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## Urban Criminal Justice: Has the Response to the HIV Epidemic Been "Fair"?

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# URBAN CRIMINAL JUSTICE: HAS THE RESPONSE TO THE HIV EPIDEMIC BEEN "FAIR?"

Richard T. Andrias\*

## I. Introduction

The HIV epidemic as we know it is almost a decade old. Untold thousands have died and it is estimated that one million to two million Americans are infected.<sup>1</sup> Nevertheless, too often it has been irrational fears of contagion and disapproval of the subcultures associated with the illness that have driven society's response to the HIV epidemic. Has the legal community, which prides itself on being governed by due process and rationality, reacted any differently than the society at large? To what degree have legal decisions and policies been governed by fear, prejudice and ignorance rather than by science and sound public health policy? This Essay will explore the response of the criminal justice system to the HIV epidemic in three areas: specific cases that have been the focus of public debate; attempts to criminalize activities thought to spread the disease; and rule-making efforts by courts and court administrators that affect HIV litigants.

## II. The Science of Contagion

Despite numerous articles in the popular press and legal periodicals,<sup>2</sup> many Americans still fear HIV/AIDS infection by casual contact. However, no scientific evidence has emerged indicating that HIV, a blood borne pathogen, can be transmitted by other than blood-to-blood transmission or sexual contact between an infected person and his or her uninfected partner. There have been no reported cases of infection by casual contact even in households where persons share utensils, toothbrushes and other personal items over a sustained period.<sup>3</sup> Similarly, although trace amounts of the virus

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1. NATIONAL COMM'N ON AIDS, *AMERICA LIVING WITH AIDS* (1991).

2. See, e.g., Alexandra M. Levine, *Acquired Immunodeficiency Syndrome: The Facts*, 65 S. CAL. L. REV. 423 (1991).

3. G.H. Friedland et al., *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).

have been isolated in saliva, as well as in tears and urine, there have been no reported cases of transmission by biting or spitting.<sup>4</sup> Although sharing of needles by intravenous drug abusers accounts for the fastest growing method of HIV transmission, a health care worker accidentally pricked by an infected needle runs only an approximately 0.4% chance of infection.<sup>5</sup>

### III. The Law and Science

The issue of how courts treat HIV defendants necessarily involves questions of science and scientific testimony regarding how HIV is spread. When issues of science arise in litigation, the courts have rightly looked to data and probability. Before allowing expert testimony on a novel technical or scientific issue, New York courts use a threshold standard of whether the issue is "sufficiently established to have gained general acceptance in the particular field in which it belongs," the so-called *Frye* test.<sup>6</sup> For example, in areas of credibility lie detector results are not generally allowed. Nor is expert testimony on eye-witness reliability admitted except in a few states and some federal courts.<sup>7</sup> However, on the issue of fingerprint identification expert testimony is allowed. Similarly, ballistic evidence to connect firearms with their projectiles and chemical tests to measure blood alcohol and the narcotic content of powders is accepted. Medical opinion testimony is allowed on the cause of death or extent of injury, as is psychiatric testimony on a defendant's competence to stand trial or ability to know and appreciate his or her acts.

As newer fields of scientific study emerge, they are accepted in court when they meet the *Frye* test. Thus, over time, expert testimony on post traumatic stress syndrome has come to be accepted by our courts,<sup>8</sup> and we have seen over the last half decade the acceptance of the science of DNA comparisons.<sup>9</sup>

The courts turn to science because due process requires it. Theoretical possibilities are not enough to decide a sophisticated dispute.

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4. D.D. Ho et al., *Infrequency of Isolation of HTLV-III Virus From Saliva in AIDS*, 313 NEW ENG. J. MED. 1606 (1985).

5. See Levine, *supra* note 2.

6. *Frye v. United States*, 293 F. 1013, 1014 (D.C. Cir. 1923); *People v. Middleton*, 54 N.Y.2d 42 (1981).

7. Wayne T. Westling, *The Case for Expert Witness Assistance to the Jury in Eyewitness Identification Cases*, 71 OR. L. REV. 93 (1992); *U.S. v. Dowling*, 753 F.2d 1224, (3d Cir. 1985).

8. *People v. Liberta*, 64 N.Y.2d 152 (1984).

9. Gary Spencer, *DNA Test Evidence Admitted for Trial*, N.Y. L.J., Oct. 26, 1992, at 1. The remaining battleground for DNA is not its validity as a tool but whether the particular procedures utilized in a specific case are reliable.

While jurors are instructed that they ultimately must decide whether or not they are persuaded by expert testimony, due process demands that jurors hear medical or scientific evidence to assist them when the issue is beyond the ken of lay jurors.

The U.S. Supreme Court in *School Board of Nassau County v. Arline*<sup>10</sup> insisted on the introduction of "medical judgments" based on the "state of medical knowledge" whenever public health measures limit constitutional rights.<sup>11</sup> This means that accurate scientific testimony should be introduced in all cases involving HIV.<sup>12</sup> Unfortunately, this mandate is not always heeded by our courts.

#### IV. Specific Cases

Many of the HIV cases that get the most public attention are examples of either the legal system's failure to consider accurate scientific information regarding HIV or the legal system's failure to correctly apply accurate information.<sup>13</sup> A review of several of these high profile cases reveals that often the "expert" testimony was not based on generally accepted scientific knowledge about HIV. In other cases, when accurate information regarding HIV was introduced, the decisions appear to ignore this evidence.

In a Walker County Texas case, a defendant named Curtis Weeks was charged and convicted of attempted murder for spitting on a prison guard.<sup>14</sup> He received a life sentence. According to press accounts the prosecution presented two experts: the first witness, a social psychologist, reportedly testified that HIV can be transmitted by saliva and by mosquitoes and by sharing an enclosed space with an infected person. The second "expert," a nurse with no training in infectious diseases, testified that the Federal Centers for Disease Control were seeking to suppress reports that AIDS can be transmitted through casual contact. The intermediate appellate court upheld Mr. Weeks's conviction and it is currently pending before the Texas court for criminal appeals.

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10. 480 U.S. 273 (1987).

11. *Id.* at 287-88.

12. While HIV is not a contagious disease, it is a disability now covered by the new Americans with Disabilities Act. 42 U.S.C. §§ 12101-12213 (Supp. II 1990) (the "ADA"). While the ADA prohibits discrimination against "qualified" persons with disabilities in employment, public services, public accommodations and telecommunications, the rational, science-based approach of the act which is also espoused by the Court in *Arline* will undoubtedly be applied by analogy to other areas of broad public concern.

13. David Margolick, *Legal System Is Assailed on AIDS Crisis*, N.Y. TIMES, Jan. 19, 1992, at A16.

14. David Margolick, *Tide of Lawsuits Portrays Society Ravaged by AIDS: Anguish and Unclear Guidelines Link Three Cases*, N.Y. TIMES, Aug. 23, 1992, at A1.

Even where the scientific and medical evidence is accurately presented at a trial, the "fairness" of the result can be a matter of debate. In a recent Tennessee case, the state health commissioner testified that there were no known cases of HIV transmission through saliva; nevertheless, a woman faced felony criminal charges for allegedly failing to tell ambulance attendants who performed mouth-to-mouth resuscitation on her fiance that he was infected with HIV.<sup>15</sup>

Another case where accurate scientific evidence was ignored involved defendant Donald J. Haines, who had slashed his wrists and arms in an apparent suicide attempt. Haines yelled at police officers that he would "give it" to them and caused blood to spray into an officer's eyes and mouth.<sup>16</sup> After he was convicted of attempted murder by a jury, the trial judge set aside the verdict and entered a verdict for a lesser felony (battery). Although there was expert testimony that Haines might be spreading a variety of diseases by his acts, there was no evidence that he could spread HIV by spitting or throwing blood.

The Indiana appeals court reversed the trial judge's action in *Haines* and reinstated the attempted murder conviction. The court noted that Indiana rejects the defense of impossibility and thus the state was not required to prove that Haines's conduct could actually have caused death. According to the court, the State showed that Haines repeatedly announced that he had AIDS and desired to infect and kill others.<sup>17</sup> It was only necessary for the state to show that Haines did all that he believed necessary to bring about an intended result.<sup>18</sup>

Another nationally discussed incident, the Eighth Circuit case of *United States v. Moore*,<sup>19</sup> also raises the issue of the application and use of accurate medical evidence. This case is also significant because the AIDS/HIV factor was singled out, when another potentially more potent infectious agent (hepatitis) was ignored by the prosecutor. In

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15. *AIDS-Related Call for Help Leads to Criminal Charge*, N.Y. TIMES, June 2, 1991, at 34. Aside from the science versus fear issue here, this case and others like it raise troubling issues of the failure by public safety officers to take universal safety precautions when involved in (even remotely) potentially exposure-prone procedures. See also *NJ v. Smith*, No. A-6363-89T1 (App. Div. Feb. 17, 1993) (HIV defendant convicted of attempted murder, aggravated assault and terroristic threats after biting a corrections officer); Elizabeth B. Capor, *HIV Exceptionalism, Or Making Plague Pay*, N.Y. L.J., Mar. 29, 1993.

16. *State v. Haines*, 545 N.E.2d 834, 839 (Ind. Ct. App. 1989).

17. *Id.* at 839.

18. *Id.*

19. 846 F.2d 1163 (8th Cir. 1988).

Moore,<sup>20</sup> a Minnesota District Court jury convicted the defendant of assault with a dangerous weapon arising out of his biting a correction officer. No skin was broken, but the defendant had told the officers he refused to be cuffed and threatened to kill them during (and after) the struggle.

The Eighth Circuit was not persuaded by Moore's argument on appeal that there was insufficient evidence to find that his mouth and teeth were deadly weapons. The court upheld the trial judge's refusal to charge that if the government failed to prove that AIDS can be transmitted by means of a bite, then it failed to prove that Moore's mouth and teeth were a deadly and dangerous weapon. The court accepted the expert testimony that:

"the medical evidence in the record was *insufficient* to establish that AIDS may be transmitted by a bite. The evidence established that there are no well proven cases of AIDS transmission by way of a bite; that contact with saliva has never been shown to transmit the disease; and that in one case a person who had been deeply bitten by a person with AIDS tested negative several months later . . . . [I]n a legal context the possibility of AIDS transmission by means of a bite is too remote to support a finding that the mouth and teeth may be considered a deadly and dangerous weapon in this respect."<sup>21</sup>

The court, nevertheless, found that the human bite was dangerous and could transmit various serious infections such as hepatitis, holding that:

"the record, viewed in the light most favorable to the government, contained sufficient evidence to allow the jury to find that Moore's mouth and teeth were used as a deadly and dangerous weapon, *even if Moore was not infected with AIDS*. As the district court correctly held, moreover, the reference to AIDS in the indictment was mere surplusage and did not limit the government to one theory of the case at trial."<sup>22</sup>

More troubling for HIV litigants, however, is the Circuit Court's outright dismissal of Moore's argument that the prosecutor singled out his HIV status. The government did not charge him under the theory that *any* bite was a deadly and dangerous instrument, but charged him in the indictment with assaulting the victim after having previously tested positive for HIV. The government appeared to have ignored the fact that Moore was also infected with hepatitis. This is

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20. *Id.*

21. *Id.* at 1168 (emphasis added).

22. *Id.* at 1167 (emphasis added).

curious in light of the fact that hepatitis is a deadly blood borne pathogen with a far greater likelihood for transmission during a bite, splattering of blood or a needle prick.<sup>23</sup> In addition, the hepatitis virus remains active outside the body longer and is more efficient in transmission. Thus Moore's argument that he was prosecuted solely because of his HIV status cannot be lightly dismissed.<sup>24</sup>

More troubling than the prosecution of these cases — which are often initiated for political purposes or a perceived need to “do something” — is the question of how emergency and/or public safety officers are educated, trained and equipped. Where public safety officers are not educated about the actual methods of transmission, they often focus on erroneous risks (air borne contagion or spitting) and overlook genuine potential dangers (blood spills and needle pricks). In jurisdictions where public safety officers are educated about the methods of transmission of HIV and are trained about taking universal precautions when an exposure-prone event occurs (blood spills, etc.), there are few calls for criminal prosecutions when incidents do occur. Gloves, eye shields and other appropriate barriers and protective equipment must be made available where the situation warrants but should not be used to stigmatize a defendant where there is no exposure-prone event or potential for violence.<sup>25</sup> Overreactions such as masks or shields can escalate a tense situation and even provoke a violent response. In reality, most AIDS inflicted defendants are debilitated physically and mentally, and incidents of contagion are rare. In New York County today a significant percentage of the defendant population has tested HIV positive, yet the correction and court officers handle detainees without incident or undue concern.

## V. Criminalization of AIDS

The incurable nature of HIV disease and early confusion about the nature of transmission understandably lead to various punitive efforts to deter infected persons from transmitting the virus to others. Legal

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23. See Levine, *supra* note 2.

24. While the Occupational Safety and Health Administration treats HIV and hepatitis in the same guidelines, 56 Fed. Reg. 235 (1991), and the Centers for Disease Control's recommendations for preventing exposure to HIV and hepatitis during invasive procedures are the same, *Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedure*, 38 MORBIDITY & MORTALITY WKLY. REP. No.18, July 12, 1991, there have been no reported cases prosecuting deadly assault by a hepatitis carrier.

25. Joint Subcommittee on AIDS in the Criminal Justice System of the Committee on Corrections and the Committee on Criminal Justice Operations and Budget, *AIDS and the Criminal Justice System: A Preliminary Report and Recommendations*, 42 REC. ASS'N BAR CITY N.Y. 901 (1987).

measures have ranged from criminal prosecution to outright isolation. To a great extent the way in which one views the role of criminal sanctions in the effort to combat the spread of HIV depends upon whether one sees the crisis as one of public health or public order.

### A. Quarantine

In an attempt to put some perspective on the AIDS epidemic, the Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic (the "Watkins Report")<sup>26</sup> provided a 350-year chronology of public health epidemics and the public health responses to each. Throughout history, mankind has consistently responded to epidemics by isolating the supposed carriers of the disease.<sup>27</sup> During the plague that ravaged fourteenth century Europe, people shunned one another and parents even abandoned their children.<sup>28</sup> In America, formal governmental quarantine efforts, while often thought to be nineteenth and twentieth century creations, date back to revolutionary times.<sup>29</sup>

In the past, states have imposed quarantines for contagious diseases such as leprosy, yellow fever, cholera, and in the late 1800s and early 1900s, for tuberculosis. Virtually all of the quarantine statutes on the books today, however, were passed prior to the age of procedural due process.<sup>30</sup> Ironically at the point when more and more medical historians were noting the inappropriateness and ineffectiveness of many past quarantine efforts,<sup>31</sup> the fear of AIDS has created new calls for utilizing dormant quarantine provisions and efforts to pass new AIDS-specific quarantine measures.<sup>32</sup>

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26. REPORT OF THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC (June 24, 1988) [hereinafter HIV EPIDEMIC].

27. BARBARA TUCHMAN, *A DISTANT MIRROR* (Alfred A. Knopf ed., 1978).

28. *Id.*

29. HIV EPIDEMIC, *supra* note 26.

30. New York City has just revised its TB quarantine provisions in March 1993 to bring them in line with late 20th century process guarantees. Mireya Navarro, *New York City to Detain Patients Who Fail to Finish TB Treatment*, N.Y. TIMES, Mar. 10, 1993, at A1.

31. Douglas Shenson, *When Fear Conquers*, N.Y. TIMES, Feb. 28, 1985, § 6 (Magazine), at 35-41; David F. Musto, *Quarantine and the Problem of AIDS*, 64 MILBANK Q. 97 (1986).

32. Larry Gostin, *Traditional Public Health Strategies, in AIDS AND THE LAW: A GUIDE FOR THE PUBLIC* (Harlon L. Dalton et al. eds., 1987); Note, *The Constitutional Rights of AIDS Carriers*, 99 HARV. L. REV. 1274 (1986); Wendy E. Parmet, *Law, Social Policy, and Contagious Disease: A Symposium on Acquired Immune Deficiency Syndrome (AIDS): AIDS and Quarantine: The Revival of an Archaic Doctrine*, 14 HOFSTRA L. REV. 53 (1985); Kathleen M. Sullivan & Martha A. Field, *AIDS and the Coercive Power of the State*, 23 HARV. C.R.-C.L. L. REV. 139 (1988).

Because of the vast potential numbers involved and because of current due process requirements, few instances of quarantining AIDS patients have been reported. Furthermore, public health authorities almost universally agree that this technique is not sound medical practice because the HIV virus is transmitted by behaviors that put an uninfected person at risk, and not by classic airborne contagion. Thus, because quarantine would have to continue until the patient stopped his or her activity, the possibility for indefinite or permanent exile exists. Both the National Commission on AIDS and the American Bar Association urge that the best policy for prevention of the spread of HIV is education.<sup>33</sup>

### B. Punishment Under Existing Penal Statutes

In theory, traditional criminal law provisions are available to punish behavior that risks the transmission of the HIV virus. For example, under New York's criminal law (derived substantially from the Model Penal Code), a person can be charged with "intentionally," "knowingly," or "recklessly" endangering the life of another or with "criminal negligence."<sup>34</sup> Murder, in addition to being intentional, may be charged where one is reckless under circumstances evincing a depraved indifference to human life.<sup>35</sup> Recklessness requires only that the actor be aware of and consciously disregard a substantial and unjustifiable risk.<sup>36</sup>

In the context of the usual methods of HIV transmission, such as sexual acts or sharing intravenous needles, proof of an intentional state of mind (murder and assault) or even the lesser standard of recklessness (reckless endangerment), would appear difficult, if not remote. Prosecutors would have to prove the defendant entered into sexual acts or needle sharing with the objective or knowledge that he will cause harm to his partner.

Aside from these state-of-mind problems, proof of causation is an additional obstacle in prosecutions for murder, manslaughter or criminally negligent homicide. Demonstrating that it was the defendant's act or acts that caused the victim's infection is a major evidentiary problem, which may be further exacerbated by the delay in the victim's production of HIV antibodies and by the long period before the onset of disease (or death).

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33. See LIVING WITH AIDS, *supra* note 1 and ABA POLICY ON AIDS AND THE CRIMINAL JUSTICE SYSTEM (1989).

34. N.Y. PENAL LAW § 15.05 (McKinney 1987).

35. *Id.* § 125.25(2).

36. *Id.* § 15.05(3).

### C. Punishment Under AIDS-Specific Criminal Statutes

Given the difficulties with the traditional criminal law approach, other remedies have been sought to deter and punish those who spread the HIV infection. Approximately half of the states have public health laws making it a public health offense to knowingly infect someone with a sexually transmitted disease during sexual intercourse. However, AIDS is not generally classified as a sexually transmitted disease and thus these statutes are of little help to those seeking penal sanctions.

As a result, Florida, Idaho, Louisiana, and Washington have enacted AIDS-specific statutes that make criminal the act of *knowingly*<sup>37</sup> engaging in *behavior* which risks or creates a risk of transmitting the HIV virus.<sup>38</sup> And, in 1990, the federal government passed The Ryan White AIDS Funding Bill,<sup>39</sup> which contains a requirement that before a state can receive grants under the act, the state must certify that "the criminal laws of the state are adequate to prosecute any HIV infected individual" who "knows that he or she is infected with HIV and intends to expose another to HIV" by means of donating blood, semen or breast milk, or through sexual activity or through sharing a hypodermic needle. The bill provides that the informed consent of the recipient is a defense. To the extent this federal provision encourages states to criminalize HIV transmission, it suffers from the same intent-based limitation referred to above.

Despite occasional high profile prosecutions,<sup>40</sup> the criminal sanction approach has not worked in the two areas it was designed to affect: punishing persons who are transmitting the virus and deterring others. The infection rates, particularly among intravenous drug abusers and the female partners of infected drug abusers, continues to rise at alarming rates.<sup>41</sup> Furthermore, the geographic distribution of cases is increasing beyond the urban epicenters. There are literally too many potential offenders to prosecute. The real danger in the penal law approach, however, is that it may be driving infected persons underground.

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37. "Knowing" is a lesser standard that simply requires the actor's knowledge of his infection and the risk of transmission.

38. See Gostin, *supra* note 22, at 1050.

39. Ryan White Comprehensive AIDS Resources Emergency Act of 1990, Pub. L. No. 101-381, § 2647, 104 Stat. 576 (1990).

40. *Man Faces Charges for Keeping Secret His AIDS Infection*, N.Y. TIMES, Jan. 14, 1992, at B7; David McKay, *AIDS Disclosure Case To Go To Trial, Judge Rules*, DETROIT FREE PRESS, Oct. 23, 1991.

41. Joyce A. O'Neil et al., *Drug Use Forecasting: An Insight Into Arrestee Drug Use*, NAT'L INST. JUST. REP., June 1991, at 11.

There is broad agreement that the soundest public policy approach to stemming the epidemic is to stress education, voluntary testing and counseling. However, the criminal sanctions approach could have the opposite effect. The "knowing" or "intentional" transmission standard creates a clear incentive not to be tested so that the infected person could remain ignorant of his HIV status and thus presumably not be criminally responsible for infecting others.

## VI. Mandatory AIDS Testing

Whether a defendant charged with rape (or another sex offense where the victim was put at risk of infection) should be compelled to undergo HIV antibody testing in order to provide the victim with defendant's HIV antibody status is one of the most difficult public policy issues confronting society today. While a number of states have statutes directed at the issue, in many jurisdictions applications for testing are made to the court as a matter of discretion. New York is a state that has been forced to confront the issue of mandatory AIDS testing. The Watkins Report recommended that sexual assault defendants be tested right away, while the New York Governor's Task Force on Rape, Sexual Assault and Child Abuse stressed the testing and counseling of the victim.<sup>42</sup>

Clearly, no fair judicial system would keep meaningful information from one put at risk of a deadly disease because of an abstract principle of confidentiality. Such a course of action would not be fair or principled. Nonetheless there are numerous legal obstacles to forced testing, including Fourth Amendment considerations<sup>43</sup> and whether the HIV status of the defendant is "meaningful information" to a victim given the present science of antibody testing.

There are practical problems as well. For example, testing an alleged sex offender, even immediately after an offense, may not be effective. Because an infected offender may not have developed HIV antibodies at the time of the test due to the several-week to several-month lag time between infection and antibody production, the HIV antibody test may not accurately reflect the alleged offender's infected status. A negative test result might mean that the defendant is not infectious; but it may also mean that he has not developed HIV antibodies. Repeated tests must be undertaken and an intervening infec-

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42. *Rape, Sexual Assault, and Child Sexual Abuse: Working Towards a More Responsive Society*, FINAL REPORT OF GOVERNOR'S TASK FORCE ON RAPE AND SEXUAL ASSAULT 95 (April 1990).

43. Lisa Simotas, *In Search of a Balance: AIDS, Rape and the Special Needs Doctrine*, 66 N.Y.U. L. REV. 1881 (1991).

tion can occur. Furthermore, a positive test result on the defendant does not mean the victim was infected by the single contact with the defendant. The odds of transmission in even a single violent sexual act are relatively low.<sup>44</sup> Thus, for a victim, the only absolutely reliable way to determine infection is to be periodically tested and to have no additional exposure.

Even assuming that test results could provide reliable and valuable information, the question still remains of how and when to test alleged sex offenders. Given the presumption of innocence, arguably testing before conviction is unfair. And, while a convicted defendant is no longer presumed innocent and has fewer procedural rights, there are also problems with testing after conviction. First it could be weeks before a plea bargain is reached or months before the defendant is convicted by verdict. Second, there is the possibility of acquittal or dismissal where the defendant may have, nevertheless, infected the victim. In either case, (late test results or no test results) conviction is not an adequate triggering event.

For similar reasons, indictment is not necessarily a good marker. Indictments can be delayed, particularly where a defendant is at liberty. Furthermore, a prosecutor may be unable to obtain an indictment for reasons unrelated to whether the accused is the true perpetrator.

If conviction or indictment is not the proper point, what is? In answering this question it is important to guard against potential abuse of HIV test results by a prosecutor (denial of bail, arbitrary enhanced charges, and distorted plea discussions).<sup>45</sup> Positive HIV test results in the hands of a pressured prosecutor might turn the constitutional principle of the presumption of innocence on its head.

One possible solution would be to assist the victim in bringing an immediate civil action to obtain a court-ordered HIV test. Orders to show cause and civil discovery devices could be used. This can be done out of the glare of the criminal charge, and the defendant's privacy could be guaranteed by the judge's conditioning the release of the results to the victim on absolute confidentiality. Furthermore, the showing required for discovery under civil rules is far less stringent than is required in a criminal case or for indictment or conviction.

The final question that must be addressed is whether there is a legal basis for testing an accused for informational as opposed to evidentiary purposes. For example, section 240.40(2)(b)(v) of New York's

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44. See Levine, *supra* note 2, at 439-40.

45. William Blaberson, *Fear of AIDS With Rape: How a Case Was Affected*, N.Y. TIMES, July 9, 1990, at B1.

Criminal Procedure Law provides generally for court-ordered testing to obtain evidence (i.e., material and relevant evidence); but there is no comparable statutory right for mere information purposes.

Despite these and other problems posed by mandatory AIDS testing, many argue that the victim has a right to know an alleged assailant's HIV status. While the result may not be determinative,<sup>46</sup> the victim who is properly counseled may at any rate want to begin immediate treatment with promising new prophylactic drugs.

### VII. Administrative Approach

There have been widespread reports about HIV defendants being discriminated against because of their HIV status, and many are concerned about lawyers hesitating to represent HIV defendants and about delays and failing to produce defendants in court. Both the Association of the Bar of the City of New York and the American Bar Association decided to study the issue of AIDS and the justice system. The premise underlying both reviews was that a change of administrative rules — provided that it is legally just and medically sound — could avoid hundreds of lawsuits and save millions of dollars. Enlightened administrative rulemaking is also the best solution for individual HIV defendants. The last thing an HIV defendant needs is to be embroiled in a lawsuit. Time is not on the side of an HIV litigant. Because of physical and mental decline, energy and resolve are often in short supply. An infected person should be allowed to get on with the rest of his or her life, to attend to his or her medical needs, and put his or her personal affairs in order without the debilitating prospect of fighting for his or her fundamental due process rights in the course of a criminal case or in a civil case where HIV discrimination issues have been needlessly injected.

After studying the problems nationally, the American Bar Association adopted the following policy guidelines<sup>47</sup> in early 1989:

An attorney should not refuse to represent, or limit or modify representation, because of a person's known or perceived HIV status. A person should not be denied access to counsel because of his or her known or perceived HIV status. Where the person has a right to counsel, the court shall insure that the person's access to counsel is scrupulously honored.

A criminal prosecution involving a defendant known or perceived

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46. As direct viral tests are developed, which would *immediately* measure the defendant's HIV status, many of these arguments may change and the balance of factors will clearly shift toward testing a defendant (particularly if identity is not at issue).

47. ABA POLICY ON AIDS AND THE CRIMINAL JUSTICE SYSTEM 1-2 (1989).

to be infected with HIV should proceed in the same fashion as any other case. No unusual safety or security precautions should be employed, unless the defendant is violent or poses a demonstrated risk of escape.

Unless a defendant's physical condition prevents him or her from attending court, a defendant's HIV status should not be the basis for denying or limiting his or her access to the courtroom, or a reason for avoiding court appearances.

Where, in a jury trial, the defendant's HIV status may become an issue in the case, the court should permit or conduct a full voir dire on the issues. If the defendant's status has been publicized or is apparent, at the request of the defendant, the court should permit or conduct a full voir dire on the issue.

Similarly the Association of the Bar of the City of New York issued a detailed report and recommendations designed to overcome instances in New York of HIV defendants being treated in a discriminatory manner by lawyers and court personnel.<sup>48</sup> The report was in part a response to the 1988 New York State Office of Court Administration issued "Guidelines for Infectious Diseases." While the preamble of this directive spoke in high-minded terms about not subjecting persons in a court proceeding to "needless humiliation or embarrassment," the guidelines themselves were not helpful in dispelling the myths about AIDS and in fact gave credence to many of those myths. The guidelines were widely criticized<sup>49</sup> particularly for the provisions that appear to permit exclusion of HIV defendants from the courtroom and allowing court officers to distance themselves from persons suspected of being infected with HIV.<sup>50</sup>

Few, if any, lawyers appear to have balked at representing HIV defendants. My own experience in a Criminal Term of New York County Supreme Court has been that lawyers now aggressively defend HIV defendants. The major impediment to resolving these cases is the difficulty in obtaining accurate and current medical information.

### VIII. The New York Experience

In many respects New York has been spared the worst examples of fear and stigma-based judicial decisions, such as those discussed

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48. ASS'N OF THE BAR OF THE CITY OF N.Y., AIDS AND THE CRIMINAL JUSTICE SYSTEM: A FINAL REPORT AND RECOMMENDATIONS (July 1989).

49. *Id.* at 164-177.

50. Recently the Office of Court Administration issued a much improved OSHA-based "Exposure Control Plan," but this plan covers only blood-borne pathogens such as HIV and hepatitis (HBV). However, tuberculosis and other infectious diseases are presumably still covered by the ill-conceived 1988 guidelines.

above. Possibly because of the large number of infected defendants, New York courts have had to deal with these issues early on in the epidemic. Of course, many opinions are never reported in the *New York Law Journal* or the New York Official Reports, and it is therefore difficult to get a true measure of decisions that ignore medical fact and scientific reality.

One reason New York has generally dealt fairly with HIV defendants is the statutory provision allowing the judge to dismiss an indictment in the interests of justice when there exists "some compelling factor, consideration or circumstances clearly demonstrating that conviction or prosecution . . . would constitute or result in injustice."<sup>51</sup> Before making such a determination, the court must consider ten factors, including the history, character and condition of the defendant, and any other relevant fact indicating that a judgment of conviction would serve no useful purpose.<sup>52</sup> As those familiar with AIDS litigation in New York know, a *Clayton* motion to dismiss in the interests of justice is among the most frequently employed procedural tools when a severely ill defendant is faced with a mandatory (or probable) jail term.

Even where defendants fail to get their case dismissed by the trial judge, Spring 1992 amendments to the state's Penal and Correction Laws have added a new procedure to help defendants with advanced HIV diseases. Subject to certain exceptions for crimes such as murder and rape, a defendant in state prison may be released on medical parole prior to the expiration of his or her mandatory state prison minimum term, provided they are suffering from a "terminal illness" and are "physically incapable of presenting any danger to society."<sup>53</sup> While the program has great promise, initial experience has indicated that the qualifying definitions may be too restrictive and that the procedures may be too cumbersome to be utilized by sick prisoners with little or no access to legal assistance.

While the availability of the *Clayton* motion and the new medical parole procedures should take some pressure off the back end of the criminal justice system, clearly problems in the courts remain with respect to HIV defendants. Moreover, the scope of the problem is still expanding. This is not surprising given the connection between HIV and intravenous drug abuse.

Crucial to alleviating the HIV burden on individuals, society and the courts are prevention efforts such as education and drug and HIV

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51. N.Y. CRIM. PROC. LAW § 210.20(1)(i) (McKinney 1982).

52. *Id.* § 210.40.

53. 1992 N.Y. LAWS, ch. 55 at 136-39.

counseling, particularly in the communities most directly affected. In the New York City Criminal Courts, pilot projects have been put in place that may assist drug offenders and sex offenders in obtaining drug programs and HIV education, counseling and testing.<sup>54</sup> It is of particular significance that these programs are offered prior to arraignment because while the New York City Department of Correction has educational drug and HIV programs, the majority of defendants are released on their own recognizance or on bail after arraignment.

In the final analysis, the true test of whether New York has learned from its early experiences in dealing with HIV and has produced policies that are consistent with medical facts will be revealed in the next few months as the state and particularly the city confront the emerging TB epidemic. The intersection of HIV and drug abuse has caused massive problems for the criminal justice system, particularly in the correctional facilities where in 1991 8,000 persons in state prisons were estimated to be HIV-infected and 900 of whom were symptomatic with opportunistic diseases.<sup>55</sup> The same HIV-infected population, because of its suppressed immune system, is at risk of TB, and particularly the Multiple Drug Resistant (MDR) strains of TB. The vexing issues of testing and confidentiality will have to be rethought because a defendant's HIV status is particularly relevant to potential TB carriers, resulting from an HIV person's depressed immune system adversely affecting the accuracy of standard TB tests.<sup>56</sup> The standard TB test on a TB carrier who is HIV positive often reveals a negative or inconclusive TB result with potentially disastrous consequences because the TB would not be treated in the early stages when a strict drug regime can be effective.

There is evidence that the experience with HIV has helped the criminal justice system deal with TB in a scientific and nondiscriminatory manner. The New York City Correction Department has built expensive new isolation units, and the State Department of Correctional Services has issued AIDS and TB guidelines.<sup>57</sup> The New York State Commission of Correction issued a special Report on MDR-

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54. *Treatment Readiness Program (TRP)*, Criminal Court Directives, May 21, 1992; *Drug Treatment Referral Program*, Sept. 3, 1992.

55. Stephen Machon, Correctional Ass'n of New York, *Prisoners with HIV AIDS and TB/MDR-TB: The Epidemic Within the Epidemic: Analysis, Demographics and Treatment Access in New York State Correctional Facilities* (1992).

56. Andrew Rosenthal, *HIV Infection Foiling Test that Detect Deadly TB Germ*, N.Y. TIMES, Dec. 10, 1991, at 1.

57. DEPARTMENT OF CORRECTIONAL SERVICES PRISON HEALTH CHALLENGES, AIDS AND TUBERCULOSIS (1992).

TB<sup>58</sup> and the city has just issued the Final Report of its Task Force on "Tuberculosis in the Criminal Justice System."<sup>59</sup> The city is considering matching by computer active TB patients known to the Health Department, with those arraigned in Criminal Court so that medications can continue and correctional officials can be forewarned.

Ultimately, however, the role of the criminal justice system is limited in dealing with the related HIV and TB epidemics. Because most defendants in the New York City courts come to their court appearances from the streets and most defendants are given nonincarceratory sentences, community-based education and medical treatment must be made available.

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58. NEW YORK STATE COMM'N OF CORRECTION — MEDICAL REVIEW BOARD SPECIAL REPORT, AN OUTBREAK OF MULTIPLE DRUG RESISTANT TUBERCULOSIS AMONG NEW YORK STATE CORRECTIONAL FACILITY INMATES (July 1992).

59. FINAL REPORT OF THE N.Y. CITY TASK FORCE ON TUBERCULOSIS IN THE CRIMINAL JUSTICE SYSTEM (June 1992).