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Stauter: United States v. Moore: The Witch Hunt Begins

UNITED STATES v. MOORE: AIDS AND THE CRIMINAL LAW

THE WITCH HUNT BEGINS

by

ROBERT LOUIS STAUTER, MD., J.D.*

INTRODUCTION

Acquired Immune Deficiency Syndrome is best known by its acronym AIDS. AIDS was first described in 1981.¹ Many of the studies reported to the public by the medical community have presented consoling, but often premature conclusions about the spread of AIDS and its risk factors.

No matter what the general consensus is about the contagiousness of this disease, AIDS is spreading rapidly. It was described in June 1981; by June 1983 there were 1,800 cases reported in the United States.² When the Surgeon General of the United States, Dr. C. Everett Koop, published his report on AIDS in October, 1986, the number of reported cases had escalated to 25,000.³ By July 1988, just twenty one months later, the Centers for Disease Control (CDC) in Atlanta reported in excess of 70,000 cases. The CDC acknowledges that failure to report all cases of AIDS and misdiagnosis of others, results in numbers that do not represent the total number of cases.⁴

With the number of people who have this disease doubling every year,⁵ the question becomes - when should the public panic? A panic will be avoided only by educating the public as to the facts, not by consoling them with misinformation.

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¹ A. Moss, P. Bacchetti, D. Osmond, W. Krompf, R. Chaisson, D. States, L. Wilber, J. Allain, & L. Carlson, *Seropositivity for HIV and the Development of AIDS or Aids Related Condition; Three Year Followup of the San Francisco General Hospital Cohort*, 296 BRITISH MED.J. 745, 745 (1988) (hereinafter A. Moss).

² S. Landesman & L. Vieira, *Acquired Immune Deficiency Syndrome (AIDS): A Review*, 143 ARCHIVES INTERNAL MED. Vol. 2307, 2307 (1983).

³ U.S. Dept. of Health and Human Services, *Surgeon General's Report on Acquired Immune Deficiency Syndrome* 1, 12 (1986).

⁴ Telephone interview with AIDS Hotline, Center for Disease Control, Atlanta (August 17, 1988).

⁵ A. Fauci & H.C. Lane, *The Acquired Immunodeficiency Syndrome (AIDS)*, HARRISON'S PRINCIPLES OF INTERNAL MEDICINE, 1392-6 (E. Braunwald, K. Isselbacher, R. Petersdorf, L. Wilson, J. Martin, A. Fauci 11th ed. 1987) (hereinafter A. Fauci).

*United States v. Moore*⁶ is one of the first cases to discuss AIDS and criminal responsibility. The opinions of the trial and appellate courts in this case have considered whether the jury in a criminal trial could find a man (who has the antibody in his blood to the virus that causes AIDS) guilty of assault with a deadly or dangerous weapon for having bitten two correctional officers.

The *United States v. Moore* opinions written by Federal District Judge Diana E. Murphy⁷ and Circuit Judge Timbers⁸ reveal a fundamental misunderstanding of the disease process of AIDS. The purpose of this article is to help the reader critically analyze these court opinions. To facilitate this discussion the article will first provide the reader with some very basic, yet very technical, vocabulary used by medical specialists who care for and study patients with AIDS.

ACQUIRED IMMUNE DEFICIENCY SYNDROME

Acquired Immune Deficiency Syndrome is the result of an infection with a virus. That virus was discovered in 1983 by Barre-Sinoussi, Montagnier, and their colleagues at the Pasteur Institute of Paris, France.⁹ They named the virus lymphadenopathy associated virus (LAV).¹⁰ The same virus was identified by Gallo, Popovic, and their colleagues in the United States in 1984; they called the virus HTLV-III¹¹. Both teams have subsequently agreed to use the same name for the virus - human immunodeficiency virus (HIV).¹² HIV is the same virus that has also been referred to as HTLV-III and LAV. The term "AIDS virus" is a misnomer. Although HIV is the cause of AIDS, AIDS and HIV are not synonymous. HIV is the virus and AIDS is the disease.

A virus is a tiny agent that can cause an infection. It is not capable of independent metabolism and can only replicate while within a living cell. Like all living organisms, a virus contains a genetic pattern that guides its reproduction. A virus is made up of a central genetic core and a protein protective outer coating. The genetic core provides the blueprint for making a duplicate of the virus. It is composed of genetic building material called nucleic acid, which can be in a virus in one of two different structural forms, DNA or RNA, depending on the type of virus. DNA and RNA are the two types of fundamental genetic building blocks that are incorporated into all living organisms. The genetic structure of a virus provides it with the capacity to reproduce. Only through reproduction (replication) can a virus

⁶ 669 F. Supp. 289 (D. Minn. 1987).

⁷ *Id.*

⁸ 846 F.2d 1163 (8th Cir. 1988).

⁹ P. Mortimer, *The Virus and the Tests*, 294 BRIT. MED. J. 1602, 1602 (1987).

¹⁰ *Id.*

¹¹ *Id.*

¹² *Id.*

cause an infection.¹³

The protective outer coating of a virus is called the capsid,¹⁴ which is in contact with the virus's environment. When a virus infects the human body it is this capsid that gives the virus its recognizable identity. The human immune system, once it recognizes the virus as "foreign," mounts an immune response to "fight" the infection.

The subspecialty of medicine that deals with the body's ability to "fight" infection is immunology.¹⁵ The influx of the vocabulary of this discipline has led to much confusion for anyone trying to use these terms who is not familiar with their nuances. Immunology is the study of the body's immune system. This system is dedicated to fighting infection and exists in two forms: (1) cellular immunity and (2) humoral immunity. Cellular immunity involves blood cells, commonly referred to as white blood cells, that are dedicated to fighting infections by destroying materials and cells that are foreign (not recognized as belonging to the body). In contrast, humoral immunity is a defense system composed of antibodies.¹⁶

An antibody is a protein structure made by the host body (the person in whose blood the antibody exists) to destroy materials and cells foreign to it. Antibodies are produced when the body recognizes that a foreign substance is present. That foreign substance in immunologic terms is referred to as an antigen.¹⁷ An antigen is any foreign substance that will trigger the body to make antibodies. Viruses are antigens because they trigger antibodies to be made. The antibody which is produced is used to kill a virus by attaching to it. Once an antibody directed against a virus attaches to it other immune defense systems destroy the virus. No disease can ever be spread by exposing a person to an antibody to that disease. An antibody is protective. Only a virus or in this case an antigen (when it is a living virus) can cause a disease to spread. Antibodies are never contagious.¹⁸

Antigens do not have to be live viruses. They can also be other foreign substances, protein parts of a virus, or killed viruses. It is this last fact that has led to the use of killed viruses or virus particles to vaccinate people for the prevention of the spread of disease. For example, to create an immunity against rabies, a person can be injected with the pieces of killed rabies virus. When these foreign particles are recognized in the blood, the human body starts to mount an "immune response" by making antibodies to them. These antibodies have a very specific receptor site that will recognize and attach to the antigen (virus particle) which they were created

¹³ DORLAND'S MEDICAL DICTIONARY 1458 (26th ed.1985) (hereinafter DORLAND).

¹⁴ *Id.*

¹⁵ See A. FAUCI, *supra* note 5, at 1392-96..

¹⁶ DORLAND, *supra* note 9, at 652.

¹⁷ *Id.* at 90.

¹⁸ A. FAUCI, *supra* note 5.

to destroy.¹⁹

When a person is injected with particles of a killed virus, no infection occurs from the vaccination because since the virus is dead, it cannot move into the cells of the body and reproduce. If later, on the other hand, the live virus that would cause rabies should enter the body, these pre-made antibodies will recognize the same antigen in the virus and will attach to the live virus and kill it. Thus, the live virus is destroyed before it can cause infection demonstrating that the person has been effectively immunized.

Antibodies created to fight one infection will not be effective against a different type of virus or infection. In other words, antibodies are antigen specific.²⁰ Some antibodies, like the antibodies to tetanus, are not produced by the body's immune system forever and the body, from time to time, has to be restimulated to make the antibody. That is why people must have a tetanus shot (vaccine or antigen injection) every ten years.²¹

Many viral illnesses create their own immunity. For example, once a person has chicken pox or measles, the live virus that causes the chicken pox or the measles triggers the formation of an antibody. This produces a natural immunity; the person will not have the same disease again. Now that there is a vaccine to measles, the illness of measles can be prevented by using the vaccine to create antibody protection. Each vaccine varies as to effectiveness and duration of effect.²²

In some cases antibodies are actually harvested from donated blood and are administered to another person to protect them from getting an infection. There are many examples of this in the modern practice of medicine. For example, antibodies to rabies virus are collected and when a person is suspected of having been exposed to the rabies virus, a dose of this rabies antibody is administered to the patient. This is to provide immediate protection. Delayed protection is also provided by injecting the person with the killed rabies virus vaccine. An "immune response" develops and antibodies to the rabies virus are produced. The antibodies that were administered provide immunity during the short period of delay between the vaccine injection and the development of antibodies by the host's immune system. Similarly, when a person is exposed to the hepatitis B virus, an injection of concentrated hepatitis B antibody is given in an attempt to kill the hepatitis B virus (antigen) before it can cause an infection.²³

The hallmark problem with AIDS is that the antibody that is produced against the Human Immunodeficiency Virus (HIV) is *not* effective at destroying HIV (the

¹⁹ DORLAND, *supra* note 9, at 90.

²⁰ *Id.*

²¹ *Id.*

²² *Id.*

²³ <http://deexchange.uakron.edu/akronlawreview/vol22/iss4/2>

virus which causes AIDS).²⁴ The reason for this antibody failure has yet to be recognized. So, unlike hepatitis B and rabies, an injection of the antibodies to HIV will apparently not prevent a subsequent infection with HIV.

Public Confusion

The two most prominent misconceptions about AIDS are that AIDS and HIV are synonymous, and that every person who is positive for the HIV antibody is a “carrier of AIDS.” Everyone who is infected with HIV does not have AIDS. Persons who have been infected by the Human Immunodeficiency Virus (HIV) can be classified into one of three subsets:

(1) HIV-antibody positive—these are persons who are noted to have the HIV antibody in their blood but have no symptoms. The fact that they have the HIV antibody does not mean that they still harbor the HIV (virus) or that they are infectious for HIV. Persons who are HIV antibody positive should not be referred to as having AIDS and should not be considered AIDS carriers. Having the antibody in their blood, without more, does not cause them to meet the diagnostic criteria for AIDS. Referring to persons as being “carriers,” implies that they are infectious for a virus. All persons who have the HIV antibody are not “carriers.” Just because a person has the HIV antibody in their blood does not also mean that they have the virus (antigen). In fact, most HIV antibody positive persons are not contagious for the virus.²⁵

(2) AIDS-Related Complex (ARC)—these are persons who have the HIV antibody in their blood, plus they have some other evidence of illness which could include symptoms such as night sweats, fatigue, chronic diarrhea, swollen lymph glands, weight loss of greater than fifteen pounds, or fever.²⁶

(3) AIDS - as defined by the Centers For Disease Control in Atlanta — is present when there is: (1) an antibody to HIV in the person’s blood, (2) a disease process that demonstrates a defect in cellular immunity occurring in a person who has no known cause for decreased immunity, and (3) evidence of Kaposi’s sarcoma or a serious opportunistic infection (an infection not found in a person who has normal immunity). Kaposi’s sarcoma is a skin tumor that is not seen in young people who have a normal immune system. Examples of the serious opportunistic infections that lead to the diagnosis of AIDS are:

Pneumocystis carinii pneumonia - a type of pneumonia that would not be seen in persons with normal immunity.

²⁴ See J. GROOPMAN, *The Acquired Immunodeficiency Syndrome*, Cecil Textbook of Medicine (L. Wyngaarden & L. Smith, Jr., 18th ed. 1988) 1794-1800. (hereinafter J. GROOPMAN).

²⁵ *Id.* at 1803.

²⁶ *Id.*

Pneumonia or infection around the brain - caused by very uncommon fungus or virus infections examples of which include: candidiasis, cryptococcosis, cytomegalovirus, toxoplasmosis, or atypical mycobacteriosis.

Inflammation of the esophagus - from a yeast infection (candidiasis) or from the virus herpes simplex.²⁷

When a person initially becomes infected with HIV the illness is called the "acute syndrome." Some people will have no symptoms during this period, while others will have a flu-like illness. The time sequence from initial infection to onset of symptoms varies from six days to seven weeks. The symptoms of fever, muscle aches, joint aches, and just generally "not feeling well," if they develop, last from two to four weeks. This is followed by recovery from the flu-like illness; the antibodies to HIV can be found in the blood three to twelve weeks after the acute syndrome.²⁸

The actual clinical disease state of "AIDS" is not diagnosed unless a person develops one of the opportunistic infections that are part of the diagnostic criteria for AIDS. Without these diagnostic criteria, the patient either has ARC or is simply HIV antibody positive. AIDS, as such, is a lethal disease. No one diagnosed as having clinical AIDS has had a recovery of the immune system.²⁹

Although it was originally thought that about 30% of persons who are HIV antibody positive would develop AIDS within five years,³⁰ a recent study indicates that at least 75% of people positive for HIV antibody will develop AIDS.³¹ The authors of this later study conclude that "we should regard progression to clinical AIDS after infection with HIV as the norm rather than the exception."³² This implies that all persons positive for HIV antibody will eventually develop clinical AIDS.

The HIV has been found, but is not always present, in the blood, semen, vaginal secretions, saliva, breast milk, tears, urine, serum, cerebrospinal fluid, and lung fluid of HIV infected persons.³³

Of the persons in the United States who have AIDS, 73% are homosexual or bisexual men, 17% are intravenous drug abusers, 7% are adult patients with no identified risk factors, 2% are recipients of blood or blood products who are not

²⁷ *Id.* at 1800, 1803-4.

²⁸ *Id.* at 1803.

²⁹ A. FAUCI, *supra* note 5, at 1396.

³⁰ A. MOSS, *supra* note 1, at 745.

³¹ *Id.* at 750.

³² *See id.* at 750.

³³ G. Friedland & R. Klein, *Transmission of the Human Innumodeficiency Virus*, 317 NEW ENG. J. MED., 1125, 1132 (1987).

hemophiliacs, 1% are hemophiliacs, and 1% are heterosexual partners of individuals who are HIV antibody positive or have AIDS.³⁴ As of February 1988 one half of the 55,000 persons who have had AIDS in the United States have died.³⁵

The Risk of HIV Infection

The obvious concern is how hard is it to become infected with HIV? From the very beginning of this disease the public has been convinced that no matter who is at risk for this disease — “it can’t be me.” Early investigators said those at risk were homosexual males (who were sexually promiscuous, had passive (receptive) anal intercourse, and did “poppers” (amyl nitrite inhalants)), intravenous drug abusers, hemophiliacs, and Haitians.³⁶ During the past few years, Haitians have been dropped from the high risk group; that population seemed to have a high incidence of the disease because of a high incidence of intravenous drug use.

There have been cases of HIV infection that are not part of the “classic” risk factors. Examples of these cases include: an HIV infection from artificial insemination (the semen carried the virus),³⁷ infection of a child from the breast milk of its mother³⁸ and there are still a significant number of persons who have the HIV antibody and claim they are not in a high-risk group.³⁹

Dr. C. Everett Koop, in the Surgeon General’s Report, states:

There is no risk of non-sexual infection in most of the situations we encounter in our daily lives. We know that family members living with individuals who have the AIDS virus [sic] do not become infected except through sexual contact. There is no evidence of transmission (spread) of AIDS virus [sic] by everyday contact even though these family members shared food, towels, cups, razors, even tooth brushes, and kissed each other.⁴⁰

The opinion that family members and casual contacts do not become infected with HIV is based on a study by Dr. Gerald Friedland that was published in *The New England Journal of Medicine* in February, 1986.⁴¹ This study is widely quoted and is published in one of the most respected American medical journals.

³⁴ A. FAUCI, *supra* note 5, at 1393.

³⁵ Landesman, *supra* note 2, at 2307.

³⁶ *Id.*

³⁷ G. Friedland & R. Klein, *supra* note 28, at 1129.

³⁸ *Id.* at 1131.

³⁹ A. FAUCI, *supra* note 5, at 1393.

⁴⁰ HHS, *supra* note 3, at 13.

⁴¹ G. Friedland, B. Saltzman, M. Rogers, P. Kahl, M. Lesser, M. Mayers & R. Klein, *Lack of Transmission of HTLV-III/LAV Infection To Household Contacts of Patients with AIDS or AIDS-Related Complex with Oral Candidiasis*, 314 NEW ENG. J. MED. 344, 348 (1986) (hereinafter G. Friedland).

On reading Dr. Friedland's study it is interesting to note that his team set out to study the 233 household contacts of 60 patients who had AIDS or ARC.⁴² Of the 233 household contacts, 36 were correctly removed from the study because they were sexual partners of the 60 patients and as such would be at risk from the sexual spread of HIV.⁴³ The study was done to look at the risk of non-sexual spread of the virus.⁴⁴ A significant problem with this study is that 89 of the household contacts refused to participate in the study.⁴⁵ Those 89 persons (nearly one half of the population to be studied) were not examined and were not tested for the presence of the HIV antibody; they gave various excuses for not wanting to be part of the study.⁴⁶ Seven others were excluded for being in independent high risk groups or for being a household contact with the AIDS or ARC patient for less than three months.⁴⁷

The study actually consisted of testing 101 persons out of the 233 people who were at the same level of risk.⁴⁸ The 132 people, who were not part of the study, were not randomly excluded.⁴⁹ In an attempt to validate their study, the authors stated that they "believe that there was no discernible selection bias in the study population that might weaken [their] conclusions."⁵⁰ This is an absurd scientific assumption, a type of random de-selection. It would seem more reasonable to assume that persons fearing they are at risk of being infected with HIV would be the most likely to want not to be part of the study.

Of the 101 people studied, one child was found to have the HIV antibody.⁵¹ The authors of the study concluded that since the child's mother had AIDS, the child had contracted HIV around the time of birth.⁵² This conclusion would lead a critical reader of the study to believe that since every child who they studied was living with a parent who had AIDS or ARC (by the definition of the study), that the authors could have attributed any child's positive antibody status to having contracted it "around the time of their birth." No wonder researchers found that HIV is not casually spread; they could explain away any case as not being from casual contact. The study would be more credible if it could demonstrate that the child in fact had the HIV antibody at birth from an infection acquired while in the maternal womb.

A study of the current medical literature reporting the incidence of HIV antibody in the babies of or the sexual partners of HIV antibody positive patients is enlightening. These statistics reveal that approximately forty to fifty percent of

⁴² *Id.* at 345.

⁴³ *Id.*

⁴⁴ *Id.* at 344.

⁴⁵ *Id.* at 345.

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ *Id.* at 348.

⁵¹ *Id.* at 347.

⁵² *Id.*

babies born to mothers with AIDS were positive for the HIV antibody.⁵³ Ten percent of the regular sexual partners of HIV antibody positive hemophiliac patients were found to be positive for the HIV antibody.⁵⁴ Therefore; men and women with HIV antibody positive blood and/or AIDS do not pass the HIV (virus) on to their sexual partners or unborn children 100% of the time. The explanation of this may come from exploring who are the "carriers" of the antigen (virus).

Who Has the Virus

Medical science has recently developed the technology to detect the presence of the HIV antigen (the presence of the actual virus instead of just the antibody). Fifty percent of sixteen patients studied with AIDS or severe ARC were found to have high levels of the virus present in their blood.⁵⁵ Twenty-three percent of ninety-six HIV antibody positive hemophiliacs were found to have the HIV virus present in their blood.⁵⁶ Thirteen percent of HIV antibody positive homosexual men were found to have the HIV antigen (virus) in their blood.⁵⁷

The pattern that seems to be developing is that persons who have AIDS are more likely to infect their sexual partners than are persons with ARC. And persons with ARC are more likely to infect their sexual partners than are persons who are only HIV antibody positive. The French have reconfirmed this data by showing that in their population: 47.6% of patients with AIDS had the virus identified in their blood.⁵⁸ 21.7% of patients with ARC had the virus identified in their blood.⁵⁹ 2.8% of HIV antibody positive patients had the virus identified in their blood.⁶⁰

The conclusion that can be drawn from these studies, which look at the number of persons infected from child birth or sexual contact with people who have AIDS, ARC, or HIV antibody positive blood, is that persons with AIDS are most likely to be contagious for HIV, while persons with HIV antibody positive blood and no other symptoms, are least likely to be contagious for the virus. This may explain why HIV

⁵³ G. Friedland & R. Klein, *supra* note 28, at 1131.

⁵⁴ M. Blomback, *Prevalence of HIV Antibodies in Heterosexual Female Partners*, 18 SCAND. J. INFECTIOUS DISEASES, 497-500 (1986).

⁵⁵ G. Jackson, D. Paul, L. Falk, M. Rubenis, J. Despotes, D. Mack, M. Knigge, E. Emesen, *HIB Antigenemia in AIDS*, 108 ANNALS OF INTERNAL MED. 175, 176 (1988) (hereinafter G. Jackson).

⁵⁶ J. Allain Y. Laurian, D. Paul, F. Verroust, M. Leuther, C. Gaznrgal, D. Senn, M. Larrieu & C. Bosseu, *Long-Term Evaluation of HIV Antigen and Antibodies to p24 and gp41 in Patients with Hemophilia*, 317 NEW ENG. J. MED. 1114 (1987)(hereinafter J. Allain).

⁵⁷ K. Mayer L. Falk, D. Paul, G. Dawson, A. Stoddard, L. McCoster, S. Saltzman, M. Moon, R. Ferriani, J. Groopman, *Correlation of Enzyme-Linked Immunosorbent Assays, for Serum Human Immunodeficiency Virus Antigens and Antibodies to Recombinant Viral Proteins with Subsequent Chemical Outcomes in a Cohort of Asymptomatic Homosexual Men*, AM. J. MED., 208 (1987).

⁵⁸ A. Baillou F. Barin, J. Allain, G. Petat, P. Kocheleff, P. Kadende, & A. Goudeau, *HIV Antigenemia in Patients With Aids and AIDS-Related Disorders: A Comparison Between European & Central African Populations*, 156 J. INFECTIOUS DISEASES, 830, 832 (1987).

⁵⁹ *Id.* at 832.

⁶⁰ *Id.*

appears to not be spreading as quickly through the heterosexual population of the United States. Those heterosexuals who harbor the HIV antibody but have no other manifestations of illness, are not as contagious as persons with the full disease process of AIDS. The problem is that when persons in the heterosexual population who are now HIV antibody positive develop AIDS, a much higher percentage of them will become infectious for HIV and the incidence of infection with HIV will accelerate again (as it did in the homosexual population in the early 1980s).

In one study, the HIV antigen (virus) was recovered from 56% of the blood specimens of persons at different stages of HIV infection. This study also tried to isolate the virus from saliva and found that only 1% of the specimens of saliva contained the virus.⁶¹ This may point to the fact that even though HIV has been identified in saliva, the amount of virus or presence of the virus in saliva is uncommon. Since in casual contact the most common body fluid shared between household contacts would be saliva, this may explain why there is no non-sexual or non-hematogenous spread of the infection or if there is, at least a very small incidence of it.

The Friedland article noted that of the 101 people tested who were in contact with the sixty AIDS and ARC patients, only one child was positive for the HIV antibody. This case may be explained by a casual spread of the infection. Assuming, hypothetically, that fifty percent of the sixty AIDS patients would be positive for the HIV (virus) only thirty of the patients should have been positive for the HIV antigen (virus). Only those thirty would put their sexual partners at risk of HIV contact. If it is then assumed that one percent of the sixty AIDS patients would have HIV in their saliva, it may not be unusual to find the HIV virus in one person's saliva. It is possible that the one child acquired the HIV through the casual contact of her parent's saliva. Even if the route of infection of HIV could be saliva, since presence of the HIV antigen in saliva is only about one percent of persons with AIDS, the risk is very small. The risk is probably even less in someone who is only positive for the HIV antibody and does not have AIDS.⁶²

In summary, heterosexual intercourse, homosexual intercourse, and intravenous drug abuse only put persons into high risk groups to the extent that they sexually participate or share needles with persons infected with HIV. Intravenous drug use with sterile needles and sterile drugs cannot cause the spread of HIV. Heterosexual or homosexual intercourse with partners who are not infected with HIV cannot cause the spread of HIV. If the HIV virus does spread through casual contact, the incidence of it must be on a very small, and as of yet unrecognized, scale.

⁶¹ M. Sande, *Transmission of Aids: the Case Against Causal Contagion*, 314 NEW ENG. J. MED. 380-382 (1986).

⁶² The HIV-antibody patient emits less virus than the AIDS patient. See *supra* text accompanying notes 44-51.

CARELESS USE OF THE MEDICAL NOMENCLATURE BY
THE *UNITED STATES V. MOORE* COURT CREATES CONFUSION

On September 3, 1987, the court, in *United States v. Moore*⁶³ denied James Vernell Moore's motions for judgment of acquittal and for a new trial. Moore, in a trial by jury, had been convicted of two counts of assault with a deadly or dangerous weapon.

The jury found that since Moore has both the HIV antibody and hepatitis antibody in his blood, his teeth constituted a deadly or dangerous weapon when he bit two federal correctional officers. The "[d]efendant move[d] for a judgment of acquittal on the ground that the evidence at trial was insufficient to sustain a conviction for assault with a deadly or dangerous weapon."⁶⁴

After the motions were denied, the ruling was appealed to the United States Court of Appeals for the Eighth Circuit on the issue of sufficiency of the evidence for the jury to have found that Moore had assaulted the federal officers with a deadly or dangerous weapon.⁶⁵ The court affirmed the lower court's ruling, holding that the evidence was sufficient to support the jury's finding.⁶⁶ These court opinions evidence a misunderstanding of the nomenclature of the immunologic terms of HIV infection. The courts' errors in the use of the medical nomenclature will be considered individually.

First, AIDS and Human Immunodeficiency Virus (HIV) are not synonymous. The trial court acknowledged that Moore had tested positive to the HIV antibody, and then stated in a footnote that "This virus is commonly referred to as AIDS (Acquired Immune Deficiency Syndrome)."⁶⁷ Only a superficial analysis is required to see that even though Moore tested positive to the HIV antibody, this limited information cannot determine whether he is HIV antigen positive (has the virus in his blood), is HIV antibody positive, has ARC, or has AIDS. The court erred in equating the HIV (virus) with AIDS. The appellate court similarly demonstrated a lack of understanding when it wrote "the virus commonly referred to as AIDS...."⁶⁸ and "Moore had tested positive for antibodies for the Human Immunodeficiency Virus ("HIV virus") which are considered to be indicative of the presence of

⁶³ 669 F. Supp. 289 (D. Minn. 1987).

⁶⁴ *Id.* at 289.

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

⁶⁶ Circuit Judge Timbers was sitting by designation from the Second Circuit. *Id.* The Second Circuit includes in its jurisdiction the state of New York, which has the highest incidence of AIDS of any state in the United States. As of July 18, 1988 the Centers for Disease Control in Atlanta have 16,890 reported cases of AIDS in New York. *See supra* note 4.

⁶⁷ 669 F. Supp. at 289.

⁶⁸ 846 F. 2d at 1168.

Acquired Immune Deficiency Syndrome (“AIDS”).⁶⁹ HIV is not referred to as AIDS; AIDS is diagnosed only after many more criteria are met than the mere presence of the antibodies to the Human Immunodeficiency Virus.

Second, *the antibodies to HIV and the HIV virus are not the same*. A virus is a particle that potentially spreads the infection and the antibody is a protein made by the infected person’s body in an attempt to destroy the virus. The antibody is *not* an infectious agent. The infection cannot be spread by exposure to the pure antibody to any virus.

The lower court opinion states that the “[d]efendant had been informed that he had both the *AIDS virus and the hepatitis antibody* and that he could potentially transmit the diseases to other persons (emphasis supplied).⁷⁰ This quote is ambiguous. At first glance one is lead to believe that Moore’s blood contained the “AIDS virus” [HIV] as well as the hepatitis antibody. The quote could also be read that Moore’s blood contained the “AIDS virus” [HIV] *antibody* and the hepatitis antibody. It is most likely that the later analysis is correct because earlier in its opinion the court stated that the “indictment alleged that he had tested positive for the Human Immunodeficiency Virus (HIV) *antibody*...” (emphasis supplied).⁷¹ It is likely this information was copied correctly from the indictment and that Moore is actually positive for the HIV antibody. Since the footnote reveals that the court believes the virus and AIDS to be one in the same, such an error could be expected.

The court stated that Moore “had tested positive for the HIV virus”⁷² and that “Dr. Clifford Gastineau had Moore tested for the HIV virus because his long time heroin addiction placed him in a risk category for AIDS.”⁷³ Even now that HIV antigen (virus) testing is available, it is not done as a screen to determine who is HIV infected. It is much more likely that Dr. Gastineau actually tested Moore’s blood for the presence of the HIV antibody and not the virus (HIV).

The most likely scenario is that Moore’s blood is positive for the HIV antibody and the hepatitis B antibody.⁷⁴ The antigen status of Moore’s blood to either of these infectious diseases is unknown. A few years ago the HIV antigen test was not available for general use. The test for the hepatitis B antigen has been readily available. It is not disclosed whether Moore’s blood was tested for the presence of the antigen (virus) for either HIV or hepatitis B. If Moore’s blood is positive for the hepatitis antibody, it would be rare that it would also contain the hepatitis antigen

⁶⁹ *Id.* at 1164.

⁷⁰ 669 F. Supp. at 290.

⁷¹ *Id.* at 289.

⁷² 846 F. 2d at 1164.

⁷³ *Id.* at 1164.

⁷⁴ Hepatitis B antibody is the antibody against the virus that is the cause of the inflammation of the liver in hepatitis B. Hepatitis B antibody destroys the hepatitis B antigen (virus). See generally WYNGAARDEN, *supra*

note 22.

(virus). The antibody to hepatitis is protective and once a person's blood becomes positive for the antibody the virus (antigen) is rapidly cleared from the blood.⁷⁵

Moore's blood could very easily be tested for the presence of hepatitis antigen and if it is not present, and the antibody is present, he could not transmit hepatitis to anyone no matter what he does with his blood. In fact, if Moore could inject only his hepatitis B antibodies into the blood streams of the two federal corrections officers, his antibodies to the hepatitis virus would provide temporary protection and actually prevent the officers from getting hepatitis B for a limited period of time.

Unlike hepatitis, the HIV antibody is not protective and as discussed earlier, can co-exist with the HIV antigen (virus).⁷⁶ If Moore's blood contains the HIV antigen, (virus) then he is potentially infectious for HIV. Again, it is not disclosed whether Moore has AIDS, ARC, or is just HIV antibody positive. If Moore is HIV antibody, positive but does not have ARC or AIDS his chances of having the HIV antigen in his blood are between 2% and 10%.⁷⁷ The chances of the HIV antigen being in his saliva, even if he had AIDS, is less than 1%.⁷⁸

If Moore has ARC, the chances of finding the HIV antigen in his blood is about 22%,⁷⁹ and the chance of the antigen being in his saliva is probably much less than the 1% described with patients who have AIDS. It is unlikely that Moore has actual AIDS since he is not described in the case as having been ill from the HIV infection, only that he is HIV antibody positive.⁸⁰ It is difficult for a critical reader of these opinions to respect them when the opinions are replete with so many misstatements and misuses of the nomenclature of immunology.

THE LEGAL INTERPRETATION AND ANALYSIS OF THE ASSAULT STATUTE CREATES CONFUSION

James Vernell Moore was convicted on June 24, 1987 of two counts of assault with a deadly or dangerous weapon in violation of 18 U.S.C. §§ 111 & 1114.

Section 111 of Title 18 of the United States Code states:

Whoever forcibly assaults, resists, opposes, impedes, intimidates, or interferes with any person designated in section 1114 of this title while engaged in or on account of the performance of his official

⁷⁵ J. GROOPMAN, *supra* note 24.

⁷⁶ See *supra* text accompanying note 24.

⁷⁷ See *supra* text accompanying notes 59-60.

⁷⁸ See *supra* text accompanying notes 61-62.

⁷⁹ See *supra* text accompanying note 59.

⁸⁰ 669 F. Supp. at 289.

duties, shall be fined not more than \$5,000 or imprisoned not more than three years, or both.

Whoever, in the commission of any such acts uses a deadly or dangerous weapon, shall be fined not more than \$10,000 or imprisoned not more than ten years, or both.⁸¹

Section 1114 of Title 18 of the United States Code does designate, *inter alia*, “any officer or employee of any United States penal or correctional institution....”⁸² Thus, if Moore did assault a federal corrections officer with a deadly or dangerous weapon, he could be fined not more than \$10,000 or imprisoned not more than ten years. The question to be addressed here is whether he really committed these statutory crimes.

The court of appeals opinion demonstrates a problem with interpretation of the statute. The issue to be considered is whether the jury could have found that the prosecution met the burden of proving beyond a reasonable doubt that the defendant’s mouth and teeth were a dangerous weapon.

As to the statutory definition of a “deadly or dangerous weapon” both courts noted that a deadly or dangerous weapon is an object that is “used in a manner *likely* to endanger life or inflict serious bodily harm” (emphasis supplied).⁸³ In determining whether Moore’s teeth and mouth were a “deadly or dangerous weapon” the jury heard testimony that the “defendant had been informed that he had both the AIDS virus⁸⁴ and the hepatitis antibody and that he *could potentially* transmit the diseases to other persons.” (emphasis supplied).⁸⁵

The jury also heard testimony from Dr. C.F. Gastineau that: “any human bite *can* cause a serious infection given the variety of infectious microorganisms present in the human mouth.” He also testified that “blood is sometimes present in the mouth, particularly if an individual has ill-fitting teeth or gum problems. He testified that the defendant has some false teeth or a bridge....” (emphasis supplied).⁸⁶

The issue in the motion to the lower court and on appeal was whether the “evidence was sufficient to support a jury finding that [the] defendant’s mouth and teeth were used as a deadly or dangerous weapon.”⁸⁷ The statute used to convict Moore requires a finding that he used a “deadly or dangerous weapon.” The parties

⁸¹ 18 U.S.C. § 111 (1986).

⁸² 18 U.S.C. § 1114 (1986).

⁸³ 669 F. Supp. at 290; 846 F. 2d at 1166.

⁸⁴ It is unlikely Moore had been tested for the presence of the actual virus. See *supra* text accompanying notes 74-75.

⁸⁵ 669 F. Supp. at 290.

⁸⁶ *Id.*

⁸⁷ 669 F. Supp. at 289; 846 F. 2d at 1163.

agreed as to the definition of those terms. The definition⁸⁸ of such a weapon required that the object be used in a manner likely to endanger life or inflict serious bodily harm. Could the jury have found beyond a reasonable doubt that the object was “likely to endanger life” when the testimony was that (1) “he *could potentially* transmit the diseases...” (emphasis supplied),⁸⁹ and (2) “any bite *can* cause a serious infection...” (emphasis supplied).⁹⁰ The doctor also testified that blood is *sometimes* present in the mouth, particularly if the individual has ill-fitting teeth or gum problems, but yet the doctor did *not* testify that the defendant had either of those dental conditions. The doctor did volunteer that the defendant “has some false teeth or a bridge.”⁹¹ It is of interest that such an inexacting testimony was tolerated.

How could the jury have found to the standard of proof of beyond a reasonable doubt that the object was *likely* to “inflict serious bodily harm” when the testimony was that “any human bite *can cause* a serious infection?” (emphasis supplied).⁹²

On appeal the court stated that “[s]ince a human bite has the *capacity* to inflict serious bodily harm, we hold that the human mouth and teeth are a deadly and dangerous weapon in circumstances like those in the instant case, even if the harm actually inflicted was not severe” (emphasis supplied).⁹³

The law requires an analysis of the manner of the use, not of capacity of the object (human teeth in this case). The law agreed upon by the parties defines a “‘deadly and dangerous weapon’ as an object ‘used in a manner likely to endanger life or inflict serious bodily harm’”⁹⁴ not as an act that has the “‘capacity to inflict serious bodily harm.’” Here the court reached its result by altering the two part test described in *United States v. Johnson*⁹⁵ for determining whether an object is a dangerous weapon. The court came to this result by quoting language from *United States v. Bey*⁹⁶ which it used as authority the language of *United States v. Johnson*.⁹⁷

⁸⁸ 669 F. Supp. at 290.

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ *Id.*

⁹² *Id.*

⁹³ 846 F.2d at 1167. It is of interest that in the lower court opinion in the language the Judge used to state that the “evidence supports the guilty verdicts” she used a footnote to explain that:

This is not to say that the human mouth and teeth would always constitute a deadly or dangerous weapon or that every assault by someone with the AIDS virus would fit within the statute 669 F. Supp. at 290.

It is alarming to note that even though Judge Murphy probably does not know whether Mr. Moore has “the AIDS virus [HIV]” that she is so cavalier as to state that other persons who do have the virus may not be found to have a mouth that is a “‘deadly or dangerous weapon.’” Yet, Circuit Judge Timbers said the mouth and teeth are a deadly or dangerous weapon even in the absence of AIDS. 846 F. 2d at 1168.

⁹⁴ 846 F. 2d at 1166.

⁹⁵ 324 F.2d 264 (4th Cir. 1963).

⁹⁶ 667 F.2d 7 (5th Cir. 1982).

⁹⁷ 324 F. 2d at 264.

The court quoted *Bey* quoting *Johnson* to write “In short, ‘what constitutes a dangerous weapon depends not on the nature of the object itself but on its capacity, given the manner of its use, to ‘endanger life or inflict great bodily harm.’”⁹⁸

In quoting *Bey*, the court tried to make the second prong of the *Johnson* test “capacity” instead of the “used in a manner likely” to endanger life or inflict serious bodily harm required by *Johnson*. The court held “[s]ince a human bite has the *capacity* to inflict serious bodily harm, we hold that the human mouth and teeth are a deadly and dangerous weapon in circumstances like those in the instant case, even if the harm actually inflicted was not severe.”⁹⁹ The major problem with the court’s analysis is that it ignores the language of “given the manner of its use...” which limits the application of the law. It is this language that restricts the term deadly or dangerous weapon to the instances when the object is “used in a manner likely to endanger life or inflict serious bodily harm”.¹⁰⁰

To learn about the test for whether an object is a dangerous weapon, it is revealing to read the *Johnson* opinion instead of reading it as quoted in *Bey*. At first glance, *Johnson* appears to create a test for what constitutes a dangerous weapon by stating that: “While it may not be a dangerous weapon per se, almost any object ‘which as used or attempted to be used *may* danger life or inflict great bodily harm’ or which, as it is sometimes expressed, ‘is *likely* to produce death or great bodily harm, can *in certain circumstances* be a dangerous weapon.” (Emphasis supplied, citations omitted).¹⁰¹

The confusion is whether the test for a deadly or dangerous weapon is one that requires the object to be used in a manner that: (1) is “*likely* to endanger life or inflict serious bodily harm.”¹⁰² or (2) “*may* endanger life or inflict great bodily harm.”¹⁰³ or (3) has the “*capacity* to inflict serious bodily harm.”¹⁰⁴

If not carefully studied it appears that the *Johnson* test would make an object “dangerous” if it “may” endanger life and that the test lessens the requirement that the object must “likely” produce death or great bodily harm. It is the “in certain circumstances” language which restricts the “may” language to circumstances of when the use is in a manner likely to endanger life or inflict great bodily harm. This latter fact is verified when the *Johnson* court states that “[n]ot the object’s latent capability alone, but that, coupled with the manner of its use, is determinative.”¹⁰⁵ It is this “manner of its use” language that once again requires the test to include “used in a manner likely to endanger life or inflict serious bodily harm” prong of

⁹⁸ 846 F. 2d at 1166.

⁹⁹ See *id.* at 1167.

¹⁰⁰ See *id.* at 1166.

¹⁰¹ 324 F. 2d at 266.

¹⁰² 846 F. 2d at 1166.

¹⁰³ *United States v. Anderson*, 190 F. Supp. 589, 590 (M. Md. 1961).

¹⁰⁴ 846 F 2d at 1167.

¹⁰⁵ 324 F. 2d at 266.

the test.

Consequently, when the *Johnson* and *Bey* courts limit their test by saying “manner of its use”¹⁰⁶ and “in certain circumstances”¹⁰⁷ they are referring to when it is “likely to produce death or serious bodily harm.” The *Moore* court did not address this most important prong of the test.

In exploring where the *Johnson* court derived the “may” test that it used in conjunction with the “likely to produce” test, one must look to the cited authority *United States v. Anderson*.¹⁰⁸ *Anderson* involved a defendant who threw a club at another car while passing it on the highway at 85 miles per hour. The club struck the windshield of the car and caused it to careen out of control, roll over several times, and cause injury to all the occupants of the car. The *Anderson* court held the use of a club in this manner to be a “dangerous weapon” and stated that “[a] ‘dangerous weapon’ is one which as used or attempted to be used may endanger life or inflict great bodily harm (emphasis supplied).¹⁰⁹

The word “may” weakens the *Johnson* test which requires a finding that the object must be “likely to produce” harm. Only in studying the authority used by the *Anderson* court for this use of “may” is one able to discern the problem. *Anderson* cites four cases as authority *Price v. United States*,¹¹⁰ *United States v. Williams*,¹¹¹ *Tatum v. United States*,¹¹² and *Medlin v. United States*.¹¹³

Price is a 1907 case which struck down a conviction for “assault with a dangerous weapon” because the gun that the defendant was using was not loaded. The *Price* court quoted the “likely to produce” language and then went on (without citing apparent authority) to editorialize that “[o]r perhaps it is more accurately described as a weapon which in the manner in which it is used or attempted to be used may endanger life or inflict great bodily harm” (emphasis supplied).¹¹⁴ So even though the *Price* court did state the “may” language, it actually used the “likely to produce” test to hold that a person’s use of an unloaded pistol in a threatening manner is not a dangerous weapon.

If a defendant points a gun at a complaining witness in a threatening manner when the witness does not know that the gun is unloaded and the court finds that this use of a gun is not a deadly or dangerous weapon, how can a court support a finding

¹⁰⁶ 667 F. 2d at 11.

¹⁰⁷ 324 F. 2d at 266.

¹⁰⁸ 190 F. Supp. 589 (M. Md. 1961).

¹⁰⁹ *Id.* at 591.

¹¹⁰ 156 F. 950 (9th Cir. 1907).

¹¹¹ 2 F. 61 (D. Or. 1880).

¹¹² 110 F.2d 555 (D.C. Cir. 1940).

¹¹³ 207 F.2d 33 (D.C. Cir. 1953), *cert. denied*, 347 U.S. 905.

¹¹⁴ 156 F. at 952.

that when a defendant tries to bite two parties by pressing his teeth against the legs of their trousers and causes a saliva mark on one and an abrasion from the moist trouser material rubbing against the skin of the other party he has used a deadly or dangerous weapon?

The *Williams* court used the “likely to produce” language and did not use the “may” language. This case should not have been used as authority for *Anderson* to state the “may” test. *Tatum* used the “likely to produce” language to find that a person who threw a corrosive chemical onto another person was using a dangerous weapon. *Tatum* did not use the “may” test and so should not have been authority for the *Anderson* court use of this term. The *Medlin* court determined that shoes on the feet of the defendant are a dangerous weapon when they inflict serious injuries. The *Medlin* court did not entertain a “likely to produce” or “may” analysis because they determined that, since serious injury did in fact occur, the object (the shoes) was a dangerous weapon used in that manner and no analysis was required.

Johnson announced the *Anderson* “may” test even though *Anderson* had used four cases for authority which had not used the test themselves. Only *Price*, and then without authority, mentioned the “may” test that was quoted into *Johnson* and appears to have lead the court to create the “capacity” evaluation. Even *Johnson* court recognized that its “may” test was limited to “in certain circumstances” and the “in certain circumstances” seems to be when the manner of use is “likely” to produce harm. *Johnson* held that a chair made of metal and plastic which had been wielded overhead and used to strike a victim’s head was a dangerous weapon. It seems reasonable that members of a jury would be able to find beyond a reasonable doubt that a chair being wielded in a manner so as to strike someone in the head would be likely to endanger life or inflict serious bodily harm.

The appellate court in *Moore* used the quote from *Bey* to try to create a test for dangerous weapon, which requires only a finding of “capacity” instead of the “manner likely” to endanger life or inflict serious bodily harm which the court itself declared as the rule. In sum, both the *Bey* and *Johnson* courts limited the “capacity” test to circumstances when the manner of use is “likely to produce” harm which is consistent with the definitions used by the *Moore* opinions, but not with the results of those opinions.

In the instant case of *United States v. Moore*, the government did not satisfy the burden of demonstrating that the object used by Moore was *likely* to cause anything. The facts presented by the court are that Moore tried to bite the officers on their legs through their uniform pants. The attempt of Moore to bite the officers was not even teeth on bare skin. One officer sustained only moist skin (from saliva) and the other received only an abrasion from the moist cloth rubbing against his leg. Neither officer sustained a puncture wound from the Moore “bite.”

In order to convict Moore, the government had to prove beyond a reasonable doubt that Moore's mouth and teeth were used in a manner likely to endanger life or inflict serious bodily harm. It cannot do this on evidence that uses testimony which includes qualified language as "could" and "may potentially." Moore must be acquitted of the assault conviction that included the use of a deadly or dangerous weapon and should be held to the simple assault charge.¹¹⁵

MOORE WAS DENIED HIS CONSTITUTIONAL RIGHT TO ADEQUATE COUNSEL

Moore's jury instruction evidenced a misunderstanding of the AIDS terms

The defendant made a motion for a new trial based on the court's denying his request for jury instruction twelve. The defendant's jury instruction twelve read:

The issue of whether the human mouth and teeth are a deadly or dangerous weapon is a factual determination which you must make.

If the government has failed to prove beyond a reasonable doubt that *the virus commonly referred to as AIDS* can be transmitted from one human being to another human being by a bite, the government has failed to prove that the human mouth and teeth are a deadly or dangerous weapon (emphasis supplied).¹¹⁶

This jury instruction, demonstrates that its author does not understand the difference between HIV, AIDS, and a virus or an antibody.

The *Moore* court denied the defendant's motion for a new trial because the "[d]efendant's proposed instruction would prevent the jury from considering all of the evidence relating to the human bites in this case."¹¹⁷ One must consider that when the court wrote "all the evidence relating to the human bites in this case" the court was referring to the belief that besides Moore's "potential" risk of spreading HIV, the court believed, and surely the jury was lead to believe, that Moore could spread hepatitis, and that "any human bite can cause a serious infection."¹¹⁸

It is exceedingly unlikely that Moore could have spread hepatitis to the two officers.¹¹⁹ In fact, it is most likely that if Moore could have "spread" his hepatitis

¹¹⁵ He should have been convicted of the 18 U.S.C. § 111 crime of simple assault of a correctional officer that is punishable by a fine of not more than \$5,000 or imprisonment of not more than three years, or both and not of the crime of assault with a deadly or dangerous weapon. 18 U.S.C. 111 (1986).

¹¹⁶ 669 F. Supp. at 290.

¹¹⁷ *See id.* at 291.

¹¹⁸ The testimony of Dr. Gastineau. *See id.* at 290.

¹¹⁹ *See supra* text accompanying note 23.

antibodies to the officers that this would have provided them protection from developing hepatitis. If the court instructed that the jury could find that Moore's mouth is a deadly or dangerous weapon because "any human bite can cause a serious infection" then every school child who bites an offending student is at risk for a jail sentence or significant fine in Minnesota.¹²⁰

It is unlikely the jury would have found Moore's mouth to be a dangerous weapon if they had understood that: (1) his chances of being infectious for HIV from his blood is less than 10% and much less for a bite injury (if there is any risk at all from a bite), (2) he was not infectious for hepatitis, and (3) that Moore's teeth never came into direct contact with either officers' skin and the only injury was an abrasion from Moore's teeth causing one of the officer's own pant leg to rub against his skin.

Moore's counsel should have kept from the jury Moore's alleged intention to kill the officers

It will remain unknown whether Moore, in attempting to "bite" the two officers intended to kill them (or so the testimony states). Specific intent is not an element of the 18 U.S.C. § 111 assault crime.¹²¹

Why was the evidence of Moore's intent presented to the jury? Is it inflammatory and have a prejudicial effect when the defendant is HIV antibody positive? Should it have been presented as an admission of intent in a trial for a crime that does not require proving specific intent?

What was the testimony? Is it true that "[a]fter the incident, defendant stated that he intended to kill the officers?"¹²² Or is the *New York Times* account accurate that reported "Mr. Moore was accused of biting two guards ... as he was being reprimanded for smoking in a no-smoking area.... Mr. Moore later told a nurse he hoped the guards would get AIDS...."¹²³ Or is the court of appeals account accurate that "Moore told Debra Alberts, a nurse at the FMC, that he had 'wanted to hurt them bad, wanted to kill the bastards.' He also said that he 'hopes the wounds that he inflicted on the officers when he bit them were bad enough that they get the disease that he has.'"¹²⁴

Perhaps he said all three; there is no difference between "hoping" and "intending" when neither of these are required for the statutory crime and neither are

¹²⁰ MINN. STAT. § 609.222 (1986) states that whoever assaults with a dangerous weapon may be sentenced to imprisonment for not more than five years or to payment of a fine of not more than \$10,000, or both.

¹²¹ See generally *United States v. Hill*, 526 F.2d 1019, cert. denied, 425 U.S. 940 (1975); *United States v. Marcelllo*, 423 F.2d 993, cert. denied, 398 U.S. 959 (1970).

¹²² 669 F. Supp. at 290.

¹²³ The *New York Times*, June 25, 1987, at 18, col. 6.

¹²⁴ 846 F. 2d at 1165.

at issue in determining whether Mr. Moore's teeth are a deadly or dangerous weapon? It is reasonable to believe that this testimony, if admitted, would inflame the jury. Moore's counsel should have suppressed this testimony and not allowed it to reach the jury.

Moore's jury instructions may not have been adequate

Moore's counsel should have presented a jury instruction that told the jury that in order to convict Moore of assault with a deadly or dangerous weapon they had to find beyond a reasonable doubt that Moore had used his mouth and teeth in a manner likely to endanger life or inflict serious bodily harm.

No evidence was presented as to the likeliness of infection from a "bite" when the wound does not contain a puncture mark and when the injury is only an abrasion caused by the cloth of the uniform material soaked with saliva being rubbed across the skin. The jury was only presented testimony as to what might result if an actual bite occurred, not what is likely to occur. Without testimony of the likeliness of infection from the actual manner in which the teeth were used, it is hard to believe a jury could reach the threshold of beyond a reasonable doubt.

Moore's counsel should not have permitted testimony that showed Moore is HIV antibody positive

The statute used to convict Moore requires only a showing of the use of a deadly or dangerous weapon. Certainly no one has shown that AIDS can be transmitted by passive contact and there have been no reported cases of spread of HIV by biting. If the prosecution was able to show that Moore assaulted the officers with a deadly or dangerous weapon it would not be based on Moore's capacity to "spread AIDS" to them. The prosecution would be able to effectively present their case without introducing to the jury Moore's HIV status. To the jury this information would surely be inflammatory.

CONCLUSION

Lawyers who represent defendants charged with crimes that involve HIV or AIDS and judges who hear cases that involve these issues have a duty to learn about the Human Immunodeficiency Virus and the disease states it causes. To confuse a virus with an antibody is tantamount to confusing fire with water. It is hard to believe that in the United States of America in the late 1980s this level of misinformation is allowed to strip a man of his freedom.

Any person who engages in any high risk behavior knowing that he or she has been infected with the human immunodeficiency virus should be penalized severely. This penalty must be one created by the legislature not one designed by judges who

“bend the law” to include those infected with HIV.

Was *United States v. Moore* a case of trial-by-jury or was it a “witch hunt” by some other name?