SEX OFFENDERS WITH AIDS: HOW SHOULD THEY BE PUNISHED

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Sexual intimacy in the time of AIDS is at best risky and at worst a death wish. Sexual responsibility has become the catch phrase and safe sex is the order of the day. More and more, partners are expected to disclose to each other their sexual histories and to take the necessary precaution to protect the other and themselves from contracting any sexually transmissible disease, especially AIDS.

Sadly, sexual responsibility or maturity can hardly be expected of sex offenders. The fact that they use brute force or craft to vent their sexual frustrations on an unwilling woman proves their disrespect for her humanity and dignity. Compounding the agony of a woman who is sexually violated is the fear of contracting AIDS. Hardly anything could be more devastating.

Not surprisingly then, when Congress reimposed the death penalty under Republic Act No. 7659, it defined rape with AIDS as a heinous crime deserving the death penalty. But is this the best way to punish such sex offender with AIDS?

This thesis aims to examine the question: ***What is the most appropriate and equitable manner of punishing AIDS-infected rapists?*** *Its ultimate goal is to make a policy recommendation regarding the best way to penalize rapists with AIDS. To this end, three things must be accomplished, namely:*

(1) To show the inadequacy of § 11 of Republic Act No. 7659, which imposes the death penalty for an accused rapist who "knows that he is afflicted with the AIDS disease";

(2) To examine the possibility of making an AIDS-infected rapist criminally liable under traditional penal statutes; and

(3) To examine the wisdom of bringing rape with AIDS under an AIDS-specific statute.

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INTRODUCTION

A. Premise

AIDS and rape. "Few subjects are as emotionally troubling..."[1] Society's reaction to the onset of the AIDS epidemic has consistently been one of fear and confusion; but at times, it has seen periods of despair, denial, discrimination, prejudice, and paranoia. "One consequence of the new societal awareness is the increased hesitancy with which individuals approach intimate contact. When intimate contact is involuntary as in the case of rape, fear of exposure to the disease is especially pronounced."[2] Today, women must face the dreaded possibility of not only being violated, but in the process, contracting a fatal disease as well. In *an era of AIDS, "the crime of rape ... can carry with it a death sentence — for the victim."*[3] Doubtless, the physical and emotional trauma accompanying rape is compounded by the threat of contracting AIDS from the assailant.

"It is no surprise, then, that since May 1991, at least 23 [States of the American Union] have passed laws concerning HIV testing of sexual offenders, and at least 70 bills were proposed in 26 states during the 1991 legislative session alone."[4] Nor is this phenomenon confined to the United States. As of yet, there are no Philippine laws with respect to mandatory AIDS testing of sex offenders; what exists is a law which is immeasurably tougher on crime: Republic Act No. 7659, or the "Heinous Crimes Law."

Section 11 of Republic Act No. 7659 made substantial amendments to Article 335 of the Revised Penal Code with respect to the circumstances attendant in the commission of rape and how each case is penalized. The definition of rape and the manner of its commission was maintained, as well as its penalty which is *reclusion perpetua.* What was added were several aggravating circumstances which qualify the "simple rape" to a "qualified rape," punishable by death. As amended, Article 335 in paragraph 7 now reads:

> "The death penalty shall also be imposed if the crime of rape is committed with any of the following attendant circumstances:
>
> ". . . .
>
> "(5) *When the offender knows that he is afflicted with the Acquired Immune Deficiency Syndrome (AIDS) disease."*

[1] Paul H. MacDonald, *AIDS, Rape, and the Fourth Amendment: Schemes for Mandatory AIDS Testing of Sex Offenders,* 43 VANDERBILT LAW REV. 1607 (1990).

[2] *Id.* at 1608.

[3] *About Rape and AIDS: Victims First or Justice Last?* New York Forum, 6 Jan. 1993, at 40.

[4] *Id.*

And *so in an era of AIDS, rape carries with it a death penalty — this time, for the assailant.*

It must be noted that the law speaks of an offender who *knows that he is afflicted with the AIDS disease.* It may be observed (and is so submitted) that the law as worded is too vague and imprecise; it is susceptible to various interpretations. For instance, what does it mean to be afflicted with the *AIDS disease* ? Does the law require that an offender have full-blown AIDS or does it merely require that the he be HIV-positive? What does it mean that one *knows* that one is afflicted? Is mere suspicion enough? Is mere membership in a high-risk group sufficient? If the offender thinks that he might be an AIDS carrier but does not know it for sure because he has not been tested, is he guilty under the above provision? Is an AIDS test mandatory for the purpose of knowing? Since the act allegedly committed is rape, will consent of the victim constitute a defense to the rape even in the light of the possibility of transmission?

By the manner the law was worded, it may be surmised[5] that the condition of the offender knowing that he has AIDS is made an aggravating or qualifying circumstance to the act of committing rape. In this case, it is *the act itself* which is punished and not the result of the act. It is for this reason that the afflictive penalty for simple rape which is *reclusion perpetua* is increased to the capital penalty. However, it is well-settled that aggravating circumstances must be strictly construed in favor of the offender and must be clearly proven by the prosecution. This becomes more urgent in the light of the fact that the law is subject to various interpretations.

Alternatively, the Senate may have created a special complex crime by equating the crime of rape with AIDS with that of rape with homicide. In fact, the crime of rape with homicide has likewise been made into a capital crime under Republic Act No. 7659.[6] In this case, it is the *resulting crime* which is made the basis of the penalty. It is noteworthy that if or when a woman contracts AIDS by reason of the rape, she would have contracted a fatal disease.

However, it is entirely possible that that the victim might not contract AIDS. If this be the case, the spirit behind equating the crime of rape with AIDS with the crime of rape with homicide would be for naught: the victim did not die. There would arise the anomalous situation where an offender is given the capital punishment for a crime which, for all intents and purposes, amounts only to a simple rape punishable by *reclusion perpetua,* and is obviously not a capital crime.

[5] [The author has searched congressional records for the relevant deliberations of the Senate and Bicameral Conference Committee on the provision on rape with AIDS, but to no avail.] Congressman Pablo Garcia, who was the Chairman of the Bicameral Conference Committee for the House of Representatives, says that the provision on rape with AIDS was never discussed.

[6] Revised Penal Code, art. 335 par. 6 (1994).

B. Statement of the Thesis

The apparent purpose of the law in criminalizing the transmission of the AIDS virus is to punish the infected rapist, who obviously has more malice in his heart than the rapist who is not so afflicted. But the law as it is now worded is plainly deficient in that it does not appreciate the complexity of AIDS as a disease and a social phenomena. Neither does it prescribe different penalties for the resulting crimes. If it aims to punish the act as committed, the law is itself subject to various interpretations and would consequently give the judge too much discretion as to how it should be applied.

The object of this thesis is to examine the different alternatives available to our criminal law system which would allow us to effectively and adequately penalize sex offenders with AIDS, and to evaluate which of these alternatives is best suited in carrying out the purpose of the criminalization of AIDS. These alternatives are as follows:

(a) To apply the provisions of the Revised Penal Code on homicide, rape, and rape with homicide; and

(b) To enact AIDS-specific legislation which will deal specifically with crimes committed by AIDS-infected assailants, which will include rape with AIDS.

I. A MEDICAL BACKGROUND

On A.I.D.S -

To begin with, there was this strange fact; though the infection was there, the moon had often four times circled the earth before clear symptoms of the disease appeared. For when it has once been received into the body it does not immediately declare itself; rather it lies dormant for a certain time and gradually gains strength as it feeds. Meanwhile, however, the sufferers, weighed down by strange heaviness and irresistible languor, are going through life with increasing weakness, moving sluggishly in every limb. Their eyes, too, have lost their natural keenness; the colour is driven from their faces and deserts their unhappy brows.

- GIROLAMO FRACASTORO
Syphilis sive Morbus Gallicus[7]

A. The Facts About A.I.D.S

The words of the famed sixteenth-century poet-physician Girolamo Fracastoro sound rather foreboding, for while the Latin verses of his celebrated work *Syphilis sive*

[7] JOHN LANGONE, AIDS: THE FACTS 3 (1991).

Morbus Gallicus clearly speak of syphilis or the "French disease," they might understandably be used to describe the most puzzling illness of our time — AIDS.

"AIDS" stands for Acquired Immune Deficiency Syndrome. AIDS is "a lethal clinical condition characterized by a breakdown in the body's natural defenses against disease; this immune collapse leaves the way open to a variety of serious illnesses — opportunistic infections — that are not usually found in people with healthy immune systems or that, if they are present under normal circumstances, have only relatively mild repercussions."[8]

1. THE IMMUNE SYSTEM

The immune system is "the body system that is responsible for destroying the disease-causing agents that it encounters."[9] The immune system has six major components, grouped into cells and proteins. For purposes of this study, it is important to take note only of one type of cells, the lymphocytes.

"Lymphocytes" are special white blood cells composed of B-cells and T-cells. B-cells produce the antibodies that identify and begin to destroy disease-causing organisms, whereas T-cells are responsible for cellular immunity, i.e. they attack and kill antigens directly. T lymphocytes are divided into two groups, namely: (i) the T4 helper cells, which encourage the B-cells to produce more antibodies; and (ii) the suppressor cells, which work to shut down B-cell production once infection is overcome.[10]

2. THE VIRUS WHICH CAUSES AIDS

AIDS is caused by the human immunodeficiency virus or "HIV," which is a retrovirus.[11] "HIV infiltrates the body by inserting its genetic code into the normal chromosomes of its human host,"[12] where the HIV replicates and shuts down the immune system by gradually killing off the T4 helper cells, "... limiting the body's

[8] *Id.* at 3-4.

[9] David S. Gordon, *Immune System*, 1994 MICROSOFT ENCARTA.

[10] Gordon, *Immune System*, 1994 Microsoft Encarta David Kennon Moody, *AIDS and Rape: The Constitutional Dimensions of Mandatory Testing of Sex Offenders*, CORNELL LAW REV. 239 (1990).

[11] A *retrovirus* is one with the ability to attach itself to the host cell's reproductive machinery. It is characterized by a unique mode of replication within the cells of their hosts. HIV's genetic code is contained in a single strand of RNA which is transferred to the host cell's DNA via an enzyme called *reverse transcriptase* which has been encoded by HIV. Since genetic information usually flows from DNA to RNA, the reversal of the virus's genetic flow of information makes the virus a retrovirus.

[12] Royce Richard Bedward, *AIDS Testing of Rape Suspects: Have the Rights of the Accused Met Their Match?* UNIV. OF ILLINOIS LAW REV. 348 (1990).

ability to fight infection ..."[13] The HIV virus therefore "preys on the body's immune system, eventually leaving the individual vulnerable to a host of opportunistic infections and illnesses that normal, healthy individuals are able to resist."[14] These opportunistic infections include *pneumocystis carinii* pneumonia, tuberculosis, and Kaposi's sarcoma. Evidence suggests that HIV infection also is linked to disorders of the central nervous system that may cause a variety of degenerative neurological conditions.[15]

3. INFECTED PERSONS

Persons who are infected with HIV are referred to as "seropositive." The term refers to individuals whose blood test indicates that they have been exposed to HIV regardless of whether they exhibit symptoms of illness.[16]

Seropositives react to the virus in various ways. They may show no signs of the disease, in which case they are referred to as "asymptomatic." The largest percentage of seropositives are totally asymptomatic. However, persons who are asymptomatic are presumably capable of passing the virus along if they engage in high-risk behavior. Also, a seemingly healthy mother may pass the infection along to her infant child during pregnancy, and even after birth through her breast milk. (See *Transmission*, further below.)

Seropositives may also develop AIDS-related complex or ARC. An early estimate places at twenty-five *per centum* (25%) the number of seropositives who will move into this category.[17] As a general rule, the symptoms and ailments which often appear during the ARC stage vary in severity and in frequency. They are however, usually not life-threatening. Although ARC itself is non-fatal, some persons with ARC later develop full-blown AIDS. The symptoms include fever, night sweats, diarrhea, fatigue, skin rashes, weight loss, and swollen lymph nodes.[18]

Seropositives may develop full-blown AIDS, and are referred to as "symptomatic." This is the final and most severe stage of infection. Patients are diagnosed as symptomatic "if they have a positive blood test for antibodies to the virus (See AIDS *testing*, further below), a positive culture for the virus itself, and positive results on lab tests that demonstrate profound immune dysfunction and a loss of specific class of disease-

[13] MOODY, *supra* note 10, at 240.

[14] Paul H. MacDonald, *AIDS, Rape, and the Fourth Amendment: Schemes for Mandatory AIDS Testing of Sex Offenders*, 43 VANDERBILT LAW REV. 1609-1610 (1990).

[15] *Id.* at 1610.

[16] Mark Blumberg, *AIDS: Analyzing a New Dimension in Rape Victimization*, in AIDS: THE IMPACT ON THE CRIMINAL JUSTICE SYSTEM 86 (1988).

[17] LANGONE, *supra* note 7, at 11.

[18] BEDWARD, *supra* note 12, at 349.

fighting ... T-4 lymphocytes."[19] As the illness progresses, the symptomatic patient acquires a variety of life-threatening secondary infections — or what are commonly termed as opportunistic diseases — which his body is unable to fend off. Perhaps the most common of these secondary infections is *pneumocystis carinii* pneumonia or PCP, with most AIDS patients eventually dying of AIDS-related pneumonia.[20] Within two to three years from the emergence of the clinical disease, the patient dies.

4. FROM SEROPOSITIVE TO SYMPTOMATIC

Seroconversion, which is the process by which the immune system produces the antibodies to HIV in response to the presence of viral protein components, generally occurs within three months of HIV infection.[21] Persons whose tests show the presence of antibodies are referred to as "seropositive" or "HIV-positive." (See *AIDS testing*, below.)

It is not yet known what proportion of those testing positive will eventually develop full-blown AIDS. This is because the incubation period of AIDS is rather long, from seven to eight years by one study.[22] In 1986, C. Everett Koop, the former Surgeon General of the United States, published that twenty to thirty *per centum* (20% to 30%) of such persons will progress to the final stage within five years. The Public Health Service estimates chart a thirty-five *per centum* (35%) progression to AIDS over six to eight years.[23] However, a more recent study[24] suggests that ninety-nine *per centum* (99%) of seropositive may eventually develop AIDS.

5. AIDS TESTING

The so-called AIDS test is really *not* a test for AIDS. "The HIV antibody test detects antibodies formed by the immune system against the human immunodeficiency virus; it does not look for the virus itself. It searches for antibodies produced against a number of viral capsule and core antigens."[25]

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[19] LANGONE, *supra* note 7, at 14.

[20] Interview with Dennis Maducduc, M.D., M.P.H. Program Manager of the *National AIDS/STD Prevention and Control Program, Department of Health* (14 Dec. 1994).

[21] MACDONALD, *supra* note 14, at 1612.

[22] BLUMBERG, *supra* note 16, at 79, quoting Kung-Jong Lui, William Darrow, & George Rutherford III, *A model-based estimate of mean incubation period for AIDS in homosexual men*, SCIENCE, 3 June 1988 at 1333-1335.

[23] LANGONE, *supra* note 7, at 216.

[24] BLEMBERG, *supra* note 16, at 79.

[25] Paul T. Carne, Michael Ross & Richard J. Kemp, *A practitioner's guide to HIV testing, Could it be* HIV? THE CLINICAL RECOGNITION OF HIV INFECTION, 64 (1994) [hereinafter cited as Carne].

There are two tests which are currently used to determine whether someone is an AIDS carrier, namely: (a) the ELISA; and (b) the Western Blot.

Initially, an ELISA test is performed. The ELISA (or enzyme-linked immunosorbent assay) was designed to be expedient, and can be performed quickly and easily, in about three hours.[26] It is performed mainly for screening purposes in that it was originally developed by researchers to test large quantities of blood products for HIV. "Unfortunately, this test can also detect antibodies to antigens other than HIV and may give a false positive result. While very *sensitive*, the test is not entirely *specific*."[27] This makes the ELISA significantly less reliable[28] than the Western Blot. Hence, the ELISA is used as a general screening test to detect samples which require further testing using the Western Blot.

"A positive or indeterminate ELISA result means that the sample will be tested further by the western blot method. Because it detects antibodies to a number of specific HIV viral proteins, this confirmatory test is regarded as being very specific for HIV. Samples tested in this manner that give a negative result are reported as negative."[29] Thus, the standard methodology is to make the individual undergo the ELISA which is a screening test, and if the same yields a positive result, to subject it to a confirmatory test like the Western Blot.[30]

The process of testing for HIV is inherently inexact. The major problem with HIV testing is that the tests determine only the presence of HIV antibodies. The ELISA will usually begin to detect antibodies from two weeks to two months after infection. For practical purposes, if results remain negative three months after exposure, it is likely that infection has not occurred. There are, however, some individuals who still test negative even after twelve weeks; however, by the sixth month, the antibodies will appear practically in every case. The time interval between infection and the moment when the ELISA becomes positive is known as the "window period." Within this period an infected person will test negative; however, such person is fully capable

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[26] MACDONALD, *supra* note 14, at 1613; BEDWARD, *supra* note 12, at 350.

[27] Carne, *supra* note 25, at 64.

[28] Mr. Langone writes that the results of an ELISA test are reasonably accurate even without confirmatory testing. He points out, however, that a single test cannot automatically establish that a person is infected. It is possible that a positive test may result from exposure to viruses other than HIV. For instance, persons suffering from both alcoholism and liver-damaging hepatitis-B virus often test positive for HIV but show no evidence of such infection when retested with more definitive laboratory procedures. (*Supra* note 1, at 216-217.)

[29] Carne, *supra* note 25, at 64.

[30] MACDONALD, *supra* note 14, at 1613; MOODY, *supra* note 10, at 241.

of transmitting the virus despite the fact that his tests prove negative.[31] In fact, "[o]n first exposure to HIV, there is typically a two to four week period of intense viral replication..."[32] It bears stressing then that a negative HIV antibody test could mean either of two things: (a) that the patient has not been infected with the virus; or (b) that the infection was so recent that the detectable antibodies to the virus have not appeared in the blood.

The timing problem brought on by the window period is made worse by the high incidence of "false positives." False positives refer to "test results that wrongly indicate the presence of AIDS-virus antibodies in patients' and donors' blood or semen..."[33] According to the 1988 report of the Centers for Disease Control, among the high-risk populations, the risk of a false positive is extremely low, i.e. only 0.5% of patients testing positive are not infected with HIV. However, among low-risk populations the likelihood of a false positive increases dramatically. Of those testing positive, 28.2% are not infected with AIDS.[34]

Scientists are refining AIDS tests to make them more accurate. Current approaches include developing tests that detect HIV's protein by-products rather than the antibodies produced against it, and tests that detect the virus itself. Two American firms, Dupont and Abbott Diagnostics, have each developed kits that detect the virus itself by locating p24, a protein nestled in the viral core.[35] The p24 antigen test "... measures the blood level of a viral core protein [p24]."[36] As it turns out, however, these kits are cumbersome and require several hours to yield results.

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[31] BEDWARD, *supra* note 12, at 351; MOODY, *supra* note 10 at 241; LANGONE, *supra* note 7 at 215-216; CARNE, et al., *supra* note 25, at 64.

In fact, soon after the infection, the level of antigens is very high as well as the amount of circulating virus. "This period of high negative antibody test and high virus load is also a period of high infectivity." (CARNE, *supra* note 7, at 64)

This conclusion is supported by Dr. Dennis Maducdoc, who says that it is in the earliest stages of infection as well as in the final stage of AIDS that an AIDS-carrier is most infectious.

[32] Michael J. Boyle, Marilyn McMurchie, Brett Tindall, & David A. Cooper, *HIV seroconversion illness,* COULD IT BE HIV? THE CLINICAL RECOGNITION OF HIV INFECTION, 15 (1994).

[33] LANGONE, *supra* note 7, at 217.

[34] MOODY, *supra* note 10, at 241.

Langone writes that with respect to blood donations, it is estimated that out of any given sample of blood donors who test positive on a single ELISA, half to two-thirds may be false positives. Uninfected persons sometimes give off positive reactions due to the sensitivity of the test. (LANGONE, *supra* note 1, at 217.)

[35] LANGONE, *supra* note 7, at 219-220.

[36] Carne, *supra* note 25, at 64.

6. TRANSMISSION

Scientists have isolated HIV in body fluids such as blood, semen, vaginal fluids, saliva, tears, urine, and breast milk. However, "... the routes the virus chooses to invade a human being are quite limited ..."[37] AIDS is a blood-borne disease, "blood [representing] a significant method of transmission when there is a large inoculum."[38] As a consequence of this, transmission of the virus generally requires either: (a) intimate sexual contact; (b) direct exposure to infected blood; or (c) perinatal exposure. The disease is therefore not spread through casual physical contact or through inanimate objects.[39] "HIV transmission through means other than sexual, perinatal, or invasive blood exposure is, therefore, very low."[40]

7. THE HIGH-RISK GROUPS

AIDS occurs primarily among (a) homosexual and bisexual males who have been the receptive partners in anal sex; (b) intravenous drug users who share contaminated needles; and (c) children unfortunate enough to be born of infected mother.[41] However, the Gay Men's Health Crisis published its 1 October 1994 statistics in GMHC Facts[42] showing that forty *per centum* (40%) of the AIDS cases worldwide are among women, more than that of children under five — who presumably were infected by their mothers — who make up one-third.

8. TRANSMISSION THROUGH SEX; HIGH-RISK BEHAVIOR

"The primary means for transmission of AIDS is direct mucous membrane or bloodstream contact with a sexual partner's blood or semen infected with HIV."[43] Researchers have devoted a great deal of attention to the risks associated with various sexual practices. It is important to elicit details of sexual practices because there is a

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[37] LANGONE, *supra* note 7, at 70.

[38] Larry Gostin, *The Politics of AIDS: Compulsory State Powers, Public Health, and Civil Liberties,* 49 OHIO STATE JOURNAL 1025 (1989), *citing* Gerald Friedland & Robert Klein, *Transmission of the Human Immunodeficiency Virus,* 317 NEW ENGLAND J. OF MED. 1125, 1128-1130 (1987).

[39] LANGONE, *supra* note 7, at 70; Robert C. Gallo, M.D., *Acquired Immune Deficiency Syndrome,* 1994 MICROSOFT ENCARTA.

[40] MACDONALD, *supra* note 14, at 1611.

[41] *Id.*

[42] GMHC Facts is a monthly summary of facts about the programs of the Gay Men's Health Crisis, Inc. and the AIDS epidemic. Its statistics are taken from various sources including the World Health Organization, the Centers for Disease Control, and public and private research studies.

[43] WILLIAM P. SHURGIN & PAULA E. BERG, LEGAL ASPECTS OF AIDS 23 (1993 CUMULATIVE SUPP.).

need to establish whether vaginal or anal penetration has occurred; and with respect to male-to-male sex, whether a patient is the receptive or insertive partner, or both.[44]

The practice of anal sex deserves considerable explanation. The anatomy of the interior of the rectum, which is the lower part of the large intestine that ends in the anus, explains why AIDS has been largely a disease involving this common homosexual practice. Explains one author:

> "The rectum is lined with fragile, columnar cells that are easily damaged and invaded by infectious agents, and, like the rest of the digestive tract, it is rich in blood capillaries. Moreover, the closer to the anus, the more the blood vessels there are. Thrusting an erect penis into the rectum, even after using a lubricant, can devastate the cellular layer, opening enough tears to allow easy passage of the AIDS virus in ejaculated semen to enter the bloodstream."[45]

As to the matter of which of the sexual partners in anal intercourse is more at risk, the same author explains:

> "Although the risk of the so-called active-insertive partner in anal sex has not yet been established, it is believed to be far lower than for the receptive partner. Some clinicians believe, however, that the active insertive partner also stands a chance of getting an AIDS infection since the opening of the penis might be invaded by infected blood from the receptive partner. Also, if the active partner has lesions on his penis, the virus might have an easier time of it."[46]

Multiplicity of partners, either heterosexual or homosexual would, expectedly, increase the risk of infection. People who have unprotected sexual contacts outside a mutually monogamous relationship are at significant risk.[47]

Oral sex is one of the most common practices — if not the most common practice — of homosexual intercourse, as well as with heterosexual encounters. While theoretically risky, oral sex is considered a low-risk sexual practice in regard to HIV-transmission.[48]

B. *A.I.D.S. World-Wide*

An estimated 17 million people world-wide are infected with HIV. The World Health Organization estimates that 3 million people were infected in 1993 alone. More than 2.5 million people worldwide have died of AIDS.

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[44] Virginia Furner & Michael Ross, *Lifestyle clues in the recognition of HIV infection,* COULD IT BE HIV? THE CLINICAL RECOGNITION OF HIV INFECTION, 13 (1994)[hereinafter cited as Furner].

[45] LANGONE, *supra* note 7, at 98.

[46] *Id.*

[47] Carne, *supra* note 25, at 65.

[48] Furner, *supra* note 44, at 14.

According to the WHO, seventy-five *per centum* (75%) of those infected were infected through heterosexual sex. Forty *per centum* (40%) of the cases are among women. One-fifth of all people with AIDS are in their twenties and were probably infected during their teens. One-third of the AIDS cases worldwide are children under age five.[49]

C. *A.I.D.S. in the United States*

In the United States, AIDS has been transmitted primarily in two ways, namely: (a) through sexual contact; and (b) through sharing of infected needles by intravenous drug abusers. The Centers for Disease Control reported in AIDS *weekly surveillance report* dated 26 December 1988, that over ninety *per centum* (90%) of the reported cases have occurred among two high-risk groups, namely the homosexual or bisexual males and intravenous drug users.

The latest statistics (as of 30 June 1994) show that there have been 401,749 reported AIDS cases in the United States. There have been 243,423 reported AIDS deaths. The Centers for Disease Control estimate from about 1 million to about 1.5 million Americans are infected with HIV. One in every 100 men and one in every 600 women are infected. There is one AIDS-related death every 23 minutes in the United States.[50]

Nearly sixty *per centum* (60%) of Americans with AIDS are people of color.[51] AIDS cases among women jumped 9.8% in 1992; cases among men increased 2.5%. Sex, not injecting drug use, is now the leading cause of new AIDS cases among women. AIDS is the leading cause of death for young adults in sixty-four (64) U.S. cities. The rate of HIV infection among adolescents doubles each year.[52]

D. *A.I.D.S. in the Philippines*

The Department of Health began documenting AIDS cases in the Philippines starting with the year 1984. From 1984 to October 1994, five hundred sixty-five (565) Filipinos have been found to be HIV-positive. Of those 565, one hundred and seventy-one (171) have full-blown AIDS. Of the 171 individuals who are symptomatic, ninety-six (96) have died of AIDS.[53]

Of the 565 seropositives, three hundred and ninety-two (392) individuals (or 69.38%) were infected through sexual transmission. Of these 392 patients, two hundred and ninety (290) are heterosexuals (or 73.98%); whereas one hundred and two (102) are either homosexuals or bisexuals (or 26.02%).

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[49] *See supra* note 42.

[50] *Id.*

[51] *Id.*

[52] See *supra* note 42.

[53] DEPARTMENT OF HEALTH, OCTOBER 1994 MONTHLY UPDATE, HIV/AIDS REGISTRY, Table 2.

Infection through tainted blood and blood products accounts for eight (8) out of the 565, or approximately 1.416%. Sharing of needles and syringes accounts for three (3), or approximately 0.53%. Perinatal infection accounts for eight (8), or approximately 1.416%. Finally (and, perhaps, curiously), one hundred and fifty-four cases, or 27.26%, are of unknown risk factors.[54]

The statistics support the conclusion that in our country, the high-risk groups are significantly different from those of the global or American situations. While infection through sexual intercourse is likewise the primary risk factor, here, it is the heterosexual community that is hardest hit. Sharing infected needles and syringes accounts for the least number of infections mainly because injecting heroin or cocaine is are rarely practiced, if at all. Notably, heroin and cocaine are scarcely even available. Additionally, the most common secondary infection which eventually leads to the death of those who have full-blown AIDS is tuberculosis.[55]

E. Transmission from Men to Women and the risk to rape victims: A matter of Anatomy and Probabilities

What is the risk of HIV infection for rape victims? To answer this question, several matters deserve preliminary consideration.

First, what sexual practices are performed during the rape? Since rape requires that the offender "[have] carnal knowledge of a woman,"[56] we must assume that rape victim suffered forced vaginal intercourse, or in the case of statutory rape, vaginal intercourse whether forced or not.

Second, what is the risk of a woman being infected with HIV from a single act of forced vaginal intercourse? The answer to this question depends on another, viz: can HIV be transmitted as easily through conventional, i.e. vaginal intercourse between men and women, as it is between infected males who engage in anal intercourse?

Third, what proportion of offenders are likely to be infected with HIV?[57]

In their 1988 study, Norman Hearst and Stephen Hulley noted that the likelihood that a female would seroconvert, i.e. become infected with the AIDS virus, as a result of a single act of unprotected sexual intercourse with a seropositive male is about 1 in

[54] *Id.*, Table 4.

[55] Interview with Maducdoc; "[I]t is noteworthy that an estimated 4.4 million people worldwide are infected with both TB and HIV, *supra* note 42.

[56] Revised Penal Code, art. 335 (1932).

[57] BLUMBERG, *supra* note 16, at 80-81.

every 500 to 1 in every 1,000.[58] The study[59] of Padian, Wiley, and Winkelstein placed the seroconversion rate at 1 in every 1,000. On the other hand, the risk of contracting HIV in a single sexual encounter while using a condom (assuming 90% effectiveness of said barrier contraception) is estimated to be 1 in 10,000.[60]

Studies suggest that the risk of transmission increases as exposure becomes more frequent. Gerald Friedland and Robert Klein, in their study "Transmission of the human immunodeficiency virus," published in the 29 October 1987 edition of the New England Journal of Medicine, noted that:

"[t]he available data indicate that HIV transmission is not highly efficient in a single or few exposures, unless one receives a very large inoculum. The widespread dissemination of HIV is more likely the result of multiple repeated exposures over time."[61]

Clearly, the risk of contracting HIV from a single heterosexual encounter is small. In fact, according to Friedland and Klein, the majority of heterosexual persons who have engaged in vaginal intercourse on a continuing basis with infected partners have not become seropositive. However, the risk of infection increases significantly for those who have ongoing sexual relationships with an infected partner. Even if the likelihood of seroconversion form a single encounter is at best 1 in 500, there is still a considerable risk to the uninfected partner as sexual contacts become more frequent.[62]

The woman who engages in conventional or vaginal intercourse with an HIV-positive man is more apt to seroconvert than he from her if the situation were reversed.[63] A woman's genital anatomy, however, seems to be in her favor insofar as transmission is concerned. Says one author:

> "Designed to withstand the trauma of intercourse as well as childbirth, the vagina has fewer blood vessels than the rectum, and is usually naturally lubricated during intercourse. Also inside are multiple layers of platelike squamous cells that resist rupture and provide a fairly effective barrier against infective agents, presumably including the AIDS virus, which appears to require access to the bloodstream."[64]

[58] MOODY, *supra* note 10 at 241. *citing* Hearst & Hulley, *Preventing the heterosexual spread of AIDS: Are we giving our patients the best advice?* JOURNAL OF THE AMERICAN MEDICAL ASS'N.

[59] GOSTIN, *supra* note 38 at 1022, *citing* Padian, Wiley & Winkelstein, *Male to Female Transmission of Human Immunodeficiency Virus: Current Results, Infectivity Rates, and San Francisco Population Seroprevalence Estimates,* presented at the Third International Conference on AIDS, Washington D.C. 4 June 1987.

[60] BLUMBERG, *supra* note 16.

[61] *Id.*

[62] *Id.* at 81, 87.

[63] LANGONE, *supra* note 7, at 94.

[64] *Id.* at. 96.

Can HIV then be transmitted as easily from a man to a woman through vaginal intercourse as it is between infected males who engage in anal intercourse? The answer appears to be in the negative.

After determining the likelihood that a woman can be infected from a single act of forced vaginal intercourse, the final question must then be asked: What proportion of rapists are infected with HIV? As was previously noted, the number of rape victims who are likely to seroconvert is a function not only of the risks associated with a single act of forced vaginal intercourse, but also of the proportion of sex offenders who are HIV-positive. Sadly, this information is not currently available for both the American and Philippine settings. However, it is possible to estimate the proportion of infected offenders using available epidemiological data from the United States.

The previously cited study of Hearst and Hulley entitled "Preventing the Heterosexual Spread of AIDS: Are We Giving Our Patients the Best Advice?" (1988), the authors laid out the worst case scenario. If a rapist were from a high-risk category (i.e. either a homosexual or bisexual male or an intravenous drug user, who constitute 90% of the AIDS cases in the U.S.), in which the prevalence of HIV was 1 in 20, and the likelihood of contracting the virus from a single act of forced vaginal intercourse was 1 in 500, the risk of getting AIDS would be 1 in 10,000 (i.e. 1/500 x 1/20).[65]

However, it is quite unlikely that homosexual or bisexual men, would, to any considerable extent, participate in sexual assaults directed towards women. Intravenous drug addicts are also unlikely to engage in such violent behavior. Generally, alcohol is far more likely to be a precipitating factor in rape than heroin use.[66] This information is pertinent in the light of a study[67] made by the Centers for Disease Control on the seroprevalence among military recruits. This community was made the test group because they approximate some of the demographic characteristics of apprehended rape offenders. Applicants for the armed forces are largely male; they are of the age where they are likely to be sexually active; they tend to be disproportionately drawn from minority groups; and finally, because the military attempts to exclude individuals who are gay or are drug abusers, they are far less likely to be members of the high risk groups.

The findings from tests given to prospective military recruits over a two-year period indicate that for every 1,000 individuals, 1.5 or 0.15% are infected with HIV. Data from the National Crime Survey indicate that 45,640 completed rape victimizations were committed in the U.S. in 1986 (Bureau of Statistics, 1988). Assuming 0.15% (or 1.5 : 1,000) of these are seropositive, then 68 (or more precisely, 68.46) of these individuals would have the capacity to infect their victims through forced vaginal intercourse.

[65] MOODY, *supra* note 10, at 241-242.

[66] BLUMBERG, *supra* note 16, at 81-82.

[67] *Id. citing* Centers for Disease Control, *Human Immunodeficiency Virus Infection in the United States: A Review of Current Knowledge*, MORBIDITY AND MORTALITY WEEKLY REPORT, (18 Dec. 1987).

But since the risk of infection from a single heterosexual exposure is 0.02% (or 1 : 500), less than 1 case (or 0.13692) of AIDS contracted from rape would result.[68]

Let us recall the paper of Hearst and Hulley, where their worst case scenario indicated a 1 : 1,000 chance of HIV infection resulting from rape. They naturally included a best case scenario. In such a case, if the rapist were to come from a low-risk category where the seroprevalence rate is 1 in 10,000 and the risk of infection from a single act of vaginal intercourse being 1 in 500, the risk would be 1 in 500,000.

It is clear therefore that the chances of a rape victim seroconverting are at best infinitesimal.

II. A CRITIQUE OF THE PRESENT LAW -

The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding.

- LOUIS D. BRANDEIS (1928)

The law on rape accompanied with AIDS reads as follows:

"The death penalty shall also be imposed if the crime of rape is committed with any of the following attendant circumstances:

". . . .

"(5) When the offender knows that he is afflicted with the Acquired Immune Deficiency Syndrome (AIDS) disease."[69]

There are a few significant questions which come to the fore when one is faced with the current law. First, what does it mean to know that one has AIDS? Is mere membership in a high-risk group sufficient? Surely this would not suffice for only one in twenty (or five *per centum*) will be seropositive. Is a hunch borne out by the manifestation of certain symptoms adequate knowledge? Perhaps not, for some symptoms of AIDS — in all of its stages — are symptoms of other diseases as well.

How must we then interpret the required knowing? The required knowledge which is most consistent with justice is knowledge of afflicton resulting from AIDS testing. However, this poses problems as well. As was earlier noted, HIV testing is inherently inexact because the tests determine not the presence of the virus itself but

[68] *Id.* at p. 82.

[69] Revised Penal Code, art. 335, par. 7 (5)

of the presence of antibodies produced in reaction to the virus. (A classic case of affirming the consequent, which, every student of logic will tell you, is a fallacy.)

It will be recalled that there exists a period of latency or "window period" of three to twelve weeks within which the HIV antibodies are expected to develop. If a potential rapist takes the HIV test before the antibodies appear, he would then test negative. If he later commits a rape when the antibodies appear, by legal contemplation then, he is not deemed to know that he is infected with HIV. Therefore, he will then be guilty not of rape with AIDS but merely of simple rape. On the other hand, if the positive test results of a potential rapist turn out to be false positives, and then he subsequently commits rape, by legal contemplation he is deemed to have known of his affliction with the AIDS disease; however, such knowledge would be erroneous since he is not so afflicted. Unfortunately, these situations are not addressed by the law. For this reason alone, the law is plainly deficient.

Second, what does the law contemplate when it says "afflicted with the ... (AIDS) disease?" The disease AIDS progresses in several stages; AIDS is really the final and most serious stage of its progression. Another way of putting it is that a person who is HIV-positive may react to the virus in several ways. He may be asymptomatic; he may develop AIDS-related complex or ARC; or he may develop full-blown AIDS, whereupon he will be referred to as symptomatic.

It is noteworthy that the law does not specify which of these reactions is covered by the provision. Is it only those who have full-blown AIDS who are covered or does it comprise all seropositives, whether symptomatic or not? The law gives no indication. It makes no distinctions. It is a familiar legal maxim that where the law makes no distinctions, we ought not to.

However, distinctions are in order. Being seropositive does not necessarily lead to the conclusion that one has AIDS. The statistics, in fact, lean toward *not* becoming symptomatic. It is important to determine the stage at which the assailant had sexual intercourse with the victim because the danger of infection varies among the stages. Two to four weeks after exposure is a period of intense replication of the virus. The amount of circulating virus is very high, which makes the carrier highly infectious. As antibodies are produced to fight the virus, infectivity declines. The final stage when the carrier is symptomatic is likewise a stage when he is highly infectious. It is clear therefore that the period or stage during which an assailant committed the rape is relevant to the question of whether such rape could lead to the victim's infection. Yet the law does not make any reference to these stages. This is another reason why the law is deficient.

The result of this absence of specificity in the law is that the judge will be given almost unlimited control as to the interpretation of paragraph 7 (5) of Article 335. Absent any specific guidelines with respect to when and how or if at all the suspect knew he was infected, and at what stage of infection the suspect committed the rape, the judge is given unbridled discretion to determine these questions, and consequently,

the applicability of the law. The life and freedom of a suspect would then depend solely exercise of one magistrate of the tremendous power vested upon him. Surely, this would be inconsistent with due process.

What then is the most appropriate manner of punishing sex offenders with HIV for knowingly engaging in behavior which are likely to cause the infection or seroconversion of their victims?

As the AIDS epidemic gained momentum in the United States, increasingly criminal law was resorted to as the mechanism for both deterrence and punishment of risky behavior. There is a considerable number of criminal prosecutions where HIV-transmission was brought under traditional penal statutes. On the other hand, some states have enacted legislation specific to HIV transmission. These two alternatives deserve ample consideration.

III. APPLYING TRADITIONAL CRIMINAL LAW TO AIDS TRANSMISSION -

What is most intriguing — or perhaps puzzling — about the present law is that it gives no indication of the purpose of punishing rape accompanied with AIDS with the death penalty. Is it to punish the resulting crime, homicide, in this case? Or is it to punish the special malevolence with which the offender committed the felony. It is important to know this if one is to find a way to properly punish sex offenders with AIDS.

It is noteworthy that the acts of rape other than "simple rape" may be categorized as either falling under those which are punished on the basis of the resulting crime and those which have attendant aggravating circumstances. Under which category then does rape with AIDS fall? While it may be observed that the manner in which the law was worded seems to indicate that the purpose of the law is to punish the mere commission of the act itself, still, one wonders whether such a rape would "earn" for the offender the capital punishment absent any possibility that the woman would be infected and consequently die as a result of her rape.

AIDS litigation in the United States has seen criminal prosecutions being brought under traditional penal statutes, charging crimes like murder, attempted murder, sexual assault, and others. We must then examine the possibility of bringing rape with AIDS under certain felonies defined in the Revised Penal Code.

A. Consumated or Frustrated Homicide

Bringing a homicide charge against a sex offender with AIDS would be an instance where it is the resulting crime that is punished. In our jurisdiction, homicide

is defined as "the unlawful killing of any person, which is neither parricide, murder nor infanticide."[70] The elements of homicide are as follows:

> "(1) That *a person was killed;*
> "(2) That the accused killed him without any justifying circumstance;
> "(3) That *the accused had the intention to kill,* which is presumed;
> "(4) That the killing was not attended by any of the qualifying circumstances of murder, or by that of parricide or infanticide."[71]

We consider homicide as a possible solution in the light of Article 4(1) of the Revised Penal Code which provides that:

> "[c]riminal liability shall be incurred:
>
> "1. By any person committing a felony *(delito)* although the wrongful act done be different from that which he intended."

Justice Reyes comments that "[o]ne who commits an intentional felony is responsible for all the consequences which may naturally and logically result therefrom, whether foreseen or intended or not."[72] He explains that "ordinarily, when a person commits a felony *with malice* he intends the consequences of his felonious act. But there are cases where the consequences of the felonious act of the offender are *not intended* by him. In those cases 'the wrongful act done' is 'different from that which he intended.'"[73] The rationale for Article 4(1) is found in the doctrine that he who is the cause of the cause is the cause of the evil caused.

In order that a person may be held criminally liable for a felony different from that which he intended, the following requisites must concur:

> "a. That an intentional *felony* has been committed; and
> "b. That the *wrong done* to the aggrieved person be the *direct, natural* and *logical consequence* of the *felony* committed by the offender."[74]

Applying Article 4(1) of the Revised Penal Code, if as a consequence of the rape committed, the rape victim dies, the resulting crime will be homicide. It must therefore be proven that the resulting homicide (arising presumably from the woman's

[70] LUIS B. REYES, 2 THE REVISED PENAL CODE, 466 (12th ed. 1981).

[71] *Id.* (emphasis supplied)

[72] LUIS B. REYES, 1 The Revised Penal Code, 64 (12th ed. 1981).

[73] *Id.*

[74] *Id.* at p. 69.

seroconversion) was the direct, natural, and logical cause of the rape. What is being invoked in this case is the doctrine of proximate cause. Proximate cause is "that cause, which, in the *natural and continuous sequence, unbroken by any efficient intervening cause,* produces the injury, and *without which the result would not have occurred.*"[75] (Underscoring supplied)

As a matter of proof, then, it must be clearly shown that the woman's AIDS-related death was the direct, natural, and logical consequence of the rape committed by the seropositive rapist, and that further, without such rape, she would not have contracted such disease. Thus, "even if an infected person knowingly engages in high-risk behavior with someone who subsequently is diagnosed as HIV-positive, he cannot be held liable for transmitting the virus absent proof that the accuser's infection is traceable to that behavior."[76] Herein lies the inadequacy of charging the offender with homicide under Article 249 in relation to Article 4(1) of the Revised Penal Code: there is much difficulty in the matter of proof.

First, assuming the offender was seropositive, it must be proven that there was an actual infection of the rape victim by the accused. This is difficult to prove, even with an AIDS test. An HIV-positive rapist will not necessarily infect his victim; in fact, he is not likely to. As earlier explained in Part 1, the likelihood of seroconverting after a single act of vaginal intercourse is from a high of 1 : 500 to a low of 1 : 1,000. Factoring in the probability that a rapist may be HIV-positive, the likelihood of seroconversion fall dramatically to 1 : 500,000.

Second, it must be proven that between the rape and the death of the victim as a consequence of AIDS, there existed no efficient intervening cause. An efficient intervening cause is "an active force that intervened between the felony committed and the resulting injury, and the active force is a distinct act or fact absolutely foreign from the felonious act of the accused."[77]

How then can the doctrines of proximate cause and efficient intervening cause be applied to prosecuting the sex offender with AIDS with homicide? For one, it must be proven that there was no other act or event between the rape and her death which could have caused her seroconversion; in other words, that the rape victim did not herself engage in high-risk behavior and that it was through the rape alone that she could have been infected. This would necessarily involve a thorough investigation of her sexual relations, drug use, as well as her medical history. Did she engage in unprotected sex with a seropositive partner? How often did she have sexual relations with him? Did she share an IV needle with someone who was HIV-positive? Did she have a transfusion and was the blood tainted? Clearly, the woman will suffer an invasion upon her privacy.

[75] REYES, *supra* note 70, at 76. (emphasis supplied)

[76] Harlon Dalton, *Criminal Law,* AIDS LAW TODAY: A NEW GUIDE FOR THE PUBLIC, 242-243 (1993).

[77] REYES, *supra* note 72, at 82.

Additionally, certain facts must be established before the death of the victim is presumed to be the natural consequence of the physical injuries inflicted, namely:

> "1. That the victim at the time the physical injuries were inflicted was in normal health.
> "2. That the death may be expected from the physical injuries inflicted.
> "3. That death ensued within a reasonable time."[78]

Under the above quoted requisites, it would likewise be imperative to prove that at the time of the rape, the woman was herself not HIV-positive. Otherwise, the offender cannot be held liable for her death but only for her rape. But again, this extends to the accused an open invitation to investigate his victim's sex life and drug history. Shall we permit the woman to be violated twice?

That the death should ensue within a reasonable time also poses a problem. It is generally accepted that persons with AIDS (or PWA's) usually die five to eight years after infection. This time is the norm. It could then be said that if the victim died 5 to 8 years after the rape, she would have died within a reasonable time. True. But the length of time only compounds the problem of determining the proximate cause of the disease and proving that there was no efficient intervening cause. Apart from these, it must be proven that the behavior engaged in by the offender could have caused the victim's death.

But the most glaring and fatal defect of any attempt to bring rape with AIDS under the felony of homicide is the requirement that the victim must die. As earlier noted, there is an infinitesimal chance that the offended woman would even get infected with the virus if she were raped. This does not take into account the likelihood working in her favor that she may not even develop full-blown AIDS. There arises then an absurdity: charged with homicide, the offender may not have even killed the offended party. Plainly then, homicide is not the appropriate charge.

If the rape victim does not die, the charge of frustrated homicide may be brought. There exists a frustrated felony "when the offender performs all acts of execution which would produce the felony as a consequence but which, nevertheless, do not produce it by reason of causes independent of the will of the perpetrator."[79] But even if the death of the victim is not an element of the crime, there is still a requirement of actual purpose to kill. In the case of consummated homicide, intent to kill is presumed; in frustrated homicide, however, it is not. Intent is a state of mind which is difficult to prove. It is difficult to imagine an offender proclaiming that he intends to kill his rape victim through AIDS. Likewise, the definition requires that the act committed would have produced the felony charged but did not for causes beyond the offender's control.

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[78] REYES, *supra* note 72, at 82.

[79] Revised Penal Code, art. 6.

There have been several American cases[80] involving biting and spitting where the offenders announced the fact that they have HIV and that they wished their victims to die. Although these cases do not involve rape, they are instructive because they show the tendency of courts to convict those charged of attempted murder even though the acts committed by them are not likely to transmit the virus.

In *Curtis Weeks v. State of Texas*[81] the convict Weeks was being transferred to another prison when he suddenly went wild and refused to be restrained. Once restrained, he screamed at the guard, saying that he was HIV-4 and that he was "going to take someone with him when he went."[82] He spat twice in the face of his guard. During the trial, Dr. Mark Dowell was asked whether the virus could be transmitted through saliva on a "one-shot deal." He answered that the possibility is low but certainly not zero."[83] Convicted of attempted murder and sentenced to 99 years in prison for spitting at a correctional officer, Weeks appealed. The Eleventh Court of Appeals of Eastland, Texas affirmed the trial court's decision.

In *State v. Smith*[84] a New Jersey inmate bit a prison officer and shouted "now die." He was sentenced to 20 years in prison for attempted murder and an additional 5 years for aggravated assault.

The opposite view was taken by the appellate court in *Brock v. State.* The Alabama Court of Criminal Appeals reversed the a first-degree assault conviction, saying that the prosecution had failed to "prove that the [HIV-positive] defendant used his mouth and teeth under circumstances highly capable of causing death or physical injury."[85]

It may be observed that the courts tend to render guilty verdicts and stiff sentences notwithstanding the lack of definitive proof that biting and spitting can actually transmit the virus. To be sure, inmates cannot be permitted to threaten law enforces with impunity. Ideally, however, such minor offenses as biting and spitting should be treated the same way as they were before AIDS.[86]

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[80] Even though these U.S. cases all involve "attempted murder," they seem to satisfy the elements of frustrated homicide under our Revised Penal code at least at first glance.

[81] Weeks v. Texas, *reported in* AIDS Litigation Reporter, Vol. 4, Update 3-1993, p. 125 (1992); Texas v. Weeks, 58 U.S.L.W. 2343 (Tex. Dist. Ct. 4 Nov. 1989).

[82] *Id.* at 125.

[83] *Id.* at 126.

[84] Dalton, *supra* note 76, at 243.

[85] *Id.* Brock v. State, 555 So. 2d 285 (Ala. Ct. App. 1989), aff'd. 580 So. 2d 1390 (Ala. 1991).

[86] *Id.* at 243, 249.

In *State of Indiana v. Donald J. Haines*[87] two police officers found Haines lying on the floor in a pool of his own blood. As they approached to help him, he screamed that he had AIDS and should be left to die. Not heeding his call, Haines told Officer Dennis that he would "use his wounds" and began jerking his arms at Dennis, causing blood to spray into the latter's mouth and eyes. Haines struggled with two emergency medical technicians, threatening to infect them with AIDS and spitting at them. Haines was charged with three counts of attempted murder. Initially, the trial court convicted him of all three charges but later on, the trial judge vacated the jury's judgements and entered judgements of conviction as to three counts of battery. In vacating the jury's judgements, the judge said:

> "Looking at the evidence in this case ... I find that the State failed in its burden of establishing ... that spitting, biting, or throwing blood at the victims is a method of transmitting AIDS or ARC. So, there's absolutely no evidence linking those factors which I consider to be essential to the State's burden of proving a substantial step in the case. It is my decision today to correct that error."[88]

The State appealed. The appellate court reinstated the attempted murder convictions, stating that under the Indiana attempt statute, when the defendant has done all that he *believes* necessary to cause the intended result, irrespective of whether it is in fact possible, he has committed an attempt.

Applying our own criminal law statute, it is likely that this "impossibility" defense would be upheld, resulting in an acquittal from the attempted rape charge. An impossible crime is one which "... would be an offense against persons or property, were it not for the inherent impossibility of its accomplishment or *on account of the employment of inadequate or ineffectual means.*"[89]

While it cannot be said that it is inherently impossible that biting, spitting, or throwing blood at one's victims would result in their seroconversion and eventual death, it may well be said that such acts would constitute ineffectual means. This must be differentiated from a frustrated felony where the means employed are in fact effectual.

If we are to recall how minute the chances are that a woman would seroconvert as a result of being raped, and dying as a consequence thereof, it can be concluded then that even a frustrated felony charge will not be appropriate for penalizing sex offenders with AIDS.

[87] State v. Haines, 545 N.E. 2d 834 (Ind. Ct. App. 1989), *reported in* AIDS Litigation Reporter, Vol. 4, Update 3-1993, p. 68.

[88] State v. Haines, 545 N.E. 2d 834 (Ind. Ct. App. 1989), *reported in* AIDS Litigation Reporter, Vol. 4, Update 3-1993, p. 68. (emphasis supplied)

[89] Revised Penal Code, art. 4.

B. Rape with Homicide as a Complex Crime: The Case of People v. *Acosta*

It was earlier mentioned that the spirit behind the law which made rape attended with AIDS a capital crime could be that the legislators had equated this with the crime of rape with homicide. Although a mere assumption, this is actually supported by jurisprudence.

In 1934, the Supreme Court rendered its decision on a case entitled *The People of the Philippine Islands v. Marcelino Acosta y Rivera.*[90] In this case, the defendant Acosta succeeded in having sexual intercourse with a fourteen year old virgin by threatening to kill her with a penknife. On that occasion, the defendant was suffering from gonorrhea. He infected the victim, who, three months later died of peritonitis, a complication of gonorrhea. The Court of Appeals found him guilty of two separate crimes of rape and homicide and passed sentence for both. On appeal by the defendant, the Supreme Court passed upon the legal question of whether the crimes of rape and homicide should be considered as independent crimes, or as the complex crime of rape with homicide. The Supreme Court ruled that the crimes should be treated as a complex crime, applying Article 48 of the Revised Penal Code, as amended by Act No. 4000, which reads:

> "ART. 48. *Penalty for complex crimes. - When a single act constitutes two or more grave or less grave felonies,* ... the same to be applied in its maximum period."[91] *(emphasis supplied)*

The Court ruled that: "[t]aking into consideration the weight of the evidence and *the fact that both crimes, rape and homicide, were but the result of a single act, which is the sexual intercourse, ... such acts should be held as constituting the complex crime of rape with homicide...*"[92]

At the outset, it must be noted that the ruling in this case had already been made inapplicable by the enactment of Republic Act No. 2632, making rape with homicide a special complex crime under Article 335 of the Revised Penal Code. (See *Rape with Homicide as a Special Complex Crime.*) However, the possibility of reviving the doctrine of *People vs. Acosta* is still worth examining if we are to determine the most appropriate manner of punishing sex offenders with AIDS.

One observation that may be made with respect to the ruling in this case is that it is based on the appreciation of the evidence for the prosecution. The evidence consisted of the testimonies of two doctors: the first, Dr. Pariño, examined the victim

[90] People v. Acosta, 60 Phil. 158 (1934).

[91] Revised Penal Code, art. 48.

[92] Acosta, 60 Phil. at 161. (emphasis supplied)

and diagnosed that she had been raped as well as her having gonorrhea; the second, Dr. Calderon categorically declared that the victim died of peritonitis caused by the gonorrhea. There is likewise the *ante mortem* statement of the victim, reiterating that the defendant raped her and that he infected her with the disease.

The Court ruled that the prosecution's evidence was convincing. It found that the rape and the homicide resulted from a single act. As to the evidence it relied upon to support its conclusion, the Court said:

> "There is not the least doubt but that the defendant abused the unfortunate girl, as alleged. *Neither is there any doubt that her death was caused by the sexual intercourse which he had against the will of the offended party,* although the immediate cause thereof ... was the peritonitis which, in that case, was but a mere complication of the gonorrhœa from which the patient was suffering."[93]

The language used by the Supreme Court is revealing. It speaks of the indubitability of the causal connection between the rape, the infection, and the resulting death of the victim. Indeed, the Court could not have ruled otherwise for the surrounding facts simply confirm their stance. It is useful to recall the requisites earlier averted to with respect to establishing whether death may be presumed to be the natural consequence of the physical injuries inflicted. They are:

> "1. That the victim at the time the physical injuries were inflicted was in normal health.
> "2. That the death may be expected from the physical injuries inflicted.
> "3. That death ensued within a reasonable time."[94]

First and foremost, the victim was a virgin when she was raped. Gonorrhea, being as it is a sexually transmissible disease, could not have been acquired in any manner other than through the sexual intercourse between the defendant and his victim. It cannot therefore be doubted that prior to the rape, the victim was not suffering from gonorrhea. This fact therefore satisfies the first requisite, namely, that the victim the time the injuries were inflicted was in normal health. It also satisfies the second requisite that the death may be expected from the physical injuries inflicted, since the facts bear out that the victim died of a disease which was a complication of gonorrhea. The third requisite is likewise satisfied, since the victim died three months after the attack — a reasonable time.

Can the same things be said for a death resulting from an AIDS infection consequent to the rape? An examination of the concurrence of the three requisites is in order.

[93] Acosta, 60 Phil. at 161. (emphasis supplied)

[94] Reyes, *supra* note 78, at 80.

First, in order to determine whether the rape victim enjoyed "normal health," there would be a need to determine if she was herself HIV-positive. As was noted earlier, this would involve an investigation into her history with respect to sexual practices, drug use, blood transfusions, and other risk factors, consequently amounting to a serious invasion of the woman's privacy.

Second, there arises a problem with respect to proving whether the victim's death came as a consequence of her rape. It must first be established that if indeed the victim enjoyed normal health, that the rapist was HIV-positive. That would involve a mandatory testing of the sex offender, the wisdom of which is is open to question.

Next, it must be proven that after the exposure, transmission to and infection of the woman followed. This is not as easy as in the case of gonorrhea. The transmission rate of *Neisseria gonorrhea* after a single sexual exposure is fifty *per centum* (50%) for a woman (and 22% to 25% for a man).[95] Its incubation period is 2 to 7 days.[96] It is also readily diagnosed by staining a smear of vaginal discharge to reveal the the bacteria.[97] With AIDS it is different. The transmission rate after a single instance of sexual exposure is from a high of 1 : 1,000 to a low of 1 : 500. The window period for the development of antibodies is anywhere from three weeks to six months. And as may recalled, AIDS testing is inherently inexact, receiving results which could turn out to be false positives or false negatives.

Finally, it must be established that the victim died of a secondary infection which she could not have fought off because she had AIDS. But since the time within which a patient dies of the syndrome, if at all, is five to ten years from exposure, such length of time is likely to produce doubt as to whether she really died of an AIDS-related infection that can be directly traced to the rape and to no other high-risk behavior prior to or after the rape. This would necessitate constant monitoring which is not only administratively impracticable but highly intrusive.

This is not to say that the ruling in *People v. Acosta* is erroneous. In fact, the conclusions arrived at by the court were quite inescapable. It cannot, however, be applied to rape with AIDS. While both AIDS and gonorrhea are sexually transmissible diseases, the risks involved in sexual transmission are very different. *People v. Acosta* should not therefore be made to apply because upon further investigation, the situations are really not the same.

C. Rape with Homicide as a Special Complex Crime

People vs. Acosta, which applied Article 48 of the Revised Penal Code, was decided in 1934. On 18 June 1960, Republic Act No. 2632 was approved, amending Article 335

[95] Gostin, *supra* note 38, at 1021, *citing* Peterman & Curran, *Sexual Transmission of Human Immunodeficiency Virus*, 256 J. OF THE AM. MED. ASS'N 55 (1988).

[96] "Gonorrhea," 1994 MICROSOFT ENCARTA.

[97] *Id.*

of the Revised Penal Code with respect to how rape is committed. Among its amendments was the following:

"When *by reason* or *on the occasion of the rape,* a homicide is committed the penalty shall be *reclusion perpetua* to death."[98]

On 20 June 1964, Republic Act. No 4111 was approved thereby increasing the penalty of rape with homicide to death.[99] The effect of the enactment of these laws is to make rape with homicide a special complex crime under Article 335 of the Revised Penal Code; thus, it is no longer covered by Article 48. Therefore, the ruling in *People v. Acosta* is no longer controlling.[100]

Yet it seems that *People v. Acosta* has not entirely been discarded. Justice Luis B. Reyes, commenting on the special complex crime under Article 335, says that "[a]nother illustration of rape with homicide is where the rapist, who was suffering from gonorrhea, infected the victim who died as a result."[101] Justice Ramon C. Aquino likewise uses this as an example.[102]

Both authors state that rape with homicide is a variant of rape similar to the special complex crimes of robbery with homicide and rape defined in Articles 294 and 297. As to the meaning of the phrases "on the occasion" and "by reason" of the robbery, both authors cite the case of *People of the Philippines v. Agustin Mangulabnan, et al.* The case states that the English version of the Revised Penal Code is a poor translation of the prevailing Spanish text which reads:

> "1. Con la pena de reclusion perpétua a muerte, cuando con motivo o con ocasion del robo *resultare* homicidio."[103]

The Supreme Court ruled that "in order to determine the existence of the crime of robbery with homicide *it is enough that a homicide would result by reason or on the occasion of the robbery.*"[104] Applying this ruling to the case of rape with homicide, it thus suffices that *death would result from the rape.* This would again bring up the question of causality. Was the rape victim's death caused by the rape? Was the rape victim infected as a consequence of the rape? Did this infection cause her death?

[98] Republic Act No. 2632, § 1. (emphasis supplied)

[99] Republic Act. No. 4111, § 1.

[100] REYES, *supra* note 72, at 638.

[101] REYES, *supra* note 70, at 781.

[102] Ramon C. Aquino, 3 THE REVISED PENAL CODE, 407 (1988).

[103] Revised Penal Code , art. 294 (1), *cited in* People v. Mangulabnan, 99 Phil 993, at 999 (1956).

[104] Mangulabnan, 99 Phil. 999. (emphasis supplied)

D. "Aggravated" Rape

An alternative way of interpreting the provision on rape with AIDS is that it was made into a capital crime for the purpose of punishing the offender, who knowing that he was infected with a sexually transmissible and fatal disease, was perverse enough to continue with his sinister plan of violating an unwilling woman. One possibility therefore of applying traditional criminal statutes to rape with AIDS is to use the circumstance of knowing that one has AIDS as an aggravating circumstance, and thus to increase the penalty for rape. This has, in fact, been done by at least two United States courts.

In *State of Oregon v. Joseph Arthur Guayante* (1989)[105] the accused was appealing his conviction by the Circuit Court of Lane County to the Court of Appeals of the State of Oregon. The trial court convicted him of 1 count of sexual abuse and 2 counts each of attempted rape and sodomy. It sentenced him to 1 year on the sexual abuse conviction to be served concurrently with 10 years on the first sodomy count, followed by 5 years for the first attempted rape, followed by 10 years on the second sodomy count, followed by 5 years for the second attempted rape, for a total of 30 years.

Before imposing sentence, the trial judge spoke the following words:

> "THE COURT: Let me ask you, do you have AIDS?
> "[DEFENDANT]: Yes, I do.
> "THE COURT: Did you know it when you were doing it with this little girl?
> "[DEFENDANT]: Yes, I did.
> "THE COURT: ... [y]ou know that you carry in your body one of the most deadly and dangerous diseases to hit the earth since the 13th Century.
>
> *"This is a crime that approaches attempted murder, whether or not you are charged with it.* It's about the ... most reprehensible behavior I can imagine, to put an innocent girl, ... in danger of her life, in a circumstance in which she could have a prolonged illness and suffer for years, and die one of the most horrible deaths possible.
>
> *"The Court takes notice of the AIDS epidemic. The Court takes notice of the way people are dying of AIDS. ... It's horrible and you've done something terrible, and you're going to the penitentiary for a substantial period of time as a result of your actions."*[106]

On appeal to the Court of Appeals, the accused assigns as error the imposition of consecutive sentences. It is his contention that the trial court erred in considering an improper aggravating circumstance in imposing consecutive sentences. He argues that the court acted without statutory authority by imposing disproportionately harsh

[105] State v. Guayante. (1989), *reported in* AIDS Litigation Reporter, Vol. 4 , Update 3-1993, p. 77.

[106] *Id.* (emphasis supplied)

sentences to punish his *status* as a person with AIDS, and thereby violating the prohibition in the Oregon Constitution against cruel and unjust punishment.

The issue presented by the assignment of error is "whether placing a sexual assault victim at risk of contracting ... (AIDS) is an aggravating factor that the trial court may appropriately consider in imposing maximum consecutive sentences."[107] The Court of Appeals ruled in the affirmative. The court found the argument of the accused that he was being punished for his status of being an AIDS carrier untenable. It ruled:

> "The trial court did not impose the sentences because defendant *has* AIDS. Rather, the colloquy makes clear that *the aggravating factor that the court weighed was defendant's knowledge that he had a sexually transmitted disease when he committed the crimes and his willingness nonetheless to expose the 13-year old victim to an incurable fatal disease.*"[108]

The Court of Appeals concluded by saying a court has broad powers and discretion in the imposition of sentence and in weighing the aggravating and mitigating circumstances, and that in the present case, the trial court did not abuse its discretion.

In *Wilford Cooper v. State of Florida* (1989),[109] Cooper was charged with 2 counts of sexual battery of a child between the ages of twelve and eighteen while in a position of familial or custodial authority, 1 count of soliciting a child twelve years of age or older but less than eighteen to engage in sexual activity while in a position of familial or custodial authority, and 1 count of aggravated battery. All counts involved the same seventeen year old victim. He was tried by a jury and found guilty of all 4 counts of the information. Four days prior to the trial, the results of an AIDS test revealed that Cooper was HIV-positive. The jury was not informed of this fact.

The Circuit Court for Leon County sentenced Cooper to concurrent terms of 30 years on each of the 2 counts of sexual battery, followed by 5 years on the solicitation count, followed by a consecutive 10-year term of probation on the aggravated battery count. In departing from the recommended guideline sentence of 12 to 17 years, the trial court gave, among others, the following reason:

> "3. The offenses of sexual battery were committed by the defendant *with total disregard of the high likelihood that the defendant had been exposed to the aids virus and that by sexual contact with his victim there was a strong likelihood that, the victim would be subjected to the dreaded disease. Such reckless disregard for the physical illness and emotional trauma which would likely result to the victim*, confirmed by the fact that the defendant has now been tested positive for AIDS, is a clear and convincing reason for departures from a guideline sentence."[110]

[107] *Id.* at p. 78.

[108] *Id.* at p. 79 (emphasis supplied)

[109] Cooper v. Florida, *reported in* AIDS Litigation Reporter, Vol. 4 , Update 3-1993, p. 43 (1989).

Cooper appeals his sentences for sexual battery, solicitation, and aggravated battery on the ground that they exceed the sentencing guideline recommendation, contending that the trial court's reasons for departing from the recommended guideline sentence are not valid, clear, and convincing.

The District Court of Appeals of the First District of Florida disagrees with Cooper's contention and affirms the trial court's decision. The appellate court said in its majority opinion:

> "We ... agree with the trial court that the third reason for departure is a valid, clear and convincing reason. Because of his life-style, Cooper knew or should have known that he had been exposed to the AIDS virus and that by sexual battery upon his victim there was a strong likelihood that the victim would be exposed to AIDS. Prior to the sentencing Cooper tested positive for AIDS and the sexual assaults may result in the victim contracting the deadly disease."[111]

Judge Shivers dissents from the majority opinion of Judge Thompson and Booth. He believes that the third reason for departure is invalid. At the sentencing hearing, the trial court commented that "this defendant, *having been an admitted homosexual for years, knew or should have known the likelihood of his having AIDS as a result of these homosexual contacts* ..."[112] Judge Shivers reasons out that the only evidence in the record regarding Cooper's knowledge of his affliction is his statement to the court made prior to jury selection, that he was told "on Friday" that he had tested positive for HIV. The record contains no evidence to support the trial court's comment that Cooper "knew or should have known" that he has AIDS based merely on his having been a homosexual for years.[113]

The difference between these two American cases is clear: while in *State of Oregon v. Guayante,* it was admitted by the accused that he knew, at the time he committed the sexual assault that he had AIDS, in *Florida v. Cooper,* the accused found out about his seropositivity *after* he committed the sexual assaults — in fact, after he was arrested and indicted. Herein lies the difficulty with respect to making the circumstance of knowing that one has AIDS in the commission of rape: it is subject to liberal or even loose interpretation and, consequently, to abuse.

What degree of knowledge is required so that a sex offender can be said to have "known" that he has AIDS? Is a mere hunch sufficient? Is it enough that he exhibits

[110] Cooper v. Florida, *reported in* AIDS Litigation Reporter, Vol. 4, Update 3-1993, p 43 (1989), *emphasis supplied.*

[111] *Id.* at 46.

[112] *Id.* at 47.

[113] *Id.*

symptoms? Is it enough that he is a practicing homosexual or an IV drug abuses who shares needles? It doesn't seems so. As was earlier stated (See *Part 2: A Critique of the Present Law*) the knowledge most consistent with justice is knowledge of affliction resulting from an AIDS test. In *Oregon v. Guayante,* there was no mention at all of an AIDS test. The defendant made a judicial admission of his having knowledge of his affliction when he committed the crime. There is no indication, however, as to exactly how he acquired knowledge of his condition. He may or may not have known this from tests.

In *Cooper v. Florida,* the defendant committed the sexual assaults before he had the benefit of knowing of his physical condition from an AIDS test. He cannot therefore be said to have known that he had AIDS. Yet the Court ruled that *by the mere fact that he was a homosexual, he knew or should have known that he would have AIDS.* Reading between the lines, it seems that, as was contended by the accused in *Oregon, the accused in Cooper was punished for his status of being a person with AIDS.* Mere membership in a high-risk group seems to be the threshold of required knowledge. It charges the defendant of knowledge of affliction which would later be used to aggravate his crime if he commits any sex offense. *Florida v. Cooper* sets a dangerous precedent.

When AIDS first came to the fore, it became known as the disease of "those people" — the homosexuals. In fact, the U.S. doctors and researchers who initially studied AIDS and who were perhaps neither prejudiced nor judgemental called it "GRIDS" for Gay-Related Immune Deficiency Syndrome. Even the gay press called the disease "gay cancer" or "gay pneumonia". There is thus an undeniable tendency to equate AIDS with homosexuality. Lately IV drug users have joined gays in the AIDS equation. While it is true that the high-risk groups of the United States are homosexual/bisexual men and IV drug abusers, still, mere membership in these two high-risk groups cannot be taken as synonymous with HIV infection. Seroprevalence is at five *per centum* (5%); only one in twenty of the members of these two groups will be HIV-positive.

To say therefore, as the trial court in *Cooper* did, that a defendant "knew or should have known of the likelihood of his having AIDS as a result of ... homosexual contacts"[114] is a grave injustice. The effect would be a status-based conviction, not one based on definitive knowledge that one is engaging in risky behavior. This fosters judicial prejudice towards members of society who are already marginalized, if not outrightly persecuted as in the case of gays.[115] What guarantee can we give an accused that a judge will not lower the threshold of required knowledge even more to, let's say, experiencing a symptom like loss of appetite? Unless it can be assured that courts

[114] Cooper v. Florida, *reported in* AIDS Litigation Reporter, Vol. 4, Update 3-1993, 43, at 47 (1989).

[115] It is rather unfortunate that ours is not a liberal society. The sad fact is that there is no general tolerance — much less, acceptance — of people who are different. And although judges are expected to be persons who are far wiser than we and immune to the follies of prejudice, it seems too optimistic to hope that they be men and women ahead of their time, at least as far as our culture is concerned.

will strictly construe "knowledge" of affliction as coming from results from both ELISA and Western Blot tests, the knowledge should not be used to aggravate the crime of rape.

E. Some Final Observations and United States v. Moore

In *United States of America v. James Vernell Moore* (1988),[116] prisoner Moore, after testing positive for HIV, bit two correctional officers during a struggle. He was charged with 2 counts of assault with a deadly and dangerous weapon. At the trial, Dr. Clifford Gastineau testified that the medical profession knows of no well-proven instances in which a human bite has resulted in transmission of the virus to the bitten person. He agreed with a medical manual offered in evidence that stated there was no evidence that AIDS can be transmitted through any contact that does not involve the exchange of body fluids and that, while the virus has appeared in minute amounts in saliva it has never been shown to have spread through contact with saliva. But he likewise testified that apart from the matter of AIDS, a human bite can be dangerous; in fact, much more dangerous than a dog bite, saying that there are 30 to 50 varieties of germs in the human mouth which, acting in concert, could cause serious infection.

The District Court of Minnesota convicted Moore. He appeals to the U.S. Court of Appeals. On appeal, he claims that there was insufficient evidence to sustain the finding that Moore's mouth and teeth were a deadly and dangerous weapon. He likewise claims that the trial court was in error when it refused to instruct the jury that if the government failed to prove that AIDS can be transmitted by means of a bite, it would have failed to prove that his teeth and mouth were deadly and dangerous weapons.

The Court of Appeals affirmed the trial court's decision. To the issue of whether teeth and the human mouth are deadly and dangerous weapons, the court said:

> "[T]he object need not be inherently dangerous, or a 'weapon' by definition ... Courts frequently have considered various objects to be deadly and dangerous, including ... normally innocuous objects ... In short, what constitutes a dangerous weapon depends not on the nature of the object itself but on its capacity, given the manner of its use, to endanger life or inflict great bodily harm. Courts have held that in appropriate circumstances a part of the body may be a dangerous weapon."[117]

As to whether AIDS may be transmitted through biting, the court held:

> "... Moore [may not have] transmitted any of the 30 to 50 varieties of germs he might have transmitted to the officers. He nevertheless used his mouth and

[116] US v. Moore, 846 F. 2d 1163 (8th Cir 1988), *reported in* AIDS Litigation Reporter, Vol. 4 , Update 3-1993, p.7.

[117] Moore, 846 F. 2d 1163, at 10.

teeth in a way that *could* have transmitted disease. It was only a fortuity that he did not do so ... *Since a human bite has the capacity to inflict serious bodily harm, we hold that the human mouth and teeth are a deadly an dangerous weapon in circumstances like those in the instant case, even if the harm actually inflicted was not severe ... Moore's mouth and teeth were used as a deadly and dangerous weapon, even if Moore was not infected with AIDS."*[118] (emphasis supplied)

The Court of Appeals upheld the aggravated assault charge against Moore on the questionable proposition that his teeth constituted a deadly weapon apart from his HIV infection. In so doing, the court failed to treat seriously the probability that absent the defendant's infection, the charge of assault with a deadly weapon would not have been lodged.[119] It cannot seriously be claimed that Moore's seropositivity had nothing to do with his conviction for aggravated assault for committing such a microaggression as biting his prison guard.

"Issues related to AIDS are highly inflammatory. On the one hand, jurors may feel sympathy for a defendant with AIDS under certain circumstances. On the other hand, polls have shown that irrational fear of persons with AIDS is widespread."[120] It seems that the fact that a defendant has HIV makes prosecutors fearful and thus they proffer trumped up charges for acts which would otherwise constitute minor offenses. This is a misguided practice. The aggravated assault charge in *US v. Moore* "has more to do with misbelief and prejudice than any clearly thought out position on culpability or degree of danger involved."[121]

The cases discussed under this chapter demonstrate how the fact that a defendant has AIDS affects the judgment of the court. Courts lay down rather lengthy prison sentences for behaviors which according to medical authorities are not likely to transmit the virus. Courts punish defendants based on their status as persons with AIDS.

Apart from this, it may be observed that traditional crimes are inappropriate for punishing behavior which puts others at susbstantial risk, particularly rape. There are serious problems of proving causality — that a specific act led to the infection of the victim. Proving criminal intent is also a problem. Then of course, there is the matter of establishing whether a certain type of behavior — in this case, rape — is really likely to transmit the virus, infect the victim, and consequently cause her death.[122]

[118] Moore, 846 F. 2d 1163.

[119] Dalton, *supra* note 76, at 243.

[120] Paul Albert, Cynthia Stewart, & Mark Vermeulen, *Criminal Law and Procedure*, AIDS PRACTICE MANUAL: A LEGAL AND EDUCATIONAL GUIDE, Second Ed., 1, 3 (1988).

[121] Gostin, *supra* note 38, at 1050.

[122] Donald H.J. Hermann, *AIDS and the Law*, AIDS & ETHICS, 277, 296 (1991).

In response to the inadequacies of the traditional criminal law in punishing risky behavior, U.S. state legislatures have enacted or proposed legislation specific to HIV. This shall be discussed in the following chapter.

IV. CREATING AN AIDS-SPECIFIC STATUTE

The Revised Penal Code was not drafted and enacted with AIDS, or any other communicable disease, in mind. In 1932, no one could have foreseen the coming of such a puzzling disease as AIDS. The Revised Penal Code therefore provides little guidance to prosecutors and judges as to what constitutes HIV-related criminal behavior. The use of traditional penal law "imperils the accused's due process right to fair notice of what the law commands."[123] Added to this, there are serious problems with respect to proving harm, causality, and intent.

Many central questions are left unanswered. If the rape victim had full knowledge of the offender's affliction, should that constitute a defense? If the offender merely thought that he was an AIDS carrier but did not know for sure because he had not been tested, should he be guilty of any felony? If an offender intends to harm his victim but the victim never becomes infected, should the offender be punished?[124] An AIDS-specific statute[125] could explicitly resolve these important issues. We must therefore consider some helpful guidelines in the enactment of such a statute.

A. Advantages and Disadvantages of HIV-Specific Statutes

Unlike traditional penal statutes, *HIV-specific statutes require no proof of harm, causality, or criminal intent. It is enough that an offender engages in prohibited behavior.* The explicit inclusion of omission to inform makes it clear that people who are HIV-positive are not expected to be chaste; they need only be responsible. Therefore, sex with a consenting partner does not violate the law.[126]

In addition to these, there are two important advantages of AIDS-specific laws over traditional penal laws, namely: (i) *they convey clear warning to defendants of what constitutes a crime;* and (ii) *they focus on real risks*, like sexual intercourse and needle sharing, instead of biting and spitting.[127] The effect of this is that the responsibility of

[123] Dalton, *supra* note 76, at 250.

[124] Kathleen M. Sullivan & Martha A. Field, *AIDS and the Coercive Power of the State*, 23 HARVARD CIVIL RIGHTS-CIVIL LIBERTIES LAW REVIEW 139, 172 (1988) [hereinafter cited as Sullivan & Field].

[125] Typically, the HIV-specific statutes enacted by U.S. state legislatures are composed of three elements, namely: (i) that the accused had knowledge that he or she is HIV-positive ; (ii) that a prohibited act is committed; and (iii) that the accused failed to inform his or her partner (in sex or needle-sharing) of his/her HIV-status.

[126] Dalton, *supra* note 76, at 251.

[127] Sullivan & Field, *supra* note 124, at 172; Dalton, *supra* note 76, at 251.

defining a crime would rest with the legislators (as it should be) and not with individual prosecutors.

To be sure, AIDS-specific statutes that have been enacted are not without their failings. There are a few that focus mainly on prostitutes without any basis for concluding that they are disproportionately likely to transmit HIV.[128] Some are underinclusive in that they regulate unsafe sex but not unsafe drug use.[129] Some are overinclusive in that they fail to distinguish between sexual conduct likely to transmit HIV from conduct that poses little risk.[130] However, these inadequacies may be solved by careful and thoughtful legislation.

There are those, however, who argue against the enactment of HIV-specific criminal sanctions on more serious grounds. First, criminal statutes outlawing private consensual activity (like sodomy statutes) have not proven to be particularly effective from the standpoint of deterrence. Second, these statutes may be of little practical use in halting the spread of the virus and may even divert the legislature's attention from implementing the more effective measures of individual counseling and mass public education. Third, these statues would have a tremendous invasive impact on the right to privacy not only of the HIV-carrier, but of his or her partner as well. And fourth, there is always the danger that the law be selectively applied to harass persons based on their sexual orientation, or be used oppressively to punish those whom society perceives as having questionable morals.[131]

B. What Behavior should the Statute Eencourage or Discourage?

Before the AIDS-specific statute is drafted, one must consider first how we expect a person with AIDS to act. The answer to this question would involve the balancing of public with private interests.

At one extreme, is the so-called "total-abstinence view".[132] One could argue that people who are HIV-positive should abstain altogether from behavior which poses any risk of transmitting the virus to others. Under this view, having sexual intercourse while knowing that one is seropositive would be a crime no matter how completely one disclosed one's condition and no matter how much precaution one took. Under the total-abstinence view the public interest in stopping the spread of AIDS would simply outweigh any right of the individual to engage in sexual activity.

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[128] Dalton, *supra* note 76, at 251, *citing* as an example Ga. Code Ann. § 16-5-60(c) (Harrison Supp. 1989).

[129] *Id. citing as an example* Ill. Ann. Stat. ch. 38, para. 12-16.2 (Smith-Hurd Supp. 1990).

[130] *Id.*

[131] American Bar Association, AIDS: THE LEGAL ISSUES (DISCUSSION DRAFT OF THE AMERICAN BAR ASSOCIATION AIDS COORDINATING COMMITTEE, p. 28 (1988).

[132] Sullivan & Field, *supra* note 124, at 186.

At the opposite extreme is the so-called "total-permissiveness approach"[133] where it is argued that making decisions as to what risks one undertakes should be an entirely private matter. This view clearly values the individual interest in pursuing sexual intimacy over the public interest of stopping the spread of AIDS. Consent and precautions would be matters for individuals to decide on and not for the government to prescribe. The only AIDS transmission this view might regard as criminal is that involving an unwitting victim, i.e. one who lacked an informed choice because his partner did not disclose his condition. But even then, the total-permissiveness approach might regard such victim as having assumed the risk by having engaged in sex in the first place. (Of course, if the unwitting victim was also unwilling in that she was raped, such a defense could not be invoked.)

These two extremes are too simplistic and quite unacceptable. The total-abstinence view overestimates the effectiveness of criminal law and undervalues the individual interest in reproductive freedom. The policy is also unrealistic and inhumane because it expects HIV-positives to give up sexual intercourse for the rest of their lives.[134] On the other hand, the total-permissiveness approach wrongly minimizes the public interest in stopping the spread of the virus. It is not clear that individuals should always be permitted to endanger themselves as they deem fit. Different persons may assess the risks involved differently and, oftentimes, not so intelligently. There is a strong public interest in containing the virus; consequently the state has an interest in protecting even a consenting victim in order to protect that victim's future partners.[135]

The more appropriate policy would recognize both the individual's right to sexual intimacy as well as the public interest in protecting the uninfected and stopping the spread of the virus. This middle ground would permit sex but would also encourage (or more precisely, mandate) disclosure and precautions. It would warn persons with AIDS that their sexual activities will be punishable if they do not disclose their condition to their partners and do not use precautions.[136]

C. Two Approaches to Structuring An A.I.D.S.- Specific Statute

There are two basic approaches to criminalizing AIDS transmission, namely: (i) Classical Culpability; and (ii) Affirmative Duty.

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[133] *Id.* at 175

[134] *Id.*

[135] *Id.*

[136] *Id.*

1. THE CLASSICAL CULPABILITY APPROACH

This approach would criminalize the act of AIDS transmission by any means so long as it was accompanied by the requisite state of mind. The advantage of this approach is that it focuses on acts, not on persons, and would thus apply to all instead of singling out persons with AIDS. The difficulty of this approach is defining a requisite state of mind that is practical and fair. As was discussed in *Part 3* on *Consummated or Frustrated Homicide*, the requisite intent to kill would be difficult to prove. Such must necessarily be inferred from the actions of the offender. We have learned that in cases of frustrated homicide, the offender's intent to kill may be deduced from the weapon used. What then would be the weapon used by our HIV-positive assailant? AIDS? This is quite a stretch of the meaning of the word "weapon"!

This approach would also give far too much discretion to the judge. Popular anxiety, irrationality, and hysteria about AIDS are far too likely to cause vindictive or discriminatory verdicts. Moreover, even the most rational judge would be confused with the ever-evolving scientific understanding about the nature of AIDS and its transmission. As can be seen in the U.S. cases, where science is uncertain, courts may wish to impose very strict norms of conduct.[137]

2. THE AFFIRMATIVE DUTY APPROACH

The problems of the Classical Culpability approach may be avoided by enacting instead a criminal law geared less to punishing culpable acts than to imposing affirmative duties of disclosure and precaution on persons who are HIV-positive. When these duties are specified, there is less room for judicial discretion for determining the offender's state of mind.

Such a law might punish AIDS transmission if the following requisites concur: (i) *that he actually knew from testing or diagnosis that he is seropositive; and* (ii) *that he failed to disclose this condition to his partner or failed to use appropriate precautions.* In other words, only the combination of disclosure *and* precautions could suffice as a defense. This proposed law would require knowledge that one is HIV-positive, but nothing more except an act of transmission without disclosure or precautions. In this sense, this approach imposes a kind of strict liability, like the liability imposed on common carriers.

Though strict, this method is not unfair. First of all, the requirement of knowledge ensures that it is not mere ignorance which is punished. Second, it respects the right of people to engage in sexual intercourse, but imposes upon them the duty to act responsibly. Third, it thereby provides much clearer notice of what their obligations

[137] Martha A. Field & Kathleen M. Sullivan, *AIDS and the Criminal Law*, AIDS: THE IMPACT ON THE CRIMINAL JUSTICE SYSTEM, 111, 123.

are than in the Classic Culpability Approach. The purpose here is to mold behavior, to induce people to take care with a dangerous disease when they alone are in a position to do so.[138]

The Affirmative Duty Approach appears preferable to the Classic Culpability Approach. It more clearly imposes on seropositives an affirmative duty, as a condition precedent to engaging in risky behavior, to fully disclose their condition to their partners and to obtain their consent, and to take precautionary measures. This approach provides us with a realistic chance of influencing behavior because it permits seropositives to engage in sex provided they act responsibly.[139] But most importantly, for as long as the AIDS epidemic carries with it popular fears and prejudices, a statute enacted using the Affirmative Duty Approach would minimize the risk of convictions swayed by such fear and prejudice.

Needless to say, enacting this statute would be a most delicate undertaking as it would regulate sexual activity. If experience is any indication, any attempt by government to regulate sex will be met by the fiercest opposition from civil libertarians and the most ardent support from the Catholic Church and self-appointed guardians of morality. To be sure, it will be a police power measure; yet it must be so drafted so as not to give government the license to police our bedrooms. Some part of human activity must be kept sacred and private and hence, beyond the reach of even the long arm of the law.[140] This law must provide the narrowest restrictions on the most private of all human activities. Whatever acts the legislature may deem necessary to regulate must be clearly defined and unequivocally set forth; anything beyond this would be a matter of conscience.

3. THE PROPOSED STATUTE

An AIDS statute enacted applying the Affirmative Duty Approach may be worded as follows: *No person who has tested seropositive shall intentionally expose another to the human immunodeficiency virus (HIV) through intimate sexual contact or the sharing of hypodermic needles for intravenous drug use, unless (a) he informs his partner of his infection, who nonetheless consents to the intimate contact; and (b) he uses the appropriate precautions as required by the circumstances.*

There may also be some preliminary reference to the meaning of the words "tested" and "intimate sexual contact." The required testing refers to *both* the ELISA and Western Blot tests, for only after the confirmatory Western Blot can a patient definitely know that he or she is seropositive.

[138] Sullivan & Field, *supra* note124, at 186

[139] Sullivan & Field, *supra* note 124, at 184

[140] If the Sexual Revolution and the "Post-Sexual Revolution" have taught us anything, it is that the reproductive freedom of every person must be respected and not interfered with, for as long as such a person is a consenting adult. Of course, there is also the corollary duty of every individual to act responsibly and to be held accountable for his or her actions.

"Intimate sexual contact" must be defined as contact characterized by direct mucous membrane or bloodstream contact with a sexual partner's blood or semen. This includes the following: (a) anal intercourse with intraanal ejaculation; (b) vaginal intercourse with intravaginal ejaculation; and possibly (c) oral copulation.[141] This would exclude sexual contact which could be termed as "non-invasive," like kissing. In any event, it must be made clear that in case of multiple sex partners, the twin duties of disclosure and precautions become all the more so imperative.

V. RECOMMENDATIONS -

The ultimate goal of this thesis is to determine the most appropriate manner of punishing sex offenders who committed rape knowing themselves to be HIV-positive. How then should they be punished? Applying the Affirmative Duty Approach, anyone then who engages in risky behavior — whether it be sexual intercourse or intravenous drug use — who knows that he is seropositive and does not disclose to his partner his condition or takes precautionary measures, would be guilty of violating the AIDS statute.

Of those offenders whose risk-factor is engaging in sexual intercourse, both rapists and "non-rapists" would be included. In other words, whether the sexual intercourse was consensual or was done with force, violence, or intimidation, both sets of actors will be punished equally. This, however, seems rather unfair to those who engaged in consensual sexual intercourse. They should not be punished with equal severity as those who actually violate women. It is humbly suggested that if the person engaging some risky behavior which does not amount to rape, knew of his affliction but still pursued his high-risk activity without informing his partner, he should be held liable under the AIDS statute.

If that high-risk behavior happens to be rape, and the rapist knew of his affliction at the time of the commission of the rape, he should be made to answer under both the AIDS statute and Article 335 of the Revised Penal Code on simple rape. It seems that the duty to disclose would not even be material for even if the rapist discloses his condition to his victim, the latter is helpless to withhold consent. Precisely, she is being forced into having sexual intercourse with him. As to the alternative duty of taking precautions, even on the off chance that the rapist would wear a condom during the rape, he would still not escape liability for it is only when lack of knowledge and the use of precautions concur that the rapist would have a defense under the AIDS statute.

[141] It was said in *Part 1* that while oral sex is theoretically risky, it is considered a low-risk sexual practice in regard to HIV transmission. However, since this is one of the most common practices of homosexual as well as heterosexual intercourse, it may be wise to include the same in the definition, for the purpose of regulation.

If, on the other hand, the rapist did not know of his being seropositive, he should be held liable under the Revised Penal Code alone. His liability would be for simple rape. The victim could recover damages — actual, moral, and exemplary. The actual damages would consist of medical bills, hospital expenses, and the like. The moral damages awarded could be especially generous, considering the "... mental anguish, fright, serious anxiety, ... and similar injury"[142] brought about by knowing that one had been raped by one who is seropositive. The exemplary damages would surely be granted by the court to provide fair warning to future evildoers.

All said, this solution seems to be the most appropriate and most equitable for both the offending and the offended party.

[142] New Civil Code, art. 2217.