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Notes

IT TAKES TWO TO TANGO: RETHINKING NEGLIGENCE LIABILITY FOR THE SEXUAL TRANSMISSION OF AIDS

William Sundbeck†

I. INTRODUCTION

SINCE THE FIRST CASES OF acquired immune deficiency syndrome (AIDS) were reported in Los Angeles in 1981, AIDS has evolved into a serious public health risk.1 While the disease was originally considered confined to narrow populations of homosexuals and intravenous (IV) drug users, AIDS is currently spreading more rapidly among heterosexuals than any other group.2 As the AIDS epidemic grows, legislative and judicial responses are becoming more frequent.3 In the face of the growing AIDS epidemic, many commentators have anticipated the availability of a negligence action for those who contract AIDS through sexual contact with infected partners.4

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2. Thomas R. O'Brien et al., Acquisition and Transmission of HIV, in THE MEDICAL MANAGEMENT OF AIDS 3, 4-5 (Merle A. Sande & Paul A. Volberding eds., 3d ed., 1992) (explaining that while heterosexual transmission is still a small percentage of AIDS cases, it is the class growing most rapidly).
3. See generally Roger N. Braden, AIDS: Dealing with the Plague, 19 N. KY. L. REV. 277, 281-83 (1992) (providing an example of the broad range of legislative responses to AIDS in Kentucky and Ohio); Stewart F. Hancock, Jr., AIDS and the Law, N.Y. ST. B.J., Feb. 1993, at 8, 8 (discussing the flood of AIDS cases reaching the courts).
These commentators suggest that a negligence action for the sexual transmission of AIDS can be modeled after negligence actions for the sexual transmission of venereal diseases and genital herpes. Particularly, some commentators conclude that because of the substantial public policy interest in stopping the spread of sexually transmitted diseases, courts should reject contributory and comparative negligence and assumption of the risk as defenses, leaving the defendant to bear the entire duty of care.

This Note rejects this conclusion and proposes that the courts recognize the defenses of contributory and comparative negligence in AIDS transmission cases. Part II of this Note provides a general overview of the nature of AIDS and the scope of the AIDS crisis. Part III outlines the case law involving the negligent transmission of venereal diseases, emphasizing the tendency to place the entire duty of care on defendants.

5. See, e.g., DelaRosa, supra note 4, at 105 (suggesting that courts may find a duty not to transmit AIDS based on precedent from other sexual disease cases); Elber, supra note 4, at 923-24 (observing that case law for the negligent transmission of AIDS will likely be influenced by cases involving Herpes Simplex II (genital herpes) because it most closely resembles AIDS); Linda K. Burdt & Robert S. Caldwell, Note, The Real Fatal Attraction: Civil and Criminal Liability for the Sexual Transmission of AIDS, 37 Drake L. Rev. 657, 664 (1987-88) (stating that the basis for a negligence action for the sexual transmission of AIDS is analogous to the basis for liability involving other sexual diseases); Deane Kenworthy Corliss, Comment, AIDS—Liability for Negligent Transmission, 18 Cumb. L. Rev. 691, 709 (1988) (stating that venereal disease cases have developed the liability rules upon which negligence liability for the sexual transmission of AIDS will be based); Papelian, supra note 4, at 677 (concluding that based on principles announced in cases involving venereal diseases, courts appear ready to recognize a negligence cause of action for the sexual transmission of AIDS).

6. See DelaRosa, supra note 4, at 114 (concluding that it is crucial to the well-being of society that courts impose a duty on persons not to transmit HIV); Elber, supra note 4, at 941-44 (discussing possible defenses in AIDS transmission cases and concluding that public policy does not favor their use); Papelian, supra note 4, at 662 (concluding that the defenses of contributory negligence and assumption of the risk have not fared well in cases of sexually transmitted diseases).
Part III evaluates the attempts to analogize venereal disease cases to AIDS cases and considers this analogy in light of the traditional goals of the tort system. Part IV examines the scope of a would-be defendant's duty to avoid transmitting AIDS.

This Note's proposal is intended to discourage suits where plaintiffs have not made reasonable attempts to ascertain the risk of contracting AIDS from potential partners. This proposal is also intended to encourage full disclosure of potential risks, reduce the incidence of AIDS, and prevent the social costs of AIDS from being shifted to the general public.

II. THE NATURE OF THE AIDS CRISIS

A. The Progression of AIDS

AIDS is caused by a retrovirus named human immunodeficiency virus (HIV). The virus especially impacts T-helper lymphocyte cells. Since T-helper lymphocyte cells coordinate a number of critical functions of the immune system, damage to the cells leads to the deterioration of the body's immune functions.

The course and manifestations of HIV infection can vary substantially, but several stages are common. During the early weeks following infection, there is sometimes the occurrence of mononucleosis-like symptoms, such as fever, malaise,

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7. Centers for Disease Control, 1993 Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults, 41 MORBIDITY AND MORTALITY WKLY. REP. 1, 1 (Dec. 18, 1992) [hereinafter Centers for Disease Control, 1993 Classification System].
8. See ADRIAN MOSS, HIV AND AIDS MANAGEMENT BY THE PRIMARY CARE TEAM 10-11 (1992) (stating that HIV has "a particular affinity for human T-helper lymphocyte, although it may infect other cells"). Once the virus invades the T-helper lymphocyte cells, it may replicate and eventually severely damage the cell's immune function. Id. at 11.
9. See Centers for Disease Control, 1993 Classification System, supra note 7, at 1 (stating that T-helper lymphocytes coordinate significant immunologic functions without which there is a progressive impairment of the immune system).
10. Id. (explaining that "studies of the natural history of HIV infection have manifested a wide spectrum of disease manifestations ranging from asymptomatic infection to life-threatening characterized by opportunistic infections and cancers").
11. See generally MERCK RESEARCH LABORATORIES, THE MERCK MANUAL OF DIAGNOSIS AND THERAPY 80-82 (Robert Berkow et al. eds., 16th ed., 1992) (identifying some of the stages experienced by AIDS patients: (1) antibody negative asymptomatic carrier stage, (2) acute mononucleosis-like syndrome stage, (3) antibody positive asymptomatic carrier stage, (4) AIDS-related complex (ARC) stage, and (5) full blown AIDS characterized by life-threatening characteristic infections or certain forms of cancer).
rash, and generalized enlargement of the lymph nodes. Following this initial stage of acute symptoms, HIV lies dormant, and the carrier is asymptomatic. This stage is often followed by the AIDS-related complex (ARC) stage in which the individual experiences several symptoms closely associated with AIDS including weight loss, fever, malaise, fatigue, chronic diarrhea, and anemia. Once the immune system has been sufficiently depleted, the patient is classified as having AIDS and becomes susceptible to opportunistic infections or secondary cancers.

Despite significant advances in treating the opportunistic infections caused by AIDS, over 95% of AIDS patients die from these opportunistic infections. An individual who is infected with HIV may remain infected and able to transmit the virus during his entire life although rare exceptions have been reported.

12. See id. at 80 (reporting that this stage is seen in a minority of patients between two and four weeks after infection). Seroconversion for AIDS antibodies usually occurs one to three months later. Id.

13. See generally Scenario Committee on AIDS, Steering Committee on Future Health Scenarios AIDS up to the Year 2000, at 3 (1992) [hereinafter Scenario Committee] (observing that the asymptomatic stage lasts a substantial period of time).

14. See Merck Research Laboratories, supra note 11, at 80-81 (defining ARC as a pattern of chronic symptoms occurring in those who are HIV-positive but do not have the listed clinical conditions that define AIDS). The ARC stage does not occur in all AIDS patients. See id. at 81. It should be noted that the term ARC has recently fallen out of use among some in the medical community. See Office of Technology Assessment, U.S. Congress, The CDC's Case Definition of AIDS: Implications of the Proposed Revisions—Background Paper 50 (U.S. Government Printing Office, Aug. 1992) [hereinafter Office of Technology Assessment] (noting that the medical community used the term ARC to describe those patients who manifested symptoms that commonly occurred in AIDS patients but did not meet one of the 23 clinical conditions originally used by the Centers for Disease Control (CDC) to define AIDS). Since the CDC's definition of AIDS has now been expanded to include those whose T-helper lymphocyte count has fallen below a baseline level, many of those who were originally diagnosed as having ARC may now be classified as having AIDS. See id.; see also Centers for Disease Control, 1993 Classification System, supra note 7 and accompanying text (discussing the CDC's 1993 expansion of the AIDS definition and the accompanying increase in reported cases).

15. See generally Office of Technology Assessment, supra note 14, at 49 (noting that the primary effect of AIDS is an "acquired, persistent and profound functional depression in cell-mediated immunity" leading to infections and cancers that do not ordinarily occur in persons with normal immunity).

16. Merck Research Laboratories, supra note 15, at 83. While opportunistic infections still cause the death of many AIDS patients, recent advances in managing opportunistic infections have led to reductions in their incidence, morbidity, and mortality. Id.

17. Moss, supra note 8, at 11.

18. Id.
B. The Prevalence of AIDS

The AIDS epidemic has had a profound effect on American society, invoking comparisons to the Black Plague that ravaged Europe between 1348 and 1350. In 1991, approximately 58,000 new AIDS cases were reported by the Centers for Disease Control (CDC), raising the total number of reported AIDS cases to 206,392. Of the total reported cases, over 133,233 deaths had been reported by the end of 1991. Initially, the CDC predicted that between 50,000 and 60,000 new cases would be reported annually from 1992 to 1994; however, in 1993, the CDC expanded its definition of AIDS, causing the number of reported AIDS cases to increase by 204% from the number reported in 1991. Thus, by the thirtieth week of 1993, over 67,732 new AIDS cases had already been reported. The CDC predicted that the drastic increase in 1993 would level off because it largely reflected cases which

19. National Research Council, The Social Impact of AIDS in the United States 5 (1993) (stating that while AIDS has invoked comparisons with many plagues of the past, the AIDS epidemic has most commonly been compared to the bubonic plague (Black Death)).


22. Id.

23. Centers for Disease Control, Projections, supra note 19.

24. Centers for Disease Control, 1993 Classification System, supra note 7, at 4 (expanding AIDS surveillance case definition to include all HIV-infected persons with a T-helper cell count below 200). Under the CDC's original definition, published in 1987, an individual was classified as having AIDS if he manifested one of 23 clinical conditions. See id. at 16-17 (listing the 23 clinical conditions which constituted a definitive diagnosis of AIDS under the 1986 system). The expanded definition was intended to reflect the clinical importance of T-helper lymphocyte cells in AIDS diagnosis. Id. at 1. The 1993 classification system includes anyone with a T-helper lymphocyte count below a base level or with one of 26 clinical conditions as having AIDS. Id.


26. See Centers for Disease Control, Update: Barrier Protection Against HIV Infection on Other Sexually Transmitted Diseases, 42 Morbidity and Mortality Weekly Rep. 589, 593 (Aug. 6, 1993) (summarizing the total number of reported AIDS cases through July 31, 1993).
had accumulated before 1993 but did not fall within the old classification scheme.\textsuperscript{27}

Even more significantly, 1 to 1.5 million people are infected with HIV, the virus that causes AIDS,\textsuperscript{28} even though the infection may be completely latent.\textsuperscript{29} The danger of those who are asymptomatic and seropositive inadvertently transmitting the disease is increased because most Americans do not believe that their risk of contracting the virus is significant.\textsuperscript{30}

The prevalence of AIDS threatens to seriously tax the public health care system.\textsuperscript{31} Although the original estimates of the average expenditure per AIDS patient were grossly overestimated, the costs remain substantial.\textsuperscript{32} Moreover, there is an increasing risk that AIDS patients will be screened out of the private insurance market,\textsuperscript{33} thereby shifting the burden of financing the AIDS crisis to the public sector. AIDS already

\textsuperscript{27} Centers for Disease Control, \textit{Impact of Expanded AIDS Definition, supra} note 25, at 309-10.

\textsuperscript{28} Hancock, \textit{supra} note 3, at 8.

\textsuperscript{29} See \textit{Merck Research Laboratories, supra} note 11, at 80 (describing the asymptomatic seropositive stage of AIDS manifested in many individuals infected with HIV).

\textsuperscript{30} Thomas A. Peterson et al., \textit{Prevention of the Sexual Transmission of HIV, in AIDS: Etiology, Diagnosis, Treatment and Prevention} 443, 443 (Vincent Devita et al. eds., 3d ed., 1992) (reporting that "over 95% of Americans feel they are at little or no risk of developing AIDS").

\textsuperscript{31} National Research Council, \textit{supra} note 19, at 11 (noting that the AIDS crisis has sent over 200,000 people into the health care system and may send one million more people who are disproportionately dependent on public funds).

\textsuperscript{32} See \textit{id.} at 68-69 (observing that while the earliest estimates predicted that the cost for AIDS patients would be $147,000 per patient from diagnosis to death, most estimates are now between $40,000 and $50,000). Other sources estimate the costs as having a much greater range. See Daniel Shacknai, \textit{Wealth = Health: The Public Financing of AIDS Care, in AIDS Agenda Emerging Issues in Civil Rights}, 181, 198 n.5 (Nan D. Hunter & William B. Rubenstein eds., 1992) (noting that the average lifetime cost of AIDS is between $53,000 and $100,580). It also has been argued that the total lifetime costs of AIDS is less than the costs for some cancers. See Mark H. Jackson, \textit{Health Insurance: The Battle over Limits on Coverage, in AIDS Agenda Emerging Issues in Civil Rights}, 147, 171 n.12 (Nan D. Hunter & William B. Rubenstein eds., 1992) (discussing the trend among insurance companies to exclude AIDS patients). This comparison has an obvious flaw. The risk of contracting AIDS is much more significantly linked to behavior. While a person can reduce the risk of some cancers through lifestyle changes, the person may still be at a significant risk because of a genetic predisposition. On the other hand, a person can almost completely eliminate the risk of contracting AIDS by avoiding risky conduct. Thus, the high costs associated with AIDS may be more disconcerting since the costs could be practically eliminated through behavior modification.

\textsuperscript{33} See Jackson, \textit{supra} note 32, at 147; Nicholas A. Papa, Comment, \textit{Testing the Insurance Industry's Response to the AIDS Epidemic, 18 Ohio N.U. L. Rev.} 687, 692 (1992) (reporting the results of a recent study by the Congressional Office of Technology Assessment showing that 86% of private insurers will screen applicants for AIDS). Cali-
poses a significant drain on public funds.\textsuperscript{34} This drain is likely to grow substantially since the 1 to 1.5 million individuals infected with HIV are disproportionately from the pool of uninsured or underinsured.\textsuperscript{35} AIDS is also increasingly a disease of the poor.\textsuperscript{36} This result is hardly surprising since the debilitating effects of AIDS eventually make AIDS patients unable to continue working.\textsuperscript{37}

C. The Means of Transmission

The primary means of transmitting HIV include the following: (1) sexual contact; (2) transfusion of blood or blood products; (3) the sharing of IV drug needles; and (4) perinatal transmission.\textsuperscript{38} Several factors affect the probability of transmitting HIV including the degree of infectivity (believed to be highest immediately after exposure to HIV or the development of full-blown AIDS) and the degree of exposure.\textsuperscript{39} Contact with bodily fluid is necessary to transmit the virus; HIV cannot be transmitted through casual contact.\textsuperscript{40} While the virus theoretically could be transmitted by shared razors or toothbrushes,
no cases have been reported of transmission by these means; and there have been no reported cases of HIV transmission from contact with saliva as a result of coughing or sneezing. Since even intimate contact without the exchange of bodily fluids cannot transmit the virus, there is no risk of infection from casual contact like hugging or touching.

D. Incubation Period

A 1989 report of the CDC found that 95% of those exposed to HIV "seroconvert" (develop HIV antibodies) within six months after the exposure. In rare cases, seroconversion may take more than one year. While there is no test for AIDS, the enzyme-linked immunosorbent assay (ELISA) and the Western blot test can be used to test for HIV. Although the period of time from HIV infection to full-blown AIDS can

taining infected cells or plasma). The bodily fluids capable of transmitting HIV are the following: (1) blood, (2) semen, (3) vaginal secretions, (4) breast milk, and (5) saliva. Id. See Moss, supra note 8, at 19-20 (noting that while in theory the virus may be transmitted this way, no evidence has demonstrated that the virus actually is transmitted in this manner, and normal hygiene would discourage most people from sharing razors and toothbrushes).

42. MERCK RESEARCH LABORATORIES, supra note 11, at 78.

43. This fact has lead to the recommendation that condoms be used as a barrier to HIV transmission. See Peterson et al., supra note 30, at 446 (reporting that studies have shown that HIV will not pass through an intact latex condom). Although the use of latex condoms is an effective barrier to the risk of transmitting HIV, condoms do not eliminate all of the risks of contracting HIV because condoms may be defective or misused. See id. (suggesting that the reasons latex condoms may not be 100% effective in preventing the spread of HIV include: (1) the tendency of condoms to slip off; (2) the inability of condoms to cover all parts of the penis; and (3) the wide misuse of condoms). The failure rate for condoms is estimated at 2% when used consistently; however, a more typical failure rate is 12% because couples use condoms inconsistently. See id. (stating condoms fail in preventing pregnancy in 12 out of 100 couples during the course of a year because most couples who rely on condoms occasionally engage in sexual relations without them).

44. See id. (noting that AIDS cannot be transmitted through even intimate nonsexual contact because transmission requires contact with a bodily fluid).


46. See id. (noting that the CDC has stated that it is "extremely unlikely" that a person who has not seroconverted after a year will later seroconvert).

47. See Michael S. Saag, AIDS Testing Now and in the Future, in THE MEDICAL MANAGEMENT OF AIDS, 33, 33 (Merle A. Sande & Paul A. Volberding eds., 3d ed., 1992) (explaining that although there is no test for "AIDS per se," there are antibody tests that can detect HIV infection when an individual has developed HIV antibodies and no cross reacting antibodies are present).
vary substantially, research has shown that 54% of those infected with HIV progress to full blown AIDS within eleven years. Additionally, the average time between infection with HIV and the development of full-blown AIDS is between 7.8 and 8.2 years.

E. High-Risk Groups

When AIDS was first discovered, it was thought to be confined to certain demographic groups commonly referred to as "high-risk groups." These groups included homosexual or bisexual men and IV drug users. However, while unprotected homosexual and bisexual activity and IV drug use remain risky, the risk of contracting HIV results from unsafe practices, not membership in a particular demographic group. Further, the notion of high-risk groups may encourage unsafe practices because persons outside these groups may underestimate the degree of risk associated with their behavior. As groups not traditionally associated with AIDS (i.e., heterosexuals, women, and children) have contracted the disease with increasing frequency.

48. See generally Moss, supra note 8, at 11 (reporting the results of a major study indicating that 19% of those infected had not become symptomatic even after 8 to 12 years).

49. See Scenario Committee, supra note 13, at 3-4 (citing a study among gay men in the United States).

50. See generally Joel B. Korin et al., Civil Liability for the Transmission of AIDS, N.J. L. AW., Jan./Feb. 1989, at 40, 43 (observing that the CDC has found that the average time between exposure to HIV and development of full-blown AIDS in male homosexuals is 7.8 years, which is comparable to the 8.2 year estimate for transfusion-related AIDS transmission).

51. See Moss, supra note 8, at 17 (stating that at the beginning of the AIDS epidemic, certain groups appeared to be uniquely at risk of HIV infection).

52. See Papelian, supra note 4, at 652 (explaining that out of the 70,000 people diagnosed with AIDS between 1981 and 1988, 70% were homosexual or bisexual men, 19% were IV drug users, 4% were heterosexuals, 3% were transfusion recipients, and 1% were hemophiliacs exposed to contaminated blood); see also Moss, supra note 8, at 17 (observing that prostitutes, Africans, and those who had sex with a member of a high-risk group were later added to the list of high-risk groups).

53. See Moss, supra note 8, at 17 (arguing that behavior rather than membership places one at risk for contracting HIV).

54. Id. (arguing that the "high-risk group" notion is "fatally flawed" because it promotes a false sense of security among those not classified as high risk). See supra note 30 (noting that over 95% of Americans do not believe they are at risk of contracting AIDS). A scheme involving "high-risk groups" also may encourage discrimination against those who are designated "high risk." Id.
frequency, the drastic increase of AIDS in these groups has rendered it virtually impossible to assess the risk of contracting AIDS from a particular partner. Engaging in any sexual conduct when one does not know the full sexual history of one's partner and all that partner's past partners exposes one to the risk of contracting the virus. Given that 1 to 1.5 million people may be unaware they are HIV positive, this risk may be growing at an exponential rate.

F. Prospects for a Cure

Substantial progress has been made in controlling the opportunistic infections and secondary cancers associated with AIDS. These recent advances in managing the symptoms and manifestations of AIDS have improved the quality and duration of life for AIDS patients. The virus is fatal, however, in patients who progress to full-blown AIDS. There also is still

55. See generally Merck Research Laboratories, supra note 11, at 80 (noting that while less than 10% of those who were infected with AIDS were women, AIDS was increasing more rapidly among women than men); Centers for Disease Control, Update: Acquired Immunodeficiency Syndrome — United States 1991, 41 Morbidity & Mortality Wkly. Rep. 463, 464 (July 3, 1992) [hereinafter Centers for Disease Control, Update] (reporting that the percentage of women infected with HIV during 1991 increased by 15%); Office of Technology Assessment, supra note 14, at 67 (predicting that if current trends continue AIDS will soon become one of the five leading causes of death among women of reproductive age); Moss, supra note 8, at 18 (reporting that AIDS is now the leading cause of death among young women in New York).

56. See Moss, supra note 8, at 17-18 (arguing that because it is one's behavior that creates the risk of contracting AIDS, the AIDS epidemic will not subside unless all people engage in safe practices).

57. Id. at 18 (arguing that as AIDS becomes more rampant there may be very few people who have never been exposed to the risk of contracting AIDS). This situation is further complicated because some people have contracted the virus after engaging in unprotected sexual relations with only one or two partners while others have been exposed to the virus repeatedly over a number of years and never contracted AIDS. Id.

58. See id. (observing that absent knowledge that a partner has a clear history of high-risk activity or has never engaged in high-risk activity, it is virtually impossible to assess the degree of risk).

59. See supra text accompanying note 28 (noting that 1 to 1.5 million people are infected with HIV).

60. See Moss, supra note 8, at 46 (noting that the immune system can now be monitored much more accurately allowing for more effective diagnosis, prevention, and treatment of tumors and infections caused by AIDS).

61. Id.

62. Scenario Committee, supra note 13, at 4 (referring to AIDS as a fatal disease).
no cure for AIDS. Moreover, a vaccine is unlikely to be developed in the near future because HIV changes its genetic makeup frequently.

III. ANALYSIS

A. The Venereal Disease Model and Case Law

Numerous commentators suggest that the courts should recognize a negligence cause of action for the sexual transmission of AIDS. These commentators argue that the liability rules in AIDS cases should be based on an analogy to cases involving the sexual transmission of venereal diseases and genital herpes.

The duty to take reasonable measures to avoid infecting a sexual partner with a venereal disease is well-established. The courts also have generally applied this analysis in cases involving genital herpes. Commentators have placed particular emphasis on cases involving the transmission of genital herpes since genital herpes, like AIDS, is incurable and has a long latency period.

63. Moss, supra note 8, at 46.
64. Id. at 54.
65. See supra notes 4-5 and accompanying text (providing an illustrative sampling of commentators who have taken this view).
66. Id.
68. See Papelian, supra note 4, at 663 (noting that courts have generally found genital herpes substantially similar to venereal diseases justifying the extension of venereal disease case law to cover genital herpes). See also Kathleen K., 198 Cal. Rptr. at 276 (holding that genital herpes is actionable under the venereal disease statute); Long, 333 S.E.2d at 856 (finding that while herpes is not a venereal disease, it is serious and incurable and the state has an interest in preventing its spread); R.A.P. v. B.J.P., 428 N.W.2d 103, 108 (Minn. Ct. App. 1988) (imposing a duty to either avoid sexual contact or warn one's partner of the risk of contracting genital herpes).
69. See, e.g. Elber, supra note 4, at 923-24 (stating that genital herpes provides the closest counterpart to AIDS based on genital herpes' means of transmission, latency period, and incurability); Papelian, supra note 4, at 663 (contending that genital herpes cases are most analogous to AIDS cases because genital herpes has a long latency period and is incurable).
Courts originally based the duty not to transmit venereal diseases to a sexual partner on the nature of the relationship between the parties. In *Crowell v. Crowell,* the Supreme Court of North Carolina became the first court to recognize the validity of a negligence cause of action for the sexual transmission of a venereal disease. The court stated "it is a well-settled proposition of law that a person is liable if he negligently exposes another to a contagious disease." Similarly, in *Maharam v. Maharam,* the court found that a thirty-one year marriage provided the basis for imposing an affirmative duty to warn one's spouse of the risk of infection. Since these cases involved husbands and wives, the decisions were limited to marital relationships.

The courts eventually expanded the scope of this duty to warn by finding a duty regardless of the nature of the relationship between the parties. In *Long v. Adams,* the plaintiff prevailed on her negligence claim after being infected with genital herpes even though the parties were unmarried. While explicitly declining to find a general duty to warn, the court held that sexual partners owe a duty of reasonable care to their partners. In *Duke v. Housen,* the plaintiff brought a negligence action claiming that she was infected with gonorrhea after a seventeen-day relationship with the defendant. The trial court held that the defendant had a duty to warn and awarded damages. While the Wyoming Supreme Court vacated the judgment because the statute of limitations had run, the court stated "[o]ne who negligently exposes another to an infectious or contagious disease, which such other person thereby contracts, can be held liable in damages."
In *Kathleen K. v. Robert B.*, the court clearly articulated a rationale for imposing a duty even where the sexual partners are not married. The California Court of Appeals rejected the defendant's argument that no confidential trust relationship exists when sexual partners are unmarried. The court reasoned that a party to an intimate relationship is entitled to a certain degree of confidence and trust that his/her partner is not infected with a disease. Thus, the court recognized the value of preserving the trust and confidence that is an inherent part of an intimate relationship.

The *Kathleen K.* decision is particularly significant because the court implicitly included AIDS within the state's venereal disease statute. The court found that genital herpes is sufficiently similar to venereal diseases to be actionable under the state's venereal disease statute. Moreover, the court suggested that AIDS also might be actionable under the state statute:

Like AIDS (genital herpes) is now known by the public to be a contagious and dreadful disease. . . . If a person *knowingly* has genital herpes, AIDS or some other contagious and serious disease, a limited representation that he or she does not have a venereal disease is no defense to this type of action.

However, it is important to note that the court specifically referred to a defendant who "knowingly" creates a risk of spreading a sexual disease. Since most individuals who are HIV-positive do not know they are infected, the applicability of the court's analysis to AIDS cases is unclear.

**B. The Analogy to Venereal Disease Cases in the AIDS Context**

By analogizing AIDS to venereal disease and genital herpes cases, commentators have emphasized the importance of imposing liability on would-be defendants to avoid the sexual risk of spreading a contagious disease.

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83. *Id.* at 276-77.
84. *Id.*
85. *Id.* at 276 n.3.
86. *Id.*
87. *Id.* (emphasis added).
88. *Id.*
89. *See supra* text accompanying notes 28-29 (explaining that 1 to 1.5 million people who are infected with HIV may be asymptomatic).
transmission of AIDS. Several rationales have been offered to justify placing the entire burden of care on defendants. Some have argued that because many HIV-positive individuals are asymptomatic, plaintiffs cannot effectively rely on sensory evidence to guard against contracting the virus. Second, imposing a duty on plaintiffs to avoid the spread of AIDS may encourage reckless conduct by those who are HIV-positive and contribute to the spread of AIDS. Finally, since AIDS is fatal, there is an even greater imperative to impose liability on defendants than in venereal disease and genital herpes cases.

Commentators argue that the affirmative defenses of contributory or comparative negligence, or assumption of the risk would be effective.

90. See, e.g., David P. Brigham, You Never Told Me... You Never Asked, Tort Liability for the Sexual Transmission of AIDS, 91 DICK. L. REV. 529, 546 (1986) (arguing that imposing a duty on plaintiffs in AIDS cases is neither an “effective or equitable proposition”); DelaRosa, supra note 4, at 111 (arguing that the duty in AIDS cases must remain on the defendants because most of the people infected with HIV display no symptoms so potential partners cannot protect themselves); Burdt & Caldwell, supra note 5, at 679-80 (suggesting that if a defendant does not have obvious symptoms or is not a member of a high-risk group, “there is a strong argument that the plaintiff should not be required to inquire about the defendant’s health”); Richard C. Shoenstein, Note, Standards of Conduct, Multiple Defendants, and Full Recovery of Damages in Tort Liability for the Transmission of Human Immunodeficiency Virus, 18 HOFSTRA L. REV. 37, 66-72 (1989) (suggesting that alternative liability’s shifting of the burden of proof to defendants in AIDS cases should be used to facilitate plaintiffs bringing a negligence cause of action).

91. See DelaRosa, supra note 4, at 111 (stating that because most HIV-positive individuals are asymptomatic, plaintiffs are not in a position to identify those infected with HIV and avoid sexual contact with them).

92. See Brigham, supra note 90, at 546 (stating that the “only way” to prevent the spread of AIDS is to impose liability on potential defendants); Elber, supra note 4, at 945 (commenting that allowing defendants to assert affirmative defenses in AIDS cases may encourage reckless conduct that will spread the disease). See also Burdt & Caldwell, supra note 5, at 679 (contrasting a substantial public policy interest in protecting public health with the recognition of the assumption of the risk in AIDS cases).

93. See Elber, supra note 4, at 941 (contending that recognition of assumption of the risk in AIDS cases is outweighed by the societal imperative of preventing the spread of AIDS, which is fatal).

94. Contributory negligence imposes a duty on plaintiffs to take reasonable measures to avoid exposing themselves to an unreasonable risk of harm. See W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 65, at 451 (5th ed. 1984) [hereinafter PROSSER ON TORTS]. If the plaintiff fails to take reasonable care to avoid injury, he is barred from recovery. Id. § 65, at 451-52. Similarly, comparative negligence requires a plaintiff to take reasonable care to avoid being injured. See generally id. § 67, at 468-74 (discussing comparative negligence as a means of apportioning damages to avoid completely barring claims under contributory negligence). Comparative negligence does not bar recovery entirely; rather it merely reduces the award in proportion to the plaintiff’s fault. Id. By contrast, assumption of the risk bars recovery when the plaintiff voluntarily takes a known risk even if his conduct is reasonable. See generally id. § 68, at 490 (explaining that the plaintiff’s consent to take the risk relieves the defendant of the duty to act reasonably).
should not be a bar in AIDS transmission cases. These commentators note the courts’ reluctance to recognize these defenses in cases involving other sexually transmitted diseases. The traditional reluctance is based on the courts’ unwillingness to embrace the view “that the risk of contracting [a] disease must be assumed when entering a sexual relationship.” Thus, no duty is imposed on would-be plaintiffs in venereal disease cases. By extension, commentators generally have argued that the courts should not impose such a duty in AIDS cases.

This analysis relies heavily on the similarity between AIDS and other sexually transmitted diseases. Commentators emphasize that the only significant difference between AIDS and other sexually transmitted diseases, particularly genital herpes, is that AIDS is deadly. Further, commentators contend that the fatal nature of AIDS makes it even more imperative that liability be imposed on defendants in AIDS cases.

95. See, e.g., Elber, supra note 4, at 941 (stating that recognizing the assumption of the risk defense in AIDS cases is likely to contribute to the spread of AIDS by granting immunity to defendants); Burdt & Caldwell, supra note 5, at 679 (contending that there is a strong public policy rationale against permitting the assumption of the risk defense in AIDS cases as evidenced by numerous state statutes prohibiting the transmission of venereal diseases). See also Brigham, supra note 90, at 546 (rejecting the notion of imposing a duty to inquire on plaintiffs in AIDS cases); DelaRosa, supra note 4, at 111 (advocating that any duty to disclose or abstain must fall upon the infected party). But see Papelian, supra note 4, at 676 (suggesting that recognizing assumption of the risk would impose the responsibility of taking precaution on both parties in a sexual relationship).

96. See, e.g., Papelian, supra note 4, at 677 (observing that the defenses of contributory negligence and assumption of the risk have proven unsuccessful in sexual disease cases). See also Kathleen K. v. Robert B., 992, 198 Cal. Rptr. 273, 277 (Cal. Ct. App. 1984) (finding that the plaintiff’s consent to intercourse was ineffective where infection with a venereal disease was fraudulently concealed).

97. Papelian, supra note 4, at 677.

98. See supra note 95 and accompanying text (discussing the consensus among commentators in favor of rejecting affirmative defenses which would place a burden on would-be defendants).

99. See Elber, supra note 4, at 924 (observing that while genital herpes is not fatal, it is similar to AIDS because genital herpes has a latency period and is incurable).

100. Id. (arguing that since AIDS is fatal even “stricter legal boundaries of civil liability” are appropriate). See also Fredrickson, supra note 4, at 970-71 (stating that imposing a duty on defendants in AIDS cases may be even more imperative because the consequences of contracting AIDS are “far more horrific and devastating” than contracting other sexually transmitted diseases).
C. Shortcomings of the Venereal Disease Model in the AIDS Context

The most significant inadequacy of the venereal disease model in the AIDS context is its dependence on two related assumptions. The first assumption is that the difference in the magnitude of harm between AIDS and other sexually transmitted diseases should not significantly affect the courts' analysis. The other assumption is that even if the difference in harm is treated as a significant factor, the more substantial harm from AIDS justifies imposing even more stringent liability on would-be defendants. These two assumptions are hardly self-evident.

The magnitude of harm is one of the most significant factors in defining an appropriate standard of care. In the seminal case of United States v. Carroll Towing Co., Judge Learned Hand articulated the significance of the degree of harm in finding a duty to take care. Judge Learned Hand explained that the duty to take care is a function of three variables: (1) the probability of harm (P); (2) the magnitude of loss (L); and (3) the burden of taking adequate precautions (B). Based on this analysis, he concluded that if \( P \times L \), no liability should be imposed. Thus, if the probability of harm is minimal, a court may find a duty where the magnitude of harm is great and decline to find a duty where the magnitude of harm is minimal. A court may find a duty where the magnitude of harm is great and decline to find a duty where the magnitude of harm is minimal.

101. See supra note 99 and accompanying text (distinguishing AIDS from other sexually transmitted diseases because AIDS is deadly).

102. See supra note 100 and accompanying text (discussing commentators' view that the greater magnitude of harm in AIDS cases imposes an even greater moral imperative to ensure that defendants who infect others are held liable).

103. See Restatement (Second) Of Torts § 291 (1977) (suggesting that where the gravity of harm is extremely great, courts will find a duty). See also Rowland v. Christian, 443 P.2d 561, 564 (Cal. 1964) (outlining the factors that serve as criteria for finding a duty of care); Prosser On Torts, supra note 94, § 31 (noting that even if the odds are a thousand-to-one against a train arriving at an intersection at the same time a car does, the potential harm of death is serious enough to require the driver to look for a train).

104. 159 F.2d 169 (2d Cir. 1947).

105. See id. at 173 (explaining that if the burden of adequate precautions exceeds the probability of harm multiplied by the degree of harm, no duty will lie).

106. Id.

107. Id.

108. Id.
harm is small.\textsuperscript{109} Since the magnitude of harm resulting from infection with HIV far exceeds that of genital herpes,\textsuperscript{110} AIDS requires a very different result.

Moreover, the assumption that any increase in the magnitude of harm justifies imposing even more stringent liability is also questionable. AIDS is already responsible for enormous social costs.\textsuperscript{111} The tort system is an expensive method of allocating costs because it entails substantial transaction costs.\textsuperscript{112} These transaction costs are justified only if imposing more stringent liability yields an offsetting increase in social utility.\textsuperscript{113}

D. The Venereal Disease Model and Goals of the Tort System

The significance of the venereal disease model's failure to account for the social costs of AIDS becomes evident when examined in light of the traditional goals of the tort system. The tort system has been viewed as having three broad objectives: (1) reinforcing social norms; (2) compensating victims; and (3) discouraging unsafe conduct.\textsuperscript{114} The objective of reinforcing societal norms is a two-fold concern. First, tort law reflects social

\begin{itemize}
  \item \textsuperscript{109} Prosser on Torts, supra note 94, § 31 (stating "[a]s the gravity of the possible harm increases, the apparent likelihood of its occurrence need be correspondingly less to generate a duty of precaution").
  \item \textsuperscript{110} The injury inflicted by transmitting genital herpes consists of painful sores and blisters on the genitals, thighs, and buttocks as well as painful urination. In women, blisters also develop on the cervix. Laurence Corey & Patricia G. Spear, Infections with Herpes Simplex Viruses (pt. 2), 314 New. Eng. J. Med. 749, 750 (1986). In contrast, AIDS is a fatal disease that requires enormous medical expenditures by the individual as well as the public. See supra text accompanying notes 31-37 (examining the enormous public and private medical expenditures AIDS entails).
  \item \textsuperscript{111} See supra notes 31-37 and accompanying text (discussing the nature and scope of the social costs associated with the AIDS crisis).
  \item \textsuperscript{112} Howard A. Latin, Problem-Solving Behavior and Theories of Tort Liability, 73 Cal. L. Rev. 677, 733 (1985) (stating that litigation is a very expensive means of allocating loss); see also Neil K. Komesar, Injuries and Institutions: Tort Reform, Tort Theory, and Beyond, 65 N.Y.U. L. Rev. 23, 23 (1990) (noting that the tort system is "very expensive"); Stephen D. Sugarman, Doing Away with Tort Law, 73 Cal. L. Rev. 555, 596 (1985) (observing that the tort system is "fabulously expensive" and entails significant public expense).
  \item \textsuperscript{113} See Latin, supra note 112, at 733 (arguing that imposing liability is justified only if the resulting increase in social utility is commensurate with the increase in transaction costs).
  \item \textsuperscript{114} See Richard L. Abel, The Real Tort Crisis—Too Few Claims, 48 Ohio St. L.J. 443, 455 (1987) (observing that most scholars list these as the principle objectives of tort law).
\end{itemize}
norms against activities with relatively little social utility when compared with their risk of injury. These norms are reinforced by imposing liability because the tortfeasor is punished, and the violation and punishment are publicized. Second, tort law reinforces corrective justice social norms. Society generally holds that when a wrongdoer injures someone the wrongdoer and not the injured party should bear the loss.

The venereal disease model does not effectively reinforce either of these social norms in AIDS transmission cases. This model imposes no duty of care on would-be plaintiffs. Thus, social norms against unsafe conduct are reinforced for AIDS carriers but not their partners although both parties to a sexual relationship engage in unsafe conduct by failing to take adequate precautions to avoid infection. Social norms against unsafe conduct also are not reinforced because plaintiffs frequently will be unable to recover from those who infect them. Recovery is unlikely because the long latency period and fatal nature of AIDS means that many defendants will be judgment-proof by the time a decision is rendered. Even if a defendant is solvent at the time of infection, the long latency period of AIDS makes proving causation extremely difficult. Because would-be defendants will rarely pay damages out of their own pocket, it is unlikely that imposing liability will reinforce social norms against unsafe conduct. Similarly, this inability of

115. See id. at 458 (stating that a breach of the required standard of care constitutes the violation of a social norm).
116. See id. at 455 (arguing that it is critical to maintaining the norm against unsafe conduct that the wrongdoer be punished and his violation be publicized).
117. See Sugarman, supra note 112, at 603 (noting that the norm of corrective justice derives from the view that it is only morally right that the injurer bear the loss).
118. See supra notes 95-96 and accompanying text (discussing the rejection of affirmative defenses as a means of imposing a duty on plaintiffs in venereal disease cases).
119. See supra notes 33-36 and accompanying text (discussing the depressed economic status of some AIDS patients and their potential dependence on public funds).
120. See, e.g., Brigham, supra note 90, at 548 (stating that "the plaintiff's ability to prove that the defendant was the one who actually transmitted the disease may be tenuous at best"); Elber, supra note 4, at 939 (listing AIDS' long latency period as a reason why proving causation will be difficult in AIDS cases). Plaintiffs also may be unable to prove causation because AIDS may be transmitted by means other than sexual contact. See id. (listing this among reasons proving causation in AIDS cases will be difficult); Burdt & Caldwell, supra note 5, at 676 (noting that proving causation will pose problems in AIDS cases because HIV is transmitted by means other than sexual intercourse). See generally supra part II.C. (discussing the means by which AIDS may be transmitted).
121. See generally supra note 116 and accompanying text (explaining that tort law reinforces social norms by sanctioning the tortfeasor and publicizing the violation).
plaintiffs to recover also means corrective justice norms will not be reinforced. Since defendants will frequently be judgment-proof, medical costs often will not be shifted from the "wrongdoer" to the "injured party."

The second goal of tort law, compensation, generally is viewed as the primary objective of the tort system. The emphasis on compensation reflects society's compassion for a person who has been wrongfully injured. Compensation is also intended to address certain economic concerns. A key economic concern is restoring the productive capacity of the victim. A related concern is preventing the victim from becoming dependent on public funds.

The venereal disease model also fails to promote compensation goals in AIDS transmission cases. Other sexual diseases generally do not render those infected destitute so the traditional model effectively shifts losses from those infected to those they infect. However, since defendants in AIDS cases will often be judgment-proof, there can be no comparable shifting of losses. Moreover, even if a defendant is not judgment-proof, payment of damages may only hasten the defendant's own dependence on public funds.

The third goal of tort law, deterrence, is the most controversial. Many courts and commentators still view deter-

122. See supra note 119 and accompanying text (observing that the long latency period and fatal nature of AIDS will leave many defendants judgment-proof).
123. See Abel, supra note 114, at 456 (noting that twentieth century tort law makes compensation the primary objective of the tort system). See also Sugarman, supra note 112, at 591 (discussing the increased popularity of viewing the tort system's primary goal as compensation).
124. See Abel, supra note 114, at 456 (noting that for some commentators the motivation for making compensation the central objective of tort law is compassion for injured parties).
125. Id.
126. Id. (listing this concern as a factor justifying the view that compensation is the central goal of tort law).
127. Id. (listing this concern as an economic motivation for the central role of compensation in tort law).
128. See generally supra note 110 (contrasting AIDS with genital herpes, the only other incurable sexually transmitted disease).
129. See supra note 119 and accompanying text.
130. See supra notes 31-37 and accompanying text (discussing the dependence of some AIDS patients on public funds and the insurance industry's response to the AIDS crisis).
131. See generally Sugarman, supra note 112, at 564-90 (providing a comprehensive criticism of tort law's effectiveness as a deterrent to dangerous conduct).
rence as a fundamental objective of tort law. However, recently tort law’s effectiveness as a deterrent has been criticized by proponents of tort reform. While a detailed evaluation of these criticisms is beyond the scope of this Note, some of these criticisms are particularly pertinent to AIDS transmission cases.

One set of criticisms emphasize the deterrent effect of other factors, such as self-preservation and personal morality. Self-preservation deters tortious conduct because would-be defendants often endanger themselves by such conduct. The desire to avoid causing injury to one’s own body may discourage conduct that endangers others. Personal morality also discourages unsafe conduct if the defendant perceives the risk of harm to others. Self-preservation and personal morality may be much more influential than the tenuous possibility of tort liability in deterring conduct likely to spread AIDS. This distinction is particularly true because AIDS is fatal. Consequently, the marginal gain in deterrence from imposing liability may not justify the transaction costs associated with the tort system.

A more fundamental criticism of the deterrence rationale focuses on the tort system’s frequent failure to sanction

132. See Daniel W. Shuman, The Psychology of Deterrence in Tort Law, 42 Kan. L. Rev. 115, 131 (noting that judges and lawyers continue to emphasize the deterrence role of tort law). See, e.g., Nicholas v. Homelite Corp., 780 F.2d 1150, 1153 (5th Cir. 1986) (asserting that “the threat of a reduction in recovery will provide future consumers with the very incentive for more careful use which the doctrine of comparative fault was intended to engender”); Estate of Cargill v. City of Rochester, 406 A.2d 704, 706 (N.H. 1979) (stating that “[t]he threat of tort liability acts as an incentive for persons... to take steps to reduce the risk of injury”).

133. See Shuman, supra note 132, at 131 (noting that commentators continue to emphasize deterrence as a goal of tort law).

134. See supra note 131 and accompanying text (providing a comprehensive criticism of deterrence as a goal of tort law).

135. Sugarman, supra note 112, at 561 (listing these as factors that deter potential defendants from unsafe conduct).

136. Id. at 562 (arguing that the drive to protect oneself from injury also may protect others).

137. Id. at 563 (stating that “moral inhibitions serve to block self-satisfying behavior that would unreasonably endanger others”).

138. The transaction costs include the administrative costs associated with resolving the dispute. See generally Steven Shavell, Economic Analysis of Accident Law 262-63 (1987) (discussing the administrative costs the parties to a lawsuit must incur). Specifically, these transaction costs include the time and effort spent by the parties as well as their lawyers and insurers. Id. Substantial transaction costs are also incurred by the public sector in operating the courts and the public health care system.
tortfeasors. Monetary damages provide the primary mechanism for imposing sanctions aimed at deterrence. The deterrence theory rests on the premise that the threat of tort damages forces would-be defendants to internalize accident costs. The resulting increase in the total cost of unsafe conduct provides an incentive to avoid such conduct. Additionally, the fault principle is designed to adjust the size of an award to influence the conduct of both parties. The deterrence impact of judgments is greatly diminished, however, when the judgments are satisfied by insurance. More significantly, the deterrence effect may be non-existent if the party is judgment-proof or dependent on public funds. A low probability of a successful suit also undermines deterrence goals. Numerous studies show that the probability associated with imposing sanctions is crucial to the sanctions' impact on behavior. Thus, the threat of sanctions will be discounted when liability turns on issues that are difficult to prove.

The venereal disease model also fails to promote these deterrence goals in AIDS transmission cases. Since actual recov-

139. See Latin, supra note 112, at 678 (explaining that deterrence theory is premised on a view that by increasing costs, liability provides an incentive to include the accident cost in cost-benefit analysis).

140. See generally Shavell, supra note 138, at 26-29 (discussing how a liability rule's distribution of accident costs provides incentives to avoid dangerous conduct).

141. Sugarman, supra note 112, at 586 (noting that tort law uses fault principles to discourage plaintiffs from engaging in dangerous conduct).

142. Id. at 573 (noting that the ability to completely insure against a risk shifts the "direct" deterrent pressure to the insurer); see Guido Calabresi, First Party, Third Party, and Product Liability Systems: Can Economic Analysis of Law Tell Us Anything About Them?, 69 IOWA L. REV. 833, 840 (1984) (noting that social insurance eliminates accident avoidance incentives because losses are shifted to society as a whole).

143. See Shuman, supra note 132, at 120 (noting that deterrence only occurs where would-be defendants are solvent); Sugarman, supra note 112, at 572 (arguing that the threat of liability is not meaningful for would-be defendants with no wealth or income).

144. See Paxman v. Campbell, 612 F.2d 848, 870 (4th Cir. 1980) (Winter, J., concurring and dissenting) (stating "the chilling effect . . . of imposing personal liability . . . is much more attenuated when the liability is to be satisfied from governmental funds").

145. See Sugarman, supra note 112, at 569 (discussing the tendency of defendants to discount the risk of liability based on the difficulty plaintiffs face in proving factual issues).

146. Shuman, supra note 132, at 121 (observing that empirical research has conclusively shown that the certainty of sanctions significantly influences the level of deterrence). Research also has shown that the severity is not as influential and only becomes relevant after a certain threshold of certainty is reached. Id.

147. See Sugarman, supra note 112, at 569.
ery is problematic in AIDS cases,148 would-be defendants may not internalize the cost of potential tort damages.149 Moreover, the deterrent effect of tort liability is further diminished by some AIDS patients' dependence on public funds.150

Finally, because the venereal disease model imposes a duty only on those who are infected,151 their partners' unsafe conduct is not deterred. In venereal disease cases, the courts avoid imposing a duty on plaintiffs because courts view sexual relationships as confidential trust relationships.152 The courts reason that the intimate nature of the relationship should allow sexual partners to trust that their partner will not infect them.153 Since most other sexual diseases are less severe than AIDS,154 promoting trust and confidence in intimate relationships may justify allowing plaintiffs to rely entirely on their partners to take precautions. AIDS, however, entails much more staggering costs on both the individual and society. Avoiding these substantial costs outweighs the importance of promoting unconditional trust and confidence in intimate relationships.

Determining the most appropriate allocation of the duty of care in AIDS cases requires an examination of the costs and benefits of available alternatives. The next section of this Note will examine the possible alternatives available under the venereal disease model, where the entire burden of care falls on defendants. This model will be contrasted with a proposal that attempts to fairly balance the burden of care between both sexual partners.

148. See supra note 119 and accompanying text (explaining that AIDS victims may be judgment-proof).

149. See generally supra notes 140-43 (discussing the means by which liability forces parties to internalize accident costs and the impact of private and public insurance on this internalization process).

150. Id.

151. See supra notes 94-98 and accompanying text (discussing commentators' view that comparative or contributory negligence and assumption of the risk should be rejected in AIDS cases as in other venereal disease cases).

152. See Kathleen K. v. Robert B., 198 Cal. Rptr. 273, 276-77 (Cal. Ct. App. 1984) (finding that a fiduciary relationship exists in sexual relationships between unmarried partners). The court specifically noted that a certain amount of trust and confidence exists in all intimate relations. Id. See also Edward Barron Estate Co. v. Woodruff Co., 126 P. 351, 357 (Cal. 1912) (stating "when one of the parties ... places a known trust and confidence in the other, any misrepresentation ... is regarded as fraud").

153. See id.

154. See supra note 110 (contrasting AIDS with genital herpes).
E. Possible Scope of Defendant's Duty

Negligence is the failure to conform to the standard of care required by law to protect others from an unreasonable risk of harm. The courts will not find a defendant negligent unless he owes the injured party a duty of care. The duty issue can be viewed as a two-tiered analysis: (1) under what circumstances does the defendant owe a duty of care; and (2) what is the scope of the duty owed by the defendant.

Duty has sometimes been defined according to a cost-benefit analysis. This analysis entails balancing the value of the plaintiff's threatened interest against the value of the interest the defendant is seeking to protect. The courts weigh several factors when performing this cost-benefit analysis including: (1) foreseeability of harm; (2) degree of certainty that the plaintiff was injured; (3) closeness in causal connection between the defendant's conduct and the resulting harm; (4) prevention of future harm; (5) burden to the defendant and community of imposing a duty; and (6) ability to insure against the risk.

1. The Defendant's Duty to Disclose

Several possible standards of care could be imposed by the courts in AIDS transmission cases. First, the courts could impose a duty to disclose that one is HIV-positive. Considering that the transmission of AIDS may lead to death and significant public health expenditures, a duty to disclose one's HIV

155. PROSSER ON TORTS, supra note 94, § 30, at 164.
156. See id. (explaining that a negligence cause of action requires a duty of care).
157. See generally id. § 53, at 358-59 (discussing the factors upon which courts rely when deciding to impose a duty).
158. See id. § 32, at 173 (outlining a test which balances the costs and benefits of imposing a duty).
159. Id.
160. See Rowland v. Christian, 443 P.2d 561, 564 (Cal. 1968) (listing these factors as criteria for finding a duty).
161. See DelaRosa, supra note 4, at 109-10 (advocating a duty to disclose HIV status be imposed because AIDS is fatal); Burdt & Caldwell, supra note 5, at 673 (suggeting that since most courts recognize a duty to prevent the spread of venereal diseases, the duty to disclose HIV status logically follows).
162. See supra notes 31-37 and accompanying text (analyzing the public expenditures associated with AIDS).
status seems a minimal burden. However, imposing a duty to disclose may be impractical since an infected partner is not likely to know that he is HIV-positive until he becomes symptomatic. When the defendant is not aware of his HIV status, courts must determine what gives rise to the duty to disclose. A defendant need not possess "actual" knowledge of a risk for a duty to be imposed. However, the defendant must possess knowledge which would lead a reasonable person to recognize that his conduct poses a significant risk of harm. Some commentators have argued that a defendant who is in a high-risk group has a reason to know that sexual contact poses an unreasonable risk of harm.

What constitutes high-risk activity has not been carefully analyzed. AIDS is no longer a disease that is confined to a

163. See Brigham, supra note 90, at 545-46 (arguing that the defendant should bear a duty to disclose or abstain because the burden is inconsequential when compared to "the emotional trauma, hospital care and expenses, and the high possibility of death an AIDS patient faces").

164. The long asymptomatic stage of AIDS poses a unique risk because a defendant may not have any physical symptoms which would cause him to recognize the danger he poses to others. See supra notes 28-30 and accompanying text (discussing the danger of AIDS being spread by asymptomatic HIV carriers who underestimate the probability of transmitting the virus). Moreover, because antibodies frequently do not show up until six months and sometimes a year after the infection, a defendant cannot even ascertain his HIV status during this window period. See supra notes 45-46 and accompanying text (discussing AIDS' six to twelve month latency period).

165. A number of commentators have suggested that membership in a "traditional high-risk group," such as IV drug users or homosexuals, should be sufficient to impose a duty to warn. See, e.g., Roger B. Gainor, Note, To Have and To Hold: Tort Liability for the Interspousal Transmission of AIDS, 23 NEw. ENG. L. REV. 887, 905-06 (1988-89) (suggesting that a defendant who is in a high-risk group has a duty to protect his spouse); Schoenstein, supra note 90, at 59 (arguing that high-risk group status could be a basis for imposing a duty). See also Braden, supra note 3, at 300 (noting one commentator's view that membership in a high-risk group would create a significant risk of harm). However, at least one commentator has expressly rejected the notion that high-risk group status alone should be sufficient to impose a duty to warn. See, Papelian, supra note 4, at 665-66 (arguing that the courts are unlikely to find high risk alone sufficient to impose a duty).

166. See generally PROSSER ON TORTS, supra note 94, § 32, at 182 (explaining that knowledge will be imputed to a defendant where the defendant does not perceive what is apparent to a reasonably prudent person).

167. See generally id. § 32, at 184-85 (noting that when an individual possesses knowledge which would lead a reasonable person to investigate, the defendant cannot proceed in "conscious ignorance").

168. See supra note 165 (listing commentators who espouse this view).

169. See, e.g., Schoenstein, supra note 165, at 59 (suggesting that the courts use IV drug use, homosexuality, and sexual intercourse with multiple partners as a basis for imposing liability).
few demographic groups. A person is placed at risk for contracting AIDS by high-risk behavior, not by membership in a particular demographic group. Given the rapid growth of AIDS in the heterosexual community, the courts should consider the inequity of imposing a duty exclusively on "traditional high-risk groups," such as homosexuals and IV drug users.

The inequity of imposing a duty only on traditional high-risk groups is even more troubling because such a duty would invoke the zone of privacy surrounding intimate sexual relationships. In Lasher v. Kleinberg, a father's cross-complaint for wrongful birth based on the plaintiff's false claim that she was using birth control was dismissed because the court characterized the cross-complaint as "nothing more than asking the court to supervise the promises made between two consenting adults [concerning their] private sexual conduct."

Under Lasher's holding, a court's attempt to supervise promises between consenting adults regarding their sexual conduct would constitute an impermissible intrusion into the privacy surrounding intimate sexual relationships. The court specifically observed that "[c]laims such as [these] . . . arise from conduct so intensely private that the courts should not be asked to nor attempt to resolve [them]."

Similarly, in In Re L. Pamela P., the court rejected a wrongful birth claim because the claim required an inquiry constituting an "impermissible invasion of the 'zone of privacy created by several fundamental constitutional guarantees.'"

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170. See supra notes 2, 55 and accompanying text (surveying the rapid spread of AIDS outside traditional high-risk groups).
171. See Moss, supra note 8, at 17 (stating that the notion of high-risk groups is "fatally flawed" because it promotes a false sense of security among those not designated "high risk").
172. See supra note 2 and accompanying text (observing that AIDS is spreading more rapidly among heterosexuals than any other demographic group).
173. The United States Supreme Court has ruled that an individual has a right to privacy in his or her sexual relationships. See, e.g., Eisenstadt v. Baird, 405 U.S. 438, 453-54 (1972) (finding that the right to privacy prohibits the government from intruding into decisions as fundamental as whether to bear or beget a child).
175. Id. at 619.
176. Id. at 620.
177. See id. at 621.
178. Id. at 619.
180. Id. at 767 (quoting Griswold v. Connecticut, 381 U.S. 479, 485 (1965)).
However, the right to privacy in intimate relations can be infringed if governmental intrusion is warranted. In *Barbara A. v. John G.*, the court permitted a duty to be imposed on a father trying to evade support obligations, explicitly rejecting the defendant's claim that imposing a duty of care would violate his right to privacy. The court emphasized the strong public policy against eliminating much or all of the father's financial support to the child.

In *Kathleen K. v. Robert B.*, the right to privacy defense also was rejected. The plaintiff alleged that she was infected with genital herpes despite the defendant's assurances that he was free of venereal disease, and the court concluded that the complaint stated a cause of action.

The right to privacy may pose a significant barrier to imposing a duty in AIDS cases. Most commentators have relied heavily on *Kathleen K.* as a basis for imposing a duty in AIDS cases. This analysis relies on the view that preventing the spread of disease and compensating the victim justify invading the right to privacy. However, the tort system is poorly equipped to promote the traditional goals of tort law in AIDS transmission cases. Given the tenuous link in AIDS cases between imposing liability and traditional tort goals, the state's

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181. *See* Barbara A. v. John G., 193 Cal. Rptr. 422, 430 (Cal. Ct. App. 1983) (stating that the "right to privacy is not absolute," and the state may enact laws to protect public health even though they infringe on the right to privacy).

182. *Id.* at 422.

183. *See id.* at 426-427 (finding that a mother could state a cause of action despite the defendant's claim that it would invade his right to privacy).

184. *See id.* at 431 (holding that no public policy concerns were established which would permit the right to privacy to insulate the defendant's tortious conduct from judicial inquiry into his sexual relations).

185. *See id.* at 429 (observing that assessing damages based on the mother's false representations would have the practical effect of reducing the father's financial support of the child).


187. *Id.* at 276.

188. *Id.* at 277.

189. *See, e.g.*, Fredrickson, *supra* note 4, at 974 (stating that the courts reasoning in *Kathleen K.* would "obviously" apply to AIDS cases); Gainor, *supra* note 165, at 913-14 (contending that based on *Kathleen K.*, the right to privacy would not bar claims in AIDS cases).

190. *See* Fredrickson, *supra* note 4, at 974 (stating that the right to privacy would be outweighed by public policy concerns about the spread of AIDS); Gainor, *supra* note 165, at 914 (arguing that the right to privacy would not bar a plaintiff's claim because of the strong state interest in preventing the spread of AIDS).

191. *See supra* part III.D.
rationale for invading an intimate consensual relationship may not be sufficiently compelling. Thus, the courts may decline to invade the right to privacy by imposing a duty to disclose exclusively on defendants.

Imposing a duty to disclose high-risk status also might violate the Equal Protection Clause. A classification scheme that involves a fundamental right, such as the right to privacy, is subject to strict scrutiny. Unless there is a compelling state interest and the means are narrowly tailored, the state may not infringe on the right to privacy. The Equal Protection Clause is violated if: (1) those similarly situated are treated differently; or (2) those not similarly situated are treated the same.

As noted above, a duty imposed solely on defendants to disclose high-risk status might not sufficiently promote tort goals to constitute a compelling state interest. Even if a court found a compelling state interest, the scheme is not narrowly tailored. Since "high-risk behavior" rather than "high-risk status" creates a risk of HIV infection, a legal rule that emphasizes status rather than behavior is inherently more suspect under Equal Protection Clause analysis.

A duty based on high-risk status would be both underinclusive and overinclusive. The duty would be underinclusive because it would impose no duty on heterosexuals engaging in

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192. See Shoenstein, supra note 90, at 83 (stating that placing a higher burden on those who engage in homosexual activities than those who engage in similar heterosexual activities may violate the Equal Protection Clause).


194. See id. § 16.6, at 1452 (observing that very few cases involving a fundamental right have applied strict scrutiny and upheld a classification scheme). See also id. § 16.6, at 1451 (noting Professor Gunther's characterization of strict scrutiny as strict in theory and fatal in fact).

195. Id. § 16.1, at 1438.

196. See supra part II.E. (providing an overview of the shortcomings of "high-risk groups" nomenclature).

197. See Shoenstein, supra note 90, at 84 (noting that legal principles aimed at a specific conduct and not a particular class are more likely to withstand Equal Protection Clause challenges).

198. Underinclusive analysis applies to a classification scheme that includes some sources of a particular harm while excluding others. See TRIBE, supra note 193, at § 16.4, at 1447 (explaining that underinclusive classifications exclude individuals similarly situated with respect to a particular harm). Overinclusive analysis applies to classification schemes that include persons who do not contribute to the harm. Id. § 16.4, at 1449.
extremely high-risk activities. Thus, a heterosexual would be permitted to have many sexual partners and take no precautions without having a duty imposed. Moreover, the duty would be overinclusive because a homosexual who does not have multiple partners and takes precautions and an IV drug user who never shares needles might be included even though a “promiscuous” heterosexual poses a greater risk.

Arguably, the state may attempt to prevent the spread of AIDS by attacking some aspects of the AIDS crisis while not addressing others; however, high-risk behavior and not one’s membership in a particular demographic group is the sole factor that creates a risk of infection. A legal rule based on high-risk conduct and not high-risk status would be a permissible means of addressing the AIDS crisis. One kind of high-risk behavior could be targeted without including all other forms of risky behavior. For example, a choice to concentrate on sharing of IV drug needles rather than unsafe sexual practices would be permissible. However, the tenuous fit between “high-risk status” and the risk of spreading AIDS is unlikely to be sufficient to withstand strict scrutiny.

These Equal Protection concerns could be addressed by imposing a duty to disclose high-risk behavior rather than membership in a “high-risk group.” This scheme would include non-drug using heterosexuals who have multiple sexual partners without taking precautions. A duty to disclose high-risk behavior creates a “perfect fit” between the classification scheme and those whose behavior poses a significant risk.

However, a detailed inquiry into the frequency and nature of one’s sexual conduct more seriously invades the right to privacy. If the standard of care is a duty to disclose high-risk be-

199. See generally supra notes 2, 55 and accompanying text (discussing the spread of AIDS among groups who have not traditionally been classified as high risk, such as heterosexuals, women, and children).

200. See generally Peterson, supra note 43 (explaining that latex condoms are a highly effective barrier to HIV infection).

201. See supra note 53 and accompanying text (noting that a person’s behavior and not membership in a particular demographic group places a person at risk for contracting AIDS).

202. See Tribe, supra note 193, § 16.4, at 1447 n.4 (noting that courts rarely invalidate statutes exclusively on the basis of underinclusiveness).

203. See generally supra notes 57-59 and accompanying text (noting that engaging in any sexual conduct without knowing the sexual history of a partner or taking other precautions creates a risk of contracting AIDS).
havior, the courts will be forced to probe closely the sexual history of litigants. This inquiry would constitute a substantial intrusion into the zone of privacy surrounding intimate relations. Because such a disclosure requires specific details, the requirement is even more intrusive than requiring disclosure of high-risk status. Moreover, this type of inquiry might entail substantial legal and administrative costs.

In *Doe v. Doe*, a New York court specifically declined to impose a duty to disclose high-risk behavior where a wife alleged fraud and intentional infliction of emotional distress based on her husband’s homosexual affairs. The court held that the husband did not owe his wife a duty to disclose his high-risk activities. While this case involved a plaintiff who was not infected with HIV, the court’s holding suggests that the courts may be unwilling to delve deeply into the sexual history of litigants to find a duty.

Finally, some commentators would impose a duty to disclose on members of high-risk groups with physical symptoms. This standard of care is reasonable but somewhat impractical. Much of the difficulty with defining a duty in AIDS cases results from the long latency period of AIDS, which leaves the majority of those infected without symptoms. Since most of those infected have no symptoms and are unaware of the risk they pose to others, this standard of care would apply to only a small number of those infected. Most

204. *See generally* Maharam v. Maharam, 510 N.Y.S.2d 104 (N.Y. App. Div. 1986) (discussing the Supreme Court’s protection of the sphere of privacy surrounding intimate sexual relationships); *see also* supra text accompanying notes 72-73.

205. The additional fact finding entailed by a detailed inquiry into the sexual history of the parties would necessarily increase litigation expenses. See Shavell, supra note 138, at 262-63 (discussing the high administrative costs of litigation).


207. *See id.* at 596-97.

208. *Id.*

209. *Id.* at 597.

210. *Id.*

211. *See, e.g.*, Brigham, supra note 90, at 546 (contending that those in high-risk groups who manifest symptoms should have a duty to take care). Another commentator argues that a member of a high-risk group who is exhibiting symptoms beyond a normal illness should have a duty to warn. Elber, supra note 4, at 936.

212. *See supra* part II.D. (discussing the long stage during which the defendant has no symptoms but is able to transmit the virus).

213. *See* Hancock, supra note 3, at 8 (stating that some of the 1 to 1.5 million people infected with HIV may be unaware they are infected).
importantly, this standard would not require those without symptoms to alert their partners of a potential risk.\textsuperscript{214}

2. Defendant’s Duty to Abstain

Commentators also have advocated imposing a duty on people infected with HIV to abstain entirely from sexual contact.\textsuperscript{215} Many of the issues raised by imposing a duty to warn are also implicated by imposing a duty to abstain. There is a problem in determining what gives rise to the duty to abstain. It may be a relatively easy matter to impose a duty to abstain on one who knows that he is HIV-positive; however, the long latency period of the virus leaves many of those infected unaware of the risk of transmission.

Moreover, once those infected display physical manifestations, such as pneumonia symptoms, would-be plaintiffs have a reason to be on notice.\textsuperscript{216} It would seem reasonable to charge plaintiffs with at least some duty of care once observable physical symptoms manifest themselves.

A duty to abstain would infringe more seriously on the right to privacy than a disclosure requirement;\textsuperscript{217} however, a compelling interest may be asserted, such as protecting public health or compensating innocent third parties. A duty to abstain is unlikely to withstand strict scrutiny as a means of promoting these interests. The means would not be narrowly tailored to impose the minimum infringement on the right to engage in intimate relations. There are several less restrictive means, such as requiring disclosure of participation in high-risk

\textsuperscript{214} The asymptomatic status of most of those infected has been offered as a rationale for imposing the whole burden of care on HIV carriers. \textit{See}, e.g., DelaRosa, \textit{supra} note 4, at 111 (contending that because many of those infected have no symptoms, uninfected partners cannot protect themselves).

\textsuperscript{215} \textit{See}, e.g., Elber, \textit{supra} note 4, at 931 (contending that in the AIDS context, the duty of reasonable care would be to abstain entirely from sexual activity).

\textsuperscript{216} \textit{See} Burdt & Caldwell, \textit{supra} note 5, at 675 (suggesting that a plaintiff may be able to establish that the defendant “should have known” if the defendant was experiencing symptoms). \textit{But see} Brigham, \textit{supra} note 90, at 546-47 (arguing that a symptomatic party who is not in a high-risk group should not be imputed with knowledge of his HIV status because it is difficult to differentiate the symptoms of HIV infection from common illnesses).

\textsuperscript{217} A duty of disclosure necessarily entails some intrusion into the zone of privacy protecting intimate relations. \textit{See} discussion \textit{supra} part II.E.1. However, the duty to abstain entirely denies an individual’s fundamental right to engage in intimate sexual relations. \textit{See} Skinner v. Oklahoma, 316 U.S. 535 (1942) (finding that a law requiring mandatory sterilization of sex offenders violates the right to procreation).
activity, use of a condom, or consent to an AIDS test. All of these means would permit continued, albeit restricted, participation in intimate relationships.

3. Defendant’s Duty to Be AIDS Tested

The courts also could require that defendants ascertain their HIV status before engaging in sexual relations. This approach has several benefits. First, since HIV tests are highly reliable, this standard of care would assure that those who comply do not inadvertently transmit the disease. Next to abstaining entirely, which more seriously infringes the right to privacy, imposing a duty to be tested is the surest way to prevent the unintentional spread of AIDS.

Moreover, a duty to be tested would ameliorate some of the problems created by the latency period of AIDS. With either a duty to disclose or abstain, courts must determine what knowledge gives rise to the duty. However, defendants who have had an AIDS test will have actual knowledge of the risk of infecting their partners. Since there would be a record of the defendant’s HIV status, the courts would save the administrative costs of determining whether the defendant “knew” his HIV status. Furthermore, deserving plaintiffs would be able to prove causation more easily, which may be extremely difficult.

218. See Elber, supra note 4, at 937-38 (noting that a person who honestly believes he is not infected is not necessarily relieved of the duty of ascertaining his true HIV status). See also Alice D. v. William M., 450 N.Y.S.2d 350, 355 (N.Y. Civ. Ct. 1982) (holding that the defendant was negligent even though he honestly believed he was sterile because he did not take reasonable care to determine his true status).

219. AIDS testing is a highly reliable way for people to obtain definitive information about their HIV status. See Moss, supra note 8, at 23 (noting that the false-positive rate of HIV tests is negligible).

220. Id.

221. See supra part III.E.2.

222. If one is tested for AIDS, one will be aware of one’s HIV status. It is also reasonable to assume that some individuals who learn they are HIV-positive will feel morally compelled to avoid high-risk sexual contact. See supra notes 135-38 and accompanying text.

223. Although a small number of people may be misled by false test results, this problem is negligible given the high reliability of AIDS tests. See Moss, supra note 8, at 23. However, there is a window period of six to twelve months after exposure during which the test results may not show the presence of HIV. See supra notes 45-46 and accompanying text (discussing the latency period).
in AIDS cases. At least there would be no doubt about the defendant's ability to infect the plaintiff at the time of the party's encounter.

An even more substantial benefit of imposing a duty to be tested is that it would encourage people to ascertain their HIV status. Since obtaining an AIDS test would prevent liability, those who are sexually active would have a strong incentive to be tested. This practice would put those infected on notice that unprotected sexual contact poses a significant risk to sexual partners. It is reasonable to assume that some people who learn they are HIV-positive will feel a compelling moral obligation not to expose unknowing partners.

However, HIV will not necessarily be detected until six months after exposure. As a result, imposing a duty to be tested for AIDS has its own shortcomings. First, the duty to be tested infringes on the right to privacy even more extensively than the duty to disclose or the duty to use a condom. The right to privacy is implicated at two levels: (1) the requirement that a party abstain from sexual intercourse for six to twelve months until reliable results of an AIDS test can be obtained; and (2) the requirement that to engage in private intimate relations a potential defendant must submit to an AIDS test.

The lag time between exposure and a conclusive test result poses an even more basic problem. The courts must determine what liability rules to apply during the interim period. Would-be defendants could be required to abstain from intercourse during this period. However, requiring abstinence would likely constitute an overly broad infringement on the right to pri-

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224. The problem of proving causation in AIDS cases has been the subject of extensive commentary. See supra note 120 (listing commentators who argue that proving causation will be difficult in AIDS transmission cases).

225. See generally supra notes 135-37 and accompanying text (discussing the role of personal moral constraints in discouraging tortious conduct).

226. See Moss, supra note 8, at 24.

227. See Goldberg, supra notes 45-46 and accompanying text (noting that a negative test during the first six months after exposure means only that the person has not developed HIV antibodies).

228. The New York Supreme Court has explicitly rejected attempts to compel defendants to submit to AIDS tests so that plaintiffs can determine if they are at risk. See Anne D. v. Raymond D., 528 N.Y.S.2d 775, 778 (N.Y. Sup. Ct. 1988) (holding that a wife's involvement in extramarital affairs was insufficient to force her to submit to AIDS testing).
Here also, the courts may consider the duty to disclose or to use a condom, a less intrusive invasion of the right to privacy. 230

Alternatively, if an individual is tested before engaging in sexual activity with a new partner, the courts could permit him to remain sexually active during the “window period.” A defendant who was tested would not be negligent even if his test results could not be confidently relied on. This approach would yield some of the benefits that flow from increased HIV testing. 231 However, allowing defendants to rely on test results that may well be invalid creates a serious inequity. A plaintiff would be barred from receiving compensation even if he has taken extensive precautions.

Plaintiffs could be protected by combining the duty to be tested with the duty to disclose that the test results are inconclusive. This type of disclosure requirement avoids some problems of the duty to disclose high-risk or HIV-positive status. As noted above, the duty to disclose HIV status is impractical since most of those infected do not know their HIV status. 232 By contrast, the duty to disclose in this context turns on the defendant’s lack of knowledge. Similarly, this approach does not entail the Equal Protection Clause concerns associated with a duty to disclose high-risk status. 233

However, this hybrid duty would not work within the traditional venereal disease model. The venereal disease model rejects the use of affirmative defenses, such as contributory or comparative negligence or assumption of the risk. 234 Even if the defendant discloses that his test result is not conclusive, he would be subject to the same degree of liability. The venereal

229. See discussion supra at part III.E.2. (discussing the probability that requiring parties to abstain from sexual intercourse likely would be considered an overly broad invasion of the right to privacy).

230. A requirement that a defendant disclose he has not yet obtained a valid test result since his last sexual contact also would be less intrusive.

231. See supra notes 220-24 and accompanying text (discussing the benefits of increased HIV testing). These benefits would be undermined to some extent because the test would not necessarily alert the defendant to his actual HIV status.

232. See generally supra notes 27-28 and accompanying text (observing that some of the 1 to 1.5 million people infected remain asymptomatic).

233. See supra notes 192-202 and accompanying text (analyzing the Equal Protection Clause concerns associated with imposing a duty to disclose high-risk status).

234. See supra notes 94-96 and accompanying text (analyzing the venereal disease model’s rejection of these affirmative defenses).
disease model would not reduce the recovery of a plaintiff who relies on an inconclusive test result. Thus, the defendant has no incentive to make such a disclosure. While this hybrid approach has numerous benefits, it does not work if the entire duty of care is imposed on would-be defendants.

4. Defendant’s Duty to Use a Condom

A final standard of care that should be considered is the duty to use a latex condom during sexual intercourse. This standard of care makes some sense since latex condoms are effective barriers against HIV transmission. Compliance with the appropriate standard of care, that is, use of a condom, would extinguish the defendant’s liability even though condoms may fail to prevent the transmission of the virus because of misuse or defects. Thus, plaintiffs who take substantial precautions to avoid contracting AIDS would be left entirely without a remedy. A more appropriate approach is to apportion a plaintiff’s recovery by balancing the care taken by both partners.

IV. SOLUTION—SHIFTING THE BURDEN

The venereal disease model imposes the entire duty to avoid the spread of AIDS on would-be defendants. A more efficient and equitable approach is to impose a duty on all sexual partners. The courts should adopt a rule that discourages both parties from conduct likely to result in substantial expenditures in public funds. The courts have generally rejected contributory or comparative negligence and assumption of the risk theories in sexually transmitted disease cases. However, the huge social costs associated with AIDS dictates that plaintiffs not be allowed to proceed in “ignorant bliss” when confronted with the risk of HIV infection.

235. See Peterson, supra note 43, at 446 (discussing the effectiveness of latex condoms in preventing transmission of HIV).
236. Id.
237. See supra notes 94-96 and accompanying text (discussing the courts’ and commentators’ rejection of affirmative defenses in venereal disease cases).
238. See id. The courts have been unwilling to recognize these affirmative defenses because of a hesitancy to conclude that “the risk of contracting a disease must be assumed when entering a sexual relationship.” See Papelian, supra note 4, at 677.
A duty should be imposed on all persons to inquire about the sexual history of their partners. Comparative negligence jurisdictions should apply this standard to reduce awards to plaintiffs who do not take adequate precautions to avoid contracting AIDS. In contributory negligence jurisdictions, this standard should be applied to bar claims when the plaintiff fails to take adequate precautions. In AIDS cases, comparative negligence will yield the most equitable and efficient results. Moreover, contributory negligence will yield more equitable and efficient results than the venereal disease model. This solution is aimed at cases where negligence theories are most appropriate—those where the defendant does not "know" his HIV status. The reason for this limitation is that liability for "knowingly" or "intentionally" infecting another with AIDS is more easily established. Before exploring the benefits of applying contributory and comparative negligence in AIDS transmission cases, the reasons for rejecting assumption of the risk as an alternative will be examined.

A. Assumption of the Risk

A party can expressly or impliedly assume the risk. Express assumption of the risk consists of an express agreement between the parties that the defendant is under no obligation of care to the plaintiff. By contrast, a party impliedly assumes the risk if fully aware of the risk, the party "freely and voluntarily" chooses to confront it. Under the assumption of the risk doctrine, a plaintiff who continues in the face of a known

239. When the defendant "knows" he is HIV-positive, his intent to infect his partner can be inferred from his engaging in sexual relations while knowing he is infected. See State v. Lankford, 102 A. 63, 64 (Del. 1917) (inferring intent of husband to communicate syphilis to his wife from the "actual results" of engaging in sexual relations while infected). Additionally, the affirmative defenses of contributory negligence and assumption of the risk do not apply to intentional torts. See generally PROSSER ON TORTS, supra note 94, § 65, at 451 (characterizing contributory negligence and assumption of the risk as defenses to negligence actions). If the defendant "knows" he is HIV-positive, causation also will be easier to establish. Since the defendant was HIV-positive at the time of the sexual contact, the plaintiff should be able to show that the defendant was capable of infecting the plaintiff.

240. See PROSSER ON TORTS, supra note 94, § 68, at 482-86 (distinguishing express assumption of the risk from implied assumption of the risk).

241. Id. at 482.

242. See id. at 485 (stating that "by entering freely and voluntarily into any relation or situation where the negligence of the defendant is obvious" the plaintiff may be found to have impliedly assumed the risk of harm). Assumption of the risk results from "knowledge and acquiescence" to a known risk while contributory negligence consists of conduct that
risk is barred from recovery no matter how "reasonable" his conduct.\textsuperscript{243}

The express assumption of the risk is not likely to be relevant when the defendant does not "know" he is HIV-positive. An express assumption of the risk defense could arise if the plaintiff agrees to sexual relations with the defendant after the defendant discloses that he is infected.\textsuperscript{244} If the defendant does not know his HIV status, however, this disclosure would not be possible.\textsuperscript{245} Considering the prevalence of AIDS,\textsuperscript{246} a plaintiff who engages in sexual relations without knowledge of the defendant's HIV status may be held to have impliedly assumed the risk.\textsuperscript{247} The argument in favor of applying assumption of the risk is even stronger if: (1) the plaintiff never inquires about the defendant's HIV status,\textsuperscript{248} or (2) the plaintiff engages in sexual relations with the defendant despite knowledge of the defendant's high-risk activity.\textsuperscript{249}

Under this analysis, a plaintiff who engages in sexual relations without asking about a partner's HIV status and taking appropriate precautions would be barred from recovery. Generally, courts have avoided imposing a duty on plaintiffs in venere...
real disease cases; however, the courts could curb the rising social costs of AIDS by applying the assumption of the risk defense. The social costs of AIDS is already staggering. Further, the administrative costs of allowing the courts to be inundated with AIDS transmission cases may increase substantially these social costs.

Assumption of the risk also promotes the deterrence objectives of tort law by imposing a duty on would-be plaintiffs (uninfected sexual partners). By preventing recovery in AIDS transmission cases, assumption of the risk increases an unintended partner’s cost of engaging in high-risk activities. This increased cost might deter a would-be plaintiff from engaging in unsafe conduct, thereby, slowing the spread of AIDS. Unlike the venereal disease model, assumption of the risk, in theory, provides an incentive for all sexual partners to avoid spreading AIDS rather than only would-be defendants. As a corollary, social norms against conduct that contribute to the spread of AIDS are also reinforced.

While assumption of the risk would encourage plaintiffs to avoid contracting HIV in practice, this defense places the duty of care entirely on plaintiffs. Assumption of the risk would

250. See supra note 96 and accompanying text (discussing the courts’ reluctance to impose such a duty).
251. Cf. Shavell, supra note 138, at 28 (explaining that a liability rule reducing the total cost to a plaintiff of engaging in an activity may encourage plaintiffs to engage in the activity at a level that exceeds the societal optimum).
252. See supra notes 31-37 and accompanying text (examining the enormous strain AIDS has placed on the public health care system).
253. See Shavell, supra note 138, at 262-63 (stating that the administrative costs of litigation are so high that many estimates predict that the costs equal or exceed the amount received by victims). Since many AIDS victims are likely to be judgment-proof, the administrative costs to society may substantially exceed the compensation received by plaintiffs. The court system is already inundated with AIDS cases. See Braden, supra note 3, at 281 (noting that the courts have been faced with a “glut of AIDS-related filings and will soon be confronted with a staggering number of AIDS cases”). See also Hancock, supra note 3, at 8 (estimating that over 1500 AIDS-related cases are currently pending).
254. See supra notes 139-47 and accompanying text (explaining that imposing liability creates an incentive to take care).
255. The extent to which the assumption of the risk “overshifts” the burden of care explains why it has fallen out of favor in many jurisdictions. See Prosser on Torts, supra note 94, § 68, at 493-96 (discussing the trend of the courts to abolish the defense or absorb it into the comparative negligence system because it denies recovery to plaintiffs who should recover). The problem with assumption of the risk is that even when the plaintiff has taken reasonable steps to avoid contracting HIV, he would not be able to recover against a “grossly negligent” defendant. See id. at 495 (indicating that a defendant may assume the risk even where the defendant’s conduct is “willful, wanton, or reckless”). Thus, assumption of the risk is a mechanical rule that shifts the burden completely to the
not allow courts to balance the defendant's degree of culpability against that of the plaintiff.\textsuperscript{256} Ironically, assumption of the risk merely reverses the distribution of the duty under the venereal disease model. The venereal disease model permits plaintiffs to engage in repeated high-risk activity without being denied recovery. Conversely, assumption of the risk allows defendants to engage in repeated high-risk activities without exposure to liability. Thus, assumption of the risk swings the duty pendulum too far in the direction of plaintiffs and imposes no duty on would-be defendants to avoid spreading HIV.\textsuperscript{257} Moreover, assumption of the risk would create inequitable results because the "virgin plaintiff"\textsuperscript{258} would not recover even against a reckless defendant. So while assumption of the risk has some appeal, it rewards reckless conduct likely to contribute to the spread of AIDS.

B. Contributory Negligence

Contributory negligence is the failure to take the degree of care an ordinary prudent person would take to protect himself from an unreasonable risk of harm.\textsuperscript{259} Unlike assumption of the risk, a plaintiff is only contributorily negligent if the costs and benefits associated with his conduct would lead an ordinary prudent person to abstain.\textsuperscript{260} Thus, contributory negligence entails a balancing approach like that used in determining whether to impose a duty on defendants.\textsuperscript{261} A plaintiff who fails

\textsuperscript{256} See \textit{id.} at 494 (discussing the genuine hardships created by assumption of the risk and the defense's effect of removing the defendant's duty of care). Assumption of the risk also can inadvertently result in legally protecting the party who is primarily at fault. \textit{See id.} at 493 (discussing the tendency of assumption of the risk to deny recovery to a plaintiff who deserves to recover).

\textsuperscript{257} See \textit{Elber, supra} note 4, at 941 (arguing that the assumption of the risk may contribute to the spread of AIDS by granting immunity to defendants). \textit{But see Papelian, supra} note 4, at 677 (contending that plaintiffs should be held to assume the risk to curb the spread of AIDS because the risk of disease is as great as that of pregnancy).

\textsuperscript{258} This term is used to refer to a person who has never engaged in any high-risk activity including sexual contact with a partner exposed to high-risk activity.

\textsuperscript{259} \textit{Restatement (Second) Of Torts} § 463 (1977) (defining contributory negligence).

\textsuperscript{260} See \textit{Prosser On Torts, supra} note 94, § 65, at 453 (explaining that the contributory negligence standard involves the same reasonable person standard and cost-benefit analysis as ordinary negligence).

\textsuperscript{261} \textit{Id.}
to take the care an ordinary prudent person would take to avoid an unreasonable risk of harm is completely barred from recovery.\textsuperscript{262} Unlike assumption of the risk, contributory negligence would impose a duty on both sexual partners to avoid spreading HIV.\textsuperscript{263} Contributory negligence would allow the "virgin plaintiff" to recover against the "careless defendant."\textsuperscript{264} If the plaintiff takes reasonable precaution to avoid spreading HIV, he is not barred from recovery.\textsuperscript{265}

By imposing a duty on both partners, contributory negligence promotes a more socially optimal outcome than the traditional model or assumption of the risk. First, contributory negligence provides a more appropriate means of reinforcing social norms against unsafe conduct by imposing a duty on all sexual partners to take precautions. Contributory negligence also provides a better means of reinforcing these norms than assumption of the risk because plaintiffs who take precautions to avoid HIV are rewarded, and defendants who violate these norms do not easily escape liability.

Additionally, contributory negligence more effectively promotes corrective justice norms than assumption of the risk. A plaintiff who has taken reasonable precautions to protect his-

\begin{itemize}
\item \textsuperscript{262} Although contributory negligence is less rigid than assumption of the risk because only unreasonable conduct extinguishes the defendant's liability, contributory negligence, too, has a rigid mechanical impact once the plaintiff falls below the required standard of care. \textit{See generally} PROSSER ON TORTS, supra note 94, § 67, at 468-69 (discussing contributory negligence's effect of placing the entire burden of care on the plaintiff even when both parties are responsible for the harm). At that point, the defendant is relieved from any duty of care even if his conduct is far more negligent. \textit{See id.} at 469 (noting that the plaintiff is denied recovery even though the defendant's negligent conduct may have played an even greater role in causing the resulting harm). \textit{But see id.} § 65, at 462 (noting that recovery is not necessarily barred if the defendant's conduct rises to the level of "wanton" or "willful" negligence).
\item \textsuperscript{263} It should be noted that assumption of the risk completely eliminates the defendant's general duty to avoid the unreasonable risk of harm where the plaintiff voluntarily engages in the potentially harmful activity.
\item \textsuperscript{264} This term refers to a defendant who has engaged in intermittent high-risk activity without taking reasonable precautions to avoid contracting the HIV infection. The term is not intended to include what might be called "gross negligence" or "recklessness." The rationale for this limitation is that contributory negligence is not a defense to more aggravated forms of negligence referred to by courts as "willful, wanton, or reckless." \textit{See generally} PROSSER ON TORTS, supra note 94, § 65, at 462 (outlining the scope of the contributory negligence defense).
\item \textsuperscript{265} The nature of those precautions will be determined by the scope and magnitude of the risk balanced against the cost of taking care incurred by the plaintiff and society. \textit{See generally id.} at § 453-54 (discussing the factors the courts weigh when evaluating the reasonableness of a plaintiff's conduct).
\end{itemize}
self can recover against a careless defendant. In this scenario, the wrongdoer and not the infected party bears the loss. Corrective justice norms also would be carefully tailored to reward only those who have taken adequate precautions. This narrow tailoring is justified since society as a whole bears a disproportionate amount of the costs associated with the AIDS crisis.

Contributory negligence also promotes deterrence goals better than the venereal disease model or assumption of the risk. Contributory negligence does not entirely shift the burden of care to the plaintiff or defendant. Contributory negligence promotes deterrence goals by forcing both parties to take reasonable precautions to avoid the spread of AIDS. Thus, plaintiffs are not rewarded for conduct likely to spread AIDS, and defendants must take care not to act recklessly even if the plaintiff is negligent.

Although contributory negligence resolves the easy case of the “virgin plaintiff” and the “careless defendant,” the defense has significant shortcomings. First, the defense may not provide defendants with sufficient incentives to avoid high-risk activity.\footnote{266} Since the plaintiff is completely barred from recovery once he falls below the required standard of care, the defendant can be extremely careless and escape liability.\footnote{267} Thus, contributory negligence does not provide enough incentive to discourage conduct likely to spread AIDS.

Moreover, a plaintiff may fail to inquire about the defendant’s HIV status. The defendant could then engage in careless (though not reckless) conduct with immunity. This scenario is significant because contributory negligence requires setting an appropriate standard of care. The minimum conceivable standard of care would require plaintiffs to ask about their partners’ HIV status.\footnote{268} If a plaintiff does not even attempt to as-

\begin{footnotes}
\footnote{266. If the plaintiff is contributorily negligent, the defendant is immune from liability absent “wanton, willful, or reckless” conduct. See PROSSER ON TORTS, supra note 94, § 65, at 462. Thus, once the plaintiff has been negligent, the defendant has no incentive to take care. For example, a court may find a plaintiff who does not inquire about the HIV status of his partner contributorily negligent. The defendant could then engage in sexual relations without taking precautions such as using a condom or discussing his sexual history.}
\footnote{267. Id.}
\footnote{268. The duty to inquire about a partner’s HIV status would seem to be the least intrusive burden that could be imposed on the plaintiff. See Brigham, supra note 90, at 545 (characterizing the duty to say “I have AIDS” as a minimal burden on defendants in AIDS transmission cases).}
\end{footnotes}
IT TAKES TWO TO TANGO

Certain a partner's HIV status, the plaintiff's argument that he has taken minimum precautions to protect himself is unconvincing; however, the duty to ask about a partner's HIV status has a serious weakness as the standard of care. This standard of care would effectively shift the entire duty to the plaintiff. A plaintiff would be expected to inquire about the HIV status of a partner before engaging in sexual relations. If the plaintiff fails to ask about a partner's HIV status, the partner is relieved of the duty to take precautions. Viewed another way, if the plaintiff never inquires about his partner's HIV status, the defendant's duty is never triggered. Thus, while contributory negligence is superior both to the venereal disease model and assumption of the risk, this defense also fails to equitably allocate the burden of avoiding AIDS or to adequately promote tort objectives.

C. Comparative Negligence

Comparative negligence provides the most efficient rule because it entails balancing both the defendant's and plaintiff's conduct. Since the plaintiff is not entirely barred from recovery even if his own negligence contributes to his injury, the plaintiff does not bear the entire loss if the defendant has substantially contributed to the injury. Instead of barring the plaintiff's claim entirely, the plaintiff's recovery is reduced in proportion to his own contribution to his injury.

The majority of jurisdictions have shifted to this doctrine. Two benefits of comparative negligence may explain the doctrine's growing popularity. First, comparative negligence ameliorates the hardships associated with shifting the entire burden to the plaintiff in the first instance. Under this

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269. This is modified by the caveat noted above that contributory negligence is not a defense to more aggravated forms of negligence like "recklessness." See generally supra note 265 and accompanying text (discussing the factors the courts weigh when evaluating the reasonableness of a plaintiff's conduct).

270. See PROSSER ON TORTS, supra note 94, § 67, at 472 (explaining that "pure" comparative negligence reduces recovery in proportion to the fault of the plaintiff).

271. See id. at 468-69 (discussing the hardship created if the plaintiff bears the entire loss when the defendant is far more at fault).

272. See supra note 269 and accompanying text.

273. See PROSSER ON TORTS, supra note 94, § 67, at 471 (observing that over 40 states have already switched to comparative negligence by legislative or court action).

274. See id. at 468-69 (discussing the widespread view that contributory negligence unfairly imposes the entire loss on the plaintiff when both parties are responsible).
doctrine, the plaintiff's negligence does not give the defendant immunity to engage in unsafe conduct.\textsuperscript{275} Second, comparative negligence produces economically optimal outcomes.\textsuperscript{276} Because liability is assigned according to fault, both parties are forced to internalize the costs of their high-risk conduct. Theoretically, because the parties internalize these costs, neither over- or under-deterrence of the parties' conduct occurs.\textsuperscript{277} Thus, defendants will continue risky behavior only until the resulting damage award no longer makes continuing the behavior worth the costs. Similarly, plaintiffs will engage in high-risk conduct only if the benefits offset a potential reduction in recovery.

Comparative negligence provides several additional benefits. First, this doctrine provides the most equitable distribution of the duty of care in AIDS cases.\textsuperscript{278} All sexual partners can take precautions that are equally effective in avoiding spreading AIDS.\textsuperscript{279} Thus, recovery should be apportioned according to the degree of care taken by each of the parties.

Unlike contributory negligence and assumption of the risk, comparative negligence is not a rigid mechanical rule. A minor breach in the appropriate standard of care by a plaintiff does not cut off liability if the defendant is more at fault. Thus, a defendant is not rewarded for unsafe conduct, such as not wearing a condom, if the plaintiff fails to inquire about the defendant's HIV status.

Comparative negligence effectively reinforces social norms against unsafe conduct likely to spread AIDS. Comparative negligence's balancing approach directly apportions liability according to the parties' conformance with social norms against high-risk conduct. Comparative negligence also ideally serves corrective justice goals by directly adjusting the level of recovery according to the degree of fault.

\textsuperscript{275} See generally id. at 470-71 (describing comparative negligence as a system that apportions damages between the parties according to their degree of fault).

\textsuperscript{276} See Shavell, supra note 138, at 40 (noting that the defense of comparative negligence will yield optimal results because both parties will take the most efficient level of care).

\textsuperscript{277} See Sugarman, supra note 112, at 613-15 (explaining that the internalization of cost is believed to force the proper "activity level" by both parties).

\textsuperscript{278} Cf. Goldberg, supra note 45, at 90 (contending that because most people know about the risk of AIDS and how to avoid contracting AIDS, both sexual partners should take precautions).

\textsuperscript{279} See id.
Comparative negligence also provides the optimal rule for deterring conduct likely to spread AIDS. Again, recovery is directly tied to the degree of care taken by the parties to avoid the spread of HIV. Measures taken to reduce the spread of AIDS will yield proportional reductions in damage awards. Thus, there is no disincentive to avoid further precautions once a certain level of care is met. Theoretically, both parties will take additional precautions until their marginal utility from additional precautions does not exceed the costs of the precaution. Additionally, careless plaintiffs will be discouraged from bringing suits with the substantial transaction costs associated with the tort system. Yet incentives designed to deter more dangerous conduct by defendants would not be diluted.

If the minimum duty to avoid comparative negligence is the duty to inquire about high-risk conduct, then an optimal allocation of duty occurs. First, if a plaintiff does not inquire about a potential partner’s high-risk conduct, his degree of fault might be so substantial that recovery would be barred; however, the courts could still grant reduced recovery against extremely careless defendants or if the plaintiff takes other precautions to protect himself, such as using a condom.

Some plaintiffs may ask about the HIV status or sexual history of their partner, yet proceed in the face of an obvious risk. These plaintiffs would be barred unless their conduct was reasonable considering the defendants’ disclosure. For example, a defendant might disclose he did not know his HIV status but had engaged in sexual relations with several other partners. Given this disclosure, a plaintiff who engaged in sexual relations while using a condom should not be barred from recovery. The plaintiff would be rewarded for both inquiring about the sexual history of his partner and taking reasonable precautions based on that disclosure. Further, the defendant would be penalized for not taking any precautions.

This approach also would allow a more appropriate non-discriminatory use of “high-risk status.” A would-be defendant might disclose he is a member of a high-risk group. If a plain-

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280. See generally Latin, supra note 112, at 708 (noting that “legal doctrines must ensure that the creation of risk avoidance incentives for one type of party does not dilute incentives for the other party”).

281. See id. at 733 (explaining that the huge expense of the tort system is only warranted if liability achieves some corresponding increase in social utility).
tiff possessed such information, he might reasonably be expected to ask a partner about actual high-risk activity. Thus, no undue burden is placed on particular demographic groups simply because of their high-risk status. Both high-risk and non-high-risk groups would be expected to disclose only high-risk conduct. The only duty created by high-risk "status" would actually be imposed on the partner who is not a member of a high-risk group.

Finally, comparative negligence provides the best approach to balancing the conflicting values of privacy and trust and confidence in intimate relationships. Any creation of a duty in AIDS cases will entail some intrusion into the protected realm of intimate sexual relations. Because comparative negligence is less mechanical, the doctrine allows the parties to shape the nature of that intrusion. The only burden the state imposes on the right to privacy is the burden of acting reasonably toward one another. The parties themselves are permitted to structure their activities to meet this general standard. Admittedly, this approach may require would-be plaintiffs to assume that a potential partner may be infected with HIV. While the extent that litigants can rely on their partners to protect them from AIDS will be reduced, the high social costs of HIV infection justifies requiring a plaintiff to do more than merely assume a partner is HIV negative.

V. CONCLUSION

AIDS is an incurable fatal disease that is spreading at an epidemic rate. This epidemic already poses a significant drain on public health care funds. This financial crisis will only grow as the 1 to 1.5 million Americans who are currently infected with HIV, but may be asymptomatic, develop full-blown AIDS. Slowing the spread of AIDS must remain a national priority.

The tort system should be utilized to help curb this epidemic. In the past, the tort system has been used to deter the spread of other sexually transmitted diseases. The courts have been able to foster trust and confidence in intimate sexual relationships by rejecting affirmative defenses like contributory or comparative negligence and assumption of the risk. Promoting trust and confidence in intimate relationships has been viewed as more important than the slight marginal gain in deterrence
that might be reached by imposing a duty on both parties to a sexual relationship.

The costs associated with AIDS are far more substantial. Because AIDS is fatal and leaves most of those afflicted destitute, the traditional approach falls short in the AIDS context. Would-be defendants will generally be dependent on public funds. Neither the tort system’s compensation nor deterrence goals are served by only imposing a duty on would-be defendants. Further, because of the extensive social cost of AIDS, slowing its spread justifies requiring all sexual partners to take adequate precautions to avoid infection.

Contributory and comparative negligence provide an incentive to all sexual partners to take precautions to avoid spreading AIDS. The AIDS crisis has become too serious to merely allow would-be plaintiffs to proceed in “ignorant bliss,” because it is the public that will ultimately bear the cost of health care and litigation.