Criminalizing HIV Transmission: Lessons from History and a Model for the Future

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COMMENTS

CRIMINALIZING HIV TRANSMISSION:
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The Acquired Immunodeficiency Syndrome (AIDS)\(^1\) epidemic is now more than a decade old in the United States.\(^2\) More than 200,000 cases of AIDS have been reported to public health organizations, and over 100,000 people have died from AIDS-related illnesses.\(^3\) The ultimate dimension of the public health catastrophe that this disease will inflict upon Americans is difficult to project because of the inherent difficulty of its detection\(^4\) and the

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1. AIDS is an immunodeficiency syndrome manifested by the onset of one or more of seven rare opportunistic diseases that result from infection with Human Immunodeficiency Virus (HIV). Centers for Disease Control, Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome, 36 MORBIDITY & MORTALITY WKLY. REP. 1, 3 (1 Supp. 1987). For a list of the opportunistic diseases, see infra note 22.

2. The first manifestations of what physicians later diagnosed as AIDS occurred in 1981 when four homosexual males in Los Angeles developed unusual cases of pneumatic pneumo-

3. Centers for Disease Control, Mortality Attributable to HIV Infection/AIDS—United States, 40 MORBIDITY & MORTALITY WKLY. REP. 41, 41 (1991). The Centers for Disease Control (CDC) estimates that AIDS is the second leading cause of death among men between the ages of 25 and 44 years. Id. at 41. Moreover, it is the leading cause of death among young adult males in San Francisco, New York, and Los Angeles. Id. at 43. The pattern of HIV infection has shifted over the course of the last decade; while most deaths in the early years of the AIDS epidemic occurred among Whites, the death rate is highest among Blacks and Hispanics. Id. at 41. AIDS has also become a leading cause of death among minority children. In New York State in 1988, AIDS was the leading cause of death among Hispanic children aged 1 to 4 years and the second leading cause of death among Black children within the same age group. Id. at 44.

4. See U.S. DEP’T OF HEALTH AND HUM. SERVS., SURGEON GENERAL’S REPORT ON ACQUIRED IMMUNE DEFICIENCY SYNDROME 13 (1986). The report estimates that over 1.5 million people who show no symptoms of AIDS-related diseases may be infected with HIV and capable of infecting others. It is presently estimated that 20 to 30% of those persons will develop AIDS. Id. Cf. Ruth L. Berkelman et al., Epidemiology of Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome, 86 AM. J. MED. 761, 761 (1989). The latency period between HIV infection and development of AIDS is variable; however, researchers predict that 78 to 100% of persons infected with HIV will develop AIDS within 15 years. Id. The CDC estimates that one million persons are currently infected with HIV and

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modest expectations of developing a curative treatment. Although the rate of increase in reported cases of AIDS has declined, the disease remains the principal health priority of the United States. The grave medical and social consequences of AIDS continue to prompt many forms of response. Nevertheless, no consensus exists as to the most effective means to control the spread of this fatal disease.

The public health response to the AIDS crisis in the United States has been implemented largely through a combination of federal and state legislation establishing a range of noncoercive AIDS related programs. State legislatures have also enacted coercive measures aimed at controlling the HIV infection rate, despite public health experts' disavowal of the effectiveness of these compulsory measures. A recent trend in state AIDS legislation involves the formulation of means to prosecute individuals for intentional

predicts that 165,000 to 215,000 will die from AIDS by the end of 1993. Centers for Disease Control, supra note 3, at 42.

5. Current treatments for AIDS are not curative; they merely delay the onset of opportunistic diseases. See infra note 26.

6. Centers for Disease Control, Update: Acquired Immunodeficiency Syndrome—United States, 1981-1988, 38 MORBIDITY & MORTALITY WKLY. REP. 229, 230 (1989). A single exception to this trend existed in 1987, when the rate of reported AIDS cases increased; however, this increase followed an expansion of the list of diseases constituting AIDS. See Centers for Disease Control, supra note 1, at 3S-15S. Several explanations have been offered for the change in the HIV infection rate: 1) changes in behavior or "saturation" of infection among the highest risk categories—homosexual and bisexual men; 2) less complete or more delayed AIDS case reporting; and 3) new therapies that slow the development of AIDS leading to fewer diagnoses and reports. Centers for Disease Control, The Future Course of AIDS in the United States, 263 JAMA 1539, 1539 (1990).

7. AIDS INFORMATION SOURCEBOOK 3 (H. Robert Malinowsky & Gerald J. Perry eds., 2d ed. 1990). In May 1983, Edward N. Brandt, Assistant Secretary of Health and Human Services, announced that AIDS had become the number one priority of the U.S. Public Health Service. Id.

8. Noncoercive measures focusing on education and counselling have been a major focus of the government's public health response. These programs rely upon voluntary participation by the targeted group of the population, e.g., voluntary HIV testing or distribution of AIDS information to pregnant women and female teenagers. Coercive programs compel participation in testing or counselling programs based upon one's status as HIV positive, or as a prisoner, for instance. For a summary of recent coercive and noncoercive AIDS public health legislation enacted by state governments see infra notes 92-94 and see generally, Lawrence O. Gostin, Public Health Strategies for Confronting AIDS, 261 JAMA 1621 (1989).

9. See Gostin, supra note 8, at 1629 ("[L]egislation for compulsory screening, isolation, and criminalization has proceeded despite the absence of evidence that it is efficacious and the fact that it often contradicts explicit public health advice."); see also Lawrence O. Gostin et al., The Case Against Compulsory Casefinding in Controlling AIDS: Testing, Screening, and Reporting, 12 AM. J.L. & MED. 7, 7 (1987) (faulting legislatures for failing to plan how to use the collected information and for not considering the detrimental effect such programs will have on participation in public health programs for education, counselling, and treatment); see also U.S. DEP'T HEALTH AND HUM. SERVS., SURGEON GENERAL'S REPORT supra note 4, at 33-34 (rejecting compulsory blood testing and quarantine as effective responses to AIDS crisis).
transmission of HIV. An implicit catalyst to this state legislative activity is
the recent passage of The Ryan White Comprehensive AIDS Resources
relief grants contingent upon a state's showing statutory capability to prose-
cute individuals infected with HIV who intentionally or knowingly infect or
expose others through sexual contact, blood or tissue donation, or through
the sharing of a hypodermic needle. Several alternative means to satisfy
the federal requirement are available to the states. In addition to enacting
statutes that criminalize the intentional exposure of others to the AIDS vi-
rus, states may also satisfy the federal requirement through several statutory
alternatives.

One of the alternatives is to include HIV in existing public health statutes
that were enacted over a century ago to control the spread of syphilis, an
earlier epidemic sharing several important characteristics with AIDS. The

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11. Section 2647 of the Act states:

(a) IN GENERAL—The Secretary [of the Department of Health and Human Serv-
ices] may not make a grant under section 2641 to a State unless the chief executive
officer determines that the criminal laws of the State are adequate to prosecute any
HIV infected individual, subject to the condition described in subsection (b), who—

12. See infra note 60.
similarity of the modes of transmission of syphilis and AIDS, along with the common sociological and public health consequences of infection, makes a comparison of the public health response to syphilis and AIDS useful in assessing the effectiveness of imposing criminal liability on acts that risk HIV transmission.

The similarity between syphilis and AIDS, including a comparison of the etiologies, pathologies, modes of transmission, and social implications of these epidemics is discussed in Part I of this Comment. Parts II and III examine the historical parallels of the coercive and noncoercive public health response to syphilis and AIDS, preceded by an analysis of case law empowering states to invoke laws to protect public health. Part IV sets out three statutory schemes used by the states to criminalize transmission of HIV. The requisite elements and evidentiary requirements of each statutory alternative are critically analyzed in order to measure their prospective effectiveness.

In conclusion, this Comment recognizes that many of the effective noncoercive elements of the public health campaign to control the spread of syphilis have been duplicated in response to the AIDS epidemic. However, continued success of these public health programs is jeopardized by the states’ use of traditional criminal law and public health statutes to prosecute individuals for activity risking HIV transmission. An AIDS-specific statute imposing criminal liability for a limited number of high-risk activities, and incorporating the defense of consent, will effectively serve the criminal law objectives of punishment and deterrence at a lower cost to enforcement resources and personal privacy. Nevertheless, even a narrowly drawn statute that criminalizes only the most culpable HIV risking behavior—intentional and knowing commission of acts risking HIV transmission—may exacerbate the public health crisis from AIDS. Elements of intent in these statutes, which require a defendant to know he is infected with HIV, create a disincentive for persons engaging in activities posing a high risk of HIV transmission to determine whether they have been infected with the virus. To the extent criminal statutes are used at all in the public health effort to control the spread of AIDS, they should be used 1) as a means of informing the public of the proscribed acts medically proven as capable of transmitting HIV, 2) to assuage public fears of casual contagion, and 3) to encourage persons to determine their HIV status and participate in counselling and treatment programs.

I. DIVERSE ORIGINS OF A COMMON RESULT

An analysis of the efforts to comprehend and control syphilis in the late
AIDS, conversely, is caused by a human retrovirus, Human Immunodeficiency Virus (HIV), which attacks the immune system, leaving victims susceptible to a host of fatal opportunistic diseases. Transmission of the causative agent of both syphilis and HIV occurs primarily through sexual contact; although several additional activities have been documented as modes of transmission of HIV. The availability of a curative treatment for syphilis represents a major difference between the two diseases, but also highlights the fallacious use of public health measures as a short term remedy prior to the discovery of a curative treatment. Early therapies for treating syphilis were expensive, painful, and often produced seri-

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20. Brandt, supra note 14, at 375. The major pathologies resulting from syphilis infection include degenerative heart, brain, and optical disease, and, if the infection reaches the spinal cord, paralysis. Dowling, supra note 19, at 84.


22. The CDC documents the number of HIV infected persons who contract any one of several opportunistic diseases: pneumonia, disseminated cytomegalovirus, disseminated mycobacterium avium-intracellulare, candida esophagitis, mucocutaneous herpes simplex, cryptococcus neoformans menangitis, cerebral toxoplasma gondii, and enteric cryptosporidiosis. Centers for Disease Control, supra note 1, at 1S. The CDC recently proposed to expand the definition of AIDS beyond the seven opportunistic diseases. Wider Definition May Swell AIDS Total, N.Y. Times, Nov. 15, 1991, at A16. The proposed definition would include persons infected with HIV and whose blood showed a laboratory count of less than 200 CD4 lymphocyte cells per cubic millimeter. Id. The lymphocyte cells are the primary target of HIV and a reduced count is a precursor of AIDS-related illness. Id. Under the amended definition, the number of AIDS cases in the United States could nearly double. Id.


24. In addition to sexual contact, other documented modes of HIV transmission include transfer of blood or blood products, intravenous drug use, and perinatal events—infection during pregnancy or childbirth. Friedland & Klein, supra note 23, at 1125. The fear among the public that HIV may be transmitted through casual contact—kissing, sharing household utensils, etc.—remains unsubstantiated by medical evidence. See James W. Curran, The Epidemiology of AIDS: Current Status and Future Prospects, 229 Sci. 1352, 1356 (1985) (reporting household members frequently touching and sharing common household items with AIDS victims have shown no meaningful increase in risk of HIV infection from this contact); Gerald H. Friedland & Robert S. Klein, Lack of Transmission of HTLV-III/LAV Infection to Household Contacts of Patients with AIDS or AIDS-Related Complex with Oral Candidiasis, 314 New Eng. J. Med. 344, 348 (1986) (finding household members who are not sex partners of, nor born to, person with AIDS are at minimal risk of infection); see also Margaret A. Fischl et al., Evaluation of Heterosexual Partners, Children, and Household Contacts of Adults with AIDS, 257 JAMA 640, 644 (1987) (finding no HIV infection resulting from casual household contact with adults with AIDS).

nineteenth century serves as a useful analog for assessing the public health response to the AIDS epidemic in the late twentieth century. Syphilis and AIDS possess several commonalities: both have existed in epidemic proportions, each may be sexually transmitted and manifest after a long latency period; the two have severe pathological consequences; and both have created fear and hysteria among the general public. Syphilis and AIDS possess distinct etiological origins. Syphilis is caused by a microorganism transferred through the bloodstream to internal organs with the potential of causing a variety of serious or even fatal patholo-

13. Several other epidemics are not suitable for comparison to AIDS for the purposes of ascertaining an appropriate public health response to control infection rates. Tuberculosis, for example, was a major epidemic in the early years of the twentieth century. At its peak, the tuberculosis epidemic caused the death of over 400 Americans each day. LEIGH M. HODGES, THE PEOPLE AGAINST TUBERCULOSIS 7 (1942). This extremely contagious disease is transmitted through the inhalation of tubercle bacilli ejected from an infected individual while coughing, sneezing, or speaking. Neither the transmitter nor the contractor can voluntarily control the spread of the disease. Prior to the development of an effective cure, restrictions on personal autonomy may arguably have been the only appropriate response to control the spread of the disease. Kathryn Render, Comment, Tuberculosis Chapters: A Model for Future AIDS Legislation?, 32 ST. LOUIS U. L.J. 1145, 1146 (1988) (examining tuberculosis legislation as a guide to the legislative response to AIDS). Neither syphilis nor HIV, however, have been documented to be transmittable by casual contact. See infra notes 24, 37. Therefore other less restrictive public health responses to control infection are appropriate.

14. Reporting of cases of syphilis infection was not organized on a national scale during its epidemic years; however, Brandt indicates that studies suggest that 10% of the population was infected and that syphilis was “a health problem of enormous dimensions.” Allan M. Brandt, The Syphilis Epidemic and its Relation to AIDS, 239 SCI. 375, 376 (1988).

In addition to the statistics cited in the Surgeon General’s report, see U.S. DEP’T HEALTH HUM. SERVS., supra note 4, other studies suggest that AIDS accounted for 9% of the total mortality of men in the United States aged 25 to 34 in 1987 and was the seventh highest cause of premature mortality of all persons in the United States in 1987. Berkelman et al., supra note 4, at 762.

15. Brandt, supra note 14, at 375.

16. John C. Cutler & R.C. Arnold, Venereal Disease Control by Health Departments in the Past: Lessons for the Present, 78 AM. J. PUB. HEALTH 372, 372 (1988); see also, Berkelman et al., supra note 4, at 761 (finding that the mean latency period between infection with HIV and diagnosis of AIDS as a result of the appearance of an opportunistic disease is estimated to be 7.8 years).

17. Brandt, supra note 14, at 375.

18. The fear and hysteria produced by syphilis in its early epidemic years, and currently by AIDS, originate from the inability of the medical research community to provide an effective treatment for an extremely contagious disease. Allan M. Brandt, AIDS: From Social History to Social Policy, 14 LAW MED. & HEALTH CARE 231, 236 (1986).

ous side effects. Available treatments for AIDS, none of which are curative, also produce serious side effects in some patients. The discovery of penicillin’s effectiveness in treating syphilis led to a precipitous decline in the rate of syphilis infection. Despite the current widespread availability of antibiotics, the rate of syphilis infection has increased substantially in recent years. This phenomenon may reflect changes in public attitudes towards sex as well as changes in the political and economic commitment to public health programs. This statistic supports the thesis that social forces—not a curative treatment—may ultimately be the controlling factor in the public health effort to control HIV infection.

For seventy years, this nation has struggled to control the spread of syphilis. Its recent resurgence, coupled with the AIDS epidemic, provides an even greater impetus for public health officials to examine the deep social and moral forces affecting sexual conduct. Compulsory measures limiting individual liberty, while placing hope in the discovery of a medical cure as a panacea, failed as a public health response to syphilis. Therefore, similar restrictions on individual liberty or reliance on a future curative treatment for AIDS will not necessarily eliminate the disease from the population. Effective noncoercive public health measures are necessary to achieve long

25. Physicians treated syphilis-related diseases principally with mercury. Dowling, supra note 19, at 92. The metal’s toxicity often resulted in “loss of teeth, tongue fissures, and hemorrhaging of the bowel.” Brandt, supra note 14, at 376. Later, the drug Salvarsan became the treatment of choice but was also toxic and required numerous injections over a two year period; only an estimated 25% of treated patients followed the therapy to completion. Id.


27. Incidence of syphilis fell from 72 cases per 100,000 persons in 1943, the year of penicillin’s introduction as a treatment for syphilis, to about 4 per 100,000 by 1956. Brandt, supra note 14, at 379.


31. See infra note 71 and accompanying text.
term control of HIV infection.\textsuperscript{32}

\section*{II. SYphilIS AND THE POLICE POWER OF THE STATE}

In the sixteenth century, syphilis began to spread in alarming rates throughout Europe.\textsuperscript{33} The disease became a major public health concern in the early nineteenth century during a period of devastating infection rates that coincided with a breakthrough in the identification of the causative organism and efficacious treatments.\textsuperscript{34} Ignorance, if not purposeful nonrecognition of the modes of transmission of syphilis, hampered early efforts to control the disease.\textsuperscript{35} An early explanation for the rise in infection rates of syphilis during the nineteenth century identified the source of infection as the thousands of immigrants entering America.\textsuperscript{36} Some physicians asserted that syphilis could be spread through casual contact.\textsuperscript{37}

This so-called “discovery” unleashed an array of fears about disease and sexuality in society, resulting in widespread panic\textsuperscript{38} and stigmatization of the infected,\textsuperscript{39} despite medical evidence refuting such a theory.\textsuperscript{40} One noted commentator on the social aspects of syphilis infection suggests that disclosure of the true cause of contagion, promiscuity across several classes of society, was suppressed as denial of the fact that syphilis represented a metaphor

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\textsuperscript{32} See Cutler \& Arnold, \textit{supra} note 16, at 375 (stating that “only the involvement of all levels of government, the community at large, and the medical, educational, industrial, and social work sectors” will succeed in controlling the spread of AIDS); \textsc{The Nat’l Comm’n on Acquired Immune Deficiency Syndrome, America Living With AIDS} 19 (1991) (“Until a cure or vaccine is found, education and prevention are the only hope for altering the course of the HIV epidemic.”).
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\textsuperscript{33} \textsc{Dowling, supra} note 19, at 84. The actual origin of the disease remains unknown; one theory hypothesizes that the disease was present at the dawn of civilization, while another suggests that the disease was imported to Europe from the New World by Columbus’s crew returning from the first voyage in 1493. \textit{Id.}
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\textsuperscript{34} Brandt, \textit{supra} note 14, at 375-76.
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\textsuperscript{35} \textsc{Dowling, supra} note 19, at 95 (“The prevalent attitude toward syphilis in the sixteenth and seventeenth centuries was one of hopelessness and in the next two centuries was one of indifference. Toward the end of the nineteenth century syphilis came to be looked on as a disgrace.”).
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\textsuperscript{36} Brandt, \textit{supra} note 14, at 376. Medical examinations at the ports contradicted such a theory and the source was then identified as immigrant prostitutes working in the major cities. \textit{Id.}
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\textsuperscript{37} Doctors later attributed infection with syphilis—without substantiation—to contact with toilet seats, drinking cups, door knobs, pens, and pencils. \textit{Id.}
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\textsuperscript{38} According to Brandt, manifestations of the panic surrounding syphilis contagion may have reflected denial. For example, during World War I, the U.S. Navy removed doorknobs from its battleships to prevent the spread of infection, despite the large number of cases of sexually transmitted syphilis among sailors. Brandt, \textit{supra} note 18, at 232.
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\textsuperscript{39} Allan M. Brandt, \textit{No Magic Bullet} 184 (1987).
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\textsuperscript{40} Brandt, \textit{supra} note 18, at 232.
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of society's changing values about sexuality. The primary means to control the spread of syphilis—and other communicable diseases in the early nineteenth century—was the enactment of public health laws under the police power of the state.

A. Constitutional Basis for Public Health Laws

The authority of the states to exercise their police power to protect public health is derived from the Constitution. Within such power is the authority of the state legislature to enact laws that protect public health and safety. In Jacobson v. Massachusetts, the Supreme Court first enunciated the standard for evaluating a state's exercise of its police power. Virtually all state action in the public health arena has been upheld as a result of the broad deference to states' enactment of public health laws required by Jacobson. When conflicts arise between politicians and public health officials

41. Id. at 232-33. According to Brandt, "[t]he problem of syphilis was seen as one dimension of a larger breakdown in values that emphasized the sanctity of the home, the domestic role of women, and the principle of strict marital sexuality." Brandt, supra note 14, at 376.
42. See generally Dowling, supra note 19.
43. The "police power" has never been defined in plain terms. Stone v. Mississippi, 101 U.S. 814, 818 (1880) ("Many attempts have been made in this Court and elsewhere to define the police power, but never with entire success."). Black's Law Dictionary defines the police power as:

An authority conferred by the American constitutional system in the Tenth Amendment, U.S. Constitution, upon the individual states, and, in turn, delegated to local governments, through which they are enabled to establish a special department of police; adopt such laws and regulations as tend to prevent the commission of fraud and crime, and secure generally the comfort, safety, morals, health, and prosperity of its citizens by preserving the public order, preventing a conflict of rights in the common intercourse of the citizens, and insuring to each an uninterrupted enjoyment of all the privileges conferred upon him or her by the general laws.

44. The Tenth Amendment states: "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." U.S. Const. amend. X, § 10.
45. In Gibbons v. Ogden, the United States Supreme Court first recognized the application of the police power to protect public health. 22 U.S. (9 Wheat.) 1, 4 (1824).
46. 197 U.S. 11, 25 (1905). The Court held that states maintain the power to enact mandatory vaccination laws within the scope of their police power that "embrace, at least, such reasonable regulations established directly by legislative enactment as will protect the public health and the public safety." Id. Laws that are "exercised in particular circumstances and in reference to particular persons in such an arbitrary, unreasonable manner, or might go so far beyond what was reasonably required for the safety of the public . . . [will] authorize or compel the courts to interfere for the protection of such persons." Id. at 28.
47. This power has been construed to permit state legislatures to not only take reasonable action when an epidemic actually exists, but also to define what constitutes a contagious disease and take preventive actions. Jacobson, 197 U.S. at 27; In re Halko, 54 Cal. Rptr. 661, 663 (Cal. Ct. App. 1966) (stating that the legislature is vested with broad discretion in determining
regarding the best course of action for controlling the spread of disease, they are settled by the legislatures. The result in Jacobson allows state legislatures to enact coercive public health laws under their police power without substantiating the measures from a medical efficacy standpoint.

The result in Jacobson allows state legislatures to enact coercive public health laws under their police power without substantiating the measures from a medical efficacy standpoint.

States first began to exercise their police power in the late nineteenth century in an effort to combat the spread of a series of contagious diseases. Quarantine, mandatory physical examinations, and vaccination were the primary means employed to combat contagious diseases and were upheld as constitutional applications of the police power.

The impetus for the first major public health response to syphilis resulted from large numbers of infections among military draftees and troops inca-

what are contagious and infectious diseases and in adopting means for preventing the spread thereof; Kirk v. Wyman, 65 S.E. 387, 390 (S.C. 1909) (holding that isolation orders invalidated only upon prima facie showing that the manner of isolation was so clearly beyond what was necessary as to be arbitrary).

48. In Jacobson, the Court illustrated the tension between medical and lay opinion regarding the appropriate responses to control infection:

The fact that the belief is not universal is not controlling, for there is scarcely any kind of belief that is accepted by everyone. The possibility that the belief may be wrong, and that science may yet show it to be wrong, is not conclusive; for the legislature has the right to pass laws which, according to the common belief of the people, are adapted to prevent the spread of contagious diseases.

197 U.S. at 34-35 (quoting Viemeister v. White, 170 N.Y. 235 (1904)).


51. Under most public health statutes, “quarantine” means both the isolation of the healthy who have been exposed to an infectious disease, and also isolation of the infected. Parmet, supra note 50, at 59.


53. Several state courts upheld early applications of the police power to quarantine. See, e.g., People ex. rel. Barmore v. Robertson, 134 N.E. 815, 819 (Ill. 1922) (typhoid carrier); Ex parte Caselli, 204 P. 364, 364 (Mont. 1922) (individual with gonorrhea); Kirk v. Wyman, 65 S.E. 387, 388-90 (S.C. 1909) (leprosy victim). Mandatory vaccination laws were also upeld. See, e.g., Jacobson v. Massachusetts, 197 U.S. 11, 38 (1905); Abeel v. Clark, 24 P. 383, 384 (Cal. 1890); Duffield v. School Dist., 29 A. 742, 743 (Pa. 1894). But see Potts v. Breen, 47 N.E. 81, 85 (Ill. 1897) (holding that the state improperly enacted compulsory vaccination ordinance in community where there was no incidence of smallpox).
pacitated by the disease during World War I. The national priority of the war effort prompted the development of a massive public health program designed to contain the spread of syphilis under the leadership of the United States Public Health Service (USPHS). The program was in large part coercive. It mandated the closing of houses of prostitution, the quarantine and isolation of prostitutes, and punitive treatment of servicemen. Despite the magnitude of this effort, evidence indicates that infection rates of syphilis remained high during and after World War I.

B. Public Health Offenses

In addition to the involuntary measures used to control the spread of infection, the states' police power was also invoked through public health statutes that punished certain types of behavior by persons infected with a communicable or venereal disease. The definitional provisions of most

54. Examination of servicemen during induction into World War I indicated that 5.6% of the men were infected with some type of venereal disease. Due to acquired infection during active duty, it was approximated that 7.5% of men were infected during the War. Authorities used these figures, because of the large population sampled, to extrapolate that approximately 10% of the United States population was infected with a venereal disease at the time of the War. William J. Brown et al., Syphilis and Other Venereal Diseases 58 (1970).


56. The military viewed brothels as a potential catastrophic health risk given the tendency of troops to visit them during training. Brandt, supra note 14, at 375.

57. In 1918, Congress enacted the Chamberlain-Kahn Act establishing state grant programs for syphilis treatment and a federal fund to provide for civilian isolation and quarantine by local agencies. As a result, 30,000 women were quarantined during the War as "public health menaces." Id. at 377.

58. Treatment involved a painful injection of medication directly into the urethra. Id. at 375. Court martial often resulted if infection manifested. Brown et al., supra note 54, at 136. The authors suggest that it is understandable that punishment was used as a control measure in the military since great numbers of soldiers were being incapacitated in war time and in the absence of a totally effective cure, sexual abstinence had to be encouraged. Id. at 137.

59. Brown et al., supra note 54, at 137; Dowling, supra note 19, at 97. The punitive measures resulted in a decrease from 35 new cases of syphilis per 1000 persons in 1911, to 15 in 1917, but remained high in comparison with peacetime standards. Id.

60. See Gostin, supra note 50, at 49. Communicable or infectious disease statutes generally impose minimal criminal penalties for the intentional or knowing exposure of another to one of the listed diseases. Sullivan & Field, supra note 50, at 169-70; see, e.g., Okla. Stat. Ann. tit. 21, § 1192 (West 1983) (felony for intentional or reckless transmission of a designated infectious disease); Tex. Health & Safety Code Ann. § 81.066 (West 1990) (misdemeanor to knowingly conceal or attempt to conceal exposure to or carrier status of a communicable disease; misdemeanor for person infected with such a disease to attend or attempt to attend a public or private place or gathering).

state public health offense statutes identify syphilis as either a venereal or sexually transmitted disease. Although most states had the statutory authority to prosecute for offenses that risked the transmission of syphilis during its epidemic years, the statutes were rarely enforced, except against prostitutes. The lack of prosecutions under these statutes may be explained by the difficulty of enforcement, and by the minor penalties imposed for their violation. The failure of coercive solutions to control syphilis infection prior to the introduction of an effective therapy after World War II suggests that punitive public health efforts, in the absence of programs to encourage information and treatment, were ineffective responses to the epidemic.

C. Success of the Noncoercive Response

Prior to the introduction of penicillin as a treatment for syphilis, a reinvigorated Public Health Service sponsored a multifaceted plan of reporting, testing, and education. The plan proposed confidential testing centers, prompt therapy, sexual contact tracing, premarital testing, and a comprehensive program of public education that emphasized prevention, recognition of symptoms, and treatment for infection. The change in attitudes on the part of the public towards syphilis—from an affliction of the immoral to a disease of grave public health consequence—led to Congressional willing-
ness to fund the USPHS initiatives. The massive venereal disease control program initiated by the USPHS during the 1930s resulted in a significant reduction in the incidence of syphilis over the next decade. 

Success in reducing the incidence of syphilis after World War II was shortlived. The sharp rise in syphilis infection rates within ten years of the advent of penicillin led public health officials to conclude that long-term control of syphilis required a social, not a medical solution.

III. AMERICAN RESPONSE TO THE DEVASTATION OF AIDS

Fear and panic marked the initial reaction of Americans to the outbreak of syphilis infection at the turn of the century. Seventy years later, modern society, accustomed to sexually transmitted diseases and the effectiveness of antibiotics, was shocked by the rapidly debilitating and fatal disease known as AIDS, a disease against which antibiotics proved ineffective. Society was again forced to confront changing sexual and social values as a result of the early incidence of AIDS cases reported among homosexual males.

The hostility of a large part of the American public towards the homosexual lifestyle was intensified by the AIDS outbreak. Remarkably similar reports of hysteria followed the growing AIDS epidemic despite the particu

68. In 1938, Congress passed the La Follette-Bulwinkle Act funding the expansion of the Venereal Disease Division of the USPHS as well as local programs. Pub. L. No. 75-540, 52 Stat. 439 (1938).
69. See Cutler & Arnold, supra note 16, at 373 (describing the National Venereal Disease Control Program organized by Surgeon General Parran).
70. The death rate from syphilis declined from a peak of 19.1 deaths per 100,000 persons in 1918, to 9.3 per 100,000 in 1946. Dowling, supra note 19, at 102.
71. The number of cases of primary and secondary syphilis rose from a low of 3.8 cases per 100,000 persons in 1957, to 7.1 in 1960, and 12.3 in 1965—virtually the same level experienced during World War I. Cutler & Arnold, supra note 16, at 375.
72. Id. Cutler and Arnold describe how the success in controlling syphilis after World War II—especially with the advances in penicillin therapy—led Congress to conclude that funding of full scale venereal disease control programs was no longer necessary. The authors state that after 1958, the funding reductions were reflected in the rise in syphilis incidence as state and local governments were forced to scale back treatment programs. Id.
73. Brandt, supra note 18, at 232.
74. Brandt describes how the insusceptibility of AIDS to antibiotics “fractured [the public’s] false sense of security.” Id. at 234.
75. See Gottlieb et al., supra note 2. Early scientific opinion attributed the cause of the disease to a particular immunodeficiency characteristic of the homosexual. Id. at 1429. Initially, AIDS was known as Gay Related Immunodeficiency Complex. AIDS INFORMATION SOURCEBOOK, supra note 7, at foreword.
76. Homosexual males, whether or not infected with HIV, have been targets of discrimination and violence. Brandt, supra note 18, at 234. As syphilis represented a manifestation of society’s anxiety and denial of promiscuity among the masses, AIDS was seen as a metaphor for society’s discomfort with homosexuality. See generally, Susan Sontag, AIDS AND ITS METAPHORS (1989).
larized characteristic of the infected population; 77 fears of AIDS contagion through casual contact abounded. 78 HIV infection in homosexuals was believed by some to be a "just" punishment for the practice of "immoral behavior." 79 The anxiety and fear of contagion experienced by the American public from the reports of the deadly virus among homosexuals was exacerbated by the expansion of contagion to females and heterosexuals. 80 As with syphilis, society could no longer place the blame for AIDS on those whom it considered to violate the "moral order." 81

While military necessity may have stimulated the public health response to syphilis, the early confinement of HIV infection to the male homosexual community arguably acted as an impediment to the government's commitment to AIDS research and treatment. 82 Official recognition of the disease as a major health issue arguably lagged evidence that AIDS would become a major cause of death of Americans. 83

77. Although assured that HIV was not highly contagious, emergency personnel in some areas refused to treat homosexuals. Leon Eisenberg, The Genesis of Fear: AIDS and the Public's Response to Science, 14 LAW, MED. & HEALTH CARE 243, 243-45 (1986).

78. A 1985 poll found that 47% of the respondents believed that AIDS could be transmitted through the sharing of a drinking glass. Brandt, supra note 18, at 234. Thirty-four percent of the respondents to a different survey believed it was unsafe to "associate" with an AIDS victim even when no physical contact was involved. Erik Eckholm, Poll Finds Many AIDS Fears that Experts Say are Groundless, N.Y. TIMES, Sept. 12, 1985, at B11; see also Richard Green, The Transmission of AIDS, in AIDS AND THE LAW 28 (Harlon L. Dalton et al. eds., 1987) (discussing several incidents in which people believed casual contact could lead to infection with AIDS, including where a court required a defendant with AIDS to wear surgical mask at trial, and where a television crew agreed to tape an interview with AIDS patients only upon the condition that the microphones would be thrown away after the interview).

79. Brandt, supra note 18, at 235.

80. Eisenberg, supra note 77, at 245.

81. Public awareness of HIV infections resulting from blood transfusions, infected mothers of newborns, and other conduct that was neither sexual nor drug related dissipated the moralizing of HIV infection. Id.

82. Brandt, supra note 18, at 235. Some commentators spoke out against government funding of AIDS research. Patrick Buchanan, a former speechwriter for President Reagan stated: "The poor homosexuals—they have declared war upon Nature and now Nature is exacting an awful retribution." Id. William F. Buckley, Jr., Editor of the National Review, recommended mandatory universal screening and tattooing of HIV positive individuals on their forearms and buttocks to warn those who might share needles or have sex with such individuals. Id. at 236.

An analysis of the early research commitment to AIDS by Randy Shilts is a poignant illustration of the alleged delay in AIDS program funding:

[R]In 1982, the National Institutes of Health's [NIH] research on Toxic Shock Syndrome, a mystery that had by then been solved, amounted to $36,100 per death. NIH's Legionnaire's spending in the most recent fiscal year amounted to $34,841 per death. By contrast, the health institute had spent about $3,225 per AIDS death in fiscal 1981 and $8,991 in fiscal 1982.


83. In May, 1983 (two years after initial reports of AIDS deaths), then Health and
Criminalizing AIDS

Coincident with the first major AIDS funding bill, then Surgeon General C. Everett Koop authored a comprehensive governmental report on the epidemiology of AIDS, behavior modification guidelines to reduce the risk of infection, and educational and monitoring programs to be sponsored by the government. The Surgeon General's Report on Acquired Immune Deficiency Syndrome declared that AIDS would produce "profound changes" in society—a comment echoed fifty years earlier when the government began its public health response to syphilis. After establishing a national strategy for action, the report rejected the use of several proposed measures to control the epidemic; many of these represented the earlier ineffective and morassic responses to syphilis. In 1988, the Presidential Commission on the Human Immunodeficiency Virus Epidemic released its final report. The

Human Services Assistant Secretary Edward N. Brandt indicated that "AIDS ha[d] become the number one [health] priority." AIDS INFORMATION SOURCEBOOK, supra note 7, at 3. President Reagan's first public speech on AIDS was delivered in 1987. Id. at 11.


The Act also established The National Commission on Acquired Immune Deficiency Syndrome as the successor to the President's Commission on Acquired Immune Deficiency Syndrome. National Commission on Acquired Immune Deficiency Syndrome Act, Pub. L. 100-607, 102 Stat. 3062, 3104 (1988) (codified at 42 U.S.C. § 300cc) [hereinafter National Commission]. The Act charged the National Commission with monitoring the implementation of the recommendations of the Presidential Commission. Id. In addition, the National Commission must evaluate the adequacy of, and make recommendations regarding 1) issues of healthcare and research relating to AIDS; 2) dissemination of AIDS information; 3) behavior changes needed to combat AIDS; 4) federal and state laws on civil rights relating to AIDS; 5) federal research, treatment and education programs; and 6) international coordination and cooperation concerning AIDS data collection, research, and treatment. Id. § 243. The Act called for the creation of a fifteen member commission to be composed of five individuals appointed each by the President, House, and Senate on the basis that the selected persons be "specially qualified to serve . . . by reason of their education, training, or experience." Id. § 244.

86. Id. at 28; Brandt, supra note 14, at 376.
87. The report stated that compulsory blood testing of individuals is unnecessary given the cost and likelihood of producing false positive and false negative results. U.S. DEP'T HEALTH AND HUM. SERVS., supra note 4, at 33. It also rejected quarantine as a control measure since AIDS is not spread by casual contact. However, quarantine did remain a local government alternative to prevent intentional exposure by recalcitrant HIV carriers. Id. In addition, the report rejected identification of AIDS patients by physical marking as a discriminatory artifact. Id.
report presented a detailed national strategy to combat AIDS, including recommendations and means to reduce the further spread of HIV, manage the care of HIV infected individuals, and enhance the nation's efforts to find a cure. The report also advocated criminalization of acts that risk transmission of HIV to another person. By 1989, all fifty states had enacted some form of AIDS legislation dealing with reporting, education, or testing.

AIDS-related public health programs have produced early success.

The President's Commission on AIDS: What Did it Do?, 79 AM. J. PUB. HEALTH 868, 868 (1989). The President charged the Commission with the mission of informing the President, the Secretary of the Department of Health and Human Services, and other cabinet members of the public health dangers from the spread of HIV and resulting illnesses, including medical, legal, ethical, social, and economic impacts. PRESIDENTIAL REPORT, supra, at 193. In addition, the President requested that the Commission recommend measures that federal, state, and local officials could take to protect the public, assist in finding a cure, and care for those with the disease. Id. at 70. Finally, the Commission was to assess educational efforts, analyze governmental response, review the United States history of dealing with communicable disease, evaluate the current state of AIDS research, and examine policies for the development of drugs. Id.

89. AIDS INFORMATION SOURCEBOOK, supra note 7, at 13.

90. The Commission's recommendations seek to strike a proper balance between our obligation as a society toward those members of society who have HIV, and those members of society who do not. To slow or stop the spread of the virus, to provide proper medical care for those who have contracted the virus, and protect the rights of both infected and non-infected persons. . . . PRESIDENTIAL REPORT, supra note 88, at XVII.

More specifically, the Commission advocated increased research funding, public access to voluntary testing, institution of partner notification programs, integration of educational programs with drug programs, and sponsorship of efforts by state governments to strengthen laws criminalizing the intentional transmission of AIDS. Id.

91. PRESIDENTIAL REPORT, supra note 88, at 130. The Commission pointed out the problems of prosecution under traditional criminal law statutes and recommended the enactment of AIDS-specific statutes that prosecute individuals who "knowingly conduct themselves in ways that pose a significant risk of transmission to others." Id. The Commission cautioned that "criminal sanctions for HIV transmission must be carefully drawn, must be directed only towards behavior which is scientifically established as a mode of transmission, and should be employed only when all other public health and civil actions fail to produce responsible behavior." Id.


95. The incidence of HIV infection among white homosexual males has decreased over
Nevertheless, political and moral challenges to the substance of education programs and the politics of funding jeopardize the achievement of governmental objectives. The conflict between politicians and public health experts over the effectiveness of coercive programs and criminal sanctions in the AIDS public health strategy is especially threatening to the success of these programs. Using the historical antecedent of the public health response to syphilis, the comprehensive public health strategies which focused on voluntary testing and education to combat syphilis infection may also, over time, be successful in controlling the spread of AIDS.

The past several years; however, rates of infection among other sectors of the population continue to rise. Centers for Disease Control, supra note 3, at 43. See also Becker & Joseph, supra note 30, at 407 (finding statistical correlation between level of knowledge about AIDS and behavior change).


98. Public health experts are critical of restrictions on AIDS educational programs that "impede the ability of public officials to disseminate effective AIDS prevention materials." Gostin, supra note 8, at 1624.


100. The National Commission on Acquired Immune Deficiency Syndrome stated that "prevention is currently our only hope of altering the course of the HIV epidemic and . . . efforts in this sector have been grossly underutilized . . . ." NAT'L COMM'N ON ACQUIRED IMMUNE DEFICIENCY SYNDROME, supra note 32, at 1.
this nation’s experience with syphilis demonstrates that disproportional spending on research aimed at discovering a curative treatment for AIDS—at the expense of substantial appropriations for education, information, and treatment—is unlikely to be the optimal public health response.\footnote{101}

IV. AIDS AND THE POLICE POWER

A. AIDS Public Health Law: Jacobson Revisited

The police power has been invoked to some degree by every state to protect the public from the spread of HIV.\footnote{102} Public health officials have criticized compulsory HIV screening as unnecessarily intrusive because it is generally ineffective\footnote{103} and impedes efforts to encourage participation in voluntary testing and educational programs.\footnote{104} Nevertheless, a mandatory HIV testing statute was recently upheld by the California Court of Appeals in \textit{Love v. Superior Court} despite a constitutional challenge that it violated the Fourth Amendment, the due process clause, and the equal protection clause.\footnote{105} Relying on \textit{Jacobson v. Massachusetts},\footnote{106} the \textit{Love} court accorded a large degree of deference to the legislature’s efforts to adopt means for preventing the spread of contagious diseases.\footnote{107} The \textit{Jacobson} standard, however, has been criticized as outdated.\footnote{108} First, it fails to reflect contem-

\footnote{101. See DOWLING, supra note 19, at 148 (stating that despite the wide availability of an effective cure, rates of syphilis infection rose with the liberalization of attitudes towards sex, and with variations in the level of funding of public health programs). The National Commission on Acquired Immune Deficiency Syndrome stated:
[P]revention strategies will remain key even after the development of effective drugs or vaccines. There are valuable lessons to be learned from earlier experiences with sexually transmitted diseases. Effective and inexpensive treatments for many of these diseases have long been available, yet drugs alone have not stemmed the tide of infections[.]
\textit{NAT'L COMM'N ON ACQUIRED IMMUNE DEFICIENCY SYNDROME}, supra note 32, at 1.}

\footnote{102. See supra notes 92-95.}

\footnote{103. Gostin, supra note 8, at 1625. This is especially true in the case of mandatory testing as a condition of marriage. Gostin cites results of a survey in Illinois that found only five confirmed positive HIV test results among 44,726 marriage applicants. \textit{Id}. Another study estimated the cost of each positive result at $60,000 to $100,000. \textit{Id}. Finally, premarital screening is ineffective to prevent transmission since sexual activity occurs outside of marriage. \textit{Id}.}

\footnote{104. \textit{Id.} at 1627.}

\footnote{105. 276 Cal. Rptr. 660, 662 (1990) (upholding compulsory HIV testing and counselling of convicted prostitute upheld as reasonable promotion of legitimate government interest).}

\footnote{106. 197 U.S. 11 (1905).}

\footnote{107. \textit{Love v. Superior Court}, 276 Cal. Rptr. at 662.}

\footnote{108. Buris, supra note 49, at 495-96 (citing case law demonstrating courts’ movement towards adopting medical criteria to assess legitimacy of the states’ exercise of their public health power).}
porary notions of due process, equal protection, and the right to privacy. Second, the medical reasonableness standard of review has been more strictly applied by courts since *Jacobson*. Nevertheless, *Jacobson* remains the judicial standard and allows legislators to attempt to control an epidemic through coercive measures, including criminalization, that have been rejected by public health professionals.

States have used three statutory alternatives to prosecute individuals for acts risking HIV transmission that will satisfy the federal requirement under CARE. These include: 1) traditional criminal law statutes, 2) public offense statutes that incorporate HIV infection into the definition of sexually transmittable diseases, and 3) AIDS-specific statutes proscribing particular acts by HIV infected persons.

**B. Traditional Criminal Law**

Criminal law objectives of punishment and deterrence may reasonably be served by extending liability and criminal penalties to HIV infected individuals who act in a manner likely to infect another with HIV. The transmission of the deadly virus will result in a harm not unlike that inflicted by any other criminal behavior. Therefore, legislators should define standards of conduct in order to punish those who fail to comply with such standards and deter others from engaging in activities likely to transmit HIV to others.

In theory, any person who 1) commits or attempts to commit an act that infects another, accompanied by the statutorily defined mental state, and 2) has the potential of causing harm or death to another could be prose-

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111. *Gostin*, *supra* note 8, at 1629 ("[P]olitical pressures on legislators to use the coercive powers of the state to combat the [AIDS] epidemic are unmistakable.").

112. 104 Stat. 576. The CARE framework represents a statutory minimum that permits prosecutions for the commission of enumerated acts. States may use their police powers under new or existing statutes to prosecute individuals for these acts. *Id.* § 2647.


115. *Gostin*, *supra* note 8, at 1627.

To be convicted of criminal homicide, a person must either: 1) purposely commit an act with the desire that the act infect another with HIV; 2) know that he or she carried the HIV virus, and commit an act that risks HIV infection with the knowledge that this act could infect and kill another; or 3) be aware of both the risk that he or she was infected with HIV and that the act committed could infect and kill another, and commit an act demonstrating disregard for human life. In addition to the mental state requirements, the act committed must cause the victim's death.

Murder requires the highest level of culpability for prosecution. While it is conceivable that a purposeful or knowing murder by HIV transmission could be proven, the difficulty of proving intent and causation would be significant. The level of culpability for manslaughter will more likely be met when a person, not intending to kill another, commits an HIV transmitting act while aware of the actual or likely infection, thus demonstrating a disregard for human life. One may be charged with manslaughter when the death of a person results from HIV transmission by a person who recklessly infects another with knowledge of his HIV status, but the state of mind falls below extreme indifference to the value of human life. Finally,

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117. Most criminal statutes require that both a physical act and mens rea (requisite mental state) be present to prosecute the accused. See Wayne R. LaFave & Austin W. Scott, Jr., Criminal Law § 3.4, at 212 (2d ed. 1986).
121. The Model Penal Code defines murder as "the killing of another human being either purposely, knowingly, or recklessly under circumstances manifesting extreme indifference to the value of human life." Model Penal Code § 210.2(1)(b) (1962). To be convicted of homicide, the defendant must have the requisite mental state with regard to each element of the offense. Id.
122. Examples of when mens rea could be proven include a prostitute who knows that he or she is infected with HIV and continues to have sex knowing that the client may become infected; or an HIV infected person who commits rape knowing that the victim may become infected. Sullivan & Field, supra note 50, at 164.
123. Purposeful or knowing infection with HIV would be extremely difficult or impossible to prove because the likelihood of transmitting HIV to another person as a result of one sexual encounter is unknown and only a limited number of acts possess any scientific possibility of contagion. Friedland & Klein, supra note 23, at 1125-29.
124. Death following HIV infection may not occur for several years. Sullivan & Field, supra note 50, at 165-66. Some states limit the statute of limitations for homicide to one year and a day. Id. at 166. Furthermore, the difficulty of pinpointing infection to a single exposure by the perpetrator would be immense. Id.
125. Id. at 163.
126. Model Penal Code § 210.3(1)(a) (1962); see also Sullivan & Field, supra note 50, at 164.
negligent homicide requires the lowest level of culpability; a conviction could result if a person infects another with HIV by disregarding the risk of infection of which he should be aware. This would be a gross deviation from the standard of care that a reasonable person would have observed in the situation. Reckless or negligent culpability requirements afford great latitude in setting a standard of care against which to measure a defendant's conduct. This situation creates the likelihood of subjective assessment of a defendant's conduct by the jury, allowing any prejudices and fears of contagion to influence the decision, because no definitive objective quantum of transmission risk or appropriate standard governing reasonableness exists in this particular situation.

Criminal statutes may also be used to prosecute HIV-transmitting conduct that does not result in death or infection. Prosecutors may charge a defendant with assault for culpable conduct that does not result in bodily injury. A defendant can be charged with aggravated assault if he causes or attempts to cause serious bodily injury to another either purposely, knowingly, or recklessly manifesting indifference to the value of human life.

The homicide and assault models suffer from similar shortcomings when applied to the act of HIV transmission. Current medical knowledge is incompatible with a finding that a person could act, on every occasion, with the knowledge that HIV infection of another could result from the activity. Proof that the defendant acted with the requisite state of mind requires proof of infection and proof that the virus could be transmitted through the individual's conduct. In the absence of conclusive medical data about the risk of transmission of HIV by a particular act, it is impossible for a person to intend or know that his conduct will infect another. Moreover, when the highest grade of the offense of homicide or assault depends on the defendant's knowledge of infection, prosecutions under these statutes would serve to discourage persons from using public health services to determine their HIV status and seek treatment and counselling.

129. Id. at 166.
130. Id.
131. Id.
133. Id. at 82.
134. Id. at 82. The Model Penal Code defines bodily injury as "physical pain, illness, or any impairment of physical condition." Model Penal Code § 210.0(2) (1962).
136. Id. at 83. The risk of HIV infection as a result of a single or several sexual encounters is unknown. Friedland & Klein, supra note 23, at 1129. Similarly, infection through intravenous drug use is related to repeated exposures to contaminated blood. Id. at 1128.
C. Public Health Offenses

Public health offense statutes provide an alternate means of imposing criminal liability for HIV risking behavior under the public health derivative of the state police power. On their face, these statutes are appropriately narrow; they typically impose criminal liability for the intentional or knowing exposure of another to HIV.\(^{137}\) Nevertheless, the statutes are overinclusive with respect to HIV since they potentially criminalize casual contacts that pose no risk of HIV infection.\(^{138}\) Statutes that proscribe casual contacts that have no medically documented risk of causing infection appear to fail the Jacobson reasonableness standard for government restrictions on personal autonomy. Under these statutes, the criminalization of sexual intercourse where a person knows of his HIV infection also may infringe on constitutionally protected privacy interests.\(^{139}\) Some public health offense statutes make it unlawful to perform any act that exposes another to infection, but fail to specify the proscribed acts or to define "exposure."\(^{140}\) In addition, lenient penalty provisions present significant shortcomings in proscribing acts of intentional HIV transmission.\(^{141}\) The incurability of AIDS requires a

establish that the defendant either had knowledge of his infection or at least an awareness of the likelihood of infection.


138. See Sullivan & Field, supra note 50, at 171. Sullivan and Field also assert that statutes that include HIV infection as a sexually transmitted venereal disease are underinclusive since they do not account for the other modes of HIV transmission. Id.

139. The Supreme Court has never held that sexual intercourse is a fundamental right; it has, however, protected areas involving personal autonomy and intimate contact in the context of access to birth control, procreation, and abortion by requiring strict scrutiny of any state law that infringes on these fundamental interests. See Roe v. Wade, 410 U.S. 113 (1973) (invalidating state law limiting woman's choice of abortion); Eisenstadt v. Baird, 405 U.S. 438 (1972) (extending right to possess contraceptives to unmarried persons); Griswold v. Connecticut, 381 U.S. 479 (1965) (invalidating state law barring use of contraceptives by married couples); but cf. Bowers v. Hardwick, 478 U.S. 186 (1986) (refusing to find a fundamental right to homosexual sodomy).

140. See Ala. Code § 22-11A-21(c) (1990) (making unlawful the knowing transmission, assumption of the risk of transmission, or performance of any act which will probably or likely transmit a sexually transmitted disease to another); Okla. Stat. Ann. tit. 21, § 1192.1 (West Supp. 1991) (making unlawful the engagement by a person in any activity with the intent to infect or to cause to be infected another person with HIV); see also W. Va. Code § 16-4-20 (1991) (making unlawful the performance by a person suffering from an infectious venereal disease of any act which exposes another to infection). These broadly worded statutes may encourage abortions since a mother could be prosecuted if she delivers an HIV infected baby after finding out that she is infected with HIV. See Michael L. Closen & Scott H. Isaacman, Are AIDS-Transmission Laws Encouraging Abortion?, A.B.A. J., Dec. 1990, at 77.

more severe penalty if the objective is to deter others from behavior that risks HIV transmission.\textsuperscript{142} In summary, HIV and curable venereal diseases are incompatibly grouped together under existing statutes that criminalize acts of intentional exposure or infection of others with a contagious disease.

In most cases it will be difficult to overcome the obstacles under traditional criminal law and public health offense statutes to successfully prosecute persons engaging in behavior that presents a risk of HIV transmission. One study showed that courts dismissed a majority of cases brought under public health offense statutes because of the difficulty of proving intent to transmit HIV.\textsuperscript{143} Other cases in which persons have been prosecuted for conduct that risks HIV transmission have been brought under the assault model for spitting at or biting another person.\textsuperscript{144} These acts, though committed maliciously, are extremely unlikely modes of HIV transmission.\textsuperscript{145} Imposition of harsh penalties for acts that may not be criminal in the absence of AIDS\textsuperscript{146} reflects the hysteria engendered by the disease rather than application of appropriate sanctions for dangerous behavior.\textsuperscript{147}

The issue of consent is an additional shortcoming to the use of criminal statutes to control the spread of HIV infection. The defense of consent is available under the Model Penal Code only if the injury is reasonably foreseeable.\textsuperscript{148} Consent to sexual intercourse does not imply consent to the exposure of another person to the AIDS virus with a maximum fine of $5000 dollars, or a maximum prison term (with or without hard labor) of ten years.

\textsuperscript{142} Classification of the proscribed act as a felony would be more appropriate.


\textsuperscript{144} Gostin, supra note 8, at 1627.


\textsuperscript{146} Berkelman, supra note 4, at 766 ("[T]he risk of HIV transmission following exposure to saliva is extremely low, if not zero . . . ."). At least one court has taken judicial notice of the fact that teeth are not deadly weapons for the purpose of an aggravated assault prosecution. Brock v. State, 555 S.2d 285 (Ala. Crim. App. 1989) (overturning aggravated assault conviction where record did not support conclusion that biting could transmit HIV). \textit{But cf.} United States v. Moore, 846 F.2d at 1167 (teeth are dangerous weapons within context of aggravated assault statute regardless of whether defendant was infected with HIV).

\textsuperscript{147} While biting meets the simple assault definition under the Model Penal Code, spitting probably does not. \textit{Model Penal Code} § 211.1(a) (1962) ("A person is guilty of assault if he attempts to cause or . . . causes bodily injury to another[.]"). Bodily injury includes physical pain, illness or any impairment of physical condition. \textit{Id.} § 210.0(2).

\textsuperscript{148} Schultz, supra note 113, at 112.

\textit{Id.} at 106.
bility of infliction of serious bodily injury.\textsuperscript{149} Therefore, the defense may not be available if infection results from sexual intercourse unless the risk of possible HIV infection is fully disclosed to the partner and prophylactics are used.\textsuperscript{150}

Since most HIV transmitting acts are consensual,\textsuperscript{151} criminal statutes effectively criminalize risks accepted by individuals.\textsuperscript{152} Under current public health law precedent, these risks, even if protected by a constitutional right to privacy, would likely be overridden by the police power authority of the states to control contagion.\textsuperscript{153} Hence, providing a defense of informed consent in statutes that criminalize sexual activity by persons with knowledge of their HIV infection would likely discourage dangerous behavior by eliminating the disincentive for such persons to discover their HIV status and promote the use of prophylactic devices.\textsuperscript{154}

\section{The AIDS-Specific Statute}

The obstacles to prosecuting HIV transmitting activities under traditional criminal law\textsuperscript{155} and the inappropriateness of applying public health statutes to AIDS have led several states to draft AIDS-specific statutes that dispense with the difficulty of proving intent by proscribing particular acts by persons who know that they are infected with HIV.\textsuperscript{156} These statutes generally impose criminal liability on persons who intend to infect another by committing specific acts that are medically proven modes of transmitting HIV, or who, knowing of their HIV-positive status, commit such acts even if the intent to infect another is absent.\textsuperscript{157} Most AIDS-specific statutes provide a

\textsuperscript{149} Id.

\textsuperscript{150} The defense of consent is inapplicable to infection by illicit intravenous drug use because the Model Penal Code disallows consent to commit illegal activities. MODEL PENAL CODE § 2.11(2)(b) (1962).

\textsuperscript{151} The Centers for Disease Control does not compile data on HIV transmission as a result of rape. Telephone Interview with staff member of National AIDS Information Hotline (Oct. 10, 1991). However, one study conducted by CDC found that when females with no known risk factor to HIV became infected, the infection was not attributable to sexual assault. Mark Blumberg, \textit{Transmission of the AIDS Virus Through Criminal Activity}, 25 CRIM. L. BULL. 454, 459 (1989). Where the conduct is non-consensual, e.g., rape, criminal laws already impose harsh penalties to deter and punish such conduct. See MODEL PENAL CODE § 213.1(1) (1962) (classifying forcible rape of a female by a male as a first degree felony).

\textsuperscript{152} Sullivan & Field, \textit{supra} note 50, at 158.

\textsuperscript{153} Id. at 174.

\textsuperscript{154} Schultz, \textit{supra} note 113, at 107.

\textsuperscript{155} Gostin, \textit{supra} note 8, at 1627.


defense of consent that is met if the actors have informed their partners of their condition and of the risk involved in the activity, or if persons donating body fluids, tissues, or organs have been told by a physician that they are not infected with HIV. 158

The AIDS-specific statute appears to be the best method to establish a coercive public health response to control the spread of HIV infection. 159 Such a statute more narrowly proscribes the conduct likely to infect another with HIV by focusing on the act, rather than on the result. Consequently, the statute serves as a clear warning to HIV infected individuals that they must fully disclose their HIV status before engaging in HIV-transmitting behavior. 160 By limiting the state of mind requirement to the highest level of culpability, 161 the statute eliminates the overly broad reach of lower grade criminal statutes that penalize reckless or negligent transmission of HIV and

§ 44-29-145 (Law. Co-op. Supp. 1990). Idaho is an example of one of the more comprehensive AIDS-specific statutes:

(1) 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 immune deficiency syndrome (AIDS), AIDS related complexes (ARC), or other manifestations of 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 in the state prison for a period not to exceed fifteen (15) years, by fine not in excess of five thousand dollars ($5,000), or by both such imprisonment and fine.

(2) DEFINITIONS. As used in this section:
(a) “Body Fluid” means semen, . . . blood, saliva, vaginal secretion, breast milk, and urine.
(b) “Transfer” means engaging in sexual activity by genital-genital contact, oral-genital contact, anal-genital contact; or permitting the use of a hypodermic syringe, needle, or similar device without sterilization; or giving, whether or not for value, blood, semen, body tissue, or organs to a person, blood bank, hospital, or other medical care facility for purposes of transfer to another person.

(3) DEFENSES:
(a) Consent. It is an affirmative defense that the sexual activity took place between consenting adults after full disclosure by the accused of the risk of such activity.
(b) Medical advice. It is an affirmative defense that the transfer of body fluid, body tissue, or organs occurred after advice from a licensed physician that the accused was noninfectious.


158. See IDAHO CODE § 39-608(3)(a), supra note 157; see also Sullivan & Field, supra note 50, at 172.

159. See PRESIDENTIAL REPORT, supra note 88, at 130 (“An HIV-specific statute . . . would provide clear notice of socially unacceptable behavior specific to the HIV epidemic and tailor punishment to the specific crime of HIV transmission.”).


161. Most HIV specific statutes make it a criminal offense to knowingly or purposely engage in behavior that exposes another to the risk of HIV infection. Hermann, supra note 156, at 370.
are prone to manipulation by juries. By criminalizing intentional conduct, the statute does not penalize individuals for learning their HIV status because acting with the knowledge of infection alone is not proscribed if the actor has fully informed a consenting partner of the risks of HIV transmission. The more severe penalties imposed under these statutes compared to those under public health statutes reflect the life-threatening consequence of HIV transmission and therefore may have a stronger deterrent effect. Most importantly, an AIDS-specific statute that incorporates a defense of informed consent recognizes that HIV infection occurs predominantly through consensual sexual contact. As a result, constitutional privacy protections relating to intimate personal contact are less likely to be invoked upon challenges to the statutes in court.

The appropriateness of criminalizing HIV transmitting behavior remains controversial. However, recent federal legislation requiring states to have the capability to prosecute HIV-transmitting behavior in order to receive emergency AIDS funding has limited the debate to how to criminalize, rather than whether to criminalize. While traditional criminal law statutes and public health statutes are available to impose criminal liability, each

162. For instance, a jury could convict a defendant of a criminal offense that merely requires a negligent state of mind if it believes that the defendant should have been aware of his infection. This would sidestep the requirement that the prosecutor prove that the defendant had knowledge of his infection, allowing a jury great latitude in imposing its own moral code on a defendant's activities. See Sullivan and Field, supra note 50, at 179.

163. However, a broadly drafted public health statute may impose liability on such a person if, with the knowledge of his HIV infection, the individual engages in an act that the legislature considers likely to transmit HIV. See supra note 140.

164. See Berkelman, supra note 4, at 762, 765 (finding that over 60% of reported AIDS cases occurred among homosexual/bisexual males, an additional 5% of reported cases occur as a result of heterosexual activity).

165. Several prominent public health and legal experts oppose criminalization: "The use of coercive powers, far from accomplishing the ostensible objective of impeding the AIDS epidemic, could well fuel it." Gostin, supra note 8, at 1629. Schultz states that "any attempt to press the criminal law into service for the purpose of furthering the public health goal of reducing the spread of the AIDS virus will be expensive, ineffective, and counterproductive." Schultz, supra note 113, at 113. Sullivan and Field cite the threat of "massive government intrusion into sexual privacy" and the danger of "selective prosecution and misuse of criminal law to harass unpopular groups" as costs of AIDS criminalization. Sullivan and Field, supra note 50, at 187. Conversely, law enforcement and elected officials cite the need to protect the population from infection by the intentional acts of HIV infected persons as the rationale for criminal measures. See, e.g., PRESIDENTIAL REPORT supra note 88, at 130 (stating that HIV-infected individuals who act in a manner that poses a significant risk of infection to another must be held responsible for their actions as are those persons who act outside the criminal law's established parameters of acceptable behavior).

166. The CARE Act effectively requires states to have the capability to prosecute individuals for acts that risk HIV infection by making grants of emergency AIDS funds contingent upon a showing of this capability. See supra note 11.
appears ill-suited to impose criminal liability for HIV transmission. An AIDS-specific statute that limits the proscribed acts, imposes liability for only purposeful or intentional infection, and includes a defense of consent represents the best method to criminalize HIV transmission.

Nevertheless, even the most narrowly drawn statute proscribing behavior medically proven to transmit HIV is not likely to be an effective weapon in the public health effort to control the spread of HIV infection. The statute may enable law enforcement officials to prosecute individuals who attempt to infect another with HIV. However, such a statute will be virtually unenforceable because of the private nature of the acts proscribed and the inherent difficulty of proving that a person had knowledge of his infection at the time the act was committed. In addition, while consensual sexual intercourse between an HIV infected person and another person informed of the risk of HIV transmission may protect the infected person from criminal liability, the absence of an additional requirement that the partners use prophylactics to guard against HIV transmission does little to control the spread of infection. Finally, consensual sexual activity between two people, entirely legal prior to the AIDS crisis, would become criminal upon a determination of a party's HIV positive status. Implicitly, this person would be discouraged from being tested for HIV.

Perhaps most importantly, AIDS-specific statutes will do little to deter acts that risk HIV infection among the populations where HIV infection is growing most rapidly—heterosexual minorities in urban areas and intravenous drug users and their sexual partners. These groups are the least

167. Dr. Lawrence O. Gostin, who tracks all AIDS related cases for the AIDS Litigation Project of The Department of Health and Human Services, estimates that the total number of criminal cases brought in civilian and military courts is more than 200. Rorie Sherman, Criminal Prosecutions on AIDS Growing, NAT'L L.J., Oct. 14, 1991, at 3. However, Gostin states that "[he is] personally not aware of one case in which there has been an actual transmission." Id. at 38.

168. The prosecution must prove knowledge of infection at the time of the act. One of the only methods of proving this is to subpoena medical records indicating that a person was tested and informed that he was infected with HIV. Schultz, supra note 113, at 110 n.212. However, in cases where persons have reason to suspect they are infected with HIV, knowledge may be inferred if such persons willfully ignore the likelihood of infection. Sullivan and Field, supra note 50, at 184.

169. Sullivan and Field, supra note 50, at 183 (asserting that requiring the use of prophylactics would help contain the spread of the disease and protect the sexual partner who may not understand the risk that they consented to).

170. Hermann, supra note 156, at 357.

likely to participate in public health programs to discover their HIV status and to take the appropriate precautions encouraged by the AIDS-specific statute. Therefore, the AIDS-specific statute should not be used by states as the sole means of attempting to control the spread of HIV infection, but rather as one measure in the overall public health response to the spread of HIV infection. The statutes should serve to effectively inform society of the acts most likely to transmit HIV; proscribe only the most culpable conduct, thereby assuaging the continuing public fear of contagion by casual contact; and encourage, not inhibit, participation in testing and treatment programs.

V. CONCLUSION

The syphilis epidemic suffered by the American population in the early years of the twentieth century prompted a coercive public health response aimed at isolating and punishing persons suspected of accelerating infection through their activity. Later programs informed, educated, tested, and counselled the public about the disease, and, in combination with effective treatments, significantly controlled its spread. The common mode of sexual transmission of syphilis and AIDS, and the similar responses the diseases evoke in the public, make a comparison of the public health response to syphilis and AIDS instructive in view of the recent federal mandate to criminalize the intentional transmission of AIDS.

The importance of commitment to public health programs to combat the spread of AIDS over the long term, rather than as a short term response in advance of a curative treatment, is reinforced by the recent significant increase in incidence of syphilis, despite the wide availability of penicillin. A review of the public health response to syphilis indicates that the coercive elements were unsuccessful in comparison with noncoercive programs. Several of the noncoercive programs initiated in the syphilis era have achieved some early success in the fight to control HIV infection. If these programs are to continue to be successful, their objectives must not be thwarted by the

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172. See O'Brien, supra note 10 (citing the financial burden on innercity public health care systems limiting access to AIDS programs). In November, 1991, professional basketball star Earvin "Magic" Johnson announced that he had tested positive for HIV and would retire immediately from the game. Richard W. Stevenson, Magic Johnson Retires, Saying he has AIDS Infection, N.Y. TIMES, Nov. 8, 1991, at A1. The announcement by Johnson, a black athlete and role model to thousands of young Americans, is expected to increase awareness of AIDS, especially among young blacks Americans. Michael Specter, Magic's Loud Message For Young Black Men, N.Y. TIMES, Nov. 8, 1991, at B12. Health officials hope that Johnson's announcement will further assist the black community—a group "disproportionately affected by the disease yet the hardest to reach through education efforts"—in overcoming the stigma of AIDS as a disease limited to homosexuals and drug abusers and encourage the community to seek AIDS information and counselling. Id.
use of criminal statutes that perpetuate the public’s fears that HIV can be transmitted by casual contact or make knowledge of HIV infection an element of the offense. Statutes that criminalize virtually any act by persons who know of their HIV infection discourage participation in HIV testing and treatment programs.

AIDS-specific statutes that impose liability only for behavior medically proven to transmit HIV and incorporate a defense of informed consent are the preferred means of criminalizing the intentional transmission of HIV. However, even the most narrowly drafted HIV criminal statute may prove to be counter-productive in the fight against HIV infection. A statute that requires defendants to know of their HIV infection at the time of the criminal act will discourage persons from determining their HIV status and entering education and treatment programs. The social and economic cost of this strategy outweighs any benefit likely to result from prosecuting the few individuals who use the intentional transmission of HIV as a means of causing serious injury or death to another person.

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