Liability for 'Knowing' Transmission of HIV: The Evolution of a Duty to Disclose

Jody B. Gabel
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THE EVOLUTION OF A DUTY TO DISCLOSE

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I. INTRODUCTION

THE advent of Acquired Immunodeficiency Syndrome (AIDS) over a decade ago brought fear to a small segment of the United States population. Initially diagnosed in two specific risk groups, male homosexuals and intravenous drug users,1 AIDS is now the third leading cause of death in men and women between the ages of twenty-five and forty-four in this country.2 Two reports from the Centers for Disease Control (CDC) evidence the pervasive spread of AIDS in the United States: by 1987, the CDC reported 28,098 cumulative cases of AIDS;3 using the same reporting methods through January 1992, the number of reported AIDS cases had increased to 209,693.4 The severity of AIDS, which is currently both incurable and fatal, combined with the fact that it is primarily transmitted through volitional conduct, has caused fear

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1. Eileen Keerdja, 'Homosexual Plague' Strikes New Victims, NEWSWEEK, Aug. 23, 1982, at 10 (reporting that a "mysterious and deadly illness" had begun to develop in male homosexuals); see also Matt Clark et al., AIDS: A Lethal Mystery Story, NEWSWEEK, Dec. 27, 1982, at 63 (describing the initial prevalence of AIDS in homosexuals and heroin addicts).

2. SURGEON GENERAL'S REPORT TO THE AMERICAN PUBLIC ON HIV INFECTION AND AIDS, 1 (1993) [hereinafter 1993 SURGEON GENERAL'S REPORT] ("AIDS is already a leading killer of men and women 15 to 44 years old in our country"); AIDS Deaths Increase Disease Spreading Among Those 15-44, FT. LAUDERDALE SUN-SENTINEL, June 11, 1993, at 10A (Bill Grigg, a spokesperson for the U.S. Public Health Service, reported that AIDS, cancer and heart disease are the leading causes of death in this age group.).

3. Update: Acquired Immunodeficiency Syndrome-United States, 35 MORTALITY & MORBIDITY WEEKLY REP. No. 49, 757 (Dec. 12, 1986) (Table 1 showing cumulative cases of AIDS reported in the United States through Dec. 6, 1986).

4. CENTERS FOR DISEASE CONTROL, HIV/AIDS SURVEILLANCE 1, 5 (Feb. 1992)(Table 1 depicting cumulative AIDS cases in all 50 states, the District of Columbia, and four U.S. Territories). In January 1992 the CDC also reported that the second 100,000 cases of AIDS occurred within 26 months, whereas eight years transpired before the first 100,000 cases were reported in the United States. AIDS Epidemic Rapidly Hits 200,000 Cases, FT. LAUDERDALE SUN SENTINEL, Jan. 17, 1992, at 3A.
and often irrational proposals for containing this modern epidemic.\(^5\) AIDS-related litigation also has escalated in the United States. Approximately thirty criminal and civil cases were filed by 1987 that charged the intentional or knowing transmission of the human immunodeficiency virus (HIV), the retrovirus which ultimately causes AIDS.\(^6\) By September 1991, this number had increased to 840 AIDS-related cases nationwide.\(^7\) Prosecutions occur on traditional grounds, such as attempted murder\(^8\) and assault with a deadly weapon.\(^9\) In addition, civil litigation occurs under specialized state statutes that prohibit knowing exposure or transmission of HIV to another person.\(^10\) The cases reviewed in this Comment involve a minuscule portion of HIV-positive individuals who continue to engage in behavior that is recognized as a mode of HIV transmission.\(^11\)

5. Examples of the general public's irrational fear of contracting HIV or AIDS abound in newspapers across the United States. In 1988, the Texas Association of Realtors told its members that occupancy by an AIDS patient could be viewed by some buyers as a defect in the house, much like a bad roof or the presence of radon gas. Peter Applebome, AIDS, Like a Roof, Is Realtors' Concern, N.Y. TIMES, Mar. 14, 1988, at A14. Misconceptions often mutate into unreasonable suggestions that attract public attention and support, as evidenced in an editorial written by William F. Buckley in 1986. William F. Buckley Jr., Crucial Steps in Combatting the AIDS Epidemic; Identify All the Carriers, N.Y. TIMES, Mar. 18, 1986, at A27. To contain the spread of AIDS, Buckley suggested tattooing all individuals with AIDS to warn other people of their infliction. Id. “Everyone detected with AIDS should be tattooed in the upper forearm to protect common-needle users, and on the buttocks, to prevent the victimization of other homosexuals.” Id. As incredulous as this editorial appeared, a limited survey of Florida residents in 1992 revealed that 82% of the people polled believed HIV-positive individuals “should carry identification.” Seth Borenstein, Poll Shows 4 in 5 Support IDs on Those Carrying HIV, Ft. LAUDERDALE SUN SENTINEL, Oct. 28, 1992, at 6A (survey polled 1,217 randomly selected Florida residents by telephone with a three percent margin of error). These are only a few examples of the persistent misconceptions and apprehension exhibited by the public regarding HIV and AIDS transmission.


11. Of the estimated one million individuals infected with HIV, the number of cases involving intentional or knowing attempts to transmit HIV constitute a minute portion of this population. See Sally Squires, Spreading AIDS on Purpose; Especially in the Military, Prosecution Is Sought in Rare Cases, WASH. Post, Apr. 19, 1988, at Z6 (similar sentiments from criminal prosecutors advocating limited role for AIDS-related prosecution). The purpose of this Report is to assess those recalcitrant cases and the associated charges under which convictions occur. The dignity of individuals who are HIV-positive or suffering from AIDS should not be maligned by the actions of a few who exceed the normal parameters of human decency.
This Comment provides an overview of HIV-related litigation in the United States and the evolution of a duty for HIV-positive individuals to either refrain from knowingly exposing others to the virus or to disclose their infection prior to engaging in risk-related conduct. Because of the fear associated with this disease, whether justified or unreasonable, it is crucial to recognize that sanctions for knowing transmission of HIV should exist only to punish behavior that is intentional and threatening to the health of another person. To knowingly place another individual at risk of contracting HIV, without full disclosure of one's HIV-positive status, is a reprehensible act deserving penalty or criminal sanction.12

This Comment initially provides a brief description of the epidemiology, transmission and prevalence of HIV infection and AIDS to establish a context for assessing HIV-related litigation in the United States. This Comment assesses unique military prosecutions for knowing exposure or transmission of HIV under military codes and regulations; analyzes prosecutions based upon traditional criminal charges in both the military and civilian populations; reviews the development and operation of specialized state statutes prohibiting knowing transmission of HIV; discusses the ramifications of transmission of HIV from a Florida dentist to his patients;13 and proposes that a duty to disclose applies to HIV-positive health care professionals who perform exposure-prone procedures.

II. EPIDEMIOLOGY, TRANSMISSION, AND PREVALENCE OF HIV INFECTION AND AIDS

An assessment of the evolution of HIV-related litigation necessitates a basic understanding of the epidemiology and prevalence of HIV in-

12. See Mack Reed, Area Man Is Accused of Passing AIDS Virus, L.A. TIMES, Jan. 12, 1991, at B1 (reporting that gay rights activists and experts in AIDS law “applauded prosecution” of a man who allegedly had repeated sex with a woman without disclosing his HIV-positive status, resulting in actual transmission of HIV to both the woman and her baby); see also Squires, supra note 11, at Z6 (reporting on attitudes toward criminalizing the transmission of AIDS and only using such measures for individuals who recklessly or intentionally endanger others by their behavior). Several psychological studies researching the issue of why some individuals continue to engage in unprotected sexual intercourse after testing positive for HIV indicate that some “people may be overwhelmed by the raw need for sex, protected or otherwise; others may simply become careless after awhile; still others seem to develop a malicious form of dependency on their partners.” Kevin Krajick, Private Passions & Public Health; For Some People it Takes More Than an AIDS Test to Temper Fatal Attractions, PSYCHOL. TODAY, May 1988, at 50. Two psychologists at the University of California “found that one-quarter of heterosexual and homosexual people at two test sites said they did not intend to tell casual partners if they turned out to be infected.” Id.
13. See infra text accompanying notes 219-234.
fection and AIDS in the United States. AIDS consists of a "specific group of diseases or conditions which are indicative of severe immuno-suppression related to infection with the human immunodeficiency virus (HIV)." Scientific research has continued from 1981 through today, regarding HIV transmission and the ultimate destruction of the body's immune system during the last stages of the infection, or "full-blown" AIDS. The first reported cases of AIDS occurred in Los Angeles in 1981, where five homosexual men contracted an unusual form of infection called pneumocystis carinii pneumonia. In 1983, researchers identified the virus, subsequently named the human immunodeficiency virus (HIV). HIV attacks the body's immune system by adhering to a susceptible class of white blood cells, CD4+ T-lymphocytes, or T-cells, which normally operate to fight infection.

Upon initial infection with HIV, a person usually experiences flu-like symptoms, such as fever, chills and general malaise. During this initial phase, 20 to 40% of the body's T-cells die due to contact with HIV. The immune system reacts to the presence of HIV by manufacturing antibodies to fight the virus and replenishing the T-cells to almost normal levels. This rebound of T-cells accounts for the lack of any further signs of HIV infection beyond the typical flu or cold-like symptoms near the time of exposure. Medical research indicates that some individuals remain HIV-positive and symptom-free for as long as two to ten years before the virus finally destroys the immune system's


17. Id. For a detailed description of the clinical manifestations of HIV infection and subsequent progression to AIDS, see Abe M. Macher, HIV Disease/AIDS: Medical Background, AIDS and the Law 1, 4-17 (Wiley Law Publications Editorial Staff eds., 2d ed. 1992).


19. Id.
ability to fight infections.20 This latency period is the most dangerous aspect of HIV infection because an infected person may be ignorant of both the infection and the propensity to infect others.21 During the latency period, the only indication that a person may be infected with HIV is through a positive HIV test, the presence of recurrent illnesses such as opportunistic infections, or suspicion of high risk for HIV infection based upon lifestyle or risk-related conduct.22

HIV testing is performed in a two-stage process that screens the blood for the presence of antibodies produced as a result of exposure to HIV. The ELISA test (enzyme-linked immunoabsorbent assay) screens the blood and indicates a positive result when these antibodies are detected.23 Further confirmation occurs through the Western Blot test, which detects the elevation of antibodies that combat HIV. This second test also identifies antibodies produced in response to proteins of a specific molecular weight in the same range as HIV. Positive results on both the ELISA and Western Blot test indicate HIV infection.24

Current medical research indicates the existence of at least two species of HIV, HIV-1 and HIV-2.25 Of the two, HIV-1 accounts for the majority of infections in the United States and the world.26 The HIV-1 strain consists of five separate families, “each differing from the others genetically by as much as 30% and randomly scattered throughout the world.”27 Through DNA analysis, a sample of HIV-1 from one person

20. Id.; see also Update: Acquired Immunodeficiency Syndrome-United States, 35 Morbidity & Mortality Weekly Rep. No. 35, 17, 29 (Jan. 17, 1986) (reporting that AIDS cases have resulted from HIV exposure “up to seven years before diagnosis”).


22. See 1986 Surgeon General’s Report, supra note 21, at 2784 (informing the American public that “[a]nyone who thinks he or she is infected or involved in high risk behaviors should not donate his/her blood, organs, tissues, or sperm because they may now contain the AIDS virus”); see also 1993 Surgeon General’s Report, supra note 2, at 10 (providing a section entitled “Assess Your Own Risk” with questions to evaluate the possibility of exposure to HIV based on lifestyle or experience).


26. Id.

27. Id.
can be genetically identified and compared to the molecular structure of HIV-1 from an alleged victim to assess the probability of transmission from the original person.28

HIV transmission occurs through sexual contact with an infected person, exposure to infected blood or blood products, and perinatally from an infected mother to her newborn.29 Although HIV has been isolated from saliva, tears, urine and other body fluids, "epidemiologic evidence has implicated only blood, semen, vaginal secretions and possibly breast milk in transmission."30 There is no medical evidence to indicate that HIV can be transmitted by casual nonsexual contact or by insects bites.31 Furthermore, there are no documented cases of HIV transmission through saliva in conjunction with acts of biting or spitting by an infected individual.32

Of all possible modes of transmission, sexual contact is the most common means of exposure to HIV.33 Homosexual contact accounts for 56% of all reported AIDS cases.34 However, United States Surgeon General Antonia Coello Novello indicated that 39% of reported AIDS cases in women in 1992 resulted from heterosexual contact, an increase of 42% since 1990.35 Research also indicates that male-to-female sexual


29. Macher, supra note 17, at 4-5.


31. Herrmann, supra note 23, at 5; see generally 1986 Surgeon General's Report, supra note 21, at 2784 (informing the American public of the modes of HIV transmission and preventive measures to decrease the possibility of contracting the virus); see also 1993 SURGEON GENERAL'S REPORT, supra note 2, at 8 (explaining that HIV is not transmitted through mosquito or other bug bites).


34. CENTERS FOR DISEASE CONTROL, HIV/AIDS SURVEILLANCE 1, 15 (Feb. 1992) (Table 10 showing 56% of 206,171 AIDS cases reported through January 1992 resulted from homosexual exposure).

35. Paul Raeburn, Women and AIDS: U.S. Report Focuses on Dangers and Outlines Precautions, TALLAHASSEE DEMOCRAT, June 11, 1993, at A1; see also 1993 SURGEON GENERAL'S REPORT, supra note 2, at 1 (describing that almost "half of the cases of AIDS in women have been reported in the last 2 years").
transmission of HIV is more prevalent than the incidence of female-to-male transmission.\textsuperscript{36} Regardless of the gender of the transmitting partner, 11,687 people acquired AIDS through heterosexual transmission through January 1992.\textsuperscript{37} According to statistics from the CDC, over 62\% of all AIDS cases reported through January 1992 involved transmission through either homosexual or heterosexual intercourse.\textsuperscript{38}

One of the most important methods for containing the spread of HIV and AIDS is education regarding abstinence, monogamy and the proper use of condoms.\textsuperscript{39} Several reports indicate that Americans still engage in high-risk activities such as unprotected sexual intercourse or the sharing of hypodermic needles during intravenous drug use.\textsuperscript{40} The 1991 statistics for AIDS cases ranked Puerto Rico first in the nation with an annual rate of AIDS cases equal to 48.4\% per 100,000 population, New York second with 45\%, and Florida third with an annual rate of 41.8\%.\textsuperscript{41} Due to the prevalence of AIDS, public health departments and officials occupy a critical role in reaching the American population and advocating preventive sexual practices and safe behavior.\textsuperscript{42}

This Comment focuses on the "knowing" transmission of HIV, which should be reduced through education, yet somehow continues to escalate throughout all groups in the population. The advent of criminal prosecutions for transmission or exposure to HIV, mandating a duty to refrain from activity known to transmit the virus, has resulted in successful criminal prosecutions of noncompliant behavior where education and an emphasis on social responsibility have failed. Prosecutions for knowing transmission of HIV originated in the unique and

\begin{itemize}
  \item \textsuperscript{37} CENTERS FOR DISEASE CONTROL, HIV/AIDS SURVEILLANCE, 1, 15 (Feb. 1992).
  \item \textsuperscript{38} Id.
  \item \textsuperscript{39} Lawrence O. Gostin, \textit{The Future of Public Health Law}, 12 Am. J.L. & Med. 461, 464 (1986)(advocating a public health approach by educating individuals on the modes of transmission and specifically targeting high risk groups to alter behavior patterns).
  \item \textsuperscript{40} See, e.g., AIDS Deaths Increase, Disease Spreading Among Those 15-44, Ft. LAUDERDALE SUN SENTINEL, June 11, 1993, at 10A (U.S. Surgeon General, while reporting that HIV continues to spread despite educational efforts, stated that "[t]oo many people continue to take chances and too many of them become infected"); Bill Thompson, \textit{Too Many Americans Foolishly Ignore AIDS Warning: 'It Can Happen to You"}, Ft. LAUDERDALE SUN SENTINEL, Nov. 23, 1992, at 9A (according to the Associated Press, the "most extensive national sex survey in more than 40 years reveals that 'heterosexual Americans are not taking seriously the risks of AIDS'").
  \item \textsuperscript{41} CENTERS FOR DISEASE CONTROL, HIV/AIDS SURVEILLANCE, 1, 5 (Feb. 1992) (Table I showing cumulative AIDS cases per 100,000 population reported in all fifty states, the District of Columbia, and four U.S. territories).
  \item \textsuperscript{42} Gostin, \textit{The Politics of AIDS}, supra note 32, at 1019 (advocating public health measures such as education, counseling, and retraining human behavior to contain the spread of HIV and AIDS).
\end{itemize}
disciplined environment of the United States Military, which established the basis for similar civilian litigation.

III. UNIQUE MILITARY PROSECUTIONS FOR KNOWING TRANSMISSION OF HIV

To assess military prosecutions, the military codes, regulations, and medical procedures for HIV testing and counseling must be briefly described. The Department of Defense implemented procedures for mandatory testing of all potential recruits in 1985, which included policies for identification, surveillance, and preventive medicine counselling of servicemembers who tested positive for HIV. The standard procedure commences with an ELISA test, and if positive, a Western Blot test for confirmation. The medical staff then evaluates the servicemember’s medical status and provides extensive counseling about the fatality of AIDS, the transmission of HIV through sexual acts, and the responsibility to either abstain from sexual intercourse or to use condoms to decrease the possibility of transmission.

A. Conviction Under Article 134: Acts Which Prejudice or Discredit the Military

Generally, a military conviction occurs when an HIV-positive servicemember either had unprotected sexual intercourse or failed to disclose his or her HIV-positive status prior to engaging in sexual conduct. The foundation for "knowing" transmission is established through standard medical procedures that include extensive counseling regarding HIV transmission and the responsibilities of all HIV-positive individuals. Each servicemember who receives preventive medicine counseling must sign an informative counseling sheet that includes notification that noncompliance may result in adverse actions or punishment. Prior to 1988, preventive medicine counseling did not include an order from the servicemember’s commanding officer mandating compliance with the medical requirements. However, noncompliance with the counseling

44. Id. at 361.
45. Melissa Wells-Petry, Anatomy of an AIDS Case: Deadly Disease as an Aspect of Deadly Crime, 1988 Army Law. 17, 18; see also Squires, supra note 11, at Z6 (reporting that "married couples in which only one partner is HIV positive are permitted to have unprotected sex with each other," whereas all single individuals in the military must comply with safe sex orders).
48. Id. at 361.
requirements could result in discharge or criminal penalties under Article 134 of the Military Code, also known as the General Article.\textsuperscript{49}

Prosecution under Article 134 requires a demonstration that the defendant did, or failed to perform, certain acts that prejudiced or discredited the Armed Forces.\textsuperscript{50} The gravamen of a charge relating to knowing transmission of HIV is reckless endangerment of another individual’s health. Court-martial and criminal prosecution under Article 134 are best assessed through a brief analysis of United States v. Morris,\textsuperscript{51} the first reported military case involving charges for HIV-related misconduct.\textsuperscript{52} The defendant was charged and convicted of consensual sodomy and sexual intercourse while knowing he was HIV-positive, thus exhibiting a wanton disregard for human life.\textsuperscript{53} On appeal, the defendant asserted that he engaged in “non-deviant sexual intercourse with a female” and could not be held liable for placing the victim at risk because no one in authority told him such conduct would constitute a violation of the military code.\textsuperscript{54}

The court stated that the defendant’s “actions in willfully and deliberately exposing another servicemember to the risk of contracting HIV virus certainly rises to the level of conduct that is prejudicial to good order and discipline.”\textsuperscript{55} The court also noted that each servicemember receives careful instructions regarding Article 134, both upon entry into the armed forces and after six months of service.\textsuperscript{56} Furthermore, the

\textsuperscript{49} 10 U.S.C. § 934 (1983); see also Wells-Petry, \textit{supra} note 45, at 25-26 (describing the general elements of Article 134 and the possibility of conviction for noncompliance with preventive medicine counseling requirements).

\textsuperscript{50} United States v. Woods, 27 M.J. 749, 751 (N.M.C.M.R. 1988), \textit{aff’d}, 28 M.J. 318 (C.M.A. 1989). The court cautioned that Article 134 is not a "catchall" provision to make all irregular or improper acts the basis for court-martial. \textit{Id.} at 750. However, in assessing an indictment based on violations of Article 134, the court held that a criminal offense was alleged based upon the stated facts in the case:

the accused is alleged to have engaged in unprotected sexual intercourse, knowing that his seminal fluid contained a deadly virus capable of being transmitted by means of sexual intercourse, that unprotected sexual intercourse was inherently dangerous to his partner, and that the probable consequence of such act was death or great bodily harm.

\textit{Id.} at 750. The court explained that there is no requirement that the alleged misconduct be prohibited by an official order or regulation for prosecution under Article 134. \textit{Id.}


\textsuperscript{52} Boorstinc, \textit{supra} note 6, at A1 (reporting that Private Morris was believed to be the first person charged with the crime of exposing another individual to HIV during sexual intercourse).


\textsuperscript{55} \textit{Morris}, 30 M.J. at 1225.

\textsuperscript{56} \textit{Id.}
court considered the testimony of several people at trial that established
the defendant had received counseling regarding the fatality of HIV,
understood that sexual intercourse is a common mode of transmission,
and knew that by not using condoms he increased the likelihood of
placing others at risk. All of these factors demonstrated that the de-
fendant was aware that "he had a fatal disease and that his conduct
clearly posed a danger to his sexual partners." 

Additionally, the defendant asserted that the female victim not only
consented to sexual intercourse, but also knew that he was infected with
HIV prior to engaging in such conduct and did not require him to wear
a condom during at least 75% of their sexual encounters. The court
rejected this informed consent defense, explaining that the gravamen of
the offense was that the defendant engaged in unprotected sex knowing
that such conduct was an "inherently dangerous" act likely to produce
great bodily harm or death. Finally, the court emphasized that the
compelling public policy goal inherent in this case was to deter service-
members from engaging in further reckless behavior and combatting
the spread of a deadly disease, regardless of the victim's informed con-
sent.

The decision in Morris illustrates that the duty is specifically imposed
upon the HIV-positive servicemember to use barrier protection and to
inform sexual partners of his or her HIV status. Under this factual sce-

ario, the victim's consent to sexual intercourse does not exonerate con-
duct that is performed while the defendant knows the consequences of
HIV infection and the likelihood of transmission. Under Article 134,
actual injury or transmission of HIV is not required because the offense
is based upon conduct which violates the good order and discipline of
the military. The HIV-specific statutes operate under the same public
policy principle and require the same minimal burden of proof for im-
posing liability.

B. Conviction Under Article 90: Willful Disobedience of a "Safe-
Sex" Order

In 1988, military commanders began issuing orders to follow preven-
tive medicine counseling requirements to use condoms when engaging


57. Id.
58. Id.
59. Id. at 1228.
60. Id.
61. Id.
62. See infra notes 179-205, and accompanying text.
in sexual intercourse and to inform any sexual partners of one's HIV-positive status. The military explanation for implementing "safe sex" orders and disclosure requirements is provided on the top of every order: "[b]ecause of the necessity to safeguard the overall health, welfare, safety, and reputation of this command, and to ensure unit readiness and the ability of the unit to accomplish its mission, certain behavior and unsafe health procedures must be proscribed for members who are diagnosed as positive for HIV infection." Any servicemember who violates the order is subject to a charge of willful disobedience of a superior commissioned officer and discharge under Article 90.

In United States v. Womack, the defendant challenged the validity of a "safe sex" order on the basis that the prohibited conduct was not a likely mode of transmission and was therefore overly restrictive. The defendant tested positive for HIV, received standard preventive medicine counseling, and was ordered to inform all sexual partners of his HIV status, to use condoms to protect his partners from contact with "certain" of his bodily fluids, and to refrain from sodomy or homosexual acts. The defendant proceeded to perform non-consensual fellatio on an inebriated airman, resulting in charges of forceful sodomy and willful disobedience of his commanding officer's order.

The court assessed the requirements of the safe sex order and concluded that the duty to disclose one's HIV-positive status to present and future sexual partners, and to refrain from homosexual activity, were reasonable requirements aimed at minimizing the spread of HIV and AIDS. The court then addressed the portion of the order which imposed an affirmative duty upon the defendant to take measures during sexual activity to protect partners from exposure to his blood, semen, urine, feces, or saliva. Under the facts presented, the potential transmission agent was saliva. Even though medical expert testimony established that no reported case showed that HIV was transmitted through saliva, the court stated that the testimony demonstrated the possibility of transmission through either a break in the skin of the victim's penis or bleeding gum disease in the defendant. These findings provided a
rational basis for the order to include saliva as a transmission fluid. In affirming the defendant's conviction, the court held that all aspects of the safe sex order constituted a "lawful exercise of command authority." The court's decision in Womack demonstrates that the burden of proof required to establish both intent and the possibility of HIV transmission is also minimal under Article 90.

An HIV-positive servicemember can also be convicted of willful disobedience of a safe sex order when a condom is used during sexual intercourse, but the partner is not informed of his or her HIV infection. In United States v. Negron, the defendant was convicted of willful disobedience of a lawful order in violation of Article 90, and sentenced to a dishonorable discharge, forfeiture of pay for six months, and reduction to private first-class. Upon notification of his HIV-positive status, the defendant received standard preventive medicine counseling which included a verbal and written order from his commanding officer to inform prospective sexual partners of his HIV diagnosis prior to any sexual contact. Thereafter, the defendant engaged in two sexual encounters with a female servicemember while wearing a condom, but failed to inform her of his HIV-positive status. On appeal, the defendant challenged the safe sex order as an unconstitutional restriction of private sexual activity. The court stated that although the defendant had some expectation of privacy in his sexual activities:

that expectation must be subordinated to the constitutionally recognized and compelling principle that in every well-ordered society charged with the duty of conserving the safety of its members the

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75. Id.; see also 1993 Surgeon General's Report, supra note 2, at 6 (informing the public that oral sex does present a risk of contracting HIV if the performer has sores or cuts in his or her mouth).
76. Womack, 27 M.J. at 634.
77. As demonstrated in Womack, some possibility of transmission must be demonstrated to sustain the validity of a military order to refrain from specific sexual activity. Therefore, medical expert testimony is a crucial factor in all HIV-related prosecutions. In United States v. Perez, 33 M.J. 1050, 1053 (A.C.M.R. 1991), the court dismissed the defendant's conviction for adultery and assault consummated by battery because the government failed to prove that the defendant had the ability to assault the victim by transmitting the HIV virus. The defense expert on HIV testified that based "upon the fact that Sergeant Perez has a vasectomy and the fact that he has not transmitted the virus to either his wife or to other sexual partners, my best medical opinion is that Sergeant Perez can't transmit the virus because he has an acellular semen specimen." Id. This type of a defense is exceedingly uncommon in AIDS or HIV-related cases.
79. The defendant also was convicted of two charges of adultery under Articles 90 and 134 which factored into his sentence. Id. at 775.
80. Id. at 776 & n.1.
81. Id. at 776.
82. Id. at 778.
The court affirmed the defendant’s conviction and noted that his conduct resulted in two violations, a week apart, during which the defendant had time not only to reflect on his conduct, but also ample opportunity to avoid any further dangerous acts.\(^8^4\)

The validity of a safe sex order was similarly challenged in United States v. Dumford,\(^8^5\) where the defendant engaged in unprotected sexual intercourse without disclosing his HIV-positive status, immediately following his preventive medicine counseling at a nearby hospital.\(^8^6\) The basis of the defendant’s challenge was that the safe sex order could not extend to consensual intercourse with a civilian while he was off base. The defendant acknowledged the validity of protecting the health and welfare of the military community, but argued that “‘protecting every civilian in the world from a military AIDS carrier stretches a valid military interest beyond the point of adequately protecting the rights of the individuals.’”\(^8^7\)

In upholding the validity of the order, the court stated that the obligation to disclose one’s HIV-positive status prior to sexual intercourse must encompass civilian partners, because to find otherwise would be tantamount to the military relinquishing its obligation to curtail this type of conduct and the spread of AIDS.\(^8^8\)

As these cases demonstrate, the military structure provides a disciplined environment in which “knowing” transmission of HIV can be monitored, and quite often, successfully prosecuted. The standard procedures for preventive medicine counseling and subsequent orders to follow these guidelines impose a duty upon servicemembers to disclose

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83. Id. at 778. A full discussion of the constitutional issues inherent in HIV and AIDS regulation is beyond the scope of this Comment. For an in-depth analysis in this area, see The Constitutional Rights of AIDS Carriers, 99 Harv. L. Rev. 1274 (1986) (assessing how courts should respond to public health regulations enacted in response to AIDS and the threat to individual liberties), and Deborah Jones Merritt, Communicable Disease And Constitutional Law: Controlling AIDS, 61 N.Y.U. L. Rev. 739 (1986) (discussing equal protection jurisprudence and formulating a new standard for judging the constitutionality of AIDS regulations).

84. Negron, 28 M.J. at 779.


86. Id. at 838.

87. Id.

88. Id. Also note that the court upheld the defendant’s conviction for aggravated assault as well as disobeying a “safe sex” order under Article 90. Id. at 839. The defendant received a sentence including a dishonorable discharge, confinement for two years, total forfeiture of all pay, and reduction to airman basic. Id.
their HIV infection to sexual partners and to use condoms during such encounters. Breaching this duty to disclose establishes a specific basis for prosecution for conduct in violation of Articles 90 and 134. Although convictions for disobedience of “safe sex” orders and conduct which discredits or prejudices the armed forces are unique to the military, traditional criminal law charges provide a basis for convicting HIV-positive individuals who knowingly engage in conduct likely to expose others to HIV in both the military and civilian populations.

IV. TRADITIONAL CRIMINAL PROSECUTIONS FOR KNOWING TRANSMISSION OF HIV

In 1987, newspaper articles contained speculation that criminal prosecutors, seeking to charge individuals with knowing transmission of HIV, would face an impossible burden of proof in order to gain convictions for such conduct. Only three years later, fifty-four HIV-related criminal prosecutions had occurred in the United States, resulting in convictions for attempted murder and assault. Academic debate continues on the issue of whether criminalizing HIV transmission will actually deter knowing transmission of the virus, or merely encourage individuals to purposely refrain from HIV testing in order to avoid criminal sanctions through ignorance of their infection. Regardless of the ultimate public benefit or detriment resulting from such prosecutions, the knowing transmission of HIV is now a punish-

89. See, e.g., Boorstinc, supra note 6, at 11 (explaining that prosecutors would have to show that the defendant carried the virus, knew of the infection, and passed HIV to the victim); Richard Lacayo, Assault With a Deadly Virus; What Should Courts Do When AIDS is Allegedly Used as a Weapon?, Time, July 20, 1987, at 63 (speculating that prosecutors may have to "prove that an accused was both infected and aware of that fact"); Doreen Weisenhaus, AIDS Criminal Laws, Cases Rise; A Dozen States Considering Bills, NAT'L L.J., July 20, 1987, at 3 (reporting on evidentiary problems in prosecutions for knowing transmission of HIV).


92. See, e.g., Stephen V. Kenney, Comment, Criminalizing HIV Transmission: Lessons From History and A Model For the Future, 8 J. CONTEMP. HEALTH L. & POL'Y 245, 272-73 (1992) (explaining that prosecutions based on "knowing" transmission of HIV may discourage individuals from being tested for the virus); Donald H.J. Hermann, Criminalizing Conduct Related to HIV Transmission, 9 ST. LOUIS U. PUB. L. REV. 351, 356-57 (1990) (stating the disadvantage of criminal statutes is reduction in HIV testing to avoid establishing a basis for criminal liability).
able offense under either criminal law theories or specialized statutes in virtually every state and the armed forces. The standard of conduct prescribed by these state statutes is very similar to the duty imposed upon HIV positive servicemembers under Article 90—to both inform prospective sexual partners of their infection and use protective measures during sexual encounters. This new standard of conduct evolved from prosecutions that expanded traditional criminal law theories to encompass conduct that knowingly placed others at risk for contracting HIV.

A. Military Prosecutions Under Traditional Criminal Law

Aggravated assault under Article 128 of the Military Code is a common basis for prosecuting "knowing" exposure or transmission of HIV, as demonstrated by the military court's analysis in United States v. Johnson. In that case, the defendant tested positive for HIV in July 1987, and received extensive medical counseling about HIV, its transmission through sexual contact, and his obligation to both inform prospective sexual partners of his HIV status and utilize appropriate protective measures. Upon his return from the medical evaluation and counseling, the defendant met a seventeen-year-old male and, in the course of the evening, performed fellatio on the young man. After this encounter, the defendant also placed his "unsheathed" penis between the victim's legs. At trial, the court found the defendant guilty of consensual fellatio and aggravated assault by means likely to produce death or bodily harm.

The basic element of aggravated assault is an assault by "means" likely to produce death or grievous bodily harm. After reviewing commentaries and cases resulting in assault convictions, the court concluded that "semen carrying the HIV virus indeed can be a 'means' to

93. Lawrence O. Gostin, Harvard Professor of Law and Director of the U.S. Public Health Service AIDS Litigation Project, stated that approximately "300 people around the country have faced charges that they purposely tried to infect someone with HIV." Louisiana AIDS Law Faces U.S. Challenge, Ft. Lauderdale Sun Sentinel, Nov. 18, 1992, at 5A. Additionally, 25 states now have AIDS-specific statutes that prohibit knowing transmission of HIV. Id. See infra text accompanying notes 179-205.

94. See supra notes 64-88, and accompanying text.


97. Id. at 800-01.

98. Id. at 801.

99. Id.

100. Wells-Petry, supra note 45, at 23-24.
commit aggravated assault.” Because the charge in this case was an “attempt-type” assault, the prosecution had to demonstrate the specific intent of the defendant to cause, or the subjective belief that his conduct would cause, serious bodily injury. The court explained that the defendant’s intent was to “gain sexual gratification by releasing semen” which carried HIV and, therefore, constituted a “means” likely to cause death or bodily harm. The court emphasized that although the victim stopped the attempt, the defendant performed an overt act, by trying to engage in unprotected intercourse with the victim, which was sufficient to establish a criminal attempt.

Expert testimony at trial established that, regardless of whether actual penetration occurred, gratification through release of HIV-infected semen in this case constituted an assault likely to result in death or grievous bodily harm. The defendant asserted that the victim’s consent to the sexual acts he performed precluded a conviction. The court rejected this consent defense, stating that “[w]hatever the degree of assent to sexual by-play between the individuals, there was no approval by the victim to transmission of the AIDS disease.” Accordingly, the court upheld the defendant’s conviction for aggravated assault.

The issue of consent also arose in United States v. Joseph, where the court upheld the defendant’s conviction for aggravated assault through the exchange of HIV-positive seminal fluid during intercourse. The defendant received routine counseling after testing HIV positive in 1988. Evidence admitted at trial included a four-page counseling sheet given to the defendant, which stressed that sexual intercourse spreads HIV and the only “absolute way” to prevent transmission is through abstinence. The victim testified that she feared becoming pregnant and insisted that the defendant wear a condom during sexual intercourse. The court concluded that the victim did not consent to being placed at risk of contracting the AIDS virus be-

104. Id.
105. Id.
106. Id. at 804.
107. Id. at 805.
109. Id. at 962.
110. Id.
111. Id. at 962-63.
cause her testimony exhibited only a fear of becoming pregnant, not any fear of contracting a sexually transmitted disease.112

Additionally, the defendant sought a reversal of his assault conviction because he wore a condom during intercourse and failed to ejaculate.113 However, the victim testified that she tested HIV-positive six months after having intercourse with the defendant, which raised the issue of whether one sexual encounter with an infected individual wearing a condom could result in transmission of the virus.114 Medical expert testimony offered on this issue established the possibility of HIV transmission in pre-ejaculation fluid by an analogy to the recognized risk of pregnancy when the penis is withdrawn prior to actual ejaculation.115 The testimony also showed that a study of couples who used condoms over a two-year period resulted in pregnancies in 5 to 15% of the women involved.116 Based on this testimony, the court concluded that the defendant knew he was HIV-positive, that sexual intercourse was a mode of transmission, and that a condom could not absolutely prevent infection of his sexual partners.117 Accordingly, the court affirmed the defendant's conviction and subsequent discharge.118

The likelihood of transmission plays a significant role in both aggravated assault cases and cases where HIV-positive defendants are prosecuted under Articles 90 and 134. However, under the traditional criminal law charge, the likelihood of harm must exceed mere speculation or a remote possibility.119 In United States v. Schoolfield,120 the court characterized the actions of an HIV-positive defendant who knowingly engaged in unprotected intercourse as being "similar to that of pointing a loaded gun at a victim. In this case, by analogy, because he is HIV-positive, the appellant's gun is loaded and he as-
saults his victims by merely placing his penis in their vagina, whether or not he ejaculates in them. 121 In contrast, actual harm did occur in United States v. Stewart. 122 There the defendant knowingly engaged in repeated acts of unprotected sexual intercourse without disclosure of his HIV status, which apparently resulted in his partner testing positive for HIV. 123

These military cases attracted public attention and established a basis for criminal prosecution of knowing HIV transmission through both specific prohibitive orders and the traditional criminal law theory of aggravated assault. The military courts developed a body of case law in which the legitimate public policy of combatting the spread of HIV and AIDS justified convictions for private sexual activity that places unsuspecting individuals at risk of contracting the virus. The courts also determined that consent to sexual intercourse does not constitute acceptance of the risk of acquiring HIV from an individual who knows of his or her HIV-positive status, but fails to disclose this information to a partner. The servicemembers' knowledge of their HIV-positive status, combined with conduct likely to result in transmission of HIV, established the requisite intent needed for an aggravated assault conviction. As the duty to disclose was enforced in these cases under criminal law charges, similar state prosecutions also commenced for knowing transmission of HIV under traditional criminal law statutes. The result was an escalation of HIV-related litigation in the United States.

B. Civilian Prosecutions: Assault by Means of HIV Exposure or Transmission

As in the military cases discussed above, the most common and successful civilian prosecutions related to HIV occur under the charge of assault through the possible transmission of the virus. In these civilian cases, the facts must similarly show either the possibility of actual transmission of HIV through the defendant's conduct or the subjec-

121. Id. at 551. Lawrence Gostin, Executive Director of the American Society of Law and Medicine, criticized the "loaded gun" analogy and opined that the essential element of sexual offenses is knowledge of one's HIV-positive status, which merely provides an incentive for individuals to refrain from being tested. Letter, Spreading AIDS on Purpose, WASH. POST, May 3, 1988, at Z4 (response to article by Sally Squires, see Squires, supra note 11, at Z6). Members of the military, however, would not fall into the category of individuals who have the option to refrain from testing due to the mandatory screening policy in the armed forces.

122. 29 M.J. 92 (C.M.A. 1989); see also United States v. Joseph, 33 M.J. 960 (N.M.C.M.R. 1991) (court heard testimony from the victim that she contracted HIV from defendant through sexual intercourse), aff'd, 37 M.J. 392 (C.M.A. 1993); see also supra text accompanying notes 108-119.

123. Stewart, 29 M.J. at 93 n.1.
tive belief by the defendant that transmission was possible. Two cases prosecuted in 1987 demonstrate the requisite burden of proof for convicting an individual for assault by knowingly placing others at risk of contracting HIV through a human bite.

In *United States v. Moore*, the court upheld a conviction for assault with a deadly weapon where an HIV-positive defendant bit a federal corrections officer and the defendant's teeth were considered a deadly weapon. At trial, a medical expert testified that, although there had been no reports of HIV transmission through biting, a human bite can be dangerous because the human mouth carries thirty to fifty varieties of germs. The defendant challenged the subsequent conviction on the basis that his HIV-positive status influenced the jury's decision, even though medical testimony established only a remote possibility of HIV transmission through biting. The court rejected this argument and stated that the trial record contained sufficient evidence for the jury to find that the defendant's mouth and teeth "were a deadly and dangerous weapon, regardless of the presence or absence of AIDS." Conversely in *Brock v. State*, an Alabama court reversed the defendant's conviction of first-degree assault for attempted transmission of HIV. Under Alabama law, first-degree assault lies where the defendant commits an assault with intent to cause, and actually inflicts, serious bodily injury by means of a deadly or dangerous instrument. The record demonstrated that the defendant, knowing he was HIV-positive, bit a corrections officer on the arm during an altercation. The defendant was convicted of first-degree assault for using his mouth as a deadly weapon and causing serious bodily injury by biting the officer and possibly transmitting HIV. In reviewing the trial record, the appellate court stated that there was no evidence presented at trial to show that biting was a possible means of spreading AIDS, nor was there any evidence to support a finding of serious bodily injury.

124. 846 F.2d 1163 (8th Cir. 1988).
125. *Id.* at 1164.
126. *Id.* at 1165.
127. *Id.* at 1167.
128. *Id.* at 1168. The decision in *Moore* was criticized for creating a precedent for juries to convict an HIV-positive individual "for assault with a deadly and dangerous weapon under the pretense of convicting the defendant for transmitting dangerous germs." Carlton D. Stansbury, *Deadly and Dangerous Weapons and AIDS: The Moore Analysis is Likely to be Dangerous*, 74 *Iowa L. Rev.* 951, 952 (1989).
130. *Id.* at 287.
131. *Id.*
132. *Id.* at 286-87.
133. *Id.* at 288.
In the alternative, the court stated that the prosecution also failed to prove that the defendant "intended to cause serious physical injury when he bit" the officer. Ultimately, the court held that the evidence did establish the elements of assault in the third degree, a charge totally unrelated to the defendant's HIV-positive status.

The court in Scroggins v. State used the same analysis as in Brock to uphold a conviction for aggravated assault with intent to commit murder against an HIV-positive defendant who bit a police officer. The prosecution demonstrated that the defendant raised excess saliva into his mouth and then bit the officer's arm, resulting in a wound that took ten months to heal. An admission by the defendant demonstrated that he knew that he was HIV-positive at the time of the altercation. In comparison to both Moore and Brock, the court held that the jury's finding of intent was supported by evidence establishing that the defendant filled his mouth with excess saliva prior to biting the officer, thus increasing the possibility of transmitting the virus. The court emphasized that impossibility of committing the intended crime is not a defense when the defendant believed he could transmit the virus through the method employed.

Specific intent to inflict serious bodily harm was the issue on appeal in Commonwealth v. Brown. The HIV-positive defendant was convicted of aggravated assault by the means of throwing fecal matter in the face of a prison guard. When confronted after the incident, the defendant stated that the officer was tampering with his mail and he kept cups of fecal liquid in his cell to combat such intrusions. The evidence demonstrated that the defendant received counseling from both a physician and a nurse after he tested positive for HIV, which included information that the virus is transmitted through bodily fluids. The court upheld the conviction for aggravated assault because the evidence, showing the defendant's prior knowledge of HIV transmission in conjunction with the act of throwing infected fecal

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134. Id.
137. Id. at 15.
138. Id.
139. Id.
140. Id. at 18. Additionally, the court noted that the defendant merely laughed when the police officer asked if he had AIDS. Id.
141. Id.
143. Id. at 431.
144. Id.
matter in the prison guard's face, established a specific intent to inflict serious physical injury.\textsuperscript{145}

Finally, \textit{Zule v. State},\textsuperscript{146} provides an example of a conviction for aggravated sexual assault by homosexual intercourse and actual transmission of HIV to a minor victim. The facts show that the defendant, knowing he was HIV-positive, engaged in anal intercourse with a fifteen-year-old male.\textsuperscript{147} This sexual encounter occurred in 1987, and by mid-1989, the victim tested positive for HIV.\textsuperscript{148} The defendant asserted that the prosecution failed to show that the victim did not acquire HIV from another sexual encounter in 1989 with a different partner.\textsuperscript{149} However, extensive medical testimony at trial analyzed the sequence of sexual encounters and showed that in this case, the victim or "penetrated party is much more likely to contract HIV than the penetrator."\textsuperscript{150} Whereas in the victim's only other sexual encounter, he was the "penetrator" which decreased the possibility of his contracting HIV from that partner. The court noted that the testimony also established that the defendant's ability to transmit the virus was heightened because he was in the latter stages of HIV infection at the time of the encounter.\textsuperscript{151} Based upon this evidence, the court upheld the defendant's conviction for aggravated sexual assault and transmission of HIV.\textsuperscript{152}

In all of these cases, the defendants were aware of their HIV-positive status and either intended to transmit HIV or knew that their conduct could result in the possibility of transmitting the virus. The elements of assault do not mandate a demonstration of actual HIV transmission in order to convict a defendant for conduct which may result in serious bodily injury. When an HIV-positive individual's assaultive conduct is preceded by threats of death against another or calculated efforts to bring about such a result, the offense can rise to the level of attempted murder.

\textbf{C. Civilian Prosecutions: Attempted Murder Based Upon Possibility of HIV Exposure or Transmission}

Although less common than convictions for assault with the virus, successful prosecutions do occur for attempted murder based upon in-

\begin{thebibliography}{99}
\bibitem{145} Id.
\bibitem{146} Id. 802 S.W.2d 28 (Tex. Ct. App. 1990).
\bibitem{147} Id. at 32-33.
\bibitem{148} Id. at 34-35.
\bibitem{149} Id.
\bibitem{150} Id. at 35.
\bibitem{151} Id.
\bibitem{152} Id.
\end{thebibliography}
tentional infliction of HIV. The elements of this offense, as applied to the conduct of an HIV-positive individual, require that the person purposely or knowingly attempted to engage in conduct that would result in the death of another, if the circumstances were as the person believed them to be, or the person actually took a substantial step to effectuate the death of another. 153 Prosecuted conduct in several cases consisted of knowingly engaging in sexual intercourse or intentional biting and spitting while infected with HIV. The premise for conviction is that successful completion of these activities would result in the victim’s death.

Perhaps no other area of criminal prosecution for HIV transmission generates as much criticism as cases that elevate biting and spitting to the offense of attempted murder. 154 Although medical research does not support this premise, and no known cases have resulted in actual HIV transmission, 155 convictions for attempted murder do occur under specific and limited circumstances. An Indiana case, State v. Haines, 156 provides a factual scenario where scratching, biting and spitting by an HIV-positive individual established the basis for attempted murder. On appeal, the court reversed the trial judge’s ruling that vacated the defendant’s conviction for three counts of attempted murder and imposed a conviction for three counts of battery. 157

The facts show that police officers arrived at the defendant’s apartment after receiving a call about a possible suicide. Upon entering the apartment, the officers found the defendant lying unconscious on the floor in a pool of blood leaking from slash wounds in his wrists. 158 Shortly thereafter, the defendant regained consciousness and screamed that “he should be left to die because he had AIDS.” 159 As

153. Model Penal Code §§ 5.01, 210.2 (Criminal Attempt and Murder respectively).
154. E.g., Amy Goldstein, HIV Victim Charged in Attack, Bite Called Attempt to Kill U.S. Officer, Wash. Post, June 5, 1992, at D1 (reporting that the case of an HIV-positive man charged with attempted murder for biting U.S. Secret Service Officer caused an angry reaction from AIDS activists); Gostin, supra note 121 at 24 (stating that even "if the criminal law could deter biting or spitting, it still probably would not prevent one case of AIDS, since these behaviors do not spread the virus"); David Margolick, The AIDS Docket: A Special Report; Tide of Lawsuits Portrays Society Ravaged by AIDS, N.Y. Times, Aug. 23, 1992, at 1 (reporting on the case of a man accused of attempted murder by spitting on a prison guard and his defense lawyer commenting that “spittle saturated with H.I.V., is no murder weapon”).
155. Lifson, supra note 32, at 1354 (stating that the risk of infection after exposure to saliva in casual settings should be negligible); Gerald H. Friedland & Robert S. Klein, Transmission of the Human Immunodeficiency Virus, 317 New. Eng. J. Med. 1125, 1126 (1987) (Table 1 showing only three known modes of HIV transmission, which include exposure through contaminated blood, sexual intercourse, and perinatal transfer from mother to fetus).
157. Id. at 835.
158. Id.
159. Id.
paramedics arrived, the defendant became combative and threatened to give the officers AIDS through his bleeding wounds. The defendant flailed his arms and sprayed blood into an officer's eyes and mouth. As the defendant struggled against the emergency medical personnel, he proceeded to scratch, bite and spit on several officers and paramedics. The defendant also commented that "he was going to show everyone else what it was like to have the disease and die."

In his defense, the defendant argued that the prosecution did not present evidence to support the inference that his conduct constituted a substantial step toward the commission of murder because medical testimony failed to show the likelihood of HIV transmission through his actions. In rejecting this argument, the court stated that impossibility is not a defense to attempted murder where the defendant "did all that he believed necessary to bring about an intended result."

Furthermore, the court noted that a medical expert testified that direct exposure to HIV-positive blood through the mouth, eyes and skin had resulted in HIV transmission in three cases involving health care workers. Testimony at trial also established that the defendant received counseling from his doctor when he tested positive for HIV, which included information regarding the lethal nature of HIV and the modes of transmission. Based upon the defendant's knowledge of his HIV-positive status, the fatality of the disease, and his belief that HIV could be transmitted by throwing infected blood, biting, and spitting, the court held that sufficient evidence existed to support the jury's finding that the defendant possessed the requisite intent and purposely "took a substantial step toward the commission of murder."

As demonstrated in *Haines*, the impossibility of HIV transmission is not a defense where the prosecution demonstrates the specific intent and substantial action by the defendant to effectuate the death of another person. Expert medical opinions provide the correlation between intentional conduct and the possibility of HIV transmission to support a conviction for attempted murder. In *Weeks v. State*, the court upheld a conviction for attempted murder where an HIV-positive inmate spit on a prison guard. After previous threats to infect prison guards with HIV, the defendant spit twice at a guard, covering his glasses,

160. *Id.* at 835.
161. *Id.* at 838.
162. *Id.* at 838-39.
163. *Id.* at 839-841.
164. *Id.* at 841. A newspaper report indicated that Haines received a sentence of six years in the state penitentiary as a result of the remanded jury trial. See Squires, *supra* note 11, at 26.
lips and nose with saliva. Testimony of witnesses revealed that the defendant "told everybody that he had AIDS and that he was going to take as many [people] with him as he could" when he died of the disease. A medical expert testified that there was a "theoretical" possibility of transmitting HIV by spitting into a person's mouth or nose, especially if the defendant was in the latter and more contagious stages of HIV infection. The defense expert contradicted this testimony by stating that no documentation existed to show that HIV could be transmitted through saliva, and if this type of transmission were possible, many cases would already have been reported. Although the medical expert testimony was in conflict, the court upheld the defendant's conviction for attempted murder because sufficient evidence existed to show that the defendant "could have transmitted HIV by spitting."

Although the possibility of HIV transmission in Weeks was "theoretical," the controlling factors in upholding his conviction for attempted murder were the defendant's prior threats to kill the prison guards through infection with HIV and his belief that spitting could accomplish this purpose. Cases involving prosecutions for biting and spitting by HIV-positive individuals generally evidence intent through prior threatening behavior by the defendants. However, charges of attempted murder based on knowing transmission of HIV through sexual intercourse infrequently include manifestations of intent through murderous threats. In these rare cases, intent must be established through the act of knowingly engaging in sexual intercourse while infected with HIV, comprehension of the fatality of the disease, knowledge of the modes of transmission, and the surrounding circumstances.

For example, in 1992, an Oregon judge sentenced an HIV-positive man to sixty-five months in prison for attempted murder on the basis

166. Id. at 561.
167. Id.
168. Id. at 563.
169. Id. at 564.
170. Id. at 565.
172. In a Florida case, State v. Sherouse, 536 So. 2d 1194, 1195 (Fla. 5th DCA 1989), the court addressed the merit of charges for attempted involuntary manslaughter against a an HIV-positive prostitute who offered and agreed to engage in sexual intercourse with two males on separate occasions. After holding that the crime of involuntary manslaughter is not recognized in Florida, the court explained that ironically "a charge of the greater crime of attempted second degree murder arguably could have been sustained since second degree murder does not require any specific intent to kill another person." Id. (emphasis in original).
of knowingly exposing a seventeen-year-old girl to HIV through sexual intercourse. The defendant had unprotected sex with the victim while knowing he was HIV-positive. Actual transmission was not an issue because the victim tested negative for HIV after the encounter. However, aggravating circumstances did support the conviction because this was not the only reported incident in which the defendant knowingly engaged in unprotected sexual intercourse without warning his partners. In a similar case in 1991, the same defendant pled no contest and received probation for the same type of conduct. The female victim in this earlier case developed AIDS. The third victim who engaged in sexual intercourse with the defendant subsequently died of AIDS.

In contrast, most cases involving the possibility of knowing transmission of HIV through sexual intercourse do not present circumstances which support the charge of attempted murder. In 1987, a man with HIV who sexually attacked a female patient in a hospital mental ward was charged with attempted murder on the basis of transmission of HIV. The defendant’s knowledge of his HIV-positive status in conjunction with his sexual attack provided the grounds for attempted murder, rather than evidence of a specific intent to cause death. In the absence of actual transmission, specific intent exhibited by murderous threats, or the subjective belief by the individual that his or her behavior could effectuate the death of another person, a successful prosecution for attempted murder is not likely to occur.

173. *Man Gets 9-year Prison Term for Exposing Girl to HIV, Drugs, Chi. Trib.*, Dec. 1, 1992, at M5 (reporting that Alberto Gonzalez was sentenced to 65 months in prison for knowingly exposing a seventeen-year-old girl to HIV).


175. *Id.*


177. In a similar case in 1993, a Florida man was charged with attempted first degree murder for allegedly forcing three young boys to have anal intercourse with him while knowing he was infected with HIV. Wilda L. White, *Controversy Surrounds Case of AIDS as a Deadly Weapon*, Tallahassee Democrat, July 8, 1993, at 2C. The newspaper report explained that under Florida law, prosecutors can charge the defendant with attempted murder even though "there is no claim that he intended to kill the young boys he is accused of raping." *Id.* The prosecutors will be required to show that the HIV-positive rapist "could cause the death of his victim." *Id.* The testimony of medical experts is crucial in this type of case to establish the likelihood of actual transmission of HIV in order to obtain a conviction for attempted murder.*Id.*

178. In 1987 Joseph Edward Markowski was charged with two counts of attempted murder and two counts of assault with great bodily injury for having unprotected sex with another man while knowing he could transmit HIV. Terry Pristin, *Key Witness Refuses to Testify in AIDS Murder Attempt Trial*, L.A. Times, Sept. 2, 1987, at Metro 3. The victim, who tested HIV-
This brief analysis reveals an initiative to penalize conduct that knowingly or deliberately places others at an uninformed risk of contracting HIV. To convict under either assault or attempted murder statutes, however, the facts of the incident must correspond to the individual elements of the offense. Due to this rigid format, twenty-five states have enacted specialized statutes that provide the independent offense of knowing or intentional transmission of HIV through sexual or other types of contact.179

V. SPECIALIZED STATE STATUTES PROHIBITING KNOWING TRANSMISSION OF HIV

Specialized state statutes impose liability for failing to disclose one’s HIV-positive status to sexual partners or for failing to use protective measures during sexual intercourse. In addition to prosecution under traditional criminal law theories, these statutes create a basis for a specific standard of acceptable conduct. These statutes contain three essential elements: (1) the person knowingly, (2) engaged in defined behavior, (3) likely to transmit HIV.180 From this basic model, some states have expanded the basis for liability by penalizing individuals who do not disclose their HIV-positive status to partners prior to en-
gaging in sexual contact.\textsuperscript{181} Knowledge of one’s HIV-positive status establishes the intent requirement for prosecution under most of the specialized statutes.\textsuperscript{182} An analysis of two cases that resulted in convictions for “knowingly” engaging in proscribed conduct illustrates prosecution under an HIV-specific statute.

In \textit{People v. Dempsey},\textsuperscript{183} the defendant was charged with aggravated criminal sexual assault and criminal transmission of HIV, a specific offense under the Illinois Criminal Code.\textsuperscript{184} The facts adduced at trial show that in 1989 the defendant was informed by his physician that he had HIV and also received counseling about his potential to infect others through transmission of body fluids, such as blood and semen.\textsuperscript{185} The victim in this case was the defendant’s nine-year-old brother, who slept in the defendant’s room one evening in 1990. At trial, the victim testified that early the next morning the defendant placed his penis in the victim’s mouth and ejaculated.\textsuperscript{186} After hearing testimony regarding the defendant’s knowledge of his infection and the modes of HIV transmission, the jury convicted the defendant on both charges.\textsuperscript{187}

On appeal, the defendant challenged his conviction for criminal transmission of HIV on the basis that the statute was “unconstitutionally vague and therefore invalid.”\textsuperscript{188} In upholding the statute, the court explained that the statute as applied to the defendant in this case provided sufficient notice that the charged conduct constituted a criminal offense.\textsuperscript{189} The statute provided that a person commits “criminal transmission of HIV when he or she, knowing that he or she is in-

\textsuperscript{181} See, e.g., \textsc{tex. code ann.} \textsection 22.012 (West Supp. 1993). Intentional exposure of another to AIDS or HIV occurs when an infected person “intentionally engages in conduct reasonably likely to result in the transfer” of bodily fluids and “the other person consented to the transfer but at the time of giving consent had not been informed by the actor that the actor had AIDS or was a carrier of HIV.”\textit{id.}

\textsuperscript{182} See \textsc{ga. code ann.} \textsection 16-5-60 (Michie Supp. 1992) (prohibiting any HIV infected person from “knowingly” engaging in sexual intercourse without disclosing his or her infection to the other person); \textsc{idaho code} \textsection 39-608 (Supp. 1992) (stating that any person “who exposes another in any manner with the intent to infect or, \textit{knowing} that he or she is or has been afflicted . . . is guilty of a felony . . . .”) (emphasis added); \textsc{sc. code ann.} \textsection 44-29-145 (Law. Co-op. Supp. 1992) (stating that it is unlawful for a person who “knows that he is infected” with HIV to “knowingly” engage in sexual intercourse).

\textsuperscript{183} 610 N.E.2d 208 (Ill. App. Ct. 5th 1993).

\textsuperscript{184} See Criminal Transmission of HIV \textsc{ill. stat. ann.} 1989 ch. 38, para. 12-16.2(a)(1) (Smith-Hurd Supp. 1992). In \textit{Dempsey}, the court reached the conviction based upon the 1989 provision that is essentially the same as the 1992 statute.

\textsuperscript{185} \textit{Dempsey}, 610 N.E.2d at 213.

\textsuperscript{186} \textit{id.} at 210.

\textsuperscript{187} \textit{id.} at 216.

\textsuperscript{188} \textit{id.} at 222.

\textsuperscript{189} \textit{id.}
fected with HIV engages in intimate contact with another,” which includes exposure to the body fluids of an HIV-infected person in a “manner that could result in the transmission of HIV.” The court explained that the evidence demonstrated that the defendant knew HIV could be transmitted through semen and that oral intercourse was a possible means of transmission. Therefore, the court concluded that the defendant’s conduct clearly fell within the proscribed conduct under the statute.

Compared to the complex medical expert testimony employed in previous cases where “knowing” transmission of HIV formed the basis for assault or attempted murder charges, the analysis in Dempsey was straightforward due to the correlation between the statutory elements and the charged conduct. The evolution of HIV-specific statutes has resulted in effective prosecutions for knowingly engaging in conduct that is likely to result in HIV transmission. The prosecution must show that the defendant knew of his or her HIV-positive status and the means of HIV transmission, prior to engaging in conduct that is likely to place another at an uninformed risk of contracting the virus. A specific intent to transmit the virus or cause bodily harm is not an element of most of these statutory offenses.

State v. Stark provides an example of a conviction for “intentional” transmission of HIV through heterosexual intercourse under the Washington specialized statute that contains an “intent” element. In this case, the defendant exposed three female partners to HIV over the course of two years. Testimony at trial showed that the defen-

190. Id.
191. Id. at 223.
192. The Dempsey case also provides an example of an abuse of discretion in the sentencing phase of an HIV-related charge. Id. at 227. The trial judge sentenced the defendant to 33 years for criminal sexual assault and seven years for criminal transmission of HIV. Id. at 210. The appellate court remanded the case for resentencing before a different judge due to these comments by the trial judge while addressing the defendant:

Let everybody be innocent bystanders while you run through the crowd at will, and wherever you find a possibility spread your sperm or body fluids maybe in a way to cause a spread of this horrible disease. . . . I hope that people who hear of this will think it's best if they have the HIV virus that they start protecting the public and not be like a mad dog out in the wilds biting anything that comes along or stands still or falls over backwards.

Id. at 226.

Finally, the appellate court concluded as follows: “[t]he sentencing judge was so prejudiced by fear of the disease that he let improper factors influence him and did not consider the requisite statutory factors.” Id. at 227. Another example of irrational judicial conduct includes the imposition of a 10 foot rule in court that allowed guards to remain 10 feet from HIV-infected defendants. See Courts Found to Perpetuate AIDS Myths, Judges Misunderstand Risks, Report Says, L.A. Times, Jan. 19, 1992, at A18.

194. Id. at 112.
dant tested positive for HIV in 1988 and received extensive counseling on five occasions at a local health department. ‘‘He was taught about ‘safe sex,’ the risk of spreading the infection, and the necessity of informing his partners before engaging in sexual activity with them.’’ 195

Thereafter, the defendant engaged in unprotected sexual intercourse with the first victim on two occasions prior to informing her that he was HIV-positive. After six sexual encounters with the second victim, the defendant not only informed her of his HIV status, but also gave her an AZT pill ‘‘to slow down the process of the AIDS.’’ 196 The final victim testified that the defendant never wore a condom or informed her of his HIV infection, even though they had sexual intercourse almost every night for a month. When this victim ended the relationship, the defendant ‘‘told her that he carried HIV and explained that if he had told her, she would not have had anything to do with him.’’ 197 Finally, a friend testified that she had told the defendant that he had a responsibility to protect others from transmission of the virus. He responded, ‘‘I don’t care. If I’m going to die, everybody’s going to die.’’ 198 Based on this evidence, the trial court convicted the defendant on three counts of assault in the second degree. 199

The specialized statute provided that any person who ‘‘exposes or transmits’’ HIV with intent to do bodily harm is guilty of assault in the second-degree. 200 Therefore, this HIV-specific statute requires a demonstration of ‘‘intent’’ beyond the mere knowledge of one’s HIV-positive status and engaging in conduct likely to transmit HIV. Nevertheless, the court held that the defendant’s knowledge of his HIV infection, his conduct which exposed all three victims to HIV, and his comments evincing disregard for the health of these victims, established sufficient ‘‘intent’’ to cause bodily harm as required under the statute. 201 This reasoning is similar to that in the aforementioned as-

195. Id. at 111.
196. Id. at 112. AZT is an acronym for antiretroviral zidovudine, a drug used to forestall the effects of HIV on the infected person’s immune system. ‘‘Although AZT does not kill HIV, treatment with AZT may increase a patient’s survival time by delaying further deterioration of the immune system and decreasing the frequency and severity of opportunistic infections.’’ Macher, supra note 17, at 16.
197. Stark, 832 P.2d at 112.
198. Id.
199. Id. at 111-12.
200. Id. n.1.
201. Id. at 114. As in Dempsey, the appellate court remanded this case for resentencing because of an abuse of discretion by the trial judge. The trial court imposed an exceptional sentence of 10 years, due to the defendant’s irresponsible conduct and ‘‘future dangerousness’’ to society. Id. at 116-17. The appellate court explained there was no evidence showing that any of the victims contracted the virus or that the defendant’s conduct was the most egregious, thus
sault and attempted murder cases. However, the elements of exposure and transmission of HIV are specifically defined in statutes, such as Washington's, which eliminates the need for extensive testimony regarding the possible modes of transmission based upon the charged conduct.

Statutes criminalizing HIV transmission usually include an affirmative defense where the defendant informed the victim of his or her HIV infection prior to engaging in conduct likely to transmit the virus. For example, the statutes enacted in Arkansas, Florida, Georgia, Idaho, Illinois, Louisiana, South Carolina and Texas include provisions recognizing "informed" consent by the victim as an affirmative defense to the charge of criminal transmission of HIV. However, the victim's consent merely to engage in sexual intercourse does not operate as an affirmative defense in the absence of prior notification by the accused of his or her HIV-positive status. Similarly, defenses such as withdrawal prior to ejaculation, or lack of medical evidence to support the likelihood of transmission by the means employed, are unlikely to prevail because the elements of knowledge and prohibited conduct are defined by the statute rather than by the probability of transmission.

The scope of HIV-specific statutes and the corresponding penalties imposed for violations vary from state to state. The Louisiana statute does not include an intent element, and establishes a possible sentence of ten years of imprisonment with or without hard labor and a maximum fine of $5,000 for knowing exposure or transmission of HIV. In 1990 an HIV-positive man was convicted for criminally exposing an eight-year-old boy to HIV and faced a possible sentence of seven years

supporting an exceptional sentence. Id. at 117. For examples of cases in which the defendant's HIV-positive status did constitute an aggravating factor in the calculation of the sentence, see State v. Farmer, 805 P.2d 200 (Wash. 1991) (upholding exceptional sentence on the basis of the defendant's deliberate cruelty to a juvenile by engaging in sexual intercourse while knowing or believing he was HIV-positive), and Cooper v. State, 539 So. 2d 508 (Fla. 1st DCA 1989)(affirming heightened sentence on the basis of the defendant's reckless disregard for the health of sexual battery victim by engaging in sexual intercourse with the minor knowing or suspecting he was HIV-positive).


in prison under the Illinois specialized statute. Under Florida’s specialized statute, “knowing” transmission of HIV constitutes a misdemeanor offense carrying a maximum sentence of one year imprisonment. These are only a few examples of the varied penalties that states impose for knowing transmission of HIV. These specialized statutes have been criticized because they impose penalties in the absence of actual injury or transmission of the virus.

Opponents of HIV-related prosecutions claim that in the absence of actual transmission or injury, no liability should be imposed for risk-related conduct. This position advocates that education, counseling and behavior remodification present more advantageous methods for combatting the spread of HIV or AIDS than criminal sanctions. This view appears to presume that only one public policy approach can be successful in restraining the spread of AIDS and recalcitrant behavior. The importance of education and social services should not preclude prosecutions for those few HIV-positive individuals who continue to “knowingly” engage in conduct that threatens the health of others and perpetuates HIV transmission. Consequently, a public health approach and criminal liability for conduct that knowingly places unsuspecting individuals at risk are not mutually exclusive, but rather adjuncts in an effort to cultivate and enforce a new standard of conduct within our society.

204. Passed the Virus, Nat’l L.J., Nov. 5, 1990, at 6 (reporting the conviction of Randall Lee Dempsey, believed to be the first conviction under the HIV specific statute in Illinois).

205. Fla. Stat. § 384.34 (1993). In the 1993 session, the Florida Legislature passed Chapter 93-227, which established the offense of “criminal transmission of HIV” for offenders who previously tested HIV-positive after convictions for offenses such as sexual battery, incest, assault, battery or prostitution and proceed to commit a second or subsequent offense after testing positive. Ch. 93-227 § 8, 1993 Fla. Sess. Law Serv. 1814, 1818 (West)(to be codified at Fla. Stat. § 775.0877). This type of offense is different from the usual “knowing transmission” statutes because the basis for criminal liability is associated with an existing crime rather than merely engaging in consensual sexual intercourse with knowledge of one’s HIV-positive status. This new offense should circumvent prior difficulties in effectively controlling the spread of HIV by infected prostitutes. For a report on this problem, see Bob LaMendola, Hookers Walking the Streets Hiding HIV Dangers, Ft. Lauderdale Sun-Sentinel, Feb. 4, 1992, at 1B (describing the difficulties in prosecuting prostitutes under Florida’s specialized statute due to the confidentiality laws preventing police and prosecutors from seeing an individual’s HIV test results).

206. For example, section 211.1 of the Model Penal Code provides that a person is guilty of assault if he or she “attempts to cause or purposely, knowingly, or recklessly causes bodily injury to another.” Model Penal Code § 211.1 (1962) (emphasis added). The possibility of criminal conviction for an attempted assault is very similar to convictions for knowing transmission because actual harm is not an element of the offense.

VI. LIABILITY FOR KNOWING TRANSMISSION OF HIV IN THE HEALTH-CARE SETTING

The previous sections of this Comment provide an overview of HIV-related litigation in the United States. Whether under the Military Codes and Regulations, traditional criminal law theories, or specialized state statutes, the knowing exposure or transmission of HIV to an uninformed person constitutes a punishable offense. Concurrent with this type of litigation, a new standard of conduct has emerged that mandates individuals with HIV refrain from engaging in conduct known to place others at risk of contracting the virus. After considering the development of this new social responsibility in the context of both the military and civilian populations, it is not surprising that public concern regarding "knowing" transmission or exposure to HIV would extend to the health care setting. Recognition of an equivalent duty for HIV-positive health care workers to either refrain from risk-related procedures or disclose their infection to patients is the final stage of this analysis.

A. Establishing a Medical Duty to Refrain from Knowing Transmission of HIV

In 1987 the Centers for Disease Control (CDC) published "Recommendations for Prevention of HIV Transmission in Health-Care Settings."\(^{208}\) The CDC advocated the use of "universal precautions" for all patients, even in the absence of actual documentation of infection with HIV.\(^{209}\) Barrier protection through the use of gloves, masks, protective eyewear and face shields were recommended during any procedures likely to result in exposure to blood or other body fluids.\(^{210}\) Although the majority of the CDC's recommendations focused upon health care workers taking precautions against acquiring HIV from patient contact, the final section of the report dealt with the "management of infected health-care workers."\(^{211}\)

The CDC acknowledged that although no known transmissions of HIV from health care worker to patient had been reported, transmission during invasive procedures remained a possibility.\(^{212}\) In addition

\(^{209}\) Id. at 5S. The CDC explained that since "medical history and examination cannot reliably identify all patients infected with HIV or other blood-borne pathogens, blood and body-fluid precautions should be consistently used for all patients." Id. (emphasis in original).
\(^{210}\) Id. at 6S.
\(^{211}\) Id. at 16S.
\(^{212}\) Id. at 7S.
to emphasizing the need for infected health care workers to follow
universal precautions, the CDC stated:

The question of whether workers infected with HIV—especially
those who perform invasive procedures—can adequately and safely
be allowed to perform patient-care duties or whether their work
assignments should be changed must be determined on an individual
basis. These decisions should be made by the health-care worker's
personal physician(s) in conjunction with the medical directors and
personnel health service staff of the employing institution or
hospital.213

The recommendation for self-enforcement on an ad hoc basis was due
in part to the exceedingly low risk of transmission from an infected
health care worker to a patient. The prospective risk of an HIV-posi-
tive surgeon infecting a patient through one surgical operation ranges
from 1 in 42,000 to 1 in 420,000.214 Therefore, the likelihood of HIV
transmission from an infected health care worker who does not per-
form highly invasive procedures would constitute an even lower per-
centage of risk to the patient.215 Whereas, the risk of a health care
worker acquiring HIV from an infected needle stick or exposure to the
mucous membranes of an infected patient is estimated in the range of
0.9% to 0.03%.216

In 1988 the American Medical Association Council on Ethical and
Judicial Affairs published what appeared to be a more stringent rec-
ommendation for HIV-positive physicians. While emphasizing a non-
discriminatory approach for the treatment of all HIV-positive
individuals, the Council explained:

213. Recommendations for Prevention of HIV Transmission in Health-Care Settings, 36
214. Alain J. Marengo-Rowe, Of Mole and Trojan Horse: Human Immunodeficiency Virus
Infection, 60 DEF. COUNS. J. 376, 380 (1993) (estimates based upon report in CDC, Estimates of
the Risks of Endemic Transmission of Hepatitis B Virus and Human Immunodeficiency Virus to
Patients by the Percutaneous Route During Invasive Surgical and Dental Procedures (1991)); see
also Lawrence Gostin, HIV-Infected Physicians and the Practice of Seriously Invasive Proce-
dures, 19 HASTINGS CENTER REP. 32, 33 (1989) [hereinafter Gostin, HIV-Infected Physicians]
estimating the possible risk of an HIV-positive surgeon infecting a patient to be in the range of
1 in 130,000 or 1 in 126, based upon the frequency of operations performed by the surgeon that
increases the cumulative risk of transmission).
215. Recommendations for Preventing Transmission of Human Immunodeficiency Virus
and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures, 40 MORBIDITY &
MORTALITY WEEKLY REPORT NO. RR-8, 1, 4 (July 12, 1991).
216. Gostin, HIV-Infected Physicians, supra note 214, at 33; see also Michael D. Hagan, et
al. Routine Preoperative Screening for HIV: Does the Risk to the Surgeon Outweigh the Risk to
the Patient?, 259 J. AM. MED. ASSOC. 1357, 1358 (1988) (calculating the risk of HIV infection on
the basis of skin puncture rates for surgeons and extrapolating on the basis of the number of
invasive procedures performed).
in the special context of the provision of medical care, the Council believes that if a risk of transmission of an infectious disease from a physician to a patient exists, disclosure of that risk to patients is not enough; patients are entitled to expect that their physicians will not increase their exposure to the risk of contracting an infectious disease, even minimally. If no risk exists, disclosure of the physician's medical condition to his or her patients will serve no rational purpose; if a risk does exist, the physician should not engage in the activity.\textsuperscript{217}

This recommendation parallels the specialized state statutes regarding knowing transmission of HIV in that an ethical "duty" is imposed upon a physician to refrain from activities that pose a risk of HIV transmission to his or her patients. The Council additionally recommended that an HIV-positive physician disclose his or her infection to colleagues in order to discuss the prudence of continued practice and the associated risk for his or her patients.\textsuperscript{218} The basis for extending liability to physicians for knowing transmission of HIV through invasive procedures was established through this recommendation. However, one essential component was absent—an enforcement provision.

\textbf{B. Documented HIV Transmission from a Health Care Worker to Five Patients}

The effectiveness of self-enforcement and the imposition of an ethical duty for HIV-positive physicians to refrain from invasive procedures was questioned in 1990 when the CDC reported that a twenty-three-year-old woman had contracted HIV from her dentist.\textsuperscript{219} The subsequent CDC investigation revealed that the dentist, Dr. David Acer, was diagnosed with HIV infection in late 1986, and with AIDS in September 1987.\textsuperscript{220} Kimberly Bergalis, the infected patient, had six

\begin{itemize}
\item \textsuperscript{217} \textit{Ethical Issues Involved in the Growing AIDS Crisis}, COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AMERICAN MEDICAL ASSOCIATION, 259 J. AM. MED. ASSOC. 1360, 1361 (1988).
\item \textsuperscript{218} \textit{Id.} One article criticized the disclosure recommendation as improvident "given the actual experiences of HIV-infected physicians, who after such disclosures, often found themselves without employment." Mark Barnes, et al., \textit{The HIV-Infected Health Care Professional: Employment Policies and Public Health}, 18 LAW, MED. \& HEALTH CARE 311, 315 (1990).
\item \textsuperscript{219} Lawrence K. Altman, \textit{U.S. Says Study Suggests Dentist Conveyed AIDS}, N.Y. TIMES, July 27, 1990, at A1 (relating that the CDC reported "for the first time a health professional with AIDS had transmitted the virus that causes the disease to a patient during a medical procedure").
\item \textsuperscript{220} Carol Ciesielski, et al., \textit{Transmission of Human Immunodeficiency Virus in a Dental Practice}, 116 ANNALS OF INTERNAL MED. 798, 801 (1992) (the AIDS diagnosis was based upon a biopsy of his palate that indicated Kaposi's sarcoma and a depressed CD4+ lymphocyte count). This article, from the Centers for Disease Control, Atlanta, Georgia, details the investigative study of the possible modes of transmission from Dr. Acer to eight of his patients through DNA analysis of his HIV strain compared to those of the infected patients. \textit{Id.} at 798.
\end{itemize}
dental visits with Dr. Acer between November 1987 and June 1989, which included prophylactic cleanings, cosmetic bondings and a final visit for extractions of her molars.\textsuperscript{221} Her medical records indicated that four weeks after the extractions, she was treated by her family physician for a sore throat and ulcerated tonsils.\textsuperscript{222} In December 1989 she developed pneumocystis carinii pneumonia and was diagnosed with AIDS.\textsuperscript{223} In the course of the investigation, the CDC identified four additional patients as being infected with a strain of HIV closely related to that of Dr. Acer.\textsuperscript{224}

The CDC team concluded that the preponderance of evidence supported a direct dentist-to-patient transmission as opposed to any other alternative theory of transmission.\textsuperscript{225} However, the investigation failed to identify the actual mode of transmission from Dr. Acer to his patients. The CDC report explained that if contaminated instruments or equipment were assumed to be the primary transmission mechanism, then one would expect to find an association between the appointment dates and times of the infected patients, yet none were identified.\textsuperscript{226}

Interviews with Dr. Acer’s staff indicated that instruments were cleaned by methods known to kill HIV prior to use on any patients. Although the dentist wore gloves during all patient procedures, the possibility of experiencing accidental cuts in his hands while performing invasive procedures was heightened by the fact that Dr. Acer suffered periods of fatigue and ill health during the infected patients’ visits.\textsuperscript{227}

The CDC did not find substantial support for the hypothesis that Dr. Acer intentionally transmitted HIV to his patients.\textsuperscript{228} The investig-
in the sixth victim as eighteen-year-old Sherry Johnson of Florida). Harold Jaffe, director of AIDS research at the CDC, commented that the "report of the sixth patient has certainly raised more questions about the possibility of criminal intent." Id. Also in 1992 a friend of Dr. Acer's opined that the physician had a "possible" motive for intentionally inflicting his patients: "He was angry that America was ignoring AIDS and once said, 'When it starts affecting grandmothers and younger people, then you'll see something done.'" Id.

230. Id. at 804.
231. Id.; see also Barnes, supra note 215, at 323 (concluding that the risk of transmission during invasive procedures performed by infected health-care workers is remote).
233. See Fla. Stat. § 384.29 (1990) (providing that "all information and records held by the department [HRS] or its authorized representatives relating to known or suspected cases of sexually transmissible diseases shall be strictly confidential"); see also Fla. Stat. § 384.23 (1990)(defining sexually transmissible diseases to include the human immunodeficiency virus).
C. Congressional Response to Health Care Worker Transmission of HIV

During the 1991 legislative sessions in the U.S. Congress, numerous congressional enactments were proposed in reaction to the documentation of actual transmission of HIV in the health care setting. The proposed legislation ranged in severity from advocating criminal sanctions for knowingly exposing patients to HIV,\(^{235}\) to mandatory testing for all health care workers and disclosure of positive test results to patients,\(^{236}\) to mandating state compliance with CDC recommendations to minimize the possibility of HIV transmission.\(^{237}\) Senators and representatives emphasized the need for enhanced accountability by health care professionals beyond the existing ethical duty to individually determine when their HIV-positive status becomes a threat to their patients.\(^{238}\)

The most stringent proposal, offered by Senator Helms of North Carolina, sought to impose criminal sanctions upon any HIV-positive health care worker who, with knowledge of his or her HIV infection, performed invasive medical procedures without prior disclosure of Bergalis to an investigator at the Florida Department of HRS in which Ms. Bergalis stated: "‘Anyone who knew Dr. Acer was infected and had full-blown AIDS and stood by not doing a damn thing about it. You are all just as guilty as he was.’); see also Barbara Kantrowtiz, et al., *Doctors and AIDS*, *Newsweek*, July 1, 1991, at 49. This article includes an interview with Barbara Webb, another patient who was infected by Dr. Acer. Ms. Webb explained that earlier in 1992 when eye surgery was recommended by her physician, she informed him of her HIV-positive status and told him she would not be insulted if he refused to perform the operation. *Id.* She was prepared to go to an AIDS clinic in the event he refused, explaining: "And it wouldn’t have bothered me at all to go down. I just gave him the option. Nobody gave me the option." *Id.* Only two years after the onset of AIDS from her exposure to Dr. Acer, Kimberly Bergalis died on December 8, 1991. See Warren E. Leary, *A.M.A. Backs Off on an AIDS Risk List*, *N.Y. Times*, Dec. 15, 1991, at 1.


\(^{238}\) See, e.g., 137 Cong. Rec. S10331, 10349 (daily ed. July 11, 1991) (Democratic Senator Ted Kennedy of Massachusetts, advocating strict adherence by health care workers to universal precautions and to uniform national standards for infection control as the best method to protect against HIV transmission); 137 Cong. Rec. H5203, 5207 (daily ed. June 26, 1991) (Democratic Representative Burton of Indiana stating that Dr. Acer must have known he was violating the tenets of the Hippocratic Oath when he exposed his patients to HIV).
this condition to the patient.\textsuperscript{239} The proposed penalty was a fine of not more than $10,000, or imprisonment for a minimum of ten years, or both.\textsuperscript{240} The purpose of this legislation was analogous to the specialized statutes enacted by many states: to punish infected health care workers who "recklessly provide medical treatment to unknowing patients without informing them" of the possibility of exposure to HIV.\textsuperscript{241}

As an alternative to criminal liability, Representative Dannemeyer of California sponsored a bill entitled "The Kimberly Bergalis Patient and Health Care Providers Protection Act of 1991."\textsuperscript{242} The proposal called for mandatory HIV testing of health care workers who perform procedures identified by the Secretary of Health and Human Services as posing a risk of HIV or other specified communicable disease transmission from a health care worker to a patient.\textsuperscript{243} Any health care worker who tested positive for HIV would be prohibited from performing the listed procedures unless the worker informed the patient of the worker's HIV-positive status, the risk of transmission associated with the indicated procedure, and obtained the written consent of the patient.\textsuperscript{244} Reciprocal provisions provided for HIV testing of patients scheduled to receive the same listed procedures.

Contemporaneous to these proposals, the CDC, on July 12, 1991, issued comprehensive guidelines for the prevention of HIV transmission.\textsuperscript{245} The CDC stressed compliance with universal precautions and recommended that health care workers with skin lesions or weeping dermatitis should refrain from all direct patient contact.\textsuperscript{246} The CDC advocated that health care providers and professional organizations identify exposure-prone procedures that would subsequently constitute the basis for practice restrictions of infected health care workers.\textsuperscript{247} The recommendations stressed that professionals who perform invasive procedures should seek HIV testing and health care workers

\begin{itemize}
\item \textsuperscript{239} 137 CONG. REC. S9776, S9778 (daily ed. July 11, 1991).
\item \textsuperscript{240} Id.
\item \textsuperscript{241} Id. at S9786 (statement by Republican Senator Strom Thurmond of South Carolina, subsequent cosponsor of Amendment 734).
\item \textsuperscript{242} 137 CONG. REC. H5203 (daily ed. June 26, 1991).
\item \textsuperscript{243} 137 CONG. REC. E2376, E2376-77 (daily ed. June 26, 1991).
\item \textsuperscript{244} Id. at E2377.
\item \textsuperscript{245} Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures, 40 MORBIDITY & MORTALITY WEEKLY REP. No. RR-8, 1, 5 (July 12, 1991).
\item \textsuperscript{246} Id.
\item \textsuperscript{247} Id. The CDC also defined exposure-prone procedures as those that involve "digital palpation of a needle tip in a body cavity or the simultaneous presence of the HCW's [health care worker's] fingers and a needle or other sharp instrument or object in a poorly visualized or highly confined anatomic site." Id. at 4.
\end{itemize}
who know that they are HIV-positive should either refrain from exposure-prone procedures, or inform patients of their HIV-positive status prior to performing such procedures. Through an amendment, offered by Senator Dole of Kansas, states would be required to adopt the 1991 CDC guidelines, as well as any prospective recommendations, and enforce compliance by health care workers through disciplinary actions under state licensure authority.

The final enactment, Section 633 of the Treasury, Postal Service and General Government Appropriations Act of 1992 required each State Public Health Official to certify adoption of either the CDC guidelines or equivalent provisions to the Secretary of Health and Human Services within one year after the date of the enactment. This section also contained enforcement provisions applicable to health care workers and the states:

State guidelines shall apply to health professionals practicing within the State and shall be consistent with Federal law. Compliance with such guidelines shall be the responsibility of the State Public Health Official. Said responsibilities shall include a process for determining what appropriate disciplinary or other actions shall be taken to ensure compliance. If such certification is not provided under this section within the one-year period, the State shall be ineligible to receive assistance under the Public Health Service Act.

The enactment represented a compromise between the imposition of criminal penalties for knowing transmission of HIV and the self-enforcement policy adopted by the American Medical Association in 1988. The CDC guidelines would also define prohibited conduct for HIV-positive health care workers through the development of a restricted list of exposure-prone procedures. Thus, a medical duty to refrain from such procedures would be imposed on infected health care professionals through independent enforcement provisions adopted in each state.

248. Id.
251. § 633, 105 Stat. at 876.
252. Id.
However, the foundation for establishing this medical duty—a list of exposure-prone procedures—never materialized, due to the unexpected refusal of health care organizations to identify procedures that constitute a high risk of HIV transmission.\textsuperscript{254} Instead, the American Medical Association, the American Dental Association, and the Assistant Secretary of Health and Human Services advocated the need for additional research to accurately assess the risk of HIV transmission.\textsuperscript{255} Consequently, the CDC receded from the exposure-prone list and provided direction for state health departments to establish their own policies and restrictions for HIV-infected health care professionals.\textsuperscript{256} Beyond the federal requirement to implement either the CDC guidelines or equivalent provisions, the medical duty to refrain from risk related procedures or disclose one’s HIV-positive status to prospective patients remained an ethical requirement subject to regulations developed by the individual states.

\textbf{D. State Courts Recognizing a Medical Duty to Disclose or Refrain from Practice}

Although many state legislatures have proposed bills to ensure safety in the delivery of health care services by HIV-positive professionals,\textsuperscript{257} state court decisions have established precedents for upholding the patient’s interest in knowing the HIV status of a health care worker. A brief discussion of several state court decisions demonstrates that in the absence of an established list of exposure-prone procedures, state courts are assessing the inherent risk of HIV transmission in specific medical situations and the resultant duty of health care professionals to refrain from knowingly placing a patient at risk of contracting HIV. A duty to inform both prospective and prior patients of the possibility of HIV exposure is imposed when an HIV-positive health care worker knows of his or her infection and practices in an area involving invasive surgical procedures.

\begin{footnotes}
\footnotetext[255]{Id.; see also Warren E. Leary, \textit{A.M.A. Backs Off on an AIDS Risk List}, N.Y. \textsc{Times}, Dec. 15, 1991, § 1, at 38 (reporting that the basis for rejecting the implementation of an exposure-prone list was the lack of scientific justification for such a measure).}
\footnotetext[256]{Lawrence K. Altman, \textit{U.S. to Let States Set Rules on AIDS-Infected Health Workers}, N.Y. \textsc{Times}, June 16, 1992, at C7.}
\footnotetext[257]{See Donald H.J. Hermann, \textit{State Legislatures Consider Bills Dealing With HIV-Infected Health Care Providers in Face of CDC Inaction}, 24 \textsc{J. Health \& Hosp. Law} 215 (July 1991)(discussing bills under consideration in several states on the issue of mandatory HIV testing, disclosure of HIV-positive status, and practice restrictions for health care professionals).}
\end{footnotes}
I. New Jersey: Duty to Disclose Physician's HIV Status to
Prospective Patients

In *Estate of Behringer v. Princeton Medical Center,*\(^ {258}\) the New Jersey Superior Court upheld the medical center's policy requiring an HIV-positive surgeon to inform patients of his infection prior to performing any type of invasive surgical procedure. In this case, the plaintiff was a board-certified ENT (ear-nose-throat) specialist and a plastic surgeon who contracted AIDS in June 1987.\(^ {259}\) Following his diagnosis, the medical center suspended the plaintiff's surgical privileges pending a review of the restrictions that would be imposed on his practice. After consideration of the CDC guidelines advocating an ad hoc assessment for restricting the continued practice of infected health care workers,\(^ {260}\) the medical center board of trustees required the use of a special informed consent verification for any patient scheduled to undergo an invasive procedure by an HIV-positive surgeon. Adhering to the recommendations of the American Medical Association (AMA), the medical center adopted an additional policy providing that a "physician or health care provider with known HIV seropositivity may continue to treat patients at The Medical Center at Princeton, but shall not perform procedures that pose any risk of HIV transmission to the patient."\(^ {261}\) As a result of the informed consent requirement and his "potential risk" for transmitting HIV, the plaintiff never performed surgery at the medical center following his diagnosis with AIDS.\(^ {262}\)

In assessing the validity of the medical center's policies restricting the practice of the plaintiff, the court stated that the discontinuation of his surgical procedures must be based upon a "reasonable probability of substantial harm" as well as a "materially enhanced risk of serious injury" to patients.\(^ {263}\) The plaintiff argued that the risk of


\(^{259}\) Id. at 1254. Behringer's estate filed suit against Princeton Medical Center for breach of confidentiality regarding the surgeon's infection with HIV and violation of New Jersey law due to the imposition of conditions on the surgeon's performance of surgical procedures and subsequent revocation of all surgical privileges. Id. For the purposes of this Comment, the discussion of this case focuses upon the latter claim concerning the medical center's requirement that the surgeon obtain the informed consent of any prospective surgical patient acknowledging that the patient was informed of the surgeon's HIV infection and agreed to undergo the indicated surgery after receiving this information. Id. at 1258-59. Also, the discussion of this case will refer to the plaintiff as William H. Behringer, rather than his estate.

\(^{260}\) Id. at 1257-58; see supra text accompanying notes 211-13.

\(^{261}\) Behringer, 592 A.2d at 1260 (emphasis in original); see supra text accompanying notes 217-18.

\(^{262}\) Behringer, 592 A.2d at 1260.

\(^{263}\) Id. at 1276.
HIV transmission from an infected surgeon to a patient is too remote to impose practice restrictions or an informed consent requirement prior to the performance of surgical procedures.264 Rather than concentrating solely upon the risk of transmission, the court recognized that the additional risk of a surgical accident, such as “a needle-stick or scalpel cut, during surgery performed by an HIV-positive surgeon, may subject a previously uninfected patient to months or even years of continual HIV testing.”265 Therefore, the combination of the risk of transmission and the risk of surgical accident constituted a reasonable probability of substantial harm and an enhanced risk of injury to a patient under these circumstances.266

The court summarized the justification for upholding an informed consent requirement for patients of an HIV-positive surgeon:

If there is to be an ultimate arbiter of whether the patient is to be treated invasively by an AIDS-positive surgeon, the arbiter will be the fully-informed patient. The ultimate risk to the patient is so absolute—so devastating—that it is untenable to argue against informed consent combined with a restriction on procedures which present “any risk” to the patient.267

The court held that the medical center’s policies were proper due to the thorough investigation undertaken prior to the imposition of the practice restrictions and the informed consent requirement, even though these actions resulted in the discontinuation of the plaintiff’s surgical practice.268

The decision in Behringer extends the duty to refrain from knowing transmission of HIV to health care workers in the context of invasive surgical procedures.269 The court recognized that AIDS is a fatal dis-
ease and exposure to HIV by any mode of transmission results in testing for at least one year after an individual comes in contact with the virus.\textsuperscript{270} Although the risk of transmission from an HIV-positive surgeon to a patient is remote during an invasive procedure, the consequence of a surgical accident places the patient at an unknown risk which, in the opinion of the court, is unacceptable.\textsuperscript{271} By balancing the patient's interest in knowing all of the risks associated with a medically indicated procedure against the surgeon's interest in continuing to practice invasive surgery, the court concluded that the "patient's rights must prevail."\textsuperscript{272} New Jersey's strong policy supporting patient rights was a primary factor in the court's decision. However, the reasoning employed also illustrates an assessment and subsequent enforcement of both the CDC and the AMA recommendations for infected health care workers.

2. \textit{Pennsylvania: Duty to Notify Prior Patients of Physician's HIV Status}

The Pennsylvania Superior Court recognized the duty to disclose a physician's HIV-positive status to prior surgical patients in order to test, counsel and treat any affected individuals in \textit{In re Milton S. Hershey Medical Center}.\textsuperscript{273} In this case, a physician, practicing in obstetrics and gynecology in a joint residency at two local hospitals, sustained a cut in his surgical glove during an invasive operation, thereby exposing a patient to his blood.\textsuperscript{274} After voluntarily submitting significant risk of transmission associated with the prohibited procedures); see also Melinda Henneberger, \textit{Pharmacist with H.I.V. Awarded Job}, \textit{N.Y. Times}, Jan. 12, 1993 at B5 (reporting that the Westchester County Medical Center reached a settlement agreement with the pharmacist and offered him a job free of any work restrictions).

\textsuperscript{270} Behringer, 592 A.2d at 1280 (emphasizing that testing a patient for HIV after a surgical accident involving an HIV-positive surgeon imposes anxiety during the wait for test results, "and the possible alterations to life style and child-bearing during the testing period, even if those results ultimately are negative").

\textsuperscript{271} Id. The duty to disclose was also recognized in \textit{Leckelt v. Board of Commissioners of Hospital District No. 1}, 909 F.2d 820 (5th Cir. 1990), where the court upheld the hospital's employment decision to terminate a licensed practical nurse for his persistent failure to provide his HIV test results to the hospital's infection control practitioner. The court stated that the hospital's "strong interests in maintaining a safe workplace through infection control outweighed the limited intrusion on any privacy interest of Leckelt in the results of his HIV antibody test." \textit{Id.} at 833. For an analysis of the ramifications of the \textit{Leckelt} decision, see L.A. Vash, \textit{Leckelt v. Board of Commissioners of Hospital District No. 1: Forced Disclosure for HIV Infected Health Care Workers}, 65 Tul. L. Rev. 1722 (1991).

\textsuperscript{272} Behringer, 592 A.2d at 1283. See also Gostin, \textit{HIV-Infected Physicians}, supra note 214, at 36 (advocating that "a physician who knows, or ought to know, that he or she is HIV-positive, should voluntarily refrain from practicing seriously invasive procedures").


\textsuperscript{274} \textit{Id.} at 1291.
to testing the next day, the physician tested positive for HIV. The physician then informed the appropriate individuals at both hospitals and undertook a leave of absence due to his diagnosis. After identifying the number of patients treated by the physician during his joint residency, both hospitals filed petitions seeking to disclose information regarding the physician’s HIV infection to prior patients and specific staff members.

The issue on appeal was whether the trial court abused its discretion or violated the State’s Confidentiality of HIV-Related Information Act by granting the hospitals’ petitions for limited disclosure of the physician’s HIV status. The Superior Court of Pennsylvania stated that the purpose of the Confidentiality Act was to promote voluntary HIV testing and to impose stringent exceptions for disclosure of the subsequent test results. The statute provided an exception for disclosure of an individual’s HIV status only upon the demonstration of a “compelling need” before a court. The physician argued that such a need was not demonstrated by the hospitals under the facts of the case. Furthermore, the physician asserted that an affirmance of the disclosure order would not only discourage other health care professionals from seeking voluntary HIV testing, but also would impose liability on all hospitals if they fail to follow the same disclosure standard in similar situations.

In assessing these arguments, the court recognized the physician’s right to privacy, but explained that the public health interest in combating the spread of AIDS must prevail:

Without question, one’s health problems are a private matter to be dealt with by the individual in the way s/he feels most comfortable and sees fit. However, Dr. Doe’s medical problem was not merely his. It became a public concern the moment he picked up a surgical instrument and became part of a team involved in invasive procedures.

The court upheld the disclosure order on the basis of the invasive nature of the procedures performed by the physician and the possibility

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275. Id. at 1292.
276. Id. at 1293. The Hershey Medical Center identified 279 patients treated by the resident, referred to as Dr. Doe in the court's opinion, in addition to the 168 patients treated at the Harrisburg Hospital during his joint residency. Id. at 1292.
277. Id. at 1294.
278. Id. at 1295.
279. Id.
280. Id. at 1295-96.
281. Id. at 1298 (emphasis in original).
of infected patients inadvertently transmitting HIV to other unsuspecting individuals as a result of nondisclosure in this case. The court concluded that the order contained sufficient restrictions on the disclosure of the name of the physician to ensure the optimum degree of confidentiality by allowing the hospitals to notify patients about the HIV-positive status of a "resident physician" in order to offer the opportunity for counseling and HIV testing.

3. Maryland: Negligent Failure to Warn Patients of a Physician’s HIV Status

In *Faya v. Almaraz*, the Maryland Court of Appeals held that the plaintiffs pled sufficient facts to establish a cause of action in negligence against a surgeon diagnosed with AIDS and the hospital in which he practiced for failure to warn the plaintiffs of his infection prior to their surgical operations. The defendant, an oncology surgeon specializing in breast cancer, tested HIV-positive in 1986 and performed a partial mastectomy on plaintiff Faya in October 1988. In October of the following year, the defendant was diagnosed with AIDS on the basis of an opportunistic eye infection. One month after receiving his AIDS diagnosis, he operated on plaintiff Rossi to remove a benign lump from her breast. Both plaintiffs learned of their physician’s HIV infection from a local newspaper after he died of AIDS in November 1990.

The plaintiffs filed separate suits claiming negligence on the part of the physician. The trial court dismissed both cases due to the fact that the plaintiffs tested HIV-negative after learning of the physician’s AIDS diagnosis; neither complaint pled sufficient allegations of exposure to HIV; and the damages asserted were based upon unsubstantiated fears of contracting HIV as demonstrated by their negative status for more than six months. The Maryland Court of Appeals

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282. Id. at 1300, 1302.
283. Id. at 1301; see also Gordon G. Keyes, *Health-Care Professionals with AIDS: The Risk of Transmission Balanced Against the Interests of Professionals and Institutions*, 16 J.C. & U.L. 589 (1990) (discussing the alternatives for hospitals and medical teaching institutions to protect patients from the risk of acquiring HIV during invasive procedures performed by infected health care workers).
286. Id.
287. Id. at 330-31.
explained that in order to reverse the dismissal of the plaintiffs' claims, the record must reveal that the defendant breached a recognized duty of care which proximately caused a legally compensable injury. Based on the facts of this case, the court found that it was foreseeable that the defendant could transmit HIV to his patients during invasive surgery, thus alleging the basis for a duty of care to either refrain from performing such procedures or to inform surgical patients of his infection.

The court then addressed whether the plaintiffs' fear of contracting HIV, resulting in multiple psychological symptoms and distress, constituted a legally recognized injury. After reviewing several decisions from other states, the court held that the plaintiffs' alleged fear of acquiring HIV was not "initially unreasonable, as a matter of law, even though the averments of the complaints did not identify any actual channel of transmission." Therefore, the court concluded that the plaintiffs could recover damages only for the period of "reasonable" anxiety commencing with their discovery of the physician's AIDS diagnosis and ending upon their receipt of negative test results for HIV. After finding sufficient allegations to reverse the dismissal of their claims, the court also concluded that these facts supported a cause of action in negligence against the hospital in which the defendant had operating privileges on the basis of vicarious liability and agency principles.

Although the final disposition of Almaraz is pending, the decision of the Maryland Court of Appeals recognizes the duty of a health care professional infected with HIV to either refrain from invasive procedures or disclose this condition to prospective patients at risk of contracting the virus. In explaining the basis for this duty, the court referred to the policy statements of the AMA advocating that an HIV-positive health care worker should either "refrain from doing procedures that pose a significant risk of HIV transmission or perform these procedures only with the consent of the patient and the permis-

288. Id. at 333. For an in-depth analysis of potential liability for negligent transmission of HIV from a health care worker to a patient under Florida case law, see Diane A. Tomlinson, Physicians with AIDS and Their Duty to Patients, 43 FLA. L. REV. 561 (1991).
289. Almaraz, 620 A.2d at 334.
290. Id.
291. Id. at 336-37.
292. Id. at 337.
293. Almaraz, 620 A.2d at 339; see also Keyes, supra note 283, at 611-12 (discussing the possible liability of health care institutions for failing to either restrict the duties of HIV-positive professionals or impose an informed consent requirement).
sion of a local review committee. The decision in Almaraz demonstrates that although guidelines and recommendations of medical organizations are not controlling, courts will refer to these guidelines when confronted with the difficult task of analyzing the actions of a HIV-positive health care worker in these situations.

The decisions in Almaraz, In re Hershey Medical Center and Behringer support a duty to disclose the HIV-positive status of a physician in the context of invasive procedures. In each case, the court assessed the nature of the physician’s practice, the associated risk of HIV transmission to patients, and the expectation of the patient to avoid foreseeable complications from the indicated procedure. Because medical organizations refrained from identifying exposure-prone procedures, state courts assumed the role of assessing whether a substantial risk of harm or injury was inherent in a specific medical procedure to warrant either the disclosure of the physician’s HIV-positive status or the imposition of practice restrictions. Consequently, prudent health care decisions regarding the continued practice of an HIV-positive surgeon should include a consideration of the patient’s perception of the risk of HIV exposure during an invasive procedure. This trilogy of state court cases provides a foundation for other states to extend the duty to refrain from knowing transmission of HIV to the health care setting.

VII. Conclusion

Court decisions and specialized statutes impose liability for knowing transmission of HIV, whether in the context of individual risk-related conduct or the delivery of health care services, because a person who knows of his or her HIV-positive status can minimize the risk of transmitting HIV to others through responsible conduct. Johnson v. West Virginia University Hospitals provides an example of the extreme cost of failing to minimize the risk of HIV transmission in the health care setting. In Johnson, hospital emergency room personnel summoned a security officer to subdue a combative AIDS patient, but failed to post an infectious disease sign outside the patient’s room or to verbally warn the officer of the patient’s diagnosis. With blood in and around his mouth from a prior self-inflicted bite, the patient proceeded to bite and break the skin of the officer’s arm, causing signifi-

294. Almaraz, 620 A.2d at 334 (quoting from American Medical Association, Digest of HIV/AIDS Policy, (Sept. 14, 1992)).
296. Id. at 891.
cant bleeding. The security officer filed suit against the hospital for negligent failure to warn him of the patient’s AIDS diagnosis and his subsequent emotional distress, resulting in a jury verdict of $1.9 million.

On appeal, the court explained that a cause of action for emotional distress due to fear of contracting AIDS must include evidence of actual exposure to the disease. The court concluded that there “is no dispute that the AIDS-infected blood of the patient came into contact with the blood of the appellee.” In upholding the jury verdict, the court emphasized that the hospital’s policy of posting warning signs to alert individuals of a patient’s infectious disease “clearly” established the basis for a negligent failure to warn the appellee. Although the failure to warn involved a third party in Johnson, the facts do not differ significantly from a scenario in which a patient undergoes an invasive procedure and later discovers that the surgeon was HIV-positive. Just as the hospital’s policy of posting warning signs established the basis for a duty to warn, the guidelines of the Centers for Disease Control and the American Medical Association establish the basis for an HIV-positive health care worker to refrain from exposure-prone procedures or perform such procedures only after obtaining the informed consent of the patient. It is not illogical to hypothesize that similar compensation may occur in a future case based on a claim that a health care worker failed to inform a patient of his or her HIV-positive status prior to performing an exposure-prone procedure.

Although the risk of transmission from an HIV-positive health care worker to a patient during an invasive procedure is statistically remote, a 1991 Gallup poll of 618 adults revealed that 95% of the survey group believed HIV-positive surgeons should be required to inform patients of their infection prior to treatment. Moreover, the

297. Id.
298. Id. at 892.
299. Id. at 893.
300. Id.
301. Id.
302. See supra notes 208-218, and accompanying text.
303. See supra text accompanying notes 214-16. Additionally, the CDC reported only one patient as testing HIV-positive out of numerous patients treated by a general surgeon, a surgical resident, and dental student, all of whom were HIV-positive and performed invasive procedures. For a review of the actual statistics for each health care professional in the study, see Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures, 40 Morbidity & Mortality Weekly Rep. No. RR-8, 1, 3-4 (July 12, 1991).
304. Kantrowitz, supra note 234, at 49. The Gallup organization conducted the survey by telephone with a margin of error of plus or minus five percent. Id. The survey also showed that 90% of the survey group believed all health care workers should inform patients of their HIV-status and 97% favored reciprocal disclosure by patients. Id.
CDC's investigation of the David Acer case did not instill public confidence in the remote possibility of contracting HIV from infected health care workers, but rather emphasized the uncertainty regarding the actual mode of HIV transmission from the dentist to his patients.\textsuperscript{305} Newspaper reports of physicians who continue to practice with knowledge that they are HIV-positive or diagnosed with AIDS, evoke public outrage and astonishment that a person dedicated to treating patients would knowingly place those same people at an unsuspected risk of contracting the virus.\textsuperscript{306} These sentiments evidence an irrational fear when compared to the remote possibility of transmission in a treatment setting, yet they also indicate a general expectation for educated medical professionals to act responsibly in a public health crisis.

Perhaps the hospitals' responses in \textit{Behringer} and \textit{In re Hershey Medical Center} will become the standard for "responsible" conduct in deciding whether to impose practice restrictions, informed consent requirements, or disclosure of a health care worker's HIV status. The law in this area is evolving with the same emphasis on knowledge of one's HIV infection and minimizing the risk of exposing unsuspecting individuals to HIV as with the specialized state statutes that prohibit knowing transmission during sexual and other types of conduct. Military and civilian prosecutions under traditional criminal law theories and specialized statutes evidence a consistent public interest in deterring the knowing, and thereby avoidable, transmission of the virus. Whether imposed by medical organizations, state legislatures, or the judiciary, the duty to disclose or refrain from risk-related conduct is being extended to HIV-positive health care professionals who perform invasive procedures in order to prevent "knowing" transmission of HIV under any circumstances.

\textsuperscript{305} See supra notes 219-234, and accompanying text.

\textsuperscript{306} Kantrowitz, supra note 234, at 49 (reporting that a Minneapolis pediatrician infected with HIV continued to perform deliveries and vaginal examinations with "weeping lesions" on his hands and arms); see also George Hackett and Daniel Shapiro, 'I Want Him Crucified', \textit{Newsweek}, Oct. 5, 1987, at 36 (reporting the reaction of a Houston woman after learning that her children's pediatrician was HIV-positive: "I want him crucified . . . I really don't care if it ruins his practice; I don't want him to go somewhere else to treat other little babies").