

Article

Sex Torts

Deana A. Pollard[†]

Introduction	770
I. The State's Interest in Slowing the Spread of Sexual Disease	772
A. The Facts Regarding the Sexual Disease Epidemic in America	772
B. The Enormous Health Care Costs of Sexually Transmitted Diseases	781
C. Who Is Spreading Sexual Diseases?	783
II. Historical and Current Sex Tort Jurisprudence	787
A. Sexual Behavior and the Law: A Brief History	788
B. Sex Torts Today	793
1. Negligence Theory	795
2. Intentional Theories	802
III. Strict Liability for Transmitting a Sexual Disease	803
A. Does Strict Liability for Sexual Disease Transmission Further Social Justice?	804
B. Will Adopting Strict Liability Deter Sexual Disease Transmission?	810
1. Individual Deterrence Based On The Rational Actor Assumption	812
2. Social Control Models of Deterrence, Behavioral Law Theories, and Norms	819
Conclusion	824

[†] Associate Professor of Law, Texas Southern University, Thurgood Marshall School of Law. I thank my colleagues and friends for their insightful and comprehensive comments on an earlier draft. Many thanks to Martha Davis, Constance Fain, Tom Kleven, and especially Dannye Holley and Marty Levy. I am grateful to Ed Laumann for his commitment to social science and generosity in sharing his research. I thank my research assistants, Simeon Coker and ChiQuia Roberson, and the editors of the Minnesota Law Review for their courtesy and professionalism. Above all, I thank my son, Ryan Alexander Pollard, for his patience with Mom's work, and my fiancé, David J. Sacks, for his consistent personal support. Copyright © 2007 Deana A. Pollard.

INTRODUCTION

The sexual practices of a small percentage of Americans are costing the American public billions of dollars each year. The United States has the highest sexually transmitted disease (STD)¹ infection rate in the industrialized world, a rate *fifty to one hundred times* that of other industrialized countries.² There is a multitude of reasons why the sexual disease rate in the United States is out of control. This Article discusses tort law's role in allowing some Americans to view sex and sexual partners with no regard for safety or health, and concludes that the current negligence-based analysis in sex tort³ cases should be replaced by strict liability.

The law can directly affect public opinion and behavior through its deterrent, expressive, and educational functions.⁴ While various other forms of state action are vitally important to controlling social threats,⁵ tort law is the barometer of minimal civil expectations in interpersonal relations. Prior to the mid-twentieth century, sex tort law offered protection against reputation and emotional injury resulting from unfair or fraudulently induced seduction, but the "heartbalm" torts were substantially eviscerated in the latter half of the twentieth century. As a result, a "caveat emptor" standard in sex tort actions

1. Formerly referred to as venereal disease (VD), sexually transmitted diseases (STDs) and sexually transmitted infections (STIs) collectively include a number of infections that affect human genitalia and are transmitted sexually. See, e.g., INST. OF MED., *THE HIDDEN EPIDEMIC: CONFRONTING SEXUALLY TRANSMITTED DISEASES* 1–2 (Thomas R. Eng & William T. Butler eds., 1997) [hereinafter *THE HIDDEN EPIDEMIC*]; Barbara K. Hecht & Frederick Hecht *Condoms and Sexually Transmitted Infections*, MEDICINET.COM, July 7, 2004, <http://www.medicinenet.com/script/main/art.asp?articlekey=33590>.

2. AM. SOC. HEALTH ASS'N, *SEXUALLY TRANSMITTED DISEASES: HOW MANY CASES AND AT WHAT COST?* 10 (Linda L. Alexander et al. eds., 1998), available at http://www.kff.org/womenshealth/1445-std_rep.cfm [hereinafter *ASHA—WHAT COST?*]; Mary G. Leary, *Tort Liability for Sexually Transmitted Disease*, in 88 AM. JUR. TRIALS § 1, at 153 (2003).

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

4. See, e.g., Roscoe Pound, *Theory of Social Interests*, 15 PAPERS & PROC. AM. SOC. SOC'Y 16, 16–17, 20–23 (1920). Tort doctrine is intended to control social choices by deterring socially undesirable, blameworthy, or uneconomical behavior, and to provide compensation to victims of civil wrongdoing. See DAN B. DOBBS, *THE LAW OF TORTS* 17–21 (2000).

5. Examples of such essential state action include compulsory education for minors and criminal law enforcement.

emerged. This standard has probably contributed to the major epidemic of STDs that has developed in the United States in the last thirty years⁶ by failing to discourage irresponsible sexual practices.

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

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

This paper will proceed in three parts. Part I will focus on the facts of sexual disease, including data relating to the number of infections in the United States, the resultant annual medical costs, and the actors responsible for the high infection rate. Part II will briefly review the history of sex tort jurisprudence in America over the past century and will describe current sex tort law's inefficient negligence-based jurisprudence relative to the new wave of sex tort litigation based on disease transmission. Part III will argue that strict liability is a superior theory of sex tort liability in accordance with traditional

6. Medical Institute for Sexual Health, *The STD Epidemic* (1994), <http://www.wprc.org/10.23.0.0.1.0.phtml>; see also THE HIDDEN EPIDEMIC, *supra* note 1, *passim*.

tort doctrine, economic choice theory, behavioral choice theory, and the expressive function of law.

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

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

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

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

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

A. THE FACTS REGARDING THE SEXUAL DISEASE EPIDEMIC IN AMERICA

Sexually transmitted diseases, or STDs, are caused by more than twenty-five infectious organisms that are transmit-

7. *Skillings v. Allen*, 173 N.W. 663, 664 (Minn. 1919).

8. INST. OF MED., *THE HIDDEN EPIDEMIC: CONFRONTING SEXUALLY TRANSMITTED DISEASES: SUMMARY* 43 (1997).

ted through sexual activity.⁹ In the 1960s, the only significant STDs were syphilis and gonorrhea, both of which were easily cured with antibiotics.¹⁰ Since 1980, however, at least eight *new* STDs have been identified, including HIV/AIDS.¹¹ STDs accounted for eighty-seven percent of all cases among the top ten most frequently reported infections in the United States during 1995.¹² Five of the top ten reportable¹³ infectious diseases in 1995 were either exclusively or largely transmitted during sex, including the top four: chlamydia, gonorrhea, AIDS, and syphilis.¹⁴ Currently, it is estimated that between seventy and one hundred million Americans have been infected with an STD, with 15.3 million new cases¹⁵ of STDs among Americans every year, including three million new cases of STDs annually among American teenagers.¹⁶ In 1993, a review of actual causes of death in the United States estimated that thirty thousand deaths occurred as a result of unprotected intercourse, leading to the finding that “unprotected intercourse now represents one of the most rapidly increasing causes of death in the country.”¹⁷

9. Ziad A. Memish & Abimbola O. Osoba, *Sexually Transmitted Diseases and Travel*, 21 INT'L J. ANTIMICROBIAL AGENTS 131, 131, abstr. (2003).

10. Medical Institute for Sexual Health, *supra* note 6; *cf.* Kathleen K. v. Robert B., 198 Cal. Rptr. 273, 276 n.3 (Cal. Ct. App. 1984) (noting that genital herpes was “not listed among the ‘venereal diseases’ covered by the California Health and Safety Code” because “that section was enacted in 1957, long before herpes” was considered a threat to public health).

11. THE HIDDEN EPIDEMIC, *supra* note 1, at 39. For definitions and symptoms of the most common STDs, see Leary, *supra* note 2, § 2.

12. THE HIDDEN EPIDEMIC, *supra* note 1, at 28.

13. “Reportable” means that health care providers are required to report cases to state health departments and the Centers for Disease Control and Prevention (CDC). ASHA—WHAT COST?, *supra* note 2, at 4; *see also* THE HIDDEN EPIDEMIC, *supra* note 1, at 196 (“Syphilis and gonorrhea are reportable conditions in all . . . states.”).

14. THE HIDDEN EPIDEMIC, *supra* note 1, at 28.

15. *Id.* There is a difference between the number of cases of STDs and the number of people infected, because the same very sexually active core group members are contracting multiple infections, and each infection is counted as a case. Thus, the case number will exceed the number of people infected. Telephone Interview with Professor Ed Laumann, Professor of Sociology, Univ. of Chicago, in Chicago, Ill. (Aug. 3, 2005).

16. THE HIDDEN EPIDEMIC, *supra* note 1, at 28; *see also* ASHA—WHAT COST?, *supra* note 2, at 8, 12; Douglas T. Fleming et al., *Herpes Simplex Virus Type 2 in the United States, 1976 to 1994*, 337 NEW. ENG. J. MED. 1105, 1105–11 (1997).

17. J. Michael McGinnis & William H. Foege, *Actual Causes of Death in the United States*, 18 J. AM. MED. ASS'N 2207, 2210 (1993). At least twenty-five diseases are spread primarily through sexual activity. KAISER FAMILY FOUND., THE TIP OF THE ICEBERG: HOW BIG IS THE STD EPIDEMIC IN THE U.S.? 1

While the public may believe that AIDS is the most dangerous STD, this belief does not reflect the disease's relatively low prevalence.¹⁸ HIV/AIDS is not the only STD that is life-threatening; left untreated, diseases such as gonorrhea, syphilis, genital herpes, and the human papilloma virus can cause serious health consequences, lead to various forms of cancer, and kill.¹⁹

Bacterial STDs, such as chlamydia,²⁰ gonorrhea, syphilis, and trichomoniasis, are usually cured with antibiotic treatment and rendered non-infectious if detected,²¹ although researchers

(1998), <http://www.kff.org/womenshealth/upload/the-tip-of-the-iceberg-how-big-is-the-STD-epidemic-in-the-u-s-q-a.pdf> [hereinafter TIP OF THE ICEBERG]. Further, the CDC has concluded that STDs remain one of the most "under recognized" health problems in the United States. See CTRS. FOR DISEASE CONTROL & PREVENTION, TRACKING THE HIDDEN EPIDEMICS: TRENDS IN STDs IN THE UNITED STATES 1 (2000) [hereinafter CDC—TRENDS]; see also INST. OF MED., *supra* note 8, at 1–4.

18. It is an established principle of public health law that a health risk that causes a less serious health problem (such as serious illness and possibly cancer, leading to death, i.e., genital herpes) can have a much larger impact on overall public health if it affects a larger percentage of the population than a health risk that has a higher probability of causing death (such as AIDS) but affects a much smaller percentage of the population. See, e.g., Geoffrey Rose, *Sick Individuals and Sick Populations*, 14 INT'L J. EPIDEMIOLOGY 32, 37 (1985).

19. EDWARD O. LAUMANN ET AL., THE SOCIAL ORGANIZATION OF SEXUALITY 377 (1994).

20. *Chlamydia trachomatis* is the second most common bacterial infection in the United States. ASHA—WHAT COST?, *supra* note 2, at 5, 16–17. In 1996, there were three million new cases of chlamydia and 650,000 new cases of gonorrhea. *Id.* These curable bacterial infections are largely asymptomatic, with 75% of women and 50% of men unaware of their chlamydia infection, and many women unaware that they have gonorrhea. CDC—TRENDS, *supra* note 17, at 6, 9. If left untreated, up to 40% of women with chlamydia will develop pelvic inflammatory disease (PID); gonorrhea is also a major cause of PID. *Id.* PID in turn causes infertility in 20% of women who have it, and at least 15% of all infertile American women are infertile because of tubal damage caused by PID. INST. OF MED., *supra* note 8, at 5. Ectopic pregnancy results in 9% of PID cases, "making ectopic pregnancy one of the leading and most preventable causes of maternal death during pregnancy." *Id.* The highest rate of acute infection requiring hospitalization for chlamydia is among teenagers between the ages of fifteen and nineteen. Pregnancy Ctrs. of Cent. Va., Teen Sex and Pregnancy Fact Sheet, <http://www.virginiapregnancy.org/teenfacts.html> (last visited Oct. 15, 2006) [hereinafter Teen Sex Fact Sheet]. It is estimated that one in four sexually active teens have chlamydia, and that 75% of infected young women and 25% of infected young men have no symptoms. *Id.*

21. Although bacterial strains, such as gonorrhea, typically can be cured using antimicrobial drugs, the effectiveness of these drugs has become limited because of the strains' increasing resistance to the drugs. See, e.g., J. Todd

believe that the majority of infected persons are unaware that they are infected.²² If left untreated, bacterial STDs can cause pelvic inflammatory disease (PID) in women, which can lead to infertility and chronic pain.²³

Half of all new STD infections are viral and incurable.²⁴ Viral STDs, such as genital herpes (HSV-2 or Herpes Simplex II), human papilloma virus (HPV), hepatitis B, and AIDS are incurable and may be transmitted throughout the life of the carrier.²⁵ Genital herpes and HPV are sharply on the rise,²⁶ and in 1998 accounted for sixty-five of the approximately sixty-eight million infections among Americans.²⁷ HPV and genital herpes are rapidly infecting Americans and can lead to tragic consequences, including cancer and death.

Genital herpes is the most common viral STD in the United States.²⁸ The number of Americans infected with herpes grew by 30% between the late 1970s and late 1990s,²⁹ such that at least 20% of persons over age twelve in the United States—forty-five million Americans—had genital herpes as of 1998.³⁰ Some researchers believe that the number of symptomatic cases of herpes in the United States grew *eleven fold* during the 1970s and 1980s.³¹ “Complications associated with genital herpes include meningitis, cervical cancer, miscarriage, premature

Weber, *Appropriate Use of Antimicrobial Drugs*, 294 J. AM. MED. ASS'N 2354, 2356 (2005).

22. See CDC—TRENDS, *supra* note 17, at 9; INST. OF MED., *supra* note 8, at 7–8; Barbara Moscicki et al., *The Use and Limitations of Endocervical Gram Stains and Mucopurulent Cervicitis as Predictors for Chlamydia Trachomatis in Female Adolescents*, 157 AM. J. OBSTETRICS & GYNECOLOGY 65, 65, 70 (1987).

23. CDC—TRENDS, *supra* note 17, at 6–9; INST. OF MED., *supra* note 8, at 5.

24. ASHA—WHAT COST?, *supra* note 2, at 5; CDC—TRENDS, *supra* note 17, at 1–2.

25. ASHA—WHAT COST?, *supra* note 2, at 5.

26. See, e.g., B.N. v. K.K., 538 A.2d 1175, 1178 n.7 (Md. 1988) (“[Genital herpes] is spreading rapidly in the United States.” (alteration in original)).

27. ASHA—WHAT COST?, *supra* note 2, at 5. This figure is no doubt higher today, eight years after this study was conducted, as around fifteen million new cases occur every year in the United States. *Id.* at 4.

28. CDC—TRENDS, *supra* note 17, at 20.

29. *Id.*; TIP OF THE ICEBERG, *supra* note 17, at 5; see also Fleming, *supra* note 16, at 1109 tbl.5 (documenting the changes in the number of people who tested positive for HSV-2 from 1976 to 1980 and from 1988 to 1994).

30. TIP OF THE ICEBERG, *supra* note 17, at 2, 5.

31. ASHA—WHAT COST?, *supra* note 2, at 17.

delivery, and high mortality rate of babies born to mothers with herpes.”³²

HPV is one of the two most common new cases of STDs in the United States, the other being trichomoniasis.³³ These two diseases account for 70% of new STD cases each year.³⁴ An estimated 20 million Americans currently have HPV and another 5.5 million are infected every year.³⁵ Researchers in Seattle recently estimated that 80% of sexually active Americans will acquire at least one strain of HPV at some point in their lives.³⁶ There are at least thirty distinct strains of HPV that can infect human genitalia, some of which cause genital warts.³⁷ Some strains are controlled by the body’s immune system without the carrier ever knowing about the infection.³⁸ But the more dangerous strains cause “subclinical” infections, so-called because they are invisible and often go undetected or may lie dormant for years.³⁹ At least some of these strains lead to a variety of cancers, including cancer of the cervix, vagina, vulva, anus, and penis.⁴⁰ HPV may cause more than 90% of all cases of cervical cancer, the seventh most common type of cancer in women,⁴¹

32. R.A.P. v. B.J.P., 428 N.W.2d 103, 107 n.5 (Minn. Ct. App. 1988) (citing B.N. v. K.K., 538 A.2d 1175, 1178 n.7 (Md. 1988)).

33. Trichomoniasis is caused by a microscopic parasite, and is therefore curable. CDC—TRENDS, *supra* note 17, at 24; see ASHA—WHAT COST?, *supra* note 2, at 6. If left untreated, it increases the risk of contracting HIV/AIDS, and can cause premature birth and low birth weight babies among infected pregnant women. CDC—TRENDS, *supra* note 17, at 24. There is currently no national surveillance data on trichomoniasis, but it is estimated that five million new cases of trichomoniasis occur each year in the United States. TIP OF THE ICEBERG, *supra* note 17, at 2. This disease accounts for half of all curable STIs worldwide. ASHA—WHAT COST?, *supra* note 2, at 18. Yet, only 2% of men and 3% of women named trichomoniasis when asked to identify known STDs. TIP OF THE ICEBERG, *supra* note 17, at 4.

34. ASHA—WHAT COST?, *supra* note 2, at 20.

35. See CDC—TRENDS, *supra* note 17, at 2.

36. DANIEL E. MONTAÑO ET AL., EXECUTIVE SUMMARY: RESULTS FROM HPV PROVIDER SURVEY: KNOWLEDGE, ATTITUDES, AND PRACTICES ABOUT GENITAL HPV INFECTION AND RELATED CONDITIONS 1 (2005), <http://www.cdc.gov/std/hpv/HPVProviderSurveyExecSum.pdf>.

37. CDC—TRENDS, *supra* note 17, at 18.

38. *Id.*

39. *Id.*; see INST. OF MED., *supra* note 8, at 8. Four strains of HPV, types 16, 18, 31, and 45, account for 80% of all cervical cancer. See CDC—TRENDS, *supra* note 17, at 18.

40. CDC—TRENDS, *supra* note 17, at 18; INST. OF MED., *supra* note 8, at 4.

41. INST. OF MED., *supra* note 8, at 4.

killing about five thousand women every year in the United States.⁴²

More recent research indicates that there are 6.2 million new cases of HPV annually, driving these figures higher.⁴³ There is no cure for HPV;⁴⁴ it causes the largest number of STD-related life-threatening illnesses next to AIDS,⁴⁵ and it is the fastest-growing STD in the United States.⁴⁶ One of the biggest problems with HPV is that research shows that condoms may have little, if any, effect on preventing this disease.⁴⁷ Yet, of Americans polled, only 8% of men and 13% of women were able to identify HPV as a common STD when asked to name STDs of which they had heard.⁴⁸

Americans' lack of knowledge about HPV is representative of a more generalized ignorance about STDs. The American public is frighteningly unaware of the STD epidemic, with surveys showing that around 70% of men and women think that fewer than 10% of Americans will get an STD in their lifetime, although the true figure is at least 25%,⁴⁹ with recent estimates as high as 80%.⁵⁰ In 1993, 84% of women surveyed were not concerned about acquiring an STD, including 72% of young women (18–24) and 78% of women who reported having “many” sexual partners.⁵¹ In general, the health consequences of STDs are “hidden” from public attention for several reasons, including the fact that most people who have an STD do not know

42. TIP OF THE ICEBERG, *supra* note 17, at 4. One particular type of HPV, type 16, is responsible for 50% of all cases of cervical cancer. MEDICAL COLLEGE OF WISCONSIN, HEALTHLINK, <http://healthlink.mcs.edu/article/976735469.html> (last visited Oct. 15, 2006).

43. MONTAÑO ET AL., *supra* note 36, at 1.

44. CDC—TRENDS, *supra* note 17, at 18.

45. INST. OF MED., *supra* note 8, at 6.

46. See ASHA—WHAT COST?, *supra* note 2, at 5.

47. See MONTAÑO ET AL., *supra* note 36, at 2. “Although the effect of condoms in preventing HPV is inconclusive,” condoms can reduce the risk of two of the most common HPV-related conditions: genital warts and cervical cancer. *Id.*

48. TIP OF THE ICEBERG, *supra* note 17, at 4. While clinicians generally are aware of the prevalence of HPV, only 63% knew that genital HPV in men increases the risk of penile and anogenital cancers. MONTAÑO ET AL., *supra* note 36, at 6.

49. ASHA—WHAT COST?, *supra* note 2, at 10. The surveys were conducted in 1998 by the Kaiser Family Foundation and *Glamour* magazine. *Id.*

50. See MONTAÑO ET AL., *supra* note 36, at 2.

51. EDK ASSOC., WOMEN & SEXUALLY TRANSMITTED DISEASES: THE DANGERS OF DENIAL 6 tbl.1 (1994).

that they have one.⁵² Major health consequences of STDs, such as infertility, cancer, and chronic pain, occur years after the initial infection, so the link between the STD and the health consequences is not recognized. Also, the stigma attached to contracting an STD inhibits open public discourse, education, and legal redress.⁵³ Americans of all ages are confronted with

52. See CDC—TRENDS, *supra* note 17, at 9; INST. OF MED., *supra* note 8, at 7–8. The silent nature of the STD epidemic is probably the greatest public health threat. ASHA—WHAT COST?, *supra* note 2, at 8. In general, STDs are more severe and occur more frequently among women, in part because they are transmitted most readily from a male to a female, and in part because they are more likely to remain undetected in females. INST. OF MED., *supra* note 8, at 3. Almost every STD can be transmitted from a pregnant woman to her fetus, which, because of the immature immune system of the fetus, results in tragic consequences, including low birth weight, premature birth, conjunctivitis, pneumonia, neurologic problems, and congenital abnormalities. ASHA—WHAT COST?, *supra* note 2, at 9. STDs can also be transmitted to babies through breastfeeding. INST. OF MED., *supra* note 8, at 2.

53. Relative to other societies American sexuality is largely private and secret, a vestige of the Victorian social system. See ALLAN M. BRANDT, NO MAGIC BULLET: A SOCIAL HISTORY OF VENEREAL DISEASE IN THE UNITED STATES SINCE 1980, at 23–31 (1985). Social taboos regarding sexuality juxtaposed with constant sexual images in the mass media, and particularly the Internet, have created a culture where sexual cognitive dissonance is ubiquitous, which leads to unhealthy sexual behavior such as promiscuous, clandestine sex. THE HIDDEN EPIDEMIC, *supra* note 1, at 86–107. American attitudes toward sex have impeded sexuality and STD education programs, hindered communications among family members, and promoted a fixation on sexuality. *Id.* Contrary to the popular assumption that Victorian values have caused sexual repression in America, Michel Foucault has argued that American discourse and fixation on sex is more about producing and using sex as power than about repression. MICHAEL FOUCAULT, THE HISTORY OF SEXUALITY, VOLUME I: AN INTRODUCTION (Robert Hurley trans., 1978). That is, sexual choices derive their meaning through social discourse about sex, through labeling people in accordance with their sexuality, and otherwise through socially constructing meaning grounded in sexual behavior. *Id.* at 17–49. American secrecy regarding sex and the attendant lack of communication and education regarding STDs, coupled with a proliferation of sexual images in the mass media and increased sexuality in American youth, have created a recipe for the very serious STD epidemic we face today. THE HIDDEN EPIDEMIC, *supra* note 1, at 86–107. For example, there are ten incidents of sexual behavior per hour on prime time television, but most of the images depict non-marital sexual relationships as the norm and fail to broach the subject of contraception or sexual disease. *Id.* at 92. This irresponsible production has an enormous impact on young people's sexual mores. See, e.g., D.T. Lowry & J.A. Schidler, *Prime Time TV Portrayals of Sex, "Safe Sex," and AIDS: A Longitudinal Analysis*, 70 JOURNALISM Q. 628 (1993) (detailing the impact of television on adolescent sexuality). Such productions are, however protected by the First Amendment. See *United States v. Playboy Entertainment Group, Inc.*, 529 US 803, 823–27 (2000).

an enormous health risk that is largely silent.⁵⁴

The impact of STDs on America's youth is particularly troublesome.⁵⁵ Adolescents and young adults have the highest rates of sexually transmitted diseases.⁵⁶ Approximately twenty-five percent of new STD cases involve fifteen- to nineteen-year olds.⁵⁷ About half of all new HIV infections occur in people under age twenty-five; most are infected through sex.⁵⁸ AIDS is the sixth leading cause of death among young men and women.⁵⁹ Every day, eight thousand teenagers in the United States contract an STD—approximately three million per year,

54. Over half of adults and teens surveyed stated that their doctors spent "no time at all" discussing STDs with them. ASHA—WHAT COST?, *supra* note 2, at 10; *see also* THE HIDDEN EPIDEMIC, *supra* note 1, at 86–107 (discussing the impact of silence and secrecy on the STD epidemic).

55. In California alone, approximately 1.2 million cases of STDs occur each year, approximately 250,000 of which occur among teenagers. DIV. OF COMMUNICABLE DISEASE CONTROL, CAL. DEP'T OF HEALTH SERVS., COMMUNICABLE DISEASE CONTROL IN CALIFORNIA 17 (2000), *available at* http://www.dhs.ca.gov/ps/dcdc/pdf/CDC2000_Document.pdf. In a University of Washington study of university students, cervical infection was eight times greater than all other STD infections combined. UNIV. WASH. DEP'T OF HEALTH SERVS., EMERGING SEXUALLY TRANSMITTED DISEASES (1998), *available at* <http://depts.washington.edu/eminf/1998/std/std1.htm> (citing studies led by Dr. Laura Koutsky at the University of Washington). Yet, only one in five teens says that they think they are at risk of getting an STD. ASHA—WHAT COST?, *supra* note 2, at 10. Perhaps for this reason, most single men and women (two-thirds) say that they do not consistently use condoms. *Id.*

56. ASHA—WHAT COST?, *supra* note 2, at 8 (stating that about two-thirds of all new STD cases occur in people ages fifteen through twenty-four); Diane R. Blake, *Adolescent Sexually Transmitted Diseases: Recent Developments*, CURRENT INFECTIOUS DISEASE REP., April 2004, at 141, 141.

57. ASHA—WHAT COST?, *supra* note 2, at 8.

58. CTRS. FOR DISEASE CONTROL & PREVENTION, CDC HIV/AIDS FACT SHEET: HIV/AIDS AMONG YOUTH 1–3 (2006). Among American youth, minorities have been hit particularly hard by HIV/AIDS, with young blacks representing sixty-five percent of AIDS cases reported among thirteen- through nineteen-year-olds in 2002; Latino teens represented twenty percent. CTRS. FOR DISEASE CONTROL AND PREVENTION, HIV/AIDS SURVEILLANCE IN ADOLESCENTS, L265 Slide Series (2002).

59. Teen Sex Fact Sheet, *supra* note 20. About fifty percent of all new HIV cases are found in people under age twenty-five. CTRS. FOR DISEASE CONTROL & PREVENTION, HIV PREVENTION STRATEGIC PLAN THROUGH 2005, at 18 (January 2001), *available at* <http://www.cdc.gov/hiv/pubs/prev-strat-plan.pdf>. AIDS is also the third leading cause of death for African Americans ages twenty-five through fifty-four, and was the leading cause of death of African American women ages twenty-five through thirty-four in 2002. *See* Robert N. Anderson & Betty L. Smith, *Deaths: Leading Causes for 2002*, NAT'L VITAL STAT. REP. 67–70 (Mar. 7, 2005), *available at* http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_17.pdf.

or about one every ten seconds.⁶⁰ At least two-thirds of people who acquire STDs in the United States are younger than twenty-five; at least one quarter are teenagers,⁶¹ and it appears that the percentage of young people afflicted is rising.⁶² Teenage girls have the highest rate of chlamydia,⁶³ a common cause of PID, which can lead to infertility; at least ten percent of sexually active teens are infected with this disease.⁶⁴

There are a number of reasons why teenagers and young adults are at the greatest risk for acquiring an STD: they may have less immunity than adults; they are more likely to have multiple sex partners and to select partners who are high-risk; they are more likely to engage in unprotected sex; and the age of first sexual activity has decreased while the age at first marriage has increased, resulting in more non-marital, non-monogamous sexual activity.⁶⁵ In sum, American teens and young adults are becoming sexually active at a younger age than prior generations, and they have more sexual partners.⁶⁶

60. MEG MEEKER, EPIDEMIC: HOW TEEN SEX IS KILLING OUR KIDS 12 (2002).

61. ASHA—WHAT COST?, *supra* note 2, at 8; TIP OF THE ICEBERG, *supra* note 17, at 3.

62. Teenagers are more sexually active today than in prior generations and sexual disease is quickly proliferating. See THE HIDDEN EPIDEMIC, *supra* note 1, at 36–37.

63. CDC—TRENDS, *supra* note 17, at 9. The ectropion of the cervix of a female teenager is physically more vulnerable to infection than that of a woman in her twenties. Jean R. Anderson & Michelle D. Wilson, *Caring for Teenagers with Salpingitis*, CONTEMP. OB/GYN, August 1990, at 103, 103. One result is that sexually active fifteen-year-olds have a one in eight chance of developing PID, but by age twenty-four, that probability decreases to one in eighty. Jia Kani & Michael W. Adler, *Epidemiology of Pelvic Inflammatory Disease*, in PELVIC INFLAMMATORY DISEASE 7, 9 (1992).

64. L. Weström, *Incidence, Prevalence, and Trends of Acute Pelvic Inflammatory Disease and Its Consequences in Industrialized Countries*, 138 AM. J. OBSTETRICS & GYNECOLOGY 880, 885–87 (1980).

65. THE HIDDEN EPIDEMIC, *supra* note 1, at 69–108. Alcohol and other substance abuse are known to be associated with high-risk sexual behavior that leads to STDs, both generally and among youth. *Id.* at 76–79.

66. Teens and young adults around the world are having sex at a younger age than previous generations, and are having sex more frequently and with more partners. 2005 DUREX GLOBAL SEX SURVEY, <http://www.durex.com/gss> (last visited Oct. 15, 2006). More than three hundred thousand sexually active and non-sexually active teenagers and adults across forty-one countries were studied. See *id.* The United States and Canada have among the lowest average ages of first intercourse, at about seventeen years of age—and the age of a young person's first sexual experience is declining at an alarming rate. *Id.* Overall, people have sex 103 times per year, and globally the average number of partners is 9, whereas in the United States, the average number of partners

Indeed, the United States and Canada currently have among the youngest ages of first sexual experience, at 16.9 and 17 years, and one study has found that twenty-five percent of sixth graders, thirty-three percent of seventh graders, and half of eighth graders have had sexual intercourse.⁶⁷ Thus, despite the publicity surrounding a current “abstinence movement” among American youth, research shows a dramatic increase in adolescent sexual activity in the last few decades, and early sexual activity is clearly linked to a greater number of sexual partners and a greater risk of acquiring a sexually transmitted disease.⁶⁸

B. THE ENORMOUS HEALTH CARE COSTS OF SEXUALLY TRANSMITTED DISEASES

The most recent estimates of the costs of STDs in the United States are astounding and underscore the need for immediate changes in education, public policy, and law. Experts

is 10.7. In 1993, the World Bank estimated that STDs excluding AIDS are the second leading cause of healthy life lost among women ages fifteen to forty-four in developing countries. *See* WORLD BANK, WORLD DEVELOPMENT REPORT 1993, at 223. Only eleven percent of teens get most of their sex education from parents or family; most learn through peers whose information is largely inaccurate. THE HIDDEN EPIDEMIC, *supra* note 1, at 90. Clearly, sexual disease education is desperately needed to help curb the sexual disease rate among American youths. *See id.* at 86–107. The so called “abstinence only” sex education method is counterproductive and exacerbating the sexual disease problem, because it fails to educate youth about birth control and protection from disease. *See id.*

67. 2005 DUREX GLOBAL SEX SURVEY, *supra* note 66; INST. OF MED., *supra* note 8, at 13.

68. The percentage of American high school students who have had sex decreased 7.4% from 1991 to 2003, from 54.1% to 46.7%. Ctrs. for Disease Control and Prevention, *Surveillance Summaries*, MORBIDITY & MORTALITY WKLY. REP., May 21, 2004 at 29, 29 available at <http://www.cdc.gov/mmwr/PDF/SS/SS5302.pdf>. About sixty percent of high school seniors have had sex. Teen Sex Fact Sheet, *supra* note 20. This source also states that seventy-seven percent of nineteen-year-old females and eighty-five percent of nineteen-year-old males have had sex. *Id.* (citing URBAN INST., NATIONAL SURVEY OF ADOLESCENT MALES, NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT (1995)); CTRS FOR DISEASE CONTROL, NATIONAL SURVEY OF FAMILY GROWTH (1995); *see also* ASPEN EDUC. GROUP, SEXUAL PROMISCUITY IN ADOLESCENTS, <http://www.aspeneducation.com/factsheetpromiscuity.html> (last visited Oct. 8, 2006) (stating that 66.4% of twelfth-graders have had sex). By age nineteen, more than half of Americans have had sex, with some sources reporting that nearly twenty percent of fifteen-year-olds, sixty percent of twelfth graders, and eighty percent of nineteen-year-olds have had sex. ASPEN EDUC. GROUP, *supra*. Ignorance among teens and young adults probably contributes significantly to the STD rate among this group. Approximately four million teens contract an STD every year. ASHA—WHAT COST?, *supra* note 2, at 4, 8.

estimate that the medical costs alone associated with sexual disease in the United States already exceed sixteen billion dollars per year and are growing rapidly.⁶⁹ In 2004, researchers with the Alan Guttmacher Institute estimated that the direct costs of STDs, including HIV, among all age groups was between \$9.3 and \$15 billion in the United States in the mid 1990s, adjusted to year 2000 dollars.⁷⁰ This figure includes only the eight major STDs—HIV, HPV, HSV-2, hepatitis B, chlamydia, gonorrhea, trichomoniasis, and syphilis⁷¹—and since indirect and intangible costs were not included, the total costs are probably substantially higher.⁷² In 1997, some research indicated that the annual cost was closer to seventeen billion dollars.⁷³ Texas and New York each have costs of over six hundred million dollars per year, while California's total yearly costs are over one billion dollars.⁷⁴

About nine million young Americans ages fifteen to twenty-four contract an STD every year, with a total estimated burden of \$6.5 billion.⁷⁵ Viral STDs, such as HIV, HSV-2, and HPV accounted for ninety-four percent of the total burden (\$6.2 billion), while nonviral/bacterial STDs accounted for only six percent of the burden (\$400 million).⁷⁶ HIV and HPV were by far the most costly STDs in terms of total estimated direct medical costs, accounting for ninety percent of the total burden, or \$5.9

69. TIP OF THE ICEBERG, *supra* note 17, at 3 (estimating the cost of STDs at seventeen billion dollars annually); Harrel W. Chesson et al., *The Estimated Direct Medical Cost of Sexually Transmitted Diseases Among American Youth, 2000*, 36 PERSP. ON SEXUAL & REPROD. HEALTH 11, 11 (2004) (estimating the direct costs of STDs to be between \$9.3 and \$15 billion in year 2000 dollars).

70. Chesson et al., *supra* note 69, at 11. Costs refer to direct medical and non-medical costs of treating STDs. *Id.* Direct medical costs include costs involved with treating acute STDs and the sequelae of untreated or inadequately treated STDs, such as clinician visits, hospitalization, diagnostic testing, and drug therapy. *Id.* Direct nonmedical costs include cost of transportation to medical services. *Id.* These direct costs must be distinguished from indirect medical costs such as productivity losses, lost wages attributable to STDs, and intangible costs such as human pain and suffering; indirect medical costs are not included in these estimates. *Id.* These costs would obviously be higher if expressed in current U.S. dollars. *Id.*

71. *Id.* (excluding hepatitis C and bacterial vaginosis).

72. *Id.*

73. TIP OF THE ICEBERG, *supra* note 17, at 3 (estimating that seven billion dollars in costs results from HIV/AIDS annually and another ten billion dollars per year results from other STDs).

74. ASHA—WHAT COST?, *supra* note 2, at 26 tbl.5.

75. Chesson et al., *supra* note 69, at 11, 15.

76. *Id.*

billion.⁷⁷ Young people thus represent the class creating the most substantial economic burden in America relating to sexually transmitted diseases. Americans as a whole are paying the price through the cost-spreading function of insurance and government aid.⁷⁸ These costs do not begin to include the enormous emotional and mental health costs associated with early sexual activity and STD infection.⁷⁹

C. WHO IS SPREADING SEXUAL DISEASES?

The number of sexually diseased persons in the United States could lead one to assume that these diseases are spread randomly throughout the population. However, researchers believe that this is not the case at all.⁸⁰ A core group of sexually promiscuous people is responsible for the vast majority of new sexual disease cases; the vast majority of Americans never transmit a sexual disease to another person, even if they have one.⁸¹

The most important datum relative to the transmission of a sexual infection is the number of other sexual partners the infected person's partners have during an infectious period.⁸²

77. *Id.*

78. In one study of patients receiving care for HIV, forty-seven percent were covered by Medicaid or Medicare, thirty-three percent had private insurance, and twenty percent were uninsured. William E. Cunningham et al., *Prevalence and Predictors of Highly Active Antiretroviral Therapy Use in Patients with HIV Infection in the United States*, 25 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES 115, 118 (2000).

79. When compared to sexually inactive teens, sexually active teens are more likely to be depressed (3.3 times more likely for girls, 2.4 times more likely for boys) and to commit suicide (2.8 times more likely for girls and 8.6 times more likely for boys). ROBERT E. RECTOR ET AL., THE HERITAGE FOUNDATION, CENTER FOR DATA ANALYSIS REPORT #CDA03-04, SEXUALLY ACTIVE TEENAGERS ARE MORE LIKELY TO BE DEPRESSED AND TO ATTEMPT SUICIDE 1-5 (June 2, 2004), available at http://www.heritage.org/Research/Family/upload/43062_1.pdf (relying on data from the National Longitudinal Survey of Adolescent Health, Wave II, 1996, which is funded by the National Institute of Child Health and Human Development (NICHD) and seventeen other federal agencies). The researchers controlled for race, gender, exact age, and family income and found that there was virtually no impact on the statistics, meaning that sexual activity appears to be the cause of the increased depression and attempted suicide, not confounding factors such as race or socioeconomic status. *Id.* at 5, 7-8. Not surprisingly, sixty-three percent of teens who had been sexually active expressed regret and wished that they had waited longer to have sex. *Id.* at 5 tbl.2.

80. Interview with Ed Laumann, *supra* note 15.

81. *See id.*

82. *Id.*

The most current available research indicates that over eighty percent of Americans ages eighteen to fifty-nine have zero or one sex partner in any given year, sixteen percent have between two and four partners, and only three percent have more than five sex partners.⁸³ Age has a strong negative correlation with number of sex partners; younger persons have many more sex partners than older persons.⁸⁴ Of course, the greater the number of sex partners, the greater the chance of acquiring a sexual disease; and, once a disease is contracted, the greater the number of subsequent sexual partners who are exposed.⁸⁵ Thus, within this core group of sexually active persons, the risk of infection rises not linearly as the number of partners rises, but exponentially.⁸⁶

People who have sex with people whom they have known for less than one month are four to five times more likely to contract a sexual disease.⁸⁷ People who have concurrent (non-monogamous) sexual partnering during some period of time create the greatest risk of spreading an infection if they contract one. Research has found that of those persons who admitted to having two partners in the past year, fifty-one percent had two or more partners concurrently during at least part of the past year.⁸⁸ Of those who reported having three partners in the past year, sixty-one percent reported concurrent sexual re-

83. LAUMANN ET AL., *supra* note 19, at 185. This is the most current comprehensive data on numbers of sex partners per year, and probably remains accurate for Americans over age twenty-eight, who were eighteen at the time of the studies. However, considering other evidence that persons under age twenty-five are generally much more promiscuous than prior generations, disproportionately represent new cases of sexual disease, and were not included in this study, this data may not be accurate relative to this younger group of Americans. *See, e.g.*, 2005 DUREX GLOBAL SEX SURVEY, *supra* note 66 (demonstrating the marked differences in promiscuity between teenagers of the current generation and teenagers of previous generations). This data nonetheless demonstrates that most Americans' sexual practices remain monogamous and grossly divergent from that portrayed by television and other media forms. *See THE HIDDEN EPIDEMIC, supra* note 1, at 86–107.

84. LAUMANN ET AL., *supra* note 19, at 185–86. To the extent that this research is somewhat outdated, and considering the disease rate among young persons and the fact that young persons have always had more partners than older persons, it is logical to conclude that persons under age thirty are largely responsible for spreading sexual diseases and are frequently infecting others in the same age group.

85. *Id.* at 376–441.

86. Interview with Ed Laumann, *supra* note 15.

87. LAUMANN ET AL., *supra* note 19, at 408–09 tbl.11.15.

88. *Id.* at 183 tbl.5.2.

relationships, and of those who had six or more partners in the past year, eighty-five percent reported concurrent sexual relationships.⁸⁹ For persons with two partners in the past year that were concurrent, the length of time during which the person had sexual relations with both averaged 2.5 months; for those who had six or more partners in the past year, the period during which they had overlapping sexual relationships rose to 7.6 months.⁹⁰ Of the persons who admit to having had three or more partners in the past twelve months, thirty percent stated that their partners also had three or more partners during the same period.⁹¹

Research further reveals that twenty-seven percent of men and forty-eight percent of women who report having had more than ten partners since age eighteen contract at least one STD, and thirty-seven percent of men and fifty-five percent of women who report having had twenty-one or more partners since age eighteen contract at least one STD.⁹² Since about three percent of persons report having more than five partners in the same year,⁹³ young persons who have not yet married have the greatest number of partners,⁹⁴ and younger persons have more partners than similarly situated persons in prior generations,⁹⁵ it becomes clear that a small fraction of the American public is responsible for the continued reproduction of several highly infectious STDs, meaning that these people spread the infection to at least one other person before they are no longer infectious.⁹⁶ Other research has shown that persons with viral STDs have at least as many sexual partners, if not more, than per-

89. *Id.*

90. *Id.*

91. *Id.* at 404.

92. *Id.* at 387 tbl.11.6. The type of disease also plays a role in the ease of transmission. For example, bacterial infections are transmissible following a short incubation period and are no longer communicable after treatment. People with bacterial infections such as chlamydia and gonorrhea are usually infectious for about a month if they have symptoms, and about four months if they are asymptomatic. *Id.* at 424. Bacterial infections are generally the most highly transmissible STDs. *Id.* Viral STDs cannot be cured, and persons infected with these STDs can be infected for years rather than months after being exposed. For example, AIDS can be transmitted continuously by the infected person, while genital herpes and warts are intermittently transmissible, usually during outbreaks or other symptoms of the disease. *Id.*

93. *Id.* at 184.

94. *Id.* at 178 tbl.5.1B, 208 tbl.5.9A.

95. *Id.* at 204 tbl.5.7.

96. *Id.* at 424–25

sons who have never been infected with an STD, and that persons with viral STDs do not moderate their sexual contact with others in any appreciable way.⁹⁷ In addition, persons with a history of both bacterial and viral infections report having sex more frequently (gauged as number of sex acts per week) than those who have never been infected.⁹⁸ Finally, persons with prior viral infections, in particular the youngest group ages eighteen to twenty-nine, “use condoms during vaginal intercourse *far less often* than [those with no prior STDs].”⁹⁹ Thus, while the consistent use of condoms can control the transmission of a variety of STDs,¹⁰⁰ some of the most sexually irresponsible members of society are failing to use them.¹⁰¹

Although core group members often transmit diseases to other core group members, they also connect with non-core group members, passing sexual diseases to the general public.¹⁰² Due to the nature of infectious antigens’ need for new bodies to stay in circulation, if the three percent of Americans¹⁰³ who represent the core group were to stop transmitting

97. *Id.* at 425.

98. *Id.*

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

100. *Id.* at 422 tbl.11.23. There have been a few studies about actual condom use. Younger persons are much more likely to use condoms than older persons. *Id.* at 426 tbl.11.24B. Young persons demonstrate less trust that a sexual partner will not transmit a disease. The researchers asked whether respondents agreed with the statement, “You don’t need to use a condom if you know your partner well.” Seventy-four percent of respondents ages eighteen to twenty-four disagreed, while fifty-nine percent overall disagreed. *Id.* at 430. Perhaps ironically, the persons who had had fewer sexual partners were less trusting that a partner would not give them a disease. Or, perhaps their level of caution was the reason that they had had fewer sex partners. *Id.* at 430–31. Persons who had never had an STD were more likely to use condoms than those who had been infected with a viral STD. *Id.* at 426 tbl.11.24B.

101. Among persons who have had sex with four or more other persons in the last year, condom use never exceeds 30.8% other than in one-night stand situations, in which condom use rises to between 59% and 63%. *Id.* at 418–21, tbls.11.21–.22. This category includes persons who have sex with twenty, thirty, or even more partners per year—that is, the riskiest group of individuals.

102. *Id.* at 184, 424. However, since the non-core group members usually are not engaged in concurrent sexual relationships, they rarely transmit the disease to any other person. *Id.* at 424.

103. This three percent of Americans includes a larger percent of persons under age twenty-five, and a much smaller percent of persons over age forty-

diseases, *all* sexually transmitted diseases would die out when all infected persons died; thus, some epidemiologists believe that three percent of Americans may be responsible for one hundred percent of sexual disease perpetration.¹⁰⁴ Even if these figures are not exact, there is no question that a small, core group of Americans is responsible for the vast majority of new STD cases in the United States.

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

II. HISTORICAL AND CURRENT SEX TORT JURISPRUDENCE

*“The history of man indicates that as soon as he created the relationship of marriage, adultery was not far behind.”*¹⁰⁵

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

five, who are generally married and so presumably “exit” the sexual market. Interview with Ed Laumann, *supra* note 15.

104. *Id.* Professor Laumann disputes this conclusion, which is based on mathematical models which assume pure random mixing. *Id.*

105. Daniel E. Murray, *Ancient Laws on Adultery—A Synopsis*, 1 J. FAM. L. 89, 89 (1961).

A. SEXUAL BEHAVIOR AND THE LAW: A BRIEF HISTORY

*“Amatory torts . . . have been abolished. . . . The derisive term “heartbalm” attached to the breach of promise action is an indication that public policy no longer considers money damages appropriate for what is perceived as only an ordinary broken heart.”*¹⁰⁶

Regulation of sexual conduct can be traced to ancient law and has been a constant throughout history. Most of the ancient laws relating to sexual impropriety dealt with adultery.¹⁰⁷ Most U.S. states still have criminal statutes on the books providing for punishment of adultery, but criminal prosecutions are virtually non-existent.¹⁰⁸

Historically, the American tort system has actively deterred socially undesirable sexual conduct other than adultery. In the latter part of the nineteenth century, actions for seduction were among the most common forms of civil actions, and were usually successful.¹⁰⁹ Prior to the 1930s, U.S. courts entertained actions for alienation of affections,¹¹⁰ criminal conver-

106. Conley v. Romeri, 806 N.E.2d 933, 938 n.5 (Mass. App. Ct. 2004) (quoting Jeffrey D. Kobar, Note, *Heartbalm Statutes and Deceit Actions*, 83 MICH. L. REV. 1770, 1778 (1985)).

107. Ancient punishment for adultery included being eaten alive by dogs, death of both parties, bodily mutilation of the adulterer, and, in ancient Rome, giving both the husband and the father the “right” to kill the guilty parties. See William R. Corbett, *A Somewhat Modest Proposal to Prevent Adultery and Save Families: Two Old Torts Looking for a New Career*, 33 ARIZ. ST. L.J. 985, 1002–03 (2001); Jill Jones, Comment, *Fanning an Old Flame: Alienation of Affections and Criminal Conversation Revisited*, 26 PEPP. L. REV. 61, 64–65 & nn.29–33 (1998). English common law considered adultery to be a tort, not a crime, and “allowed the husband of an adulterous wife to sue his wife’s lover for money damages in a criminal conversation action.” See Jones, *supra*, at 65. Early American Puritans forced adulterers to wear a scarlet “A” in lieu of death as punishment for adultery. See *id.* at 65 n.37.

108. See Jones, *supra* note 107, at 65–66. However, criminal seduction convictions relating to minors have been recorded as recently as 1988. See *People v. Bayless*, No. C043952, 2004 WL 2341477, at *2 (Cal. Ct. App. 2004) (noting that the defendant had been convicted of seduction of a minor in 1988). *Am-burgey v. Commonwealth*, 415 S.W.2d 103, 104 (Ky. 1967) (emphasizing that the seduction victim was under age twenty-one); Dan Subotnik, “*Sue Me, Sue Me, What Can You Do to Me? I Love You*”: A Disquisition on Law, Sex, and Talk, 47 FLA. L. REV. 311, 324 n.58 (1995).

109. Jane E. Larson, “*Women Understand So Little, They Call My Good Nature Deceit*”: A Feminist Rethinking of Seduction, 93 COLUM. L. REV. 374, 383–84 (1993).

110. See Jones, *supra* note 107, at 66–67. Alienation of affections occurred when a third party’s interference destroyed the affection that existed between

sation,¹¹¹ seduction,¹¹² and breach of marriage promise.¹¹³ What bound these four “heartbalm” torts together was their common focus on legal redress for emotional and reputational injury resulting from sexual misconduct; disease control was not a factor.¹¹⁴

During the latter half of the twentieth century, heartbalm torts were eviscerated, essentially on the ground that public policy does not support civil redress for broken hearts, and that women who brought heartbalm actions were abusing men through the civil court system. Early feminists who sought freedom from paternalistic laws and obsolete common law conceptions of women as property of men¹¹⁵ fueled the first anti-heartbalm movement as part of the first American sex revolution that began in the 1930s.¹¹⁶ Indiana’s enactment of the Act

spouses prior to the interference. *Id.* at 68–69. This tort was known as “enticement” in English common law, and could be brought against any meddling third party, even without sexual involvement, such as mothers-in-law. *Id.* at 66, 68–69. Some scholars assert that alienation of affections did not evolve from enticement. *Id.* at 67.

111. *Id.* at 66–68. This tort involved a third party’s adulterous relationship with a plaintiff’s spouse. It was a strict liability tort, as there were no real defenses. *Id.* Defendants were liable even if the adulterous spouse lived apart from the plaintiff and represented herself to be unmarried. *Id.* This tort was known as “seduction” in English common law. *Id.*

112. Seduction went through some changes in American law, and this tort was codified in many states beginning in Iowa in 1851, and allowed women to sue in their own name for damages resulting from the devastating social injury that resulted at that time from premarital sex or unwed motherhood. *See* Larson, *supra* note 109, at 385–86.

113. *Id.* at 394 & n.85.

114. *Id.*

115. All of these torts originated from the concept that women were property, which is why fathers and husbands had the right to sue the men who took sexual advantage of their daughters or wives, as this constituted an interference with their property rights and loss of the woman’s services to the plaintiff. *See id.* at 382–83; *see also* WILLIAM L. PROSSER, *LAW OF TORTS* 875 (4th ed. 1971) (explaining that a wife’s consent did not destroy the husband’s criminal conversation action, since the wife was considered property: “it was considered that [the wife] was no more capable of giving consent which would prejudice the husband’s interest than would his horse” (citing 8 HOLDSWORTH, *HISTORY OF ENGLISH LAW* 430 (2d ed. 1937))).

116. *See, e.g.,* Subotnik, *supra* note 108, at 320–21. Ironically, the arguments that fueled the movement to abandon heartbalm torts were hardly consistent with the view that women were independent, competent people who did not need the law’s protection. Instead, the main arguments in support of the anti-heartbalm movement centered on women’s alleged misuse of the torts to extort money from men, with newspaper articles calling plaintiffs in these cases “goldiggers” and “blackmailers” who used the heartbalm torts as tools for extortion. Larson, *supra* note 109, at 394–96.

To Promote Public Morals initiated the movement, abolishing all of the state's heartbalm torts.¹¹⁷ Other states quickly proposed similar legislation, and much of the rhetoric surrounding the new legislation was misogynistic, focusing on the "goldiggers" who blackmailed money from men through sex tort vehicles.¹¹⁸ Nonetheless, even though twenty-three states considered anti-heartbalm legislation in 1935, only eight states had passed such legislation by 1950.¹¹⁹

A second wave of anti-heartbalm legislation emerged with the second American sexual revolution of the 1960s.¹²⁰ This period, of course, involved a sweeping rejection of traditional American values. Traditional beliefs about sexual morality and gender roles were abandoned, as more women moved from the home into the workforce and, perhaps above all, women gained substantial control over their reproductive function with the birth control pill.¹²¹ No doubt spurred in part by the release of the Kinsey reports¹²² and the popularization of pornography

117. See 1935 Ind. Acts 1009 (codified at IND. CODE ANN. § 2-508 (LexisNexis 1945)); Corbett, *supra* note 107, at 1007–08.

118. See Corbett, *supra* note 107, at 1007–10; Larson, *supra* note 109, at 394–400, 445–48.

119. See Corbett, *supra* note 107, at 1008 nn.100–03.

120. Although most people think of the American sexual revolution as a 1960s phenomenon, from a sociological and legislative standpoint, it is really the second wave of a sexual revolution that began in the 1930s when Victorian concepts were rejected by early feminists, and female power and sexual expression became more socially acceptable. In addition, the 1960s sexual revolution probably began no later than 1953, when Kinsey's second report and Playboy magazine came out, as these items caused people to reassess sexual norms. See *infra* notes 122–23.

121. At least some scholars believe that this control over childbirth ushered in an "era of liberated sexual practices, where openness and sexual freedom would reign." EDWARD A. WYNNE & KEVIN RYAN, RECLAIMING OUR SCHOOLS: TEACHING CHARACTER, ACADEMICS, AND DISCIPLINE 225–26 (2d ed. 1997).

122. In 1948 and 1953, respectively, Alfred Kinsey and his colleagues published the first "scientific" data regarding male and female promiscuity. See ALFRED C. KINSEY ET AL., SEXUAL BEHAVIOR IN THE HUMAN MALE 3 (1948) [hereinafter KINSEY, MALE SEXUAL BEHAVIOR]; ALFRED C. KINSEY ET AL., SEXUAL BEHAVIOR IN THE HUMAN FEMALE 3 (1953) [hereinafter KINSEY, FEMALE SEXUAL BEHAVIOR]. Despite methodological flaws, the most serious of which related to the unrepresentative sexual nature of the subjects of the study, who were recruited from "[a] fraternity here, a college class there, a PTA from a third place, and a group of homosexual men from somewhere else," the Kinsey reports were widely read, "shocked the nation and became enshrined as the nation's report card on sexual behavior." ROBERT T. MICHAEL ET AL., SEX IN AMERICA 15–20 (1994). The reports stated, *inter alia*, that ninety percent of men and fifty percent of women had premarital sex, that almost all men and sixty percent of women masturbated, and that fifty percent

through publications such as *Playboy*,¹²³ sex came out of the closet and into the streets, and consensual sex outside of marriage, masturbation, cohabitation, birth control, and even abortion became more accepted.¹²⁴ The only practical consequences of adultery or other irresponsible or deceptive sexual behavior were a lover's contempt, and possibly a relatively benign, curable sexual disease.¹²⁵

of men had extramarital sex. KINSEY, MALE SEXUAL BEHAVIOR, *supra* at 502, 551, 585; KINSEY, FEMALE SEXUAL BEHAVIOR, *supra* at 151, 286. This news disturbed Americans and may have contributed to the increased sexuality of Americans thereafter. MICHAEL ET AL., *supra*, at 20. Indeed, Kinsey is reported to have encouraged pedophiles to sexually violate "from 317 to 2035 infants and children," to have been involved in a variety of perverse sexual practices, and ultimately, to have died as a result of "orchitis," a lethal infection of the testicles that results from masochistic masturbation. Judith A. Reisman, *Crafting Bi/Homosexual Youth*, 14 REGENT U. L. REV. 283, 312 (2002). Kinsey's inaccurate data, and the resultant societal reaction, may have contributed greatly to the rise of sexual disease in America, as behavioral research shows that people's perceptions of what others are doing impacts their own choices and can alter norms. *See infra* Part III.B.2. What is clear is that prior to Kinsey's publications, the only common sexually transmitted diseases were gonorrhea and syphilis—both bacterial, and both easily treatable with antibiotics. But now, the sexual disease epidemic involves so many incurable, viral antigens that scientists cannot even count them accurately. *See supra* Part I.A.

123. The first edition of *Playboy* came out in December of 1953, the same year Kinsey's second report was released. *Playboy* FAQ, <http://www.playboy.com/worldofplayboy/faq/firstissue.html> (last visited Oct. 7, 2006). Seventy thousand copies of the first *Playboy* edition were printed and over 54,000 were sold, at fifty cents per copy, no doubt in large part because Marilyn Monroe was the centerfold. *Id.*; *see What Makes Marilyn?*, PLAYBOY, Dec. 1953, at 17, 19. On the first issue's first page, Hugh Hefner wrote, "[w]e believe too, that we are filling a publishing need only slightly less important than the one just taken care of by the Kinsey Report." *Volume 1, Number 1*, PLAYBOY, Dec. 1953, at 1, 1. There was no date on the original issue of *Playboy*, as Hefner did not know if the magazine would sell, and whether a second edition would be financially feasible. *Playboy* FAQ, *supra*. For the same reason, Hefner's name does not appear on the first edition, for fear that if it failed, he'd have trouble getting another publishing job. *Id.*

124. Anita L. Allen, *Privacy and the Public Official: Talking About Sex as a Dilemma for Democracy*, 67 GEO. WASH. L. REV. 1165, 1176 (1999).

125. In 1950, the only common sexual diseases were gonorrhea and syphilis, which were bacterial and curable. *See supra* Part I.A. Divorce law underwent radical changes as the "no fault" divorce trend, beginning in Washington State in 1973, spread quickly, removing economic consequences for adultery leading to divorce. *See* HARRY D. KRAUSE ET AL., FAMILY LAW 2 (5th ed. 2003). Prior to no-fault divorce, adultery was grounds for divorce and often diminished substantially the adulterer's property rights in the divorce settlement. *See* Linda D. Elrod & Robert G. Spector, *A Review of the Year in Family Law: State Courts React to Troxel*, 35 FAM. L.Q. 577, 611–12 (2002). However, a few

During the sexual revolution of the 1960s, feminist sex reformers sought to advance women's rights by reshaping the law's regulation of sex,¹²⁶ and a new wave of the anti-heartbalm movement ensued. This time, reforms were very successful.¹²⁷ Today, no more than nine states recognize alienation of affections or criminal conversation.¹²⁸ Seduction has been abolished by statute in all but seventeen states, and twenty-one states have interpreted their anti-heartbalm statutes to prohibit breach of promise actions.¹²⁹

Judicial sentiment surrounding the second wave of the anti-heartbalm movement revealed the sexual revolution's apparent impact on American norms. Courts expressed the view that the heartbalm torts "diminished human dignity" by airing such matters in the courts, and that the prevalence (and apparent societal acceptance) of extramarital affairs could clog the court system with vexatious litigation if such torts were allowed.¹³⁰ In turn, these reforms conveyed a message to society that the law was not concerned about sexual misconduct,¹³¹ in-

states continue to bar alimony altogether when the claimant spouse is found guilty of adultery causing divorce. *See, e.g.*, GA. CODE ANN. § 19-6-1 (2004).

126. As part of this movement, rape laws were also changed to protect women. For example, laws eliminated the marital exception to rape and prohibited sexual harassment. *See, e.g.*, Larson, *supra* note 109, at 400–01.

127. *See* Corbett, *supra* note 107, at 1009–10.

128. *Id.* at 1009.

129. *See* Subotnik, *supra* note 108, at 321–22.

130. *See* Feldman v. Feldman, 480 A.2d 34, 36 (N.H. 1984); Jones, *supra* note 107, at 72–73; *see also* Norton v. MacFarlane, 818 P.2d 8, 12 (Utah 1991) (stating that allegations of sexual misconduct no longer carry a significant stigma).

131. At least one legal scholar has argued that Lorena Bobbit's self-help decision to remove her husband's penis while he slept resulted in part from a lack of legal remedies. *See* Gretchen Reynolds, *A Breach of Promise*, CHI. MAG., Apr. 1994, at 114, 114. In 1997, a North Carolina jury ordered a husband's adulterous lover to pay his wife one million dollars after deciding that the lover lured him away from his wife and family. *See* Hutelmyer v. Cox, 514 S.E.2d 554 (N.C. Ct. App. 1999); Terry Carter, "She Done Me Wrong": A Jury Agrees, Awarding a Jilted Wife \$1 Million in an Alienation of Affection Suit Against the "Other Woman," A.B.A. J., Oct. 1997, at 24. In an interview with Dateline NBC, jurors stated that they wanted to send a message about marriage and morality and to make clear that "homewreckers" were wrong. *Dateline NBC: Three's Company; Woman Accused of Breaking up Marriage Sued by Ex-Wife* (NBC television broadcast Dec. 15, 1997). The show described the case pursued by Dorothy Hutelmyer against her husband's secretary as a "symbol for the prevailing thoughts about relationships and marriage in this area." *Id.* The secretary-defendant later stated that, in retrospect, she would not have dated Joe Hutelmyer under the circumstances, and would have waited until he was divorced before seducing him. *Id.* This contention is contrary to one

cluding adultery,¹³² in part because sex tort law was focused on broken hearts and injury to dignity, not deadly diseases. The absence of legal sanctions for sexual misconduct,¹³³ and resulting contemporary belief among some Americans that they owe nothing to their sexual partners, fail to discourage sexual promiscuity,¹³⁴ and contribute to the sexual disease epidemic. Tort law's current message to society regarding sexuality is clearly "caveat emptor."¹³⁵

B. SEX TORTS TODAY

*"[P]laintiff's claim clearly is barred The very illegal act to which the plaintiff consented [premarital sex] . . . produced the injuries and damages of which she complains [genital herpes]. And, the foregoing principle [illegal acts bar recovery in tort] applies even though defendant concealed his infection from the plaintiff."*¹³⁶

The sexual disease epidemic necessitates a reassessment of tort law's proper function in sexual relations, as a new wave of sex tort litigation—seeking damages for sexual disease transmission—has been growing over the past twenty years and will likely continue to grow commensurate with the proliferation of

court's opinion that in matters of sex, the risk of damages is not a deterrent. See *Neal v. Neal*, 873 P.2d 871, 875 (Idaho 1994).

132. A high percentage of Americans say that adultery is wrong, and in fact more Americans say so today than in the 1970s (around 85%), yet when asked if they thought less of a person who they knew had committed adultery, only about 60% said they lost esteem for that person. Bruce Handy, *How We Really Feel About Fidelity*, TIME, Aug. 31, 1998 at 52, 52–53. In a 1998 CNN/Time poll, 86% of Americans responded that adultery was wrong, compared with 76% in 1977. CNN.com, Allpolitics, *How Do Americans View Adultery?* (Aug. 20, 1998), <http://www.cnn.com/ALLPOLITICS/1998/08/20/adultery.poll>.

133. This has led one legal commentator to conclude, "The current lack of penalties for adultery and interference with family relationships is shockingly new." See Jones, *supra* note 107, at 64.

134. "Promiscuity" does not carry a moral connotation but means "indiscriminate" or "not restricted to one sexual partner." MERRIAM-WEBSTER'S COLLEGIATE DICTIONARY 994 (11th ed. 2003).

135. See Larson, *supra* note 109, at 413 ("Ironically, the principle of caveat emptor remains most vigorously alive in the sexual marketplace.").

136. *Zysk v. Zysk*, 404 S.E.2d 721, 722 (Va. 1990). This case was essentially overruled by the Supreme Court decision in *Lawrence v. Texas*, 539 U.S. 558, 558–78 (2003), which held a Texas statute banning same-sex sodomy between consenting adults unconstitutional. *Id.*; *Martin v. Zihler*, 607 S.E.2d 367, 370 (Va. 2005) (holding that the personal liberty rights guaranteed by *Lawrence* extend to premarital sex).

sexual disease. Although a few states have recognized negligent transmission of sexual disease since the late nineteenth or early twentieth century,¹³⁷ courts all over the United States are addressing as an issue of first impression the question of whether civil liability is appropriate for sexual disease transmission.¹³⁸ Courts are grappling for liability standards in sex

137. Tort recovery for the negligent transmission of a contagious disease, such as whooping cough, has existed in the United States since the latter part of the nineteenth century. *See, e.g.*, *Smith v. Baker*, 20 F. 709, 709–10 (S.D.N.Y. 1884) (whooping cough); *Gilbert v. Hoffman*, 23 N.W. 632, 632, 634 (Iowa 1885) (smallpox); *Kowalske v. Armour & Co.*, 220 N.W.2d 268, 270–71, 273–74 (Minn. 1974) (brucellosis); *Skillings v. Allen*, 173 N.W. 663, 664 (Minn. 1919) (scarlet fever); *Franklin v. Butcher*, 129 S.W. 428, 428, 431 (Mo. 1910) (smallpox); *Hendricks v. Butcher*, 129 S.W. 431, 432–33 (Mo. Ct. App. 1910) (smallpox); *Earle v. Kuklo*, 98 A.2d 107, 108–09 (N.J. Super. 1953) (tuberculosis); *Kliegel v. Aitken*, 69 N.W. 67, 67, 69 (Wis. 1896) (typhoid fever). Transmission of a sexual disease has constituted a crime in some states since the early twentieth century. *See, e.g.*, OKLA. STAT. ANN. tit. 63 § 1-519 (1991 & Supp. 2006) (originally enacted as OKLA. STAT. ANN. tit. 63 § 543 (1921)); *State v. Lankford*, 102 A. 63, 64 (Del. Ct. Gen. Sess. 1917) (syphilis). Tort liability has also been recognized for sexual disease transmission in some states since the late nineteenth and early twentieth centuries. *See, e.g.*, *White v. Nellis*, 31 N.Y. 405, 405, 410 (1865) (venereal disease); *Crowell v. Crowell*, 105 S.E. 206, 206, 208, 210 (N.C. 1920) (unspecified venereal disease); *De Vall v. Strunk*, 96 S.W.2d 245, 246–47 (Tex. Civ. App. 1936) (crabs). However, disease has not been the focus of sex tort law until fairly recently, a result of the sexual disease epidemic. *See, e.g.*, *Berner v. Caldwell*, 543 So.2d 686, 687, 690 (Ala. 1989) (genital herpes); *Doe v. Roe*, 267 Cal. Rptr. 564, 564, 568 (Cal. App. 1990) (genital herpes); *Kathleen K. v. Robert B.*, 198 Cal. Rptr. 273, 274, 277 (Cal. App. 1984) (genital herpes); *Cerniglia v. Levasseur*, No. CV950548181, 1995 WL 500673 at *1–2, *6 (Conn. Super. Ct. Aug. 15, 1995) (genital herpes to a third party); *Long v. Adams*, 333 S.E.2d 852, 853, 856 (Ga. Ct. App. 1985) (genital herpes); *Meany v. Meany*, 639 So.2d 229, 230–31, 237 (La. 1994) (genital herpes); *McPherson v. McPherson*, 712 A.2d 1043, 1044, 1046–47 (Me. 1998) (human papilloma virus); *M.M.D. v. B.L.G.*, 467 N.W.2d 645, 646, 648 (Minn. Ct. App. 1991) (herpes); *R.A.P. v. B.J.P.*, 428 N.W.2d 103, 105–06 (Minn. Ct. App. 1988) (herpes); *S.A.V. v. K.G.V.*, 708 S.W.2d 651, 652–53 (Mo. 1986) (herpes); *G.L. v. M.L.*, 550 A.2d 525, 526, 528 (N.J. Sup. Ct. 1988) (genital herpes); *Plaza v. Estate of Wisser*, 626 N.Y.S.2d 446, 449, 545–55 (N.Y. App. Div. 1995) (HIV); *Schenk v. Devall*, 613 N.Y.S.2d 478, 479–80 (N.Y. App. Div. 1994) (herpes); *Desideri v. Brown*, 584 N.Y.S.2d 815, 815–16 (N.Y. App. Div. 1992) (venereal disease); *Maharam v. Maharam*, 510 N.Y.S.2d 104, 105, 108–09 (N.Y. App. Div. 1986) (herpes); *Tischler v. Dimenna*, 609 N.Y.S.2d 1002, 1002–03, 1009–10 (N.Y. Sup. Ct. 1994) (AIDS); *Doe v. Roe*, 598 N.Y.S.2d 678, 679–80 (N.Y. Just. Ct. 1993) (chlamydia); *Mussivand v. David*, 544 N.E.2d 265, 265, 273–74 (Ohio 1989) (venereal disease); *Lockhart v. Loosen*, 943 P.2d 1074, 1076–77, 1081–82 (Okla. 1997) (genital herpes); *Duke v. Housen*, 589 P.2d 334, 337–38, 353 (Wyo. 1979) (gonorrhea).

138. *See, e.g.*, *McPherson v. McPherson*, 712 A.2d 1043, 1045 (Me. 1998) (“Turning to [plaintiff’s] novel theory of negligence, we must first determine whether a negligence action may be based on the transmission of a sexually transmitted disease, an issue of first impression in Maine.”); *B.N. v. K.K.*, 538

tort cases while holding tight to anti-heartbalm sentiment. This stance has resulted in sex tort jurisprudence that is unclear and unpredictable, thereby failing to meet tort law's goals of deterrence, education, and compensation in light of a very serious public health threat.¹³⁹ Although sexual disease cases are almost always brought as negligence actions, courts have also recognized sex torts grounded in fraud, intentional infliction of emotional distress, and battery where the plaintiff contracted a sexual disease.¹⁴⁰ This Section argues that negligence and intentional tort theories do not further social policy in sexual disease transmission cases.

1. Negligence Theory

*"[P]ersons who engage in unprotected sex, at a time of the prevalence of sexually transmitted diseases, including some that are fatal, assume the risk of contracting such diseases. Both parties in an intimate relationship have a duty to adequately protect themselves. When one ventures out in the rain without an umbrella, should they complain when they get wet?"*¹⁴¹

This quote expresses a typical judicial attitude toward sexual disease transmission: while courts recognize the prevalence of the public health threat, their attitude toward persons foolish enough to contract a sexual disease trumps solid public policy analysis. Opinions such as this shame the victim and allow sexual disease perpetrators to pay no regard to others' health. Since this opinion was written in 1993, tens of millions of Americans have contracted sexual diseases.¹⁴²

A.2d 1175, 1176 (Md. Ct. App. 1988) (answering affirmatively the question from the District Court: "Does Maryland Recognize A Cause of Action for Either Fraud, Intentional Infliction Of Emotional Distress, Or Negligence Resulting From the Sexual Transmission Of A Dangerous, Contagious, and Incurable Disease, Such As Genital Herpes?").

139. Some states are still in the process of abolishing heartbalm torts. See, e.g., *Neal v. Neal*, 873 P.2d 871, 875 (Idaho 1994) (finding that Idaho no longer recognizes criminal conversation as a tort).

140. A few cases have also recognized negligent infliction of emotional distress, but these usually involve fear of contracting AIDS and are generally analyzed consistent with toxic tort cases, focusing on fear of future disease. See, e.g., *Tischler v. Dimenna*, 609 N.Y.S.2d 1002 (N.Y. Sup. Ct. 1994).

141. *Doe v. Roe*, 598 N.Y.S.2d 678, 681 (N.Y. Just. Ct. 1993).

142. See *supra* Part I.A.

Sexual disease transmission cases rely almost exclusively on negligence theory,¹⁴³ a fault-based tort which is unpredictable, inefficient, and often extremely embarrassing for the parties involved in sex tort cases. Although all contemporary courts that have dealt with the issue have found that it is possible to state a claim for negligent transmission of a sexual disease, the current negligence paradigm creates prohibitively expensive and embarrassing fact-specific litigation and the attendant problem of very uncertain liability, thereby failing to deter irresponsible sexual conduct. Primarily, judges seem reluctant to establish a clear duty of care relative to sexual activity,¹⁴⁴ instead adopting a case-by-case inquiry to determine whether a duty to protect a sexual partner from a sexual disease should exist.¹⁴⁵ In addressing the question of duty, courts have focused on the nature of the parties' relationship and whether the defendant knew or should have known of his disease, to establish the foreseeability of infecting others. A California opinion exemplifies the case-by-case approach to the duty question:

In determining whether a duty should be imposed, the courts are guided by the basic principle . . . that everyone is responsible for injury occasioned to another by his own want of ordinary care or

143. See, e.g., Michele L. Mekel, *Kiss and Tell: Making the Case for the Tortious Transmission of Herpes and Human Papilloma Virus*, 66 MO. L. REV. 929, 938–39 (2001). Negligent conduct is conduct that creates an unreasonable risk of harm to a person to whom a duty of due care is owed, and is generally stated upon prima facie proof of four elements: duty, breach, harm, and causation. *Id.*

144. *But see* R.A.P. v. B.J.P., 428 N.W.2d 103, 106–08 (Minn. Ct. App. 1988) (noting that persons with sexual diseases are in the best position to control the spread of the disease).

145. Although some courts have found that a duty to avoid infecting others always exists where the defendant knows of his disease, defendants often do not know, or claim that they do not know, resulting in courts finding no duty based on lack of foreseeability. See, e.g., *Doe v. Roe*, 267 Cal. Rptr. 564, 566–67 (Cal. Ct. App. 1990) (“Ordinarily foreseeability is a question of fact.” “The degree of foreseeability necessary to warrant the finding of a duty will vary from case to case.” (quoting *Bigbee v. Pac. Tel. & Tel.*, 665 P.2d 947, 950 (Cal. 1983); *Isaacs v. Huntington Mem. Hosp.*, 695 P.2d 653, 658 (Cal. 1985))). Courts have similarly found a breach of the duty on the basis of varying degrees of careless actions. See, e.g., *Berner v. Caldwell*, 543 So. 2d 686, 689 (Ala. 1989) (carelessly exposing others to infection); *Doe*, 267 Cal. Rptr. at 565, 567 (failing to inform a sexual partner that defendant had herpes and failing to put on a condom); *M.M.D. v. B.L.G.*, 467 N.W.2d 645 (Minn. Ct. App. 1991) (failing to obtain a diagnosis and treatment where defendant claims he was unaware of the infection but had recurring genital sores and had received medical advice that they may be herpes); *Leary*, *supra* note 2, at 176 n.17 (describing the imposition of liability for failure to abstain from sex).

skill. . . [I]n cases where the burden of preventing future harm is great, a high degree of foreseeability may be required. On the other hand, in cases where there are strong policy reasons for preventing the harm, or the harm can be prevented by simple means, a lesser degree of foreseeability may be required. . . . [In the case of herpes], it is beyond question that our state's policy of preventing the spread of venereal disease is great and that the burden of warning a prospective sex partner is small. Thus, only a slight degree of foreseeability was needed to warrant the imposition of a duty of due care in the present case [of herpes transmission].¹⁴⁶

An Oklahoma decision is representative of the unpredictable nature of the duty inquiry: "The length and nature of the parties' relationship, its degree of intimacy, and [defendant's] knowledge of her condition are all factors to consider in order to determine whether [defendant's] conduct created . . . a duty to lessen the risk or take precautions to protect others. . . ."¹⁴⁷

The unclear duty standard that has emerged in sexual disease cases¹⁴⁸ has prompted defendants to make numerous ar-

146. *Doe*, 267 Cal. Rptr. at 566–67; *see also* *Cerniglia v. Levasseur*, No. CV950548181, 1995 WL 500673, at *3–4 (Conn. Super. Ct. Aug. 15, 1995) (holding that persons with a venereal disease have a duty to use reasonable care to avoid infecting others with whom they engage in sexual conduct); *McPherson v. McPherson*, 712 A.2d 1043, 1046 (Me. 1998) (finding that a defendant cannot be liable for negligent transmission of the human papilloma virus to his wife where the trial court found that he did not know or have reason to know that he had the disease at the time he infected his wife; and that, absent foreseeability, defendant cannot be found to have breached a duty of care); *M.M.D.*, 467 N.W.2d at 647 ("A reasonable person with recurring sores on the genitals . . . has a duty to avoid sexual contact, or at least to inform potential sex partners about the genital sores and [his] physician's advice."); *R.A.P.*, 428 N.W.2d at 106–07 ("Minnesota courts have long recognized that the preservation of public health is a matter of great public importance. Legal duties and rules must therefore be designed, whenever possible, to help prevent the spread of dangerous, communicable diseases." (citing *Skillings v. Allen*, 173 N.W. 663, 664 (Minn. 1919))).

147. *Smith v. Speligene*, 990 P.2d 312, 315–16 (Okla. Civ. App. 1999). This case involved Herpes Simplex I, which plaintiff alleged he contracted from his former girlfriend. *Id.* at 315–16. The court utilized zone of risk analysis. *See id.* Although the case does not indicate which part of his body was infected, HSVI is usually related to oral herpes, but can be transmitted to other body parts and can be painful. All herpes viruses are incurable. K. Holmes et al., *Sexually Transmissible Diseases (Venereal Infections)*, in *CLINICAL CONCEPTS OF INFECTIOUS DISEASES* 232, 245–46 (Leighton E. Cluff & Joseph E. Johnson eds., 3d ed. 1982).

148. *See, e.g., R.A.P.*, 428 N.W.2d at 108 ("The scope of the duty of care which we recognize here will necessarily vary depending upon the facts of individual cases. As one commentator has noted, the three words 'I have herpes' will be sufficient in most cases to give fair notice of the danger of infection, and to fulfill the duty to use reasonable care to avoid transmitting the disease. Whether the duty to take reasonable precaution to avoid transmission of her-

guments asserting that no duty is owed to a sexual partner, including: that no duty exists to disclose sexual disease to a sexual partner prior to sex;¹⁴⁹ that no duty exists to the spouse of a paramour;¹⁵⁰ that no duty exists absent a confirmed diagnosis of the disease;¹⁵¹ that no duty exists to disclose extramarital sexual relations to one's spouse absent knowledge of having contracted a disease;¹⁵² and that past promiscuous behavior within a group at high risk for contracting AIDS, without knowledge of having contracted AIDS, does not give rise to a duty to warn.¹⁵³ These arguments have been entertained, and unclear legal standards have created opportunities for some of

pes has been breached is a question of fact"); *Mussivand v. David*, 544 N.E.2d 265, 269 (Ohio 1989) ("The general principle is well established that a person who negligently exposes another to an infectious or contagious disease, which such other thereby contracts, is liable in damages therefor. The degree of diligence required to prevent exposing another to a contagious or infectious disease depends upon the character of the disease and the danger of communicating it to others."). *But c.f.* *Silver v. Levittown Union Free Sch. Dist.*, 692 N.Y.S.2d 886, 887–88 (N.Y. Sup. Ct. 1999) (holding that a wrestler owed another wrestler a duty based on his knowledge of herpes blisters on his skin and the skin-to-skin contact inherent in wrestling).

149. *See, e.g., R.A.P.*, 428 N.W.2d at 106; *Smith v. Walker*, 11 Pa. D. & C. 4th 663, 664 (Pa. Ct. Com. Pl. 1991).

150. *See, e.g., Cerniglia*, 1995 WL 500673, at *4; *Lockhart v. Loosen*, 943 P.2d 1074, 1077, 1080–81 (Okla. 1997). Both cases held that a paramour may be liable to the spouse of his or her sexual partner provided that it was foreseeable that the disease could be transmitted to the spouse (i.e., the paramour knows of the marriage, as sex between spouses was held foreseeable) and no superseding cause exists (i.e., the paramour's sex partner was not informed of the disease at the time he or she gave it to his or her spouse; if the paramour's sex partner was informed, the partner's negligence or intentional misconduct in failing to inform the spouse constitutes a superseding cause). *See Cerniglia*, 1995 WL 500673, at *4–5; *Lockhart*, 943 P.2d at 1079–81.

151. *See, e.g., Doe v. Johnson*, 817 F. Supp. 1382, 1387 (W.D. Mich. 1993).

152. *See, e.g., McPherson v. McPherson*, 712 A.2d 1043, 1044–46 (Me. 1998) (holding that no duty to be sexually faithful exists in a marriage); *In re Marriage of J.T.*, 891 P.2d 729, 732 (Wash. Ct. App. 1995) (holding that no duty exists between spouses to disclose extramarital sexual relationships). *But see S.A.V. v. K.G.V.*, 708 S.W.2d 651, 652–53 (Mo. 1986) (holding that courts can assess, define, and adjust the duty of care owed by one spouse to the other spouse).

153. *See, e.g., Johnson*, 817 F. Supp. at 1392–93. In *Johnson*, the court limited the duty to warn a sexual partner about the possibility of contracting AIDS only where the defendant: (1) has actual knowledge that he is HIV positive; (2) has experienced symptoms associated with HIV; or (3) has actual knowledge that a prior sex partner has been diagnosed as having HIV. *Id.* at 1395. The court specifically held that there was no duty to warn the plaintiff that defendant was a member of a high-risk group, and that a defendant who has had unprotected sexual encounters with multiple partners does not have a legal duty to inform a plaintiff of his or her past sexual activity. *Id.*

these arguments to succeed.¹⁵⁴ Indeed, although courts have rejected the claim that a husband owes his wife no duty to avoid transmitting herpes,¹⁵⁵ a Washington court has held that there is *no duty* of sexual fidelity even in marital relationships (that is, the marriage relationship is not a “special relationship”),¹⁵⁶ and therefore there is no duty to disclose extramarital sexual relations, despite the clear health risks involved.¹⁵⁷ Other courts more broadly define the duty to include protecting others from infection, which may involve more than merely admitting to having a disease.¹⁵⁸ Most courts have found that a duty not to spread infection exists between sexual partners if the defendant knew or should have known of his disease, regardless of

154. One court noted that a single admission, “I have herpes,” may be sufficient notice to meet the duty of care. *R.A.P.*, 428 N.W.2d at 108. Third party actions create even more fact-specific inquiries into the issue of whether duty exists. For example, in one case where a wife sued her husband’s lover for transmittal of genital herpes, the issue of whether the lover owed a duty to the wife became the subject of remand to determine: (1) whether the defendant knew or should have known that she had herpes, and had copulated with the wife’s husband while infectious; and (2) whether she knew he was married (making it foreseeable that her lover would in turn give the disease to his wife, as sexual relations between spouses are foreseeable). See *Lockhart v. Loosen*, 943 P.2d 1074, 1077, 1079–81 (Okla. 1997). In addition, even in situations in which it is determined that the lover knew all of the above, if the adulterous spouse knew or should have known of the disease and passed it on to his spouse anyway, his negligence may supersede his lover’s, cutting off proximate cause based on “termination of the risk” concepts. See *Mussivand v. David*, 544 N.E.2d 265, 272–73 (1989).

155. See, e.g., *Hamblen v. Davidson*, 50 S.W.3d 433, 439 (Tenn. Ct. App. 2000).

156. *In re Marriage of J.T.*, 891 P.2d at 730. A defendant’s relationship to the plaintiff has been held to create a duty of care in a number of circumstances, sometimes referred to as “special relationships,” and include a landowner’s duty to protect customers or tenants, a school’s duty to protect students, an employer’s duty to protect employees who are endangered on the job, and a custodian’s duty to protect persons in custody, such as prisoners and involuntarily committed mental patients. See *DOBBS*, *supra* note 4, at 875–91.

157. See *In re Marriage of J.T.*, 891 P.2d at 730; see also *McPherson v. McPherson*, 712 A.2d 1043, 1045–46 (Me. 1998) (rejecting a wife’s argument that her husband owed her a duty of sexual fidelity based on the marital relationship and that a “breach of that duty is actionable when it leads to physical harm,” and instead relying on the more general concept that “one who knows or should know that he or she is infected with a sexually transmitted disease is under a duty to protect sexual partners from infection”).

158. See, e.g., *McPherson*, 712 A.2d at 1046; *Milbank Ins. Co. v. B.L.G.*, 484 N.W.2d 52, 57 (Minn. Ct. App. 1992) (“A person who knows he has herpes has ‘a duty to use reasonable care to avoid infecting others.’” (quoting *R.A.P.*, 428 N.W.2d at 107)), called into doubt on other grounds by *Am. Family Ins. Co. v. Walser*, 628 N.W.2d 605, 610 (Minn. 2001).

marriage,¹⁵⁹ or that the intimate nature of the sexual relationship created a “special relationship,” and attendant duty of care.¹⁶⁰

Published decisions have focused on whether the defendant knew of his disease or was aware of facts such that he should have known of it, i.e., foreseeability.¹⁶¹ The problem with this standard is that many people who carry sexual diseases do not know that they have a disease, but shielding them from liability based on their own ignorance is contrary to the public policy of protecting the public from contagious diseases. The factual issues surrounding the determination of whether the defendant “knew or should have known” that he was infected, e.g., symptoms of disease, have given rise to the most successful defense in sexual disease cases: the “I did not know I had it” defense.¹⁶²

159. See, e.g., *Berner v. Caldwell*, 543 So. 2d 686, 689 (Ala. 1989); *Kathleen K. v. Robert B.*, 198 Cal. Rptr. 273, 277 (Cal. Ct. App. 1984) (“[C]onsent to sexual intercourse vitiated by one partner’s fraudulent concealment of the risk of infection with venereal disease . . . is equally applicable today, whether or not partners involved are married to each other.”); *Long v. Adams*, 333 S.E.2d 852, 855 (Ga. Ct. App. 1985); *McPherson*, 712 A.2d at 1046; *Milbank Ins. Co.*, 484 N.W.2d at 57; *R.A.P.*, 428 N.W.2d at 108 (“[P]eople suffering from genital herpes generally have a duty either to avoid sexual contact with uninfected persons or, at least, to warn potential sex partners that they have herpes before sexual contact occurs.”); *Smith v. Walker*, 11 Pa. D. & C. 4th 663, 664–65 (Pa. Ct. Com. Pl. 1991).

160. See, e.g., *Doe v. Roe*, 267 Cal. Rptr. 564, 565 (Cal. Ct. App. 1990).

161. *Leary*, *supra* note 2, at 53 & nn.17–18. For example, in *Hamblen v. Davidson*, 50 S.W.3d 433 (Tenn. Ct. App. 2000), the husband claimed that he owed no duty not to transmit herpes to his wife, but the court found that a question of material fact existed as to what the husband knew about his health condition and failed to tell his wife, which precluded summary judgment for the husband. *Id.* at 435, 439. Foreseeability is crucial to defenses such as contributory negligence and assumption of the risk (often analyzed as comparative fault). See *DOBBS*, *supra* note 4, at 534–39.

162. This factual claim by the defendant destroys foreseeability and therefore duty (and proximate cause, which turns on foreseeability) in negligence-based claims. For example, in one case in which a woman sued her ex-husband for transmittal of genital herpes, the central issue was whether there was sufficient evidence from which a jury could conclude that the defendant knew, or should have known, that he was putting his wife at risk at the time he engaged in sexual relations with her. *Meany v. Meany*, 639 So. 2d 229, 235 (La. 1994). The evidence included the following: the defendant had contact with multiple sexual partners during a period of separation from the plaintiff; the plaintiff’s first symptoms occurred after reconciliation with the defendant; and, when the plaintiff confronted the defendant with her herpes diagnosis, the defendant admitted that he had experienced a problem with penile “drip-page” and had seen a doctor about it. *Id.* at 231–32. The fact that he had multiple sexual partners during a short period of separation did not establish the foreseeability necessary to allow a finding of negligence in and of itself, but

Realistically, most sexual disease transmission is perpetrated by persons whose sexual behavior predictably results in disease transmission.¹⁶³ As a practical reality, disease perpetrators have constructive notice that they are creating an unreasonable risk of harm to others on account of their sexual practices. Yet, courts have been reluctant to impose liability based on constructive notice.

Negligence analysis undermines public policy because it is fact-specific, puts the plaintiff's sexuality on trial, and allows defendants to behave irresponsibly, claim ignorance, and externalize all of the costs of their sexual behavior not just to the victim, but to society at large (through health insurance and public aid). Not only is the current negligence paradigm failing to deter irresponsible sexual behavior, it actually discourages the most sexually active "core" group members from getting tested, because in avoiding testing they also avoid any proof of knowledge of their disease.¹⁶⁴ Tort law should encourage potential disease perpetrators to be tested and to behave responsibly to avoid disease transmission, rather than giving them a defense rooted in their own ignorance. Although causation may be difficult to establish in some cases, adopting a strict duty of

helped to establish the link between druppige and a sexual disease. *Id.* at 235–36. In another case, a man was held not liable for transmitting AIDS to his fiancée because he had no reason to know, based on the information available to the public at that time, that his single homosexual experience could have resulted in him contracting AIDS. *See C.A.U. v. R.L.*, 438 N.W.2d 441, 444 (Minn. Ct. App. 1989); *see also* *Delay v. Delay*, 707 So. 2d 400, 402 (Fla. Dist. Ct. App. 1998) (granting summary judgment in favor of the defendant-husband because he claimed no knowledge that he had a sexually transmitted disease, and no evidence was presented to prove that he knew); *McPherson*, 712 A.2d at 1046 (finding that an ex-husband did not breach a duty of care to his ex-wife by transmitting human papilloma virus to her because he did not know he had it at the time he infected her); *R.A.P.*, 428 N.W.2d at 108 (remanding the case for a determination of whether the defendant informed her husband that she had herpes before marriage and before he contracted herpes (she said), or after marriage and after he contracted herpes (he said)); *Doe v. Roe*, 598 N.Y.S.2d 678, 680–81 (N.Y. Just. Ct. 1993) (dismissing the claim because there was no proof by a preponderance of the evidence that the defendant knew she had chlamydia at the time she had sex with her boyfriend); *Smith v. Speligene*, 990 P.2d 312, 315 (Okla. Civ. App. 1999) (reasoning that the existence of a duty turned in part on the factual question of whether the defendant knew she had a contagious disease that could be transmitted to her ex-boyfriend).

163. *See supra* Part I.C.

164. Professor Mekel explains that the most logical way to prove knowledge of a disease is to obtain the defendant's medical records showing disease diagnosis; one way of avoiding such a showing of fault is to avoid diagnosis. *See* Mekel, *supra* note 143, at 953.

care would avoid the most difficult analysis relating to foreseeability in current sex tort jurisprudence.¹⁶⁵

2. Intentional Theories

Sometimes plaintiffs in sexual disease transmission cases have sought remedies under intentional tort theories. Courts have held that actions for fraud and battery may lie where the plaintiff can show that the defendant intended to deceive the plaintiff regarding a sexual disease and the plaintiff justifiably relied on the defendant's misrepresentations in consenting to sex, contracting a sexual disease as a result. Specifically, fraud claims in which the plaintiff contracts a sexually transmitted disease from the defendant require a showing that the defendant made some representation about his health that was untrue, that the plaintiff relied on the misrepresentation in agreeing to engage in sexual relations, and that the plaintiff was infected as a result.¹⁶⁶ The crucial issues in fraud claims are whether the defendant knew of his disease and whether he made false representations for the purpose of inducing the plaintiff to have sex.¹⁶⁷ Similarly, battery cases involving sex-

165. Cause-in-fact could conceivably erect huge obstacles to recovery where a plaintiff has multiple sexual partners, as it is not always possible to determine which partner transmitted the disease to the other through medical testing. *See, e.g., Doe*, 598 N.Y.S.2d at 680 (stating that there was no more proof that the defendant transmitted chlamydia to the plaintiff than there was proof that the plaintiff transmitted it to the defendant). However, cause in fact has rarely been an issue in published cases.

166. *See Leary, supra* note 2, at 189–90. The elements for fraud are: (1) false representation by the defendant; (2) the defendant knew the representation was false or made it with reckless indifference to its truth or falsity; (3) the representation was made for the purpose of inducing another to rely on it; (4) the plaintiff relied on the representation, had the right to rely on it (it was reasonable to rely on it), and would not have done the thing from which the damage resulted in the absence of the representation; and (5) the plaintiff suffered damages as a result. *See, e.g., B.N. v. K.K.*, 538 A.2d 1175, 1182 (Md. 1988). Note that the defendant's omission may also be sufficient if he knew of a disease and failed to disclose it. *See R.A.P.*, 428 N.W.2d at 108; *Plaza v. Estate of Wizer*, 626 N.Y.S.2d 446, 449, 452 (N.Y. App. Div. 1995) (addressing a case in which the homosexual defendant failed to tell his partner, the plaintiff, that his former partner died of AIDS, and the plaintiff contracted HIV from the defendant).

167. *See, e.g., B.N.*, 538 A.2d at 1182–84 (finding a cause of action for fraud where a nurse alleged that a doctor had genital herpes and was aware of his disease and nonetheless had sex with her without telling her, causing her to contract herpes); *R.A.P.*, 428 N.W.2d at 108–09 (finding that fraudulent transmission of herpes can be stated upon a showing that the defendant knew she had the disease and was silent, allowing the plaintiff to contract the disease); *Dubovsky v. Dubovsky*, 725 N.Y.S.2d 832, 837 (N.Y. Sup. Ct. 2001) (stating

ual disease turn on the concept that a plaintiff's consent to sex is vitiated based on a defendant's misrepresentation or failure to disclose a disease; the defendant's knowledge of his disease and intent to expose his partner to the disease must be shown for consent to be vitiated via fraud or mistake.¹⁶⁸ Intentional infliction of emotional distress requires a showing that the defendant acted intentionally or recklessly in giving the plaintiff a disease.¹⁶⁹ Once again, absent proof that the defendant knew of his disease, a plaintiff is unlikely to prevail.¹⁷⁰

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

III. STRICT LIABILITY FOR TRANSMITTING A SEXUAL DISEASE

*"Although loathe to create new causes of action in tort, the law must nevertheless adapt to the society in which it exists."*¹⁷¹

that one spouse failing to tell the other of a sexual disease can constitute fraud).

168. See, e.g., *Leleux v. United States*, 178 F.3d 750, 755 (5th Cir. 1999) (holding that an officer's fraudulent concealment of a disease that he transmitted via intercourse vitiated consent, so that sexual contact constituted battery); *Kathleen K. v. Robert B.*, 198 Cal. Rptr. 273, 276 (Cal. Ct. App. 1984); *Hogan v. Tavzel*, 660 So. 2d 350, 352 (Fla. Dist. Ct. App. 1995) (recognizing that a wife's consent to sex with her husband was vitiated by his failure to inform her of his genital warts, and the wife's consent without knowledge was the equivalent of no consent); *De Vall v. Strunk*, 96 S.W.2d 245, 246-47 (Tex. Civ. App. 1936).

169. See, e.g., *B.N.*, 538 A.2d at 1179-81 (recognizing that a claim for intentional infliction of emotional distress may be stated where the plaintiff shows that the defendant knew of his disease and presents proof of the other elements of the claim); *Leary*, *supra* note 2, at 193-94.

170. See *Doe*, 598 N.Y.S.2d at 692-93.

171. *Silver v. Levittown Union Free Sch. Dist.*, 692 N.Y.S.2d 886, 887 (N.Y. Sup. Ct. 1999) (holding that a wrestler who contracted herpes from another wrestler during a wrestling match stated a cause of action for negligent transmission of a disease).

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

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

A. DOES STRICT LIABILITY FOR SEXUAL DISEASE TRANSMISSION FURTHER SOCIAL JUSTICE?

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

Strict liability is superior to negligence from the perspective of individual and societal fairness and under an economic analysis of law grounded in cost-avoidance. In order to maximize public protection, strict liability is imposed for many violations of law, such as health and safety regulations, traffic laws, and narcotics control laws; intent is not required because the underlying purpose of these laws is public protection.¹⁷² Indeed, strict liability already exists relative to sexual activity resulting in pregnancy: there is no excuse for avoiding child support payments upon proof of paternity.¹⁷³ Many states already

172. See, e.g., *United States v. Dotterweich*, 320 U.S. 277, 281 (1943) (“Such legislation dispenses with the conventional requirement for criminal conduct—awareness of some wrongdoing—in the interest of the larger good it puts the burden of acting at hazard upon a person otherwise innocent but standing in responsible relation to a public danger.”).

173. The Family Support Act of 1988 adjusted the cost-benefit analysis of unprotected sexual activity by creating better enforcement mechanisms to force non-custodial parents to pay child support, whether married to the child’s custodial parent or not, thereby forcing the non-custodial parent to internalize child care costs that otherwise would remain external to them. See Family Support Act of 1988, Pub. L. No. 100-485, § 101, 102 Stat. 2343 (1988)

have criminal penalties for transmitting a sexual disease.¹⁷⁴ While some states have not allowed negligence per se liability resulting from violation of these criminal laws (a species of strict liability, as duty and breach issues are pre-determined by the legislature), others have indicated a willingness to recognize negligence per se liability. For example, it is a felony in Oklahoma to transmit a sexual disease, and civil damages have been allowed in reliance on the felony statute.¹⁷⁵ Therefore,

(codified as amended at 42 U.S.C. § 666 (2000)). This is true even where conception results from a party's contraceptive fraud, no doubt because allowing damages would divest the mother of the very funds required to support the child. *See* Wallis v. Smith, 22 P.3d 682, 684 (N.M. Ct. App. 2001); L. Pamela P. v. Frank S., 451 N.Y.S.2d 766, 766–67 (N.Y. App. Div. 1982); Sorrel v. Henson, No. 02A01-9609-00212, 1998 WL 886561, at *3–4 (Tenn. Ct. App. Dec. 18, 1998); Linda D. v. Fritz C., 687 P.2d 223, 227–28 (Wash. Ct. App. 1984); Anne M. Payne, Annotation, *Sexual Partner's Tort Liability to Other Partner for Fraudulent Misrepresentation Regarding Sterility or Use of Birth Control Resulting in Pregnancy*, 2 A.L.R. 5th 301, 311–12 (1992).

174. *See, e.g.*, OKLA. STAT. ANN. tit. 63 § 1-519 (West 2004); State v. Lankford, 102 A. 63, 64 (Del. Ct. Gen. Sess. 1917).

175. *See, e.g.*, OKLA. STAT. ANN. tit. 63 § 1-519 (West 2004) (“It shall be unlawful and a felony for any person, after becoming an infected person and before being discharged and pronounced cured by a physician in writing, to marry any other person, or to expose any other person by the act of copulation or sexual intercourse to such venereal disease or to liability to contract the venereal disease.”). This law appears to be identical, or nearly identical, to a law existing since at least 1921. *See* COMP. STAT. OKLA. ANN. § 9008 (Bunn 1921); *see also* Lockhart v. Loosen, 943 P.2d 1074, 1078 (Okla. 1997) (implying that an Oklahoma statute could support negligence per se liability); Panther v. McNight, 256 P. 916, 918 (Okla. 1926) (awarding civil damages based on the statute). Prior to 1995, California Health and Safety Code Section 3198, enacted in 1957, provided that, “any person . . . who exposes any person to or infects any person with any venereal disease . . . is guilty of a misdemeanor.” CAL. HEALTH & SAFETY CODE § 3198 (West 1990) (repealed 1995) (current version at CAL. HEALTH & SAFETY CODE § 120600). No case has addressed the issue of whether a violation of this statute results in liability based on a theory of negligence per se. New York Public Health Law Section 2307 provides: “Any person who, knowing himself or herself to be infected with an infectious venereal disease, has sexual intercourse with another shall be guilty of a misdemeanor.” N.Y. PUB. HEALTH LAW § 2307 (McKinney 2002).

In *Maharam v. Maharam*, the court stated that a husband had a duty to tell his wife that he had become infected with herpes, based on the thirty-one-year marital relationship, and failure to do so states a cause of action for constructive, if not actual, fraud. 510 N.Y.S.2d 104, 107 (N.Y. App. Div. 1986). The court stated that the duty to speak could also be predicated upon Section 2307 based on negligence per se. *Id.* An Alabama statute provides: “Any person afflicted with a sexually transmitted disease who shall knowingly transmit, or assume the risk of transmitting, or do any act which will probably or likely transmit such disease to another person shall be guilty of a Class C misdemeanor.” ALA. CODE § 22-11A-21(c) (LexisNexis 1990) In *Berner v. Caldwell*, a woman brought an action against her former boyfriend for alleg-

strict liability for sexual disease transmission is not a radical departure from existing law, but rather a predictable departure necessitated by public health policy.

General social justice policies surrounding imposition of strict tort liability, both historical and economic, support imposing strict liability for transmitting a sexual disease.¹⁷⁶ As a basic rule, as between two innocent parties, the person causing harm should pay the costs of harm rather than the person who

edly giving her herpes. 543 So. 2d 686, 686 (Ala. 1989). The court stated:

That civil liability, to be determined according to the traditional rules of tort law, should also attach to allow recovery for damages resulting from the transmission of a sexually transmitted disease is *a natural corollary to the legislative will as statutorily expressed*. With the rise in the number of reported cases of sexually transmitted diseases, and in view of the harm that results from these diseases, the imposition of such civil liability is clearly warranted.

Id. at 689 (emphasis added).

In *Mussivand v. David*, the court interpreted Ohio Revised Code section 3701.81(A) and rejected the plaintiff's argument that the statute created negligence per se liability, finding that the statute was merely a "rule of conduct." 544 N.E.2d 265, 271-72 (Ohio 1989). A Florida statute provides that it is unlawful to knowingly transmit a sexually transmitted disease. FLA. STAT. ANN. § 38.24 (West 2002).

Similarly, in *Gabriel v. Tripp*, the court reversed the appellate court's decision that violation of the statute constituted negligence per se. 576 So. 2d 404, 405 (Fla. Dist. Ct. App. 1991). The court stated that in order for a violation of a statute to constitute negligence per se, the violation must relate to a particular injury and a particular class of persons. *Id.* The court relied on a legislative declaration of intent that stated that sexually transmitted diseases are a "threat to the public and individual health and welfare of the people of the state," and that such language shows that the statute was not designed to protect a "particular class of persons, but rather the public in general." *Id.* The court held that a violation of the statute nonetheless presented prima facie evidence of negligence, but not absolute proof of negligence. *Id.*

A Louisiana statute makes it unlawful for a person to inoculate or infect another person in any manner with AIDS or to do any act that will expose another to inoculation or infection with AIDS. LA. REV. STAT. ANN. § 14:43.5 (1997). The Louisiana Supreme Court in *Meany v. Meany* relied on *Mussivand* to conclude that the statute merely states a rule of conduct. 639 So. 2d 229, 235 (La. 1994).

176. Prior to 1850, American courts followed the English common law rule that direct physical injury to another's person entailed strict liability, but beginning in 1850 in Massachusetts, courts began necessitating a showing of fault for recovery for personal injury, even if the injury was direct. *Brown v. Kendall*, 60 Mass. (6 Cush.) 292, 295-98 (1850). Since sexual disease results from direct contact, a common law trespass action should lie, although most trespass cases involved "unauthorized" use of physical force, which could exclude consensual sexual relations despite the direct nature of the injury. See DOBBS, *supra* note 4, at 259-66; Richard A. Epstein, *A Theory of Strict Liability*, 2 J. LEGAL STUD. 151, 152-53 (1973) (arguing that the shift from strict liability to negligence was based on moral, not economic, grounds).

is harmed. This result is particularly fair where the risk created by the injurer is disproportionate to the risk created by the victim. The “paradigm of reciprocity” supports imposing costs on the injurer.¹⁷⁷ Historically, strict liability has been imposed on persons and entities that choose to engage in abnormally dangerous activities, or to own wild animals with known dangerous propensities, because these individuals have chosen to create a non-reciprocal risk to society. They should pay the costs of their chosen pursuits, because avoiding all harm to others is not possible: “When an . . . individual . . . engages in systematic or repeated activity, . . . some risks are more or less typical or characteristic of the activity even when no negligence can be shown.”¹⁷⁸ Deterrence is also sometimes cited as a reason for strict liability: it encourages persons engaged in abnormally dangerous activities to find safer methods or safer places for their activities.¹⁷⁹ No fault need be shown because the nature of the activity is known to risk serious bodily harm or death to others and there is no way to control that risk altogether.¹⁸⁰ For this reason, a plaintiff’s negligence, or even intentional wrongdoing, has traditionally not barred recovery under strict liability.¹⁸¹

According to the scientific data, a small subgroup of Americans is choosing to engage in promiscuous sexual activity, lead-

177. See George P. Fletcher, *Fairness and Utility in Tort Theory*, 85 HARV. L. REV. 537, 543–51 (1972). This paradigm assumes that only one of the two sexual partners is initially carrying the disease.

178. DOBBS, *supra* note 4, at 909 (discussing enterprise (strict) liability theory).

179. *Id.* at 964–65.

180. The *Second Restatement of Torts* sets forth the following factors to consider when determining whether strict liability should be imposed on an activity: (a) the creation of a high risk of some harm to the person, land, or chattels of others; (b) with a likelihood of great harm; (c) that cannot be avoided with reasonable care; (d) the degree to which the activity is uncommon; and (e) the inappropriateness of the particular site. RESTATEMENT (SECOND) OF TORTS § 520 (1977). Whether the activity benefits the community at large so as to outweigh the risks should also be considered. *Id.* § 520(f).

181. Indeed, the *Restatement* takes the view that intervention of third parties is a part of the risk of abnormally dangerous activity, at least where the third party is not guilty of intentional wrongdoing. See DOBBS, *supra* note 4, at 960. Assumption of the risk may be a defense where the plaintiff “knowingly and unreasonably” subjects himself to the risk of harm, a condition which requires a true understanding of the nature of the risk and voluntary assumption of it. See *Rickrode v. Wistinghausen*, 340 N.W.2d 83, 87 (Mich. Ct. App. 1983) (stating that willful provocation of an animal may provide a defense to strict liability); RESTATEMENT (SECOND) OF TORTS § 524(2).

ing to a sexual disease epidemic that is costing the American public billions of dollars annually.¹⁸² The statistically few persons who choose to have sex with a large number of partners are creating a high risk of serious bodily harm or even death to others that cannot be completely eliminated by exercising reasonable care.¹⁸³ It is unfair for society at large to pay the price for the irresponsible sexual behavior of a small percentage of individuals who choose a dangerous lifestyle, particularly since their dangerous activity lacks social utility.¹⁸⁴

Liability should be placed on the party to an interaction who is in the best position to “make the cost-benefit analysis between accident costs and accident avoidance costs and to act on that decision once it is made.”¹⁸⁵ In the sexual disease context, the parties are often unable to negotiate fairly over who should bear the risk of loss, because they lack information. In a sense, an information defect is present when neither party is aware of the disease. As between a diseased individual and his uninfected sexual partner, the diseased person has superior access to information regarding his disease and the potential costs associated with transmission.¹⁸⁶ Diseased persons are

182. See *supra* Part I.C.

183. See *supra* Part I.A. While condoms can retard the spread of certain sexual diseases, the fastest growing viral disease today, the human papilloma virus, is believed not to be controllable by condom usage. See *supra* note 47 and accompanying text. In addition, we know that some of the most promiscuous people fail to use condoms regularly. See *supra* notes 99–101 and accompanying text. One reason for strict liability is to coerce those engaged in a high risk activity to find safer methods, so strict liability in the sexual disease context could encourage condom usage and thereby reduce the risks of most diseases.

184. RESTATEMENT (SECOND) OF TORTS § 520(f) (observing that determining whether an activity is abnormally dangerous involves, among other factors, “the extent to which its value to the community is outweighed by its dangerous attributes”); Guido Calabresi, *Optimal Deterrence and Accidents*, 84 YALE L.J. 656, 671 (1975) (suggesting that strict liability and collective prohibitions can approach the goal of “optimal deterrence”); Epstein, *supra* note 176, at 189 (arguing that liability should be based upon the harm caused rather than the reasonableness of the conduct). Unlike businesses that cause nuisances, for example, where a balance must be made between social value and social cost of the nuisance, there is little or no social utility resulting from irresponsible sex leading to the spread of sexual disease.

185. Guido Calabresi & Jon T. Hirschoff, *Toward a Test for Strict Liability in Torts*, 81 YALE L.J. 1055, 1060 (1972).

186. Even where the diseased person is unaware of his infection, he still has superior access to that information compared with the uninfected person, and is still “relatively more likely to find out whether avoidance is worth it.” *Id.* at 1061.

therefore the cheapest cost-avoiders, so the law should place a clear, strict duty not to transmit diseases on them.¹⁸⁷ Uninfected persons will continue to have an incentive to avoid disease transmission, as they necessarily internalize the pain and suffering and emotional distress resulting from infection. Strict liability will simply shift those costs capable of being shifted to disease perpetrators and force them to absorb at least some of the costs of their behavior, instead of externalizing most of the costs to victims and taxpayers.

From an economic standpoint, strict liability is administratively cheaper than negligence. The negligence paradigm burdens legal analysis in that it “demands evaluation of almost everything, but can give precise weight to almost nothing.”¹⁸⁸ The sexual disease cases bear out the truth that negligence creates more issues than it solves, inhibits litigation and compensation by its unpredictable application, and focuses on morality as opposed to the need for compensation and deterrence in response to a serious disease epidemic.¹⁸⁹ Strict liability avoids both the unfairness and the complications created by the negligence paradigm because it avoids the difficult fact-finding relative to the elements of duty and breach.¹⁹⁰

The plaintiff’s need for compensation and the defendant’s ability to pay have been major considerations supporting the imposition of strict product liability.¹⁹¹ While this “deep pocket” concept does not support strict liability for sex torts, it is not a reason to reject strict liability. The lack of a deep pocket in sex tort cases may be a problem whether liability is based on negli-

187. *Id.*

188. Epstein, *supra* note 176, at 171.

189. *See supra* Part II.B.I.

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

191. *See, e.g.*, DOBBS, *supra* note 4, at 975.

gence or strict liability, because insurance companies are rejecting negligence-based claims arising out of sexual relations.¹⁹² Yet, the number of sex tort actions filed continues to increase,¹⁹³ so sex tort analysis should improve in terms of clear standards of liability if not collectability. Although strict liability neither advances nor inhibits the plaintiff's ability to collect on a judgment, it is superior to negligence on other bases.

There may be even more compelling reasons for imposing strict liability for sexual disease transmission grounded in social science. Although there is debate over whether the law impacts social norms, or vice versa, and to what degree, it appears clear that when the law converges with public consensus, it is most effective as a social engineering tool. Legal doctrine has emerged grounded in the belief that promiscuous—even extramarital—sex is ubiquitous and thereby arguably socially acceptable.¹⁹⁴ Yet, research shows that the vast majority of Americans are not promiscuous and presumably do not condone promiscuity.¹⁹⁵ Sex tort law should converge with public consensus to maximize the effectiveness of both. The next section will review deterrence, norm creation, and regulation theories, concluding that strict liability is superior to negligence because it more powerfully deters sexual disease transmission and more accurately expresses social values.

B. WILL ADOPTING STRICT LIABILITY DETER SEXUAL DISEASE TRANSMISSION?

For centuries, there has been a debate about whether the law impacts human behavior, and if so, how?¹⁹⁶ Some tort

192. For example, State Farm Insurance homeowners' policies in Texas and at least some other states contain exclusions for all communicable diseases, including sexually transmitted diseases. Interview with Sophie Harbert, State Farm Ins., in Austin, Tex. (August 10, 2005). More generally, the insurance industry is expected to deny liability for sexually transmitted diseases. Interview with Loretta Wortes, Vice President, Ins. Info. Inst., in New York, N.Y. (Aug. 12, 2005).

193. See Ellen Rosner Feig, *Can You Sue over Transmission of a Sexual Disease?*, LEGALZOOM, http://www.legalzoom.com/articles/article_content/article14106.html (last visited Oct. 5, 2006).

194. See *supra* Part II.B.

195. See *supra* notes 78–81 and accompanying text.

196. There are fundamental concerns about whether law impacts behavior at all, grounded in different philosophies about the etiology of misconduct. For example, positivists believe that behavior is grounded in biological make up. See generally HOWARD S. BECKER, *OUTSIDERS: STUDIES IN THE SOCIOLOGY OF*

scholars posit that the law reflects society's values,¹⁹⁷ while others posit that the law can be used as a tool of social engineering to shape society's values.¹⁹⁸ The answer may lie somewhere in between; perhaps the relationship between law and societal values is symbiotic and fluid. There is no doubt that rational people respond to legal rules to avoid sanctions where the rules are tailored to maximize public awareness and risk aversion.¹⁹⁹ Thus, while scholars sometimes claim that morality cannot be legislated,²⁰⁰ at least some "moral" behavior has been

DEVIANCE 3–6 (1963) (describing various definitions of deviance, including the premise that deviance is based on inherent defects); David T. Lykken, *Psychopath, Sociopathy, and Crime*, 34 SOCIETY 29, 29–35 (1996) (describing a psychopath as a person whose antisocial behavior is the result of a defect within himself rather than a result of rearing, and detailing different theories of psychopathy); Nicole Hahn Rafter, *Criminal Anthropology in the United States*, 30 CRIMINOLOGY 525, 535–37 (1992) (describing criminal anthropology, as influenced by Lombardo, as ascribing to the "born criminal" theory). Cesare Lombroso, the father of criminology, expanded on the concept of biological determinism. See Lykken, *supra*, at 28–31. Organic and biological psychological theories attribute behavior to brain dysfunction or molecular biology, respectively, undermining the concept that the law is effective to change human behavior by positing that people inherit criminal traits and are "born criminals." See, e.g., BECKER, *supra*, at 21; Lykken, *supra*, at 29; Rafter, *supra*, at 525. On the other end of the spectrum is classical criminology, grounded in the prevailing philosophy of utilitarianism in the mid-eighteenth century, which has evolved into rational choice and deterrence theories, and which posits that criminals are rational and use available information concerning costs and benefits of crime in order to determine whether crime is worthwhile. See generally JEREMY BENTHAM, A FRAGMENT ON GOVERNMENT AND AN INTRODUCTION TO THE PRINCIPLE OF MORALS AND LEGISLATION 151–54 (1948) (describing the theoretical foundations of classical criminology, involving speed, certainty, and mildness); Francis Edward Devine, *Cesare Beccaria and the Theoretical Foundations of Modern Penal Jurisprudence*, 7 NEW ENG. J. PRISON L. 8, 13–21 (1982) (describing the influence pleasure and pain have over people). While there are probably many factors that give rise to antisocial behavior, the law necessarily relies on rational choice and deterrence theories, because without the basic concept that legal punishment impacts behavior, the law as a tool of social engineering would be worthless. See Daniel W. Shuman, *The Psychology of Deterrence in Tort Law*, 42 U. KAN. L. REV. 115, 123 (1993) (suggesting that clear, understandable legal standards are important to encourage people to modify their behavior).

197. See, e.g., Marshall S. Shapo, *In the Looking Glass: What Torts Scholarship Can Teach Us About the American Experience*, 89 NW. U. L. REV. 1567, 1569 (1995) (suggesting that tort jurisprudence reflects society's basic principles).

198. See *infra* Part III.B.2.

199. See *id.*

200. See, e.g., Jennifer E. McDougal, Comment, *Legislating Morality: The Actions for Alienation of Affections and Criminal Conversation in North Carolina*, 33 WAKE FOREST L. REV. 163, 163 (1998) (arguing that the alienation of affection cause of action should be abolished in North Carolina because it is

proven to be amenable to manipulation through law.²⁰¹ It is therefore fair to assume that the law can impact human behavior.²⁰²

1. Individual Deterrence Based on the Rational Actor Assumption

*"[S]ociety has continued to rely on the tort system to provide 'general deterrence.' The threat of tort liability should induce rational actors to take 'optimal care'—that is, to reduce the chance of accidents to the point at which the cost of any further accident prevention measures would exceed the injury losses they would prevent. Optimal care thus minimizes the sum of accident costs. Optimal deterrence of tortious conduct—of inefficient risk-taking—is the system's dominant utilitarian function."*²⁰³

Some commentators consider economic analysis of law the most powerful influence on legal doctrine in the past half century.²⁰⁴ Economic analysis of law relies on criminal deterrence theory's "rational actor" assumption²⁰⁵ and provides a funda-

based on obsolete theories and continues merely as a way for the state to legislate morality).

201. For example, drunk driving behavior has been proven to be controllable to a substantial degree through increased, well-publicized legal sanctions. See *infra* notes 210–12 and accompanying text.

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

203. David A. Fischer, *Proportional Liability: Statistical Evidence and the Probability Paradox*, 46 VAND. L. REV. 1201, 1204 (1993) (quoting David Rosenberg, *The Causal Connection in Mass Exposure Cases: A "Public Law" Vision of the Tort System*, 97 HARV. L. REV. 851, 861–62 (1984)).

204. See, e.g., Russell B. Korobkin & Thomas S. Ulen, *Law and Behavioral Science: Removing the Rationality Assumption from Law and Economics*, 88 CAL. L. REV. 1051, 1055 (2000) (suggesting that legal academic thought is permeated by the concern of law and economics with how actors respond to legal directives).

205. The majority of philosophical writings on human conduct are grounded in criminology, no doubt because controlling the most offensive, dangerous human conduct is a priority in any society. See Shuman, *supra* note 196, at 116 & n.5. These theories are closely related to the efficacy of tort law, because tort law, like criminal law, involves socially unacceptable conduct that government attempts to control through law. Indeed, the first time a court awarded damages was in a criminal matter. PROSSER AND KEETON ON THE LAW OF TORTS 8 (W. Page Keeton et al. eds., 5th ed. 1984).

mental truth about human behavior: people respond to incentives (a general statement of price theory).²⁰⁶ At the root of economic theory is the expectation that humans will seek rationally to maximize their expected utility or self-interest. This concept is usually referred to as “rational choice theory.”²⁰⁷ Rational choice theory relies on the assumption that the law shapes behavior by “taxing” socially undesirable behavior and “subsidizing” socially desirable behavior.²⁰⁸

Classical deterrence theory predicts that the efficacy of a legal sanction to modify behavior “rests on perceptions of certainty, swiftness and severity of formal punishment following violation of the law.”²⁰⁹ Deterrence theory posits that if the probability of being caught and suffering negative consequences is high enough, people will choose not to engage in conduct that results in sanctions.²¹⁰ The evidence that sane people do indeed consider the risk of being punished for their conduct is compelling. For example, people who believe that they will be punished for future crimes say that they will not commit future crimes,²¹¹ and robbers choose their victims and locations carefully to maximize their chances of escape.²¹²

206. Korobkin & Ulen, *supra* note 204, at 1054.

207. *Id.* at 1055, 1060–66.

208. *See id.* at 1054; Cass R. Sunstein, *Social Norms and Social Roles*, 96 COLUM. L. REV. 903, 951 (1996).

209. Dale E. Berger & William D. Marelich, *Legal and Social Control of Alcohol-Impaired Driving in California: 1983–1994*, 58 J. STUD. ON ALCOHOL 518, 518 (1997).

210. *See* Daniel S. Nagin & Greg Pogarsky, *Integrating Celerity, Impulsivity, and Extralegal Sanction Threats into a Model of General Deterrence: Theory and Evidence*, 39 CRIMINOLOGY 865, 866 (2001).

211. *See id.* at 877 (indicating that each 10% increase in sanction probability reduces the test subjects' probability of committing the offense by 3.3%).

212. *See* JAMES D. WRIGHT & PETER H. ROSSI, ARMED AND CONSIDERED DANGEROUS: A SURVEY OF FELONS AND THEIR FIREARMS 141–59 (1986) (suggesting that robbers choose victims based on tactical considerations such as the victim's vulnerability); Richard B. Felson & Steven F. Messner, *To Kill or Not to Kill? Lethal Outcomes in Injurious Attacks*, 34 CRIMINOLOGY 519, 541 (1996) (finding that felons are concerned about armed victims). Robbers also generally pick the time of day carefully and rob commercial establishments where the most cash is on hand, such as bars, supermarkets, and restaurants or, more generally, during the Christmas season. They also tend to target places close to home so that they are familiar with streets and escape routes. John J. Gibbs & Peggy Shelly, *Life in the Fast Lane: A Retrospective View by Commercial Thieves*, 19 J. RES. CRIME & DELINQ. 229, 309 (1982); William R. Smith et al., *Furthering the Integration of Routine Activity and Social Disorganization Theories: Small Units of Analysis and the Study of Street Robbery as a Diffusion Process*, 38 CRIMINOLOGY 489, 514 (2000); Peter J. Van Koppen

While sexual misconduct differs in some respects from crimes like robbery, the general thesis that people tend to maximize their “take” and minimize negative consequences—central to rational choice theory—applies equally well to impulsive, irresponsible sexual behavior. One of the reasons why sexual misconduct is so rampant, and sexual disease so pervasive, is the fact that there is very little chance of suffering any negative consequences as a result of such misconduct. Criminal researchers contend that crime persists because criminals believe that there is only a small chance of being caught, and if they are caught, there is a good chance of receiving lenient punishment.²¹³

The price or “cost” of crime is a function of the certainty of punishment and the severity of punishment.²¹⁴ Empirical studies indicate that the certainty of conviction plays a much larger role in deterring crime than does severity of punishment.²¹⁵

& Robert W.J. Jansen, *The Time to Rob: Variations in Time of Number of Commercial Robberies*, 36 J. RES. CRIME & DELINQ. 7, 10–12 (1999). Rapists demonstrate rational decision-making in choosing victims and locations. See Janet Warren et al., *Crime Scene and Distance Correlates of Serial Rape*, 14 J. QUANTITATIVE CRIMINOLOGY 35, 57 (1998). But see George Lowenstein et al., *The Effect of Sexual Arousal on Expectations of Sexual Forcefulness*, 34 J. RES. CRIME & DELINQ. 443, 443 (1997) (arguing that rational choice theory ignores the role of emotions or emotional arousal). Illegal drug use, which is similar to sexual promiscuity in that both entail pleasure-seeking behavior that may become addictive, is controlled by rational decision-making as well. People begin using drugs when they view the costs as minimal (i.e., friends or family also abuse drugs, so they are unlikely to be socially ostracized) and the benefits as outweighing the costs (the positive drug experience is unlikely to result in negative consequences). See John Petraitis et al., *Reviewing Theories of Adolescent Substance Use: Organizing Pieces in the Puzzle*, 117 PSYCHOL. BULL. 67, 68–69 (1995).

213. Cf. R. Steven Daniels et al., *Police Discretion and Elder Mistreatment: A Nested Model of Observation, Reporting and Satisfaction*, 27 J. CRIM. JUST. 209, 223 (1999) (discussing the factors influencing police decision-making with respect to reporting elder mistreatment).

214. See Dan M. Kahan, *Social Influence, Social Meaning, and Deterrence*, 83 VA. L. REV. 349, 377–78 (1997). Of course, a high conviction rate is costly to the State because it takes resources to prosecute, and the severity of punishment is also costly, especially if it involves costs relating to probation or imprisonment. See *id.* “The standard economic conception of deterrence treats severity of punishment and certainty of conviction as interchangeable components of the price of crime.” *Id.* at 377 (citing Gary S. Becker, *Crime and Punishment: An Economic Approach*, 76 J. POL. ECON. 169, 184 (1968); Richard A. Posner, *An Economic Theory of the Criminal Law*, 85 COLUM. L. REV. 1193, 1206 (1985)).

215. See Maynard L. Erickson et al., *The Deterrence Doctrine and the Perceived Certainty of Legal Punishments*, 42 AM. SOC. REV. 305, 306 (1977); Kahan, *supra* note 214, at 379–80; Shuman, *supra* note 196, at 121.

There is apparently a “tipping point,” where certainty of punishment will work because the likelihood of being caught reaches a sufficiently high level: research has found that increasing the severity of punishment leads to a lower crime rate,²¹⁶ but that increasing the severity of punishment may have little impact unless the *likelihood of getting caught is high*, because as the likelihood of getting caught decreases, the punishment—no matter how severe—tends to be discounted.²¹⁷ Accordingly, the law should engage clear liability rules to maximize certainty of punishment.²¹⁸ One way of adjusting the “price” of sexual disease transmission is to adopt strict tort liability in lieu of negligence, dramatically increasing the certainty of civil sanctions if a lawsuit is filed.

Increasing the cost of socially undesirable conduct to minimize that conduct has worked in other contexts in which the conduct is not intuitively amenable to legal manipulation. For example, over the past twenty-five years, most states significantly strengthened laws aimed at controlling alcohol-impaired driving.²¹⁹ Time series analyses have demonstrated that these changes to the law are associated with the behavior changes the laws sought to create, i.e., lower rates of drunk driving incidents and accidents.²²⁰ Between 1983 and 1994, the public’s knowledge of the new drunk driving laws, and particularly the legal blood alcohol concentration limit, increased substantially.²²¹ The single most important reason people gave for avoiding drinking and driving was the fear of getting into an accident, and the next five reasons all reflected fear of legal and

216. See MORGAN O. REYNOLDS, CRIME AND PUNISHMENT IN AMERICA 8–12 (1995).

217. See Nagin & Pogarsky, *supra* note 210, at 885; H. Laurence Ross et al., *Can Mandatory Jail Laws Deter Drunk Driving? The Arizona Case*, 81 J. CRIM. L. & CRIMINOLOGY 156, 163–64 (1990); H. Laurence Ross, *Implications of Drinking-and-Driving Law Studies for Deterrence Research*, in CRITIQUE AND EXPLANATION: ESSAYS IN HONOR OF GWYNNE NETTLER 159, 168 (Timothy F. Hartnagel & Robert A. Silverman eds., 1986).

218. See Shuman, *supra* note 196, at 123.

219. From 1981 to 1985 alone, 478 new state laws were passed to control drunk driving behavior. Berger & Marelich, *supra* note 209, at 518. In California, there have been major changes to drunk driving laws since 1982, including introducing the blood alcohol concentration (BAC) of .10% or higher as the legal limit, then lowering it to .08% for most adults, and to .01% for persons under the legal drinking age of twenty-one; increased fines; and increased jail time. *Id.*

220. See *id.* at 518–20.

221. For example, only 34% of Californians knew about the BAC legal limit in the mid-1980s, while 56% knew about it in 1994. *Id.* at 521.

monetary punishment: fear of being arrested, going to jail, losing a driver's license, paying higher insurance premiums, and paying legal fines.²²²

The trend in alcohol-impaired driving is unambiguous: alcohol-related traffic crashes in the United States have decreased markedly over the past twenty years, after legislatures increased punishment for drunk driving and people became educated about the new laws.²²³ This trend provides at least circumstantial evidence that when the costs of drunk driving were raised, that behavior was deterred, as predicted by rational choice theory. The data also supports social control theory; deterrent policies eventually impacted social norms—or perhaps revealed them—relating to drinking and driving.²²⁴

Drunk driving and irresponsible sexual behavior have some commonalities. Both behaviors are perpetrated by a small percentage of Americans who are often young, probably impulsive, and relatively unconcerned about existing norms.²²⁵ Public disapproval regarding these behaviors is, and probably always has been, strong, yet not well-recognized until publicized.²²⁶ Both behaviors may also result from addiction, yet this has not interfered substantially with the efficacy of new drunk-driving

222. *Id.* at 522.

223. *See id.* at 520–23 (finding a decrease in drunk driving due to stricter laws in the fifteen years preceding 1997). This finding is consistent with other research showing that automobile drivers respond to legal rules, e.g., that liability insurance rates impact the decision whether to drive, and the move to no-fault has resulted in more automobile deaths. *See* Richard A. Posner, *Can Lawyers Solve the Problems of the Tort System?*, 73 CAL. L. REV. 747, 749–50 (1985).

224. An increase in informal control of drunk driving from social forces also was clearly apparent from the research. For example, in a recent study, over ninety percent of persons indicated that their friends or relatives would disapprove of their driving after four drinks. Berger & Marelich, *supra* note 209, at 521. “Although it is commonly assumed that the primary impact of laws is to instill a fear of punishment [and thereby influence behavior], there is at least circumstantial evidence that, over time, laws also influence personal perceptions and social norms which in turn control behavior.” *Id.* at 519.

225. *See, e.g.*, Sunstein, *supra* note 208, at 918–19 (discussing norm-flouting and the value some attach to it). Strong sanctions may change the value of norm-flouting.

226. Most Americans do not engage in sexual relations with many partners and presumably do not approve of such behavior. *See supra* notes 81–84 and accompanying text. Regarding drunk driving, it is fair to assume that, considering the death and destruction that result from it, the vast majority of Americans disapprove of it and do not engage in such behavior. *See supra* notes 223–24 and accompanying text.

laws and would not necessarily undermine new laws strengthening consequences for irresponsible sexual behavior.

There are several important aspects of behavioral theory that support strict liability to deter risky sexual practices. First, some research indicates that people weigh losses more heavily than gains, so laws and the messages they carry must exploit humans' loss aversion tendencies.²²⁷ In other words, increasing the salience of potential losses resulting from irresponsible sex—both for disease perpetrators and uninfected persons—is more powerful than extolling the virtues of “safe sex.”²²⁸ As noted by Judge Posner, tort law must be public knowledge, because if the public is not aware of the law, the law cannot shape future behavior.²²⁹ A new regime of strict liability for sexual disease transmission would attract media attention²³⁰ and thereby educate the public and increase the salience of the risks.

227. See Christine Jolls et al., *A Behavioral Approach to Law and Economics*, 50 STAN. L. REV. 1471, 1536–37 (1998) (noting that pamphlets emphasizing the benefits to breast self-examinations to avoid cancer are less effective than pamphlets stressing the negative consequences of failing to conduct such examinations).

228. People are “loss averse” insofar as they will be more unhappy by a loss than they will be happy by an equal gain. Sunstein, *supra* note 208, at 950. For example, propagating information that breast self-examinations will save lives has been found to be far less effective in motivating breast self-examinations than propagating information that failure to self-examine can lead to death. *Id.* at 950 n.176 (citing Beth E. Meyerowitz & Shelly Chaiken, *The Effect of Message Framing on Breast Self-Examination Attitudes, Intentions, and Behavior*, 52 J. PERSONALITY & SOC. PSYCHOL. 500, 506–09 (1987)). The current “safe sex” campaign is therefore probably less effective than a campaign focusing on harms from irresponsible sex, because the latter increases the salience of the risks of unsafe sex instead of focusing on the presumed value of “safe sex.”

229. RICHARD POSNER, *ECONOMIC ANALYSIS OF LAW* 288 (5th ed. 1998).

230. The media have exploited sexual disease cases and presumably will continue to do so. For example, in 2003 when NFL star Michael Vick gave Sonya Elliott, a healthcare worker, herpes, the media exploited the case. See, e.g., Steve Wyche, *Vick Sued by Woman Genital Herpes Contracted, Alleged Ex-girlfriend Claims*, ATLANTA J.-CONST., Apr. 7, 2005, at D1. Similarly, Michelle Rudolph's \$950,000 jury verdict against L.A. Dodger pitcher Jose Lima for giving her herpes made national headlines. See, e.g., *Women [sic] Claims He Infected Her with STD*, ESPN.COM, <http://sports.espn.go.com/mlb/news/story?id=1936811> (last visited Oct. 15, 2006). Although the press coverage could be a result of the notoriety of the defendants, at least part of the attention is due to the unusual nature of these cases. A review of the comments posted on Internet sites relating to these stories demonstrates that most people are surprised that it is possible to sue someone for transmitting a sexual disease. Media attention to cases such as these encourages more lawsuits, which in turn creates more news.

Second, Americans grossly underestimate the risk of sexual disease and the potential for civil liability because they rely on available, salient data rather than the true facts (the “availability heuristic”).²³¹ They also generally assume that good things are more likely than average to happen to them and that bad things are less likely than average to happen to them (the “overconfidence bias”).²³² The public’s ignorance about the prevalence of sexual disease²³³ and the potential for civil liability exacerbates the problem of overconfidence bias: people assume they are luckier than average based on a terribly inaccurate belief about the “average” risk. A negligence-based analysis for sexual disease cases exacerbates the problems of the availability heuristic and the overconfidence bias by reducing the salience of liability risks. Adopting strict liability would increase the salience of both liability and health risks because the media would continue to exploit sex tort cases, particularly if plaintiffs’ verdicts become more common.

In sum, strict liability raises the price of sexually risky behavior and creates much greater certainty of punishment among core group members who statistically will most often be defendants in these cases. It reduces plaintiffs’ proof burden by eliminating duty and breach analysis, and discourages defendants from remaining ignorant of their sexual diseases or lying about them to escape civil liability.²³⁴ In addition, adopting

231. See Korobkin & Ulen, *supra* note 204, at 1087 (explaining that actors employ the “availability heuristic” when they “overestimate the relevance of salient or memorable incidents at the expense of base rates”); see also Jolls et al., *supra* note 227, at 1537 (reasoning that “vivid and personal information will often be more effective than statistical evidence” because “as a result of the availability heuristic, people will tend to respond to it by attaching a higher probability to the event in question”). For example, most Americans believe that car accidents kill more people than diabetes and stomach cancer, although this belief is grossly inaccurate. The “available” information regarding car accidents comes from greater media coverage, which leads the public to believe that deadly car accidents are more prevalent than death from the two diseases. Korobkin & Ulen, *supra* note 204, at 1088; see also Jolls et al., *supra* note 218, at 1477–78.

232. Korobkin & Ulen, *supra* note 204, at 1091 & nn.149–50.

233. See *supra* Part I.A. (demonstrating that people seriously underestimate the disease rate and their risk of contracting a sexual disease).

234. Assumption of the risk is still a viable defense, but to establish this defense, a defendant has the burden of showing that the plaintiff knew of the disease, understood its consequences, and voluntarily undertook responsibility for becoming infected. It seems improbable that any sane person would knowingly submit to becoming infected with a sexual disease. Indeed, nearly half of men and women surveyed stated that if they were in a new relationship and discovered that their partner had an STD, they would be “a lot less likely” to

strict liability is newsworthy, and will help to educate the public about the high sexual disease rate.

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

*“Wicked people exist. Nothing avails except to set them apart from innocent people. And many people, neither wicked nor innocent, but watchful, dissembling, and calculating of their chances, ponder our reaction to wickedness as a clue to what they might profitably do.”*²³⁵

*“[O]ne who violates a consensus incurs a cost.”*²³⁶

Whether norm²³⁷ violation and informal social consequences are considered a nonquantifiable “cost”²³⁸ or a more attenuated means of pressuring others to conform to social standards through vicarious experiences, it is clear that norms affect social choices. Humans’ fear of informal sanctions, such as disapproval by parents, peers, neighbors, and teachers, in the form of embarrassment, shame, and loss of community respect, may have a greater impact than legal punishment per se, because people seek social approval.²³⁹ Thus, although behavior

continue the relationship. ASHA—WHAT COST?, *supra* note 2, at 23. Most people say they would feel angry at a person who gave them an STD, although women are more likely (87%) than men (74%) to say so. *See id.*

235. JAMES Q. WILSON, THINKING ABOUT CRIME 260 (rev. ed. 1983).

236. Richard H. McAdams, *The Origin, Development, and Regulation of Norms*, 96 MICH. L. REV. 338, 369 (1997).

237. The term “norm” refers to an informal social standard that people follow based on a fear of external non-legal sanctions, such as ostracism, or an internalized sense of duty, which can produce guilt, or both. Some people include formal legal rules in the definition of norms. *See id.* at 350–51 nn.54–59. Cass R. Sunstein defines norms as “social attitudes of approval and disapproval, specifying what ought to be done and what ought not to be done.” Sunstein, *supra* note 208, at 914. Norms arise from a complex set of social forces, including feelings and preferences, religious and cultural mores, and legal rules. *See, e.g.,* Kahan, *supra* note 214, at 354; Cass R. Sunstein, *On the Expressive Function of Law*, 144 U. PA. L. REV. 2021, 2026–29 (1996).

238. Stated alternatively, nonquantifiable benefits include esteem from others, a lack of cognitive dissonance (by acting consistent with internal beliefs), and a feeling of “belonging” to a social system by complying with norms. These benefits are not considered in classic economic analysis of law. *See* Korobkin & Ulen, *supra* note 204, at 1057 (referring to “law and behavioral science” as a “species of legal pragmatism,” since it is more useful in setting legal policy that will produce a predictable impact on actual human behavior).

239. *See, e.g.,* CHARLES TITTLE, SANCTIONS AND SOCIAL DEVIANCE 199–203

is guided partly by legal rules and costs of rule-breaking, it is also influenced substantially by the relationship between such rules and beliefs, values, norms, psychological frames, and cognitive processing.²⁴⁰ The so-called “law and behavioral science” movement²⁴¹ or “behavioral economics”²⁴² is an outgrowth of classic law and economics, created to explain the fact that people do not always behave in a rational manner to maximize their wealth, as would be predicted by price theory, because of the influence of norms.²⁴³ Since norm sanctions are costless,

(1980); Wanda D. Foglia, *Perceptual Deterrence and the Mediating Effect of Internalized Norms Among Inner-City Teenagers*, 34 J. RES. CRIME & DELINQ. 414, 437 (1997); Donald E. Green, *Past Behavior as a Measure of Actual Future Behavior: An Unresolved Issue in Perceptual Deterrence Research*, 80 J. CRIM. L. & CRIMINOLOGY 781, 803 (1989); Daniel S. Nagin & Raymond Paternoster, *Enduring Individual Differences and Rational Choice Theories of Crime*, 27 L. & SOC'Y REV. 467, 489 (1993); cf. Matthew Silberman, *Toward a Theory of Criminal Deterrence*, 41 AM. SOC. REV. 442, 457 (1976) (“The higher the degree of moral support for the legal regulation of an offense . . . the lower the probability that the offense or offenses will be committed . . .”). In general, women are more likely to fear shame and embarrassment than men. This fact may play a role in the gender differences in crime rates—men commit more crime. See, e.g., Harold Grasmick et al., *Changes in the Sex Patterning of Perceived Threats and Sanctions*, 27 L. & SOC'Y REV. 679, 685 (1993).

240. Compare Sunstein, *supra* note 208, at 939–47 (arguing that law can affect behavior by affecting the sources of shame, pride and associated norms), Sunstein, *supra* note 237, at 2051 (reasoning that law may attempt to generate norms that will solve the collective action problem), and McAdams, *supra* note 236, at 397–409 (noting that the expressive function of law works by affecting norms), with Richard H. Pildes, *The Destruction of Social Capital Through Law*, 144 U. PA. L. REV. 2055, 2073–76 (1996) (arguing that the law may have a “norm-destroying capacity” rather than a “norm-producing capacity”).

241. Korobkin & Ulen, *supra* note 204, at 1057.

242. See Richard A. Posner, *Rational Choice, Behavioral Economics, and the Law*, 50 STAN. L. REV. 1551, 1553 (1998) (“Behavioral economics rejects the assumption that people are rational maximizers of preference satisfaction in favor of assumptions of ‘bounded rationality,’ ‘bounded willpower,’ and ‘bounded self-interest.’”). One example of bounded rationality is documented by the fact that people often put a higher value on objects that they own as opposed to objects that they do not own, even though the objects have the same objective value. That is, people tend to value the loss of items they already own higher than equivalent gains of items they seek to buy. This is known as the “endowment effect” or the “offer/asking gap,” and it appears to show that people find some sort of value above market value in items they own, which may result from feelings about ownership, or more generally, from a desire to maintain the status quo. See Korobkin & Ulen, *supra* note 204, at 1107–13; see also Donald C. Langevoort, *Behavioral Theories of Judgment and Decision Making in Legal Scholarship: A Literature Review*, 51 VAND. L. REV. 1499, 1503–04 (1998) (reasoning that people have a desire to maintain the status quo because they are somewhat inert).

243. See, e.g., Korobkin & Ulen, *supra* note 204, at 1102–03 (describing the

they are an especially efficient tool for expressing social values and shaping social choices.²⁴⁴

People's decisions about whether to abide by the law turn on their perception of others' attitudes toward the law;²⁴⁵ that is, the meaning of behavior is highly contextual, and people tend to choose behavior based on their perception of what *others* are doing.²⁴⁶ A perception that "everyone is doing it" can become self-fulfilling, and a parallel perception of little risk of being caught will arise, lessening the risk of stigma or

\$10 play ticket study as illustrative of the role context plays in decision-making).

244. See McAdams, *supra* note 236, at 355–65. Sunstein posits that the "expressive" function of law can strengthen norms the law embodies and weaken those it condemns, such as by taxing socially undesirable conduct and subsidizing socially desirable choices. See Sunstein, *supra* note 208, at 951; Sunstein, *supra* note 237, at 2026–33. Lawrence Lessig argues that legislators and judges must understand the social meaning of the behavior sought to be regulated, because it is impossible to make policy decisions relating to legal sanctions of social behavior without understanding how the law interacts with social meaning. See Lawrence Lessig, *The Regulation of Social Meaning*, 62 U. CHI. L. REV. 943, 946–58, 1019 (1995); Lawrence Lessig, *Social Meaning and Social Norms*, 144 U. PA. L. REV. 2181, 2183–84 (1996).

245. See, e.g., Kahan, *supra* note 214, at 354–55 & nn.18–20. For example, neighborhood crime rates are a much better predictor of individual delinquency than social class, probably because of the neighborhood perception that crime is common and therefore not particularly stigmatizing. *Id.* at 355 & nn.21–23. In another study, British efforts to control drunk driving by shaming offenders produced a climate of moral awareness that helped to reduce the incidence of drunk driving. John R. Snortum, *Drinking-Driving Compliance in Great Britain: The Role of Law as a "Threat" and as a "Moral Eye-Opener"*, 18 J. CRIM. JUST. 479, 495–97 (1990). The impact of informal sanctions varies, of course, depending on the size and cohesiveness of the community involved, which directly impacts whether the misconduct results in public disapproval. Thomas A. Peete et al., *Levels of Social Integration in Group Contexts and the Effects of Informal Sanction Threat on Deviance*, 32 CRIMINOLOGY 85, 99 (1994). At least in some circumstances, such as a rural ranching community governed by longstanding community codes of conduct and informal dispute resolution, norms govern behavior irrespective of legal rules, rendering the formal law surprisingly unimportant, and not even of interest to the parties involved. ROBERT C. ELLICKSON, *ORDER WITHOUT LAW: HOW NEIGHBORS SETTLE DISPUTES* 40–64 (1991).

246. For example, open signs of disorder in a vicinity, such as prostitution, public drunkenness, and panhandling signal to others that disorderly conduct is commonplace, accepted, and/or that the government cannot control it. Kahan, *supra* note 214, at 371–73. This perception in turn leads people to think that the chances of being punished are low, and that esteem costs for violating laws are also low (everyone is doing it). *Id.* In such an environment, persons who would otherwise be unlikely to engage in such conduct are more likely to do so because of these perceptions. *Id.* at 371. Other research shows that when people have recently seen others engage in responsible behavior relative to littering, they are less likely to litter. See Sunstein, *supra* note 208, at 905.

ostracism.²⁴⁷ Accordingly, if a consensus exists, but it is contrary to the public's perception of the consensus, a norm consistent with the consensus will not arise.²⁴⁸ The reason some Americans engage in irresponsible sex leading to disease is probably not because such behavior is consistent with the national consensus or that there is no national consensus, but that the consensus is not well-known, destroying its normative power.²⁴⁹

The media's preoccupation with sex and portrayal of casual sex as the norm contribute to this misperception,²⁵⁰ as does the deeply internalized, unconscious Puritanical shame that tends to silence discourse regarding the content of sexual norms. The core group responsible for the sexual disease rate is probably

247. Kahan, *supra* note 214, at 356–59 & nn.42–44, 370–71. Kahan argues that this is the mechanism that dramatically reduced crime in New York City in a mere three year period—the police concentrated on “public order” offenses and created an environment where disorder was much less apparent. *Id.* at 368–73. In Chicago, the most dramatic reductions in violent crimes occurred in the areas in which “the city’s gang loitering ordinance [was] most vigorously enforced.” *Id.* at 377.

248. Norm theorist Richard McAdams posits that a norm arises when “(1) there is a consensus about the positive or negative esteem worthiness of engaging in [a certain behavior] . . . ; (2) there is some risk that others will detect whether one engages in [that behavior]; and (3) the existence of this consensus and risk of detection is well-known within the relevant population.” See McAdams, *supra* note 236, at 358.

249. There appears to be a gross divergence between Americans’ actual sexual behavior (mostly monogamous) and Americans’ perception of Americans’ sexual behavior—a misperception that has arisen in large part due to the media’s portrayal of promiscuous sex as ubiquitous. See LAUMANN ET AL., *supra* note 19, at 3–24 (explaining that most people make sexual choices based on feelings about what is right or wrong, not based on sexual urges); *supra* note 56 (discussing the media’s portrayal of promiscuous sex); *supra* note 80 (discussing data that shows that most people do not engage in promiscuous sex). But, even if the percentage of persons engaging in promiscuous sex were higher, a strong dissent to a consensus would not preclude norm-formation. McAdams, *supra* note 236, at 358, 379–80. For example, twenty years ago, it would be considered “rude” to ask someone to stop smoking in a restaurant, as the norm was to allow smoking in public. Then, as restaurants began adopting policies against smoking, and local and state lawmaking bodies began to enact laws prohibiting smoking in public places, a consensus arose that smoking in public was the rude behavior, not the request to cease smoking. The data available today regarding the propriety of sexual promiscuity indicate a strong consensus against it. But even if a consensus did not already exist, McAdams’ analysis of consensus formation predicts that a consensus admonishing sexual promiscuity would arise if information regarding the public health threat and social costs of disease transmission were better publicized, based on “selfish esteem allocation” and other factors. See *id.* at 359.

250. See *supra* note 53 and accompanying text.

influenced by the “false” norms created by contemporary media and music, while the majority of Americans may be unaware that they are in the majority and exemplify the consensus.

A similar divergence between the consensus and public awareness of the consensus existed relative to public smoking before new laws publicized both the health risks and public sentiment.²⁵¹ Prior to the entrenchment of the consensus that smoking in public places was unacceptable, people were afraid to speak out against public smoking, perhaps not realizing that they were in the majority, as smokers disproportionately represent patrons in bars and restaurants in the same way that sexually promiscuous people are disproportionately represented on prime time television.²⁵² The “norm-cascades” that have occurred in the last thirty years relating to smoking occurred in large part because the public became aware of the adverse health consequences of smoking, and because social norms are a function of public information.²⁵³

In order to create sexual norms from an existing consensus, it is critical to propagate information that sexual promiscuity is not consistent with the societal consensus and is not condoned by society, particularly if certain subgroups—such as young Americans—operate under a mistaken belief that promiscuous sexual behavior is the norm.²⁵⁴ Considering the data, the only reason core sexual disease perpetrators are not subjected to more outspoken disapproval is likely because of a lack of publicity about the public consensus regarding their behavior.²⁵⁵ Publicity of the true consensus is crucial to create and

251. See McAdams, *supra* note 236, at 404.

252. See, e.g., *id.* at 370–80.

253. Sunstein, *supra* note 237, at 2035.

254. A legal statement about sexually promiscuous behavior is especially important to show that a consensus exists that shuns such behavior, as otherwise young Americans may succumb to the “false consensus” effect; that is, the belief that a behavior is typical, even though it is not, because other people in their age group, with whom they selectively associate, disproportionately condone such behavior. McAdams, *supra* note 236, at 401; cf. Kahan, *supra* note 214, at 373–77 (describing the role that the “false consensus” effect plays in gang membership and gang criminality). The first step is to signal to this high risk group that the behavior leading to health risks is not consistent with the consensus of most Americans, but is aberrational, very dangerous, and engaged in disproportionately among their peers. See McAdams, *supra* note 236, at 402–03. In this way, public smoking became antisocial. *Id.* at 404–06; see *supra* note 235 and accompanying text.

255. There is experimental and empirical data that suggest that people will adapt their moral convictions to those of their peers once they know what those convictions are, and that such adaptation can occur very rapidly once

entrench existing sexual norms. Publicity of the sexual disease epidemic per se will strengthen and reaffirm the consensus because the risks of sexual disease are much more serious than most Americans understand. Strict liability will increase publicity of the consensus and health risks, engaging the true power of a legal threat—its vicarious deterrent effect.²⁵⁶

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

CONCLUSION

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

people are exposed to their peers' attitudes. Kahan, *supra* note 214, at 358–59 & n.44. Increased publicity of the public health risks involved in sexual norm violation (irresponsible sex leading to sexual disease) should provide sufficient confidence among those conforming to the norm and encourage them to speak out, as happened with public smoking. See McAdams, *supra* note 236, at 404–06.

256. ALBERT BANDURA, SOCIAL FOUNDATIONS OF THOUGHT AND ACTION 330–31 (1986).