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Medical Advances, Criminal Disadvantages: The Tension Between Contemporary Antiretroviral Therapy and Criminal HIV Exposure Laws in the Workplace

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MEDICAL ADVANCES, CRIMINAL DISADVANTAGES: THE TENSION BETWEEN CONTEMPORARY ANTIRETROVIRAL THERAPY AND CRIMINAL HIV EXPOSURE LAWS IN THE WORKPLACE

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ABSTRACT

In 1988, the Washington Legislature classified intentionally exposing individuals to the human immunodeficiency virus (HIV) as criminal assault in the first degree. Lawmakers intended to penalize infected individuals without conditioning criminal liability on actual HIV transmission. Since 1988, however, medical technologies and effective HIV treatment have rapidly advanced. Recent studies indicate that effective antiretroviral therapy (ART) can reduce HIV transmission risks to a virtual impossibility during moments of intentional exposure.

Despite these medical advances, the 1988 exposure law remains unchanged. Consequently, individuals undergoing effective ART risk felony liability within the course of commonplace work conduct by intentionally exposing others to a virtually impossible chance of HIV transmission. This Article will begin by reviewing how outdated legislation and judicial precedent impact HIV-positive people, as well as the employers and employees implicated as victims under criminal exposure laws, by highlighting the stark contrast between the law and the

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technological advances in HIV treatment. The Article will then consider ways in which state legislatures and legal practitioners can simultaneously encourage responsible HIV treatment while honoring the utilitarian justifications underpinning criminal exposure laws.

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INTRODUCTION

HIV-positive individuals frequently risk felony liability by engaging in commonplace work conduct that poses a theoretical risk of HIV exposure. Since one manner of HIV transmission is "through direct, skin-penetrating blood exposure (e.g., needle-stick injuries, needle sharing, and transfusions)[,]"[1] employment tasks prone to expose blood put infected employees in liability limbo. Two Washington cases, *State v. Stark*[2] and *State v. Whitfield*,[3]

[1] Gunter Rieg, *HIV Infection and AIDS*, SEXUALLY TRANSMITTED DISEASES: A PRACTICAL GUIDE FOR PRIMARY CARE 99, 102 (Anita L. Nelson & JoAnn Voodward eds., 2006).

[2] 66 Wash. App. 423, 823 P.3d 109 (1992).

outline the elements required to charge an HIV-positive individual with first-degree assault based upon HIV exposure. First, the infected person must intentionally engage in an act capable of exposing another to HIV; second, that person must actually engage in the exposure-prone act.[4] Neither case, nor similar cases from other jurisdictions, identifies a limiting principle to mitigate exposure risk via safety precautions, disclosure, consent, or transmissibility risk. This per se criminal liability creates an anachronistic criminal liability scheme for infected employees, colleagues, clients, and employers.

I. HIV EXPOSURE UNDER WASHINGTON LAW

Since 1988, the Washington legislature has criminalized intentionally exposing another to HIV.[5] The law does not consider the actual likelihood of HIV transmission during common exposure-prone incidents. Under Washington's first-degree assault statute, criminal liability attaches when an HIV-positive individual "[a]dministers, exposes, or transmits to or causes to be taken by another. . . the human immunodeficiency virus. . . ."[6] Although the criminal actor must act "with intent to inflict great bodily harm[,]"[7] this mens rea requirement does not demand intentionally exposing another to HIV.[8]

The penal statutes criminalizing HIV exposure were reactions to two 1987 news stories that elicited nationwide HIV fear. First, the blood industry failed to screen for HIV infections in blood supplies, resulting in HIV infections from blood transfusions.[9]

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[3] 132 Wash. App. 878, 134 P.3d 1203 (2006).

[4] *See Stark*, 66 Wash. App. at 427 n.1, 823 P.3d at 112; *Whitfield*, 132 Wash. App. at 896, 134 P.3d at 1214.

[5] *See* Wash. F.B. Rep., S.B. 5044, 1997 Reg. Sess. (reclassifying HIV exposure as a first-degree, rather than second-degree, criminal assault); *see also* Act of Mar. 07, 1988, ch. 266, Wash. 1988 Reg. Sess. (codified as amended at WASH. REV. CODE § 9A.36.021) (classifying "expos[ure] or transmi[ssion of] human immunodeficiency virus" as second-degree assault).

[6] WASH. REV. CODE § 9A.36.011(1)(b) (1997).

[7] WASH. REV. CODE § 9A.36.011(1) (1997).

[8] *See* State v. Hahn, 174 Wash. 2d 126, 129, 271 P.3d 892, 893 (2012).

[9] *Cf.* Randy Shilts, *And the Band Played On: Politics, People, and the*

Second, Gaetan Dugas, an HIV-positive flight attendant, intentionally infected thousands of homosexual men. Mainstream media soon referred to Dugas as "Patient Zero," the primary HIV infector in many early United States HIV/AIDS cases.[10]

Proponents of criminal HIV exposure laws justify penalizing this intentional exposure-prone act, rather than intentional HIV exposure-transmission, for two reasons. First, the law deters overall HIV transmission by characterizing exposure, not transmission, as the criminal act. Second, criminal prosecution incapacitates the HIV-positive individuals most likely to intentionally expose others. Consequently, the criminal justice system progressively eliminates future HIV transmission incidents.[11]

II. EARLY EXPOSURE LAWS: INTERPRETATION AND APPLICATION

The first court to interpret Washington's 1988 criminal exposure law held that intentionally exposing sexual partners to HIV, even without the explicit intent to transmit HIV, constituted second-degree assault.[12] In *Stark*, the accused learned he was HIV-positive and received multiple counseling sessions about high-risk exposure activities.[13] Despite his diagnosis and counseling advisement, the defendant engaged in unprotected sexual intercourse with three victims.[14] The defendant failed to disclose his HIV status to the victims, and expressed disregard for his HIV-positive status to a third party, saying, "I don't care. If I'm going to die, everybody's going to die."[15]

Upholding his conviction, the Washington Court of Appeals noted that the legislature determined that HIV exposure

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AIDS Epidemic 190, 220–23 (1st ed. 2000) (chronicling the discovery of AIDS in the national blood supply and the subsequent lack of federal intervention).

[10] *Id.* at 11, 21–24; Susan Bolotin, *Slash, Burn, and Poison*, N.Y. TIMES, Apr. 13, 1997, at 8.

[11] *See* Zita Lazzarini, Sarah Bray & Scott Burris, *Evaluating the Impact of Criminal Laws on HIV Risk Behavior*, 30 J.L. MED. & ETHICS 239, 239 (2002).

[12] State v. Stark, 66 Wash. App. 423, 832 P.2d 109 (1992).

[13] *Id.* at 426–27.

[14] *Id.* at 427–28.

[15] *Id.* at 428.

"constitute[s] a serious and sometimes fatal threat to the public and individual health and welfare of the people. . . ."[16] Since the defendant knew he was HIV-positive and intentionally engaged in unsafe sex practices, he "was not forced to guess at what conduct was criminal."[17] The court held that Mr. Stark knowingly exposed others to HIV within the meaning of the second-degree assault statute.[18]

Stark provides important judicial precedent regarding present-day HIV exposure criminalization. The *Stark* court established the required mens rea for HIV exposure: knowingly committing an act *capable* of exposing another to HIV.[19] Furthermore, the accused need not intend to transmit HIV in order to commit assault; intentional exposure suffices.[20]

After *Stark*, the Washington Legislature revised its criminal code in order to classify HIV exposure as a first-degree assault felony. This revision was prompted, in part, by a legislative concern that "serial murderers. . .avoid full justice because the [second-degree assault] law is not designed for 'delayed murder' as occurs when a person intentionally spreads the human immunodeficiency virus."[21]

Employing the mens rea standards articulated in *Stark*, the Washington Court of Appeals upheld a first-degree assault conviction in *State v. Whitfield*.[22] In *Whitfield*, the appellant knew he was HIV positive, but rarely practiced safe sex during more than 1,000 sexual liaisons following his diagnosis.[23] Consequently, he transmitted HIV to at least five of his 17 sexual partners.[24] Whitfield challenged his first-degree assault conviction for HIV exposure on statutory preemption grounds, claiming that Washington's public health chapter, RCW 70.24, *specifically* regulated HIV exposure activity while the first-degree assault

[16] *Id.* at 431 (*quoting* RCW 70.24.015).
[17] *Id.* at 435.
[18] *Id.*
[19] *Id.* at 43–33.
[20] *Id.*
[21] WASH. S.B. REP. 55-5044, 1st Sess. (1997).
[22] 132 Wash. App. 878, 134 P.3d 1203 (2006).
[23] *Id.* at 883.
[24] *Id.* at 884.

statute criminalized *general* HIV exposure.[25] The public health chapter, Whitfield contended, preempted the assault statute due to the former statute's specific applicability.[26]

The Washington Court of Appeals rejected the appellant's contention that based upon the permissibility of per se HIV exposure determined in *State v. Stark*, an HIV-positive individual can violate a public health statute "without intending to inflict great bodily harm."[27] Intentionally exposing another to HIV satisfies the mens rea for first-degree assault prosecution under *Stark*, which resulted in the failure of the appellant's preemption argument.[28]

Like that of *Stark*, the *Whitfield* holding affects many HIV-positive individuals who work in conditions that are prone to exposure—that is, HIV-positive individuals working under conditions conducive to sustaining open wounds.[29] The *Whitfield* court determined that HIV exposure without transmission does not bar prosecution under Washington's first-degree assault statute.[30] Washington courts base exposure culpability solely upon the accused's *actions*, regardless of consent, disclosure, safety precautions, or exposure of another HIV-positive individual to HIV.[31]

Ultimately, *Stark* and *Whitfield* established prosecutorial standards requiring lower Washington courts to treat HIV exposure as a per se offense that prioritizes "preventative" criminal prosecution for the sake of general public health.

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[25] *Whitfield*, 132 Wash. App. at 888–89.
[26] *Id.*
[27] *Id.* at 888–90.
[28] *Id.*
[29] CTRS. FOR DISEASE CONTROL AND PREVENTION, *HIV Transmission*, http://www.cdc.gov/hiv/resources/qa/transmission.htm (last modified Mar. 25, 2010).
[30] *Whitfield*, 132 Wash. App. at 890–91.
[31] *Id.*

III. CONTEMPORARY HIV TREATMENT AND MAINTENANCE TECHNOLOGY

Reviewing the justifications for criminal HIV exposure laws reflects a reactionary, rather than reasonable, basis for criminalizing HIV exposure. The fear of, and potential for, increased HIV transmission in the 1980s prompted uncompromising penalties capable of preventing transmission. Since criminalizing HIV transmission would only be effective on an ad hoc basis, subsequent to actual transmission, lawmakers focused on criminalizing exposure risks.

The justifications for criminalizing HIV exposure reflect the nationwide panic and misinformation about HIV in the 1980s and early 1990s, when many state legislatures enacted criminal exposure laws. Many people believed that HIV was "invariably fatal."[32] And many associated the virus with social deviance and a criminal lifestyle, as homosexuals, intravenous drug users, and sex workers disproportionately acquired HIV in the late 1980s.[33]

Initial antiretroviral therapy for the perilous infection were narrowly effective; preliminary ART options became less effective as the virus adapted to popular antiretroviral prescriptions, resulting in increasingly resistant strains of HIV.[34]

The difficulties presented by preliminary HIV treatment instigated medical treatment efforts that, nearly three decades after the mainstream debut of rampant HIV infection, now enable an infected person to reduce transmission risk to a virtual impossibility.[35] HIV transmission risks are substantially affected by an individual's viral load, the amount of the virus present in an infected individual's blood.[36] A high viral load count indicates a

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[32] Lawrence K. Altman, *The Doctor's World; Promise and Peril of New Drugs for AIDS*, N.Y. TIMES, Feb. 8, 2000, at F1.

[33] *Id.*

[34] *See, e.g.*, Margo Kaplan, *Rethinking HIV-Exposure Crimes*, 87 IND. L.J. 1517, 1524 (2012).

[35] Pietro Vernazza, Bernard Hirchel, Enos Bernasoni & Markus Flepp, *Les personnes séropositives ne souffrant d'aucune autre MST et suivant un traitement antiretroviral efficace ne transmettent pas le VIH par voie sexuelle*, 89 BULLETIN DES MÉDICINS SUISSES 165, 165–69 (2008) (Switz.).

[36] *Id.*

large quantity of HIV per unit of bodily fluid.[37] The line between HIV exposure and HIV transmission is, thus, determined by relativity and degree; the greater the viral load, the more HIV an uninfected person is exposed to, which renders the likelihood of transmission greater.

Contemporary ART treatment, unlike treatment from the 1980s and early 1990s, significantly decreases viral load counts.[38] When a viral load reaches an "undetectable" level, less than 40 copies of HIV ribonucleic acid (RNA) per milliliter of blood, the HIV virus is not actively reproducing. In other words, an undetectable viral load indicates static, almost benign, HIV infection. Continuous ART sustains an undetectable viral load.[39] Undetectable viral loads mean that an individual's HIV status presents an exceptionally low risk of disease progression and, more importantly, a low transmission risk during moments of HIV exposure.[40]

Recent studies about the relationship between an undetectable viral load and transmission risks during exposure suggest that an HIV-positive person on effective antiretroviral therapy with completely suppressed viremia, determined by an undetectable viral load, cannot transmit HIV.[41] Specifically, an undetectable viral load renders the chances of HIV transmission a "statistical impossibility."[42]

Moreover:

> A viral load of <400 copies/mL yields an HIV transmission risk of .16% during a high-risk exposure act such as unprotected anal sex with an uninfected partner. At < 1500 copies/mL, this viral

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[37] *Id.*

[38] *See* Ari Ezra Waldman, *Exceptions: The Criminal Law's Illogical Approach to HIV-related Aggravated Assaults*, 18 VA. J. SOC. POL'Y & L. 550, 558 (2011).

[39] *See* Vernazza, *supra* note 34, at 165–69.

[40] *See* Thomas C. Quinn, et al., *Viral Load and Heterosexual Transmission of Human Immunodeficiency Virus Type 1*, 342 NEW ENG. J. MED. 921, 927 (2000).

[41] "Viremia" is a microbiology term of art that denotes a virus entering the bloodstream.

[42] *See* Quinn et al., *supra* note 40, at 926–27.

> load has not been proven as a transmittable viral load variable, indicating that viral loads < 1500 copies/mL cannot transmit the virus during any exposure period.[43]

Emerging medical research indicates, notwithstanding the inability to demonstrate a scientific impossibility, that undetectable viral loads render the risk of transmitting HIV during any exposure period as approximately 1 in 1 million.[44] Yet, an HIV-positive individual commits a felony under the criminal exposure law when he or she theoretically exposes another to HIV, regardless of whether the actual transmission risk is 1 in 1 million or virtually impossible.

IV. DIFFERENCES IN CIVIL AND CRIMINAL LAW TREATMENT OF HIV EXPOSURE

The manner in which civil litigation and criminal prosecution for HIV exposure developed in response to increasing HIV transmission rates illuminates the overbroad nature of criminal exposure laws.

In stark contrast to the reactionary criminal law response to HIV, early civil suits against HIV-positive individuals involved treating HIV exposure and transmission as a tortious injury. For example, in *Doe v. Johnson*, a female plaintiff and her infant child brought battery and negligence actions against defendant HIV-positive basketball star Earvin "Magic" Johnson following multiple unprotected sexual encounters.[45] Though Johnson did not know he was HIV-positive at the time of these encounters, the plaintiff ultimately prevailed in bringing her civil claims because Johnson knew or should have known with "substantial certainty" that he was infected based upon his active and "promiscuous" sexual lifestyle.[46]

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[43] Attia, et al., *supra* note 37 at 1397–1400; *see also* Quinn et al., *supra* note 40 at 921.

[44] *See* Waldman, *supra* note 37 at 554–56.

[45] Doe v. Johnson, 817 F. Supp. 1382, 1383–86 (W.D. Mich. 1993).

[46] *Id.* at 1386–87 (finding in favor of plaintiff against Johnson's motion to dismiss).

The *Johnson* court, and other courts addressing similar civil claims for HIV transmission or exposure, utilized foreseeability standards and a nuanced criterion for civil liability to assess likely harm resulting from HIV exposure, including individual knowledge based upon: (1) an affirmative HIV-positive diagnosis; (2) specific knowledge of particular facts indicating likely infection, such as exhibiting HIV symptoms or engaging in high-risk contact with an HIV-positive individual; or (3) regularly engaging in high-risk contact that may result in HIV exposure.[47] Differences between criminal HIV exposure laws, which prioritize per se and theoretical exposure as dangers necessitating criminal penalty, and the civil case law demonstrate a disregard for mitigating factors such as viral load, degree of risk associated with different modes of HIV exposure, disclosure, consent, and precautionary safety measures under the penal scheme.

V. APPLYING CRIMINAL EXPOSURE LAWS TO THE WORKPLACE

When theoretical HIV exposure suffices as the actus reus requirement under criminal law, many HIV-positive individuals risk committing a felony within the workplace. Those who are particularly at risk include HIV-infected healthcare practitioners who engage in exposure-prone actions such as performing invasive surgeries; drawing blood; or even performing minor procedures like stitching wounds or resetting fractured bones. Social workers with HIV who commonly engage at-risk communities with disproportionately higher HIV infection rates also face possible liability, since common interactions for social workers include conflict de-escalation involving weaponry, drug addition interventions involving dirty needles, and emergency health care for open wounds. Tactile and physical laborers, such as those working with machinery or in logging and fishing frequently jeopardize their physical health due to dangerous tools and job tasks necessary for job performance. Teachers and public administrators have responsibility for children and young adults that may require immediate medical treatment involving open

[47] *Id.* at 1388–89.

wounds. Professional and amateur athletes are commonly placed into physically damaging situations in which open wounds and bodily fluids may be exposed.

Applying overbroad criminal exposure statutes without respect or consideration for mitigating factors like actual transmissibility risk, safety precautions, disclosure, and consent renders responsible HIV-positive employees in these and other fields just as culpable and liable as an HIV-positive individual who engages in unprotected sex intending to infect his or her sexual partner.

VI. BALANCING EMPLOYEE RIGHTS WITH CRIMINAL AND EMPLOYER LIABILITY IN THE WORKPLACE

In 1998 the United States Supreme Court classified asymptomatic HIV-positive status as a disability within the meaning of the Americans with Disabilities Act (ADA).[48] As a result of this classification, legal action against HIV-positive employees must be based upon a "direct threat" within the meaning of the ADA.[49] A direct threat is a "significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation."[50] HIV risk assessment must be based on medical or other objective evidence; belief in a significant risk, even if maintained in good faith, does not relieve an employer from discriminatory liability.[51]

Disability classification under the ADA suggests that HIV-positive individuals pose no risk of harm or detriment to workplace conduct, further undermining the rationality of criminal liability.[52] This Article is not intended to suggest that state legislatures should adopt ADA standards to provide a mitigating mechanism against overbroad exposure laws; combatting overbroad criminal liability by labeling HIV status as a disability will undoubtedly reinforce

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[48] Bragdon v. Abbott, 524 U.S. 624, 641–42 (1998).

[49] *Id.*

[50] 42 U.S.C. § 12111(9) (2009).

[51] School Bd. of Nassau Cnty., Fla. v. Arline, 480 U.S. 273, 284–86 (1987).

[52] *See, e.g.*, *Bragdon*, 524 U.S. at 641–42 (discussing improper grounds for employment termination based on HIV-positive status posing a general exposure threat under the ADA).

social stigmatizations already plaguing infected individuals.[53] Rather, reference to legislative schemes other than criminal exposure laws demonstrates an imperative sensitivity and respect toward HIV infection as an individualized condition, not a presumptively fatal disease transmissible at every moment of exposure.

The ADA's treatment of HIV-positive individuals reveals that criminal laws should be reformed. The ADA's direct threat standard, coupled with an undetectable viral load and common health precautions, shows that HIV status is a protected classification based upon a medical condition irrelevant to workplace safety.[54] In other words, outdated concerns that an individual's HIV-positive status always poses a risk of infection cannot, alone, justify infringing upon an infected employee's privacy rights. Yet, an HIV-positive individual simultaneously poses negligible workplace risk and, by virtue of theoretically exposing fellow employees and clients to HIV, a transmission risk justifying felony liability.

Moreover, HIV-positive individuals employed to provide special needs through safety-sensitive tasks (e.g., health practitioners, social workers, public educators) might paradoxically advance public health interests by maintaining regular antiretroviral therapy (ART) and an undetectable viral load. Criminal exposure laws applied to workplace conduct, thus, potentially undermine public health interests in providing effective treatment by deterring responsible HIV treatment. So long as HIV exposure is defined through theoretical acts rather than individualized risk, HIV-positive individuals do not reap legal benefits from responsible ART. Once infected, an HIV-positive person remains forever criminally liable for any workplace conduct the courts deem theoretically exposure-prone.

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[53] *See* Doe v. Chand, 781 N.E.2d 340, 342 (Ill. App. Ct. 2002).

[54] *See, e.g.*, *Bragdon*, 524 U.S. 624; Suzanna Attia, et al., *Sexual Transmission of HIV According to Viral Load and Antiretroviral Therapy: Systematic Review and Meta-analysis*, 23 AIDS 1397, 1401–02 (2009).

VII. SOCIAL AND EMOTIONAL STIGMATIZATION OF HIV-POSITIVE INDIVIDUALS BEYOND THE WORKPLACE

HIV-positive individuals in the workplace must worry about more than the criminal exposure laws that render any exposure-prone act an effective felony sentence. The social and professional repercussions of a publicly known HIV infection adversely impact an HIV-positive individual's livelihood, which compounds the repercussions of criminal liability under exposure laws. Publicly acknowledging HIV-positive status frequently results in workplace and social stigmatization by creating the assumption that the individual is affiliated with socially deviant behavior such as promiscuous sex, unsafe sex practices, and intravenous drug usage.[55]

Many jurisdictions have acknowledged the aggregate stigmatization attending HIV-positive individuals. In *Doe v. Southeastern Pa. Transp. Auth. (SEPTA)*,[56] a former employee brought a civil action against his employer and supervisor for violating his right to privacy. The respondents learned about the petitioner's HIV status through numerous employee health program purchases. The Third Circuit Court of Appeals declared that the privacy interest vested in information regarding one's HIV status is particularly strong because of the stigma, potential for harassment, and "risk of much harm from non-consensual dissemination of the information that an individual is inflicted with AIDS.[57]

Additionally, in *Doe v. Chand*,[58] a patient sued his doctor for violating the local AIDS Confidentiality Act (ACA) after the doctor disclosed his AIDS status to fellow employees. The *Chand* court determined that the ACA was enacted because "the legislature . . . recognized the social stigma that attaches" to individuals known to be infected with HIV, who "are pariahs,

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[55] *See, e.g.*, Peter A. Vanable et al., *Impact of HIV-related Stigma on Health Behaviors and Psychological Adjustment Among HIV-positive Men and Women*, 10 AIDS & BEHAV. 473 (2006).

[56] 72 F.3d 1133 (3d Cir. 1995).

[57] *Id.* at 1140.

[58] 781 N.E.2d 340.

treated only slightly better than how people used to treat a leper who escaped from the colony."[59]

With the rise of social media and communications technology, an HIV-positive individual has a greater interest in protecting his or her private medical status. The Third Circuit Court of Appeals has held that highly sensitive employee information, including HIV status, within an employee's medical records necessitates notice prior to disclosure to enable an HIV-positive employee to raise a personal privacy claim.[60] Publicly announcing an individual's HIV status jeopardizes an infected individual's ability to obtain new employment, effective medical treatment and insurance, and serve in a public capacity.

Adding physical insult to criminal injury, HIV stigmatization has serious ramifications for an infected individual's mental and physical health. A 2006 study found that higher levels of HIV stigma directly correlated with symptoms of depression and/or psychiatric care.[61] The noted stigma was linked to delays by HIV-positive individuals in seeking medical care, confirming a relationship between stigma and treatment mismanagement.

Ultimately, disparately overbroad criminal penalties and the absence of mitigating factors informed by contemporary HIV medical treatment should motivate employers and state legislatures to reassess the alleged risks associated with HIV exposure. One such benchmark would be ADA standards for characteristics posing a direct threat to service and workplace conduct. A direct threat to employer and employee safety is what the legislature was actually concerned about when it enacted the criminal HIV exposure statutes. Both the criminal law and direct threat classification invoke preventative action: identifying a direct threat enables an employer to justify selective hiring, and punishing HIV exposure enables the legislature to preserve public health and safety.

Since a direct threat must pose a significant risk to health and safety that cannot be modified by treatment or preventative measures, the use of ART, consistent undetectable viral loads, and

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[59] *Id.* at 352.
[60] United States. v. Westinghouse Elec. Corp., 638 F.2d 570, 577 (1980).
[61] Vanable, *supra* note 54, at, 476-77.

sanitary precautions would allow for declassification of HIV infection as a direct threat.[62] The availability of these same measures also undermines criminalizing HIV exposure. When *per se* exposure poses little to no risk of HIV transmission, employers and employees have effectively prevented HIV transmission.

VIII. CRIMINAL HIV EXPOSURE LAWS UNDERMINE RESPONSIBLE HIV TREATMENT

As *Stark* and *Whitfield* demonstrate, courts impose criminal liability for HIV exposure, without regard for actual or potential HIV transmission risks. The *Stark* and *Whitfield* courts required the State to demonstrate three elements beyond a reasonable doubt to prosecute HIV exposure; the defendant must know he or she is HIV positive, intend to engage in an act theoretically capable of exposing another to HIV, and perform the theoretical exposure act.[63] Mitigating factors such as actual transmission risks determined by an undetectable viral load, consent, disclosure, or precautionary safety measures are glaringly absent from this burden of proof.

Yet, contemporary medical treatment and scientific advances have lessened the need for per se HIV exposure. Deterrence, a criminal jurisprudence theory that prioritizes criminal punishment as a means of inducing compliance with the law, relies upon the assumption that HIV-positive individuals are aware of both the criminal exposure law, as well as the type of behavior falling within the scope of criminal liability. For the law to deter criminal conduct, an HIV positive actor must know exactly what conduct is illegal. A person must know what conduct exposes another to HIV given effective safety precautions, an undetectable viral load, or knowing consent.

Similarly, the success of incapacitating HIV-positive individuals for HIV exposure depends upon the extent to which law enforcement agents can identify people *likely* to expose and, thus, infect others. The likelihood of infecting members of general

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[62] *See, e.g.*, 42 U.S.C. § 12111(3), (9) (2009).
[63] *See Stark*, 66 Wash. App. at 424; *Whitfield*, 132 Wash. App. at 896.

society must also be offset by how significantly the transmission risk is redirected into prisons.

The aggregate impact of these shortcomings of criminal HIV exposure laws is that many HIV-positive individuals face criminal punishment despite the fact that it is nearly impossible for them to actually transmit HIV. Continuing to punish per se exposure despite responsible ART treatment perpetuates societal misinformation regarding HIV exposure risk by conflating *theoretical* exposure with subjective, individualized exposure risk as mitigated by proper medical treatment and safety precautions. Moreover, the overinclusive "exposure" language found in the majority of criminal exposure laws fails to provide notice to HIV-positive individuals who regularly receive effective medical treatment and are frequently informed by physicians as being unable to transmit HIV in exposure moments.

HIV exposure laws thus maintain narrow mentes reae (intent to engage in conduct theoretically capable of HIV exposure) but overbroad actus rei, without a limiting principle to discern theoretical harm from actual potential harm.

CONCLUSION

Although adapting state law to every medical advancement is impractical, HIV treatment has evolved for nearly three decades. Today, infected individuals may receive treatment capable of suspending HIV growth, thereby limiting the number of infected cells and reducing infection risks in exposure-prone situations. Yet, HIV-positive individuals undergoing responsible and effective treatment continue to be criminally liable at any and every exposure-prone situation, regardless of viral load counts, precautionary measures, or even consent. Ultimately, the criminalization of HIV exposure necessitates statutory reform capable of shielding responsible HIV-positive individuals from per se criminal liability.

PRACTICE POINTERS

- Criminal defense lawyers, particularly public defenders, should utilize up-to-date HIV treatment research to present the most holistic and informed defense for clients charged under state exposure laws.
- Legislative advocates can provide local lawmakers with current HIV treatment research about antiretroviral therapy and reduced transmission risks, assist community health clinics in acquiring government funding for low-income HIV treatment, and suggest revisions to state exposure laws that minimize bright-line exposure penalties.