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AIDS: Malpractice and Transmission Liability

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I. INTRODUCTION

Before the discovery of the Human Immunodeficiency Virus (HIV),[1] the incubation period for Acquired Immune Deficiency Syndrome (AIDS) was estimated at approximately fifteen to eighteen months; more recently, estimates of the incubation period have been extended up to five years or more.[2] Like the individual exposed to the AIDS virus who must live with the possibility of developing AIDS for an extended but indefinite period of time, the legal system must anticipate the generation of a plethora of law suits over the next decade, the bases for which have already been established as a result of the transmission of the AIDS virus. Torts is one of the principal areas of litigation which will involve AIDS.

II. DIAGNOSIS, TREATMENT AND MALPRACTICE

AIDS is an impairment of the human body's natural immune system of defense against disease that renders a person vulnerable to infections and various illnesses. The damage to the immune system results primarily from the destruction of certain crucial white blood cells — known as T lymphocytes — as a consequence of the infection with HIV.[3] AIDS is an acquired condition rather than an inherited one, and it is a syndrome in that it is constituted by a number of symptoms and conditions which characterize the disorder. Persons with

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1. The virus which has been identified as causing damage to the immune system, and thus AIDS, has been named differently by various researchers. There is a growing consensus to identify the virus by the name "human immunodeficiency virus," or HIV. It is also known as human T-cell lymphotropic virus type III (HTLV-III), lymphadenopathy-associated virus (LAV), and AIDS-associated retrovirus (ARV). *See* INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES, CONFRONTING AIDS: DIRECTIONS FOR PUBLIC HEALTH, HEALTH CARE, AND RESEARCH 5-6 (1986).

2. AIDS: ETIOLOGY, DIAGNOSIS, TREATMENT AND PREVENTION 22 (V. DeVita, S. Hellman & S. Rosenberg eds. 1985).

3. *See* Allen & Curran, *Epidemiology of the Acquired Immunodeficiency Syndrome*, in ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) 4 (J. Gallin & A. Fauci eds. 1985).

AIDS are susceptible to contracting a number of diseases and opportunistic disorders caused by organisms commonly found in the environment but which are not harmful to a person whose immune system is functioning properly.[4] The early symptoms of AIDS include enlarged lymph nodes or swollen glands in the neck, groin and armpits, fatigue, loss of appetite, fever, night sweats, diarrhea, weight loss, persistent coughs, and various skin lesions.[5] Fifty-two percent of AIDS patients develop a pneumonia caused by the protozoan *pneumocystis carinii*, and approximately thirty-seven percent develop a skin cancer, Kaposi's sarcoma, or one of many other opportunistic infections such as cytomegalovirus, toxoplasma, or herpes simplex.[6]

A. Diagnosis and Treatment

The diagnosis of AIDS is difficult because there is no simple, reliable test for the disease. The ELISA (enzyme-linked immunosorbent assay), which is the blood screening test for the AIDS virus, is not a diagnostic test.[7] It merely detects the presence of antibodies, indicating that an individual has been exposed to the HIV thought to cause AIDS.[8]

The ELISA test is extremely sensitive and often registers positive results when no antibodies are present.[9] While the low incidence of false negative results makes the ELISA test an effective blood screening test, its extreme sensitivity renders it unreliable as a diagnostic tool. Furthermore, it is generally agreed that the ELISA test does not determine who will develop AIDS.

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4. *See generally* AIDS: THE EPIDEMIC OF KAPOSI'S SARCOMA AND OPPORTUNISTIC INFECTIONS (A. Friedman-Klien & L. Laubenstein eds. 1984).

5. *See* Weber & Pinching, *The Clinical Management of AIDS and HTLV-III Infection*, in THE MANAGEMENT OF AIDS PATIENTS 1 (D. Miller ed. 1985).

6. *See* Greene & Slepian, *A Clinical Approach to Opportunistic Infections Complicating the Acquired Immune Deficiency Syndrome*, in AIDS: THE EPIDEMIC OF KAPOSI'S SARCOMA AND OPPORTUNISTIC INFECTIONS, *supra* note 4, at 89; Gallo, Shaw & Markham, *The Etiology of AIDS*, in AIDS: ETIOLOGY, DIAGNOSIS, TREATMENT AND PREVENTION, *supra* note 2, at 43; AIDS: ETIOLOGY, DIAGNOSIS, TREATMENT AND PREVENTION, *supra* note 2, at 5 ("The term AIDS should be reserved for a person with at least one life-threatening opportunistic infection or Kaposi's sarcoma.").

7. The enzyme-linked immunosorbent assay (ELISA) begins with a plastic sheet covered with an extremely thin layer of virus proteins. These proteins are obtained by purifying inactivated virus grown in tissue culture. Serum from a prospective donor is added to that system and chemicals are added to produce a color reaction. The presence of antibodies is read with a spectrophotometer and graded to indicate the strength of any positive result. *See generally Sharper Tests for AIDS*, NEW SCIENTIST, May 2, 1985, at 23.

8. *Education and Foster Care of Children Infected with Human T-Lymphotropic Virus Type III/Lymphadenopathy—Associated Virus*, 33 MORBIDITY & MORTALITY WEEKLY REP. 517, 517-21 (1984).

9. *See generally* Petricciani, *Licensed Test for Antibody to Human T-Lymphotropic Virus Type III: Sensitivity and Specificity*, 103 ANNALS OF INTERNAL MED. 726 (1985).

The currently accepted method to diagnose the presence of AIDS antibodies is to conduct two successive ELISA tests. When both ELISA tests are positive, a Western Blot test is used to confirm the presence of antibodies: the Western Blot test identifies antibodies to proteins of a specific molecular weight.[10] While the Western Blot test is more reliable than the ELISA test, so that it is less likely to register a false positive result, it likewise is not a test for the HIV virus; it also tests for presence of antibodies to the virus.[11] One way of confirming an AIDS diagnosis is to follow the series of antibody tests with a T-cell test.[12] The T-cell test measures the ratio of a person's two types of T-cell lymphocytes, which provide cell-mediated immunity and are effective against intracellular bacteria, viruses, and fungi.[13] The combination of two successive positive ELISA tests and a Western Blot test, along with low T-cell levels, indicates that the HIV virus is present and is destroying the immune system mechanism.

Alternatively, AIDS is diagnosed by the presence of characteristic opportunistic or underlying diseases that indicate reduced T-cell levels. For example, a skin sample is taken from persons suspected to be suffering from Kaposi's sarcoma, and the affected area is examined microscopically for evidence of the cancer; similarly, in diagnosing *pneumocystis carinii* pneumonia, material obtained from the lung is examined for the suspected virus.[14] A diagnosis of AIDS is appropriate where there is a defect in cell-mediated immunity occurring in a person suffering from opportunistic infections with no known independent cause for diminished resistance to such diseases. Both Kaposi's sarcoma and *pneumocystis carinii* pneumonia are examples of

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10. The term "Western Blot" refers to a technique for identifying antibodies of specific molecular weight. The technique allows the identification of antibodies to specific proteins associated with HIV. *See* DIRECTOR, OFFICE OF BIOLOGICS RESEARCH AND REVIEW, PUBLIC HEALTH SERVICE, TO REGISTERED BLOOD ESTABLISHMENTS (1985). The Western Blot test is more expensive than the ELISA ($100 compared to $2-3) and technically more difficult. *See* M. WITT, AIDS AND PATIENT MANAGEMENT 7 (1986).

11. Levine & Bayer, *Screening Blood: Public Health and Medical Certainty*, HASTINGS CENTER REPORT, Special Supplement, August 1985, at 8-11.

12. One of the most significant features of AIDS is peripheral blood lymphopenia with total lymphocyte counts of less than 500/mm. That quantitative deficit of lymphocytes is due primarily to a loss of T4+ lymphocytes which bear the helper/inducer phenotype. The decrease in absolute numbers of T4+ lymphocytes is accompanied by profound abnormalities in both *in vivo* and *in vitro* lymphocyte function. P. EBBESEN, AIDS: A BASIC GUIDE FOR CLINICIANS 140 (1984).

13. *See* Friedland, *Lack of Transmission of HTLV-III/LAV Infection to Household Contacts of Patients with AIDS or AIDS-related Complex with Oral Candidiasis*, 314 NEW ENG. J. MED. 344 (1986), setting out a standard for laboratory evaluation of AIDS including complete blood count and measurement of immunoglobulin, T-cell subsets, and antibodies to HTLV-III/LAV by enzyme immunoassay.

14. Marsh, Gong & Shindler, *Questions and Answers about AIDS*, in UNDERSTANDING AIDS: A COMPREHENSIVE GUIDE 194 (V. Gong ed. 1985).

opportunistic diseases whose occurrence may suggest a diagnosis of AIDS.

At present there is no known cure for AIDS, but medical researchers agree that an aggressive clinical approach needs to be taken against the recurrent, severe and multiple opportunistic diseases that mark the course of AIDS.[15] In addition, there are several possible treatments for patients with pre-AIDS, or AIDS related complex (ARC). The infection in its early stages may be susceptible either to treatment with antibodies directed against the envelope components of HIV or to antiviral chemotherapy with such compounds as Suramin. It may also be possible to avoid widespread infection or to reduce the effects of the primary infection using viral interference by another virus, such as a noncytopathic virus, to prevent the infection of critical target cells by HIV.[16] Some treatments otherwise indicated may be inappropriate: one medical researcher has suggested that broad antibiotic coverage should be discouraged in the treatment of opportunistic infections in AIDS patients, while monotherapy may diminish the chances of superinfection with resistant microbes.[17]

Finally, the AIDS victim who is informed of the diagnosis in the early stages of the disease may undertake a variety of measures to reduce or to retard the effects of the disease. Special hygienic measures may be taken to decrease the chance of contracting opportunistic infections, and the effects of opportunistic infections may be limited with appropriate treatment.[18]

B. The Diagnosis of AIDS and Malpractice

Problems related to the diagnosis of AIDS may give rise to a cause of action for medical malpractice in several ways, including a failure to diagnose AIDS, an erroneous diagnosis, a failure to inform the patient of the diagnosis, and a failure to provide proper counseling related to an HIV antibody test. Such malpractice may give a right of redress to the AIDS victim who was misdiagnosed, to an infant born with AIDS whose parents were misdiagnosed, or to persons who contracted AIDS from a victim who was misdiagnosed.

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15. Roberts, *Treatment of Opportunistic Infections in Patients with Acquired Immune Deficiency Syndrome (AIDS)*, in THE ACQUIRED IMMUNE DEFICIENCY SYNDROME AND INFECTIONS OF HOMOSEXUAL MEN 314 (P. Ma & D. Armstrong eds. 1984).

16. AIDS: ETIOLOGY, DIAGNOSIS, TREATMENT AND PREVENTION, *supra* note 8 at 78-79.

17. Roberts, *Treatment of Opportunistic Infections in Patients with Acquired Immune Deficiency Syndrome (AIDS)*, in THE ACQUIRED IMMUNE DEFICIENCY SYNDROME AND INFECTIONS OF HOMOSEXUAL MEN, *supra* note 26 at 314-15.

18. *See generally* Cuff, *Caring for the AIDS Patient*, in UNDERSTANDING AIDS: A COMPREHENSIVE GUIDE, *supra* note 25, at 150.

1. Misdiagnosis

The failure to diagnose AIDS may cause a delay in or failure to obtain necessary treatment, which in turn results in an aggravated condition, acceleration in the course of the disease, and the premature death of the patient. Even worse, a misdiagnosis may lead to the prescription of an erroneous course of treatment with resultant injuries. Finally, an improper diagnosis may give rise to a cause of action for emotional distress.

Diagnostic testing is an important tool in proper medical practice because it may provide important clinical information or may indicate the need for additional tests. The failure to order additional testing where appropriate may in itself constitute malpractice.[19] In the AIDS context, the failure to employ the proper antibody and blood tests available for making a proper diagnosis may result in liability.

The proper characterization of the damage that a misdiagnosis causes is an important step in assessing the potential liability of a negligent physician. An AIDS victim is destined ultimately to succumb to the opportunistic diseases that flourish in the patient's weakened body, and early diagnosis and treatment will merely delay the victim's untimely death. Even though the victim eventually would die whether or not the diagnosis was timely, the misdiagnosis aggravates the victim's condition by delaying appropriate treatment.

To the extent that a failure to timely diagnose AIDS delays treatment, accelerates the course of the disease and shortens the victim's life, the delay causes a compensable harm.[20] For example, a patient timely diagnosed as having AIDS and suffering from opportunistic infection of *pneumocystis carinii* pneumonia may seek treatment with the drug azidothymidine (AZT), which slows the attack of AIDS.[21] The significance of an early and proper diagnosis is clear in such cases because AZT has been made available only to those patients diagnosed

19. *See, e.g.*, Kupersmith v. Vosburgh, 38 A.D.2d 555, 328 N.Y.S.2d 300 (1971) (failure to take blood cultures, thus preventing identification of organisms and resulting in failure to treat condition effectively with antibiotics); Price v. Neyland, 320 F.2d 674 (D.C. Cir. 1963) (physician liable for malpractice for error in diganosis and treatment of child born of parents with Rh factor blood incompatibility).

20. *See, e.g.*, Trapp v. Metz, 28 N.Y.2d 913, 271 N.E.2d 697, 323 N.Y.S.2d 166 (1971) (negligence in diagnosis caused two-year delay in surgery for cancer); Chester v. United States, 403 F. Supp. 458 (W.D. Pa. 1975), *aff'd*, 546 F.2d 415 (3d Cir. 1976) (physician's negligence in failure to order cancer tests delayed treatment, permitting premature metastasis and death); Van Vleet v. Pfeifle, 289 N.W.2d 781 (N.D. 1980) (negligence of physician in failing to diagnose cancerous condition, thereby hastening disease and causing death prematurely, is basis for malpractice action notwithstanding evidence that cancer would eventually have resulted in decedent's death even if discovered sooner.)

21. *See Burroughs Wellcome's AZT to be Standard Drug for AIDS Patients Who Have Had Pneumocystis Carinii Pneumonia: Four Month Mortality Results and Placebo Trials*, 48 THE PINK SHEET 3 (1986).

with *pneumocystis carinii* who have experienced only one attack of the pneumonia.[22] With early diagnosis and appropriate drug therapy, about ninety percent of AIDS patients with *pneumocystis carinii* pneumonia survive their first episode of the disease.[23] Perhaps the most significant benefit of an accurate diagnosis is the patient's ability to take measures to reduce exposure to other infections that may activate the T4 cells, enhance virus replication, and damage the immune system to the point of immunodeficiency.[24] As treatment protocols develop, and particularly as they are directed at early stages of the disease, greater liability will arise on the part of the physician who fails to diagnose the presence of the disease, with the result that early treatment is not obtained when such treatment is likely to have its most beneficial effect in restoring the immune system.

Similarly, any cure for AIDS developed in the near future probably will require crucial intervention or treatment during the early stages of the disease to be effective. The effectiveness of the treatment will decrease—and the severity of opportunistic diseases increase—to the extent that a misdiagnosis delays its application. The harm the patient suffers in such a case is the loss of a chance of recovering from the underlying disease. While that loss may not be compensable in some jurisdictions, courts are now more frequently recognizing such losses as actionable.[25]

Finally, a failure to diagnose AIDS may give rise to a cause of action for negligent infliction of emotional distress when a subsequent correct diagnosis is made and the patient learns that needed treatment has been delayed.[26] In addition, an incorrect positive diagnosis of AIDS conveyed to the patient without proper counseling may cause severe, disabling emotional distress.[27] If a false diagnosis should trig-

22. Moreover, the identification of the harm as an aggravation of the patient's preexisting condition has an important procedural consequence. In some jurisdictions, once the plaintiff proves that the defendant caused the aggravation, the defendant is liable for all of the plaintiff's harm unless the defendant can allocate the harm between that caused by his negligence and that caused by the original condition. *See, e.g.*, Stephens v. Koch, 192 Colo. 531, 561 P.2d 333 (1977).

23. *See* INSTITUTE OF MEDICINE OF NATIONAL ACADEMY OF SCIENCES, MOBILIZING AGAINST AIDS 46 (1986).

24. *See* THE MANAGEMENT OF AIDS PATIENTS, *supra* note 5, at 51.

25. *See, e.g.*, Mays v. United States, 608 F. Supp. 1476 (D. Colo. 1985) (discussing and adopting case law permitting damages for "lost chance" of recovery). *See also* King, *Causation, Valuation, and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences*, 90 YALE L.J. 1353 (1981).

26. *See, e.g.*, MacMahon v. Nelson, 39 Colo. App. 355, 568 P.2d 90 (1977) (emotional distress by cancer victim actionable upon learning that removal of growth had been delayed for eight months due to misdiagnosis).

27. *See generally* S. NICHOLS & D. OSTROW, PSYCHIATRIC IMPLICATIONS OF ACQUIRED IMMUNE DEFICIENCY SYNDROME 49-60 (1984). *See also* Morin, *The Psychological Impact of AIDS on Gay Men*, 39 AM. PSYCHOLOGIST 1288, 1291 (1984), in which it is reported that:

ger a response of "AIDS anxiety" with debilitating effects on a patient, the physician whose negligence resulted in the erroneous diagnosis of AIDS may be liable. Further damages—apart from the emotional distress itself—may include the cost of necessary psychological therapy or counseling and even the loss of income to the extent that the psychological damage impaired the victim's ability to work.[28]

A false or erroneous diagnosis may have other effects which provide a basis for recovery. The use of the HIV antibody test as a screening device for employment creates a distinct possibility of litigation based on an erroneous diagnostic report when the screening is limited to a single ELISA test. It is recognized that the test results in a high level of false positive results, and the incidence of false positives increases if the test is performed on non-high risk groups.[29] Moreover, the available tests only determine the presence of antibodies to the HIV virus, and not the presence of the virus itself. As in the case of false tuberculosis diagnosis, a person reported erroneously as evidencing the presence of HIV antibodies should have a cause of action where employment or legal other interests were compromised by the report of a false diagnosis.

2. Failure to Inform or to Counsel

Because a physician's failure to inform the patient that the patient has AIDS causes exactly the same harm as a failure to diagnose AIDS—it deprives the patient of an opportunity to obtain treatment—that failure to inform is also actionable.[30] A more difficult question

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Since the onset of AIDS in the gay community some asymptomatic gay men have begun to manifest acute psychological symptoms that include panic attacks, generalized anxiety, and persistent hypochondriasis characterized by somatic reactions that mimic AIDS symptoms such as night sweats and fatigue. . . . Many cases of AIDS related anxiety states are so severe as to cause impairment in social and occupational functioning. Obsessive thoughts and fears about AIDS intrude on people at inopportune moments, causing problems in concentration on the job or at home. Panic attacks sometimes result in poor occupation performance, loss of work time, strained friendships and primary partner relationships, and repeated visits to emergency rooms, AIDS screening clinics, and the offices of mental health professionals.

28. Whether an action which alleges only psychic injury—with no physical manifestations—will survive is questionable. In a New York case, the court found the doctor not negligent, but added in dicta that for public policy reasons an award for mere psychic damage "should be confined to gross negligence and is not warranted if the information is well-founded, not capricious, and does not induce harmful therapy." It may, however, constitute gross negligence not to counsel a patient properly or to fail to confirm an initial diagnosis with appropriate testing, especially given the foreseeable shock associated with informing a patient of the diagnosis. Kraus v. Spielberg, 37 Misc. 2d 29, 32, 236 N.Y.S.2d 143, 146 (1962).

29. *See generally* Petricciani, *supra* note 9.

30. *See, e.g.*, Dowling v. Mutual Life Ins. Co., 168 So. 2d 687 (La. Ct. App. 1964) (liability for failure to notify plaintiff that he had tuberculosis); Hoover v. Williamson, 236 Md. 250, 203 A.2d 861 (1964) (failure to notify patient that he had silicosis); James v. United States, 483 F. Supp. 581 (N.D.Cal. 1980) (failure to inform patient of suspected tumor).

concerning duty arises when the tests are administered for an ancillary purpose such as blood donor screening, pre-employment health testing, or insurance coverage examinations. In those sorts of cases, it is not clear that the physician-patient relationship exists so as to create a duty on the part of the physician to warn the patient of positive test results.[31] Moreover, since the ELISA is used merely as a screening test and not as a diagnostic test, a positive result suggests only that the patient should seek further testing, and the failure to inform the patient of a positive test result is not the same as failing to inform him of a diagnosis.

The possibility of traumatizing the patient and the fact that the ELISA does not diagnose AIDS may suggest that courts should not impose a duty on physicians to report positive ELISA results when the test is used for an ancillary purpose.[32] Nonetheless, the potential harm to the patient of failing to be apprised of the result and his consequential failure to seek diagnosis and treatment for his condition greatly outweighs the likelihood and harm of traumatization. In addition, the latter can be reduced greatly with proper counseling concerning the test results.[33] As a consequence, the testing of blood for AIDS in any context should create a duty on the part of the tester to inform the patient of a positive result.

The report of a positive antibody test has produced depression in persons to the point of causing some to commit suicide.[34] Especially in light of the high rate of false positive ELISA results, the failure of a

31. *Compare* Beadling v. Sirotta, 41 N.J. 555, 197 A.2d 857 (1964) (in *dicta* the court stated: "Even where chest x-rays are made and read in the course of mass tubercular surveys, for the benefit primarily of the examinee, it is doubtful that the same duty would be owed to the examinee as in the case of a private consultation at the patient's request") and Keene v. Wiggins, 69 C.A.3d 308, 138 Cal. Rptr. 3 (1977) (physician examining workmen's compensation claimant for Industrial Commission had not entered into physician-patient relationship and hence did not breach any duty in mistakenly determining that the subject's archanoditis was not amenable to surgery) *with James, supra* note 39 at 585 (duty of reasonable care to preemployment examinee breached by failure to inform him of suspected tumor), Coffee v. McDonnell Douglas Corp., 8 C.A.3d. 551 (1972) (plaintiff recovered for physician's failure to diagnose myeloma in preemployment physical where diagnosis and treatment would have lengthened plaintiff's life) *and* Betesh v. United States, 400 F. Supp. 238 (D.D.C. 1974) (plaintiff who underwent preinduction physical recovered for physician's failure to inform him of diagnosis of Hodgkin's disease which could have been treated).

32. In fact, physicians disagree as to whether blood donors should be informed of positive ELISA results. Curran, *AIDS Research and "The Window of Opportunity"*, 312 NEW ENG. J. MED. 903, 904 (1985). Some suggest that the requiring of reports to donors would encourage donors in high risk categories to capitalize on the opportunity to have a free screening, and as a consequence the incidence of false negative results would rise, and in turn increase the chance that a blood recipient would contract AIDS.

33. *See infra* note 35 and accompanying text.

34. ILLINOIS AIDS INTERDISCIPLINARY ADVISORY COUNCIL PRELIMINARY REPORT, THE CHALLENGE OF AIDS: THE ILLINOIS RESPONSE 3 (reporting that positive tests have led to depression and suicide in Illinois).

physician to provide full information about the nature of the test and the meaning of the test results could give rise to a suit in negligence. It is important, therefore, that a physician administering the antibody test and reporting its results provide appropriate counseling to the person being tested. Patients should be informed that the test is designed only to detect antibodies showing exposure to HIV and that the antibody test does not indicate whether a person will develop AIDS in the future or will remain healthy; that it is not a test for AIDS or any related disease; that it is not a test that indicates that one is protected against or immune to HIV and is therefore in no danger of getting AIDS or a related disease; and that it is not a test that indicates whether there is a risk that one may pass the HIV virus on to others.

Similarly, a doctor should never administer an HIV antibody test without the informed consent of the patient. A positive test may create psychological distress, create a basis for discrimination, result in job discrimination, and affect the availability of health and life insurance to a person. A patient cannot reasonably judge whether to submit to an antibody test unless he understands the nature of the test, the significance of its results, and the possible effects of a record of a positive test.[35] Further, a doctor may be liable in damages if a test is administered without consent where its results are obtained by others and used in a way that adversely affects the interests of the patient. When reporting the results to the patient or obtaining the patient's consent, then, the doctor should counsel as follows:

Positive Test Result: A doctor should warn the patient that based on present knowledge a positive test result probably means 1) that one has been exposed to the HIV virus, and consequently that one has been infected at some time in the past but has now recovered, and is no longer in danger either of developing AIDS or of passing the virus to other people; or 2) that one is currently infected,and may transmit the virus or may come down with AIDS, or a related disease, at some unknown time in the future; or 3) that one has never been exposed to the virus since there is a possibility of a false positive test result.

Negative Test Result: the doctor should counsel that either 1) one was never infected and is in no danger of either coming down with AIDS or of passing the virus on to other people; or 2) one is currently infected with the HIV virus which is in an incubation period and that one may be able to pass the virus on to other people and may later

35. In addition, a physician must explain the potential consequences of the patient's *refusal* to submit to an antibody test after exhibiting symptoms of AIDS or to further testing following a positive result. Truman v. Thomas, 27 Cal.3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (1980), *noted in* Note, Truman v. Thomas: *Informed Refusal in Simple Diagnostic Testing*, 14 U.C. DAVIS L. REV. 801 (1982).

develop AIDS; or that 3) one is among the number of persons with AIDS who has had a false negative test result.

3. Liability to Third Parties for Misdiagnosis

As of September 1986, 345 AIDS patients in the United States were under 13 years of age. Most of those patients (79%) are children whose mothers probably are infected with the virus.[36] The Centers for Disease Control (CDC) have issued recommendations for counseling and, when indicated, testing for antibody to HIV for women who are at increased risk of acquiring the virus and who are either pregnant or may become pregnant.[37] Such counseling is recommended so that infected women can choose to delay pregnancy until more is known about perinatal transmission, and so that already pregnant, infected women can make informed choices about their pregnancy.

Perinatal transmission of HIV from infected women to fetuses or offspring is thought to occur during pregnancy, during labor and delivery, or perhaps shortly after birth. Although the rate of perinatal transmission of HIV virus from infected pregnant women is not known, the available data suggest a high rate of transmission. The CDC have suggested that counseling and testing for the antibody to HIV to reduce perinatal transmission of AIDS is most beneficial to women who show evidence of HIV infection, women who use non-medical drugs intravenously, women who engage in prostitution, and women who are sexual partners of men at high risk or known to be infected with the virus.

Given the high risk of perinatal transmission, the failure to inform a pregnant woman at risk of the possibility of an antibody test, of the significance of a positive test result, and of the possible resultant impairment of a child born to an infected mother will give rise to an action for wrongful birth where an impaired child is born and the mother would have terminated the pregnancy if she had been properly informed.

Increasingly courts recognize a cause of action for acts or omissions which result in an unwanted child on a theory of wrongful birth. The defendant physicians in these cases are charged with negligence in failing to diagnose AIDS or to inform parents that the child might be born deformed or impaired as the result of a disease contracted by the

36. *Immunization of Children Infected with T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus*, 35 MORBIDITY & MORTALITY WEEKLY REP. 595 (1986).

37. *Recommendations for Assisting in the Prevention of Perinatal Transmission of Human T-Lymphotropic Virus Type III/Lymphadenopathy—Associated Virus and Acquired Immunodeficiency Syndrome*, 34 MORBIDITY & MORTALITY WEEKLY REP. 721 (1985).

mother in time to permit the termination of the pregnancy.[38] In a case of wrongful birth, damages are not sought on behalf of the infant, but rather by the parents for extraordinary pecuniary expenses, particularly medical expenses, required for the rearing of the child.[39] Parents suing for damages resulting from the birth of an impaired child have been granted recovery for pecuniary losses attributable to the child's condition[40] and damages for their own emotional distress.[41]

In most states, physicians, hospitals and laboratories are required by statute to report communicable diseases such as AIDS.[42] These statutes set fines and jail terms as sanctions for failure to report such communicable venereal diseases. Persons who have contracted communicable diseases (and in some cases their estates), and who have established a failure to report on the part of a physician or health care provider have recovered damages as a result of their illness or death.[43] The California Court of Appeals in 1975 recognized the right of a person to sue a hospital for its failure to report a communicable disease to the public health authorities after the plaintiff contracted a staphylococcal infection from a neighbor.[44] Such an action requires the establishment of a causal connection between the failure to file a required report of a diagnosis of a communicable disease and the contraction of the disease by the plaintiff, and it may often be difficult to establish that causal relationship.

Nonetheless, the failure of a physician or health care provider to report a diagnosis of AIDS may create liability to third persons where it can be shown that the filing of such a required report would have led a person to obtain medical treatment which would have decreased pain and suffering and possibly prolonged the person's life. A case for

38. *See, e.g.*, Robak v. United States, 658 F.2d 471 (7th Cir. 1981) (failure to inform maternity patient that she had contracted rubella, and that it may severely affect the fetus, creates liability for wrongful birth when child is born with incapacitating birth defect).

39. *See, e.g.*, DiNatale v. Lieberman, 409 So. 2d 512 (Fla. Dist. Ct. App. 1982) (negligence of physician or laboratory in failing to properly diagnose and inform parents of the impending birth of a defective child and thus depriving them of the choice to terminate the pregnancy will give rise to damages for extraordinary expenses of raising the child).

40. *See, e.g.*, Becker v. Schwartz, 46 N.Y.2d 401, 386 N.E.2d 807, 413 N.Y.S.2d 895 (1978) (allowing damages for pecuniary losses arising from physician's failure to inform parents accurately of risk involved in pregnancy arising out of hereditary diseases of Down's Syndrome and polycystic kidney disease).

41. Berman v. Allan, 80 N.J. 421, 404 A.2d 8 (1979) (permitting damages for emotional distress where child was born with birth defects and physician had failed to warn of the possibility of such defects).

42. *See, e.g.*, ALA. CODE § 22-11-4 (1981); CONN. PUB. HEALTH CODE §§ 19a-216 (1983); N.Y. PUB. HEALTH LAW § 2306 (McKinney 1980).

43. *See, e.g.*, Davis v. Rodman, 147 Ark. 385, 227 S.W. 612 (1921); Jones v. Stanko, 118 Ohio St. 147, 160 N.E. 456 (Ohio 1928).

44. Derrick v. Ontario Community Hospital, 47 Cal. App. 3d 145, 120 Cal. Rptr. 566 (1975).

liability may be especially strong where state law or public health regulation provides for "contact tracing" of sexual partners of persons diagnosed as having AIDS.[45] Such "contact tracing" permits health authorities to provide information about available medical care and proper personal health care to persons who may have been exposed to HIV by a person diagnosed as having AIDS. That information can lead the sexual partners of AIDS victims to obtain care and thereby decrease the likelihood of full development of AIDS by the person contacted. The failure to file a required report of an AIDS diagnosis makes it impossible for public health authorities to provide such assistance and information through contact tracing, and in turn may prevent a person exposed to HIV from seeking appropriate medical care or adopting personal behavioral practices which will decrease the likelihood of full development of AIDS or prevent transmission of the virus to noninfected persons.

A physician generally may warn a patient's family that there is a possibility that those in contact with the patient might contract the disease. Such a privilege to warn has specifically been recognized in early cases of sexually transmitted diseases such as syphilis,[46] and the physician may proceed to warn and counsel at least the spouse of the patient without liability for violation of the patient's right of confidentiality.[47] Whether a physician has a *duty* to warn is not clear, but such a duty may arise when a patient indicates his intention to engage in sexual activity with a particular person which makes transmission of the disease likely.[48] If a physician provides counseling about safe sexual practices to a patient diagnosed as having AIDS and the patient indicates his intention to adopt practices which minimize the risk of transmission of AIDS, the physician has probably fulfilled whatever responsibility he may have.

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45. The Colorado State Health Department has adopted a regulation requiring the reporting of individuals whose antibody tests are positive; reports are to include the person's name, age, sex and address, the name and address of the responsible physician, and such other information as is needed to locate the patient for follow-up. The director of the state's sexually transmitted disease program has indicated that if personnel time permitted, the department might undertake tracing of the sexual contacts of those persons who test positive. *See* 1 AIDS POL'Y & LAW 6 (1986).

46. *See, e.g.*, Simonsen v. Swenson, 104 Neb. 224, 177 N.W. 831 (1920).

47. Tooley v. Provident and Accident Life Insurance Co., 154 So. 2d 617 (La. 1963); Curry v. Corn, 52 Misc. 2d 1035, 277 N.Y.2d 470 (1966). *Tooley* and *Curry* relied in part on the marital relationship between the patient and the person informed, so it is not clear whether a physician may freely inform a non-spouse sexual partner. The serious consequences of AIDS suggest that physicians should have such a privilege, if indeed not a duty.

48. *See, e.g.*, Tarasoff v. Regents of the University of California, 551 P.2d 334, 131 Cal. Rptr. 14 (1976) (holding a psychologist liable for failure to warn murder victim whom patient stated intention to kill).

III. LIABILITY FOR TRANSMISSION OF AIDS

A. Transmission of AIDS

HIV has been detected in most bodily fluids including semen, blood, saliva, urine, feces, breastmilk, tears, spinal fluid, and vaginal and cervical secretions as well as in lymph nodes and in bone marrow.[49] Studies reveal that it is unlikely that the virus can be transmitted by saliva or tears. Only semen and blood have proven to be effective transmitters. Semen or blood may transmit the virus in four ways: (1) transfusion of infected blood or blood products, (2) shared use of needles by intravenous drug users, (3) childbirth to an infected mother, and, most commonly, (4) sexual intercourse.[50] Before examining the possible causes of action that may arise in relation to each of the principal modes of transmission, the special case of potential liability in the health care context will be examined.

B. Transmission of AIDS in the Health Care Context

The AIDS virus can be spread when infected fluids or materials come into contact with open sores, cuts, or lesions, which would appear to put health care workers at risk. Since 1983 the CDC have monitored groups of health care workers who have had direct exposure to contaminated blood and other fluids through needle sticks, cuts with infected instruments, and contamination of mucuous membranes and open skin lesions.[51] Of 1,498 health care workers who were tested, 666 (45 percent) had direct exposure to AIDS infected fluids; only 26 had positive reactions to an HIV antibody test. Only three of those 26 were not members of the high risk groups, and since one was tested anonymously, only two were considered to have acquired the virus occupationally. While the CDC concluded that the risk to health care workers through normal occupational exposure to

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49. *See* Archibald, Zon, Groopman, McLane & Essex, *Antibodies to Human T-Lymphotropic Virus Type III (HTLV-III) in Saliva of Acquired Immunodeficiency Syndrome (AIDS) Patients and in Persons at Risk for AIDS*, 67 BLOOD 831 (1986); Tervo, Lahdevitra, Vaheri, Valle & Sumi, *Recovery of HTLV-III from Contact Lenses*, 1986 LANCET 379; Vogt, Craven, Crawford, Witt, Hirsch, Byington & Schooley, *Isolation of HTLV-III/LAV From Cervical Secretions of Women at Risk for AIDS*, 1986 LANCET 525; Wofsy, Haver, Michaelis, Levy, Cohen, Padian & Evans, *Isolation of AIDS-Associated Retrovirus from Genital Secretions of Women with Antibodies to the Virus*, 1986 LANCET 527; Ziegler, Johnson, Cooper & Gold, *Postnatal Transmission of AIDS-Associated Retrovirus from Mother to Infant*, 1985 LANCET 896.

50. Although normal heterosexual intercourse is a likely means of transmission, the single most prevalent method of transmission, both from male to male and male to female, is anal intercourse. Anal intercourse presents an effective means of transmission because it often involves trauma of the rectal lining, which allows infected semen to enter the blood stream directly.

51. *Update: Acquired Immunodeficiency Syndrome in the San Francisco Cohort Study 1978 - 1985*, 34 MORBIDITY & MORTALITY WEEKLY REP. 575 (1985).

the AIDS virus is small, they have developed patient care procedures to minimize the risks of exposure to AIDS infected materials.[52] These procedures are the same as those which are to be followed with patients who carry similarly infectious blood diseases (such as Hepatitis B) and include special care to avoid needle stick and scalpel injuries, the wearing of gloves, and in some situations gowns, masks and eye coverings for health care workers who handle blood or other potentially infected bodily fluids or contaminated items or equipment.

The CDC recently reported the case of a mother who contracted the AIDS virus in caring for her infant.[53] The infant suffered from a serious intestinal abnormality, and the mother over a period of months frequently handled his blood, waste, and feeding tubes but did not wear gloves or wash her hands immediately following contact with the blood or secretions; she subsequently contracted AIDS. The report emphasized that the mother's care deviated from CDC guidelines, which require the wearing of gloves and appropriate washing so as to reduce risk of contracting the virus.

The CDC have promulgated additional guidelines for preventing transmission of HIV during invasive procedures including surgical entry into tissues, cavities, or organs or repair of major traumatic injuries in an operating or delivery room, emergency department, or outpatient setting, including both physician's and dentist's offices.[54] These procedures require the use of appropriate barrier precautions including masks, eye coverings and gowns. In addition, the guidelines preclude health care workers and physicians with exudative lesions or weeping dermatitis from performing invasive procedures or other direct patient-care activities. In order to preclude liability for transmission of AIDS to health care workers performing invasive procedures, as well as to patients subjected to invasive procedures, health care employers must require rigid adherence to these CDC guideliens.

C. Liability Related to Provision of Blood and Blood Products

Transmission of AIDS through blood products, including cases related to transfusions and to use by hemophiliacs of the plasma blood product Factor-VIII, has accounted for approximately two percent of

52. *Recommendations for Preventing Transmission of Human T-Lymphotropic Virus Type III/Lymphadenopathy—Associated Virus in the Workplace*, 34 MORBIDITY & MORTALITY WEEKLY REP. 681 (1985).

53. *Apparent Transmission of Human T-Lymphotropic Virus Type III/Lymphadenopathy—Associated Virus*, 35 MORBIDITY & MORTALITY WEEKLY REP. 76 (1986).

54. *Recommendations for Preventing Transmission of Human T-Lymphotropic Virus Type III/Lymphadenopathy—Associated Virus During Invasive Procedures*, 35 MORBIDITY & MORTALITY WEEKLY REP. 221 (1986).

the reported cases of AIDS. A claim of liability against a hospital or blood bank that provides infected blood would be based on the contention that the hospital or blood bank supplied an unfit product for patient use. Three bases for recovery in such actions have been suggested, including breach of an implied warranty, strict liability, and negligence.[55] In determining the potential liability of suppliers of blood and blood products, it is necessary to distinguish cases in which infected blood and blood products were received before the development and availability of screening tests for the HIV antibody from those cases arising from receipt of blood products after the development and widespread availability of the antibody screening tests.

1. Screening Tests

The availability of the HIV antibody test (the ELISA) since March 1985 has permitted organizations that collect blood and plasma to screen donations for antibody to HIV in accordance with guidelines developed by the CDC.[56] Any blood or plasma that is positive on initial testing is not to be transfused or manufactured into other products capable of transmitting infectious agents. Since the proportion of false positive results is high in a population in which the prevalence of HIV infection is low, and the incidence of false negatives is also low, the ELISA should be highly effective in screening infected blood. In order to minimize the number of false negative test results, it is recommended that members of groups at increased risk for AIDS refrain from donating blood and plasma.

It should be recognized that some risk still remains that blood which produces a negative reaction to the test may carry the virus: studies have reported several cases in which the antibody has not been detected in asymptomatic individuals infected with HIV for more than six months.[57] Blood from such persons will not produce a positive ELISA test result, so a physician or provider administering blood and blood products should inform the prospective recipient of blood and blood products of the continuing risk of infection from these products. Such informed consent should preclude any liability on the part of a

55. *See generally* Lipton, *Blood Donor Services and Liability Issues Relating to Acquired Immune Deficiency Syndrome*, 7 J. LEGAL. MED. 131 (1986); Williams, *Blood Transfusions and AIDS: A Legal Perspective*, 32 MED. TRIAL TECH. Q. 267 (1986); Miller, *Potential Liability for Transfusion—Associated AIDS*, 253 J. A.M.A. 3419 (1985).

56. *Professional Public Health Service Interagency Recommendations for Screening Donated Blood and Plasma for Antibody to the Virus Causing Acquired Immunodeficiency Syndrome*, 34 MORBIDITY & MORTALITY WEEKLY REP. 1 (1985).

57. *1982 Update on Acquired Immune Deficiency Syndrome [AIDS] Among Patients with Hemophilia A*, 31 MORBIDITY & MORTALITY WEEKLY REP. 644, 652 (1982).

physician or health care provider absent a showing of negligence in the use of the screening procedures.

2. Pre-Screening Test Guidelines

The question of liability for supplying AIDS infected blood or plasma prior to the development of the antibody test is a more complex matter. By the end of 1982, evidence had developed that AIDS was associated with blood transfusions and with the antihemophilic factor. As a result of Public Health Service studies, general recommendations for preventing transmission of AIDS through blood and blood products were developed. These recommendations resulted in the issuance of specific guidelines by the Food and Drug Administration (FDA) in March 1983 to all blood and plasma collecting facilities in the United States.[58] The guidelines called for collection centers to provide information about AIDS to donors so that the donors would be able to recognize whether they were members of groups at increased risk, to revise standard operating procedures to include specific questions regarding signs and symptoms of AIDS, and to advise donors that members at increased risk for AIDS should voluntarily not donate blood. The CDC concluded that since no specific test was known to detect AIDS at an early stage in a potential donor, all members of groups at increased risk for AIDS should refrain from donating, even though that would include many individuals who were at little risk of transmitting AIDS.[59]

3. Breach of Implied Warranty

An action for breach of an implied warranty is based on statutory sales laws which establish contractual warranties for the sale of products. In the case of a sale of blood, the seller would be bound by an implied warranty that the blood and blood products sold to a patient were fit for transfusion.[60]

In determining liability for blood infected with HTLV-III/LAV virus, analogies may be made to cases involving blood infected with hepatitis B virus (HBV). In deciding HBV transfusion liability, most courts considering the matter have held that suppliers of blood are not liable of breach of implied warranties on the basis that blood transfu-

58. OFFICE OF BIOLOGICS, NATIONAL CENTER FOR DRUGS AND BIOLOGICS, FOOD AND DRUG ADMINISTRATION, RECOMMENDATIONS TO DECREASE THE RISK OF TRANSMITTING ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) FROM PLASMA DONORS (1983).

59. *Prevention of Acquired Immune Deficiency Syndrome (AIDS): Report of Interagency Recommendations*, 32 MORBIDITY & MORTALITY WEEKLY REP. 101 (1983).

60. *See* U.C.C. §§ 2-314-15 (1977).

sions constitute a service, and not the sale of a product.[61] However, courts in Florida and New Jersey have held that blood supplied by a hospital or a blood bank is a product and as such is subject to an implied warranty of fitness.[62] Nevertheless, the legislatures of all but three states (New Jersey, Rhode Island and Vermont) and the District of Columbia have adopted statutes shielding blood suppliers from liability by providing as a matter of state law that the procurement and supplying of blood is to be treated as a service and not as a sale of a commodity, thus precluding a claim for damages based on any implied warranty.[63]

4. Strict Liability in Tort

An alternative basis for an action against a hospital or blood bank supplying HIV infected blood might be strict liability in tort. The American Law Institute's Restatement (Second) of Torts provides that strict liability should apply to a seller "who sells any product in a defective condition unreasonably dangerous to the user or consumer . . . [even if] the seller has exercised all possible care in the preparation and sale of his product. . . ."[64] The hepatitis transfusion cases are again instructive in determining the possibility of strict liability for providing HIV infected blood. In 1970, the Illinois Supreme Court held that a hospital could be held strictly liable for supplying hepatitis contaminated blood to a patient, and explicitly rejected a special exception to strict liability for "unavoidably unsafe products."[65] The Restatement's general rule of strict liability is subject to an exception for "unavoidably unsafe products" (such as the vaccine for the Pasteur treatment of rabies) which cannot be made fully safe for their intended use with the current state of knowledge.[66] However, the Illinois court ruled that this "unavoidably unsafe products" exception was intended to apply to "pure" but sometimes unsafe products, such as the vaccine for rabies, but was not meant to apply to "impure" substances such as

61. *See, e.g.*, Perlmutter v. Beth David Hospital, 308 N.Y. 100, 123 N.E.2d 792 (1954); Sloneker v. St. Joseph's Hospital, 233 F. Supp. 105 (D. Colo. 1964); White v. Sarasota County Public Hosp. Bd., 206 So. 2d 19 (Fla. Dist. Ct. App. 1968).

62. *See* Russell v. Community Blood Bank, Inc., 185 So. 2d 749 (Fla. Dist. Ct. App.), *aff'd and modified*, Community Blood Bank Inc. v. Russell, 196 So. 2d 115 (Fla. 1967). *See also* Jackson v. Muhlenburg Hosp., 53 N.J. 138, 249 A.2d 65 (1969). *But see* Brody v. Overlook Hosp., 127 N.J. Super. 331, 296 A.2d 392 (1974), *aff'd*, 66 N.J. 448, 332 A.2d 596 (1975) (limiting liability to cases where there is a known test to ascertain presence of blood contaminant).

63. *See, e.g.*, DEL. CODE ANN. tit. 6, § 2-316(5) (1974) (defining blood and blood plasma as "medical service" and not "commodities or good subject to sale" thus precluding a claim based on implied warranties that attach to sales).

64. RESTATEMENT (SECOND) OF TORTS § 402A (1965).

65. Cunningham v. MacNeal Memorial Hospital, 47 Ill. 2d 443, 266 N.E.2d 897 (1970).

66. RESTATEMENT (SECOND) OF TORTS § 402A comment k (1965).

blood containing hepatitis B virus.[67] In addition, the court reasoned that blood was a "product" and that the sale of this blood was distinct from the services provided by the hospital. The court concluded that the sale of "impure" blood created liability.[68]

Most states, including Illinois, have adopted statutes that eliminate liability without fault for those who dispense blood products.[69] These statutes declare blood transfusions to be a service exempt from the rule of strict liability for a defective product. In those states which have not adopted such statutes, the general rule seems to be that suppliers of blood containing hepatitus virus, and thus suppliers of blood containing HIV, may rely on the "unavoidably unsafe products" exception to the rule of strict liability where there is no known mechanism to ascertain that blood is contaminated by a virus.[70] This rule should provide a barrier to liability for blood supplied before the development of the HIV antibody tests, but protection from liability after the test became available requires that all blood supplies be screened for the antibody.

5. Blood Banks

In some states the restrictive application of implied warranty and strict liability rules in blood transfusion cases is not applicable where the defendant is a blood bank. Some courts have held that the providing of blood by a blood bank is considered a "sale" and the doctrines of implied warranty and strict liability will apply.[71] These courts have distinguished hospitals, which supply blood only as an incidental function to providing medical services, from blood banks, whose purpose is

67. Cunningham, *supra* note 75 at 456, 266 N.E.2d at 904.

68. *Id.* at 447, 266 N.E.2d at 899.

69. *See, e.g.*, IND. CODE § 16-8-7-2 (1963) providing:

> The procurement, processing, distribution or use of blood, plasma, blood products, blood derivatives, or other human tissue, such as cornea, bones or organs by a bank, storage facility, or hospital and the injection, transfusion or transplantation of any of them into the human body by a hospital, physician or surgeon, whether or not any renumeration is paid is declared to be for all purposes the rendition of a service and not the sale of a product. No such services shall give rise to an implied warranty of merchantability or fitness for a particular purpose, nor give rise to strict liability in tort.

See also CAL. HEALTH & SAFETY CODE § 1606 (1979); FLA. STAT. ANN. § 672.316(5) (Cum. Supp. 1986); GA. CODE ANN. § 109A-2-316 (5) (1979 and Cum. Supp. 1986); ILL. ANN. STAT. ch. 111 1/2, 5102(2) (Supp. 1986); LA. REV. STAT. ANN. § 9:2797 (West Supp. 1986); TENN. CODE ANN. § 47-2 316(5) (1979). The California law is criticized in Comment, *Hepatitis, AIDS and the Blood Product Exemption from Strict Products Liability in California: A Reassessment*, 37 HASTINGS L.J. 1101 (1986).

70. *See, e.g.*, Brody v. Overlook Hosp., 127 N.J. Super. 331, 317 A.2d 392 (1974), *aff'd*, 66 N.J. 448, 332 A.2d 596 (1975).

71. *See, e.g.*, Belle Bonfils Memorial Blood Bank v. Hansen, 195 Colo. 529, 579 P.2d 1158 (Colo. 1978); Community Blood Bank Inc. v. Russell, 196 So. 2d, 115 (Fla. 1967).

to provide blood for transfusion. In the latter context blood should be regarded as a product subject to sale.

6. Negligence

Although neither strict liability nor breach of implied warranty is generally available as a basis for suit when a hospital transfuses a patient with contaminated blood, the hospital may be liable for its negligence in administering impure blood.[72] Such liability has been found in cases of transfusions of blood contaminated with the hepatitis B virus (HBV).[73] The similarities between HBV and HIV suggest that courts faced with AIDS transmission cases should follow the precedents set in HBV transfusion cases. HIV and HBV are analogous in many respects: both viruses are transmitted parenterally and sexually; both occur in similar high risk populations including homosexuals, intravenous drug users, spouses of infected persons, and children born to infected mothers; both have incubation periods during which a person may transmit the virus without showing antibodies or other signs of disease; and both are now detectable by a screening test.

In a suit for negligence a person receiving contaminated blood would have to show that the supplier of blood failed to act reasonably in carrying out the duty of care it owed to the patient, and that the failure to meet the duty of care was the proximate cause of actual loss or damage to the patient. Generally, a provider of medical services owes a duty of care to the patient to use reasonable care under the circumstances and to possess the knowledge and exercise the degree of skill and care possessed and exercised by like providers of medical services.[74] In order to establish liability for providing HIV infected blood, a recipient will need to establish that proper screening measures either were not employed or were employed negligently. After March, 1983, this would require a showing that a blood supplier did not follow the FDA guidelines established to provide for high risk donor screening and a program of voluntary abstention by members of high risk groups. From March, 1985, this would require a showing that a blood supplier provided blood not tested by the ELISA test, as recommended by the CDC.

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72. *See, e.g.*, Hoder v. Sayet, 196 So. 2d 205 (Fla. Dist. Ct. App. 1967); Jackson v. Muhlenberg Hosp., 53 N.J. 138, 249 A.2d 65 (1969); Samuels v. Health & Hospital Corp., 432 F. Supp. 1283 (S.D.N.Y. 1977); Villarreal v. Santa Rosa Medical Center, 443 S.W.2d 622 (Tex. Ct. App. 1969).

73. *See, e.g.*, Martin v. Southern Baptist Hospital, 352 So. 2d 351, 354 (La. Ct. App. 1977).

74. *See generally* W. KEETON, PROSSER AND KEETON ON TORTS § 30 (5th ed. 1984) [hereinafter KEETON]. In addition, a hospital's failure to use the highest standard of current knowledge in testing blood will preclude its use of the "unavoidably unsafe products" exception to strict liability. Belle Bonfils Memorial Blood Bank v. Hansen, 665 P.2d 118, 127 (Colo. 1983).

7. Informed Consent and Negligent Misrepresentation

As noted above, the duty to refrain from negligence may encompass obtaining informed consent from the patient before a transfusion or administration of other blood products. This is especially true in relation to HIV testing because of the possibility of a false negative result due to the extended incubation period of the virus. Moreover, if the blood has been obtained from paid donors, the patient should be informed of the increased risks which he faces by accepting such blood. Some states have enacted statutes requiring that blood obtained from paid donors be labeled to indicate this fact.[75] It should be noted, however, that some courts have found no duty to inform patients of all the risks (such as the risk of contracting hepatitis as a result of a transfusion).[76]

Informed consent will not provide a barrier to a suit for negligence, since the consent is effective only if the blood supplier has done all that is reasonably possible to ensure that the blood is free from HIV infection. This requires that the blood suppliers follow procedures to discourage donations by members of high risk groups; to test the blood with the recommended antibody tests; or, if the blood is purchased, to ensure that these measures are taken by the supplier. Only if such measures are taken will the patient's informed consent prevent liability. Finally, a supplier of blood cannot insulate itself from liability for providing contaminated blood by requiring a patient to execute a blanket release exculpating the supplier from liability for its own negligence, since such releases are generally held to be void as contrary to public policy.[77]

D. Liability Related to Drug Use

As of January 17, 1986, seventeen percent of the persons diagnosed with AIDS were identified as intravenous (IV) drug users. Nonmedical drugs are often injected by persons sharing needles without cleaning or sterilizing the needles between uses; that enables blood containing contaminants such as HIV to pass from person to person.[78] Transmission of other highly contagious communicable diseases such

75. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 1603.5 (1979); GA. CODE ANN. § 85-5501a (1979 & Cum. Supp. 1986); ILL. REV. STAT. Ch. 111 1/2 §§ 620-24 (1972).

76. *See, e.g.*, Sloneker v. St. Jospeh's Hospital, 233 F. Supp. 105 (D. Colo. 1964); Fischer v. Wilmington Gen. Hosp., 51 Del. 554, 149 A.2d 749 (Super. Ct. 1959).

77. *See, e.g.*, Smith v. Hosp. Auth. of Walker, Dade and Catoosa Counties, 160 Ga. App. 387, 287 S.E.2d 99 (1981).

78. Various proposals have surfaced to attack the problem by providing free, sterile needles to drug users. *Free Needles for Drug Users Weighed as Anti-AIDS Tactic*, CRIM. JUST. NEWSL., Dec. 16, 1985, at 4.

as hepatitis B by such means has been documented, and it is assumed that IV drug users also transmit HIV by this means. The transmission of AIDS among intravenous drug users is thought to occur as a result of sharing or reusing blood-contaminated needles and syringes in "shooting galleries" (i.e., the apartments and other locations in metropolitan areas that are frequented by IV drug users).[79]

A person who intentionally or knowingly induces another person to use a needle contaminated with HIV commits a battery, which is an intentional, harmful or offensive, unprivileged contact with the person of another.[80] Recent expansion of the nature of actionable "offensive contact" makes the success of a battery action more likely. In a landmark case brought against the University of Chicago and Eli Lilly & Company, a federal district court found that administration of a drug without the patient's knowledge sufficiently comports with the meaning of "offensive contact" to establish a battery.[81] In that case, several women brought suit against the defendants for a series of batteries committed against them while receiving prenatal care at the university's hospital.[82] The women alleged that they were given pills of diethylstilbestrol (DES) without their knowledge or consent as part of a double blind experiment to determine the value of DES in preventing miscarriages. The women were not told they were part of an experiment, nor that the pills consisted of DES. The women did not allege any specific physical harm to themselves; however, they did claim that their children developed cellular abnormalities because of the drug and that they themselves were exposed to an increased risk of cancer. The federal court denied a motion to dismiss the battery action on the ground that the defendants intentionally administered DES as part of a planned study without the women's consent and that the ingestion of the drug by the women provided offensive contact sufficient for the tort, even though the offensive contact was made indirectly through the taking of pills. The court concluded:

> We find the administration of the drug without the patient's knowledge comports with the meaning of offensive contact. Had the drug been administered by means of a hypodermic needle, the

79. Goedert & Blattner, *The Epidemiology of AIDS and Related Conditions*, in AIDS: ETIOLOGY, DIAGNOSIS, TREATMENT AND PREVENTION, *supra* note 2, at 19.

80. RESTATEMENT (SECOND) OF TORTS §§ 18, 19 (1965) (a direct or indirect offensive contact with another person is a harm compensable under battery law). The element of intent may in appropriate cases be inferred from recklessness. *See, e.g.*, Smith v. Georgeoff, 329 Ill. App. 444, 447, 69 N.E.2d 252, 526 (1946) (proof of "express malice is unnecessary and malice can be inferred from wanton and wilful or reckless disregard of plaintiff's rights").

81. Mink v. University of Chicago, 460 F. Supp. 713 (N.D. Ill. 1978).

82. The suit was brought on behalf of 1,000 women who were part of the experiment, but the class was never certified.

> element of physical contact would clearly be sufficient. We believe that causing the patient to physically ingest a pill is undistinguishable in principle.[83]

The plaintiff, of course, must establish that his or her injuries were caused by the defendant's breach of some duty to the plaintiff.[84] A factor cited frequently by courts in determining the existence and scope of a duty is the foreseeability of the possible harm.[85] Additional factors which may be taken into account in establishing the existence and scope of a legal duty include the likelihood of injury, the magnitude of the burden of guarding against the injury, and the consequence of placing the burden of the duty on the defendant.[86] One may establish a duty on the part of a person inducing another to share needles or by sharing needles of another knowing of the likelihood of the transmission of HTLV-III/LAV by showing that it is clearly foreseeable to a prudent person that sharing needles may result in transmission of the virus. It is very likely that transmission of HIV will occur through such activity with the resultant development of AIDS in the person infected. The burden of guarding against the transmission of AIDS through the sharing of needles is not great; one might either use one's own needles or take care to sterilize reused needles. Finally, placing such a burden on one who shares needles is little hardship to that person and of great social benefit in reducing the incidence of AIDS. Thus a person who induces another to share unclean needles, especially given the general understanding of the danger of transmission of HTLV-III/LAV through such activity, fails to meet the standard of conduct of a reasonable and prudent person.

In order to recover damages on the basis of negligence in transmission of HIV or in contracting AIDS through the use of shared needles, a plaintiff must show that a particular incident in which needles were shared was the cause of transmission of the virus. As a practical matter, given the fact that it is not likely that such conduct will involve an isolated instance of sharing of needles, proof of causation may pose an insurmountable difficulty. However, if one could show that transmission occurred through an isolated instance of sharing needles and that no other activity could have made transmission possible, he may be able to establish the necessary causal relationship between transmission and the negligence of the person inducing the sharing of needles.

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83. 460 F. Supp. at 718.

84. KEETON, *supra* note 74, § 30 at 164-65.

85. *Id.*, § 53 at 356-359.

86. *Id.* at 359.

In order fully to assess the possibility of maintaining an action for negligence against a person inducing another to share needles for intravenous drug use resulting either in the transmission of HIV or in the contracting of AIDS, it is necessary to consider the most common defenses in negligence actions: the plaintiff's consent to criminal conduct, contributory negligence, and assumption of risk.

1. Illegality

Because the intravenous drug use related to HIV transmission generally involves a violation of the criminal law, the plaintiff's consensual participation in that criminal activity may affect the defendant's liability. Nonetheless, conduct committed with the intention of inflicting harm on another is ordinarily a crime despite the fact that the party harmed has consented to the conduct causing the harm. A number of courts similarly have held that consent will not protect a defendant against civil liability for damages in cases of mutual physical combat and battery.[87] A minority of courts have adopted the Restatement position that consent will defeat a civil action.[88]

The strongest case for disallowing consent as a defense to a tort claim is where the conduct is intended or very likely to bring about the death of a person. It is generally agreed that no one should have the capacity to consent to conduct intended or very likely to bring about his death, or intended to bring about physical invasion of his person likely to result in death, except when undertaken for medical reasons.[89]

Because AIDS is always fatal and susceptible to transmission through the shared use of needles, an intravenous drug user who knows that he or she has contracted AIDS may be subject to tort liability despite the consent of the other party sharing the needles. In addition, when there is a showing of intentional transmission or gross disregard of the likelihood of transmission of HIV, a survivor may maintain a suit for wrongful death against the person inducing or assisting another to engage in IV drug use with contaminated needles.

2. Contributory Negligence

Contributory negligence is conduct on the part of the plaintiff,

87. *See, e.g.*, Conduit v. Hewitt, 369 P.2d 278 (Wyo. 1962); Teeters v. Frost, 145 Okla. 273, 292 P. 356 (1930).

88. RESTATEMENT (SECOND) OF TORTS § 60 (1965). *See, e.g.*, Hart v. Geysel, 159 Wash. 632, 294 P. 570 (1930); Dixon v. Samartino, 163 S.W.2d 739 (Tex. Ct. App. 1942) (dictum).

89. KEETON, *supra* note 74, § 18 at 123. Keeton notes one early case in which a defendant was held liable to the wife of the deceased for inducing and assisting the deceased to drink three pints of whiskey which resulted in death. *See* McCue v. Klein, 60 Tex. 168 (1883).

sufficiently connected to the harm he suffered to constitute a legal cause thereof, which falls below the standard to which he is required to conform for his own protection.[90] A principled basis for denying the plaintiff recovery is that his own conduct is the proximate cause of his injury, i.e., the plaintiff's negligence is an independent intervening cause between the defendant's negligence and the resultant harm. In determining whether a plaintiff is contributorily negligent, the plaintiff is judged by the same standard of conduct as the defendant, that of the reasonable person of ordinary prudence under like circumstances.[91] Contributory negligence may consist not only of a failure to discover or to appreciate a risk which would be apparent to a reasonable person, or of a mistake in dealing with it, but also of an intentional but unreasonable exposure to a danger of which the plaintiff is aware.[92]

At common law, contributory negligence was a total bar to a plaintiff's recovery.[93] However, some states have adopted a scheme of comparative negligence which changes the effect a plaintiff's negligence has on recovery; instead of barring all recovery, it reduces the total amount of plaintiff's damages in proportion to his negligence.[94] A person who shares the unsterilized needles of another almost certainly departs from the standard of conduct of a reasonable person given the widespread understanding of the danger of becoming infected with HIV or of contracting AIDS from the sharing of needles in IV drug use and given the relative ease with which he may protect himself. As a consequence, the plaintiff who alleges that the defendant caused the transmission of AIDS likely will be barred from recovering, or at least have any award reduced as a consequence of his own negligence.

3. Assumption of Risk

The defense of assumption of risk requires a showing that the plaintiff voluntarily incurred a known risk that resulted in his injury.[95] To establish assumption of risk on the part of a plaintiff, it is necessary to show that the plaintiff knew that the risk was present, understood its nature, and freely and voluntarily incurred the risk.

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90. RESTATEMENT (SECOND) OF TORTS § 463 (1965).

91. *Id.* § 464.

92. *Id.* § 466.

93. *Id.* § 467. *See, e.g.*, Maki v. Frelk, 40 Ill. 2d 193, 239 N.E.2d 445 (1968) (applying rule to bar negligent plaintiff's claim; refusing to adopt comparative negligence without legislative mandate).

94. *See, e.g.*, Alvis v. Ribar, 85 Ill. 2d 1, 421 N.E.2d 886 (1981) (judicial adoption of comparative negligence; in effect overruling *Maki*). Some states modify that rule of "pure" comparative negligence by permitting a negligent plaintiff to recover only when the negligence of the defendant is greater. *See, e.g.*, COLO. REV. STAT. § 13-21-111 (1973).

95. KEETON, *supra* note 74, § 68 at 481.

A principal context in which a plaintiff is said to have assumed a risk is where he is aware of a risk that has already been created by the negligence of the defendant, but, nonetheless, chooses voluntarily to proceed to encounter the risk, or where he is provided some item which he knows is unsafe, but proceeds to use it anyway.[96] In most cases in which a person voluntarily accepts the use of the needles of another IV drug user or shares his own needles with another, that person can be said to have assumed the risk of being infected with HIV or of contracting AIDS as a result of shared needle use.

One significant factor in determining assumption of risk is the actual knowledge and understanding of the plaintiff with regard to the risk of contracting AIDS as a result of shared needle use. Unlike the standard of care for measuring a plaintiff's contributory negligence (the objective standard of the reasonable and prudent person), the standard of knowledge for assumption of risk is a subjective one related to the particular plaintiff and his situation.[97] The age, experience and ability to comprehend the risk in a situation will be taken into account to determine if the plaintiff consented to assume the risk of infection from shared needle use. If a plaintiff is immature or mentally impaired, he may be found not to have the competence to consent to assume the risk, and thus the person providing or sharing needles who transmits HIV through shared needle use may remain liable.

Finally, the plaintiff must freely and voluntarily participate in the sharing of needles for IV drug use before he can be said to have assumed the risk of contracting AIDS from this activity.[98] In some cases a person may be said not to have assumed a risk where he relies on the judgment of another person or an assurance that a situation is safe.[99] However, where the danger is so obvious that there can be no reasonable reliance upon an assurance, a person will be found to have assumed a risk no matter what assurances have been given.[100] An adult with knowledge of the danger of contracting AIDS from shared needle use may rely on the the initial user's assurance that he is free from HIV infection, but it is not clear that reliance in such circumstances would ever be reasonable. Consequently, that reliance probably would be ineffective to preclude a successful assertion of a defense of assumption of the risk in a case brought for negligent transmission of the virus.

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96. *Id.* at 487.

97. RESTATEMENT (SECOND) OF TORTS § 496D (1965) (plaintiff must know of risk and appreciate its unreasonable character to be charged with assumption thereof).

98. KEETON, *supra* note 74, § 68 at 485.

99. *Id.* at 490.

100. *Id.*

Although the illegality of the conduct involved in transmitting AIDS, the plaintiff's own substandard behavior, or the plaintiff's assumption of the risk may vitiate an action against the defendant, a child of a victim may be able to avoid those defenses and recover from the tortfeasor.[101]

E. Liability for Sexual Transmission of AIDS

The primary means for transmission of AIDS is direct mucous membrane or bloodstream contact with a sexual partner's blood or semen infected with HIV.[102] The primary protection for uninfected persons is to refrain from those sexual practices with infected persons or persons who are likely to be infected. Alternatively, a number of "safe sex" practices, such as use of a condom in intercourse, have been identified which should reduce the likelihood of transmission of the virus from an infected person.[103]

When one person transmits AIDS to another, a harm with lifetime consequences has occurred. If the transmitter is an asymptomatic carrier without knowledge that he or she is infected with HIV, there may be no basis for finding liability since both sexual partners are equally responsible to limit their practices to those which reduce likelihood of contracting the disease. However, where one party is aware of being infected, there is reason to place liability on that party. That is especially true when one party offers false assurance that he or she is free from infection. As one court observed: "[A] certain amount of trust and confidence exists in any intimate relationship, at least to the extent that one sexual partner represents to the other that he or she is free from venereal or other dangerous contagious disease."[104] If that trust and confidence is violated by a knowingly false assertion of lack of HIV infection and if subsequent infection of the sexual partner occurs, the law of most jurisdictions will provide a remedy.

1. Causes of Action

There is a legally enforceable duty in the context of a sexual relationship to protect against the transmission of venereal and contagious diseases including AIDS.[105] A person who knows that he or she is

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101. *See infra* notes 176-84 and accompanying text.

102. Among the sexual practices which are believed to pose the highest risk of infection with the virus are: anal intercourse with intraanal ejaculation by an infected partner, vaginal intercourse with intravaginal ejaculation by an infected partner, and ingestion of an infected partner's ejaculate.

103. *See generally* THE INSTITUTE FOR ADVANCED STUDY OF HUMAN SEXUALITY, SAFE SEX IN THE AGE OF AIDS (1986).

104. Kathleen K. v. Robert B., 150 Cal. App. 3d 992, 997, 198 Cal. Rptr. 273, 276-77 (1984).

105. A number of commentators have discussed liability issues related to the sexual transmission

infected with HIV has an affirmative obligation to disclose that fact before engaging in sexual activity. An infected partner's failure to satisfy that obligation will give rise to a cause of action. The possible theories of liability include negligence, battery, misrepresentation and tort based on statutory violation.

Liability for negligence for sexual transmission of AIDS requires establishing a duty on the part of the person transmitting AIDS which arises from the relationship between the sexual partners, a breach of that duty, a causal relationship between the defendant's conduct and the injury suffered by the sexual partner, and damages or loss to the plaintiff.[106] It is easily foreseeable that a person who knows or should know that he or she is infected with HIV or has contracted AIDS may infect a sexual partner with the virus with a resultant development of AIDS, thus giving rise to a duty to disclose the malady to partners.[107] Even those courts which hesitate to find such a broad, general duty might find a duty in the nature of the relationship existing between the parties. In a landmark case decided in 1920, a woman successfully sued her husband for wrongfully and recklessly infecting her with a "loathsome disease."[108] In finding that the defendant had breached his duty, the court relied heavily on the marital relationship between the sexual partners.[109] Subsequent cases have found that an intimate sexual relationship itself gives rise to a duty with the result that the rules of negligence are "equally applicable today, whether or not the partners involved are married to each other."[110]

A battery is an intentional and unprivileged contact with the person of another which is harmful or offensive.[111] Sexual activity satisfies the contact requirement for a cause of action in battery. In a recent California case, a woman who suffered an ectopic pregnancy and was forced to undergo surgery to save her life which rendered her sterile. The woman was found to have stated a cause of action for

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of herpes and other communicable diseases. *See* Comment, *The Consequences of an Uninformed Menage a Trois Extraordinaire: Liability to Third Parties for the Nondisclosure of Genital Herpes Between Sexual Partners*, 29 ST. LOUIS U.L.J. 787 (1985); Prentice & Murray, *Liability for Transmission of Herpes: Using Traditional Tort Principles to Encourage Honesty in Sexual Relations*, 11 J. CONTEMP. L. 67 (1984); Note, *HERPES—A Legal Cure—Can the Law Succeed Where Medicine Has Failed?*, 61 U. DET. J. URB. L. 273 (1984); Comment, *Liability in Tort for the Sexual Transmission of Disease: Genital Herpes and the Law*, 70 CORNELL L. REV. 101 (1984).

106. *See* RESTATEMENT (SECOND) OF TORTS § 281 (1965).

107. *See, e.g.*, Frankovitch v. Burton, 185 Conn. 14, 20-21, 440 A.2d 254, 259 (1981) (test of duty found in foreseeability); Brennan v. City of Eugene, 285 Or. 401, 406, 591 P.2d, 719, 722 (1979) (general rule that scope of the duty owed is governed by the concept of foreseeability).

108. Crowell v. Crowell, 180 N.C. 516, 517, 105 S.E. 206, 207 (1920).

109. 180 N.C. at 520, 105 S.E. at 210.

110. *Kathleen K.*, 150 Cal. App. 3d at 997, 198 Cal. Rptr. at 277.

111. RESTATEMENT (SECOND) OF TORTS §§ 13, 18 (1965).

battery against the man who impregnated her, based on allegations that she had consented to sexual intercourse in reliance on the man's knowingly false representation that he was sterile.[112] The transmission of HIV by an infected person or one who has contracted AIDS likewise will satisfy the requirement of harmful contact, and even more clearly than in the case of infection through shared needles.

To establish a battery, it is ordinarily necessary to show that the defendant intended to cause the unprivileged contact—that is, the transmission of the virus—but it may be enough to show that the defendant knew that he or she was infected with HIV or had contracted AIDS and intended to cause the sexual contact which in turn caused transmission of the virus. In a 1917 case, the Delaware Supreme Court upheld a defendant husband's conviction of criminal assault and battery for transmitting syphilis to his wife.[113] The court determined that the element of intent was established when it was shown that the husband had intercourse knowing he had contracted syphilis. The court observed: "If the accused knew that he was infected with syphilis, and his infection was unknown to his wife, the intent to communicate the disease to her by having sexual intercourse with her, may be inferred from the actual result."[114] Although that case involved a criminal prosecution for battery, the elements of civil and criminal battery are essentially the same. In contrast to a suit for negligence in which it is usually enough to show that a tortfeasor should have known of his or her infected condition, to establish a battery claim a person must show that the person transmitting a disease had *actual* knowledge of his infected condition.

Almost certainly the element of the offensiveness of the contact will be satisfied in cases involving the transmission of HIV. Again *Lankford* is instructive:

> A wife in confiding her person to her husband does not consent to cruel treatment, or to infection with a loathsome disease. A husband, therefore, knowing that he has such a disease, and concealing the fact from his wife, by accepting her consent, and communicating the infection to her, inflicts on her physical abuse, and injury, resulting in great bodily harm; and he becomes, notwithstanding his marital rights, guilty of an assault, and indeed, a completed battery."[115]

Similarly, a person who consents to sexual activity does not consent to

112. Barbara A. v. John G., 145 Cal. App. 3d 369, 193 Cal. Rptr. 422 (1983).

113. State v. Lankford, 29 Del. (6 Boyce) 594, 102 A. 63 (1917).

114. 29 Del. (6 Boyce) at 594, 102 A. at 64.

115. *Id.*

infection with the AIDS virus. Infection with the AIDS virus thus will be regarded as harmful or offensive contact.

An actionable misrepresentation is established by showing that the plaintiff reasonably relied to his or her detriment on the defendant's knowing or negligent misrepresentation of a material fact.[116] The liability of a mendacious suitor has been recognized by the California Court of Appeals, which held that a man's intentional misrepresentation of his sterility constituted a cause of action for deceit.[117] To establish fraud in a case of transmission of HIV or for contracting AIDS, a plaintiff must show that the defendant actually knew of his or her infectious condition and withheld that information with the purpose of inducing plaintiff to have sex. Where it can be shown that the defendant lied to the plaintiff, claiming that he or she did not have AIDS or was not infected with HIV, and the plaintiff consented to sex on the basis of the claim, the plaintiff may establish fraud and recover punitive damages, which an action for simple negligence may not permit.[118]

Many states have enacted statutes making the communication of venereal disease a crime.[119] Typically, these statutes impose a criminal penalty for the transmission of a communicable venereal disease through sexual intercourse,[120] but some states make it a crime to willfully "expose" another person to a venereal disease.[121] Courts have upheld convictions and the imposition of prison sentences for violations of these statutes,[122] and some have gone further to construe the statutes as creating a private right of action for money damages as a result of the plaintiff's having contracted a sexually transmitted

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116. RESTATEMENT (SECOND) OF TORTS § 525 (1977).

117. Barbara A. v. John G., 145 Cal. App. 3d 369, 193 Cal. Rptr. 422 (1983). The facts are set out in the text accompanying note 124, *supra*.

118. *See, e.g.*, COLO. REV. STAT. § 13-21-102(1)(a) (Cum. Supp. 1986) (award of exemplary damages requires award of actual damages plus showing that "the injury complained of [was] attended by circumstances of fraud, malice, or willful and wanton conduct. . . .").

119. *See, e.g.*, ALA. CODE § 22-16-17 (1975 & Cum. Supp. 1986) (misdemeanor); COLO. REV. STAT. §§ 25-4-401(2) and 407 (1973 & Cum. Supp. 1986) (misdemeanor); DEL. CODE ANN., tit. 16 § 701 (1983) (misdemeanor); IDAHO CODE §§ 39-601 and 607 (1986) (misdemeanor); NEV. REV. STAT. ANN. § 441.290 (Michie 1985 & Supp. 1986) (misdemeanor); N.Y. PUB. HEALTH LAW § 2307 (McKinney 1985) (misdemeanor); OKLA. STAT. ANN. tit. 63, § 1-519 (West 1984) (felony); UTAH CODE ANN. §§ 26-6-5 and 16 (1984) (misdemeanor).

120. *See, e.g.*, OKLA. STAT. ANN. tit. 43 § 1-519 (West 1984).

121. *See, e.g.*, COLO. REV. STAT. § 25-4-401(2) (1973) (misdemeanor to "wilfully expose"); NEV. REV. STAT. ANN. § 441.290 (Michie 1986) (misdemeanor to knowingly expose); S.C. CODE ANN. §§ 44-29-60 and 140 (Law. Co-op. 1976) (misdemeanor to expose another).

122. *See, e.g.*, Reynolds v. State, 49 Okla. Crim. 215, 292 P. 1046 (1920) (affirming a conviction of a man who infected a woman with gonorrhea under a statute making communication of a venereal disease a felony punishable by up to 5 years in prison).

disease.[123]

Moreover, courts often look to criminal statutes which prohibit certain conduct for determining the standard of conduct for tort liability. While a court is not obliged to adopt the criminal standard in a civil case, many courts have regarded such criminal statutes as an official determination that certain risks are foreseeable, that certain conduct is prohibited, and that no reasonable person would violate the prohibition described in the criminal statute. The position of most courts is that violation of a statute created for the protection of public is negligence per se.[124] Where negligence per se is recognized, a defendant's claim that he or she exercised due care will generally not allow him to escape liability. A minority of courts, however, find a violation of such a statute to be only evidence of negligence.[125]

The primary obstacle to basing tort liability on a statute which provides criminal penalties for communicating a venereal disease is that in many jurisdictions AIDS is not yet officially recognized as a venereal disease. Several statutes define venereal disease to include only syphilis, gonorrhea, and chancroid.[126] Other states add granuloma and lymphogranuloma venereum to the list of venereal diseases.[127] Two states have recently enacted legislation which adds AIDS to the enumeration of venereal diseases.[128] In some states, a designated state authority, such as the Commissioner of Health, has authority to promulgate the list of sexually transmitted diseases.[129] Certain jurisdictions include broad language such as "any other disease which can be sexually transmitted,"[130] and such broad language

123. *See, e.g.*, Panther v. McKnight, 125 Okla. 134, 256 P. 916 (1926) (court recognized private right of action for money damages for conduct in violation of criminal statute proscribing transmission of venereal disease).

124. *See, e.g.*, Azure v. City of Billings, 182 Mont. 234, 240, 596 P.2d 460, 464 (1979); Bayne v. Todd Shipyards Corp., 88 Wash. 2d 917, 918-19, 568 P.2d 771, 772 (1977). *See generally* KEETON, *supra* note 84, § 36.

125. *See, e.g.*, Gill v. Whiteside-Hemby Drug Co., 197 Ark. 425, 431, 122 S.W.2d 597, 601 (1938) (violation of state law is merely evidence of negligence).

126. *See, e.g.*, DEL. CODE ANN. tit. 16 § 701 (1983); FLA. STAT. ANN. § 384.01 (West 1986); LA. REV. STAT. ANN. § 401:1061 (West 1977); S.C. CODE ANN. § 44-29-60 (Law. Co-op. 1976); S.D. CODIFIED LAWS ANN. § 34-23-1 (1976); WASH. REV. CODE ANN. § 70.24.010 (1975); W. VA. CODE § 16-4-1 (1985).

127. *See, e.g.*, ALA. CODE § 22-16-1 (1975); COLO. REV. STAT. § 25-4-401 (1973); R.I. GEN. LAWS § 23-11-1 (1985 & Supp. 1986).

128. *See, e.g.*, GA. CODE ANN. § 31-21-3 (Harrison 1986); IDAHO CODE § 39-601 (Supp. 1986).

129. *See, e.g.*, N.Y. PUB. HEALTH LAW § 2311 (McKinney 1985) (Comm'r of Health); OR. REV. STAT. § 434.005(3) (1985) (Health Div. of State Dept. of Human Resources); VT. STAT. ANN. tit. 18, § 1091 (1982) (Dept. of Health).

130. *See, e.g.*, NEV. REV. STAT. ANN. § 441.050 (Michie 1986) ("or any other disease which can be sexually transmitted"); OKLA. STAT. ANN. tit. 63, § 1-517 (West 1984) ("any other disease which may be transmitted from any person to any other person through or by means of sexual intercourse and

could undoubtedly be construed to include AIDS. The California Court of Appeals which construed herpes to be a venereal disease indicated a disposition to so categorize AIDS in observing:

> Respondent's argument that genital herpes is not a venereal disease is unpersuasive. Although herpes is not listed among the venereal diseases covered by the [California] Health and Safety Code (specifically section 3001) that section was enacted in 1957, long before herpes achieved its present notoriety. We are not inclined to bar appellant's cause of action on the basis that genital herpes is not a venereal disease. It is a disease that can be propagated by sexual contact. Like AIDS it 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.[131]

Some states also have adopted broadly worded statutes providing criminal penalties for transmission of a "contagious disease."[132] Some of these "contagious disease" statutes provide a criminal penalty for one who obscenely exposes himself while inflicted with a contagious disease.[133] Other statutes apply to persons who expose others to a contagious disease.[134] Such statutes, of course, provide the same possibility of a civil remedy as do the criminal statutes prohibiting venereal disease transmission.

2. Defenses

Each of the various causes of action that potentially offer a basis for civil suit by a person who has been infected with HIV, or who has developed AIDS as a result of transmission of the virus by another individual, is subject to one or more defenses. Assumption of risk and contributory negligence may provide defenses in suits based on negligence, and consent may be offered as a defense in an action for battery. Interspousal immunity, illegality of the underlying conduct, and the right of privacy of a sexual partner also provide potential obstacles to recovery in tort actions for damages for transmission of AIDS.

The elements of assumption of risk include the plaintiff's under-

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found and declared by medical science or accredited schools of medicine to be infectious or contagious"); TENN. CODE ANN. § 68-10-101 (1983 & Supp. 1986) ("other venereal diseases").

131. Kathleen K. v. Robert B., 150 Cal. App. 3d 992, 997 n.3, 198 Cal. Rptr. 273, 276 n.3 (1984).

132. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 3353 (West 1979).

133. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 3353 (West 1979) ("any person afflicted with any contagious, infectious, or communicable disease who wilfully exposes himself . . . is guilty of a misdemeanor").

134. *See, e.g.*, IOWA CODE ANN. §§ 139.31, 139.32 (West 1972) ("[a]ny person who knowingly exposes another to infection from any communicable disease . . . shall be guilty of a misdemeanor").

standing of and voluntary exposure to risk in circumstances that indicate a willingness to accept such risk.[135] At common law, assumption of the risk was a bar to recovery in a suit brought for negligence. As a consequence, when a person infected with HIV or diagnosed as having AIDS accurately informs his sexual partner of his condition and the sexual partner understands the risk but voluntarily consents to sexual activity, the partner has expressly assumed the risk of contracting AIDS and no liability will attach for its transmission.

Mere consent to sexual activity will not, however, bar recovery.[136] Courts have distinguished, at least in the marital context, the consent to sexual activity from consent to infection with venereal disease,[137] and have reasoned that a husband's concealment of the risk of venereal disease vitiates a wife's consent to sexual intercourse and subjects him to liability for battery.[138] They have also recognized a similar vitiation of consent in intimate sexual relationship between nonmarried persons where there is fraudulent misrepresentation of freedom from venereal disease.[139]

A more difficult question is whether assumption of the risk should be *implied* when the plaintiff engages in those activities normally associated with the transmission of AIDS. The assumption of risk defense relies on the plaintiff's particular knowledge, and not on that attributed to the reasonable man, which at least makes the implied assumption more difficult to prove. But should even actual knowledge of the *general* risks associated with certain sexual practices be allowed to imply that the plaintiff assumed the risk of contracting the disease in a particular relationship where the sexual partner knew that he or she was infected with HIV or had AIDS? That it should not is clear from the fact that doing so would bar many potential plaintiffs from recovering, and as a consequence, any purported duty to disclose one's infection with AIDS would be a hollow duty indeed.[140]

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135. KEETON, *supra* note 74, § 68 at 482-92.

136. If A consents to sexual intercourse with B, who knows that A is ignorant of the fact that B has a venereal disease, B is subject to liability to A for battery, since consent to intercourse is not consent to infection with disease. RESTATEMENT (SECOND) OF TORTS §§ 496C & 496D (1965).

137. *See, e.g.*, State v. Lankford, 29 Del. (6 Boyce) 594, 102 A. 63 (1917).

138. Crowell v. Crowell, 180 N.C. 516, 105 S.E. 206 (1920). The argument is especially forceful when the state requires premarital blood tests, and thereby demonstrates a public concern about the transmission of disease. *See, e.g.*, CONN. STAT. ANN. § 466-26 (West 1986); FLA. STAT. ANN. § 741.051 (West Supp. 1984); N.J. STAT. ANN. § 37.1-9 (West Supp. 1984); N.Y. DOM. REL. LAW § 13-a (McKinney Supp. 1983). *See also* Note, *Premarital Tests for Venereal Disease*, 53 HARV. L. REV. 309, 310 (1931) (purpose of premarital venereal test laws is to prevent transmission of venereal disease to future spouse and to prospective children).

139. Kathleen K. v. Robert B., 150 Cal. App. 3d 992, 198 Cal. Rptr 273 (1984).

140. That is not to say that a person should be permitted to ignore known risks. As suggested

Since a reasonable person would realize that his chances of contracting AIDS are increased substantially if he engages in nonmonogamous sexual relationships, a person's conduct in doing so might be considered contributory negligence, and generally engaging in what have been denominated "unsafe sexual practices" may be evidence of some negligence on the part of the plaintiff, even if it does not rise to the level of assumption of the risk. In a jurisdiction in which contributory negligence is a complete bar to recovery, the distinction is merely academic. Still, in a comparative negligence state, if the plaintiff contracts AIDS and is found to have been comparatively negligent for engaging in sexual acts which created risk of transmission of the disease, his recovery will not be barred. Rather, his damages will be decreased by the amount by which his negligence contributed to his contracting the disease.

The policy which favors the imposition of a duty on persons to disclose their diseases is at least to some degree inconsistent with the imposition of a more general duty on others to restrict their sexual lives so as to avoid contracting those diseases. In comparative negligence jurisdictions, the imposition of both duties would not work as great an injustice since an infected person could still recover a portion of his damages. At the very least, while it may be socially awkward, those who engage frequently in activities most likely to allow the transmission of AIDS might be held to the less burdensome duties of inquiring of the health of their partners and taking hygienic precautions to help reduce the likelihood of infection.

Early common law barred suits by one spouse against another.[141] Although most courts have recognized that the infection of a wife with a venereal disease by her husband is tortious, those courts which have applied the common law have held that a wife cannot sue her husband for such tortious conduct.[142]

Early cases held that the doctrine of interspousal immunity precluded liability even in cases of knowing transmission of venereal disease.[143] Some jurisdictions continue to hold that a wife cannot sue her husband for deliberately infecting her with a venereal disease.[144] The

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below, such general knowledge may serve as the basis for holding that person to a duty to adopt reasonable protective measures apart from abstention.

141. *See* Merenoff v. Merenoff, 76 N.J. 535, 339-42, 388 A.2d 951, 953-55 (1978) (reviewing history of interspousal immunity).

142. *See, e.g.*, Schultz v. Christopher, 65 Wash. 496, 118 P. 629 (1911).

143. *See, e.g.*, Regina v. Clarence, [1888] 22 Q.B.D. (marital privilege permits husband to knowingly infect wife with venereal disease and escape liability for assault and battery); Schultz v. Christopher, 65 Wash. 496, 501, 118 P. 629, 631 (1911) (to permit divorced wife to recover from husband for infecting her with venereal disease during marriage would be against public policy).

144. *See, e.g.*, Bencomo v. Bencomo, 200 So. 2d 171, 173 (Fla.), *cert. denied*, 389 U.S. 970 (1967)

principal justification for interspousal immunity is the frequent curious claim that permitting an action between spouses would be a step in the direction of destroying the peace and harmony of marriage.[145]

The doctrine of interspousal immunity has been rejected more and more often in recent years. The better view is that a husband or wife is not immune from tort liability to a spouse solely by reason of the marital relationship;[146] a majority of states have abrogated the doctrine of interspousal immunity.[147] In these states, suits for battery for transmission of HIV or AIDS will not be barred. However, some states allow such actions only after a marriage has been terminated by divorce,[148] and some states have rejected interspousal immunity only in cases of intentional torts such as battery.[149] In those states which have abrogated interspousal immunity only in cases of intentional torts, a spouse would have to sue for battery, rather than negligence, in order to recover for transmission of HIV or for having contracted AIDS from a spouse.

A spouse will be unable to recover damages in those states which continue to maintain the doctrine of interspousal immunity.[150] However, some courts that adhere to the doctrine of interspousal immunity have held that it does not apply to torts committed before marriage.[151] In such a jurisdiction, persons who could show that they had been exposed to the virus or contracted the disease from sexual activities with their spouses before marriage would be able to sue their spouses for having transmitted the disease.

Where AIDS is transmitted as a result of sexual activity between homosexuals or unmarried persons, a defendant may be able to raise a defense of illegality, since in many jurisdictions the underlying sexual activity will violate statutory prohibitions against fornication,[152] sod-

(in accordance with the common law, the wife cannot maintain an action against her husband for assault and battery for deliberately infecting her with a venereal disease).

145. *See, e.g.*, Bandfield v. Bandfield, 117 Mich. 80, 82, 75 N.W. 287, 288 (1898) (to permit the wife to sue her husband would be another step toward destruction of the sacred relation of man and wife).

146. RESTATEMENT (SECOND) OF TORTS § 895F (1979 & Supp. 1982).

147. *Id.* at 287-89.

148. *See, e.g.*, Windauer v. O'Connor, 107 Ariz. 267, 485 P.2d 1157 (1971).

149. *See, e.g.*, *Windauer, supra*; Apitz v. Dames, 205 Or. 242, 287 P.2d 585 (1955); Bounds v. Caudle, 560 S.W.2d 925 (Tex. 1977); Stoker v. Stoker, 616 P.2d 590 (Utah 1980).

150. *See, e.g.*, Alfree v. Alfree, 410 A.2d 161 (Del. 1979), *appeal dismissed*, 446 U.S. 931 (1980); Jones v. Swett, 244 Ga. 715, 26 S.E.2d 610 (1979); Varholla v. Varholla, 56 Ohio St. 2d 269, 383 N.E.2d 888 (1978).

151. *See, e.g.*, O'Grady v. Potts, 193 Kan. 644, 396 P.2d 285 (1964); Hamilton v. Fulkerson, 285 S.W.2d 642 (Mo. 1955); Pearce v. Boberg, 89 Nev. 266, 510 P.2d 1358 (1973).

152. *See, e.g.*, N.C. GEN. STAT. § 14-184 (1986); R.I. GEN. LAWS § 11-6-3 (1956); S.C. CODE ANN. § 16-15-60 (Law. Co-op. 1977); WIS. STAT. § 944.15 (1985).

omy,[153] or adultery.[154] The general rule is that a person cannot maintain a cause of action for an illegal or immoral act or transaction to which he is a party.[155] The principle underlying this rule is that the law will not permit a person to take advantage of or acquire a right of action from his own unlawful act or wrong.

An early Irish case illustrates the operation of this doctrine as an absolute defense.[156] In that case, an unmarried plaintiff female sued her lover for battery for transmitting syphilis to her and her child; the plaintiff's claim was predicated on the notion that her consent was fraudulently procured by the defendant's concealment of his diseased condition. The Irish appellate court affirmed dismissal of the action on the ground that "[c]ourts of justice no more exist to provide a remedy for the consequences of immoral or illegal acts and contracts than to aid or enforce those acts or contracts themselves."[157]

The defense of illegality in the context of sexual relations has been eroded over the years. In some courts which continue to recognize the defense, it has been limited to situations where the parties are of equal guilt. In a Texas case decided in 1936, the plaintiff, a single woman, consented to sexual intercourse with the defendant allegedly because he promised to marry her.[158] As a result, she became infected with crab lice. Although the court recognized that no one by his own wrong acquires a right of action, it limited the use of this principle to cases where the parties were equally culpable. In the court's poetic language:

> [W]hatever of either illegality or immorality the two of them together may have indulged, in the woman's deception-induced and unknowing yielding of her clean body to such a union with his disease-carrying one—could not, by any just standard this tribunal knows of, have left her act so culpable as his.[159]

In more fundamental attacks, challenges have been made to the constitutionality of statutes prohibiting the underlying sexual activity. In 1976, the Iowa Supreme Court struck down the state's consensual sodomy statute on the ground that it violated constitutional protection which the United States Supreme Court had extended to "the manner

153. *See, e.g.*, N.D. CENT. CODE § 2.1-20-12 (1985); OKLA. STAT. tit. 21, § 886 (1981).

154. *See, e.g.*, N.Y. PENAL LAW § 255.17 (McKinney 1980); N.C. GEN. STAT. § 14-184 (1986); N.D. CENT. CODE § 12.1-20-09 (1985); OKLA. STAT. tit. 21, § 872 (1983); R.I. GEN. LAWS § 11-6-2 (1956); S.C. CODE ANN. § 16-15-60 (Law. Co-op. 1977); WIS. STAT. § 944.15 (1985).

155. *See, e.g.*, Wager v. Pro, 603 F.2d 1005, 1008 (D.C. Cir. 1979); Mettes v. Quinn, 89 Ill. App. 3d 77, 411 N.E.2d 549 (1980); Cole v. Taylor, 301 N.W.2d 766, 768 (Iowa 1981).

156. Hegarty v. Shine, 14 Cox's Crim. L. Cas. 145 (Irish H. Ct. 1878).

157. *Id.* at 147.

158. DeVall v. Strunk, 96 S.W.2d 245 (Tex. Ct. App. 1936).

159. *Id.* at 247.

of sexual relations performed in private between consensual adults of the opposite sex not married to each other."[160] In 1977, the New Jersey Supreme Court invalidated New Jersey's fornication law on the ground that since the United States Supreme Court had extended the right of privacy to encompass the decision to bear or beget children, "[i]t would be rather anomalous if such a decision could be constitutionally protected while the more fundamental decision as to whether to engage in the conduct which is a necessary prerequisite to childbearing could be constitutionally prohibited."[161]

That trend toward invalidating such laws on the basis of the federal constitution was cut short, at least in part, by the Supreme Court's decision in *Bowers v. Hardwick*.[162] There, the Court held that a state may prohibit sodomy consistently with the Due Process Clause.[163] *Bowers* may not, however, go very far toward bolstering the illegality defense in AIDS cases for two reasons. First, states may rely on their own constitutions to strike criminal laws regulating sexual activity between consenting adults.[164] Second, even without a finding that statutes providing criminal penalties for sexual activity between unmarried persons are unconstitutional, courts have been increasingly willing to provide recovery where a partner causes injury or knowingly transmits an incurable disease to an innocent party as a result of sexual relations. Two California courts have recently upheld plaintiffs' claims for damages arising out of sexual activity between unmarried persons. In one case, the court held that a woman stated causes of action in battery and deceit by alleging that she relied on the respondent's misrepresentation of sterility in consenting to sexual intercourse, and, as a result of intercourse, required surgery to correct an abnormal pregnancy.[165] In another case, the court found that the plaintiff stated a cause of action by charging that the defendant had

160. State v. Pilcher, 242 N.W.2d 348, 359 (Iowa 1976), citing Eisenstadt v. Baird, 405 U.S. 438 (1972).

161. State v. Saunders, 75 N.J. 200, 214, 381 A.2d 333, 340 (1977), citing Carey v. Population Serv. Int'l, 431 U.S. 678 (1977).

162. 106 S.Ct. 2841 (1986).

163. One writer has argued that the AIDS crisis should not be used as a basis for criminalizing sodomy or otherwise regulating homosexual conduct. Comment, *AIDS: A New Reason to Regulate Homosexuality?*, 11 J. CONTEMP. L. 315 (1984).

164. *Bowers* was careful to explain that

> Th[e] case does not require a judgment on whether laws against sodomy between consenting adults in general, or between homosexuals in particular, are wise or desirable. It raises no question about the right or propriety of state legislative decisions to repeal their laws that criminalize homosexual sodomy, or of state court decisions invalidating those laws on state constitutional grounds.

106 S.Ct. at 2843.

165. Barbara A. v. John G., 145 Cal. App. 3d 369, 193 Cal. Rptr. 422 (1983).

infected her with genital herpes as a result of sexual relations.[166] Neither court was faced with a defense of illegality since the underlying sexual activity was not criminal under California law. However, the courts' focus on the relative fault of the parties suggests that the transmitter may be denied the opportunity to avail himself of the defense of illegality when his action is fraudulent or grossly negligent.[167]

An action seeking judicial imposition of tort liability for sexual transmission of HIV or AIDS must overcome the assertion that such liability violates the constitutional right to privacy.[168] Courts usually are reluctant to sanction state intrusion into private relationships. The question arises, however, whether such intrusion is warranted under particular circumstances. The Arizona Supreme Court, in a case decided in 1976, upheld a husband's conviction for forcing his wife to perform fellatio on him, rejecting the argument that the United States Supreme Court cases recognizing a right to privacy in sexual relationships prevented the court from inquiring into such intimate matters.[169] The court reasoned that a state retains a compelling interest in protecting its citizens from violence.

The California Court of Appeals in 1984, in *Kathleen K. v. Robert B.*,[170] reasoned similarly that the constitutional right to privacy does not preclude an unmarried woman from suing a man in tort for transmission of herpes to her as a result of sexual intercourse. The defendant maintained that it was not the business of the judiciary to supervise the promises or claims made between two consenting adults concerning the circumstances of their private sexual conduct. The court acknowledged that the defendant had correctly focused on the constitutional right of privacy as the crux of the litigation; and that courts have recognized that in matters relating to marriage, family and

166. Kathleen K. v. Robert B., 150 Cal. App. 3d 992, 198 Cal. Rptr. 273 (1984).

167. That argument is often presented in the context of transmission of herpes through adultery or fornication. *See* sources cited *supra* note 105. Those commentators would also find support for liability in the *public's* interest in preventing the spread of venereal and communicable diseases. Although the same arguments apply just as forcefully in the context of AIDS, it must be recognized that a court could equally as well argue that illegal conduct should be discouraged, and that one means of discouraging fornication, sodomy, etc., may be to preclude tort victims from recovering for their injuries.

168. *See* Eisenstadt v. Baird, 405 U.S. 438 (1972) (ban on distribution of contraceptives to unmarried persons is unwarranted governmental intrusion into individual's right to privacy); Stanley v. Georgia, 394 U.S. 557, 564 (1969) (law regulating private possession of pornography held unconstitutional—one has right "to be free, except in very limited circumstances, from unwanted governmental intrusions into one's privacy"); Griswold v. Connecticut, 381 U.S. 479, 485-86 (1965) (state law prohibiting use of contraceptives by married couples unconstitutionally intrudes in right of marital privacy).

169. State v. Bateman, 113 Ariz. 107, 547 P.2d 6 (en banc), *cert. denied*, 429 U.S. 864 (1976) (citing Griswold v. Connecticut, 381 U.S. 479 (1965) and Eisenstadt v. Baird, 405 U.S. 438 (1972)).

170. 150 Cal. App. 3d 992, 198 Cal. Rptr 273 (1984).

sex, the right of privacy precludes unwarranted governmental intrusion. Nevertheless, the court reasoned, the right of privacy is not absolute, and in some instances it must be subordinated to the state's fundamental right to enact laws promoting public health, welfare and safety of its citizens, even though those laws may invade a person's right of privacy. In the case before the court, it was observed that the woman alleged that she sustained physical injury due to the defendant's tortious conduct in either negligently or deliberately failing to inform her that he was infected with a serious incurable venereal disease. The court concluded that the tortious nature of the defendant's conduct, coupled with the interest of the state in preventing and controlling contagious and dangerous diseases, brought the suit within the category of cases which can be maintained over a claim of right of privacy by a defendant. While the case before the California Court of Appeals involved the knowing transmission of genital herpes, the court explicitly recognized that a similar result should occur in a suit brought against a person who, knowing that he or she has AIDS, transmits the disease to a sexual partner, and that a claim of constitutional right of privacy would not preclude such a cause of action.[171]

Many jurisdictions impose penalties for the transmission of venereal disease.[172] These laws demonstrate a significant concern on the part of the state about the transmission of venereal and sexually transmitted disease. That concern should provide an adequate basis for courts to subordinate the right of privacy of persons who knowingly transmit AIDS, thus endangering the health of the community and inflicting physical injury and suffering on their sexual partners, to the right of recovery of those persons harmed by such conduct.

F. Liability for Transmission in the Context of Childbirth

It is believed that HIV is transmitted from infected women to their fetuses during pregnancy, labor and delivery.[173] There is evidence that the virus may be transmitted through breast feeding, and there have been cases reported of HIV infection related to artificial insemination. While the risk of perinatal transmission from an infected mother is high (sixty-five percent), transmission is not inevita-

171. *Id.* at 996 n.3, 198 Cal. Rptr. at 276 n.3.

172. *See, e.g.*, ALA. CODE § 22-16-17 (1975) (misdemeanor); N.Y. PUB. HEALTH LAW § 2307 (McKinney 1977) (misdemeanor); WASH. REV. CODE ANN. §§ 70.24.010-.110 (1975) (gross misdemeanor).

173. *Recommendations for Assisting in the Prevention of Perinatal Transmission of Human T-Lymphotropic Virus Type III/Lymphadenopathy—Associated Virus and Acquired Immunodeficiency Syndrome*, 34 MORBIDITY & MORTALITY WEEKLY REP. 721 (1985).

ble.[174] Those most likely to be infected with the virus are women who have tested positive for the antibody, women born in countries where heterosexual transmission is thought to occur, women who are prostitutes, and women who are partners of men who are IV drug users, bisexual, hemophiliacs, were born in countries where heterosexual transmission is thought to occur, or have evidence of HIV infection.[175]

A child born with AIDS will necessarily suffer from the disease and may die. In addition, there are many extraordinary medical expenses associated with care and treatment. Suits may be brought in the name of the child (and some cases in a parent's own right) against an infected parent or sexual partner of the mother and in some appropriate cases against blood suppliers.

A child born alive may maintain an action in every jurisdiction for prenatal injuries.[176] If the child dies as a result of such injuries after birth, an action can be maintained by his or her survivor for wrongful death.[177] The more difficult question arises as to whether claims should be permitted where the harmful contact with the mother occurs before the child is conceived. In the malpractice context, some courts have found liability for preconception injuries resulting from negligent injury to the mother some years before conception but which resulted in brain damage to the child at the time of the subsequent birth,[178] while others have denied recovery in similar cases.[179]

Most early American courts refused to allow an action between a minor child and a parent for personal torts, whether the torts were intentional or negligent.[180] Some courts have allowed recovery for personal injuries which are intentionally inflicted,[181] and several have

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174. *Id.*

175. *Id.* at 723.

176. *See* RESTATEMENT (SECOND) OF TORTS § 869 (1965).

177. *See, e.g.*, Simon v. Mullin, 34 Conn. Supp. 139, 380 A.2d 1353 (1977).

178. *See, e.g.*, Bergstreser v. Mitchell, 577 F.2d 22 (8th Cir. 1978) (child alleged that as a result of negligence of physician and hospital in performing Caesarean section upon the child's mother several months prior to his conception, his mother suffered a rupture of the uterus, which necessitated his own premature emergency Caesarean delivery during which he sustained brain damage as a result of oxygen deficiency).

179. *See, e.g.*, Albala v. City of New York, 78 A.D.2d 389, 434 N.Y.S.2d 400, *aff'd*, 54 N.Y.2d 269, 445 N.Y.S.2d 108, 429 N.E.2d 786 (1981) (prior abortion of mother resulted in perforation of uterus and subsequently caused brain damage in fetus later conceived; nonetheless, child cannot maintain action for negligence occurring prior to conception).

180. *See, e.g.*, Hastings v. Hastings, 33 N.J. 247, 163 A.2d 147 (1961); McKelvey v. McKelvey, 111 Tenn. 388, 77 S.W. 664 (1903).

181. *See, e.g.*, Treschman v. Treschman, 28 Ind. App. 206, 61 N.E. 961 (1901); Felderhoff v. Felderhoff, 473 S.W.2d 928 (Tex. 1971).

extended liability to "wilful or wanton" or reckless conduct.[182] Since 1963, more than half the states have abrogated parent-child immunity either by judicial decision or statute.[183] Some courts have gone so far as to hold parents liable for negligent or intentional prenatal injury to a child; for example, liability has been recognized where a mother ingested drugs that caused her child to be born with a deformity.[184]

There is thus authority to hold a parent liable who tranmits HIV to a child during pregnancy, and possibly for conduct prior to conception which ultimately results in transmission of the virus to the child. Thus, a mother who engages in intravenous drug use with shared needles may be liable to a child for transmission of the virus. Likewise, a father who knows that he is infected with HIV but engages in sexual intercourse and transmits the virus to the mother may be held liable for the foreseeable transmission of the HIV virus to the child and for the child's ultimate development of AIDS.

In the case of transmission through the use of shared needles, once a battery is established, the defendant's liability may extend not only to the user who contracts the virus, and to his or her survivor in a wrongful death action where death occurs, but also to the offspring of the infected person. As a general rule, one who is injured prior to or during birth by the intentional or reckless conduct of another may recover from the tortfeasor for damages for such prenatal injuries. The Supreme Court of Oklahoma recently recognized the right of a viable unborn child to recover damages for injuries caused during the mother's pregnancy. The court reasoned: "[J]ustice requires that the principle be recognized that a child has a legal right to begin life with a sound mind and body. If the wrongful conduct of another interferes with that right, and it can be established by competent proof that there is a causal connection between the wrongful interference and the harm suffered by the child when born, damages for such harm should be recoverable by the child."[185] Some courts have gone so far as to permit the child to recover from tortfeasors who harmed the mother prior to the child's conception upon finding that the child's injuries were a foreseeable consequence of the tort against the mother.[186] Thus, if a

182. *See, e.g.*, Attwood v. Estate of Attwood, 276 Ark. 230, 633 S.W.2d 366 (1982); Nudd v. Matsoukas, 7 Ill. 2d 608, 131 N.E.2d 525 (1956).

183. *See, e.g.*, Hebel v. Hebel, 435 P.2d 8 (Alaska 1967); Williams v. Williams, 369 A.2d 669 (Del. Super. Ct. 1976); Goller v. White, 20 Wis. 21, 402, 122 N.W. 193 (1963). *See also* CONN. GEN. STAT. § 2-572c (1977); N.C. GEN. STAT. § 1-539.21 (1983).

184. *See, e.g.*, Grodin v. Grodin, 102 Mich. App. 396, 301 N.W.2d 869 (1980) (liability on part of mother taking prescription drugs during pregnancy causing child's teeth to turn brown, if the mother did not act reasonably).

185. Evans v. Olson, 550 P.2d 924, 927 (Okla. 1976).

186. Mink v. University of Chicago, 460 F.Supp 713, 718 (N.D.Ill. 1978).

woman is infected with HTLV-III/LAV as a result of intentional or knowing sharing of infected needles, or as a result of intercourse with a partner who knew he was infected with HIV or had AIDS, the tortfeasor may be liable to children.

Similarly, a supplier of blood who has been negligent in providing a mother with HIV contaminated blood before or during pregnancy is probably liable to the child for injuries resulting from transmission of the virus and for ultimate contraction of AIDS. In a landmark case decided in 1977, the Illinois Supreme Court considered the question of whether a child, not conceived at the time of negligent acts related to a blood transfusion, could maintain a cause of action against a doctor and a hospital for injuries resulting from their conduct.[187] The defendants had negligently transfused the plaintiff's mother with incompatible blood when the mother was thirteen years old. The mother had no adverse reaction from the transfusion and did not learn that her blood had been sensitized until eight years later when she was pregnant. As a result of the mother's blood having been sensitized, the child suffered permanent damage to various organs, including its brain and nervous system. Even though the negligent conduct occured prior to conception, the court held that it was foreseeable that a teenage girl would later bear a child who would be injured by an improper blood transfusion.[188] The court stated that it was clear that there would be liability for this conduct if the child, unknown to the defendants, had been conceived prior to the transfusion, and reasoned that every child has "a right to be born free from prenatal injuries foreseeably caused by a breach of duty to the child's mother."[189] The court found that the availability of medical techniques which could eliminate the harm caused by the defendant's negligence justified the placing of responsibility on the defendants.[190]

IV. Possible Limitations on Tort Liability

The standards of duty imposed by courts with respect to the misdiagnosis and transmission of AIDS and defenses thereto are likely to turn on determinations of sensitive public policy questions. The plaintiff who succeeds in obtaining the recognition of—and establishing the breach of—duties in any of the contexts above has gone very far indeed. Nonetheless, that plaintiff still faces two obstacles that may prove insuperable: first, his action may be barred by a statute of limita-

187. Renslow v. Mennonite Hospital, 67 Ill. 2d 348, 367 N.E.2d 1250 (1977).

188. 67 Ill. 2d at 350, 367 N.E.2d at 1255.

189. *Id.*

190. *Id.*

tions or a statute of repose; second, after proving the defendant's duty and breach thereof, he must prove that the particular breach caused his injuries.

A. Limitations of Action

A person develops AIDS after becoming infected with HIV but ordinarily cannot be so diagnosed until his body produces sufficient antibodies to be detected or until opportunistic diseases set in, whose presence suggests the presence of HIV.[191] The latency between the initial infection with HIV and antibody development is unknown, and there is a long latency between antibody development and disease outcome in those who eventually develop AIDS.[192] And as noted above, not all carriers of the AIDS associated virus will themselves be stricken with AIDS.

Those uncertainties pose substantial barriers under statutes of limitation and statutes of repose. A statute of repose places an upper limit on the time during which an action may be commenced, and by its very nature is usually not subject to equitable tolling.[193] In addition, because the purpose of a statute of repose is to establish certainty with respect to limitations on a tortfeasor's potential liability, the commencement of its running is usually fixed by the fairly definite time of the breach of duty and not by the plaintiff's discovery thereof or injury from the breach, either of which may occur years after the breach of duty.

Such statutes are especially troubling for the AIDS victim. A diligent patient who submits himself for testing regularly may carry the AIDS virus but not be susceptible to diagnosis. Moreover, even a victim who is diagnosed as carrying the virus may not develop AIDS for several years—if he ever does—and thus not suffer any physical harm. When he files an action so as not to be barred by the statute of repose, then, his only recourse may lie in damages for emotional distress.

Even if the state's laws do not include a statute of repose, the plaintiff must still file suit within the time permitted by the appropriate statute of limitations. A statute of limitations generally bars actions not commenced within a few years of the date on which the plaintiff's

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191. *See supra* notes 8-14 and accompanying text.

192. Blattner, Biggor, Weiss, Melbye & Goedert, *Epidemiology of Human T-Lymphotropic Virus Type III and the Risk of the Acquired Immunodeficiency Syndrome*, 103 ANNALS OF INTERNAL MED. 665, 669 (1985).

193. *See, e.g.*, ILL. ANN. STAT. ch. 110, § 13-212 (Smith-Hurd 1984):

> [I]n no event shall [a malpractice] action be brought more than 4 years after the date on which occurred the act or omission or occurrence alleged in such action to have been the cause of such injury or death except [when the tortfeasor conceals the cause of action].

cause of action accrues. Because a plaintiff's cause of action ordinarily accrues either upon his discovery of the defendant's breach or upon the manifestation of his injury, statutes of limitations are often less troublesome for plaintiffs than statutes of repose in cases of torts involving latent diseases. Nonetheless, their effects may be just as draconian.

In some jurisdictions, the limitation period begins running at the time of the defendant's breach. For example, a recent New York court held that the plaintiff's cause of action for asbestosis accrued on the date of his most recent exposure to the dangerous particles.[194] While he may have had no reason to suspect the disease until years after that time, his action was nonetheless barred. In such a jurisdiction, the statute of limitations is as unforgiving to plaintiffs as a statute of repose, and in AIDS cases very often will bar recovery.

In other jurisdictions, the plaintiff's cause of action will be held to have accrued only on the date the plaintiff discovers—or reasonably should have discovered—the breach.[195] While such an interpretation may provide more protection to the AIDS plaintiff than that discussed above, it may still force him to bring an action well before any compensable or reasonably measurable harm has occurred.

The significance of that problem is illustrated by a Wyoming case in which the plaintiff discovered, well within the limitations period, that she had been infected with gonorrhea. She did not file suit until she developed serious complications as a result of the infection, however, and well after the limitations period expired.[196] The Wyoming Supreme Court held that her cause of action accrued upon her discovery of the infection and not when the most serious—and perhaps foreseeable—consequences arose.[197] Precisely the same problem will arise with many AIDS plaintiffs, and in effect they will be prevented from recovering for their most substantial injuries.[198]

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194. Steinhardt v. Johns-Manville Corp., 54 N.Y.2d 1008, 446 N.Y.S.2d 244, 430 N.E.2d 1297 (1981), *cert. denied*, 456 U.S. 967 (1982). *See also* Thornton v. Roosevelt Hosp., 47 N.Y.2d 780, 417 N.Y.S.2d 920, 391 N.E.2d 1002 (1979) (cause of action for injuries arising from injection of carcinogenic chemical accrues upon injection and not upon manifestation of injury; here, 18-year latency effectively barred action).

195. *See, e.g.*, COLO. REV. STAT. § 13-80-108(1) (Supp. 1986):

> A cause of action for injury to [a] person . . . shall be considered to accrue on the date both the injury and its cause are known or should have been known by the exercise of reasonable diligence.

196. Duke v. Housen, 589 P.2d 334 (Wyo.), *cert. denied*, 444 U.S. 863 (1979). The plaintiff had actually filed an earlier suit immediately upon realizing that she had been infected, even though she suffered only minor injuries. That complaint was dismissed, and apparently was not given collateral estoppel effect for reasons not explained in the Supreme Court's opinion.

197. The court construed several states' statutes of limitations.

198. Some states which follow the discovery rule generally may not apply it to misdiagnosis cases,

B. Causation

Extremely effective procedures have been developed for identifying the origin of HIV infection in cases of transmission of AIDS occuring from blood transfusion or receipt of blood products. Through the use of antibody tests and the development of personal histories, the identification of the origin of AIDS may provide no special evidentiary problems in the context either of transmission through childbirth or of sexual transmission to a monogamous partner.

However, given the latency period for development of the antibodies to HIV, and even more significantly the latency for developing AIDS, severe practical problems will usually arise in establishing that a particular contact transmitted the disease. A person who contracts AIDS through the use of contaminated needles likely will have been involved in too numerous incidents of drug use to isolate that particular incident which caused the transmission. Similarly, AIDS victims who engage in sexual activity frequently with different partners may find it insurmountably difficult to establish the causal element of the torts on which they rely.

V. CONCLUSION

Exposure to HIV has the potential for producing great psychological stress and anxiety. Development of AIDS with its associated opportunistic diseases and infections most often involves pain, suffering, incapacitation, and death. The individual enduring those conditions may seek compensation in the form of money damages through litigation. There are several well-established causes of action which may be pursued in the context of misdiagnosis, mistreatment, or transmission of AIDS. Medical malpractice doctrines provide a basis for recovery in the case of negligent misdiagnosis or failure to diagnose AIDS; similarly, common law negligence principles provide the most likely means of recovery when the victim contracts AIDS through the receipt of contaminated blood products. Liability for the sexual transmission of AIDS may be founded on a number of theories—some of which are more widely accepted than others—related to the negligent or intentional conduct of the transmitter.

Nevertheless, there are practical difficulties which arise in litigating AIDS victims' claims, the most substantial of which may be proving the necessary causal element of any cause of action. In addition, a

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however, and the plaintiff will face the less forgiving rule above. *See, e.g.*, Robinson v. Weaver, 550 S.W.2d 18 (Tex. 1977). *But see* Austin v. Litvak, 682 P.2d 41 (Colo. 1984) (state statute of repose which provides exception for "foreign object" and "knowing concealment" but not for "negligent misdiagnosis" held violative of state constitution's equal protection clause).

plaintiff who is able to file suit within the time allowed by statutes of limitation and repose may find it impossible to prove with certainty the harm he or she will eventually suffer. Finally, many jurisdictions may recognize defenses in cases arising out of the sexual transmission of AIDS which effectively bar the plaintiff from recovering.

Recognition of tort liability for the transmission of AIDS and for medical malpractice related to AIDS diagnosis and treatment will provide some victims with a source of relief. Moreover, recognition of liability may provide some measure of incentive to health care professionals to use proper diagnostic techniques, and to the public in general to learn about AIDS and to utilize that knowledge to avoid activities most likely to involve the transmission of HIV, or at least to adopt safer means of engaging in those activities. Nevertheless, the cost of treating an AIDS patient fully can be incredibly high and well beyond the means of many defendants. As a consequence, tort liability may have little effect in many contexts in shifting the burden of the plaintiff's illness to the negligent party. In such cases, the only effective means of assisting the AIDS patient will be through broader insurance coverage in the private sector or through government financing of the treatment of AIDS victims.