 1983, a reasonable probability of death may be easy to demonstrate once AIDS has been diagnosed. However, it would be more difficult to justify the recovery of damages where the only present harm is HIV infection, because the majority of those victims apparently will not develop AIDS.

193. Jackson, 781 F.2d at 414.
194. See Herber, 785 F.2d at 85 (holding that the infiltration of the defendant’s lungs with asbestos fibers constituted an impact sufficient enough to allow a claim for fear of cancer). The analogous argument is that infiltration of HIV into the plaintiff’s body constitutes a sufficient impact.
195. See Note, Tort Liability, supra note 17, at 196-201 (arguing that HIV infection is sufficient to meet the physical injury requirement, and that a fear of AIDS would be a reasonable consequence of HIV infection).
196. See W. Prosser & W. Keeton, supra note 61, § 54, at 360-61 (noting that such harm is “often temporary and relatively trivial,” with many courts unwilling to open the door to fraudulent claims).
197. See, e.g., Waffen v. United States Dep’t of Health and Human Servs., 799 F.2d 911, 919 (4th Cir. 1986) (arguing that a “cause of action may be brought under Maryland law for loss of a substantial possibility of survival . . . .”).
198. See, e.g. Herber., 785 F.2d at 81 (allowing such a claim when future harms can be expected to flow from present harms with reasonable probability); Jackson 781 F.2d at 412-13 (indicating that the jury is to evaluate the medical testimony concerning the reasonable probabilities). But see Eagle-Picher Indus. v. Cox, 481 So. 2d 517, 524 (Fla. Dist. Ct. App. 1985) (arguing that such recovery would run afoul of public policy and would result in inequitable results).
199. See supra text accompanying note 7.
201. See supra note 38 and accompanying text (discussing the statistics at each stage of
The third option is to allow a second suit if the full-blown AIDS and the accompanying symptoms develop. Again, such rules were first developed in the area of toxic torts. Application of this rule in AIDS litigation would be a recognition that HIV infection and "full-blown" AIDS are distinct injuries, and that separate suits can be maintained. Assuming that the plaintiff is physically and mentally able to pursue litigation once AIDS is fully developed, allowing a second suit would provide the best solution to the statute of limitations problem because it would increase the chances that such HIV victims who later develop AIDS would receive full compensation.

V. DEFENSES AND FURTHER COMPLICATIONS

In addition to the arguments already discussed in this Note, the defendant in an HIV transmission suit has a variety of other arguments at his disposal. First, the defendant may argue that the nature of the plaintiff's conduct was such that the plaintiff assumed the risk of contracting HIV or was guilty of contributory negligence. Arguments that traditionally fall under either doctrine may ultimately be inapplicable to an AIDS infection.

Recovery for prospective harm has been limited to situations where the chance of such harm is greater than 50%. Cf. Gideon v. Johns-Manville Sales Corp., 761 F.2d 1129, 1137-38 (5th Cir. 1985) (indicating that the plaintiff with a less than 50% chance of contracting cancer could probably not meet the preponderance of the evidence standard, and thus could not recover for the prospective disease). But cf. McCall v. United States, 206 F. Supp. 421, 426 (E.D. Va. 1962) (awarding damages for a 3-25% chance that the plaintiff would develop epilepsy); Herskovits v. Group Health Coop., 99 Wash. 2d 609, 614, 664 P.2d 474, 487 (1983) (holding that a cancer patient could maintain his cause of action where a hospital's negligence had reduced his chance of survival by 14%). If the 50% standard is applied, an HIV infected plaintiff would be unable to recover because his chance of contracting AIDS appears to be only 20-30%. See supra note 38 and accompanying text.

202. See, e.g., Herber 785 F.2d at 82 (holding that a cause of action for cancer does not accrue until the person discovers, or should have discovered, that he has cancer); Hagerty v. L & L Marine Servs., Inc., 788 F.2d 315, 320 (5th Cir. 1986) (finding that the development of cancer can lead to an independent cause of action); Eagle-Picher Indus., 481 So. 2d at 524-26 (rejecting the imposition of damages for potential future harm in an asbestos case, and keeping the opportunity of a second suit open); Devlin v. Johns-Manville Corp., 202 N.J. Super. 556, 568, 495 A.2d 495, 502 (1985) (recognizing asbestosis and asbestos-related cancer as two independent injuries). In Eagle-Picher Indus., the court kept the opportunity of a second suit open in order to reach a compromise between the plaintiff who might otherwise be precluded from full recovery of damages and the defendant who should not have to compensate unless an actual injury occurs. 481 So. 2d at 524-26.

203. See Note, Tort Liability, supra note 17, at 207-08 (noting that such a solution is only practical in jurisdictions that have adopted the discovery rule).

204. See infra notes 210-21 and accompanying text.

205. See infra notes 222-30 and accompanying text.
mately be examined under a comparative negligence scheme. The defendant may also assert that the plaintiff's conduct was in fact illegal, thus barring him from recovery. Alternatively, the defense may center around the protection of the defendant's own rights, including privacy rights and equal protection rights.

A. Assumption of the Risk

In general terms, the assumption of the risk defense bars recovery where there has been "knowledge of the danger and voluntary acquiescence in it" by the plaintiff. In a jurisdiction that continues to recognize assumption of the risk as a viable defense, the defendant in an AIDS negligence suit is likely to argue that the plaintiff was aware of the risk of infection through sexual contact. Such an argument will be even more persuasive if the plaintiff's contact with the defendant can be said to constitute "high risk" conduct. This is essentially an "implied assumption of the risk" argument. The first requirement of such a defense is that the plaintiff must "know that the risk is present, and he must further understand its nature . . . ." It has been held, however, that this must be knowledge of a specific risk, not knowledge of a general danger. The plaintiff should not be held to have knowledge of the specific risk unless he knows of the defendant's previous conduct or where the

206. See infra notes 231-35 and accompanying text.
207. See infra notes 236-39 and accompanying text.
208. See infra notes 240-50 and accompanying text.
209. See infra notes 251-60 and accompanying text.
210. W. PROSSER & W. KEETON, supra note 61, § 68, at 482.
212. Baruch, supra note 17, at 185 (noting that this argument is likely to center on the fact that AIDS risks have been widely publicized).
213. See W. PROSSER & W. KEETON, supra note 61, § 68, at 484 (indicating that this is the most common assumption of the risk argument, where consent to assume the risk is "to be implied from the conduct of the plaintiff under the circumstances.").
214. Id. at 487.
215. RESTATEMENT (SECOND) OF TORTS § 496A (1965); see, e.g., Garcia v. City of South Tucson, 131 Ariz. 315, 319, 640 P.2d 1117, 1121 (Ct. App. 1981) (holding that "[a] general knowledge of 'a danger' is not sufficient, but rather plaintiff must have actual knowledge of the specific risk that injured him and appreciate its magnitude.").
216. But see Baruch, supra note 17, at 185-86 (arguing that the risk of AIDS in some
contact with the defendant itself constitutes high risk activity since the risk of AIDS is significantly higher for people who engage in high risk group activities. This is also consistent with the standard of conduct advocated earlier in this Note. Once the defendant has disclosed his or her high risk group background, the plaintiff should have knowledge of the specific risks entailed. At this point the defendant is not negligent, and the plaintiff assumes any risks if he or she proceeds with sexual activities.

The second requirement for this defense is that the plaintiff's choice to assume the risk "must be free and voluntary." Such voluntary assumption must be indicated by "some manifestation of consent to relieve the defendant of the obligation of reasonable conduct." Although the decision to have sex would appear to be a sufficient manifestation of consent, there is some precedent holding otherwise. However, where the plaintiff's conduct is "high risk" in nature, it is clearly reasonable to conclude that he has manifested such consent. Therefore, assumption of the risk should not be a problem absent facts which indicate that the plaintiff realized the specific risk of AIDS.

B. Contributory Negligence

The defense of contributory negligence consists of a showing that the plaintiff's own conduct fell below the standard it should have met for his own protection, and that such a failure was a legal cause of the injury. Under a traditional approach where contributory negligence completely barred the plaintiff's claim, the effect could be devastating. A plaintiff who did not request information on the defendant's health and experiences, who did not use a condom, communities, such as San Francisco, may be high enough to support an argument that the plaintiff had enough information to constitute knowledge of a specific risk of contracting the disease.

217. See supra note 44 and accompanying text (discussing high risk group activity).
218. See supra notes 135-38 and accompanying text (advocating disclosure of high risk activity as the acceptable standard of conduct).
219. W. PROSSER & W. KEETON, supra note 61, § 68. at 487.
220. Id. at 490.
221. See, e.g., Kathleen K. v. Robert B., 150 Cal. App. 3d 992, 198 Cal. Rptr. 273, 276 (1984) (finding that consent to sexual intercourse was not a bar to recovery where herpes was fraudulently concealed).
223. Id. at 452.
224. Cf. Stephen K. v. Roni L., 105 Cal. App. 3d 640, 645, 164 Cal. Rptr. 618, 621 (1980) (holding that the father of a child could not escape responsibility where the mother had made false and intentional misrepresentations that she was using birth control, because he was
or merely participated in high risk activities, could potentially be denied any recovery. Such analysis might be inevitable under a system that extended the standard of conduct as suggested by this Note.\footnote{226}

One possible answer to the contributory negligence defense is the argument that there is generally no duty to anticipate the negligence of others.\footnote{226} This argument is unpersuasive because failure to appreciate a risk which would be apparent to a reasonable person is sufficient to constitute contributory negligence.\footnote{227} In addition to the risk of contracting AIDS, the plaintiff may be risking the spread of AIDS if precautions are not used.\footnote{228} If the plaintiff has engaged in high risk group activities prior to contact with the defendant, the contributory negligence argument may be overwhelming. The best hope for potential AIDS plaintiffs lies in the fact that defendants are usually evaluated at a higher standard of conduct,\footnote{229} or in the fact that more than forty states have instead adopted a comparative negligence system.\footnote{230}

C. Comparative Negligence

Under a “pure” comparative negligence rule the plaintiff’s recovery is reduced in proportion to his own fault.\footnote{231} Therefore, in a suit for negligent transmission of HIV, the plaintiff’s failure to inquire, failure to use a condom or participation in high risk activity, would be weighed against the negligent action taken by the defendant (which may include failure to disclose his own infection). In a

\footnotesize{also in a position to take precautions); Baruch, supra note 17, at 186 (arguing that Stephen K. amounts to a judicial warning to use condoms).

\footnotesize{The official position taken by the Surgeon General is that “[u]nless it is possible to know with absolute certainty that neither you nor your sexual partner is carrying the virus of AIDS, you must use protective behavior.” Surgeon General’s Report, supra note 3, at 16 (emphasis in original). If this standard was set, failure to use a condom or question your sexual partner might always be considered contributory negligence.

\footnotesize{225. See supra notes 135-38 and accompanying text (advocating disclosure of high risk activities as the acceptable standard of conduct).


\footnotesize{227. W. Prosser & W. Keeton, supra note 61, § 65, at 460 (indicating an overlap with the assumption of risk defense).

\footnotesize{228. See Surgeon General’s Report, supra note 3, at 16 (concluding that even those couples with “mutually faithful monogamous relationships” are not fully protected from AIDS unless they have been both been faithful for “at least five years”).

\footnotesize{229. W. Prosser & W. Keeton, supra note 61, § 65, at 454-55.

\footnotesize{230. Id. § 67, at 471.

\footnotesize{231. Id. at 472.
“modified” comparative negligence jurisdiction, the plaintiff may be barred from recovery if his negligence is greater than that of the defendant, or if they are equally at fault.\textsuperscript{232} It is necessary, therefore, to show that the plaintiff’s conduct was less culpable than the defendant’s. The most promising argument for the plaintiff on this issue seems to be that failure to learn of one’s own infection is more culpable than a failure to know of a partner’s infection. Additionally, the plaintiff may argue, as he would against an assumption of the risk defense, that he did not have adequate “knowledge” of the risk.\textsuperscript{233} The plaintiff may also respond, as he would to a basic contributory negligence defense, that the defendant is the more culpable party.\textsuperscript{234} The ultimate effect of comparative negligence will likely depend on the specific set of facts involved and the degrees of culpability that can be assessed, given the nature of both the plaintiff’s and the defendant’s conduct. Specifically, the conduct of both parties should be examined to determine whether or not it was “high risk” in nature. Where the plaintiff’s conduct has been such that he increased his own risk of contracting HIV, the amount of possible recovery may well be reduced,\textsuperscript{235} but it seems unlikely that the defendant will escape all liability.

D. Illegality

In states with criminal statutes prohibiting fornication, adultery, or sodomy, those laws may be used as defenses to a tort action involving HIV transmission.\textsuperscript{236} Given the Supreme Court’s recent ruling that states may constitutionally prohibit consensual homosexual sodomy,\textsuperscript{237} attempts to apply these laws seem particularly likely. Faced with a plaintiff and a defendant who have both been involved in the same illegal activity, however, courts seem persuaded to hold against the more culpable party.\textsuperscript{238} In a situation where both parties

\textsuperscript{232} Id. at 473 (noting that the precise effects of the rule depend on the particular jurisdiction involved).

\textsuperscript{233} See supra notes 210-18 and accompanying text (explaining the argument as an answer to the assumption of the risk defense).

\textsuperscript{234} See supra notes 225-29 and accompanying text (examining the possible responses to a contributory negligence defense).

\textsuperscript{235} See W. Prosser & W. Keeton, supra note 61, § 67 at 468-75. For a description of apportionment of damages among joint tortfeasors as it relates to comparative negligence, see id. at 475-77.

\textsuperscript{236} See generally Baruch, supra note 17, at 188-92 (examining this type of defense).


\textsuperscript{238} See, e.g., Long v. Adams, 175 Ga. App. 538, 541, 333 S.E.2d 852, 855 (1985) (holding that “a person can recover in tort for injury suffered as a result of his own criminal
have violated a sodomy statute, it seems likely that the plaintiff could still recover against a more culpable defendant who had also violated the statute and negligently transmitted HIV.\textsuperscript{239}

E. Privacy

Privacy rights may arise in two different contexts: as an argument to preclude judicial evaluation of sexual conduct between adults or the choice of precautions exercised in such situations,\textsuperscript{240} and as an evidentiary issue during the trial itself.\textsuperscript{241}

A defendant in a negligence action for HIV transmission may argue that the court should not get involved in the sexual relations of adults or, more specifically, should not require an individual to take AIDS tests or to use specific precautions.\textsuperscript{242} Although courts have refused to adjudicate decisions regarding the personal use of birth control,\textsuperscript{243} there is some precedent to support judicial intervention in the spread of venereal disease.\textsuperscript{244} Because of the current increase in the spread of AIDS and the ever present public fear, it has been suggested that HIV testing will be mandatory within a few years.\textsuperscript{245}

activity in reversing summary judgment against the defendant in a claim charging negligent and intentional infliction of herpes); De Vall v. Strunk, 96 S.W.2d 245, 247 (Tex. Civ. App. 1936) (reversing a dismissal of a suit for damages based on fraudulent transmission of "crabs" and holding that if both the plaintiff and the defendant participated in an illegal or immoral transaction with equal guilt, the defendant's additional culpability in causing transmission of the disease could not be ignored).

\textsuperscript{239} See Baruch, supra note 17, at 183 (arguing that "[t]he AIDS plaintiff may also attempt to attack the illegality defense by pointing to its gross inequalities as applied to him as well as its futility in an era of changing mores.").

\textsuperscript{240} See Comment, Kathleen K., supra note 80, at 531 (analyzing such a defense in a herpes transmission lawsuit).

\textsuperscript{241} See infra notes 247-50 and accompanying text.

\textsuperscript{242} See Comment, Kathleen K., supra note 80, at 531 (suggesting that this argument in the herpes context "focuses on whether there should be judicial inquiry into sexual relations between consenting adults.").

\textsuperscript{243} See, e.g., Stephen K. v. Roni L., 105 Cal. App. 3d 640, 645, 164 Cal. Rptr. 618, 621 (1980) (indicating that "as a matter of public policy the practice of birth control, if any, engaged in by two partners in a consensual sexual relationship is best left to the individuals involved, free from any governmental interference.").

\textsuperscript{244} See Kathleen K. v. Robert B., 150 Cal. App. 3d 992, 996, 198 Cal. Rptr. 273, 276 (1984) (indicating that the state interest in preventing the spread of contagious disease excluded such evaluations from protection under the constitutional right of privacy).

\textsuperscript{245} Swenson, supra note 2, at 197; see also Banks & McFadden, supra note 128, at 24-25 (reporting that compulsory screening already exists in the Naval Academy for all freshmen, in the State Department "for foreign service applicants, officers, and their dependents", in the city of Nashville for potential employees of massage parlors, and in Nevada on a monthly basis for prostitutes).

Mass screening has also "been suggested for prisoners, drug treatment centers participants, homosexual males, and food handlers. Screening has also been proposed for admission
Advocates of privacy rights may consider the standard of conduct suggested by this Note as an alternative which allows more free choice on the whole than would mandatory testing. As the epidemic grows, so does the likelihood that courts will support the public health needs over the privacy concerns involved.

Privacy may also become an evidentiary issue. Because anonymity is usually guaranteed in AIDS testing programs, and because there are substantial arguments in support of confidential treatment of AIDS victims finding proof that a defendant has AIDS may be difficult. Although there may be cases where the defendant's symptoms are severe enough to indicate an obvious case of AIDS, confidentiality statutes may preclude the use of medical records in court when they are necessary. Eventually, courts may be forced to make a policy comparison between the importance of confidentiality and the importance of preventing the spread of AIDS. An important factor in such an evaluation is the belief by some that any infringement on the confidentiality of testing is likely to decrease the number of people who are willing to be tested. If the overall policy to hospitals or for obtaining medical insurance." Id. at 25.

246. Cf. Sullivan & Field, supra note 12, at 192 (arguing that civil remedies in tort are "preferable to criminal prosecutions as a means for influencing behavior in this context because they lessen the risk of state intrusion into a sensitive area of private life.").

The deterrence value of civil remedies may be less substantial than that offered by the criminal law. Id. The penalties are less severe, especially where the potential defendant has no funds to be taken. Id. "The greatest advantage of civil over criminal enforcement is not that it would provide more deterrence, but rather that it would impose less social harm." Id.

247. 100 QUESTIONS, supra note 1, at 15.

248. See generally Dickens, supra note 25, at 581 (analyzing the arguments in favor of confidentiality for AIDS victims).

249. Contra Doe v. Roe, 444 N.W.2d 437, 440-43 (Wis. App. 1989) (holding that disclosure of the plaintiff's HIV test results to the defendant in a medical malpractice action did not violate Wisconsin's confidentiality statute, and that the probative value of such evidence outweighed any prejudice to the plaintiff).

A recent plea-bargain agreement in a New York case may have stalled the evaluation of privacy rights for potential AIDS victims in that state. In the agreement, a "man whose used hypodermic needle pricked the thumb of a transit officer" agreed to be tested for HIV in return for a reduction in charges. Hays, Man Agrees to Police Call for AIDS Test, N.Y. Times, Apr. 11, 1989, at B3, col. 4. The controversial agreement prompted Richard D. Emery, a civil rights lawyer, to comment that it "marked 'a sad day' for criminal justice and that it highlighted the need to balance fears about AIDS with fairness and justice." Id. at col. 6.

250. See SURGEON GENERAL'S REPORT, supra note 3, at 30 (indicating that communities which require reporting of those infected with AIDS to public health authorities force infected persons to "go underground out of the mainstream of health care and education" and that such an effect has caused confidentiality to become the norm in health care); RECOMMENDATIONS AND GUIDELINES, supra note 44, at 20 (advocating confidentiality and freedom from discrimination as necessities in maintaining public confidence and broad participation in testing programs).
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goal of AIDS litigation is to decrease the spread of the disease, courts may be forced to maintain the confidentiality of AIDS testing. This would further reduce the likelihood that a duty to be tested could be established, and it would impose a significant evidentiary hurdle under any standard.

F. Equal Protection

Legal responses to the AIDS crisis will certainly raise constitutional questions. A rule of law that places a higher burden on those who participate in homosexual activities than those who are active in similar heterosexual practices might be attacked as a violation of equal protection. Some courts have found exclusion of AIDS victims from normal classrooms to be a violation of equal protection. Such decisions have been based on the fact that public health concerns did not require the exclusion of HIV infected students from the typical classroom setting. Despite these rulings,

251. See generally Merritt, supra note 12, at 739 (surveying the fourteenth amendment implications of AIDS restrictions involving education, occupation, and quarantine); Orland & Wise, supra note 12, at 137 (analyzing the application of privacy and equal protection rights, among other constitutional issues); Rosoff, supra note 12, at 81 (arguing that "legislation, regulatory pronouncements, and the development of common law through private litigation . . . are being woven together . . . to generate, both deliberately and inadvertently, a new synthesis of expectations as to the proper balance between individual rights and governmental power."); see also Smith, supra note 12, at 370 (discussing constitutional challenges in tort and medical malpractice areas).

252. See Orland & Wise, supra note 12, at 149 (arguing that "[t]hese kinds of responses [to the AIDS crisis] present the core question of where, given the current state of medical knowledge, the balance should be struck between the rights of AIDS victims and the threat to public safety."); Rosoff, supra note 12, at 84 (suggesting that questions of AIDS victim responsibility will require an evaluation of the traditional public health authority); Smith, supra note 12, at 387-99 (analyzing tort liability for AIDS in terms of equal protection, right to trial by jury, and right of access to the courts).


254. See Robertson, 684 F. Supp., at 1006 (ruling against a rejection of mainstreaming because the court found that "the harm to defendants in requiring that Jason be 'mainstreamed' is minimal at best. . . . the harm in sanctioning the continued isolation of Jason clearly outweighs any harm to the defendants if a preliminary injunction issues."); Ray, 666 F. Supp. at 1535 (finding that "actual, ongoing injury to Plaintiffs in this case clearly outweighs the potential harm to others, and . . . the public interest in this case weighs in favor of returning these children to an integrated classroom setting.").

One interesting deviation from this analysis is a holding by a New York Supreme Court that exclusion of AIDS victims from normal classrooms was underinclusive. District 27 Community School Bd., 130 Misc. 2d at 416, 502 N.Y.S.2d at 337. The court held:

Absent any rational basis for petitioner's proposed exclusion of only known AIDS

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equal protection is unlikely to preclude a court from adopting the standard of conduct rules suggested by this Note\textsuperscript{268} for several reasons. First, homosexuals have not been recognized as a suspect class.\textsuperscript{268} Without such a classification, strict constitutional scrutiny will not be imposed on related legislation.\textsuperscript{267} Second, courts have refused to find a constitutional right to engage in homosexual activities.\textsuperscript{266} Third, legal principles that aim at particular conduct, as opposed to a certain “class” of individuals, are likely to pass a constitutional test.\textsuperscript{269} Finally, the seriousness of AIDS as a health

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cases or carriers of the virus, without imposing such exclusion in the case of ARC patients or asymptomatic carriers who are as likely to present a risk of contagion because they too are infected with HTLV-III/LAV, such a proposal must be deemed a denial of equal protection of the laws.

\textit{Id.}; see Schwarz \& Schaffer, supra note 14 (discussing District 27 Community School Bd.). In the case of tort liability for AIDS, an underinclusiveness argument may arise because only the known risk groups are held to a higher standard of care. See supra notes 100-38 and accompanying text (examining possible standards of care for high risk individuals). But in this case, the difference is based on the risk of transmission presented. No such rationale is evident in the education cases.

\textsuperscript{255} See supra notes 135-38 and accompanying text (advocating disclosure of high risk activity as the acceptable standard of conduct).

\textsuperscript{256} See Desantis v. Pacific Tel. & Tel. Co., 608 F.2d 327, 333 (9th Cir. 1979); Orland \& Wise, supra note 12, at 151.

Additionally, it has been noted that “homosexuality is not accepted by the majority in America, [and] gay people have been the subject of widespread discrimination but are not generally protected under civil rights laws . . . .” Joseph, supra note 12, at 1099. Given the historical effect of popular views on homosexuality, it seems unlikely that equal protection rights will be used to justify the rejection of a standard of conduct that is specifically applied to people who have engaged in high risk conduct.

\textsuperscript{257} Desantis, 608 F.2d at 333; Hollowell \& Eldridge, supra note 12, at 569; Orland \& Wise, supra note 12, at 151.

Instead, it is likely that the standard of review in equal protection cases brought by HIV infected persons will be the “rational basis test.” Hollowell \& Eldridge, supra note 12, at 570. Thus, any action with “a logical relationship to a legitimate state purpose” will be upheld. \textit{Id.} at 569. It has been noted that “the rational basis test is too deferential to be an effective vehicle for HIV infected individuals mounting challenges to unfairly discriminatory laws.” \textit{Id.} Certainly, tort liability for non-disclosure of high risk activity has a logical relationship to a legitimate state purpose in that it is designed to promote candor and honesty in order to reduce the spread of a deadly disease.

\textsuperscript{258} See Bowers v. Hardwick, 478 U.S. 186, 190-91 (1986) (rejecting the argument that there is a “constitutional right of homosexuals to engage in acts of sodomy . . . .”); State v. Walsh, 713 S.W.2d 508 (Mo. 1986) (upholding a statute prohibiting deviate sexual intercourse with another person of the same sex because it applied equally to men and women).

\textsuperscript{259} See Baker v. Wade, 774 F.2d 1285, 1287 (5th Cir. 1985) (upholding a Texas statute proscribing deviate sexual intercourse with another person of the same sex because the statute is “directed at certain conduct . . . . The statute affects only those who choose to act in the manner proscribed.” (emphasis added)), \textit{cert. denied}, 478 U.S. 1022 (1986).
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threat is likely to prevent substantial constitutional protection for homosexuals.260

VI. CONCLUSIONS

In 1986 the Surgeon General reported that AIDS "is an epidemic that has already killed thousands of people, mostly young, productive Americans. In addition to illness, disability, and death, AIDS has brought fear to the hearts of most Americans—fear of disease and fear of the unknown."261 Given the extent and magnitude of the AIDS crisis,262 the judicial system will inevitably be forced to cope with it in many forms.263 In the area of tort law, the courts must create rules which fairly adjudicate the rights of the victims and serve the public's interest by reducing the threat of AIDS.

260. See Orland & Wise, supra note 12, at 161 (citing the health risk, "traditional deference accorded state action in the area of police power and public health," and historical rejection of constitutional attacks on criminal statutes involving homosexuality as indications that constitutional protection is unlikely to occur).

The desirable goal of reducing the risk of AIDS has prompted courts to reject equal protection arguments in several areas, including: statutes regulating adult bookstores, see Doe v. City of Minneapolis, 693 F. Supp. 774, 785 (D. Minn. 1988) (finding that "[t]he exemption of certain structures, however, does not support an argument for deprivation of equal protection. . . . the city must be allowed a reasonable opportunity to experiment with solutions to admittedly serious problems." (quoting City of Renton v. Playtime Theatres, Inc., 475 U.S. 41, 47 (1986) (quoting Young v. American Mini Theatres, Inc. 427 U.S. 50, 71 (1976)));

Broadway Books, Inc. v. Roberts, 642 F. Supp. 486, 490 (E.D. Tenn. 1986) (concluding that "the City is not prevented . . . by the fourteenth amendment's equal protection clause from classifying and regulating adult-oriented establishments differently from other places of entertainment."); Suburban Video, Inc. v. City of Delafield, 694 F. Supp. 585, 593 (E.D. Wis. 1988) (holding the statute was not overbroad); and prison rules, see Cordero v. Coughlin, 607 F. Supp. 9, 10 (S.D.N.Y. 1984) (arguing that "AIDS victims are not a 'suspect class' and therefore as long as there is a legitimate government end and the means used are rationally related to that end, the Equal Protection Clause is not violated."); Powell v. Department of Corrections, 647 F. Supp. 968, 971 (N.D. Okla. 1986) (noting that "[e]qual protection requirements will have been met if all members of the class (inmates who are known carriers of HTLV-III) are treated equally and if the classification is not arbitrary."); Doe v. Coughlin, 71 N.Y.2d 48, 518 N.E.2d 536, 542, 523 N.Y.S.2d 782, 788 (1987) (finding that exclusion from prison conjugal visit program was not a violation of the inmate's rights where all persons with communicable diseases were treated alike), cert. denied, 109 S. Ct. 196 (1988); see also Muhammad v. Carlson, 845 F.2d 175, 177-79 (8th Cir. 1988) (rejecting a prisoners due process claim when he had been transferred to an AIDS-restricted section of the prison without an opportunity to challenge his medical classification). But see Lopez v. Coughlin, 139 Misc. 2d 851, 854, 529 N.Y.S.2d 247, 249 (Sup. Ct. 1988) (holding that the failure to allow an AIDS infected prisoner to participate in prison release program was not rationally related to the Department of Correctional Service's interest in the inmate's health and therefore unconstitutional).

261. SURGEON GENERAL'S REPORT, supra note 3, at 3.

262. See supra notes 1-9 and accompanying text.

263. See supra notes 11-21 and accompanying text.
Courts have the option of establishing a standard of conduct that would require high risk group members to be tested for HIV infection, use condoms, fully disclose their prior high risk conduct, or any combination of these options. Creating a duty to disclose previous experiences and current risk of AIDS seems to be the most reasonable compromise between the right to privacy and the need to encourage safe sexual practices. Additionally, this responsibility is consistent with previous decisions holding that a duty exists to inform sexual partners of the presence of venereal disease. Recovery under this rule is likely to be reduced through comparative negligence where the plaintiff engages in high risk activity and makes no attempt on his own part to reduce the risk of transmission.

Where the plaintiff cannot be sure of the source of his infection, alternative liability can be used to shift the burden of proof. This general rule must be limited to cases where all potential causes have been identified and joined, where all of the defendants have acted negligently, and where all of the defendants are more culpable than the plaintiff. To hold otherwise would contradict a policy that seeks to discourage high risk activity. Additionally, it is fundamentally unfair to allow a plaintiff to prosper from the very activity that caused the defendant to be held liable.

The unique nature of the AIDS incubation period presents potential problems in dealing with applicable statutes of limitations. Recovery for fear of AIDS, recovery for a substantial likelihood of contracting AIDS, and recovery in a second suit when AIDS does ultimately develop all exist as alternative meth-
ods to approach the problem. In cases where the diagnosis of "full-blown" AIDS is clear but the symptoms have not fully developed, the substantial likelihood of recovery should be utilized. At that point, the likelihood that the disease will prove fatal is overwhelming. Where HIV is present, but AIDS has not developed, the possibility of a second suit should not be foreclosed. The plaintiff should be entitled, ultimately, to full compensation for his injuries, just as the courts allow full compensation for cancer. AIDS victims should not be limited to a recovery for fear of the disease.

These are certainly not the only questions which may need to be addressed before tort litigation for HIV transmission can be successful. However, tort litigation cannot be successful unless consideration is given to the unique medical and social factors surrounding the AIDS crisis. Such a conclusion is consistent with "the responsibility of every citizen to be informed about AIDS and to exercise the appropriate preventive measures."

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281. See supra notes 199-200 and accompanying text.
282. See supra note 6 and accompanying text.
283. See supra notes 202-03 and accompanying text.
284. See supra note 196 and accompanying text.