

SEX TORTS  
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I. INTRODUCTION

The sexual practices of a small percentage of Americans is costing the American public billions of dollars each year. The United States has the highest sexually transmitted disease (STD)<sup>1</sup> infection rate in the industrialized world, a rate *50 to 100 times* that of other industrialized countries.<sup>2</sup> There are a multitude of reasons why Americans' sexual disease rate is out of control. This article discusses tort law's role in allowing some Americans to view sex and sexual partners with no regard for safety or health, and concludes that the current negligence-based analysis in sex tort<sup>3</sup> cases should be replaced by strict liability.

The law can directly impact public opinion and behavior through its deterrence, expressive, and educational functions.<sup>4</sup> While various other forms of state action are vitally important to controlling social threats,<sup>5</sup> tort law is the barometer of minimal civil expectations in interpersonal relations. Prior to the mid 20<sup>th</sup> century sex tort law offered protection against reputation and emotional injury resulting from unfair or fraudulently-induced seduction, but the "heartbalm" torts were substantially eviscerated in the latter half of the 20<sup>th</sup> century. As a result, a "caveat emptor" standard in sex tort actions emerged. This standard has probably contributed to the major epidemic of STDs that has developed in the United States in the last 30<sup>6</sup> years by failing to discourage irresponsible sexual practices.

The urgency of a national sexual disease epidemic necessitates a reassessment of the proper standard in cases alleging sexual misconduct. Courts have

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<sup>1</sup> Formerly referred to as VD (venereal disease), STDs ("sexually transmitted diseases"), or STIs (sexually transmitted infections) refer to a number of infections that affect human genitalia and are transmitted sexually. *See, e.g.,* Barbara K. Hecht, Ph.D. and Frederick Hecht, M.D., *Condoms and Sexually Transmitted Infections*, at [www.MedicineNet.com](http://www.MedicineNet.com) (last editorial review, July 7, 2004).

<sup>2</sup> *See, e.g.,* Mary G. Leary, *Tort Liability For Sexually Transmitted Disease*, 88 Am Jur Trials 153, Section 1 (Updated June, 2004); AMERICAN SOCIAL HEALTH ASSOCIATION, SEXUALLY TRANSMITTED DISEASES: HOW MANY CASES AND AT WHAT COST? (Kaiser Family Foundation, Menlo Park, California, December 1998) (hereinafter "ASHA – WHAT COST?")

<sup>3</sup> I coined the phrase "sex torts" to refer to any conduct actionable in tort relating to sexual conduct, including sexual fraud and battery. However, this article focuses exclusively on sexual relations resulting in disease transmission.

<sup>4</sup> *See, e.g.,* Pound, *Theory of Social Interests*, 4 Pub.Am.Soc.Society 15 (1920). Tort doctrine is intended to control social choices by deterring socially undesirable, blameworthy, and/or uneconomical behavior, and to provide compensation to victims of civil wrongdoing. *See* DAN B. DOBBS, *THE LAW OF TORTS*, 12-25 (West 2000).

<sup>5</sup> For example, compulsory education for minors and criminal law.

<sup>6</sup> *See generally*, INSTITUTE OF MEDICINE, *THE HIDDEN EPIDEMIC, CONFRONTING SEXUALLY TRANSMITTED DISEASES* (National Academy Press 1997)(Thomas R. Eng & William T. Butler, Eds.) (hereinafter, "THE HIDDEN EPIDEMIC").

engaged a negligence-based paradigm in sexual disease cases based on historical precedent in contagious disease cases. However, courts' opinions in these cases reflect tension between anti-heartbalm sentiment and the public policy of slowing the disease rate by all means, including tort liability. This tension, coupled with the general fact-intensive case by case negligence analysis, has resulted in unclear legal standards and very uncertain liability even in cases of clear causation. The negligence-based paradigm deters sexual disease lawsuits and fails to deter sexual disease perpetrators. This in turn contributes to the "hidden" nature of the sexual disease epidemic and does not further the law's compensatory, deterrence, and educational goals.

Although modifying tort law is not the sole remedy for America's sexual problem, it could address the problem much more effectively than it currently does. Adopting a strict liability approach to sexual disease transmission in lieu of the current negligence standard would further the public policies of encouraging accountability by forcing disease perpetrators to internalize the costs of their behavior, providing a greater likelihood of compensation to victims, and ultimately, educating the public about the very serious and pervasive health threat at hand.

This paper will proceed in three parts. Section two will focus on the facts of sexual disease, including data relating to the number of infections in the United States, the annual medical costs, and who is responsible for the high infection rate. Section three will briefly review the history of sex tort jurisprudence in America over the past century and describe current sex tort law's inefficient negligence-based jurisprudence relative to the new wave of sex tort litigation based on disease transmission. Section four argues that strict liability is a superior theory of sex tort liability in accordance with traditional tort doctrine, economic choice theory, behavioral choice theory, and the expressive function of law.

## II. THE STATE'S INTEREST IN SLOWING THE SPREAD OF SEXUAL DISEASE

"The health of the people is an economic asset. The law recognizes its preservation as a matter of importance to the state. To the individual nothing is more valuable than health."<sup>7</sup>

America's sexual disease rate is unprecedented and unparalleled. Immediate attention to this issue is required at every level of government, to educate the public and slow disease transmission by all means possible. Nearly ten years ago, the Institute of Medicine made the following statement:

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Skilling v. Allen, 143 Minn. 323, 325-6, 173 N.W. 663, 664 (1919).

“STDs are hidden epidemics of enormous health and economic consequences in the United States. . . . All Americans have an interest in STD prevention because all communities are impacted by STDs and all individuals directly or indirectly pay for the costs of these diseases. . . . To successfully prevent STDs, many stakeholders need to redefine their mission, refocus their efforts, modify how they deliver services, and accept new responsibilities. In this process, strong leadership, innovating thinking, partnerships, and adequate resources will be required. The additional investment required to effectively prevent STDs may be considerable, but it is negligible when compared with the likely return on the investment. The process of preventing STDs must be a collaborative one. No agency, organization or sector can effectively do it alone; all members of the community must do their part. A successful national initiative to confront and prevent STDs requires widespread public awareness and participation and bold national leadership from the highest levels.”<sup>8</sup>

This paper focuses exclusively on changes to tort law that will meet the goal of slowing down the sexual disease rate better than current tort law jurisprudence. Changes to tort law are but one piece of a larger project that must be taken seriously to minimize the tragic consequences that result from sexual disease.

#### A. *The Facts Regarding The Sexual Disease Epidemic In America*

Sexually transmitted diseases, or STDs, are caused by more than 25 infectious organisms that are transmitted through sexual activity.<sup>9</sup> In the 1960’s, the only significant STDs were syphilis and gonorrhea, both of which were easily cured with antibiotics.<sup>10</sup> Since 1980, however, at least 8 *new* STDs have been identified, including HIV/AIDS.<sup>11</sup> STDs accounted for 87% of all cases among the top ten most frequently reported infections in the U.S. during 1997.<sup>12</sup> Five

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<sup>8</sup> Concluding statement from the Institute of Medicine’s Summary Report (1997), *see* THE HIDDEN EPIDEMIC, *supra* n. 6 at 43.

<sup>9</sup> Z.A. Memish & A.O. Osoba, *Sexually transmitted diseases and travel*, 21 Int. J. Antimicrob Agents, 131-4 (2003).

<sup>10</sup> Sexually Transmitted Disease (STD) Facts and Complications, Westside Pregnancy Resource Center, at <http://www.w-cpc.org/sexuality/std.html> (Medical Institute for Sexual Health [MISH], 1994). For more information, contact MISH, PO Box 4919, Austin, Texas 78765-499, (800) 892 -9484. *See also* Kathleen K. v. Robert B., 150 CalApp.3d 992, 997, n.3, 198 Cal.Rptr. 271 (1984), noting that the reason that genital herpes was not listed among the “venereal diseases” listed in the California Health and Safety Code (Section 3001) was that the section was enacted in 1957, before herpes was considered a public health threat.

<sup>11</sup> THE HIDDEN EPIDEMIC, *supra* n. 6 at 3. For definitions and symptoms of the most common sexually transmitted diseases, *see Tort Liability for Sexually Transmitted Diseases, supra* n. 2.

<sup>12</sup> W. Cates, Jr. & K.M. Stone, *Family Planning, Sexually Transmitted Diseases and Contraceptive Choice: A Literature Update – Part I*, 24 Family Planning Perspectives 75-84 (March/April 1992).

of the top 10 reportable<sup>13</sup> infectious diseases in 1997 were either exclusively or largely transmitted during sex, including the top four: Chlamydia, gonorrhea, AIDS and syphilis.<sup>14</sup> Currently, it is estimated that between 70 and 100 million Americans have been infected with a STD, with 15.3 million new cases<sup>15</sup> of STDs among Americans every year, including 3 million new cases of STDs annually among American teenagers.<sup>16</sup> In 1993, a review of actual causes of death in the United States estimated that 30,000 deaths occurred as a result of unprotected intercourse, leading to the finding that “unprotected intercourse now represents one of the most rapidly increasing causes of death in the country.”<sup>17</sup> While the public may believe that AIDS is the most dangerous STD, this is not the reality at all if the numbers of persons afflicted is considered.<sup>18</sup> HIV/AIDS is not the only STD that is life-threatening; left untreated, diseases such as gonorrhea, syphilis, genital herpes, and the human papilloma virus, can cause serious health consequences, can lead to various forms of cancer, and can kill.<sup>19</sup>

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<sup>13</sup> “Reportable” means that health care providers are required to report cases to state health departments and the CDC. *Id.* See also ASHA – WHAT COST?, *supra* n. 2 at 4.

<sup>14</sup> See Cates & Stone, *supra* n. 12.

<sup>15</sup> Note that there is a difference between number of cases of STDs and number of person infected, because the same very sexually active core group members are experiencing multiple infections and each infection is counted as a case. Thus, the case number will exceed the number of people infected. Interview with Professor Ed Laumann, University of Chicago Department of Sociology, August 3, 2005.

<sup>16</sup> ASHA – WHAT COST?, *supra* n. 2 at 8, 12; D. Fleming, et al., *Herpes Simplex Virus Type 2 in the United States, 1976-1994*, 337 N. Engl. J. Med 1105-1111 (1997).

<sup>17</sup> J.M. McGinnis & W.H. Foege, *Actual Causes of Death in the United States*, 18 J. Amer. Med. Assoc. 2207, 2210 (1993). More than 25 diseases are spread primarily through sexual activity, leading the Centers for Disease Control (CDC) to conclude that STDs are one of the most under-recognized health problems in the United States. CENTERS FOR DISEASE CONTROL, TRACKING THE HIDDEN EPIDEMIC, TRENDS IN STDs IN THE UNITED STATES 1-2 (2000)(hereinafter “CDC-TRENDS”). See also THE HIDDEN EPIDEMIC, *supra* n. 6 at 1-4.

<sup>18</sup> It is an established principle in public health law that a health risk that causes a less serious health problem (such as serious illness and possibly cancer, leading to death, i.e., genital herpes) can have a much larger impact on overall public health if it applies to a larger percentage of the population than a health risk that has a higher probability of causing death (such as AIDS) if it applies to a much smaller percentage of the population. See, e.g., Geoffrey Rose, *Sick Individuals and Sick Populations*, 14 Int’l J. Epidemiology 32, 32-38 (1985); ROBERT ROSENTHAL, META-ANALYTIC PROCEDURES FOR SOCIAL RESEARCH (rev. ed. 1991). In 1991, AIDS represented less than one half of one percent of all new cases of STDs. That is, approximately 50,000 new cases of AIDS were reported, relative to 12 million cases of other STDs, some of which can lead to deadly consequences resulting from increased susceptibility to various forms of cancer. CENTERS FOR DISEASE CONTROL, STD/HIV PREVENTION 1991 ANNUAL REPORT.

<sup>19</sup> EDWARD O. LAUMANN, JOHN H. GAGNON, ROBERT T. MICHAEL, & STUART MICHAELS, THE SOCIAL ORGANIZATION OF SEXUALITY 377-8 (1994).

Bacterial STDs, such as Chlamydia,<sup>20</sup> gonorrhea, syphilis, and trichomoniasis, are usually curable<sup>21</sup> with antibiotic treatment and rendered non-infectious if detected, although researchers believe that as many as 80% of those infected are unaware of their infection.<sup>22</sup> If left untreated, bacterial STDs can cause pelvic inflammatory disease in women, which can lead to infertility and chronic pain.<sup>23</sup>

Half of all new STD infections are viral and incurable.<sup>24</sup> Viral STDs, such as genital herpes (aka HSV-2 or Herpes Simplex II), HPV (human papilloma virus), hepatitis B, and AIDS, are incurable, and may be transmitted throughout the life of the carrier.<sup>25</sup> Genital herpes and HPV are sharply on the rise. Genital herpes and HPV accounted for 65 of the approximately 68 million infections among Americans in 1998; recent estimates are that at least 100 million Americans are affected by these two viruses today, or approximately one in

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<sup>20</sup> Chlamydia trachomatis is the second most common bacterial infection in the United States, with 3 million new cases each year, and there are about 650,000 cases of gonorrhea. ASHA – WHAT COST?, *supra* n. 2 at 5, 16-17. These curable bacterial infections are largely asymptomatic, with 75% of women and 40% of men unaware of their Chlamydia infection, and many women unaware that they have gonorrhea. CDC – TRENDS, *supra* n. 17 at 6. Without knowing of the infection, people do not seek treatment, and often pass it on to many others before they even know that they are infected. If left untreated, up to 40% of women with Chlamydia will develop pelvic inflammatory disease (PID), and gonorrhea is also a major cause of PID. CDC – TRENDS, *supra* n. 17 at 6, 9. PID in turn causes infertility in 20% of women who have it, and at least 15% of all infertile American women are infertile because of tubal damage caused by PID. THE HIDDEN EPIDEMIC, *supra* n. 6 at 5. Ectopic pregnancy results in 9% of PID cases, making ectopic pregnancy one of the leading and most preventable causes of maternal death during pregnancy. *Id.* at 5. See also [http://www.cdc.gov/nchstp/dstd/Stats-Trends/1998\\_Surv\\_Rpt\\_main\\_pg.htm](http://www.cdc.gov/nchstp/dstd/Stats-Trends/1998_Surv_Rpt_main_pg.htm). The highest rate of acute infection requiring hospitalization for Chlamydia is among teenagers between the ages of 15 and 19. CENTERS FOR DISEASE CONTROL, ANNUAL REPORT, 1993. It is estimated that one in four sexually active teens have Chlamydia, and that 75% of infected young women, and 25% of infected young men have no symptoms. JUST THE FACTS: ABOUT TEEN SEX, at [www.cvillepregnancy.org/teenfacts.html](http://www.cvillepregnancy.org/teenfacts.html), citing Urological Clinic of North America. Thus, although curable, these bacterial infections wreak havoc on Americans' health because they often go undetected, they are transmitted easily, and they can cause serious secondary health issues, especially in women.

<sup>21</sup> Gonorrhea, however, has become entirely resistant to penicillin, and the newer quinolone class of antibiotics, such as Cipro and Floxin, are quickly becoming ineffective in the United States and abroad because of the bacterium's increasing resistance to the drugs. J. Todd Weber, Director of the CDC's Office of Antimicrobial Resistance, JAMA Editorial, Nov. 2005 (quoted in U.S. News & World Report, Jan. 9, 2006, p. 55).

<sup>22</sup> Moscitiicki, B., et al, *The Use and Limitations of Endocervical Gram Stains and Mucopurulent Cervicitis as Predictors for Chlamydia Trachomatis in Female Adolescents*, 157 *Amer. J. Obstet. and Gynec.*, 1 (July 1987).; CDC – TRENDS, *supra* n. 17 at 6; THE HIDDEN EPIDEMIC, *supra* n. 6 at 7-8.

<sup>23</sup> CDC – TRENDS, *supra* n. 17 at 6-13; THE HIDDEN EPIDEMIC, *supra* n. 6 at 5.

<sup>24</sup> CDC – TRENDS, *supra* n. 17 at 1-2; ASHA – WHAT COST?, *supra* n. 2 at 5.

<sup>25</sup> ASHA – WHAT COST?, *supra* n. 2 at 6.

four Americans.<sup>26</sup> These two viruses are rapidly infecting Americans and can lead to tragic consequences, including cancer and death.

Genital herpes is the most common viral STD among Americans. The number of Americans who are infected with herpes grew by 30% between the late 70's and late 90's, such that 20%-25% of persons over age 12 in the U.S. have genital herpes as of 1998, or 45 million Americans.<sup>27</sup> Some researchers believe that the number of symptomatic cases of herpes in the U.S. grew *eleven fold* during the 1970s and 1980s.<sup>28</sup> Complications associated with genital herpes include meningitis, cervical cancer, miscarriage, premature delivery, and high mortality rate of babies born to mothers with herpes.<sup>29</sup>

The human papilloma virus, or HPV, is one of the two most common new cases of STDs in the U.S., the other being trichomoniasis;<sup>30</sup> these two STDs account for 70% of new cases each year.<sup>31</sup> It is estimated that 20 million Americans currently have HPV and another 5.5 million are infected every year.<sup>32</sup> Researchers in Seattle recently estimated that 80% of sexually active Americans will acquire at least one strain of HPV at some point in their lives.<sup>33</sup> There are at least 30 distinct strains of HPV that can infect human genitalia, some of which cause genital warts.<sup>34</sup> Some strains are controlled by the body's

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<sup>26</sup> ASHA – WHAT COST?, *supra* n. 2 at 5. This figure is no doubt higher today, as this study was conducted 7 years ago, and around 15 million new cases occur every year in the United States. *Id.* at 4.

<sup>27</sup> KAISER FAMILY FOUNDATION, THE TIP OF THE ICEBERG: HOW BIG IS THE STD EPIDEMIC IN THE U.S.? (Dec. 2, 1998)(available online at [http://www.kff.org/womenshealth/1445-std\\_qa.cfm](http://www.kff.org/womenshealth/1445-std_qa.cfm)) (hereinafter “TIP OF THE ICEBERG”); D. Fleming, et al., *Herpes Simplex Virus Type 2 in the United States, 1976-1994*, 337 N. Engl. J. Med 1105 (1997).

<sup>28</sup> ASHA – WHAT COST?, *supra* n. 2 at 17.

<sup>29</sup> See *R.A.P. v. B.J.P.*, 428 N.W.2d 103, 107 n.5 (1988), *citing* *B.N. v. K.K.*, 312 Md. 135, 538 A.2d 1175, 1178 (1988)(*citing* K. HOLMES, L. COREY & P. PEGRAM, JR., *SEXUALLY TRANSMISSIBLE DISEASES, VENEREAL INFECTION, CLINICAL CONCEPTS OF INFECTIONS DISEASES*, 232, 245 (3d ed. 1982).

<sup>30</sup> Trichomoniasis is a microscopic parasite, and therefore curable. If left untreated, it increases the risk of contracting HIV/AIDS, and can cause premature birth and low birth weight babies among infected pregnant women. There is currently no national surveillance data on trichomoniasis, but it is estimated that 5 million cases of trichomoniasis occur each year in the United States, and this disease accounts for half of all curable STIs worldwide. ASHA-WHAT COST?, *supra* n. 12 at 18. Yet, only 2% of men and 3% of women named trichomoniasis when asked to identify known STDs. TIP OF THE ICEBERG, *supra* n. 27.

<sup>31</sup> TIP OF THE ICEBERG, *supra* n. 27. ASHA – WHAT COST?, *supra* n. 2 at 20.

<sup>32</sup> CDC – TRENDS, *supra* n. 17 at 2.

<sup>33</sup> Daniel E. Montano, Ph.D., Danuta Kasprzyk, Ph.D., Linda Carlin, Ph.D., & Crystal Freeman, Ph.D., Executive Summary, *HPV Provider Survey: Knowledge, Attitudes, and Practices About Genital HPV Infection and Related Conditions*, Centers for Public Health Research and Evaluation, Seattle (June 14, 2005) (available online).

<sup>34</sup> CDC – TRENDS, *supra* n. 17 at 18.

immune system without the carrier ever knowing about it.<sup>35</sup> But the more dangerous strains cause “subclinical” infections, so-called because they are invisible and often go undetected or may lie dormant for years.<sup>36</sup> At least some of these strains lead to a variety of cancers, including cancer of the cervix, vagina, vulva, anus, and penis.<sup>37</sup> HPV causes more than 90% of all cases of cervical cancer in women, the seventh most common type of cancer in women,<sup>38</sup> a disease that kills about 5000 women every year in the United States.<sup>39</sup> There were approximately 20 million cases of HPV in America in 1998, with 5.5 million new cases estimated each year, or probably close to 60 million today.<sup>40</sup> More recent research indicates that there are 6.2 million new cases annually, driving the figure up higher.<sup>41</sup> There is no cure for HPV, it causes the largest number of STD-related life-threatening illnesses next to AIDS, and it is the fastest growing STD in America.<sup>42</sup> One of the biggest problems with HPV is that research shows that condoms may have little, if any, effect on preventing this disease.<sup>43</sup> Yet, of Americans polled, only 8% of men and 13% of women were able to identify HPV as a common STD when asked to name STDs of which they have heard.<sup>44</sup>

Americans’ lack of knowledge about HPV is representative of a more generalized ignorance about STDs. The American public is frighteningly unaware of this epidemic, with surveys showing that around 70% of men and women think that less than 10% of Americans will get an STD in their lifetime,

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<sup>35</sup> *Id.*

<sup>36</sup> THE HIDDEN EPIDEMIC, *supra* n. 6 at 8; CDC – TRENDS, *supra* n. 137 at 18. Four strains of HPV, type 16, 18, 31 & 45, account for 80% of all cervical cancer. *Id.*

<sup>37</sup> THE HIDDEN EPIDEMIC, *supra* n. 6 at 4; CDC – TRENDS, *supra* n. 17 at 18.

<sup>38</sup> THE HIDDEN EPIDEMIC, *supra* n. 6 at 4.

<sup>39</sup> HPV is believed to cause almost all cases of cancer of the vagina, vulva, penis, and anus. THE HIDDEN EPIDEMIC, *supra* n. 6 at 4. HPV type 16 is believed to be carried by 20 million people in the United States, and another 5.5 are infected each year. See MEDICAL COLLEGE OF WISCONSIN, HEALTHLINK, online at <http://healthlink.mcs.edu/article/976735469.html> (updated 10/16/2001). This virus is responsible for 50% of all cases of cervical cancer. *Id.* Two strains of HPV, 16 and 18, are believed to be responsible for 90% of all cervical cancer cases, leading to nearly 5000 deaths in the U.S. each year. See TIP OF THE ICEBERG, *supra* n. 27.

<sup>40</sup> ASHA – WHAT COST?, *supra* n. 2 at 17-18. CDC – TRENDS, *supra* n. 17 at 2. This report contains disease-specific information, including areas within the United States that are most heavily hit with particular sexual diseases. See also ASHA – WHAT COST?, *supra* n. 2 at 5.

<sup>41</sup> Montano, et al, *supra* n. 33.

<sup>42</sup> THE HIDDEN EPIDEMIC, *supra* n. 6 at 6.

<sup>43</sup> Cates & Stone, *supra* n. 12. See also Montano, et al, *supra* n. 33. Although the effect of condom use in preventing HPV is inconclusive, condoms can reduce the risk of two most common HPV related conditions: genital warts and cervical cancer. *Id.*

<sup>44</sup> Montano, et al., *supra* n. 33. While clinicians are generally aware of the prevalence of HPV, only 63% knew that genital HPV in men increases the risk of penile and anogenital cancers.

although the true figure is at least 25%,<sup>45</sup> with recent estimates as high as 80%,<sup>46</sup> and growing. Even worse, it is estimated that over 80% of persons who are infected with an STD do not know that they have an infection.<sup>47</sup> In 1993, 84% of women surveyed were not concerned about acquiring an STD, including 72% of young women (18-24) and 78% of women who reported having “many” sexual partners.<sup>48</sup> In general, the health consequences of STDs, are “hidden” from public attention for several reasons, including: most people who have an STD do not know that they have one;<sup>49</sup> Major health consequences of STDs, such as infertility, cancer, and chronic pain, occur years after the initial infection, so the link between the STD and the health consequences is not recognized. And, the stigma attached to contracting an STD inhibits open public discourse, education, and legal redress.<sup>50</sup> Americans of all ages are confronted with an enormous health risk that is largely silent.<sup>51</sup>

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<sup>45</sup> ASHA-WHAT COST?, *supra* n. 2 at 6, 10. The surveys were conducted by the Kaiser Family Foundation and Glamour Magazine. *Id.* at 10.

<sup>46</sup> See Montano et al., *supra* n. 33.

<sup>47</sup> See Moscitiicki et al., *supra* n. 22.

<sup>48</sup> EDK ASSOCIATES, WOMEN & SEXUALLY TRANSMITTED DISEASES: THE DANGERS OF DENIAL (New York: EDK Associates 1994).

<sup>49</sup> Moscitiicki et al, *supra* n. 22. The silent nature of this epidemic is probably the greatest public health threat. In general, STDs are more severe and occur more frequently among women, in part because they are transmitted most readily from a male to a female, and in part because they are more likely to remain undetected in females. THE HIDDEN EPIDEMIC, *supra* n. 6 at 3. Almost every STD can be transmitted from a pregnant woman to her fetus, with tragic consequences based on the immature immune system of a fetus, which include: low birth weight, premature birth, conjunctivitis, pneumonia, neurologic problems, and congenital abnormalities. ASHA – WHAT COST?, *supra* n. 2 at p. 9. STDs can also be transmitted to babies through breastfeeding. THE HIDDEN EPIDEMIC, *supra* n. 6 at 2.

<sup>50</sup> It is important to understand a bit about American sexual cultures and norms to fashion the most effective policy. American sexuality is largely private and secret relative to other societies, a vestige of the Victorian social system. See, e.g., A.M. BRANDT, NO MAGIC BULLET: A SOCIAL HISTORY OF VENEREAL DISEASE SINCE 1980 (1985). Social taboos regarding sexuality juxtaposed to constant sexual images in the mass media, and particularly the internet, have created a culture where sexual cognitive dissonance is ubiquitous, which leads to unhealthy sexual behavior, such as promiscuous, clandestine sex. The American conception of sex has impeded sexuality and STD education programs, hindered communications among family members, and has promoted a fixation on sexuality. Contrary to the popular assumption that Victorian values have caused sexual repression in America, Michel Foucault argues that American discourse and fixation on sex is more about producing and using sex as power than about repression. That is, sexual choices derive their meaning through social discourse about sex, labeling people in accordance with their sexuality, and otherwise socially constructing meaning grounded in sexual behavior. MICHEL FOUCAULT, THE HISTORY OF SEXUALITY, AN INTRODUCTION, VOL. I. 17-49 (1978) American secrecy regarding sex and the attendant lack of communication and education regarding STDs, coupled with a proliferation of sexual images in the mass media and increased sexuality in American youth, has created a recipe for the very serious STD epidemic we face today. THE HIDDEN EPIDEMIC, *supra* n. 6 at 10-12. For example, there are 10 incidents of sexual behavior per hour on prime time television, but most of the images depict non-marital sexual relationships as the norm and fail to broach the subject of contraception or sexual disease. *Id.* This irresponsible production has an enormous impact on young people’s sexual mores, yet is protected by the first amendment.

The impact of STDs on America's youth is particularly troublesome.<sup>52</sup> Adolescents and young adults have the highest rates of sexually transmitted diseases.<sup>53</sup> Approximately 25% of sexually active American teens contract an STD every year.<sup>54</sup> About half of all new HIV infections occur in people under age 25; most are infected through sex.<sup>55</sup> AIDS is the 6<sup>th</sup> leading cause of death among 15-25 year old Americans.<sup>56</sup> Every day, 8000 teenagers in the United States contract an STD, approximately 3 Million per year, or about 1 every 10 seconds.<sup>57</sup> At least two-thirds of people who acquire STDs in the United States are younger than 25; at least one quarter are teenagers,<sup>58</sup> and it appears that the percentage of young people afflicted is rising.<sup>59</sup> Teenage girls have the highest rate of Chlamydia,<sup>60</sup> a common cause of pelvic inflammatory disease (PID),

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*See, e.g.,* D.T. Lowry & J.A. Schidler, *Prime Time TV Portrayals of Sex, "Safe Sex," and AIDS: A Longitudinal Analysis*. 70 *Journalism Q.* 628 (1993).

<sup>51</sup> Over half of adults and teens surveyed stated that their doctors spent "no time at all" discussing STDs with them. ASHA – WHAT COST, *supra* n. 2 at 10. *See also* THE HIDDEN EPIDEMIC, *supra* n. 6 at 4-13.

<sup>52</sup> In California alone, approximately 1.2 million cases of STDs occur each year, approximately 250,000 of which occur among teenagers. Communicable Disease Control in California, Division of Communicable Disease Control, California Department of Health Services, Sacramento, California, at [www.dhs.ca.gov/dcdc](http://www.dhs.ca.gov/dcdc). In one study from the University of Washington, among university students, cervical infection was 8 times greater than all other STD infections combined. UNIVERSITY OF WASHINGTON DEPARTMENT OF HEALTH SERVICES, EMERGING SEXUALLY TRANSMITTED DISEASES (1998), available online at <http://depts.washington.edu/eminf/1998/std/std1.htm>. Yet, only one in five teens say that they think they are at risk of getting an STD. *See* ASHA – WHAT COST, *supra* n. 2 at 10. Perhaps for this reason, most single men and women (2/3) say that they do not consistently use condoms. *Id.*

<sup>53</sup> ASHA – WHAT COST, *supra* n. 2 at 8 (two-thirds of all new STD cases occur in people ages 15-24); Diane R. Blake, *Adolescent Sexually Transmitted Diseases: Recent Developments*, 6 *Curr Infect. Dis. Rep.* 141 (April 2004).

<sup>54</sup> ASHA – WHAT COST, *supra* n. 2 at 8.

<sup>55</sup> CENTERS FOR DISEASE CONTROL, FACT SHEET: YOUNG PEOPLE AT RISK - HIV/AIDS AMONG AMERICA'S YOUTH, 2002; CENTERS FOR DISEASE CONTROL, HIV/AIDS SURVEILLANCE IN ADOLESCENTS, L265 Slide Series (through 2002). Among American youth, minorities have been hit particularly hard by HIV/AIDS, with young black women representing 65% of AIDS cases reported among 13-19 year olds in 2002; Latino teens represented 20%. CENTERS FOR DISEASE CONTROL, HIV/AIDS SURVEILLANCE IN ADOLESCENTS, L265 Slide Series (through 2002).

<sup>56</sup> JUST THE FACTS: ABOUT TEEN SEX, available online [www.cvillepregnancy.org/teenfacts.html](http://www.cvillepregnancy.org/teenfacts.html). About 25% of all new HIV cases are found in people under age 22; about 50% of all new HIV cases are found in people under age 25. CENTERS FOR DISEASE CONTROL AND PREVENTION, HIV PREVENTION STRATEGIC PLAN THROUGH 2005 (September 2000).

<sup>57</sup> MEG MEEKER, HOW TEEN SEX IS KILLING OUR KIDS 12 (2002).

<sup>58</sup> ASHA – WHAT COST?, *supra* n. 2 at 8; THE TIP OF THE ICEBERG, *supra* n. 27.

<sup>59</sup> MEEKER, *supra* n. 57; THE HIDDEN EPIDEMIC, *supra* n. 6 at 13.

<sup>60</sup> CDC – TRENDS, *supra* n. 17 at 11. The ectropion of the cervix of a female teenager is physically more vulnerable to infection than that of a woman in her 20's. J.R. Anderson & M. Wilson, *Caring for Teenagers with Salpingitis*, *Contemporary OB/GYN* (August 1990). One result is that sexually active 15 year olds have a 1 in 8 chance of developing PID but

which can lead to infertility; at least 10 percent of sexually active teens are infected with this disease.<sup>61</sup>

There are a number of reasons why teenagers and young adults are at the greatest risk for acquiring an STD: they may have less immunity than adults; they are more likely to have multiple sex partners and to select partners who are high-risk; they are more likely to engage in unprotected sex; and the age of first sexual activity has decreased while the age at first marriage has increased, resulting in more non-marital, non-monogamous sexual activity.<sup>62</sup> In sum, American teens and young adults are becoming sexually active at a younger age than prior generations and have more sexual partners.<sup>63</sup> Indeed, the United States and Canada currently have the youngest age of first sexual experience, at

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by age 24, that probability decreases to 1 in 80. L. WESTRON & P. MARCH, *PELVIC INFLAMMATORY DISEASE* (1992).

<sup>61</sup> L. Westrom, *Incidence, Prevalence, and Trends of Acute Pelvic Inflammatory Disease and Its Consequences in Industrialized Countries*, 138 *Amer. J. of Obstet. & Gynec.* 880 (1980).

<sup>62</sup> THE HIDDEN EPIDEMIC, *supra* n. 6 at 13; CENTERS FOR DISEASE CONTROL, 2003 STD SURVEILLANCE REPORT. Alcohol and other substance abuse are known to be associated with high risk sexual behavior that leads to STDs, both generally and among youth. THE HIDDEN EPIDEMIC, *supra* n. 6 at 9.

<sup>63</sup> A 1999 Durex Survey revealed similar trends on a worldwide basis. Teens and young adults around the world are having sex at a younger age than previous generations, and are having sex more frequently and with more partners. 1999 DUREX GLOBAL SEX SURVEY. The survey was commissioned by the London International Group, Inc., the parent company of Durex Consumer Products, which manufactures Durex condoms, the world's leading condom manufacturer, with a 21 percent share of the global market. Five thousand sexually active and non-sexually active 16 to 21 year olds across 14 countries were studied. The United States and Canada have the lowest average age of first sex, at 15 years of age – and the age of a young person's first sexual experience is declining at an alarming rate. Overall, on average, the sexually active 16 to 21 year olds have sex 98 times per year, and globally the average number of partners is 4.9, whereas in the United States, the average number of partners is 7.5, ranking highest in number of partners. Researchers believe that the sexual behavior of youths can be attributed to the amount of anxiety and fear experienced by teens on a daily basis, with young people imitating adult sexual behavior as a means of escape. *Id.*, quoting Dr. Robert D. Simmermon, psychologist, Atlanta, Georgia. Nearly one-fifth of the 16 to 21 year olds claimed they knew someone with a sexually transmitted disease, and 7 percent stated that they knew a peer who was HIV positive. In 1993, the World Bank estimated that STDs excluding AIDS are the second leading cause of healthy life lost among women ages 15-44 in the developing countries. See WORLD BANK, *WORLD DEVELOPMENT REPORT* (1993). While 28% of the youths globally stated that they would prefer to receive sex education from their parents, friends are cited as the primary source of sex education. Only 11% of teens get most of their sex education from parents or family; most learn through peers whose information is largely inaccurate. See THE HIDDEN EPIDEMIC, *supra* n. 6 at 11. Clearly, sexual disease education is desperately needed to help curb the sexual disease rate among American youths. The so called "abstinence only" sex education method is counterproductive and exacerbating the sexual disease problem, because it fails to educate youth about birth control and protection from disease.

age 15.<sup>64</sup> Early sexual activity is clearly linked to a greater number of sexual partners and a greater risk of acquiring a sexually transmitted disease.<sup>65</sup>

### B. *The Enormous Health Care Costs Of STDs*

The most recent estimates of the costs of STDs in the United States are astounding and underscore the need for immediate changes in education, public policy, and law. Experts estimate that the medical costs alone associated with sexual disease in the United States already exceeds \$16 billion per year, and is growing rapidly.<sup>66</sup> In 2004, researchers with the Alan Guttmacher Institute estimated that the direct<sup>67</sup> costs of STDs, including HIV, among all age-groups

<sup>64</sup> 1999 DUREX GLOBAL SEX SURVEY, *supra* n. 63.

<sup>65</sup> The Centers for Disease Control data reveals that the percentage of American high school students who have had sex decreased 7.4% from 1991 to 2003, from 54.1% to 46.7%. CENTERS FOR DISEASE CONTROL AND PREVENTION, SURVEILLANCE SUMMARIES (May 2004) MMWR 2004:53 (No. SS-2). Yet, despite publicity of a current “abstinence movement” among American youth, research shows a dramatic increase in adolescent sexual activity in the last few decades. Some research has shown that between 60 and 65% of high school seniors have had sex and one study from 1995 found that 27% of high school seniors have had 4 or more partners. JUST THE FACTS: ABOUT TEEN SEX, [www.cvillepregnancy.org/teenfacts.html](http://www.cvillepregnancy.org/teenfacts.html) (60.5%). This source also states that 77% of 19 year old females and 85% of 19 year old males have had sex, *citing* THE URBAN INSTITUTE, NATIONAL SURVEY OF ADOLESCENT MALES, NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT (1995), and CENTERS FOR DISEASE CONTROL, NATIONAL SURVEY OF FAMILY GROWTH (1995). *See also* ASPEN EDUCATION GROUP, SEXUAL PROMISCUITY IN ADOLESCENTS, available online at [www.aspeneducation.com/factsheetpromiscuity.html](http://www.aspeneducation.com/factsheetpromiscuity.html) (66.4%). At least one study has found that 25% of 6<sup>th</sup> graders, and 33% of 7<sup>th</sup> graders, and half of 8<sup>th</sup> graders have had sexual intercourse. THE HIDDEN EPIDEMIC, *supra* n. 6 at 13. For more information, contact SADD, Inc. PO Box 800 Marlborough, MA 01752, (877) SADD INC, [www.sadd.org](http://www.sadd.org); Liberty Mutual Group, (800) 4 Liberty, [www.libertymutualinsurance.com](http://www.libertymutualinsurance.com). By age 19, more than half of Americans have had sex, with some sources reporting that nearly 40% of 14-year-olds, 70% of twelfth graders, and 80% of 19-year-olds have had sex. *See* JUST THE FACTS: ABOUT TEEN SEX, *supra*; PREGNANCY RESOURCE CENTER OF SNOHOMISH COUNTY: FACTS ABOUT TEEN SEX, available online at <http://www.realchoices.com/teenfacts.html>; ASPEN EDUCATION GROUP, *supra*. These discrepancies in percentages of sexually active teens may turn on the fact that many youths have adopted what I call the “Clinton definition” of sex, i.e., anything other than sexual intercourse, including anal sex and oral sex, is not “sex.” Professor Laumann is aware of this new definition of “sex.” Laumann interview, *supra* n. 15. For example teenage and 20-somethings will call themselves “virgins,” despite having given and received oral sex. One of the biggest problems with this is that some diseases, such as HPV, are transmitted through skin-to-skin contact that occurs during non-penetrative anogenital and orogenital contact, as well as through sexual intercourse, and some young people believe that STDs are transmitted through intercourse only. The ignorance among teens and young adults is probably the root of the problem with the STD rate among this group. Approximately 4 million teens contract an STD every year. ASHA – WHAT COST?, *supra* n. 2 at 4, 8.

<sup>66</sup> *See infra* nn. 67 – 72.

<sup>67</sup> Harrell W. Chesson, John M. Blandford, Thomas L. Gift, Guoyu Tao, & Kathleen L. Irwin, *The Estimated Direct Cost of Sexually Transmitted Diseases Among American Youth, 2000*, 36 Perspectives on Sexual and Reproductive Health 11 (2004)(Alan Guttmacher Institute). Costs refer to direct medical and non-medical costs of treating STDs. Direct medical

was estimated to be between 9.3 and 15 billion in the United States in the mid 1990's, adjusted to year 2000 dollars.<sup>68</sup> This figure includes only the eight major STDs – HIV, HPV, HSV-2, hepatitis B, Chlamydia, gonorrhea, trichomoniasis, and syphilis,<sup>69</sup> and since indirect and intangible costs were not included, the total cost figures are probably substantially higher.<sup>70</sup> In 1997, some research indicated that the annual cost was closer to \$17 billion.<sup>71</sup> Texas and New York each have costs of over a billion dollars a year, while California's total costs approach 2 billion.<sup>72</sup>

About 9 million young Americans, ages 15-24, contract an STD every year, with a total estimated burden of 6.5 billion in year 2000 dollars.<sup>73</sup> Viral STIs, such as HIV, HSV-2, and HPV accounted for 94% of the total burden (6.2 billion), while nonviral/bacterial STIs accounted for only 6% of the burden (.4 billion).<sup>74</sup> HIV and HPV were by far the most costly STDs in terms of total estimated direct medical costs, accounting for 90% of the total burden, or 5.9 billion.<sup>75</sup> Young people thus represent the class creating the most substantial economic burden in America relative to sexually transmitted diseases. Americans as a whole are paying the price through the cost-spreading function of insurance and government aid.<sup>76</sup> And, these costs do not begin to include the enormous emotional and mental health costs associated with early sexual activity and STD infection.<sup>77</sup>

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costs include costs involved with treating acute STDs and the sequelae of untreated or inadequately treated STDs, such as clinician visits, hospitalization, diagnostic testing, and drug therapy. Direct nonmedical costs include cost of transportation to medical services. These direct costs must be distinguished from indirect medical costs such as productivity losses, lost wages attributable to STDs, and intangible costs such as human pain and suffering; indirect medical costs are not included in the estimates contained herein.

<sup>68</sup> THE HIDDEN EPIDEMIC, *supra* n. 6 at 7; Chesson, et al., *supra* n. 67 citing, *inter alia*, ASHA – WHAT COST?, *supra* n. 2. These costs would obviously be higher if expressed in current U.S. dollars.

<sup>69</sup> For example, hepatitis C and bacterial vaginosis were excluded. Chesson, *supra* n. 67.

<sup>70</sup> See Chesson et al., *supra* n. 67.

<sup>71</sup> Chesson et al., *supra* n. 67; ASHA – WHAT COST?, *supra* n. 2 at 25-27. THE TIP OF THE ICEBERG, *supra* n. 27 (estimating that 7 billion results from HIV/AIDS, and another 10 billion a year from other STDs).

<sup>72</sup> ASHA – WHAT COST?, *supra* n. 2 at 26, Table 5.

<sup>73</sup> Chesson, et al, *supra* n. 67 at 11 – 19.

<sup>74</sup> ASHA – WHAT COST?, *supra* n. 2 at 25; Chesson, et al., *supra* n. 67.

<sup>75</sup> ASHA – WHAT COST?, *supra* n. 2 at 25; Chesson, et al., *supra* n. 67.

<sup>76</sup> In one study of patients receiving care for HIV, 47% were covered by Medicaid or Medicare, 33% had private insurance, and 20% were uninsured. W.E. Cunningham, et al., *Prevalence and predictors of highly active antiretroviral therapy use in patients with HIV infection in the United States*, 25 *Journal of Acquired Immune Deficiency Syndromes* 115 (2000).

<sup>77</sup> When compared to sexually inactive teens, sexually active teens are more likely to be depressed (3.3 times higher for girls, 2.4 times higher for boys) and to commit suicide (2.8 times higher for girls, and 8.6 times higher for boys). ROBERT E. RECTOR, KIRK A.

### C. Who Is Spreading Sexual Diseases?

The number of sexually diseased persons in the United States could lead one to assume that these diseases are spread randomly throughout the population. However, researchers believe that this is not the case at all. A “core” group of sexually promiscuous people are responsible for the vast majority of new sexual disease cases; the vast majority of Americans never transmit a sexual disease to another person, even if they have one.<sup>78</sup>

The most important datum relative to the transmission of a sexual infection is the number of sexual partners the infected person has during an infectious period.<sup>79</sup> The most current available research indicates that over 80 percent of Americans ages 18-59 have zero or one sex partner in any given year, 16% have between two and four partners, and only 3% have more than five sex partners.<sup>80</sup> Age is strongly negatively correlated with number of sex partners; younger persons have many more sex partners than older persons.<sup>81</sup> Of course, the greater number of sex partners, the greater chances of acquiring a sexual disease; and, once a disease is contracted, the greater the number of persons

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JOHNSON, PH.D., & LAUREN R. NOYES, SEXUALLY ACTIVE TEENAGERS ARE MORE LIKELY TO BE DEPRESSED AND TO COMMIT SUICIDE, THE HERITAGE FOUNDATION, CENTER FOR DATA ANALYSIS REPORT #03-04, available online at <http://www.heritage.org/Research/Family/cda0304.cfm>, relying on data from the National Longitudinal Survey of Adolescent Health, Wave II, 1996, which is funded by the National Institute of Child Health and Human Development (NICHD) and 17 other federal agencies. The researchers controlled for race, gender, exact age and family income and found that there was virtually no impact on the statistics, meaning that sexual activity appears to be the cause of the increased depression and attempted suicide, not confounding factors such as race or socioeconomic status. Not surprisingly, 66% of teens who had been sexually active expressed regret and wished that they had waited longer to have sex. *Id.*, citing NATIONAL CAMPAIGN TO PREVENT TEEN PREGNANCY, NOT JUST ANOTHER THING TO DO: TEENS TALK ABOUT SEX, REGRET, AND THE INFLUENCE OF THEIR PARENTS (June 30, 2000).

<sup>78</sup> Laumann Interview, *supra* n. 15.

<sup>79</sup> Laumann interview, *supra* n. 15.

<sup>80</sup> This is the most current comprehensive data on numbers of sex partners per year, and probably remains accurate for Americans over age 28, who were 18 at the time of the studies. However, considering other evidence that persons under age 25 are generally much more promiscuous than prior generations, disproportionately represent new cases of sexual disease, and were not included in this data, this data may not be accurate relative to this younger group of Americans. See, e.g., *supra* nn. 52-65 & accompanying text. This data nonetheless demonstrates that most Americans' sexual practices remain monogamous, and grossly divergent than that portrayed by television and other media forms. See *supra* n. 50.

<sup>81</sup> LAUMANN, et al., *supra* n. 19 at 185. To the extent that this research is somewhat outdated, and considering the disease rate among young persons and the fact that young persons have always had more partners than older persons, it is logical to conclude that persons under age 30 are largely responsible for spreading sexual diseases, and are frequently infecting others in the same age group.

who are exposed.<sup>82</sup> Thus, within this core group of sexually active persons, the risk of infection rises not arithmetically as the number of partners rises, but multiplicatively, i.e., not from one to two to three, but from one to four (two squared) to nine (three squared).<sup>83</sup>

People who have sex with people who they have known for less than a month are four to five times more likely to contract a sexual disease.<sup>84</sup> People who have concurrent (non-monogamous) sexual partnering during some period of time create the greatest risk of spreading an infection if one is contracted. Research has found that of those persons who admitted to having two partners in the past year, 62% had two or more partners during at least part of the past year.<sup>85</sup> For those who reported having three partners in the past year, 61% reported concurrent sexual relationships, and for those who had six or more partners in the past year, 85% reported concurrent sexual relationships.<sup>86</sup> For persons with two partners in the past year that were concurrent, the length of time during which the person had sexual relations with both averages 2.5 months; for those who had 6 or more partners in the past year, the period during which they had overlapping sexual relationships rises to 7.6 months.<sup>87</sup> Of the persons who admit to having had three or more partners in the past twelve months, 30% stated that their partners also had three or more partners during the same period.<sup>88</sup>

Considering that 27% of men and 48% of women who report having had more than 10 partners since age 18 contract at least one STD, and 37% of men and 55% of women who report having had 21 or more partners since age 18 contract at least one STD, a view of who is responsible for transmitting STDs begins to emerge.<sup>89</sup> When the fact that less than 3% of persons report having more than 5 partners in the same year,<sup>90</sup> young persons who have not yet

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<sup>82</sup> *Id.*, Chapter 11.

<sup>83</sup> Laumann interview, supra n. 15.

<sup>84</sup> LAUMANN, et al, supra n. 19 at 421, Table. 11.15.

<sup>85</sup> *Id.* at 183, Table 5.2.

<sup>86</sup> *Id.*

<sup>87</sup> *Id.*

<sup>88</sup> *Id.* at 404.

<sup>89</sup> The type of disease also plays a role in how easy it is to transmit. For example, bacterial infections are transmissible following a short incubation period and are no longer communicable after treatment. People with bacterial infections such as chlamydia and gonorrhea are usually infectious for about a month if they have symptoms, and about four months if they are asymptomatic. *Id.* at 424. The bacterial infections are generally the highly transmissible STDs. *Id.* at 424. Viral STDs cannot be cured, and persons infected with these can be infected for years rather than months after being exposed. For example, AIDS can be transmitted continuously by the infected person, while genital herpes and warts are intermittently transmissible, which usually is during outbreaks or other symptoms of the disease. *Id.* at 424.

<sup>90</sup> *Id.* at 184.

married have the greatest number of partners,<sup>91</sup> and younger persons have more partners than similarly situated persons in prior generations,<sup>92</sup> it becomes clear that there exists a “core” group of individuals who are responsible for the continued reproduction of several highly infectious (mostly bacterial) STDs, meaning that these people spread the infection to at least one other person before they are no longer infectious.<sup>93</sup> Other research has shown that persons with viral STDs have at least as many sexual partners, if not more, than persons who have never been infected with an STD, and that persons with viral STDs do not moderate their sexual contact with others in any appreciable way.<sup>94</sup> In addition, persons with a history of both bacterial and viral infections report having sex more frequently (gauged as number of sex acts per week) than those who have never been infected.<sup>95</sup> Finally, persons with prior viral infections, in particular the youngest group ages 18-29, use condoms during vaginal intercourse *far less often* than those with no prior STDs.<sup>96</sup> Thus, while the consistent use of condoms can control the transmission of a variety of STDs,<sup>97</sup> they are not being used by some of the most sexually irresponsible members of society.<sup>98</sup>

Although core group members often transmit diseases to other core group members, they also connect with non-core group members, passing sexual diseases to the general public.<sup>99</sup> Due to the nature of infectious antigens’ need

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<sup>91</sup> *Id.* at 178, 208, Tables 5.1B & 5.9A.

<sup>92</sup> *Id.* at 204, Table 5.7.

<sup>93</sup> *Id.* at 425 (citations omitted.)

<sup>94</sup> *Id.* at 425.

<sup>95</sup> *Id.*

<sup>96</sup> *Id.* Note that the proportion of persons studied with HIV/AIDS was very small and combined with persons infected with other viral STDs. It is possible that persons with HIV/AIDS behave differently than those with other viral infections such as genital herpes, considering the gravity of harm imposed by HIV/AIDS.

<sup>97</sup> *Id.* at 422, Table 11.23. There have been a few studies about actual condom use. Younger persons are much more likely to use condoms than older persons. *Id.* at 426, Table 11.24B. Young persons demonstrate less trust that a sexual partner will not transmit a disease. The researchers asked whether respondents agreed with the statement, “You don’t need to use a condom if you know your partner well.” 74% of respondents ages 18-24 disagreed, while 59 percent overall disagreed. *Id.* at 430. Perhaps ironically, the persons who have had fewer sexual partners were less trusting that a partner will not give them a disease. Or, perhaps their level of caution is the reason that they have had fewer sex partners. *Id.* at 430-431. Persons who have never had a STD are more likely to use condoms than those who have been infected with a viral STI. *Id.* at 426, Table 11.24B.

<sup>98</sup> Among persons who have had sex with four or more other persons in the last year, condom use never exceeds 30.8% other than in one-night stand situations, in which condom use rises to between 59% and 63%. *Id.* at 418-9, 421, Tables 11.21 and 11.22. Note that this was the category with the greatest number of reported partners in the last year in this study, so this category includes persons who have sex with 20, 30, or even more partners per year, that is, the riskiest group of individuals.

<sup>99</sup> *Id.* However, since the non-core group members usually are not engaged in concurrent sexual relationships, they rarely transmit the disease to any other person. *Id.*

for new bodies to stay in circulation, if the 3% of Americans<sup>100</sup> who represent the core group were to stop transmitting diseases, *all* sexually transmitted diseases would die out when all infected persons died; thus, some epidemiologists believe that 3% of Americans may be responsible for 100% of sexual disease perpetration.<sup>101</sup> Even if these figures are not exact, there is no question that a small, core group of Americans is responsible for the vast majority of new STD cases.

Effective policies to slow the spread of sexual disease must focus on how to educate and deter this core group. The best legal policy would consider how liability rules impact sexual choices, particularly among American youth, to discourage socially destructive sexual behavior and to expose and create healthier sexual norms. Considering the tight social networks within which core group members circulate, and the fact that even minor modifications to core group members' sexual practices (e.g., consistent condom usage) would seriously reduce the risk of most disease transmission, it seems fair to conclude that a small number of judgments – word of which would spread fast -- could have a big impact on the overall rate of sexual disease transmission.

### III. HISTORICAL AND CURRENT SEX TORT JURISPRUDENCE

“The history of man indicates that as soon as he created the relationship of marriage, adultery was not far behind.”<sup>102</sup>

This section will first briefly review the history of American law and sexuality and posit that tort law's fairly recent retreat from regulating sexual misconduct has fostered irresponsible sexual behavior, which has contributed to the current sexual disease epidemic. Next, this section will review current sex tort law, arguing that the current law is failing to meet its goals of deterrence, compensation, and protection of individuals' health.

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<sup>100</sup> Three percent of Americans include a larger percent of persons under age 25, and a much smaller percent of persons over age 45, who are generally married and so “exit” the sexual market. Laumann Interview, *supra* n. 15.

<sup>101</sup> Laumann Interview, *supra* n. 15. Professor Laumann related to me that this is the assertion of epidemiologists who model disease spread in large populations with the assumption of random mixing. This is thus a theoretically derived conclusion grounded in random mixing model theories. Empirical confirmation of the validity of such theories is ongoing, and may never be proven, considering that it is unlikely that core disease perpetrators will stop spreading diseases altogether.

<sup>102</sup> Daniel E. Murray, *Ancient Laws on Adultery – A Synopsis*, 1 J. Fam. L. 89, 89 (1961).

A. *Sexual Behavior And The Law:  
A Brief History*

“Amatory torts . . . have been abolished. . . . ‘The derisive term ‘heartbalm’ attached to the breach of promise action is an indication that public policy no longer considers money damages appropriate for what is perceived as only an ordinary broken heart’.”<sup>103</sup>

Regulation of sexual conduct can be traced to ancient law, and such regulation has been a constant throughout history. Most of the ancient laws relating to sexual impropriety dealt with adultery.<sup>104</sup> Most American states still have criminal statutes on the books providing for punishment of adultery, but criminal prosecutions are virtually non-existent.<sup>105</sup>

The American tort system historically has actively deterred other socially undesirable sexual conduct. In the latter party of the 19<sup>th</sup> century, actions for seduction were among the most common forms of civil actions, and were usually successful.<sup>106</sup> Prior to the 1930’s, American courts entertained actions for alienation of affections,<sup>107</sup> criminal conversation,<sup>108</sup> seduction,<sup>109</sup> and breach

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<sup>103</sup> Conley v. Romeri, 60 Mass.App.Ct 799, 806 N.E.2d 933, 805, n.5 (2004).

<sup>104</sup> Ancient punishment for adultery included being eaten alive by dogs, death of both parties, bodily mutilation of the adulterer, and, in ancient Rome, giving both the husband and the father the “right” to kill the guilty parties. See Comment, *Fanning An Old Flame: Alienation of Affections And Criminal Conversation Revisited*, 26 Pepp. L. Rev. 61, 65 & nn. 29-33 (1999). See also William R. Corbett, *A Somewhat Modest Proposal To Prevent Adultery And Save Families: Two Old Torts Looking For A New Career*, 33 Ariz. St. L. J. 985, 1002-3 (2001). English common law considered adultery to be a tort, not a crime, and allowed the husband of an adulterous wife to sue his wife’s lover for money damages in a criminal conversation lawsuit. See Comment, *supra* at 65. Early American Puritans forced adulterers to wear a scarlet “A” in lieu of death as punishment for adultery. See Comment, *supra* at 65 & n. 37.

<sup>105</sup> See Comment, *supra* n. 104 at 65-66. However, recent criminal seduction convictions relative to minors have been recorded as recently at 1988. See *People v. Bayless*, 2004 WL 2341477 (Cal.)(defendant had been convicted of seduction of a minor in 1988). *Amburgey v. Commonwealth*, 415 S.W.2d 103 (Ky. 1967)(seduction victim was under age 21.) See also Dan Subotnik, “*Sue Me, Sue Me, What Can You Do To Me? I Love You*”: *A Disquisition On Law, Sex, and Talk*, 47 Fla. L. Rev. 311, 324 (1995).

<sup>106</sup> Jane E. Larson, “*Women Understand So Little, They Call My Good Nature Deceit*”: *A Feminist Rethinking of Seduction*, 93 Colum. L. Rev. 374, 383-4 (1993).

<sup>107</sup> Alienation of affections is where a third party’s interference destroyed the affection that existed between spouses prior to the interference. This tort was known as “enticement” in English common law, and could be brought against any meddling third party, even without sexual involvement, such as mothers in law. Some scholars assert that alienation of affections did not evolve from enticement. See Comment, *supra* n. 104 at 66-67.

<sup>108</sup> This tort involved a third party’s adulterous relationship with plaintiff’s spouse. This tort was a strict liability tort, as there were no real defenses such as the spouse living apart from her spouse and representing herself to be unmarried. This tort was known as “seduction” in English common law. See Comment, *supra* n. 104 at 66-68.

<sup>109</sup> Seduction went through some changes in American law, and this tort was codified in many states beginning in Iowa in 1851, and allowed women to sue in their own name

of marriage promise.<sup>110</sup> What bound these 4 “heartbalm” torts together was their common focus on legal redress for emotional and reputation injury resulting from sexual misconduct; disease control was not the issue.<sup>111</sup>

During the latter half of the twentieth century, heartbalm torts were eviscerated, based essentially on the concepts that public policy does not support civil redress for broken hearts, and women who brought heartbalm actions were abusing men through the civil court system. Early feminists who sought freedom from paternalistic laws and obsolete common law conceptions of women as property of men<sup>112</sup> fueled the first anti-heartbalm movement as part of the first American sex revolution that began in the 1930’s.<sup>113</sup> Indiana’s enactment of the “Act To Promote Public Morals” initiated the movement, abolishing all of the heartbalm torts.<sup>114</sup> Other states quickly proposed similar legislation, and much of the rhetoric surrounding the new legislation was misogynistic, focusing on the “golddiggers” who blackmailed money from men through sex tort vehicles.<sup>115</sup> Yet, although 23 states considered anti-heartbalm legislation in 1935, only 8 states had passed such legislation by 1950.<sup>116</sup>

A second wave of anti-heartbalm legislation coalesced with the “second” American sexual revolution of the 1960’s.<sup>117</sup> This period, of course, involved a

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for damages resulting from the devastating social injury that resulted at that time from premarital sex or unwed motherhood. *See* Larson, *supra* n. 106 at 385-6.

<sup>110</sup> Larson, *supra* n. 106 at 394 & n. 85.

<sup>111</sup> Larson, *supra* n. 106 at 394 & n. 85.

<sup>112</sup> All of these torts originated from the concept that women were property, which is why fathers and husbands had the right to sue the men who took sexual advantage of their daughters/wives, as this was an interference with their property rights, and loss of the woman’s services to the plaintiff. *See*, Larson, *supra* n. 106 at 382-3. *See also* W. PROSSER, LAW OF TORTS 875 (4<sup>th</sup> ed. 1971)(regarding criminal conversation and the fact that a wife’s consent did not destroy the husband’s action, since wife was considered property: “it was considered that she [the wife] was no more capable of giving consent which would prejudice the husband’s interest than would his horse,” *citing* 8 HOLDSWORTH, HISTORY OF ENGLISH LAW 430 (2d ed. 1937).

<sup>113</sup> *See, e.g.*, Subotnik, *supra* n. 105 at 320-321. Ironically, the arguments that fueled the movement away from heartbalm torts were hardly consistent with the view that women were independent, competent people who did not need the law’s protection. Instead, the main arguments in support of the anti-heartbalm movement centered on women’s alleged misuse of the torts to extort money from men, with newspaper articles calling plaintiffs in these cases “golddiggers” and “blackmailers” who used the heartbalm torts as tools for extortion. Larson, *supra* n. 106 at 394-6.

<sup>114</sup> *See* Corbett, *supra* n. 104 at 1007-8; 1935 IND. ACTS, Ch. 208 Sec. 1 (codified at IND. CODE ANN. Sec. 2-508) (Burns 1946 replacement volume).

<sup>115</sup> *See, e.g.*, Larson, *supra* n. 106 at 394-400, 445-448; Corbett, *supra* n. 104 at 1007-1010.

<sup>116</sup> *See* Corbett, *supra* n. 104 at 1008 & nn. 100-103.

<sup>117</sup> Although most people think of the American Sexual Revolution as a 1960’s phenomenon, from a sociological and legislative standpoint, it is really the second wave of a sexual revolution that began in the 1930’s when Victorian concepts were rejected by early feminists, and female power and sexual expression became more socially acceptable. In addition,

sweeping rejection of traditional American values. Traditional beliefs about sexual morality and gender roles were abandoned, as more women moved from the home into the workforce and, perhaps above all, women gained substantial control over their reproductive function by the development of the birth control pill.<sup>118</sup> No doubt spurred in part by the release of the Kinsey reports,<sup>119</sup> and the popularization of pornography through publications such as *Playboy*,<sup>120</sup> sex

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the 1960's Sexual Revolution probably began no later than 1953 when Kinsey's second report and *Playboy* magazine came out, as these items caused people to reassess sexual norms.

<sup>118</sup> At least some scholars believe that this control over childbirth ushered in an "era of liberated sexual practices, where openness and sexual freedom would reign." EDWARD A. WYNNE & KEVIN RYAN, *RECLAIMING OUR SCHOOLS: A HANDBOOK ON TEACHING CHARACTER, ACADEMICS, AND DISCIPLINE* 225-6 (2d ed. 1997).

<sup>119</sup> In 1948 and 1953, respectively, Alfred Kinsey and his colleagues published the first "scientific" data regarding male and female sexuality. *See* ALFRED C. KINSEY, WARDELL B. POMEROY & CLYDE MARTIN, *SEXUAL BEHAVIOR IN THE HUMAN MALE* (1948) and ALFRED C. KINSEY, WARDELL B. POMEROY & CLYDE MARTIN, *SEXUAL BEHAVIOR IN THE HUMAN FEMALE* (1953). Despite serious methodological flaws, the most serious of which related to the unrepresentative sexual nature of the subjects of the study, who did not reflect most Americans' sexual behavior, but were volunteers who probably engaged in different sexual behavior than persons not interested in volunteering to discuss their sexuality, and consisted of "a fraternity here, a college class there, a PTA from a third place, and a group of homosexual men from somewhere else," the Kinsey reports were widely read and "shocked the nation and became enshrined as the nation's report card on sexual behavior." *See* ROBERT T. MICHAEL, JOHN H. GAGNON, EDWARD O. LAUMANN & GINA KOLATA, *SEX IN AMERICA* 15- 20 (1994). The reports stated that 90% of men and 50% of women had premarital sex, that almost all men and 3/5 of women masturbated, and that 50% of men had extramarital sex, inter alia, which was very disturbing to Americans and may have contributed to the increased sexuality of Americans thereafter, based on the view that everyone else was doing it. Ironically, the Kinsey reports have been largely rejected by the scientific community on account of gross scientific flaws, yet appear to have had a great impact on Americans' conception about the contents of normal, appropriate, ubiquitous sexual practices in America. Indeed, Kinsey is reported to have encouraged pedophiles to sexually violate "between 317 and 2035 infants and children," to have been involved in a variety of perverse sexual practices, and ultimately, to have died as a result of "orchitis," a lethal infection of the testicles that results from masochistic masturbation (whatever that is). *See* Judith A. Reisman, *Crafting Bi/Homosexual Youth*, 14 *Regent U. L. Rev.* 283, 312 (2001-2002). Kinsey has been dubbed a scientific fraud bent on propagating and encouraging his own perverse sexual ideals. *Id.* Perhaps worse, Kinsey's inaccurate data, and the resultant societal reaction may have contributed greatly to the rise of sexual disease in America, as behavioral research shows that people's perceptions of what others are doing impacts their own choices, and can alter norms. *See infra* Sec. IV.B.2. What is clear is that prior to Kinsey's publications, the only common sexually transmitted diseases were gonorrhea and syphilis, both bacterial, and both easily treatable with antibiotics, but now, the sexual disease epidemic involves so many incurable, viral antigens that they cannot even be counted accurately. *See supra* Sec. II.A.

<sup>120</sup> The first edition of *Playboy* came out in December of 1953, the same year Kinsey's second report was released. Seventy thousand copies of the first *Playboy* edition were printed, and over 54,000 sold, at fifty cents per copy, no doubt in large part because Marilyn Monroe was the centerfold. On the first issue's first page, Hugh Hefner wrote, "We believe too, that we are filling a publishing need only slightly less important than the one just taken care of by the Kinsey Report." There was no date on the original issue of *Playboy*, as Hefner did not know if the magazine would sell, and whether a second edition would be financially feasible. For the

came out of the closet and into the streets, and consensual sex outside of marriage, masturbation, cohabitation, birth control, and even abortion became more accepted.<sup>121</sup> “Free love” sentiment and bumper stickers were ubiquitous. The only practical consequences of adultery or other irresponsible or deceptive sexual behavior were a lover’s contempt, and possibly a relatively benign, curable sexual disease.<sup>122</sup>

During the sexual revolution of the 1960’s, feminist sex reformers sought to advance women’s rights by reshaping law’s regulation of sex,<sup>123</sup> and a new wave of anti-heartbalm movement ensued. This time, it was very successful.<sup>124</sup> Today, no more than 9 states recognize alienation of affections or criminal conversation.<sup>125</sup> Seduction has been abolished by statute in all but 17 states, and 21 states have interpreted their anti-heartbalm statutes to prohibit breach of promise actions.<sup>126</sup>

Judicial sentiment surrounding the second wave of the anti-heartbalm movement revealed the sexual revolution’s apparent impact on American norms. Courts expressed the view that the heartbalm torts “diminished human dignity” by airing such matters in the courts, and that the prevalence (and apparent societal acceptance) of extramarital affairs could clog the court system with vexatious litigation if such torts were allowed.<sup>127</sup> In turn, the message to

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same reason, Hefner’s name does not appear on the first edition, for fear that if it failed, he’d have trouble getting another publishing job. See [www.Playboy.com](http://www.Playboy.com).

<sup>121</sup> Anita L. Allen, *Privacy And The Public Official: Talking About Sex As A Dilemma For Democracy*, 67 *Geo. Wash. L. Rev.* 1165, 1176 (1999). More generally, social institutions and customs were intensely scrutinized, and rejected, as a part of the Vietnam War protest movement and civil rights struggle.

<sup>122</sup> In 1950, the only common sexual diseases were gonorrhea and syphilis, which were bacterial and curable. See *infra*, Sec. II.A. Divorce law underwent radical changes as the “no fault” divorce trend, beginning in Washington state in 1973, spread fast, so there were no economic consequences for adultery leading to divorce. See HARRY D. DRAUSE, LINDA D. ELROD, MARSHAGARRISON & J. THOMAS OLDHAM, *FAMILY LAW 2* (5<sup>th</sup> Ed. 2003). Prior to no-fault divorce, adultery was grounds for divorce and often diminished substantially the adulterer’s property rights in the divorce settlement. See, Linda D. Elrod & Robert G. Spector, *A Review of the Year in Family Law: State Courts React to Troxel*, 35 *Fam. L. Q.* 577 (2002). However, a few states continue to bar alimony altogether when the claimant spouse is found guilty of adultery causing divorce. See, e.g., GA. CODE ANN. Sec. 19-6-1.

<sup>123</sup> As part of this movement, rape laws were also changed to protect women, such as by eliminating the marital exception to rape, and sexual harassment laws followed. See, e.g., Larson, *supra* n. 106 at 400-401.

<sup>124</sup> See Corbett, *supra* n. 104 at 1009 – 1010.

<sup>125</sup> Corbett, *supra* n. 104 at 1009 & n. 7.

<sup>126</sup> See Subotnik, *supra* n. 105 at 321-2.

<sup>127</sup> See *Feldman v. Feldman*, 480 A.2d 34, 36 (1984); Comment, *supra* n. 104 at 72-73; *Norton v. MacFarlane*, 818 P.2d. 8, 12 (Utah 1991), where the Utah Supreme Court stated that allegations of sexual misconduct “no longer carry a significant stigma.”

society was that the law was not concerned about sexual misconduct,<sup>128</sup> including adultery,<sup>129</sup> in part because sex tort law was focused on broken hearts and injury to dignity, not deadly diseases. The absence of legal sanctions for sexual misconduct,<sup>130</sup> and resulting contemporary belief among some Americans that they owe nothing to their sexual partners, failed to discourage sexual promiscuity,<sup>131</sup> which has contributed to the sexual disease epidemic. Tort law's current message to society regarding sexuality is clearly "caveat emptor."<sup>132</sup>

### B. Sex Torts Today

"Plaintiff's claim is clearly barred . . . . The very illegal act to which the plaintiff consented [premarital sex] . . . produced the injuries and damages of which she complains [genital herpes]. And, the foregoing principle [illegal acts

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<sup>128</sup> At least one legal scholar has argued that Lorena Bobbit's self-help decision to remove her husband's penis while he slept resulted in part from a lack of legal remedies. See Gretchen Reynolds, *A Breach of Promise*, Chi.Mag. 114 (April, 1994), quoting Northwestern University Law Professor Jane E. Larson. In 1997, a North Carolina jury ordered a husband's adulterous lover to pay his wife one million dollars after deciding that the husband's secretary lured him away from his wife and family. See *Hutelmyer v. Cox*, 514 S.E.2d 554 (N.C. Ct. App. 1999), rev. den. 514 S.E.2d 146 (N.C. 1999), appeal dismissed, 542 S.E.2d 211 (N.C. 2000); Terry Carter, "She Done Me Wrong": A Jury Agrees, Awarding a Jilted Wife \$1 Million in an Alienation of Affection Suit Against the "Other Woman" ABA J. Oct. 1997 at 24. In an interview with Dateline NBC, jurors stated that they wanted to send a message about marriage and morality, and make clear that "homewreckers" were wrong. Dateline NBC (NBC television broadcast, Dec. 15, 1997) described the case pursued by Dorothy Hutelmyer against her husband's secretary a "symbol for the prevailing thoughts about marriage and relationships in this area." The secretary-defendant later stated that, in retrospect, she would not have dated Joe Hutelmyer under the circumstances, and would have waited until he was divorced before seducing him. Dateline, *supra*. This is contrary to one court's opinion that in matters of sex, risk of damages would not be a deterrent. See, *Neal v. Neal*, 873 P.2d 871, 875 (Idaho 1994).

<sup>129</sup> A high percentage of Americans say that adultery is wrong, and in fact more Americans say so today than in the 1970s (around 85%), yet when asked if they thought less of a person who they knew had committed adultery, only about 60% said they lost esteem for that person. In a 1998 CNN/Time poll, 86% of Americans responded that adultery was wrong, compared with 76% in 1977. See ALLPOLITICS, HOW DO AMERICANS VIEW ADULTERY? Available online at <http://www.cnn.com/ALLPOLITICS/1998/08/20/adultery/poll>; Bruce Handy, *How We Really Feel About Fidelity*, TIME, Aug 31, 1998.

<sup>130</sup> This has lead one legal commentator to conclude, "The current lack of penalties for adultery and interference with family relationships is shockingly new." See Comment, *supra* n. 104 at 65.

<sup>131</sup> "Promiscuity" is not intended to carry a moral connotation but means "characterized by a lack of discrimination; specif., engaging in sexual intercourse indiscriminately, or with many persons." Webster's New World Dictionary 1076 (1988).

<sup>132</sup> See Larson, *supra* n. 106 at 413: "Ironically, the principle of caveat emptor remains most vigorously alive in the sexual marketplace."

bar recovery in tort] applies even though defendant concealed his infection from the plaintiff.”<sup>133</sup>

The sexual disease epidemic necessitates a reassessment of tort law’s proper function in sexual relations, as a new wave of sex tort litigation – seeking damages for sexual disease transmission -- has been growing over the past 20 years and will likely continue to grow commensurate with the proliferation of sexual disease. Although a few states have recognized negligent transmission of sexual disease since the late 19<sup>th</sup> to early 20<sup>th</sup> century,<sup>134</sup> courts all over the United States are addressing the issue of whether civil liability is appropriate

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<sup>133</sup> *Zysk v. Zysk*, 239 Va. 32, 35, 404 S.E.2d 721, 722 (Va. 1990) This case was essentially overruled based on the Supreme Court decision in *Lawrence v. Texas*, 539 U.S. 558, 123 S. Ct. 2472 (2003). See *Martin v. Zihlerl*, 269 Va. 35, 607 S.E.2d 367 (Va. Jan. 14, 2005).

<sup>134</sup> Tort recovery for the negligent transmission of a contagious disease, such as whooping cough, has existed in the United States since the latter part of the nineteenth century. See, e.g., *Kliegel v. Aitken*, 94 Wis. 432, 69 N.W. 67 (1896) (typhoid fever); *Smith v. Baker*, 20 F. 709 (S.D.N.Y. 1884) (whooping cough); *Gilbert v. Hoffman*, 66 Iowa 205, 23 N.W. 632 (1885) (smallpox). See also *Franklin v. Butcher*, 144 Mo.App. 660, 129 S.W. 428 (1910) (smallpox); *Hendricks v. Butcher*, 144 Mo.App. 671, 129 S.W. 431 (1910) (smallpox); *Skillings v. Allen*, 143 Minn 323, 326, 173 N.W. 663, 664 (1919) (scarlet fever); *Earle v. Kuklo*, 26 N.J.Super. 471, 98 A.2d 107 (1953) (tuberculosis); *Kowalske v. Armour & Co.*, 300 Minn. 301, 305, 220 N.W.2d 268, 271 (1974) (brucellosis). Tort liability, and even criminal sanctions, for transmitting a sexual disease to another person has also been recognized for nearly a century. Transmission of a sexual disease has constituted a crime in some states since the early 20<sup>th</sup> century. See, e.g., *State v. Lankford*, 29 Del. 594, 102 A. 63, 64 (DEL.GEN.SESS.1917)(syphilis); 63 OKL.ST.ANN. Sec. 1-59 (63 O.S. 1991 Sec. 1 -519), formerly 63 OKL.ST.ANN. Sec. 543 (1921). Tort liability has also been recognized for sexual disease transmission in some states since the late 19<sup>th</sup> and early 20<sup>th</sup> centuries. See *White v. Nellis*, 31 N.Y. 405 (1865) (venereal disease); *Crowell v. Crowell*, 180 N.C. 516, 105 S.E. 206, 208 (1920) (unspecified venereal disease); *DeVall v. Strunk*, 96 S.W.2d 245, 246-247 (Tex.Civ.App.1936) (crabs). but disease has not been the focus of sex tort law until fairly recently, a result of the sexual disease epidemic. See, e.g., *Mussivand v. David*, 45 Ohio St.3d 314, 544 N.E.2d 265 (1988) (venereal disease); *R.A.P. v. B.J.P.*, 428 N.W.2d 103, 105-6 (Minn.Ct.App.1988) (herpes); *Maharam v. Maharam*, 123 A.D.2d 165, 510 N.Y.S.2d 104 (1986) (herpes); *M.M.D. v. B.L.G.*, 467 N.W.2d 645 (Minn.Ct.App.1991) (herpes); *Berner v. Caldwell*, 543 So.2d 686 (Ala.1989) (genital herpes); *Kathleen K. v. Robert B.*, 198 Cal.Rptr. 273, 150 Cal.App.3d 992 (1984) (herpes); *Long v. Adams*, 175 Ga.App. 538, 333 S.E.2d 852 (1985) (genital herpes); *S.A.V. v. K.G.V.*, 708 S.W.2d 651 (Mo. Banc 1986) (herpes); *McPherson v. McPherson*, 712 A.2d 1043 (1998) (Human Papilloma Virus [HPV]); *Roe v. Doe*, 218 Cal.App.3d 1538, 267 Cal.Rptr. 564 (1990) (genital herpes); *Meany v. Meany*, 639 So.2d 229 (La.1994) (genital herpes); *Cerniglia v. LeVasseur*, 1995 WL 500673 (Conn.Super.1995) (genital herpes – third party) (unpublished opinion); *G.L. v. M.L.*, 228 N.J.Super 566, 550 A.2d 525 (1988) (genital herpes); *Lockhart v. Loosen*, 943 P.2d 1074 (1997)(herpes); *Plaza v. Estate of Wisser*, 211 A.D.2d 111, 626 N.Y.S.2d 446 (1995)(AIDS); *Schenk v. Devall*, 205 A.D.2d 900, 613 N.Y.S.2d 478 (1994)(herpes); *Desideri v. Brown*, 184 A.D.2d 247, 584 N.Y.S.2d 815 (1992)(venereal disease); *Tischler v. Dimenna*, 160 Misc.2d 525, 609 N.Y.S.2d 1002 (1994)(AIDS); *Doe v. Roe*, 157 Misc.2d 690, 598 N.Y.S.2d 678 (1993)(Chlamydia); *Duke v. Housen*, 589 P.2d 334, 340 (Wyo) cert. den., 444 U.S. 863, 100 S.Ct. 132, 62 L.Ed.2d 86 (1979) (gonorrhoea).

for sexual disease transmission as one of “first impression.”<sup>135</sup> Courts are grappling for liability standards in sex torts cases while holding tight to anti-heartbalm sentiment, which has resulted in sex tort jurisprudence that is unclear and unpredictable, thereby failing to meet tort law’s goals of deterrence, education, and compensation relative to a very serious public health threat.<sup>136</sup> Although sexual disease cases are almost always brought as negligence actions, courts have also recognized sex torts grounded in fraud, intentional infliction of emotional distress, and battery where the plaintiff contracted a sexual disease.<sup>137</sup> This section argues that negligence and intentional tort theories do not further social policy in sexual disease transmission cases.

### 1. Negligence Theory

“[P]ersons who engage in *unprotected sex*, at a time of the prevalence of sexually transmitted diseases, including some that are fatal, assume the risk of contracting such diseases. Both parties in an intimate relationship have a duty to protect themselves. When one ventures out in the rain without an umbrella, should they complain when they get wet?”<sup>138</sup>

This quote expresses a typical judicial attitude towards sexual disease transmission: while the prevalence of the public health threat is recognized, the attitude toward persons foolish enough to contract a sexual disease trumps solid public policy analysis. Opinions such as this shame the victim, and allow sexual disease perpetrators to pay no regard to others’ health. Since the date of this opinion, tens of millions of Americans have contracted sexual diseases.<sup>139</sup>

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<sup>135</sup> See, e.g., *McPherson v. McPherson*, 712 A.2d 1043, 1045, 1998 ME 141 (1998)(“Turning to [plaintiff’s] novel theory of negligence, we must first determine whether a negligence action may be based on the transmission of a sexually transmitted disease, an issue of first impression in Maine”); *B.N. v. K.K.*, 312 Md. 135, 538 A.2d 1175 (1988)(Maryland court certified question from District Court: Does Maryland recognize a cause of action for either fraud, intentional infliction of emotional distress, or negligence resulting from the sexual transmission of a dangerous, contagious, and incurable disease, such as genital herpes? Court answered in the affirmative.)

<sup>136</sup> Some states are still in the process of abolishing heartbalm torts. See, e.g., *Neal v. Neal*, 125 Idaho 617, 873 P.2d 871 (2004)(finding that Idaho no longer recognizes criminal conversation).

<sup>137</sup> A few cases have also recognized negligent infliction of emotional distress, but these usually involve fear of contracting AIDS and are generally analyzed consistent with toxic tort cases/fear of future disease. See, e.g., *Tischler v. Lawson*, 160 Misc.2d 525, 609 N.Y.S.2d 1002 (1994).

<sup>138</sup> See *Doe v. Roe*, 157 Misc.2d 690, 598 N.Y.S.2d 678, 694 (1993)(emphasis in original).

<sup>139</sup> See supra Sec. II.A.

Sexual disease transmission cases rely almost exclusively on negligence theory,<sup>140</sup> a fault-based tort which is unpredictable, inefficient, and often extremely embarrassing for the parties involved in sex tort cases. Although all contemporary courts that have dealt with the issue have found that it is possible to state a claim for negligent transmission of a sexual disease, the current negligence paradigm has been proven to create prohibitively expensive and embarrassing fact-specific litigation and the attendant problem of very uncertain liability, which fails to deter irresponsible sexual conduct. Primarily, judges seem reluctant to establish a clear duty of care relative to sexual activity,<sup>141</sup> instead adopting a case by case inquiry to determine whether a duty to protect a sexual partner from a sexual disease should exist.<sup>142</sup> In addressing the question of duty, courts have focused on the nature of the parties' relationship, and whether defendant knew or should have known of his disease, to establish the foreseeability of infecting others.<sup>143</sup> An Oklahoma decision is

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<sup>140</sup> See, e.g., Michele L. Mekel, *Kiss And Tell: Making The Case For The Tortious Transmission Of Herpes And Human Papilloma Virus*, 66 Mo. L. Rev. 929, 938 (Fall 2001). Negligent conduct is conduct that creates an unreasonable risk of harm to a person to whom a duty of due care is owed, and is generally stated upon prima facie proof of five elements: duty, breach, harm, cause in fact, and proximate cause.

<sup>141</sup> One court noted that persons with sexual diseases are in the best position to control the spread of the disease. *R.A.P. v. B.J.P.*, 428 N.W.2d 103 (Minn. Ct. App. 1988).

<sup>142</sup> Although some courts have found that a duty to avoid infecting others always exists where defendant knows of his disease, defendants often do not know, or claim that they do not know, about their disease, and if a court believes this, they will find no duty based on no foreseeability. See, e.g., *Roe v. Doe*, 218 Cal.App.3d 1538, 1544 (1990) ("Ordinarily, foreseeability is a question of fact . . . . The degree of foreseeability necessary to warrant the finding of a duty will . . . vary from case to case.") The case by case nature of the duty inquiry has resulted in different ways of proving breach once a duty is recognized. Breach of the duty has been established by carelessly exposing others to infection, see, e.g., *Berner v. Caldwell*, 543 So.2d 686, 689 (Ala.1989); or carelessly failing to obtain a diagnosis and treatment where defendant claims he was unaware of the infection, see, e.g., *M.M.D. v. B.L.G.*, 467 N.W.2d 645 (Minn.Ct.App. 1991)(man without actual knowledge of herpes infection held to a duty of care to warn sexual partner about possible infection, where man had recurring genital sores and medical advice that they may be herpes.) Where the disease involved has obvious symptoms, so defendant's knowledge of the disease can be readily established, breach has been based on failure to inform a sexual partner, *Roe v. Doe*, 218 Cal.App.3d 1538, 1542 (1990)(herpes); failure to put on a condom, *Id.* (defendant unsuccessfully argued that since at the time that he infected plaintiff the possibility of herpes transmission without lesions (asymptomatic shedding) was not well known, even to the medical community, that he could not be faulted for believing that he could not transmit it during a period when he did not have visible lesions; the court found that asymptomatic shedding was known and that in any event, failure to warn was not acceptable); and failure to abstain from sex, see *Tort Liability For Sexually Transmitted Diseases*, *supra* n. 2 at n. 17.

<sup>143</sup> See, e.g., *Doe v. Roe*, 218 Cal.App.3d 1538, 1543-4, 267 Cal.Rptr. 564, 566-7 (1990)("In determining whether a duty should be imposed, the courts are guided by the basic principle . . . that everyone is responsible for injury occasioned to another by his own want of ordinary care or skill. . . . a number of policy considerations [should be balanced], including the foreseeability of the harm suffered, the degree of certainty the plaintiff suffered injury, the closeness of the connection between defendant's conduct and the injury suffered, the moral blame attached to the defendant's conduct and the consequences to the community of imposing a

representative of the unpredictable nature of the duty inquiry: “The length and nature of the parties’ relationship, its degree of intimacy, and [defendant’s] knowledge of her condition are all factors to consider in order to determine whether [defendant’s] conduct created . . . a duty to lessen the risk or take precautions to protect others. . . .”<sup>144</sup>

The unclear duty standard that has emerged in sexual disease cases<sup>145</sup> has caused defendants to make numerous arguments that no duty is owed to a

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duty to exercise care. . . . in cases where the burden of preventing future harm is great, a high degree of foreseeability may be required. On the other hand, in cases where there are strong policy reasons for preventing the harm, or the harm can be prevented by simple means, a lesser degree of foreseeability may be required. . . . [In the case of herpes], it is beyond question that our state’s policy of preventing the spread of venereal disease is great and that the burden of warning a prospective sex partner is small. Thus, only a slight degree of foreseeability was needed to warrant the imposition of a duty of care in the present case [of herpes transmission].” See also *R.A.P. v. B.J.P.*, 428 N.W.2d 103, 106-7 (1988)(“Minnesota courts have long recognized that the preservation of public health is a matter of great public importance. Legal duties and rules must therefore be designed, wherever possible, to help prevent the spread of dangerous, communicable diseases,” citing *Skillings v. Allen*, 143 Minn. 323, 326, 173 N.W. 663, 664 (1919)); *Cerniglia v. LeVasseur*, 1995 WL 500673 (Conn.Super.)(persons with a venereal disease have a duty to use reasonable care to avoid infecting others with whom they engage in sexual conduct); *McPherson v. McPherson*, 712 A.2d 1043, 1046 (1998)(defendant cannot be liable for negligent transmission of the Human Papilloma Virus to his wife where trial court found that he did not know or have reason to know that he had it at the time he infected his wife; absent foreseeability, defendant cannot be found to have breached a duty of care); *M.M.D. v. B.L.G.*, 467 N.W.2d 645 (Minn.Ct.App. 1991)(a reasonable person with recurring sores on genitals, who was told by a doctor that he should be tested for herpes, should know of the potential to infect others, and therefore has a duty to avoid sexual contact with others, or at least to inform them about his disease and his doctor’s advice).

<sup>144</sup> *Smith v. Speligene*, 990 P.2d 312, 315-6 (1999). This case involved Herpes Simplex I, which plaintiff alleged he contracted from his former girlfriend. The court utilized zone of risk analysis. Although the case does not indicate which part of his body was infected, HSVI is usually related to lip herpes, but can be transmitted to other body parts and can be painful. All herpes viruses are incurable. See also *B.N. v. K.K.*, 312 Md. 135, 153, 538 A.2d 1175 (1988)(an “ongoing intimate boyfriend-girlfriend relationship” may give rise to a confidential relationship creating a duty to disclose a disease, but finding no confidential relationship required because there is always a “general tort duty” to disclose sexual disease before engaging in intercourse.)

<sup>145</sup> See, e.g., *R.A.P. v. B.J.P.*, 428 N.W.2d 103, 108 (Minn.Ct.App. 1988)(“The scope of the duty of care which we recognize here will necessarily vary depending on the facts of individual cases. As one commentator has noted, the three words, “I have herpes” will be sufficient in most cases to give fair notice of the danger of infection, and to fulfill the duty to use reasonable care to avoid transmitting the disease. Whether the duty to take reasonable precaution to avoid transmission of herpes has been breached is a question of fact for the trial court or jury, as is the question of whether the breach of duty proximately caused injury to the plaintiff”); *Mussivand v. David*, 544 N.E.2d 265, 269 (Ohio 1989)(The general principle is well established that a person who negligently exposes another to an infectious or contagious disease, which such other thereby contracts, is liable for damages therefore . . . . The degree of diligence required to prevent exposing another to a contagious or infectious disease depends on the character of the disease and the danger of communicating it to others.) At least one court has held that the key issues are the degree of contact, rather than its nature, sexual or otherwise, and the defendant’s

sexual partner, such as: that no duty exists to disclose sexual disease to a sexual partner prior to sex,<sup>146</sup> that no duty exists to the spouse of a paramour,<sup>147</sup> that no duty exists absent a confirmed diagnosis of the disease,<sup>148</sup> that no duty exists to disclose extramarital sexual relations to one's spouse absent knowledge of having contracted a disease,<sup>149</sup> and that past promiscuous behavior within a group at high risk for contracting AIDS, without knowledge of having contracted AIDS, does not give rise to a duty to warn.<sup>150</sup> These arguments have been entertained, and have met with some success, on account of unclear legal standards.<sup>151</sup> Indeed, although the claim that a husband owes his wife no duty to

knowledge of his contagious disease, so that wrestler owed other wrestler duty based on defendants knowledge of his herpes blisters and the degree of skin-to-skin contact inherent in wrestling. *See Silver v. Levittown Union Free School Dist.*, 692 N.Y.S.2d 886, 887-8, 180 Misc.2d 1015, 1016-7 (1999).

<sup>146</sup> *See, e.g., R.A.P. v. B.J.P.*, 428 N.W.2d 103, 106 (1988); *Smith v. Walker*, 11 Pa.D.& C. 4<sup>th</sup> 663, 664 (Ct.Common Pleas Penn 1991); *B.N. v. K.K.*, 312 Md. 135, 151, 538 A.2d 1175 (1988).

<sup>147</sup> *See, e.g., Lockhart v. Loosen*, 943 P.2d 1074, 1077 (Okla.1997); *Cerniglia v. LeVasseur*, 1995 WL 500673 (Conn.Super)(unpublished case). Both cases held that a paramour may be liable to the spouse of his or her sexual partner provided that it was foreseeable that the disease could be transmitted to the spouse (i.e., the paramour knows of the marriage, as sex between spouses was held foreseeable) and no superseding cause exists (i.e., the paramour's sex partner was not informed of the disease at the time he or she gave it to his or her spouse; if the paramour's sex partner was informed, the negligence or intentional misconduct in failing to inform the spouse constitutes a superseding cause.)

<sup>148</sup> *See Doe v. Johnson*, 817 F. Supp. 1382 (W.D.Mich. 1993).

<sup>149</sup> *See In Re Marriage of J.T.*, 77 Wash. App. 361, 891 P.2d 729 (1995) (no duty between spouses to disclose extramarital sexual relationships); *McPherson v. McPherson*, 712 A.2d 1043, 1044-5 (no duty to be sexually faithful in a marriage). *But see SAV v. KGV*, 108 S.W.2d 651 (Mo.Sup.Ct. en banc 1986)(duty of care owed by one spouse to other spouse can be assessed, defined, and adjusted by courts).

<sup>150</sup> *Doe v. Johnson*, 817 F. Supp. 1382 (W.D.Mich. 1993). In *Johnson*, the court limited the duty to warn a sexual partner about the possibility of contracting AIDS only where the defendant: 1) has actual knowledge that he is HIV positive; 2) has experienced symptoms associated with HIV; or 3) has actual knowledge that a prior sex partner has been diagnosed as having HIV. The court specifically held that there was no duty to warn plaintiff that defendant was a member of a high-risk group, and that a defendant who has had unprotected sexual encounters with multiple partners does not have a legal duty to inform a plaintiff of his or her past sexual activity.

<sup>151</sup> One court noted that a single admission, "I have herpes," may be sufficient notice to meet the duty of care. *R.A.P. v. B.J.P.*, *supra* at 108. Third party actions create even more fact specific inquiries into the issue of whether duty exists. For example, in one case where a wife sued her husband's lover for transmittal of genital herpes, the issue of whether the lover owed a duty to the wife became the subject of remand, to determine: whether the defendant knew or should have known that she had herpes, and had copulated with the wife's husband while infectious, and whether she knew he was married (making it foreseeable that her lover would in turn give the disease to his wife, as sexual relations between spouses are foreseeable). *Lockhart v. Loosen*, 943 P.2d 1074 (Okla. 1997). In addition, even in situations in which it is determined that the lover knew all of the above, if the adulterous spouse knew or should have known of the disease and passes it on to his spouse anyhow, his negligence may supersede his lover's, cutting off proximate cause based on "termination of the risk" concepts. *See Mussivand v. David*, 45 Ohio St. 3d 3143, 544 N.E. 2d. 265 (1989).

avoid transmitting herpes has been rejected,<sup>152</sup> a Washington court has held that there is *no duty* of sexual fidelity even in marital relationships (that is, the marriage relationship is not a “special relationship”)<sup>153</sup> and therefore no duty to disclose extramarital sexual relations, despite the clear health risks involved.<sup>154</sup> Other courts more broadly define the duty to include protecting others from infection, which may involve more than a mere admission of the disease.<sup>155</sup> Most courts have found that a duty not to spread infection exists between sexual partners if the defendant knew or should have known of his disease, regardless of marriage,<sup>156</sup> or that the intimate nature of the sexual relationship created a “special relationship,” and attendant duty of care.<sup>157</sup>

The main focus in published decisions has been whether defendant knew of his disease, or was aware of facts such that he should have known of it, i.e., foreseeability.<sup>158</sup> The problem is that many people who carry sexual diseases

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<sup>152</sup> Hamblen v. Davidson, 50 S.W.3d 433 (Tenn. Ct. App. 2000) *appeal den.* (May 14, 2001).

<sup>153</sup> A defendant’s relationship to the plaintiff has been held to create a duty of care in a number of relationships, sometimes referred to as “special relationships,” and include a landowner’s duty to protect customers or tenants, a school’s duty to protect students, an employer’s duty to protect employees who are endangered on the job, and a custodian’s duty to protect persons in custody, such as prisoners and involuntarily committed mental patients. *See* DOBBS, *supra* n. 4 at 874–891.

<sup>154</sup> In *Re Marriage of J.T.*, 77 Wash.App. 361, 891 P.2d 729 (1995); *McPherson v. McPherson*, 712 A.2d 1043, 1045-6 (1998)(court rejected wife’s argument that husband owed her a duty of sexual fidelity based on the marital relationship and that breach was actionable when it lead to physical harm, instead relying on the more general concept that where a person knows or should know that he or she is infected with a sexually transmitted disease, he or she is under a duty to protect sexual partners from infection).

<sup>155</sup> *McPherson v. McPherson*; *Milbank Ins. Co. v. B.L.G.*, 484 N.W.2d 52 (Minn.Ct.App. 1992), *called into doubt on other grounds*, *American Family Ins. Co. v. Walser*, 628 N.W.2d 605 (Minn. 2001)(a person who knows he or she has herpes has a duty to use reasonable care to avoid infecting others).

<sup>156</sup> *See, e.g.*, *Kathleen K. v. Robert B.*, 150 Cal.App.3d 992, 198 Cal.Rptr. 273, 277 (1984)(“Consent to sexual intercourse vitiated by one partner’s fraudulent concealment of the risk of infection with venereal disease is equally applicable today, whether or not partners involved are married to each other”); *Smith v. Walker*, 11 Pa.D. & C. 4<sup>th</sup> 663, 665 (Ct. Common Pleas 1991); *Long v. Adams*, 175 Ga.App. 538, 333 S.E.2d 852, *cert.den.* (Ga. 1985); *Berner v. Caldwell*, 543 So.2d 686 (Ala.1989); *McPherson v. McPherson*, *supra*; *Milbank Ins. Co. v. B.L.G.*, *supra*; *Doe v. Roe*, 218 Cal.App.3d 1538, 1545, 267 Cal.Rptr. 564 (1990)(people suffering from genital herpes generally have a duty either to avoid sexual contact with uninfected persons or at least to warn potential sex partners that they have herpes before sexual contact occurs); *R.A.P. v. B.J.P.*, 428 N.W.2d 103, 108 (1988)(“people suffering from genital herpes generally have a duty either to avoid sexual contact with uninfected persons or, at least, to warn potential sex partners that they have herpes before sexual contact occurs.”)

<sup>157</sup> *Roe v. Doe*, 218 Cal.App.3d 1538, 1542 (1990)(herpes).

<sup>158</sup> *Tort Liability For Sexually Transmitted Diseases*, *supra* n. 2 at nn. 17-18 and accompanying text. For example, in *Hamblen v. Davidson*, 50 S.W.3d 433 (Tenn.Ct.App. 2000), *appeal den’d* (May 14, 2001), husband claimed that he owed no duty not to transmit herpes to his wife, but material fact existed as to what the husband knew about his health condition, and failed to tell wife, which precluded summary judgment for husband. Foreseeability is crucial to

do not know that they have a disease, but shielding them from liability based on their own ignorance is contrary to the public policy of protecting the citizenry from contagious diseases. The factual issues surrounding the determination of whether defendant “knew or should have known” that he was infected, e.g., symptoms of disease, have given rise to the most successful defense in sexual disease cases, the “I did not know I had it” defense.<sup>159</sup> Realistically, most sexual disease transmission is perpetrated by persons whose sexual behavior predictably results in disease transmission.<sup>160</sup> As a practical reality, disease perpetrators have constructive notice that they are creating an unreasonable risk of harm to others on account of their sexual practices. Yet, courts have been reluctant to impose liability based on constructive notice.

The negligence analysis is counterproductive to public policy because it is fact-specific, puts the plaintiff’s sexuality on trial, and allows defendants to behave irresponsibly, claim ignorance, and externalize all of the costs of their sexual

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defenses such as contributory negligence and assumption of the risk (often analyzed as comparative fault). See DOBBS, *supra* n. 4 at 534-9.

<sup>159</sup> This factual claim by defendant destroys foreseeability and therefore duty (and proximate cause, which turns on foreseeability) in negligence-based claims. For example, in one case where a woman sued defendant (her ex-husband) for transmittal of genital herpes, the central issue in the case was whether there was sufficient evidence from which a jury could conclude that the defendant knew, or should have known, that he was putting his wife at risk at the time he engaged in sexual relations with her. *Meany v. Meany*, 639 So.2d 229 (La. 1994), distinguished on other grounds in *Leleux v. U.S.*, 178 F.3d 750 (5<sup>th</sup> Cir. 1999). The evidence included the following: defendant had contact with multiple sexual partners during a period of separation from plaintiff; plaintiff’s first symptoms occurred after reconciliation (and resumed sexual relations) with the defendant; and, when plaintiff confronted defendant with her herpes diagnosis, defendant admitted that he had experienced a problem with penile “dripping” and had seen a doctor about it. The main issue was whether defendant’s awareness of his penile dripping constituted sufficient notice of a sexual disease such that he breached a duty of care to plaintiff by failing to take reasonable measures to make sure that whatever infection was causing the dripping was not transmitted to his wife. The fact that he had multiple sexual partners during a short period of separation did not establish the foreseeability necessary to allow a finding of negligence in and of itself, but helped to establish the link between dripping and a sexual disease. In another case, a man was held not liable for transmitting AIDS to his fiancée because he had no reason to know, based on the information available to the public at that time, that his single homosexual experience could have resulted in him contracting AIDS. *See C.A.U. v. R. L.*, 438 N.W.2d 441 (Minn.Ct.App. 1989). *See, also RAP v. BJP, supra* (case remanded to determine whether defendant informed her husband that she had herpes before marriage and before he contracted herpes (she said) or after marriage and after he contracted herpes (he said)). *See, also Delay v. Delay*, 707 So.2d 400 (Fla.Dist.Ct. App. 5<sup>th</sup> Dist. 1998)(defendant/husband claimed no knowledge that he had a sexually transmitted disease, and no evidence was presented to prove that he knew); *Smith v. Speligene*, 990 P.2d 312 (Okla. Civ.App. Div. 4 1999)(whether a duty existed turned in part on factual question of whether defendant knew she had a contagious disease that could be transmitted to defendant-ex-boyfriend); *McPherson v. McPherson*, 712 A.2d 1043 (Me. 1998)(ex-husband did not breach duty of care to ex-wife by transmitting Human Papilloma Virus because he did not know he had it at the time he infected her); *Doe v. Roe*, 157 Misc.2d 690, 598 N.Y.S.2d 678(no proof by preponderance that defendant knew she had Chlamydia at the time she had sex with her boyfriend);

<sup>160</sup> See *supra* Sec. II.C.

behavior not just to the victim, but to society at large (through health insurance and public aid). Not only is the current negligence paradigm failing to deter irresponsible sexual behavior, it actually discourages the most sexually active “core” group members from getting tested to avoid any proof of knowledge of their disease, to avoid a finding of fault under a negligence standard.<sup>161</sup> Tort law should encourage potential disease perpetrators to get tested and to behave responsibly to avoid disease transmission, not give them an escape route rooted in their own ignorance. Although causation may be difficult to establish in some cases, adopting a strict duty of care would avoid the most difficult analysis relating to foreseeability in current sex tort jurisprudence.<sup>162</sup>

## 2. *Intentional Theories*

Sometimes plaintiffs in sexual disease transmission cases have sought remedies under intentional tort theories. Courts have held that actions for fraud and battery may lie where the plaintiff can show that defendant intended to deceive plaintiff regarding a sexual disease and plaintiff justifiably relied on defendant’s misrepresentations in consenting to sex, contracting a sexual disease thereby. Specifically, fraud claims in which plaintiff contracts a sexually transmitted disease from defendant requires a showing that the defendant made some representation about his health that was untrue, that plaintiff relied on that misrepresentation in agreeing to engage in sexual relations, and that plaintiff was infected as a result.<sup>163</sup> The crucial issues in fraud claims are whether defendant knew of his disease and whether he made false representations for the purpose of inducing plaintiff to have sex.<sup>164</sup>

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<sup>161</sup> As stated by Professor Mekel, the most logical way to prove knowledge of disease is to obtain defendant’s medical records showing disease diagnosis; one way of avoiding such a showing of fault is to avoid diagnosis. *See* Mekel, *supra* n. 140 at 953.

<sup>162</sup> Cause in fact could conceivably cause huge obstacles to recovery where plaintiff has multiple sexual partners, as it is not always possible to determine which partner transmitted the disease to the other through medical testing. *See, e.g., Doe v. Roe*, 157 Misc.2d 690, 598 N.Y.S.2d 678 (1993)(there was no more proof that defendant transmitted Chlamydia to plaintiff than there was proof that plaintiff transmitted it to defendant). However, cause in fact has rarely been an issue in published cases.

<sup>163</sup> *Tort Liability For Sexually Transmitted Diseases, supra* n. 2 at Sec. 6. The elements for fraud are: 1) false representation by defendant; 2) defendant knew the representation was false or made it with reckless indifference to its truth or falsity; 3) the representation was made for the purpose of inducing another to rely on it; 4) the plaintiff relied on the representation and had the right to rely on it (it was reasonable to rely on it) and would not have done the thing from which damage resulted in the absence of the representation; and 5) plaintiff suffered damages as a result. *See, e.g., B.N. v. K.K.*, 312 Md. 135, 149, 538 A.2d 1175, 1182 (1988). Note that defendant’s omission may also be sufficient, where he knew of a disease and failed to disclose it. *RAP v. BJP*, 428 N.W.2d 103 (1988); *In the Matter of Jose Plaza*, 211 A.D.2d 111, 626 N.Y.S.2d 446 (1995)(homosexual defendant failed to tell his partner/plaintiff that his former partner died of AIDS, and plaintiff contracted HIV from defendant).

<sup>164</sup> *See, e.g., B.N. v. K.K.*, 312 Md. 135, 538 A.2d 1175 (1988), *aff’d* 349 Md. 777, 709 A.2d 1287 (1998)(nurse alleged that doctor had genital herpes and was aware of his disease and nonetheless had sex with her without telling her, causing her to contract herpes,

Similarly, battery cases involving sexual disease turn on the concept that plaintiff's consent to sex was vitiated based on defendant's misrepresentation or failure to disclose a disease; defendant's knowledge of his disease and intent to expose his partner to the disease must be shown for consent to be vitiated via fraud or mistake.<sup>165</sup> Intentional infliction of emotional distress requires a showing that defendant acted intentionally or recklessly in giving plaintiff a disease.<sup>166</sup> Once again, absent proof that defendant knew of his disease, plaintiff is unlikely to prevail.<sup>167</sup>

The fault element under these intentional tort theories is harder to prove than the fault element in negligence cases, since a finding that defendant "should have known" of his disease may be sufficient for negligence, but intentional torts require plaintiff to show that defendant actually knew of his disease. Considering the difficulty in proving defendant's knowledge of his disease, these intentional tort theories are even less effective at deterring sexual misconduct and compensating disease victims than negligence theory.

#### IV. STRICT LIABILITY FOR TRANSMITTING A SEXUAL DISEASE

"Although loathe to create new causes of action in tort law, the law must nevertheless adapt to the society in which it exists."<sup>168</sup>

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stated cause of action for fraud); *Dubovsky v. Dubovsky*, 188 Misc. 2d 127, 725 N.Y.S.2d 832 (Sup. 2001)(one spouse failing to tell other of sexual disease can constitute fraud); *R.A.P. v. B.J.P.*, 428 N.W.2d 103, 108-9 (1988)(fraudulent transmission of herpes can be stated upon showing that defendant knew she had the disease and was silent, allowing plaintiff to contract the disease).

<sup>165</sup> See, e.g., *De Vall v. Strunk*, 96 S.W.2d 245 (Tex.Civ.App. 1936); *Crowell v. Crowell*, 180 N.C.516, 105 S.E. 206 (1920); *Hogan v. Tavzel*, 660 So.2d 350 (Fla. Dist. Ct. App. 5<sup>th</sup> Dist. 1995)(wife's consent to sex with husband was vitiated by his failure to inform her of his genital warts, and wife's consent without knowledge was the equivalent of no consent, citing *Restatement of Torts Second* (1977): "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."); *Kathleen K. v. Robert B.*, 150 Cal.App.3d 992, 198 Cal.Rptr. 273 (1984), reh'g denied, opinion modified (Aug. 12, 1989); *Leleux v. U.S.*, 178 F.3d 750 (5<sup>th</sup> Cir. 1990)(officer's fraudulent concealment of disease that he transmitted via intercourse held to have vitiated consent, so that sexual contact constituted battery.)

<sup>166</sup> See, e.g., *B.N. v. K.K.*, 312 Md. 135, 146, 538 A.2d 1175, 1181 (1988), *aff'd* 349 Md. 777, 709 A.2d 1287 (1998)(recognizing that a claim for intentional infliction of emotional distress may be stated where plaintiff shows that defendant knew of his disease and presents proof of the other elements of the claim). *Tort Liability For Sexually Transmitted Diseases*, *supra* n. 2 at Sec. 7; *B.N. v. K.K.*, 312 Md. 135, 144, 538 A.2d 1175 (1988), *aff'd* 349 Md. 777, 709 A.2d 1287 (1998).

<sup>167</sup> See *Doe v. Roe*, 157 Misc. 2d 690, 598 N.Y.S.2d 678 (J.Ct. 1993).

<sup>168</sup> *Silver v. Levittown Union Free School Dist.*, 180 Misc.2d 1015, 692 N.Y.S.2d 886, 887 (1999)(wrestler who contracted herpes from other wrestler during a wrestling match stated a cause of action for negligent transmission of a disease.)

Strict liability is liability without fault. That is, defendant may be liable for conduct that is neither negligent nor intentional, based on principles of social justice and public policy which may have nothing to do with wrongdoing or punishment. These principles emerge from an analysis of a number of factors, including: maximizing control of a public health threat; fair allocation of costs, including cost-effectiveness of risk allocation (who is the cheapest cost-avoider); deterrence of cost-producing behavior; blameworthiness; and legal precedent.

There are two basic questions that must be addressed before imposing a strict duty not to transmit a sexual disease: first, is it consistent with social justice; and second, will it advance public policy by slowing the spread of sexual diseases?

A. *Does Strict Liability For Sexual Disease Transmission Further Social Justice?*

In assessing fairness, the question is whether negligence or strict liability is *more* fair as between the parties involved and society at large. Fairness is always a relative question when someone must suffer a loss, and strict liability imposes costs on a class of persons who cause harm as opposed to imposing liability on a case by case basis, i.e., a negligence analysis.

Strict liability is superior to negligence based on concepts of individual and societal fairness and an economic analysis of law grounded in cost-avoidance. In order to maximize public protection, many violations of law result in strict liability, such as health and safety regulations, traffic laws, and narcotics control laws; intent is not required because the underlying purpose of these laws is public protection.<sup>169</sup> Indeed, strict liability already exists relative to sexual activity resulting in pregnancy: there is no excuse for avoiding child support payments upon proof of paternity.<sup>170</sup> Many states already have criminal

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<sup>169</sup> See, e.g., *U.S. v. Dotterweich*, 320 U.S. 277, 280-1 (1943) (“Such legislation dispenses with the conventional requirement for criminal conduct – awareness of some wrongdoing – in the interest of the larger good it puts the burden of acting at hazard upon a person otherwise innocent but standing in responsible relation to a public danger.”)

<sup>170</sup> The Congressional Family Support Act of 1988 adjusted the cost-benefit analysis of unprotected sexual activity by creating better enforcement mechanisms to force noncustodial parents to pay child support, whether married to the child’s custodial parent or not, thereby forcing the noncustodial parent to internalize child care costs that otherwise would remain external to the noncustodial parent. This is true even where conception results from a party’s contraceptive fraud, no doubt because allowing damages would divest the mother of the very funds required to support the child. See *In re Pamela P.*, 110 Misc. 2d 978, 443 N.Y.S.2d 343 (Fam.Ct.1981), rev’d, *In re L. Pamela P. v. Frank S.*, 59 N.Y.2d 1, 462 N.Y.S.2d 819, 449 N.E.2d 713 (1983); *Sorrel v. Henson*, 1998 WL 886561 (Tenn.App. 1998); *Linda D. v. Fritz C.*, 38 Wash. App. 288, 687 P.2d 223 (1984); *Wallis v. Smith*, 130 N.M. 214, 22 P.2d 682 (2001). See also *Anne M. Payne*, Annot, *Sexual Partner’s Tort Liability to Other Partner for Fraudulent*

penalties for transmitting a sexual disease.<sup>171</sup> While some states have not allowed negligence per se liability resulting from violation of these criminal laws (a species of strict liability, as duty and breach issues are pre-determined by the legislature), others have indicated a willingness to recognize negligence per se liability.<sup>172</sup> Therefore, strict liability for sexual disease transmission is

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Misrepresentation Regarding Sterility or Use of Birth Control Resulting in Pregnancy, 2 A.L.R.5<sup>th</sup> 301 (1992).

<sup>171</sup> See e.g., *State v. Lankford*, 29 Del. 594, 102 A.63, 64 (DEL.GEN.SESS. 1917); 63 OKL.ST.ANN. Sec. 1-519 (63 O.S. 1991 Sec. 1-519, formerly 63 OK.ST.ANN. 543 (1921)).

<sup>172</sup> Indeed, tort damages were first awarded as part of a criminal prosecution. W. PAGE KEETON, PROSSER & KEETON ON TORTS 8 (5<sup>th</sup> ed. 1984), citing POLLOCK, LAW OF TORTS 150 (15<sup>th</sup> ed. 1951). A few states have recognized that violation of a statute making sexual disease transmission a crime may give rise to a negligence per se claim, but others have held that the criminal statutes set forth a policy, not grounds for a civil lawsuit. 63 OKL.ST.ANN. Section 1-519 (63 O.S.1991 Sec. 1-519) provides in pertinent part: "Diseased persons – Marriage or sexual intercourse. It shall be unlawful and a felony for any person, after becoming an infected person and before being discharged and pronounced cured by a physician in writing, to marry any other person, or to expose any other person by the act of copulation or sexual intercourse to such venereal disease or to liability to contract the same." This law appears to be identical, or nearly identical, to a law existing since at least 1921. See 63 OKL.ST.ANN. Sec 543 (Comp.St.1921 Sec. 9008); 63 O.S.1941, Sec. 543; See also *Panther v. McNight*, 125 Okla. 134, 256 P.916 (1926)(civil damages awarded relying on statute). *Lockhart v. Loosen*, 943 P.2d 1074 (1997). The court in *Lockhart* discussed the risk rule, and found against the wife because, in review of the statutory language and apparent legislative intent, she was not a member of the class sought to be protected by the statute. However, the court implied that, had the *husband* sued, he would have been a part of the protected class, and presumably would have stated a claim based on negligence per se. Cal. Health & Safety Code Section 3198, enacted in 1957, provides in part, "any person . . . who exposes any person to or infects any person with any venereal disease . . . is guilty of a misdemeanor." This section was replaced by Section 120600 in 1995, but the new statute contains the same language quoted above and the statute as a whole is almost identical. No case has addressed the issue of whether a violation of this statute results in liability based on a theory of negligence per se. NY Public Health Law Section 2307 provides: "Any person who, knowing himself or herself to be infected with an infectious venereal disease, has sexual intercourse with another shall be guilty of a misdemeanor." In *Maharam v. Maharam*, 510 N.Y.S.2d 104, 107, the court stated that a husband had a duty to tell his wife that he had become infected with herpes, based on the 31 year marital relationship, and failure to do so states a cause of action for constructive, if not actual, fraud. The court stated that the duty to speak could also be predicated upon Section 2307 based on negligence per se. ALA CODE 1975, Sec. 22-11-21(c) provides: "Any person afflicted with a sexually transmitted disease who shall knowingly transmit, or assume the risk of transmitting, or do any act which will probably or likely transmit such disease to another person shall be guilty of a Class C misdemeanor." In *Berner v. Caldwell*, 543 So.2d 686 (1989), overruled on other grounds, *Ex parte General Motors Corp.*, 769 So.2d 903 (1999), a woman brought an action against her former boyfriend for allegedly giving her herpes. The court affirmed summary judgment in favor of the boyfriend, who claimed he had no knowledge that he had herpes. The court nonetheless stated: "That civil liability, to be determined according to the traditional rules of tort law, should also attach to allow recovery for damages resulting from the transmission of a sexually transmitted disease is a natural corollary to the legislative will as statutorily expressed. With the rise in the number of reported cases of sexually transmitted diseases, and in view of the harm that results from these diseases, the imposition of such civil liability is clearly warranted." *Id.* at 689. (emphasis added.) OHIO R.C. 3701.81(A) provides: "No person, knowingly or having reasonable cause to believe

not a radical departure from existing law, but rather a predictable departure necessitated by public health policy.

General social justice policies surrounding imposition of strict tort liability, both historical and economic, support imposing strict liability for transmitting a sexual disease.<sup>173</sup> As a basic rule, as between two innocent parties, the person causing harm should pay the costs of harm as opposed to the person who is harmed, particularly where the risk created by the injurer is disproportionate to the risk created by the victim, i.e., the “paradigm of reciprocity” supports imposing costs on the injurer.<sup>174</sup> Historically, strict liability has been imposed on persons and entities that choose to engage in abnormally dangerous activities, or to own wild animals with known dangerous propensities, because they have chosen to create a non-reciprocal risk to society. The idea is that they should pay the costs of their chosen pursuits, because avoiding all harm to others is not possible: “When an . . . individual . . . engages in systematic or repeated activity, . . . , some risks are more or less typical or characteristic of

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that he is suffering from a dangerous, contagious disease, shall knowingly fail to take reasonable measures to prevent exposing himself to other persons, except when seeking medical aid.” In *Mussivand v. David*, 45 Ohio St.3d 314 (1989), the court rejected plaintiff’s argument that this statute created negligence per se liability. The court stated that where a statute did not expressly provide for civil liability, a distinction must be made between statutes that prohibit specific acts and statutes that express a rule of conduct; only the former gave rise to negligence per se liability. *Id.* at 319-320. F.S.A. (Florida) Section 384.24 provides that it is unlawful to knowingly transmit a sexually transmitted disease. In *Gabriel v. Tripp*, 576 So.2d 404 (1991), the court reversed the appellate court’s decision that violation of the statute constituted negligence per se. The court stated that in order for a violation of a statute to constitute negligence per se, it must relate to a particular injury and a particular class of persons. The court relied on a legislative declaration of intent that stated that sexually transmitted diseases are a “threat to the public and individual health and welfare of the state,” and that such language shows that the statute was not designed to protect a “particular class of persons, but rather the public in general.” *Id.* at 405. The court held that a violation of the statute nonetheless presented prima facie evidence of negligence, just not absolute proof of negligence. *Id.* Louisiana REV.STAT.ANN. Sec. 14:43.5 (West Supp.1994) makes it unlawful for a person to inoculate or infect another person in any manner with a venereal disease or to do any act which will expose another to inoculation or infection with a venereal disease. The court in *Meany v. Meany*, 639 So.2d 229 (1994) reviewed whether violation of the statute could result in liability based on negligence per se. The court first stated that the courts have not adopted a policy of strict liability, or negligence per se, when the transmission of venereal disease has been statutorily prohibited. *Id.* at 235. The court then relied on *Mussivand* to conclude that the statute merely states a rule of conduct.

<sup>173</sup> Prior to 1850, American courts followed the English common law rule that direct physical injury to another’s person entailed strict liability, but beginning in 1850 in Massachusetts, courts began necessitating a showing of fault for recovery for personal injury, even if direct. *Brown v. Kendall*, 60 Mass. 292 (1850). Since sexual disease results from direct contact, a common law Trespass action should lie, although most Trespass cases involved “unauthorized” use of physical force, which could exclude consensual sexual relations despite the direct nature of the injury. See DOBBS, *supra* n. 4 at 259-266. See also Richard A. Epstein, *A Theory of Strict Liability*, 2 J. Leg. Stud. 151, 152 & n. 2 (1973)(arguing that the shift from strict liability to negligence was based on moral, not economic, grounds).

<sup>174</sup> See George P. Fletcher, *Fairness and Utility in Tort Theory*, 85 Harv.L.Rev. 537, 543 (1972). This assumes one diseased partner in sexual activity.

the activity even when no negligence can be shown.”<sup>175</sup> Deterrence is also sometimes cited as a reason for strict liability: it encourages persons engaged in abnormally dangerous activities to find safer methods or safer places for their activities.<sup>176</sup> No fault need be shown because the nature of the activity or substance is known to risk serious bodily harm or death to others and there is no way to control that risk altogether.<sup>177</sup> For this reason, plaintiff’s negligence, or even intentional wrongdoing, has traditionally not been a bar to recovery under strict liability.<sup>178</sup>

According to the scientific data, a small subgroup of Americans are choosing to engage in promiscuous sexual activity which has led to a sexual disease epidemic that is costing the American public billions annually.<sup>179</sup> The statistically few persons who choose to have sex with a large number of partners are creating a high risk of serious bodily harm or even death to others that cannot be completely eliminated by exercising reasonable care.<sup>180</sup> It is unfair for society at large to pay the price for the irresponsible sexual behavior of a small percentage of our citizens who choose a dangerous lifestyle, particularly since their dangerous activity lacks social utility.<sup>181</sup>

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<sup>175</sup> DOBBS, *supra* n. 4 at 909 (discussing enterprise [strict] liability theory).

<sup>176</sup> DOBBS, *supra* n. 4 at 964-5.

<sup>177</sup> The Second Restatement sets forth factors to determine whether strict liability should be imposed on an activity, a) creates a high risk of some harm to the person, land or chattels of others; b) with a likelihood of great harm, c) that cannot be avoided by reasonable care, d) the activity is uncommon, and e) inappropriate to the particular site. RESTATEMENT (SECOND) OF TORTS, Sec. 520. Whether the activity benefits the community at large so as to outweigh the risks should also be considered. *Id.* at 520(f).

<sup>178</sup> Indeed, the Restatement takes the view that intervention of third parties is a part of the risk of abnormally dangerous activity, at least where the third party is not guilty of intentional wrongdoing. See DOBBS, *supra* n. 4 at 960. Assumption of the risk may be a defense where the plaintiff “knowingly and unreasonably” subjects himself to the risk of harm, which includes a true understanding of the nature of the risk and voluntary assumption of it. See RESTATEMENT (SECOND) OF TORTS, Section 524 (2); *Rickrode v. Wistinghausen*, 128 Mich.App. 240, 340 N.W.2d 83 (1983)(willfully provoking an animal may provide a defense to strict liability.)

<sup>179</sup> See *supra* Sec. II.C.

<sup>180</sup> While condoms can retard the spread of certain sexual diseases, the fastest growing viral disease today, the human papilloma virus, is believed not to be controllable by condom usage. See *supra* Sec. II.A. In addition, we know that some of the most promiscuous people fail to use condoms regularly. See *supra* Sec. II.C. One reason for strict liability is to coerce those engaged in a high risk activity to find safer methods, so strict liability in the sexual disease context could encourage condom usage and thereby reduce the risks of most diseases.

<sup>181</sup> RESTATEMENT, Sec. 520(f). Epstein, *supra* n. 238 at 189; Guido Calabresi, *Optimal Deterrence and Accidents*, 84 Yale L. J. 656, 671 (1974-1975). Unlike businesses that cause nuisances, for example, where a balance must be made between social value and social cost of the nuisance, there is little or no social utility resulting from irresponsible sex leading to the spread of sexual disease.

Liability should be placed on the party to an interaction who is in the best position to “make the cost-benefit analysis between accident costs and avoidance costs and to act on that decision once it is made.”<sup>182</sup> In the sexual disease context, there is often no ability for the parties to negotiate fairly who should bear the risk of loss, because of a lack of information. In a sense, an information defect is present when neither party is aware of the disease. As between a diseased individual and his uninfected sexual partner, the diseased person has superior access to information regarding his disease and the potential costs associated with transmission. Diseased persons are therefore the cheapest cost-avoiders, so clear, strict duty not to transmit diseases should be placed on them.<sup>183</sup> Uninfected persons will continue to have an incentive to avoid disease transmission, as they necessarily internalize the pain and suffering and emotional distress resulting from infection. Strict liability will simply shift those costs capable of being shifted to disease perpetrators and force them to absorb at least some of the costs of their behavior, instead of externalizing most of the costs to victims and taxpayers.

From an economic standpoint, strict liability is administratively cheaper than negligence. The negligence paradigm burdens legal analysis in that it “demands evaluation of almost everything, but can give precise weight to almost nothing.”<sup>184</sup> The sexual disease cases bear out the truth that negligence creates more issues than it solves, inhibits litigation and compensation by its unpredictable application, and focuses on morality as opposed to the need for compensation and deterrence relative to a serious disease epidemic. Strict liability avoids both the unfairness and complications created by the negligence paradigm because it avoids the difficult factfinding relative to the elements of duty and breach.<sup>185</sup>

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<sup>182</sup> Guido Calabresi & Jon T. Hirschoff, *Toward a Test For Strict Liability in Torts*, 81 Yale L. J. 1055, 1060 (1972).

<sup>183</sup> Even where the diseased person is unaware of his infection, he still has superior access to that information over the uninfected person, and is still “relatively more likely to find out whether avoidance is worth it.” Calabresi & Hirschoff, *supra* n. 182 at 1061.

<sup>184</sup> See Epstein, *supra* n. 173 at 171.

<sup>185</sup> Perhaps more importantly, increasing the certainty of liability directly impacts disease perpetrators’ individual cost-benefit analysis by increasing the potential costs of irresponsible sexual activity, which enhances the deterrent impact of law, ultimately reducing the number of cases of disease transmission. See *infra* Sec. IV.B.1. Core group members will most often get sued. In the short run, administrative costs could increase as a function of a greater number of claims filed resulting from the certainty of recovery. That is, the universe of claims may be enlarged such that the overall administrative costs increase despite lowered costs of each lawsuit resulting from streamlined legal analysis. See, e.g., Richard A. Posner, *Strict Liability: A Comment*, 2 J. Leg. Stud. 205, 209 (1973). However, since liability will be more certain, settlements are facilitated, which are cheaper than trials. Thus, any temporary increase to administrative costs resulting from more lawsuits will be outweighed by expedited trials, more settlement, and ultimately, less sexual disease transmission resulting from strict liability’s deterrent effect.

The plaintiff's need for compensation and defendant's ability to pay have been major considerations supporting imposition of strict products liability.<sup>186</sup> While this "deep pocket" concept does not support strict liability for sex torts, it is not a reason to reject strict liability. The lack of a deep pocket in sex tort cases may be a problem whether liability is based on negligence or strict liability, as insurance companies are rejecting negligence-based claims arising out of sexual relations, anyhow.<sup>187</sup> Yet, the number of sex tort actions filed continues to increase, so sex tort analysis should improve in terms of clear standards of liability if not collectability. Although strict liability neither advances nor inhibits the plaintiff's ability to collect on a judgment, it is superior to negligence on other bases.

There may be even more compelling reasons for imposing strict liability for sexual disease transmission grounded in social science. Although there is debate over whether the law impacts social norms, or vice versa, and to what degree, it appears clear that when the law converges with public consensus, it is most effective as a social engineering tool. Legal doctrine has emerged grounded in the belief that promiscuous – even extramarital – sex is ubiquitous and thereby arguably socially acceptable.<sup>188</sup> Yet, research shows that the vast majority of Americans are not promiscuous and presumably do not condone promiscuity. Sex tort law should converge with public consensus to maximize its effectiveness. The next section will review deterrence and norm creation/regulation theories and conclude that strict liability is superior to negligence because it more powerfully deters sexual disease and more accurately expresses social values.

*B. Will Adopting Strict Liability Deter Sexual Disease Transmission?*

For centuries, there has been a debate about whether the law impacts human behavior, and if so, how?<sup>189</sup> Some tort scholars posit that the law reflects

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<sup>186</sup> See, e.g., DOBBS, *supra* n. 4 at p. 975.

<sup>187</sup> For example, State Farm Insurance homeowners' policies contain exclusions for all communicable diseases, including sexually transmitted diseases. Interview with Sophie Harbert, State Farm Insurance, Austin, Texas, August 10, 2005. More generally, the insurance industry is expected to deny liability for sexually transmitted diseases. Interview with Loretta Wortes, Vice President, Insurance Information Institute (New York), August 12, 2005.

<sup>188</sup> See *supra* Section III.B.

<sup>189</sup> There are fundamental concerns about whether law impacts behavior at all, grounded in different philosophies about the etiology of misconduct. For example, positivists believe that behavior is grounded in biological make up. Cesare Lombroso, the "father of criminology," (1835 – 1909) expanded on the concept of biological determinism around the same time that research grounded in sociological positivism – the study of the influence of social factors to explain criminal conduct – became influential, particularly the research of researchers such as Robert Ezra Park, Ernest W. Burgess, and Louis Wirth at the University of Chicago. Organic and biological psychological theories attribute behavior to brain dysfunction or molecular biology, respectively. These theories undermine the concept that the law is effective to

society's values,<sup>190</sup> while others posit that the law can be used as a tool of social engineering, to shape society's values.<sup>191</sup> Perhaps the answer lies somewhere in between; perhaps the relationship between law and societal values is symbiotic and fluid. There is no doubt that rational people respond to legal rules to avoid sanctions where the rules are tailored to maximize public awareness and risk aversion.<sup>192</sup> Thus, while scholars sometimes claim that morality cannot be legislated,<sup>193</sup> at least some "moral" behavior has been proven to be amenable to manipulation through law.<sup>194</sup> It is therefore fair to assume that the law can impact human behavior.<sup>195</sup>

### 1. *Individual Deterrence Based On The Rational Actor Assumption*

"[S]ociety has continued to rely on the tort system to provide 'general deterrence.' The threat of tort liability should induce rational actors to take 'optimal care' – that is, to reduce the chance of accidents to the point at which

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change human behavior because they posit that people inherit criminal traits, and are "born criminals." See, e.g., David Lykken, *Psychopathy, Sociopathy, and Crime*, 34 *Society* 29 (1996); PETER SCOTT, HENRY MAUDSLEY, *PIONEERS OF CRIMINOLOGY* (1981); HOWARD BECKER, *OUTSIDERS: STUDIES IN THE SOCIOLOGY OF DEVIANCE* 21 (1963); Nicole Hahn Rafter, *Criminal Anthropology in the United States*, 30 *Criminology* 525 (1992). On the other end of the spectrum is classical criminology, grounded in the prevailing philosophy of utilitarianism in the mid-eighteenth century, which has evolved into rational choice and deterrence theories, and which posits that criminals are rational and utilize available information concerning costs and benefits of crime in order to determine whether crime is worthwhile. See Francis Edward Devine, *Cesare Beccaria and the Theoretical Foundations of Modern Penal Jurisprudence*, 7 *New England Journal on Prison Law* 8 (1982); JEREMY BENTHAM, *A FRAGMENT ON GOVERNMENT AND AN INTRODUCTION TO THE PRINCIPLE OF MORALS AND LEGISLATION* (1967). While there are probably many factors that give rise to antisocial behavior, the law necessarily relies on rational choice and deterrence theories, because without the basic concept that legal punishment impacts behavior, the law as a tool of social engineering would be worthless. See also Daniel W. Shuman, *The Psychology of Deterrence in Tort Law*, 42 *U. Kan. L. Rev.* 115 (1993).

<sup>190</sup> See, e.g., Marshall S. Shapo, *In the Looking Glass: What Torts Scholarship Can Teach Us about the American Experience*, 89 *N.W. U. L. Rev.* 1567, 1569 (tort jurisprudence reflects society's basic principles.)

<sup>191</sup> See *infra* Sec. IV.B.2.

<sup>192</sup> *Id.*

<sup>193</sup> See, e.g., Jennifer E. McDougal, *Legislating Morality: The Actions for Alienation of Affections and Criminal Conversation in North Carolina*, 33 *Wake Forest L. Rev.* 163, 177 (1998).

<sup>194</sup> For example, drunk driving behavior has been proven to be controllable to a substantial degree through increased, well-publicized legal sanctions. See *infra* Sec. IV.B.1.

<sup>195</sup> All economists, including those persons making predictions about the law's impact on behavior grounded in the rational actor assumption, make assumptions. As stated by A. Mitchell Polinsky, "The truth [about economists] is that they approach problems by making assumptions. The lie is that they make ridiculous assumptions (though, unfortunately, this is not always a lie.)" See POLINSKY, *AN INTRODUCTION TO LAW AND ECONOMICS* 2 (3<sup>rd</sup> ed. 2003).

the cost of any further accident prevention measures would exceed the injury losses they would prevent. Optimal care thus minimizes the sum of accident costs. Optimal deterrence of tortious conduct – of inefficient risk-taking—is the system’s dominant utilitarian function.”<sup>196</sup>

Economic analysis of law has been termed the most powerful influence on legal doctrine in the past half century.<sup>197</sup> Economic analysis of law relies on criminal deterrence theory’s “rational actor” assumption<sup>198</sup> and provides a fundamental truth about human behavior: people respond to incentives (a general statement of price theory).<sup>199</sup> At the root of economic theory is the expectation that humans will seek rationally to maximize their expected utility, or self-interest, usually referred to as “rational choice theory.”<sup>200</sup> Rational choice theory relies on the assumption that the law shapes behavior by “taxing” socially undesirable behavior and “subsidizing” socially desirable behavior.<sup>201</sup>

Classical deterrence theory predicts that the efficacy of a legal sanction to modify behavior rests on perceptions of certainty, swiftness, and severity of legal sanctions following a violation of the law.<sup>202</sup> Deterrence theory posits that if the probability of being caught and suffering negative consequences is high enough, people will choose not to engage in conduct that results in sanctions. The evidence that sane people do indeed consider the risk of being punished for their conduct is compelling.<sup>203</sup> Criminal researchers believe that crime persists

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<sup>196</sup> David A. Fischer, *Proportional Liability: Statistical Evidence And The Probability Paradox*, 46 Vand. L. Rev. 1201, 1204 (1993).

<sup>197</sup> See, e.g., Russell B. Korobkin & Thomas S. Ulen, *Law and Behavioral Science: Removing the Rationality Assumption From Law and Economics*, 88 Cal.L.Rev. 1051, 1055 (2000).

<sup>198</sup> The majority of philosophical writings on human conduct are grounded in criminology, no doubt because controlling the most offensive, dangerous human conduct is a priority in any society. See Daniel W. Shuman, *The Psychology of Deterrence in Tort Law*, 42 U. Kan. L. Rev. 115, 116 & n. 5 (1993). These theories are closely related to the efficacy of tort law, because tort law, like criminal law, involves socially unacceptable conduct that government attempts to control through law. Indeed, the first time damages were awarded was in a criminal matter. W. PAGE KEETON, PROSSER & KEETON ON TORTS 8 (5<sup>th</sup> ed. 1984), citing POLLOCK, LAW OF TORTS 150 (15<sup>th</sup> ed. 1951).

<sup>199</sup> Korobkin & Ulen, *supra* n. 197 at 1054.

<sup>200</sup> *Id.* at 1055, 1060-1070.

<sup>201</sup> See, generally, Cass R. Sunstein, *Social Norms and Social Roles*, 96 Colum. L. Rev. 903, 951 (1996); Korobkin & Ulen, *supra* n. 197 at 1054.

<sup>202</sup> Berger & Marelich, *Legal and Social Control of Alcohol-impaired Driving in California: 1983-1994*, 58 J. Stud. Alcohol 518, 518-20 (1997).

<sup>203</sup> For example, People who believe that they will be punished for future crimes say that they will not commit future crimes. Daniel Nagin & Greg Pogarsky, *Integrating Celerity, Impulsivity, and Extralegal Sanction Threats into a Model of General Deterrence: Theory and Evidence*, 39 Criminology 865 (2001). Robbers generally choose victims who are vulnerable, have low coercive power, and who pose no threat, such as unarmed people, elderly people, and females. Richard Felson & Steven Messner, *To Kill or Not to Kill? Lethal Outcomes in Injurious Attacks*, 34 Criminology 519, 541 (1996); JAMES WRIGHTS & PETER ROSSI, ARMED AND

because criminals believe that there is only a small chance of being caught, and if they are caught, there is a good chance of receiving lenient punishment.<sup>204</sup>

The price or “cost” of crime is a function of the certainty of punishment and the severity of punishment.<sup>205</sup> Empirical studies indicate that the certainty of conviction plays a much larger role in deterring crime than does severity of

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DANGEROUS: A SURVEY OF FELONS AND THEIR FIREARMS 141-59 (1983). Robbers also generally pick the time of day carefully, and rob commercial establishments where there is the most cash on hand, such as bars, supermarkets, and restaurants or, more generally, during the Christmas season, and tend to target places close to home so that they are aware of escape routes. Peter Van Koppen & Robert Jansen, *The Time to Rob: Variations in Time and Number of Commercial Robberies*, 36 *Journal of Research in Crime and Delinquency* 7 (1999); William Smith, Sharon Glave Frazee, & Elizabeth Davison, *Furthering the Integration of Routine Activity and Social Disorganization Theories: Small Units of Analysis and the Study of Street Robbery as a Diffusion Process*, 38 *Criminology* 489 (2000); John Gibbs & Peggy Shelly, *Life in the Fast Lane: A Retrospective View by Commercial Thieves*, 19 *Journal of Research in Crime and Delinquency* 229 (1982). Rapists also show rational decision-making in choosing victims and locations. They tend to travel away from their residences to commit the crimes, to avoid victimizing women who will recognize them. Older, more experienced rapists travel farther than younger rapists who have not learned about the increased risk of detection where victims are found close to home. Janet Warren, Roland Reboussin, Robert Hazelwood, Andrea Cummings, Natalie Gibbs & Susan Trumbetta, *Crime Scene and Distance Correlates of Serial Rape*, 14 *Journal of Quantitative Criminology* 35 (1998). Yet, research also shows that people who are easily sexually aroused say that they are more likely to act in a sexually aggressive fashion and not consider the consequences of their actions. George Lowenstein, Daniel Nagin, & Raymond Paternoster, *The Effect of Sexual Arousal on Expectations of Sexual Forcefulness*, 34 *Journal of Research in Crime and Delinquency* 443 (1997). Illegal drug use, which is similar to sexual promiscuity in that both entail pleasure seeking that may become addictive, is controlled by rational decision-making as well. People begin using drugs when they view the costs as minimal (i.e., friends or family also abuse drugs, so they are unlikely to be socially ostracized) and the benefits as outweighing the costs (the positive drug experience is unlikely to result in negative consequences). John Petraitis, Brian Flay, & Todd Miller, *Reviewing Theories of Adolescent Substance Use: Organizing Pieces in the Puzzle*, 117 *Psychological Bulletin* 67 (1995). While sexual misconduct differs in some respects from crimes like robbery, the general thesis that people tend to maximize their “take” and minimize negative consequences is central to rational choice theory, and therefore the research supports rational choice theory in relation to impulsive, irresponsible sexual behavior. It stands to reason that one of the reasons why sexual misconduct is so rampant, and sexual disease so pervasive, is the fact that there is very little chance of suffering any negative consequences as a result of such misconduct, and the perception among offenders is probably that the benefits outweigh the costs.

<sup>204</sup> R. Steven Daniels, Lorin Baumhover, William Formby, & Carolyn Clark-Daniels, *Police Discretion and Elder Mistreatment: A Nested Model of Observation, Reporting and Satisfaction*, 27 *Journal of Criminal Justice* 209 (1999).

<sup>205</sup> Dan M. Kahan, *Social Influence, Social Meaning, and Deterrence*, 83 *Va. L. Rev.* 349, 377-8 (1997). Of course, a high conviction rate is costly to the state because it takes resources to prosecute, and the severity of punishment is also costly, especially if it involves costs relating to probation or imprisonment/parole. The standard economic conception of deterrence treats severity of punishment and certainty of conviction as interchangeable components of the price of crime. *Id.* at 377, citing Gary S. Becker, *Crime and Punishment: An Economic Approach*, 76 *J. Pol. Econ.* 169 (1968); Richard A. Posner, *An Economic Theory of the Law and the Optimal Use of Non-monetary Sanctions as Deterrent*, 85 *Colum. L. Rev.* 1232 (1985).

punishment.<sup>206</sup> There is apparently a “tipping point,” where certainty of punishment will work because the likelihood of being caught reaches a sufficiently high level: research has found that increasing the severity of punishment leads to a lower crime rate,<sup>207</sup> but that increasing the severity of punishment may have little impact unless the *likelihood of getting caught is high*, because as the likelihood of getting caught decreases, the punishment – no matter how severe – tends to be discounted.<sup>208</sup> Accordingly, the law should engage certain clear liability rules to maximize certainty of punishment.<sup>209</sup> One way of adjusting the “price” of sexual disease transmission is to adopt strict tort liability in lieu of negligence, which dramatically increases the certainty of civil sanctions if a lawsuit is filed.

Increasing the cost of socially undesirable conduct to minimize the conduct has worked in other contexts in which the conduct is not intuitively amenable to legal manipulation. For example, over the past 25 years, California and most other states strengthened laws aimed at controlling alcohol-impaired driving significantly.<sup>210</sup> Time series analyses have demonstrated that these changes to the law are associated with the behavior changes the laws sought to create, i.e., lower rates of drunk driving incidents and accidents.<sup>211</sup> Between 1983 and 1994, the public’s knowledge of the new drunk driving laws, and particularly

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<sup>206</sup> Kahan, *supra* n. 205 at 379-80. *See also, e.g.*, Maynard L. Erickson, Jack P. Gibbs & Gary F. Jensen, *The Deterrence Doctrine and the Perceived Certainty of Legal Punishment*, 42 *Amer. Sociol. Rev.* 305 (1977); Shuman, *supra* n. 198 at 121 & nn. 31-33.

<sup>207</sup> The National Center for Policy Analysis has showed a direct correlation between the probability of imprisonment for a particular crime and a subsequent decline in the rate of that crime. CRIME AND PUNISHMENT IN AMERICA: 1997 UPDATE, NATIONAL CENTER FOR POLICY ANALYSIS, DALLAS, TEXAS. For example, the probability of going to prison for murder increased 17% between 1993 and 1997, and the murder rate dropped 23% during that same period; the probability of prison for robbery increased 14% and robberies declined by 21%.

<sup>208</sup> Daniel Nagin & Gregory Pogarsky, *Integrating Celerity, Impulsivity, and Extralegal Sanction Threats into a Model of General Deterrence: Theory and Evidence*, 39 *Criminology* 865, 884-5 (2001); H. LAURENCE ROSS, IMPLICATIONS OF DRINKING-AND-DRIVING LAW STUDIES FOR DETERRENCE RESEARCH, CRITIQUE AND EXPLANATION, ESSAYS IN HONOR OF GWYNNE NETTLES (1986)(Timothy Hartnagel and Robert Silverman, eds.); H. Laurence Ross, Richard McCleary, & Gary LaFree, *Can Mandatory Jail Laws Deter Drunk Driving? The Arizona Case*, 81 *Journal of Criminal Law and Criminology* 156 (1990).

<sup>209</sup> Shuman, *supra* n. 198 at 122.

<sup>210</sup> From 1981 to 1985 alone, 478 new state laws were passed to control drunk driving behavior. NATIONAL COMMISSION AGAINST DRUNK DRIVING, 1985. In California, there have been major changes to drunk driving laws since 1982, including: introducing the blood alcohol concentration (BAC) of .10% or higher as the legal limit, then lowering it to .08% for most adults, and to .01% for persons under the legal drinking age of 21; increased fines; and mandatory jail time. Berger & Marelich, *supra* n. 279 at 518-520.

<sup>211</sup> Berger & Marelich, *supra* n. 202 at 518-520.

the legal blood alcohol concentration limit, increased substantially.<sup>212</sup> The single most important reason people gave for avoiding drinking and driving was the fear of getting into an accident, and the next 5 reasons all reflected fear of legal/monetary punishment, i.e., fear of being arrested, going to jail, losing a driver's license, paying higher insurance premiums, and paying legal fines.<sup>213</sup>

The trend in alcohol-impaired driving is unambiguous: alcohol related traffic crashes in the United States have decreased markedly over the past 20 years, after legislatures increased punishment for drunk driving and people became educated about the new laws.<sup>214</sup> This provides at least circumstantial evidence that when the costs of drunk driving were raised, that behavior was deterred, as predicted by rational choice theory. The data also supports social control theory, i.e., deterrent policies eventually impacted social norms – or perhaps revealed them -- relating to drinking and driving.<sup>215</sup>

Drunk driving and irresponsible sexual behavior have some commonalities. Both behaviors are perpetrated by a small percentage of Americans who are often young, probably impulsive, and relatively unconcerned about existing norms.<sup>216</sup> Public disapproval regarding these behaviors is, and probably always has been, strong, yet not well-recognized until publicized.<sup>217</sup> Both behaviors may also result from addiction, yet this did not interfere substantially with the

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<sup>212</sup> For example, only 34% of Californians knew about the BAC legal limit in the mid 1980's, while 56% knew about it in 1994. Berger & Marelich, *supra* n. 202 at 520-522.

<sup>213</sup> *Id.* at 519-522.

<sup>214</sup> Berger & Marelich, *supra* n. 202 at 520-523. This is consistent with other research showing that automobile drivers respond to legal rules, e.g., that liability insurance rates impact the decision whether to drive, and the move to no-fault has resulted in more automobile deaths. See Richard A. Posner, *Can Lawyers Solve The Problems Of the Tort System?* 73 Cal. L. Rev. 747, 749-50 (1985).

<sup>215</sup> An increase in informal control of drunk driving from social forces also was clearly apparent from the research. For example, over 90% of persons responding that their friends or relatives would disapprove of their driving after four drinks. See Berger & Marelich, *supra* n. 202 at 519-522. Although it is often assumed that the primary impact of the law is to instill fear of punishment, and thereby influence behavior, there is at least circumstantial evidence that, over time, laws also influence personal perceptions and social norms which in turn influence behavioral choices. Berger & Marelich, *supra* n. 202 at 518-520, *citing* J. ANDENAES, *THE MORAL OR EDUCATIVE INFLUENCE OF CRIMINAL LAW, LAW, JUSTICE, AND THE INDIVIDUAL IN SOCIETY: PSYCHOLOGICAL AND LEGAL ISSUES* 50-59 (1977)(J.L. Tapp & F. J. Levine, eds.); J.R. SNORTUM, *DETERRENCE OF ALCOHOL-IMPAIRED DRIVING: AN EFFECT IN SEARCH OF A CAUSE, SOCIAL CONTROL OF THE DRINKING DRIVER* 189-226 (1988)(M.D. Laurence, J.R. Snortum, & F.E. Simring eds.)

<sup>216</sup> See, e.g., Sunstein, *supra* n. 201 at 918-9, discussing norm-flouting and the value some attach to norm-flouting. Strong sanctions may change the value in norm-flouting.

<sup>217</sup> Most Americans do not engage in sexual relations with many partners and presumably do not approve of such behavior. See *supra* sec. II.C. Regarding drunk driving, it is fair to assume that, considering the death and destruction that result from it, the vast majority of Americans disapprove of it and do not engage in such behavior. See *supra* nn. 214-5.

efficacy of new drunk driving laws and would not necessarily undermine new laws strengthening consequences for irresponsible sexual behavior.

There are a couple of other important aspects of behavioral theory that support strict liability to deter risky sexual practices. First, some research indicates that people weigh losses more heavily than gains, so laws and the messages they carry must exploit humans' loss aversion tendencies.<sup>218</sup> In other words, increasing the salience of potential losses resulting from irresponsible sex – both for disease perpetrators and uninfected persons – is more powerful than extolling the virtues of “safe sex.”<sup>219</sup> As noted by Judge Posner, tort law must be public knowledge, because if the public is not aware of the law, the law cannot shape future behavior.<sup>220</sup> A new regime of strict liability for sexual disease transmission would attract media attention,<sup>221</sup> and thereby educate the public and increase the salience of the risks.

Second, Americans are grossly underestimating the risk of sexual disease and potential for civil liability based on the availability heuristic,<sup>222</sup> i.e., relying on

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<sup>218</sup> See Christine Jolls, Cass R. Sunstein, & Richard Thaler, *A Behavioral Approach to Law and Economics*, 50 *Stan.L.Rev.* 1471, 1536-7 (1998). They give the example that pamphlets emphasizing the benefits to breast self-examinations to avoid cancer are less effective than pamphlets stressing the negative consequences of failing to conduct such examinations. See *infra* n. 219.

<sup>219</sup> People are “loss averse” insofar as they will be more unhappy by a loss than they will be happy by an equal gain. Sunstein, *supra* n. 201 at 950. For example, propagating information that breast self-examinations will save lives has been found to be far less effective in motivating breast self-exams than propagating information that failure to self-examine can lead to death. Sunstein, *supra* n. 201 at n. 176, *citing* Beth E. Meyerowitz & Shelly Chaiken, *The Effect of Message Framing on Breast Self-Examination Attitudes, Intentions, and Behavior*, 52 *J. Personality & Soc. Psychol.* 500, 506-9 (1987). The present “safe sex” campaign is therefore probably less effective than a campaign focusing on harms from irresponsible sex, because the latter increases the salience of risks of unsafe sex instead of focusing on the presumed value of “safe sex” (an oxymoron in today’s world.)

<sup>220</sup> RICHARD POSNER, *ECONOMIC ANALYSIS OF LAW* 394 (1<sup>st</sup> ed. 1972).

<sup>221</sup> The media has exploited sexual disease cases and presumably will continue to do so. For example, when NFL star Michael Vick gave Sonya Elliott, a healthcare worker, herpes in 2003, the media exploited the case. Similarly, Michelle Rudolph’s \$950,000 jury verdict against L.A. Dodger pitcher Jose Lima for giving her herpes made national headlines. Although the press coverage could be a result of the notoriety of the defendants, at least part of it is due to the unusual nature of these cases. A review of the comments posted on internet sites relating to these stories demonstrates that most people are surprised that it is possible to sue someone for transmitting a sexual disease. Media attention to cases such as these encourages more lawsuits, which in turn creates more news.

<sup>222</sup> See Korobkin and Ulen *supra* n. 197 at 1087. See also Jolls, Sunstein & Thaler, *supra* n. 218 at 1537. For example, most Americans believe that car accidents kill more people than diabetes and stomach cancer, although this is grossly inaccurate. The “available” information regarding car accidents comes from greater media coverage, which leads the public to believe that deadly car accidents are more prevalent than death from the two diseases.

available, salient data as opposed to the true facts, and generally assume that good things are more likely than average to happen to them and that bad things are less likely than average to happen to them (the “overconfidence bias”).<sup>223</sup> The public’s ignorance about the prevalence of sexual disease<sup>224</sup> and the potential for civil liability exacerbates the problem of overconfidence bias: people assume they are more lucky than average based on a terribly inaccurate belief about the “average” risk. A negligence-based analysis for sexual disease cases exacerbates the problems of the availability heuristic and overconfidence bias by reducing the salience of liability risks. Adopting strict liability would increase the salience of both liability and health risks because the media will continue to exploit sex tort cases, particularly if plaintiffs’ verdicts become more common, and presumably will inform the public of new liability standards.

In sum, strict liability raises the price of sexually risky behavior and creates much greater certainty of punishment among core group members who statistically will most often be defendants in these cases. It reduces plaintiff’s proof burden by eliminating duty and breach analysis, and discourages defendants from remaining ignorant of their sexual diseases, or lying about them to escape civil liability.<sup>225</sup> In addition, adopting strict liability is newsworthy, and will help to educate the public about the high sexual disease rate.

## 2. *Social Control Models of Deterrence, Behavioral Law Theories, and Norms*

“Wicked people exist. Nothing avails except to set them apart from innocent people. And many people, neither wicked nor innocent, but watchful, dissembling, and calculating of their chances, ponder our reaction to wickedness as a clue to what they might profitably do.”<sup>226</sup>

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Korobkin & Ulen, *supra* n. 197 at 1088. *See also* Jolls, Sunstein & Thaler, *supra* n. 218 at 1477-8.

<sup>223</sup> Korobkin & Ulen, *supra* n. 197 at 1091 & nn. 149-150.

<sup>224</sup> *See supra* Sec. II.A. People seriously underestimate the disease rate and their risk of contracting a sexual disease.

<sup>225</sup> Assumption of the risk is still a viable defense, but in accordance with this defense, defendant would have the burden of showing that plaintiff knew of the disease, understood its consequences, and voluntarily undertook responsibility for becoming infected. It seems improbable that any sane person would knowingly submit to becoming infected with a sexual disease. Indeed, nearly half of men and women surveyed stated that if they were in a new relationship and discovered that their partner had an STD, they would be “a lot less likely” to continue the relationship. Most people say they would feel angry at a person who gave them a STD, although women are more likely (87%) than men (74%) to say so. *See ASHA – WHAT COST?*, *supra* n. 2 at 23.

<sup>226</sup> JAMES Q. WILSON, *THINKING ABOUT CRIME* 128 (rev. ed. 1983).

“[O]ne who violates a consensus incurs a cost.”<sup>227</sup>

Whether norm<sup>228</sup> violation and informal social consequences are considered a non-quantifiable “cost”<sup>229</sup> or a more attenuated means of pressuring others to conform to social standards through vicarious experiences, it is clear that norms impact social choices. Humans’ fear of informal sanctions, such as disapproval by parents, peers, neighbors, and teachers, in the form of embarrassment, shame, and loss of community respect may have a greater impact than legal punishment per se, because people seek social approval.<sup>230</sup> Thus, although behavior is guided partly by legal rules and costs of rule-breaking, it is also influenced substantially by the relationship between such rules and beliefs, values, norms, psychological frames, and cognitive processing.<sup>231</sup> The so-

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<sup>227</sup> Richard H. McAdams, *The Origin, Development, and Regulation of Norms*, 96 Mich. L. Rev. 338 (1997).

<sup>228</sup> The term “norm” refers to an informal social standard that people follow based on a fear of external non-legal sanctions, such as ostracism, or an internalized sense of duty, which can produce guilt, or both. Some people include formal legal rules in the definition of norms. See McAdams, *supra* n. 227 at nn. 54-59 and accompanying text. Cass R. Sunstein defines norms as “social attitudes of approval and disapproval, specifying what ought to be done and what ought not to be done.” Sunstein, *supra* n. 201 at 914. Norms arise from a complex set of social forces, including feelings and preferences, religious and cultural mores, and legal rules. See, e.g., Cass R. Sunstein, *On The Expressive Function of Law*, 144 U. Pa. L. Rev. 2021, 2026-29 (1996); Kahan, *supra* n. 205 at 357, *citing, inter alia*, John R. Lott, Jr. & David B. Mustard, *Crime, Deterrence, and Right-To-Carry Concealed Handguns*, 26 J. Legal Stud. 1, 58 (1997).

<sup>229</sup> Stated alternatively, non-quantifiable benefits include esteem from others, a lack of cognitive dissonance (by acting consistent with internal beliefs), and a feeling of “belonging” to a social system by complying with norms, benefits not considered in classic economic analysis of law. See Korobkin & Ulen, *supra* n. 197 at 1057. These authors refer to “law and behavioral science” as a “species of legal pragmatism,” since it is more useful in setting legal policy that will produce a predictable impact on actual human behavior.

<sup>230</sup> Wanda Foglia, *Perceptual Deterrence and the Mediating Effect of Internalized Norms among Inner-City Teenagers*, 34 Journal of Research in Crime and Delinquency 414 (1997); Daniel Nagin & Raymond Paternoster, *Enduring Individual Differences and Rational Choice Theories of Crime*, 27 Law and Society Review 467 (1993); Donald Green, *Past Behavior as a Measure of Actual Future Behavior: An Unresolved Issue in Perceptual Deterrence Research*, 80 Journal of Criminal Law and Criminology 781, 803 (1989); Matthew Silberman, *Toward a Theory of Criminal Deterrence*, 21 American Sociological Review 442 (1976); Harold Grasmick, Robert Bursik, & Karyl Kinsey, *Shame and Embarrassment as Deterrents to Noncompliance with the Law: The Case of an Anti-Littering Campaign*, Paper presented at the annual meeting of the American Society of Criminology, Baltimore, November, 1990 p. 3; CHARLES TITTLE, SANCTIONS AND SOCIAL DEVIANCE (1980). In general, women are more likely to fear shame and embarrassment than men, which may play a role in the gender differences in crime rates – men commit more crime. See, e.g., Harold Grasmick, Brenda Sims Blackwell & Robert Bursik, *Changes in the Sex Patterning of Perceived Threats and Sanctions* 27 Law and Society Review 679 (1993).

<sup>231</sup> See generally Sunstein, *supra* n. 201; Sunstein, *supra* n. 228; McAdams, *supra* n. 227. See also Richard H. Pildes, *The Destruction of Social Capital Through Law*, 144 U. Pa. L. Rev. 2055 (1996). People have urges, needs, and feelings about choices that cannot be measured, only acknowledged. Richard A. Posner defines it this way: “Behavioral economics rejects the assumption that people are rational maximizers of preference satisfaction in favor of

called “law and behavioral science” movement<sup>232</sup> or “behavioral economics”<sup>233</sup> is an outgrowth of classic law and economics, created to explain the fact that people do not always behave in a rational manner to maximize their wealth, as would be predicted by price theory, because of the influence of norms.<sup>234</sup> Since norm sanctions are costless, they are an especially efficient tool for expressing social values and shaping social choices.<sup>235</sup>

People’s decisions about whether to abide by the law turn on their perception of others’ attitude towards the law;<sup>236</sup> that is, the meaning of behavior is highly

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assumptions of “bounded rationality”, “bounded willpower,” and “bounded self-interest.” See Richard Posner, *Rational Choice, Behavioral Economics, and the Law*, 50 Stan. L. Rev. 1551, 1553 (1998). One example of bounded rationality is documented by the fact that people often put a higher value on objects that they own as opposed to objects that they do not own, even though the objects have the same objective value. That is, people tend to value the loss of items they already own higher than equivalent gains of items they seek to buy. This is known as the “endowment effect” or the “offer/asking gap” and appears to show that people find some sort of value above market value in items they own, which may result from feelings about ownership, or more generally, from a desire to maintain the status quo (people are somewhat inert and prefer status over changing a state of affairs.) See Korobkin & Ulen, *supra* n. 197 at 1107-1113. See also Donald C. Langevoort, *Behavioral Theories of Judgment and Decision Making in Legal Scholarship: A Literature Review*, 51 Vand. L. Rev. 1499, 1503-4 (1998).

<sup>232</sup> Korobkin & Ulen, *supra* n. 197 at 1057.

<sup>233</sup> See Posner, *supra* n. 231.

<sup>234</sup> See, e.g., Korobkin & Ulen, *supra* n. 197 at 1102-1103 (\$10 play ticket study), citing Amos Tversky & Daniel Kahneman, *The Framing of Decisions and Psychology of Choice*, 211 Science 453 (1981).

<sup>235</sup> See McAdams, *supra* n. 227 at 342. Sunstein posits that the “expressive” function of law can strengthen norms the law embodies and weaken those it condemns, such as by taxing socially undesirable conduct and subsidizing socially desirable choices. Sunstein, *supra* n. 201 at 951; Sunstein, *supra* n. 228 at 2026-31. Lawrence Lessig argues that legislators and judges must understand the social meaning of the behavior sought to be regulated, because it is impossible to make policy decisions relating to legal sanctions of social behavior without understanding how the law interacts with social meaning. See Lawrence Lessig, *Social Meaning and Social Norms*, 144 U. Pa. L. Rev. 2181 (1996); Lawrence Lessig, *The Regulation of Social Meaning*, 62 U. Chi. L. Rev. 943 (1995).

<sup>236</sup> See, e.g., Kahan, *supra* n. 205 at 354-5 & nn. 18-20. For example, neighborhood crime rates are a much better predictor of individual delinquency than social class, probably because of the neighborhood perception that crime is common and therefore not particularly stigmatizing. *Id.* at 355 & nn. 21-23. In another study, British efforts to control drunk driving by shaming offenders produced a climate of moral awareness that helped to reduce the incidence of drunk driving. John Snortum, *Drinking-Driving Compliance in Great Britain: The Role of Law as a ‘Threat’ and as a ‘Moral Eye-Opener’*, 18 Journal of Criminal Justice 479 (1990). The impact of informal sanctions varies, of course, depending on the size and cohesiveness of the community involved, which directly impacts whether the misconduct results in public disapproval. Thomas Peete, Trudie Milner, & Michael Welch, *Levels of Social Integration in Group Contexts and the Effects of Informal Sanction Threat on Deviance*, 32 Criminology 85 (1994). At least in some circumstances, such as a rural ranching community governed by longstanding community codes of conduct and informal dispute resolution, norms govern behavior irrespective of legal rules, rendering the formal law surprisingly unimportant, not even of interest to the parties involved. See ROBERT C. ELLICKSON, *ORDER WITHOUT LAW: HOW NEIGHBORS SETTLE DISPUTES* 40-64 (1991).

contextual, and people tend to choose behavior based on their perception of what *others* are doing.<sup>237</sup> A perception that “everyone is doing it” can become self-fulfilling, and a parallel perception of little risk of being caught will arise, lessening the risk of stigmatism or ostracism.<sup>238</sup> Accordingly, if a consensus exists, but it is contrary to the public’s perception of the consensus, a norm consistent with the consensus will not arise.<sup>239</sup> The reason some Americans engage in irresponsible sex leading to disease is not because such behavior is consistent with the national consensus or that there is no national consensus, but that the consensus is not well-known, which destroys its normative power.<sup>240</sup>

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<sup>237</sup> For example, open signs of disorder in a vicinity, such as prostitution, public drunkenness, and panhandling signal to others that disorderly conduct is commonplace, accepted, and/or that the government cannot control it. This in turn leads people to think that the chances of being punished are low, and esteem costs for violating laws are also low (everyone is doing it.) In such an environment, persons who would otherwise be unlikely to engage in such conduct are more likely to because of these perceptions. Other research shows that when people have recently seen others engage in responsible behavior relative to littering, they are less likely to litter. See Sunstein, *supra* n. 201 at 905.

<sup>238</sup> Kahan, *supra* n. 205 at 356-9 & nn. 42-44, 370-371. Kahan argues that this is the mechanism that dramatically reduced crime in New York city in a mere 3 year period – the police concentrated on “public order” offenses and created an environment where disorder much less apparent. *Id.* at 368-73. Also, in Chicago, the most dramatic reductions in violent crimes occurred in the areas in which the city’s gang loitering ordinance was enforced most vigorously. *Id.* at 377.

<sup>239</sup> Norm theorist Richard McAdams posits that a norm arises when: 1) there is a consensus about the positive or negative esteem worthiness of engaging in a certain behavior; 2) there is risk that if a person engages in that behavior, others will discover their behavior; and 3) the existence of the consensus and risk of being caught are well-known within the relevant population. See McAdams, *supra* n. 227 at 358.

<sup>240</sup> There appears to be a gross divergence between Americans’ actual sexual behavior (mostly monogamous) and Americans’ perception of Americans’ sexual behavior – a misperception that has arisen in large part due to the media’s portrayal of promiscuous sex as ubiquitous. Only 3% of the population engages in promiscuous sex, meaning 5 or more partners per year. Laumann interview, *supra* n. 15. But, even if the percent of persons engaging in promiscuous sex were higher, even a strong dissent to a consensus does not preclude norm-formation. A consensus can arise even though a strong dissent exists; unanimity is not required. McAdams, *supra* n. 227 at 380. For example, 20 years ago, it would be considered “rude” to ask someone to stop smoking in a restaurant, as the norm was to allow smoking in public. Then, as restaurants began adopting policies against smoking, and local and state lawmaking bodies began to enact laws prohibiting smoking in public places, a consensus arose that smoking in public was the rude behavior, not the request to cease smoking. Thus, despite a strong dissent by smokers originally, which may have intimidated nonsmokers for some time, the consensus that smoking in public places is inappropriate took hold and gained support to the point where, today, there is little argument regarding this issue. The data available today regarding the propriety of sexual promiscuity indicates a strong consensus against it, at least in American society at large. To the extent that the consensus is not so strong in certain subgroups, such as young Americans, this should pose no problem as the information regarding the externalization of costs associated with such behavior – if publicized sufficiently - should persuade a critical mass of young people to adopt a norm against promiscuous sex, a norm most Americans clearly hold. Even if a consensus did not already exist, McAdams’s analysis of consensus formation predicts that a consensus admonishing sexual promiscuity would arise if information regarding the public health threat and

The media's preoccupation with sex and portrayal of casual sex as the norm is a factor,<sup>241</sup> as is the deeply internalized, unconscious Puritan-based shame factor that tends to silence discourse regarding the content of sexual norms. The core group responsible for the sexual disease rate is probably influenced by the "false" norms created by contemporary media and music, while the majority of Americans may be unaware that they are in the majority and exemplify the consensus.

A similar divergence between the consensus and public awareness of the consensus existed relative to public smoking before new laws publicized both the health risks and public sentiment. Prior to the entrenchment of the consensus that smoking in public places was unacceptable, people were afraid to speak out against public smoking, perhaps not realizing that they were in the majority, as smokers disproportionately represent patrons in bars and restaurants in the same way that sexually promiscuous people are disproportionately represented on prime time television.<sup>242</sup> The "norm-cascades" that have occurred in the last 30 years relating to smoking occurred in large part because the public became aware of the adverse health consequences of smoking, and because social norms are a function of public information.<sup>243</sup>

In order to create sexual norms from existing consensus, it is critical to propagate information that sexual promiscuity is not consistent with the societal consensus and is not condoned by society, particularly if certain subgroups – such as young Americans – operate under a mistaken belief that promiscuous sexual behavior is the norm.<sup>244</sup> Considering the data, the only reason why core sexual disease perpetrators are not subjected to more outspoken disapproval is likely because of a lack of publicity about the public consensus regarding their behavior.<sup>245</sup> Publicity of the true consensus is crucial to create and entrench

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social costs of disease transmission were better publicized, based on "selfish esteem allocation" and other factors. See McAdams, *supra* n. 227 at 359, quoting Philip Pettit, *Virtus Normativa: Rational Choice Perspectives*, 100 *Ethics* 725, 744 (1990).

<sup>241</sup> See *supra* n. 50.

<sup>242</sup> See, e.g., McAdams, *supra* n. 227 at 370-80.

<sup>243</sup> Sunstein, *supra* n. 228 at 2035.

<sup>244</sup> A legal statement about sexually promiscuous behavior is especially important to show that a consensus exists that shuns such behavior, as otherwise young Americans may succumb to the "false consensus" effect, that is, the belief that such behavior is typical although it is not because other person of their age group, with whom they selectively hang around, disproportionately condone such behavior. The first step is to signal to this high risk group that the behavior leading to health risks is not consistent with the consensus of most Americans, but is aberrational, very dangerous, and engaged in disproportionately among their peers. McAdams, *supra* n. 227 at 401. In this way, public smoking became antisocial. *Id.* at 404-6; see *infra* n. 335. See also Kahan, *supra* n. 205 at 374.

<sup>245</sup> There is experimental and empirical data that suggest that people will adapt their moral convictions to those of their peers once they know what they are, and that such

existing sexual norms. Publicity of the sexual disease epidemic per se will strengthen and reaffirm the consensus because the risks of sexual disease are much more serious than most Americans understand. Publicity of the consensus and health risks increases with strict liability, which engages the true power of a legal threat - its vicarious deterrent effect.<sup>246</sup>

In sum, sexually irresponsible behavior leading to the current sexual disease epidemic has been tolerated, even encouraged, among certain groups, based on inaccurate assumptions that could be exposed through the law's expressive function. The law should seek to exploit Americans' consensus condemning sexual disease transmission and to create norms consistent with public sentiment and social policy. A strict liability approach to sexual disease transmission would further the goals of educating the public and slowing the spread of sexual disease.

#### V. CONCLUSION

Sex in America has gone through enormous changes in the past century as a result of many social forces. Americans currently face an extraordinarily expensive and dangerous health care crisis as a result of the sexual behavior of a small percent of Americans. Tort law could do a much better job of encouraging socially responsible sexual behavior than it currently does. Adopting strict liability for sexual disease transmission is appropriate because sexual disease perpetrators must be deterred to the greatest extent possible. In addition, strict liability will help express Americans' consensus condemning sexual disease transmission and thereby aid in slowing the disease transmission rate through informal sanctions.

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adaptation can occur very rapidly once people are exposed to their peers' attitudes. Kahan, *supra* n. 205 at 358-9 & n. 44. Increased publicity of the public health risks involved in sexual norm violation (irresponsible sex leading to sexual disease) should provide sufficient confidence among those conforming to the norm and encourage them to speak out, which is what happened in relation to public smoking.

<sup>246</sup> ALBERT BANDURA, SOCIAL FOUNDATIONS OF THOUGHT AND ACTION 330 (1986).

## SEX TORTS

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### ABSTRACT

America has a serious sexual problem. The sexual practices of a small percentage of Americans has created an unprecedented disease rate that is costing the American public about \$20 billion per year. Lawsuits seeking damages for sexual disease transmission are on the rise, yet current sex tort law is mired with anti-heartbalm sentiment, is unpredictable, and is failing as a tool of deterrence, compensation, and education.

This Article discusses the gravity of the sexual disease crisis, part of which is the public's incredible ignorance about the rate of sexual disease, and tort law's failure to do its part to help educate the public and deter irresponsible sexual behavior. This Article concludes that, based on the high degree of risk involved in irresponsible sex, and the problems created by the current negligence-based analytical paradigm, strict liability for sexual disease transmission should be adopted. Strict liability would deter sexual disease transmission, and educate the public about the sexual disease epidemic, more effectively than negligence.

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