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Amy L. Hansen

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ESTABLISHING UNIFORMITY IN HIV-FEAR CASES: A MODIFICATION OF THE DISTINCT EVENT APPROACH

But we can't seem to make AIDS go away, either through mental gymnastics or the magic of science. And then there is death.¹

I. INTRODUCTION

In June of 1988, Bessie Carroll visited her terminally ill sister in the hospital.² After applying lotion on her sister's skin, Bessie rinsed her hands in the sink and then reached for a paper towel from what appeared to be a paper towel dispenser next to the sink.³ Instead of a paper towel dispenser, the container was an unmarked contaminated needle receptacle, and Bessie was pricked by three needles.⁴ Thus began Bessie's nightmare that she had possibly been exposed to Acquired Immune Deficiency Syndrome (AIDS)⁵ or Human Immunodeficiency Virus (HIV), the virus believed to cause AIDS,⁶ from the

1. Harlon Dalton, *Preface, AIDS AND THE LAW: A GUIDE FOR THE PUBLIC* (Harlon L. Dalton et al. eds., 1987), reprinted in *AIDS LAW TODAY* at xii, xiv (Scott Burris et al. eds., 1993).

2. *Carroll v. Sisters of St. Francis Health Servs., Inc.*, 868 S.W.2d 585, 586 (Tenn. 1993).

3. *Id.*

4. *Id.*

5. In 1981, a publication by the Center for Disease Control (CDC) officially recognized Acquired Immune Deficiency Syndrome (AIDS) as a fatal blood-borne disease. The disease causes a distinct reduction in the body's infection fighting system by destroying white blood cells. Stephen A. Skiver & James Hickey, *AIDS: Legal Issues 1992*, 19 OHIO N.U. L. REV. 839, 839 (1993). Because of the collapse of the body's immune system through a reduction in white blood cells, AIDS patients fall prey to common diseases that would ordinarily not be fatal. Jon Cohen, *What Causes the Immune System Collapse Seen in AIDS? AIDS: The Unanswered Questions*, SCI., May 28, 1993, at 1256.

6. Garry G. Mathiason & Steven B. Berlin, *AIDS in the Healthcare, Business, and Governmental Workplace*, ALI-ABA, June 3, 1993, at 637. HIV is believed to be the cause of AIDS by the CDC and other organizations. HIV gradually depletes the number of T-Lymphocyte cells without which the body's immune system cannot function. Therefore, HIV increasingly leaves the infected individual more susceptible to infection. Sidney D. Watson, *Eliminating Fear Through Comparative Risk: Docs, AIDS, and the Anti-Discrimination Ideal*, 40 BUFF. L. REV. 739, 746 (1992).

It is well established that one of four bodily fluids is needed to transmit HIV: human blood, semen (including pre-ejaculatory fluid), vaginal secretions, or breast milk. NICK SIANO, *NO TIME TO WAIT* 33 (1993). Siano asserts that urine, feces, or sweat cannot readily transmit the virus, but it is important to recognize that urine and feces can contain blood that could transmit HIV. *Id.*

The only documented modes of HIV transmission are: (1) sexual intercourse with an HIV infected person; (2) sharing needles contaminated with blood infected with the virus; (3) parenteral, mucous membrane, or non-intact skin contact with HIV-infected

needles.⁷

Although Bessie was tested for HIV on six different occasions, and all of the tests were negative, she experienced profound fear and anguish during the period in which she did not know with medical certainty whether she was infected with HIV.⁸ Bessie's fear was legitimate, given the rapid spread of HIV

blood; (4) transfusion of HIV-infected blood; (5) mother-to-child transmission during pregnancy, delivery, and breast feeding; and (6) transplants of HIV infected organs and tissues.

Watson, *supra*, at 751.

Transmission does not occur through saliva, tears, or casual contact such as hugging, kissing, sneezing, or from toilet seats. William L. Earl & Judith Kavanaugh, *Meeting the AIDS Epidemic in the Courtroom: Practical Suggestions in Litigating Your First AIDS Case*, 12 NOVA L. REV. 1203, 1206 (1988). However, in early December 1993, two cases involving household items threatened to undermine researchers' beliefs as to how the virus is transmitted. In New Jersey, two young girls were living in the same foster home and, although both of their mothers were HIV-infected, only the older girl was HIV positive since birth. It was discovered about eighteen months before the report was published that the younger girl was infected with HIV and the virus in her blood matched that of the older girl. The case threatened to undermine the belief that social contact cannot transmit the virus. However, it soon became apparent that the infection had not occurred from a new hazard but from a risk that is preventable and already known: blood passed between the two girls. The older girl frequently had nosebleeds and the younger girl had open lesions on her arms from dermatitis. Also, the two girls sometimes shared a toothbrush despite the older girl's bleeding gums and, consequently, HIV-infected blood was passed to the younger girl who may have had an open cut in her mouth. Therefore, the transfer agent was blood. Geoffrey Cowley, *AIDS Without Needles or Sex*, NEWSWEEK, Dec. 29, 1993, at 106.

A second case occurred in teenage hemophiliac brothers. The older brother tested HIV positive in 1985 when he received a contaminated blood transfusion, but the younger brother was HIV negative until 1993 when it was discovered that he was infected with a viral strain of HIV that matched his brother's viral strain. The brothers never shared needles and never had sex together, but they did share a razor blade that may have cut both in quick succession. Therefore, both cases were the result of blood to blood exposure which has been established since the beginning of the HIV epidemic as a transmitter of HIV. *Id.*; See also David Gates, *An American Tragedy in Iowa*, NEWSWEEK, Feb. 7, 1994, at 44 (chronicling a family of hemophiliacs in which seven members have died from AIDS and an eighth is HIV positive as the result of receiving contaminated blood products).

Although the majority of medical researchers attribute the cause of AIDS to HIV, some researchers believe that there are other causes of AIDS. ROBERT S. ROOT-BERNSTEIN, *RETHINKING AIDS—THE TRAGIC COST OF PREMATURE CONSENSUS* 1 (1993). Root-Bernstein argues that medical researchers have committed grave errors and contributed to the increasing number of deaths from AIDS by clinging to the idea that HIV is the sole cause of AIDS merely because of the high correlation between HIV and AIDS. *Id.* at 1, 329. Because there have been some AIDS cases where the victim was never infected with HIV, Root-Bernstein argues that there must be other causes of AIDS in addition to HIV. *Id.* at 28-30, 334. Instead, he argues that there must be co-factors such as other viruses, bacterium, and drugs. *Id.*; See also JON RAPPOPORT, *AIDS INC.: SCANDAL OF THE CENTURY* 333 (1988) (arguing that there is "no proof that AIDS is a single disease-entity or a syndrome caused by one agent"); JAD ADAMS, *AIDS: THE HIV MYTH* (1989) (arguing that HIV is not the sole cause of AIDS).

7. Carroll v. Sisters of St. Francis Health Servs., Inc., 868 S.W.2d 585, 586 (Tenn. 1993).

8. *Id.*

and AIDS,⁹ and the uncertainty that surrounds these diseases.¹⁰

The more the scientific community learns about AIDS and HIV, the less certain it becomes about all aspects of the disease.¹¹ Added to this uncertainty are conflicting opinions by some researchers that HIV does not cause AIDS¹² and skepticism about the tests that are supposed to predict whether an individual has been infected with HIV.¹³ A lack of uniformity also exists on a variety of

9. The fear of AIDS is real because, in the United States, by January 1, 1993, AIDS had caused 171,800 deaths, there were 253,448 reported cases of AIDS, and approximately 1.5 million other people were infected with HIV. Mathiason & Berlin, *supra* note 6, at 637. Since the mid-1970s, more than 17 million people (the majority in Africa) have contracted HIV. Geoffrey Cowley, *The Ever Expanding Plague: AIDS Experts Point to Asia as the Next Epicenter*, NEWSWEEK, Aug. 22, 1994, at 37. Experts also claim that over 40 million people will be infected with HIV by the year 2000. *Id.*

10. See *infra* notes 11-13 and accompanying text.

11. In 1993, *Science* magazine surveyed the world's leading AIDS researchers about their search for a vaccine or a cure for AIDS. The common response among the researchers was that the more knowledge they accumulate about the disease, the faster the assumptions that seemed intact a year ago become obsolete. John Benditt, *AIDS—The Unanswered Questions*, SCI., May 28, 1993, at 1253. Recently, researchers discarded several accepted certainties. For example, the theory that almost all of the damage is caused by HIV's direct killing of cells collapsed in the face of a new theory that indirect mechanisms are also involved. Jon Cohen, *AIDS Research: The Mood is Uncertain*, SCI., May 28, 1993, at 1254. In the area of treatment, researchers once considered the drug AZT helpful for infected patients who had not begun to show AIDS symptoms, but recently have abandoned this belief because of new data that the drug is of little help to those patients. *Id.* The limits of AZT are not new discoveries, because in people with AIDS, AZT only prevents death for possibly one year and does not cure AIDS. *Id.* For many researchers, the data simply reinforces the belief that "no drug is going to knock out HIV by itself." *Id.* at 1255.

12. See *supra* note 6 and accompanying text. Chaos and controversy appear to have transcended their existence in HIV/AIDS research and prevention to the legal system where courts have responded to HIV litigation with confusion and diverse approaches. Roger N. Braden, *AIDS: Dealing with the Plague*, 19 N. KY. L. REV. 277, 278 nn.6-7 (1992). Braden's article explores the various dilemmas that the HIV crisis presents to the courts and how courts respond to tort actions for sexual transmission of HIV/AIDS and discrimination against HIV/AIDS victims. *Id.* at 281-331. The overriding theme of Braden's work is that as the number of HIV transmission cases filed continues to increase, uniformity is needed among the states to combat this crisis. *Id.* at 331-32. Braden's solution is to create federal programs to help society deal more effectively with AIDS. *Id.*

13. Eleni Papadopoulos-Eleopoulos et al., *Is a Positive Western Blot Proof of HIV Infection*, BIO/TECH., June 1993, at 696. The two methods used to test for the presence of HIV are enzyme-linked immunosorbent assay (ELISA) and Western Blot (WB) antibody tests. *Id.* Currently, there is general acceptance that a positive WB antibody test is equivalent with HIV infection because WB is believed to be a highly sensitive test. However, there is evidence which indicates that the antibody tests are:

- (1) not standardized,
- (2) not reproducible,
- (3) possibly not specific, because the WB proteins (bands) which are considered to be encoded by the HIV genome and to be specific to HIV may not be encoded by the HIV genome and may in fact represent normal cellular proteins, and (4) not absolute, because no "gold standard" exists (the gold standard here would be HIV itself). Therefore, a positive WB may represent nothing more than cross-reactivity with non-HIV antibodies present in AIDS patients and

issues such as condom advertising,¹⁴ mandatory testing of health care workers,¹⁵ restriction of HIV positive health care workers,¹⁶ disclosure of

those at risk.

Id.

The evaluation of this problem is extremely technical, and complex and beyond the scope of this note, but the main point is that the test for HIV infection needs to be reevaluated because it may not be accurate. *Id.* One of the frightening aspects of this evidence is that there is no standardization among the laboratories who administer WB tests as to what constitutes a positive test. Therefore, the test results may depend on which lab evaluated the blood, because the labs have different criteria in determining what constitutes a negative or positive result. *Id.* at 697-98.

14. One of the greatest public policy debates has been over the advertisement of condoms. Malcolm Gladwell, *A Matter of Condom Sense; Rejection of Explicit Ads Angers AIDS Educators*, WASH. POST, Apr. 9, 1992, at C1. In 1991, federal health officials proposed a series of advertisements that promoted condoms for the practice of safe sex, but the head of the Center for Disease Control terminated these ads because he felt that they were too explicit. *Id.* As a result, the government's \$1.5 million "America Responds to AIDS" campaign could not mention the words "condom" or "sex." *Id.*

This decision was changed in 1993, and a new set of public service ads have emerged that do use the words "condom" and "sex." Jonathan Alter, *The Power to Change What's 'Cool,'* NEWSWEEK, Jan. 17, 1994, at 23. The ads are the subject of ridicule by many but, "the problem with all the snickering is not just that 200,000 Americans have already died of AIDS, but that unlike so many government programs, these ads-which also preach abstinence-may actually save lives." *Id.*

15. See Donald J. McNeil & Laurie A. Spieler, *Mandatory Testing of Hospital Employees Exposed to the AIDS Virus: Need to Know or Unwarranted Invasion of Privacy?*, 21 LOY. U. CHI. L. J. 1039, 1073 (1990) (reasoning that hospital employees who refuse to submit to HIV testing that is accompanied by appropriate guarantees of confidentiality and accommodation can be fired and that such firing will not violate either constitutional or statutory provisions, unless the state expressly prohibits such testing); Michael L. Closen, *A Call for Mandatory HIV Testing and Restriction of Certain Health Care Professionals*, 9 ST. LOUIS U. PUB. L. REV. 421, 434-38 (1990) (proposing mandatory HIV testing of health care professionals who engage in physically invasive contact with patients which is contact involving the risk of blood transmission from the health care professional to the patient). *But see* Scott H. Isaacman, *The Other Side of the Coin: HIV-Infected Health Care Workers*, 9 ST. LOUIS U. PUB. L. REV. 439, 492-93 (1990) (arguing that there should not be any mandatory testing of health care workers until there is evidence of an actual hazard to patients). *See also* Denise C. Singleton, Note, *Nonconsensual HIV Testing in the Health Care Setting: The Case for Extending the Occupational Protections of California Proposition 96 to Health Care Workers*, 26 LOY. L.A. L. REV. 1251, 1287-88 (1993) (arguing that if health care workers can document exposure to a patient's blood or body fluids, they have the option of requiring a nonconsenting patient to undergo an HIV test).

16. Gordon G. Keyes, *Health-Care Professionals with AIDS: The Risk of Transmission Balanced Against the Interests of Professionals and Institutions*, 16 J.C. & U.L. 589 (1990). Keyes proposes that hospitals and health care institutions should restrict the performance of invasive procedures by HIV positive practitioners because, although the risk of transmission is extremely low, it is still a risk. *Id.* However, HIV positive practitioners should not be restricted from performing non-invasive procedures because in those situations, no chance of blood transfer exists. *Id.*

Invasive procedures, which include most surgeries, require the health care worker to operate inside a body cavity and pose the greatest risk of HIV transmission through blood to blood exposure because it is not uncommon for health care workers to be cut during surgery. Non-invasive procedures involve mere talking and touching procedures and therefore do not pose the same risks

HIV positive test results,¹⁷ and discrimination.¹⁸ Adaptation and solutions to

as invasive procedures. See Watson, *supra* note 6, at 745-46.

17. Significant controversy surrounds the issue of disclosure by health care workers about their HIV or AIDS status to their patients. This issue is complex. On one side there is the public's interest in protection from exposure to HIV or AIDS. On the other side there is the health care worker's interest in protection from an invasion of privacy and potential discrimination. See Jennifer Hertz, Note, *Physicians with AIDS: A Proposal for Efficient Disclosure*, 59 U. CHI. L. REV. 749 (1992) (proposing an economic analysis of the costs and benefits of disclosure based on Judge Learned Hand's $B < P \times L$ formula from *United States v. Carroll Towing*, 159 F.2d 169, 173 (2d Cir. 1947)); see also Michelle Wilcox DeBarge, Note, *The Performance of Invasive Procedures by HIV-Infected Doctors: The Duty to Disclose Under the Informed Consent Doctrine*, 25 CONN. L. REV. 991, 1016-23 (1993) (arguing that the performance of invasive procedures by HIV infected physicians poses a risk of HIV infection to the patient and, therefore, under the doctrine of informed consent, doctors should be required to disclose their HIV status); Jody B. Gabel, Comment, *Liability for "Knowing" Transmission of HIV: The Evolution of a Duty to Disclose*, 21 FLA. ST. U. L. REV. 981, 1012-27 (1994) (arguing that a duty to disclose applies to HIV-positive health care professionals who perform exposure prone procedures).

Controversy also exists over whether patients have a duty to reveal their HIV status to their physicians. See, e.g., *Doe v. Roe*, 588 N.Y.S.2d 236, 241-43 (N.Y. Sup. Ct. 1992). The *Doe* court held that the patient had a legal duty to reveal his HIV status to his physician, reasoning that the risk of HIV transmission in invasive procedures is equal to the risk of transmission in sexual activity. *Id.* at 241. The court further reasoned that anyone who poses a risk of transmission of any communicable disease to another has a duty to warn others to stem the spread of disease. *Id.* at 242. See also Samuel Oddi, *Reverse Informed Consent: The Unreasonably Dangerous Patient*, 46 VAND. L. REV. 1417, 1429-35 (1993) (arguing that patients have a duty to inform health care professionals of material risks (in particular HIV-infection) associated with the patient's care).

Another issue of debate is whether physicians have a duty to warn foreseeable third parties who are at risk of contracting AIDS from the physician's patient. Michael L. Closen & Scott H. Isaacman, *Notifying Private Third Parties at Risk for HIV Infection*, TRIAL, May 1989, at 50; see Siobhan Spillane, Note, *AIDS: Establishing a Physician's Duty to Warn*, 21 RUTGER L.J. 645, 652-61 (1990) (proposing that physicians have a duty to warn foreseeable third parties who may contract the AIDS virus from the physician's patient).

Stemming from the debate over a physician's duty to warn is the precedent set forth in *Tarasoff v. Regents of the Univ. of Cal.*, 551 P.2d 334 (Cal. 1976). In *Tarasoff*, a psychotherapist's patient made violent threats against his former girlfriend during therapy, and the psychotherapist did not notify the girlfriend or the authorities about the threats. *Id.* at 341. The patient stabbed the girlfriend to death on campus, and her parents sued the university and the psychotherapist for breach of duty. *Id.* The court held that a special relationship existed between the therapist and his patient and that this relationship created affirmative duties on the part of the therapist for the benefit of the patient's intended victim, even though notification would breach the therapist's confidentiality to his patient. *Id.* at 349-51. *Tarasoff* established that liability for failure to warn applies when the object of the patient's threats or hostility is identifiable and the harm to the victim is foreseeable. *Id.* Cf. Kenneth E. Labowitz, *Beyond Tarasoff: AIDS and the Obligation to Breach Confidentiality*, 9 ST. LOUIS U. PUB. L. REV. 495, 512-17 (1990) (arguing that the *Tarasoff* rule should be applied in HIV/AIDS cases where the physician can identify foreseeable third parties who are at risk of contracting HIV/AIDS from the physician's patient). See also Sten L. Gustafson, Comment, *No Longer the Last to Know: A Proposal for Mandatory Notification of Spouses of HIV infected Individuals*, 29 HOUS. L. REV. 991, 1020-27 (1992) (proposing to statutorily require physicians to notify, through state health authorities, the spouse of an HIV or AIDS positive patient when the diagnosis is made). But see *Diaz Reyes v. United States*, 770 F. Supp. 58, 63 (D.P.R. 1991) (holding that a hospital was not liable to a wife for its failure to notify

the HIV crisis are problematic. The legal system is slow, cumbersome, and unable to quickly adapt to new crises that are suddenly thrust upon it,¹⁹ while HIV is swift and relentless. Additionally, many citizens and legislators still do not realize the magnitude of the crisis.²⁰

her that her husband had tested positive for HIV), *aff'd*, 971 F.2d 744 (1st Cir.), *cert. denied*, 112 S. Ct. 2306 (1992).

18. See *Bradley v. University of Tex. M.D. Anderson Cancer Ctr.*, 3 F.3d 922, 924 (5th Cir. 1993) (holding that a surgical technician who was infected with HIV was not "otherwise qualified" under the Rehabilitation Act to continue in his present employment and therefore, his reassignment as a procurement assistant in the purchasing department was not an act of discrimination); *Doe v. Washington Univ.*, 780 F. Supp. 628, 634 (E.D. Mo. 1991) (holding that the university could disenroll a third year dental student who was HIV positive because, though minimal, a risk of HIV transmission existed). The court in *Doe* based its decision upon the risk of transmission that could occur to the public given the large number of invasive procedures required to be performed by students under clinical graduation requirements and the recurrence of self-injury experienced by dentists. *Id.* at 632-33.

But see *Jaspersen v. Jessica's Nail Clinic*, 265 Cal. Rptr. 301, 307-08 (Cal. Ct. App. 1989) (holding that the defendant pedicure salon's firing of the plaintiff because he had AIDS violated a municipal ordinance that prohibited discrimination against individuals with AIDS); *Petri v. Bank of New York Co.*, 582 N.Y.S.2d 608, 611-12 (N.Y. Sup. Ct. 1992) (holding that the defendants had to pay unemployment compensation to the plaintiff who was fired because he was HIV positive); *Downtown Hosp. v. Sarris*, 588 N.Y.S.2d 748, 751-53 (N.Y. Cir. Ct. 1992) (holding that a landlord could not evict the plaintiffs solely because they had AIDS); *Club Swamp Annex v. White*, 561 N.Y.S.2d 609, 610-11 (N.Y. Sup. Ct. 1990) (holding that the plaintiff's employer impermissibly discriminated against the plaintiff by firing him from his job as a waiter after the plaintiff disclosed that he had AIDS); *Hummer v. Unemployment Appeals Comm'n*, 573 So. 2d 135, 137-38 (Fla. Dist. Ct. App. 1991) (holding that the plaintiff employee's failure to disclose his HIV positive status to his employer and his use of one sick leave day per month for treatment was not misconduct and therefore, the defendants had to pay unemployment benefits to the plaintiff). See also Bradford McKee, *On a Scale of Sorrows Workers with AIDS Can Find Bias Benefit Costs Tipping the Balance*, WASH. POST, Dec. 28, 1992, at F1 (describing employees with HIV or AIDS who lost their jobs after their employers discovered the employees' health status). See David I. Schulman, *AIDS Discrimination: Its Nature, Meaning and Function*, 12 NOVA L. REV. 1113, 1114-15 (1988) (reasoning that AIDS discrimination exists because of the ancient human impulse to fracture in times of crisis and victimize some to bind together the rest).

19. As one commentator stated: "Our legal system is suddenly confronted with the task of quickly applying old legal principles to a new, misunderstood, and deadly disease, all within a crowded, overburdened, and understaffed civil and criminal justice system." Abby Rubenfeld, *Today's Plague, Tomorrow's Laws: What Can Lawyers Do When an Incurable Disease Such as AIDS Threatens to Overwhelm Our Civil and Criminal Systems?*, HUM. RTS. Q., Summer 1987, at 17. Rubenfeld also states that AIDS is "tragically misplaced in a legal system notorious for being slow and cumbersome." *Id.* at 19. Rubenfeld correctly asserts that AIDS is a unique problem in our court system that is overcrowded and slow, for the AIDS virus is swift, relentless, and fatal.

20. While discussing state budget cuts for hospitals, Montana's Lieutenant Governor Dennis Rehberg stated: "The problem with AIDS is: you got it, you die. So why are we spending money on the issue?" Montana Lt. Gov. Dennis Rehberg, *Perspectives*, NEWSWEEK, Jan. 17, 1994, at 13. What Rehberg and others like him fail to understand is that AIDS does not affect just a small cross section of the country, and it is not going to disappear by itself. Without money for research on possible treatments and cures, people will continue to die from the disease, but with money for research, perhaps a cure will someday be found. In the meantime, the HIV virus is growing

In the struggle to develop standards of recovery for HIV litigation, commentators and courts compare HIV with other sexually transmitted diseases,²¹ cancer,²² and transfusion-related diseases.²³ However, no analogy between HIV and other diseases is completely sufficient because HIV is dramatically different and unique.²⁴

The only fact that everyone can agree upon is that AIDS is incurable, and once infected with HIV, it is only a matter of time until individuals will develop AIDS and die.²⁵ Therefore, within this framework of uncertainty and confusion, it is not surprising that Bessie's fear of HIV infection was acute and

stronger and ignoring it will only lead to more deaths from AIDS.

21. See Bonnie E. Elber, Note, *Negligence as a Cause of Action for Sexual Transmission of AIDS*, 19 U. TOL. L. REV. 923, 944-45 (1988) (concluding that courts should impose a legal duty upon sexually active HIV infected individuals to warn their sexual partners because courts have imposed a legal duty to warn individuals infected with gonorrhea and genital herpes); Jeanmarie Papelian, Note, *Assessing Liability for Negligent Sexual Transmission of AIDS*, 24 SUFFOLK U. L. REV. 649, 662-63 (1990) (concluding that the same standard of duty to warn sexual partners of infection imposed by the courts in transmission of venereal disease and genital herpes should be applied in HIV transmission cases). See *infra* notes 190-207 and accompanying text (discussing the standards imposed in sexually transmitted disease cases which may be applied in HIV transmission cases).

22. See John Patrick Darby, Note, *Tort Liability for the Transmission of the AIDS Virus: Damages for Fear of AIDS and Prospective AIDS*, 45 WASH. & LEE L. REV. 185 (1988). Darby argues that because of the similarities between HIV and carcinogens, courts analyzing HIV transmission liability should examine the established law of liability for exposing a plaintiff to a carcinogen. *Id.* at 188. Darby stresses the similarities between HIV and cancer by discussing the fact that the effects of both are not evident for long and variable periods and that both cause deadly and incurable diseases. *Id.* See *infra* notes 105-09 and accompanying text (analyzing fear-of-cancer and other fear-of-illness cases).

23. Joel B. Korin et al., *Civil Liability for the Transmission of AIDS*, N.J. LAW., Feb. 1989, at 41 (suggesting that in HIV-transfusion cases, the courts should seek guidance from cases which deal with transfusion-related hepatitis because both hepatitis and HIV involve transmission by a viral agent, donor screening, and testing of blood).

24. ROOT-BERNSTEIN, *supra* note 6, at 31; Dalton, *supra* note 1, at xv. HIV is also uniquely dangerous because it is a retrovirus as opposed to an ordinary virus. THE AIDS CAREGIVER'S HANDBOOK 4 (Ted Eidson ed., 1988). RNA is usually made from DNA but in a retrovirus, this process is reversed. *Id.* Therefore, HIV transcribes its genetic material (RNA) into DNA and then actually inserts that piece of DNA into the host cell. *Id.* Because HIV integrates its genetic material into the host cell, it is unlikely that any treatment can be developed to subsequently remove the RNA. *Id.* HIV is easily destroyed when outside the human body, but is virtually indestructible while in the body. Earl & Kavanaugh, *supra* note 6, at 1204. At the present time, no treatment exists that can permanently reverse the suppression of the body's immune system or protect the human body against HIV. See AIDS POL'Y & L. (BNA), Aug. 6, 1993, at 3.

25. If an individual is infected with HIV, it is only a matter of time until the individual develops AIDS, which will eventually cause a breakdown of the body's immune system. Once HIV is established in the body, it cannot be eradicated. Death is inevitable. AIDS POL'Y & L., *supra* note 24, at 3. The average time between HIV infection and development of the AIDS virus is 10.3 years, and the survival time from then until death is approximately 25 months. *Id.*

very real.²⁶ However, the Supreme Court of Tennessee ultimately held that Bessie did not have a viable cause of action and could not recover because she could not prove actual exposure to HIV.²⁷ Ironically, if Bessie had lived in another jurisdiction she may have been allowed to recover, because there is currently no uniformity among the courts in such cases.²⁸

Bessie's case is only one of many examples in the latest AIDS debate²⁹ which centers around suits by plaintiffs who are afraid that they have been exposed to HIV.³⁰ The controversy in these cases is whether recovery may be based on the plaintiff's fear of potential exposure to HIV, and whether the plaintiff needs to develop HIV to recover.³¹ The courts have struggled to

26. In the lower court decision that was eventually reversed, Linda L. Pifer, Ph.D., a professor in the Department of Clinical Laboratory Science at the University of Tennessee microbiology and an active AIDS researcher for 10 years stated in an affidavit, "All discarded needles and sharps are presumed to be infectious with regard to the AIDS virus and other blood and body fluid transmissible agents. Discarded needles must be presumed to be and are in fact capable of transmitting the AIDS virus." *Carroll v. Sisters of St. Francis Health Servs.*, 1992 WL 276717, *4 (Tenn. App. 1992).

27. *Carroll*, 868 S.W.2d at 593-94.

28. *See, e.g.*, *Bordelon v. St. Frances Cabrini Hosp.*, 640 So. 2d 476, 478-79 (La. App. 1994) (holding that the plaintiff who was erroneously given someone else's blood during surgery stated a cause of action for emotional distress stemming from her fear that she had been exposed to HIV/AIDS).

29. *See supra* notes 11-18, 21-24 and accompanying text.

30. Stephanie B. Goldberg, *AIDS Phobia: Reasonable Fears or Unreasonable Lawsuits?*, 78 A.B.A. J., June 1992, at 88.

31. *Id.* Critics give the nickname "AIDS-Phobia" to these HIV-fear cases because they see the cases as mere litigation opportunities for plaintiffs' phobic fears of HIV. *See, e.g.*, Pete Bowles, *Divorce Suit Seeks \$1M for AIDS Phobia*, NEWSDAY, July 30, 1987, at 7. The nickname is based upon a concern that the HIV-fear cases have the potential to perpetuate AIDS hysteria and unreasonable fears of how exposure to HIV occurs. DONALD H.J. HERMANN & SCOTT BURRIS, *Torts: Private Lawsuits about HIV*, in AIDS LAW TODAY, *supra* note 1, at 344. As a result of the apprehension that HIV-fear cases have the potential to create problems for the courts and society, courts are split as to whether and to what extent plaintiffs should be awarded damages for emotional distress resulting from potential HIV exposure, wherever it occurs. *Id.*

Instead of the term "AIDS-Phobia," this note uses the term "HIV-fear" because in legitimate cases, the emotional distress is not a "phobia" which is defined as "an illogical fear." WEBSTER'S NINTH NEW COLLEGIATE DICTIONARY 883 (1984). A "phobia" is an unreasonable fear that occurs when the level of anxiety is not proportional to the actual threat. W. BUTOLLO, *Phobic Behavior*, in AIDS PHOBIA: DISEASE PATTERN AND POSSIBILITIES OF TREATMENT 48 (1988). Normal anxiety is a proportionate reaction to the perceived threat, while neurotic anxiety involves a disproportionate reaction to the objective danger. ROLLO MAY, *THE MEANING OF ANXIETY* 209, 214 (1977).

This normal-neurotic differentiation is important in HIV-fear cases in determining whether the plaintiff's fear is reasonable. In states that require proof of actual exposure, the plaintiff's anxiety is normal only if the plaintiff can offer proof of the actual channel of exposure, while in other states, the determination of whether the plaintiff's anxiety is normal does not hinge upon the plaintiff's ability to prove actual exposure. *See infra* notes 131-77 and accompanying text.

The term "AIDS-Phobia" implies that all of these suits are based on unreasonable fears. This unwarranted generalization overlooks the existence of legitimate claims intended, in part, to deter

establish a standard of recovery, but out of their apprehension of a flood of claims,³² many courts have established an extremely rigid standard that denies recovery for legitimate claims by plaintiffs who fear that they have been exposed to this fatal illness.³³

In HIV-fear cases, the courts are split over whether the plaintiff may recover absent physical injury,³⁴ whether the plaintiff must first develop HIV before recovery is allowed,³⁵ and whether the actual channel of exposure to HIV must be proven.³⁶ Some disagreement also exists over the time period of

negligent and irresponsible behavior that places society at risk from the spread of HIV. See *infra* notes 213-17 and accompanying text. Plaintiffs who legitimately fear that they have been exposed to HIV deserve compensation for their trauma of potential exposure to a lingering and unmerciful disease for which there is no cure. Edward A. Adams, *Federal Law Allows Fear-Of-AIDS Claim*, N.Y. L.J., Feb. 1, 1993, at 2. Adams' article is a summary of the trial court's opinion in *Marchica v. Long Island R.R.*, 810 F. Supp. 445 (E.D.N.Y. 1993), where the plaintiff was stuck by a hypodermic needle while at work. The court reasoned that "[t]he finder of fact may conclude that the plaintiff has sustained sufficient physical injury to support an award for mental anguish . . . even though there is no proof at this time that the plaintiff has, in fact, contracted HIV/AIDS." *Marchica*, 810 F. Supp. at 453.

32. See Brian R. Garves, *In Fear-of-AIDS Cases, Proof is Key Element—Can a Plaintiff Recover Without Actual Exposure to the Disease?*, NAT'L L.J., Apr. 26, 1993, at 27-30 (explaining that courts rigidly require proof of the actual channel of exposure in HIV-fear cases because they fear that fraudulent claims would be overwhelming if the courts abandoned the standard as a result of the subjective nature of the claims).

33. See, e.g., *Lubowitz v. Albert Einstein Med. Ctr., Northern Division*, 623 A.2d 3 (Pa. 1993). In *Lubowitz*, the plaintiff was informed that blood which subsequently tested positive for AIDS was used during the plaintiff's in vitro fertilization procedure. The court held that, although the plaintiff was exposed to AIDS during the procedure, she could not recover for her fear of developing AIDS and, instead, could only recover if she actually developed AIDS in the future. *Id.* at 5.

See also *Transamerica Ins. Co. v. Doe*, 840 P.2d 288 (Ariz. Ct. App. 1992). In *Transamerica*, the plaintiffs were trained medical professionals who witnessed a car accident and then administered medical attention to the passengers. While giving cardiopulmonary resuscitation and other life-saving procedures, the plaintiffs came in direct contact with the passengers' blood. Both plaintiffs had open skin lesions that were at the area of blood contact. The plaintiffs were notified five days after the accident that one of the passengers was HIV positive. The plaintiffs then sought compensation from their insurance company, Transamerica, under their motorist coverage for bodily injury and damages, which they argued included fear from exposure to blood infected with HIV. The court held that the plaintiffs could not recover, reasoning that neither the plaintiffs' exposure to HIV infected blood, nor the drawing of their blood for HIV tests, constituted "bodily injury" under the insurance policy. *Id.* at 291.

Part of the problem with the *Transamerica* decision is that courts have disparate definitions of what constitutes bodily injury; consequently, there is inconsistent case law. See, e.g., *Marriott v. Sedco Forex Int'l Resources*, 827 F. Supp. 59, 73 (D. Mass. 1993) (holding that exposure to HIV infected blood *did* constitute a physical injury).

34. See *infra* notes 115-21, 127-30 and accompanying text.

35. See *infra* notes 110-14 and accompanying text.

36. See *infra* notes 131-77 and accompanying text.

allowable recovery,³⁷ because there is no consensus as to the accuracy of determining how soon individuals will know that they have developed HIV.³⁸ The lack of uniformity in society's response to the HIV crisis and the split among the courts as to the standard of recovery in HIV-fear cases merely creates more confusion and should be resolved to deter negligent behavior and to decrease actual and potential HIV exposure.

The purpose of this Note is to trace the events and background that have led to the current HIV-fear cases and to propose a judicial approach that will provide for uniformity as to the standard of recovery that should be employed in these cases. The HIV-fear cases are highly emotional, and critics argue that they present potential risks of perpetuating HIV hysteria and discrimination.³⁹ Therefore, the courts must establish a standard of recovery that will not increase misconceptions about the transmission of HIV and open the proverbial Pandora's Box.⁴⁰

37. See *infra* notes 178-89 and accompanying text.

38. The majority opinion among medical researchers is that 95% of those who develop HIV will test positive for the virus within six months of acquiring it. C. Robert Horsburgh et al., *Duration of Human Immunodeficiency Virus Infection Before Detection of Antibody*, THE LANCET, Sept. 16, 1989, at 637. However, the 95% figure is criticized by those who argue that the tests used to determine HIV infection are inaccurate. See *supra* note 13 and accompanying text.

39. Goldberg, *supra* note 30, at 88. In reality, the HIV-fear cases can be used as educational tools of how HIV is transmitted. Although the information about transmission has been concrete for years, there are still those in society who fear that HIV can be transmitted casually. Goldberg fears that HIV-fear cases will increase people's fears about AIDS and result in discrimination by those who do not really understand how HIV is transmitted. *Id.*

The possibility of discrimination against HIV-infected individuals is significant, and both the federal and state governments have made attempts to minimize employment discrimination. Federal and state laws designate HIV and AIDS patients as "handicapped"; therefore, HIV and AIDS patients are entitled to the same protections that other handicapped individuals receive in hiring and employment. Victoria M. Bunsen, *Employees, Privacy Rights and AIDS*, 19 COLO. LAW. 1839 (1990). The handicap designation laws protect individuals from discrimination by those who fear that HIV is casually transmitted. "Because medical studies indicate that there is no reason to fear casual daily contact with an AIDS patient, any form of discrimination or refusal to work with such a person should not be tolerated." *Id.* at 1840. Consequently, employers face liability if they fail to reprimand co-workers who refuse to work with an HIV or AIDS positive individual. *Id.*

The AIDS crisis creates issues of disclosure in employment and many commentators advocate that disclosure of an individual's HIV or AIDS status is only necessary or warranted if in the course of performing their duty, the individuals pose a risk of transmitting HIV. Thus, in most jobs, whether an individual has HIV or AIDS is irrelevant, because that status will not affect their ability to perform their job or present a risk of transmission to others. See *supra* note 18; *infra* notes 210-12 and accompanying text.

40. EDITH HAMILTON, MYTHOLOGY 88 (1942). In Greek mythology, the gods gave Pandora a box in which each god placed something harmful. The gods instructed Pandora to never open the box, but her curiosity overcame her. When she opened the box, plagues, sorrow, and mischief escaped. However, there was good in the box in the form of hope, and Greek mythology maintained that it was humankind's sole comfort against all of the evil which had escaped. Whenever an area of recovery faces possible expansion, commentators equate the action to opening Pandora's box and

No uniformity exists among the courts in dealing with the HIV-fear cases,⁴¹ and the result is that many courts deny recovery to plaintiffs who legitimately fear that they have been exposed to a fatal disease due to someone's negligence.⁴² Judicial uniformity is necessary to deter negligent behavior that may result in HIV exposure. Although the fear of HIV is real, recognition of HIV-fear cases does not mean that plaintiffs will be given license to perpetuate unrealistic fears about how exposure to the virus occurs. Instead, the solution in this Note's proposed judicial approach not only removes unjust barriers that bar recovery for legitimate claims, but also establishes boundaries to deny fraudulent claims.⁴³

Section II analyzes the general history of negligent infliction of emotional distress in the courts and in the psychological community and illustrates how the courts have increasingly recognized mental injury claims as legitimate.⁴⁴ Section II also analyzes how courts have dealt with emotional distress claims in suits for the transmission of HIV.⁴⁵ Section III analyzes the current trend of HIV-fear cases and the problems that plague the courts regarding the proper standard of recovery.⁴⁶ In addition, Section III examines the role of comparative negligence in HIV-fear cases, because as in all tort cases, the behavior of the plaintiff may also be at issue.⁴⁷ Finally, Section IV proposes a judicial approach to gain uniformity in HIV-fear cases.⁴⁸

This Note's proposed judicial approach abandons the physical manifestation

argue that doing so will only lead to more suffering. Pandora's box was used as an analogy when courts began to abandon the physical impact requirement in negligent infliction of emotional distress claims, and it also appeared when courts began recognizing pure psychic emotional claims. The same analogy is now made in HIV-fear cases. Courts are afraid that without a rigid standard of recovery, a flood of fraudulent claims will descend upon the courts, and courts will be unable to adequately recognize genuine claims given their subjective nature. Garves, *supra* note 32, at 27-30. See also *infra* notes 131-77, 226-52 and accompanying text (analyzing the courts' standards of recovery in HIV-fear cases and concluding that a different standard of recovery will not open the floodgates of litigation).

41. See *infra* notes 105-26, 151-74 and accompanying text.

42. See *Burk v. Sage Products, Inc.*, 747 F. Supp. 285, 287 (E.D. Pa. 1990) (holding that a paramedic who was pricked by a needle protruding from a defective disposal container could not recover for his fear of exposure to HIV because he could not prove that the needle was previously used on an HIV positive patient); *Poole v. Therapeutic Corp.*, 698 F. Supp. 1367, 1372 (N.D. Ill. 1988) (holding that, although the plaintiff alleged facts sufficient to constitute a reasonable fear for her safety from exposure to AIDS, absent any allegations of physical injury or illness resulting from her emotional distress, she could not recover).

43. See *infra* notes 226-52 and accompanying text.

44. See *infra* notes 55-104 and accompanying text.

45. See *infra* notes 55-76, 86-104 and accompanying text.

46. See *infra* notes 105-89 and accompanying text.

47. See *infra* notes 190-207 and accompanying text.

48. See *infra* notes 226-52 and accompanying text.

rule and proof of the actual channel of HIV exposure in favor of a requirement that plaintiffs must trace their fear to a distinct event of potential exposure.⁴⁹ This approach is a modification of the distinct event approach established in *Marriott v. Sedco Forex International*.⁵⁰ Under the modified distinct event approach, this Note concludes that the physical impact rule,⁵¹ physical manifestation rule,⁵² and the actual channel proof requirement⁵³ are unjust standards that should be abandoned in favor of a more moderate approach that recognizes the legitimacy of independent mental injuries.⁵⁴

II. THE EVOLUTION OF NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS AS A RECOGNIZED CAUSE OF ACTION

For centuries, philosophers and physicians contemplated the relationship between the body and the mind to discover why emotions may manifest themselves in physiological reactions.⁵⁵ Psychologists have asserted for years that a cause and effect relationship can exist between emotional stress and the subsequent physical symptoms that occur.⁵⁶ The early courts began to

49. See *infra* notes 226-52 and accompanying text.

50. 1993 WL 287699 (D. Mass. 1993). See *infra* notes 151-63 and accompanying text for a detailed explanation of the approach established in *Marriott* and why discussion of a modification of the approach is necessary.

51. The physical impact rule requires that a physical injury accompany the plaintiff's emotional distress. See *infra* notes 73-86 and accompanying text.

52. The physical manifestation rule requires that the plaintiff's emotional distress manifest itself in physical symptoms. See *infra* notes 64-68, 73-76, 87-90, 94-96 and accompanying text.

53. The channel of exposure rule requires the plaintiff to prove the actual means of HIV exposure. See *infra* notes 130-35 and accompanying text.

54. See *infra* notes 226-28, 235-38 and accompanying text.

55. In 1884, the first scientific attempt to explain the relationship between emotional stress and physiological accompaniments was published by William James, a psychologist. EUGENE E. LEVITT, *THE PSYCHOLOGY OF ANXIETY* 92-93 (1967). One year later, a Danish psychologist, Carl Lange, advanced a similar explanation. *Id.* The James-Lange theory proposed that an individual's perception of an exciting stimulus will provoke a reaction by an individual's reflexes. *Id.*

The James-Lange explanation was accepted for over 40 years until the 1920s, when psychologists Walter Cannon and Philip Bard proved that it was unreasonable and proposed that emotional experience and physiological reactions occur simultaneously. *Id.* at 93. Eventually, the Cannon-Bard theory was proven to be too simplistic, but it was seen as an advancement in proving that there can be a connection between individuals' emotional and physical reactions. *Id.*

The modern explanation of the relationship between the body and the mind is that the limbic system in the brain is the seat of emotional control, and when it is stimulated in certain ways, various emotional responses occur. *Id.* at 93-95. Modern society recognizes that individuals do not usually experience a physical injury or an illness without also undergoing a change in their emotional state. Melvin L. Selzer, M.D., *Psychological Stress and Legal Concepts of Disease Causation*, 56 CORNELL L. REV. 951, 952 (1971).

56. Hubert Winston Smith, *Relation of Emotions to Injury and Disease: Legal Liability for Psychic Stimuli*, 30 VA. L. REV. 193, 215 (1944). Smith states that volumes of literature exist on studies conducted to explain the relationship between emotional stress and physical symptoms. *Id.*

recognize these scientific assertions and established the premise that mental anguish can be either the result of, or accompanied by, a physical injury.⁵⁷ However, many early courts understood this relationship to mean that if a plaintiff's emotional distress is legitimate, it will *always* manifest itself in physical symptoms.⁵⁸ Consequently, those courts refused to accept the notion that emotional distress could exist independently.⁵⁹

Although the scientific community long ago recognized the reality that emotional stress and fear exist independently, the legal community has been skeptical of this premise.⁶⁰ Courts were afraid to allow recovery solely for emotional distress because of a belief that emotional injuries were intangible, and somehow not as real as physical pain.⁶¹ Courts also felt that emotional distress was difficult to value because people were affected in different ways. Therefore, it was too speculative for the court to measure in terms of damages.⁶² Consequently, the result has been a slow evolution of the

See Selzer, *supra* note 55, at 952 (asserting that almost all physical injuries or significant physical illnesses alter an individual's emotional state, and only rare individuals do not suffer an emotional change). Selzer also states that changes in the emotional state often create a related physiological change. *Id.*

57. JOHN G. FLEMING, *THE LAW OF TORTS* 146 (7th ed. 1987).

58. Terry Morehead Dworkin, *Fear of Disease and Delayed Manifestation Injuries: A Solution or a Pandora's Box?*, 53 *FORDHAM L. REV.* 527, 529 (1984). See Merton E. Marks & James T. Acuff, Jr., *Legal Issues in the Recovery for Fear of Future Disease Without Present Physical Injury*, 41 *FED'N INS. CORP. COUNS. Q.* 235, 236 (1991) (describing the belief that if emotional distress did not manifest itself in physical symptoms, it was trivial, feigned, or imagined).

59. Frances C. Whiteman, *Toxic Emotional Distress Claims: The Emerging Trend for Recovery Absent Physical Injury*, 20 *CAP. U. L. REV.* 995, 997 (1991). Courts justified their refusal to entertain pure psychic emotional distress claims by asserting that physical symptoms validated the emotional distress claim. See *infra* notes 64-67, 73-75, 86-91, 95-97 and accompanying text (analyzing the physical manifestation rule).

60. See generally Peter A. Bell, *The Bell Tolls: Toward Full Tort Recovery for Psychic Injury*, 36 *U. FLA. L. REV.* 333 (1984). Courts have been reluctant to allow recovery for emotional distress absent physical symptoms because of an apprehension that a deluge of fraudulent claims will descend upon the courts. *Id.* at 336. See also Smith, *supra* note 56, at 194 (arguing that the skepticism of courts is the result of a rule rooted in English and American law that plaintiffs cannot recover damages for their emotional distress absent another legal injury).

61. *Self-Insurers and Risk Managers: Annual Survey*, 27 *TORT & INS. L.J.* 445, 446 (Jerry A. Lindheim, ed. 1992). The evolution of emotional distress as a cause of action has been slow because the courts have been wary to recognize a claim that is difficult to measure since there is no tangible physical injury. W. PAGE KEETON ET AL., *PROSSER AND KEETON ON TORTS* § 54, at 361 (5th ed. 1984).

62. See, e.g., *Victorian Rys. Comm'n v. Coultas*, 13 *App. Cas.* 222, 57 *L. J. P. C.* 69 (P.C. 1888) (holding that allowing damages for fright would raise tremendous problems of proof because individuals are affected differently by emotional stress and therefore, the court would have to speculate as to the extent of the plaintiff's emotional injury); *Alabama Fuel & Iron Co. v. Baladoni*, 73 *So.* 205, 207 (Ala. Ct. App. 1916) (holding that emotional distress claims are too subtle and speculative to measure); *Gardner v. Cumberland Tel. Co.*, 268 *S.W.* 1108, 1110 (Ky. 1925) (denying recovery for emotional distress and reasoning that it is very easy to assert a claim of mental

recognition of emotional distress as an independent compensable injury.⁶³

Intentional infliction of emotional distress (IIED) claims were originally limited to cases where plaintiffs could demonstrate an objective consequence, such as an actual illness.⁶⁴ However, courts perceived less risk when recognizing intentional infliction of emotional distress as a compensable tort theory.⁶⁵ The logic is that outrageous intentional acts are more reliable indicators that severe emotional distress will result than are simply negligent or unreasonable acts.⁶⁶ The courts reasoned that if the defendant's act was outrageous enough to justify damages to compensate the plaintiff,⁶⁷ then the certainty of subsequent emotional distress was sufficiently clear.⁶⁸

In contrast, recovery for negligent infliction of emotional distress (NIED) faced greater skepticism and consequently, it has been in a state of fluctuation during the last twenty years as courts have struggled to define limits for recovery.⁶⁹ Courts feared that recognition of claims for NIED would open the floodgates of litigation to fraudulent claims.⁷⁰ Consequently, courts imposed

anguish, but extremely hard to disprove).

63. See generally Nancy Levit, *Ethereal Torts*, 61 GEO. WASH. L. REV. 136, 140 (1992) (analyzing the history of emotional distress claims); Nancy Campbell Brown, Note, *Predicting the Future: Present Mental Anguish for Fear of Developing Cancer in the Future as a Result of Past Asbestos Exposure*, 23 MEM. ST. U. L. REV. 337 (1993) (tracing the recognition of emotional distress claims as legitimate and compensable).

64. FLEMING, *supra* note 57, at 32.

65. TERRENCE F. KIELY, MODERN TORT LIABILITY: RECOVERY IN THE '90s 109-10 (1990). *Wilkinson v. Downton*, 2 Q.B. 57 (1897) was the first case to recognize the tort of intentional infliction of emotional distress as a separate cause of action by reasoning that intentional harm is "antisocial and warrants reproof." FLEMING, *supra* note 57, at 30.

66. KEETON ET AL., *supra* note 61, at 360-61.

67. KIELY, *supra* note 65, at 110. See also Dworkin, *supra* note 58, at 530 (explaining that the outrageousness could either be the nature of the conduct itself or abuse of a special position or knowledge).

68. See Dworkin, *supra* note 58, at 530-31 (analyzing the justification by courts that emotional distress caused by intentional behavior is easier to test for legitimacy than emotional distress caused by negligent behavior).

69. KIELY, *supra* note 65, at 109. See KEETON ET AL., *supra* note 61, § 54, at 360-61 (explaining that the three principal concerns that have caused courts to impose limitations on the recovery for negligent infliction of emotional distress are: 1) the harm is often temporary; 2) the claims could be falsified or imagined; and 3) the unfairness of punishing a merely negligent defendant for results that appear to be remote from the wrongful conduct).

70. WILLIAM L. PROSSER, HANDBOOK OF THE LAW OF TORTS § 55, at 350-51 (3d ed. 1964). See *Spearman v. McCrary*, 58 So. 927 (Ala. Ct. App. 1912); *Cohn v. Ansonia Realty Co.*, 148 N.Y.S. 3940 (N.Y. 1914) (holding that recovery for emotional distress was allowed when accompanied by a physical injury). See also Dworkin, *supra* note 58, at 529-30 (analyzing the limitations imposed by courts in emotional distress claims to prevent a deluge of fraudulent claims).

the physical impact⁷¹ and physical manifestation⁷² rules to prevent a deluge of fraudulent claims.

A. *The Physical Impact and Physical Manifestation Rules*

The logic behind the physical impact rule is that the physical impact that accompanies the mental distress provides assurance that the mental distress is not fraudulent or simulated.⁷³ Another limitation courts impose is the same physical manifestation rule applied in IIED claims.⁷⁴ Under the physical manifestation rule, courts deny recovery for NIED unless the plaintiff can prove that the emotional distress has manifested itself in physical symptoms.⁷⁵ As with the physical impact rule, the goal of the physical manifestation rule is to limit recovery to claims that can be readily verified as honest and legitimate

71. See *supra* note 51 for the definition of the physical impact rule. See *infra* notes 73-87 and accompanying text (discussing the physical impact rule).

72. See *supra* note 52 for the definition of the physical manifestation rule. See also *infra* notes 64-68, 73-76, 87-90, 94-96 and accompanying text (discussing the physical manifestation rule).

73. FLEMING, *supra* note 57, at 145. See also PROSSER, *supra* note 70, at 350-51 (explaining that the theory behind the rule was that the impact provides the "desired guarantee that the mental disturbance is genuine"). See, e.g., Preece v. Baur, 143 F. Supp. 804 (E.D. Idaho 1956); Kramer v. Ricksmeier, 139 N.W. 1091 (Iowa 1913); Morgan v. Hightower's Adm'r, 163 S.W.2d 21 (Ky. 1942); Smith v. Gowdy, 244 S.W. 678 (Ky. 1922); Falzone v. Busch, 214 A.2d 12 (N.J. 1965); Seidenbach's, Inc. v. Williams, 361 P.2d 185 (Okla. 1961); Knaub v. Gotwalt, 220 A.2d 646, 647 (Pa. 1966) (holding that although the plaintiffs were exposed to physical injury and feared for their safety, they could not recover for their mental suffering absent a physical impact).

See also Southern Express Co. v. Byers, 240 U.S. 612, 615 (1916) (holding that emotional pain without physical injury is too vague for legal redress); Holland v. Good Bros., 61 N.E.2d 544, 545 (Mass. 1945) (holding that mental anguish unaccompanied by physical injury is not compensable); Purcell v. St. Paul City Ry., 50 N.W. 1034, 1035 (Minn. 1892) (holding that mental injury alone is not a legitimate cause of action). The physical impact theory was based upon the belief that emotional damage only occurs as the result of an individual's physical injuries. David J. Leibson, *Recovery of Damages for Emotional Distress Caused by Physical Injury to Another*, 15 J. FAM. L. 163, 168 (1977). The courts which adhered to the physical impact rule believed that mental trauma alone was not a sufficient basis for recovery. *Id.*

74. See *supra* note 52 for the definition of the physical manifestation rule. See also *infra* notes 64-68, 73-76, 87-90, 94-96 and accompanying text (analyzing the application and limitations of the physical manifestation rule).

75. Dworkin, *supra* note 58, at 531. Presently, 37 jurisdictions require some form of physical injury before allowing recovery for negligent infliction of emotional distress: Alaska, Arizona, Arkansas, Colorado, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Nevada, New Hampshire, New Mexico, New York, North Dakota, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, West Virginia, Wisconsin, and Wyoming. Scott D. Marrs, *Mind Over Body: Trends Regarding the Physical Injury Requirement in Negligent Infliction of Emotional Distress and "Fear of Disease" Cases*, 28 TORT & INS. L.J. 1 (1992).

through tangible physical proof.⁷⁶

Presently, in HIV transmission cases, the plaintiff's HIV or AIDS infection provides tangible proof of injury for the courts.⁷⁷ The courts recognize that claims for emotional distress can be litigated in connection with the plaintiff's claim of HIV or AIDS infection.⁷⁸ Consequently, claims for emotional distress are litigated in connection with claims for the transmission of HIV, based on theories of breach of implied warranty against blood banks,⁷⁹ negligence,⁸⁰

76. The rationale was that physical symptoms could not be easily feigned; thus only legitimate emotional distress claims would result in physical symptoms. See Julie A. Davies, *Direct Actions for Emotional Harm: Is Compromise Possible?*, 67 WASH. L. REV. 1, 3-4 (1992) (arguing that proof of some injury is appropriate to prevent fraudulent claims because emotional distress claims are intangible, and while neither the physical impact or manifestation rules are perfect, they adequately monitor plaintiffs' claims).

But see Terri Krivosha Herring, Note, *Administering the Tort of Negligent Infliction of Mental Distress: A Synthesis*, 4 CARDOZO L. REV. 487, 497-98 (1983) (arguing that proof of physical injury is unnecessary to monitor plaintiffs' claims because psychiatrists can use various tests and methods to determine whether plaintiffs' emotional distress claims are legitimate).

77. Philip H. Corboy, *Legal Implications: The AIDS Crisis*, BRIEF, Fall 1986, at 41. Courts have held that a plaintiff infected with the AIDS virus is "indeed injured" and therefore has a recognizably compensable injury. *Id.*

78. Richard Carl Schoenstein, *Standards of Conduct, Multiple Defendants, and Full Recovery of Damages in Tort Liability for the Transmission of Human Immunodeficiency Virus*, 18 HOFSTRA L. REV. 37, 41-42 (1989).

79. Most courts bar such liability for blood banks and hospitals. Korin, *supra* note 23, at 41. The rationale behind barring the liability is "based on a concern for the adequacy of the nation's blood supply." *Id.* See also Kathryn W. Pieplow, Comment, *AIDS, Blood Banks and the Courts: The Legal Response to Transfusion Acquired Disease*, 38 S.D. L. REV. 609 (1992) (arguing for a restatement of blood shield statutes that bar liability against hospitals and blood banks for transfusion-acquired AIDS to establish a sole medical and legal standard of care); Skiver & Hickey, *supra* note 5, at 841-51 (analyzing claims against blood banks for the transmission of HIV or AIDS).

See *Wilson v. Irwin Memorial Blood Bank*, 18 Cal. Rptr. 2d 517 (Cal. Ct. App. 1993) (holding that a blood bank was not negligent in failing to ask donors about their sexual orientation in order to determine if they were at risk for AIDS, because in 1983, those questions had not yet been endorsed by the government or the blood banking associations); *Brown v. United Blood Servs.*, 858 P.2d 391 (Nev. 1993) (holding that the blood bank's failure to question donors about their history of venereal disease to screen potentially HIV infected blood was not contrary to the practice of other members of the blood bank community at the time of the incident).

But see *Quintana v. United Blood Servs.*, 827 P.2d 509, 518 (Colo. 1992) (allowing the jury, for the first time in United States history, to scrutinize blood industry standards at the time of an HIV-tainted transfusion in 1983). The jury decided that the blood bank was negligent and that the entire 1983 industry standard was inadequate. Jessamine R. Talavera, *Quintana v. United Blood Services: Examining Industry Practice in Transfusion-Related AIDS Cases*, 2 CORNELL J.L. & PUB. POL'Y 475, 477 (1993). See also J.K. & Susie L. Wadley Research Inst. & Blood Bank v. Beeson, 835 S.W.2d 689, 699 (Tex. Ct. App. 1992) (holding that the blood bank was negligent in its collection of blood and this negligence was the proximate cause of the plaintiff's HIV infection).

battery,⁸¹ and fraud.⁸² In all of these cases, the cause of action is brought after the plaintiff contracts HIV and in many cases, after the plaintiff is AIDS positive.⁸³ Therefore, the emotional distress claims in HIV transmission litigation follow the same evolution as other emotional distress claims, where the emotional distress is attached to an objective, tangible, physical impact or manifestation.⁸⁴ In these cases, the physical impact or manifestation is the plaintiff's HIV or AIDS infection.⁸⁵

Consistent problems exist with both the physical impact and physical manifestation rules in all emotional distress claims. The physical impact rule led to absurd results with courts holding that even the most trivial occurrences, such

80. Corboy, *supra* note 77, at 40-42. Under the theory of negligence, the plaintiff must establish four elements: 1) a legal duty on the part of the defendant; 2) a breach of that duty by the defendant; 3) causation between the defendant's conduct and the plaintiff's injury (the HIV infection); and 4) damages to the plaintiff. *See, e.g., Doe v. State*, 588 N.Y.S.2d 698, 702 (N.Y. Ct. Cl. 1992) (holding that correction officers were negligent in restraining a combative HIV-infected inmate when the plaintiff nurse was stuck by a needle that had been used on the inmate and subsequently developed HIV).

Significant controversy has always surrounded the issue of whether sexually active individuals have a duty to warn their sexual partners that they are at risk of contracting a sexually transmitted disease. Given the deadly nature of AIDS, the controversy over a duty to warn sexual partners of any risks has increased. David P. Brigham, *You Never Told Me . . . You Never Asked: Tort Liability for the Sexual Transmission of Aids*, 91 DICK. L. REV. 529, 544 (1986). *See C.A.U. v. R.L.*, 438 N.W.2d 441, 444 (Minn. Ct. App. 1989) (holding that the plaintiff's former fiancée was not liable for sexually transmitting AIDS to the plaintiff in 1985). The court determined that the key in cases for AIDS transmission is whether it is reasonable for the defendant to have constructive knowledge of the defendant's capability of transmitting the AIDS virus. *Id.* The court reasoned that at the time in which the parties engaged in sexual contact, the general societal notion was that AIDS could not be transmitted heterosexually. *Id.* Therefore, it was not reasonable to impose upon the defendant the constructive knowledge that he was carrying the AIDS virus. *Id.* *See also Doe v. Johnson*, 817 F. Supp. 1382, 1393 (W.D. Mich. 1993) (holding that the plaintiff must show that the defendant knew or should have known that he was infected with HIV).

81. HERMANN & BURRIS, *supra* note 31, at 342. To satisfy a claim for battery in AIDS litigation, the plaintiff must show that the defendant knew that he or she was infected and either intended to cause the contact that led to transmission of the AIDS virus or recklessly disregarded the risk of transmission and proceeded with the contact. *Id.* The plaintiff does not have to show that the defendant purposely sought to transmit the infection, but instead that the defendant intended to cause the contact that could lead to infection. *Id.*

82. *See Osborn v. Irwin Memorial Blood Bank*, 7 Cal. Rptr. 2d 101, 106 (Cal. Ct. App. 1992) (holding that the blood bank could only be liable for negligent misrepresentation and not fraud or products liability when the plaintiffs' son contracted AIDS from a blood transfusion during heart surgery and, therefore, the case was remanded for a new trial). The negligent misrepresentation was based on a statement made by the blood bank to the plaintiffs that blood donations could not be directed for use in the plaintiffs' son's operation. *Id.* at 106. In reality, the bank's procedure was to discourage, not to forbid, directed donations. *Id.*

83. *See supra* notes 79-82 and accompanying text.

84. *See supra* notes 73-76 and accompanying text.

85. *See supra* notes 73-82 and accompanying text (describing cases where the plaintiffs sued for the transmission of HIV or AIDS, and thus had a tangible physical injury).

as dust in the eye, constituted a physical impact.⁸⁶ Due to results such as these, the impact rule began to lose its effectiveness and consequently, almost every jurisdiction has abandoned it.⁸⁷ Similar to the physical impact rule, the physical manifestation rule has created inconsistent case law because courts have varying definitions of what constitutes a physical manifestation.⁸⁸

86. PROSSER, *supra* note 70, at 350-51. Prosser summarizes the various approaches by the courts in applying the physical impact rule that led to ridiculous results. "But the same courts have found 'impact' in minor contacts with the person which play no part in causing the real harm, and in themselves can have no importance whatever." *Id.* at 350 (citation omitted). See *Clark v. Choctawhatchee Elec. Coop.*, 107 So.2d 609, 611-12 (Fla. 1958) (holding that a falling power line that discharged an electrical current satisfied the physical impact rule); *Christy Bros. Circus v. Turnage*, 144 S.E. 680, 681 (Ga. 1928) (holding that a horse's evacuation of his bowels into the plaintiff's lap constituted a physical impact); *Kenney v. Wong Len*, 128 A. 343, 346-47 (N.H. 1925) (holding that a mouse hair ingested by the plaintiff in a bowl of stew satisfied the physical impact rule); *Porter v. Delaware, L. & W. R.R.*, 63 A. 860, 860 (N.J. 1906) (holding that dust in the plaintiff's eyes constituted a physical impact); *Morton v. Stack*, 170 N.E. 869, 869 (Ohio 1930) (holding that smoke inhalation was a physical impact); *Hess v. Philadelphia Transp. Co.*, 56 A.2d 89, 91 (Pa. 1948) (holding that a physical impact occurred when an electric wire struck a car). See also *Herring*, *supra* note 76, at 496 (describing how the courts began to hold that the slightest interference with the plaintiff's person was a physical impact to alleviate the rigidity of the physical impact rule).

87. *Marrs*, *supra* note 75, at 1. At the present time, only Colorado (*King v. Burris*, 588 F. Supp. 1152 (D. Colo. 1984)), Georgia (*OB-Gyn Assocs. of Albany v. Littleton*, 386 S.E.2d 146 (Ga. 1989)), Illinois (*Wetherill v. University of Chicago*, 565 F. Supp. 1553 (N.D. Ill. 1983)), Indiana (*Cullison v. Medley*, 570 N.E.2d 27 (Ind. 1991)), and Kansas (*Anderson v. Scheffler*, 752 P.2d 667 (Kan. 1988)) still adhere to the physical impact rule out of fear that abandoning it will lead to fraudulent claims.

88. There is great disparity among the jurisdictions' definitions of what constitutes a physical manifestation; consequently, the rule has lost its effectiveness. *Herring*, *supra* note 76, at 499. See, e.g., *Cosgrove v. Beymer*, 244 F. Supp. 824, 826 (D. Del. 1965) (acknowledging that, in Delaware, dizziness, mild headaches, and nervousness did not constitute physical manifestation). *But see Bowman v. Williams*, 165 A. 182, 184 (Md. 1933) (holding that weakness and nervousness did constitute a physical manifestation); *Espinosa v. Beverly Hosp.*, 249 P.2d 843, 845 (Cal. 1952) (holding that loss of sleep was not a physical manifestation). *But see Vance v. Vance*, 408 A.2d 728, 734 (Md. 1979) (holding that insomnia was a physical manifestation); *Burns v. Jaquays Mining Corp.*, 752 P.2d 28, 31 (Ariz. Ct. App. 1987) (holding that sleep disorders, manifestations of anger, headaches, personality disorders, sexual dysfunction, and other adverse health effects were not sufficient physical manifestations of emotional distress); *Allen v. Otis Elevator Co.*, 563 N.E.2d 826, 833-34 (Ill. App. Ct. 1990) (holding that nervousness did not constitute a physical manifestation). *But see Daley v. LaCroix*, 179 N.W.2d 390, 396 (Mich. 1970) (holding that claims of nervousness may satisfy the physical manifestation requirement). The physical manifestation requirement encourages extravagant pleading because it is difficult to foresee what injuries a court will deem physical and consequently, recoverable. *Herring*, *supra* note 76, at 499. Therefore, the lawyer's creativity played an important part in the litigation because "in most instances of severe mental disturbance some deleterious physical consequence can, with a little ingenuity, be found . . ." *W.E. Shipley, Annotation Comment Note—Right to Recover for Emotional Disturbance or its Physical Consequences, in the Absence of Impact or Other Actionable Wrong*, 64 A.L.R.2d 100, 117 n.18 (1959).

Although most courts still require physical manifestation of emotional distress,⁸⁹ some courts have abolished physical manifestations as a requirement for negligent infliction of emotional distress.⁹⁰ As with the physical impact rule, the solution to the inconsistent case law is to simply abolish the physical manifestation rule and recognize pure psychic emotional distress claims.⁹¹

B. Pure Psychic Claims of Emotional Distress

The common justification among the states that have abandoned the physical manifestation rule is that it is outdated and ridiculous in the face of advancements by medical science and psychology regarding the recognition and diagnosis of mental injury.⁹² These states criticize the physical manifestation rule as over-inclusive because it can lead to recovery for trivial claims merely because they are accompanied by physical symptoms.⁹³ At the same time, the

89. See *supra* notes 73-76 and accompanying text.

90. Marrs, *supra* note 75, at 2. The 14 states that have abolished the physical manifestations requirement are: Alabama, California, Connecticut, Hawaii, Maine, Missouri, Montana, Nebraska, New Jersey, North Carolina, Ohio, Oregon, Texas, and Washington. *Id.*

91. See Darby, *supra* note 22, at 200. Darby does not advocate the abandonment of the physical injury rule, but instead, he suggests a solution to easily satisfy the rule. *Id.* By following the reasoning espoused in fear of cancer cases, Darby argues that a reasonable and genuine fear of AIDS is a present injury, and therefore, the physical injury rule is satisfied. *Id.* This solution is logical and a step in the right direction to alleviate the rigidity of the physical injury rule, but it would be more logical to just abandon the rule because a mental injury is not physical and should not be treated as such. It is illogical to stretch the rule to merely circumvent it; instead, the rule should be abandoned because it is outdated. See *infra* notes 92-104 (analyzing why the physical manifestation rule should be abandoned). See also Comment, *Negligently Inflicted Mental Distress: The Case for an Independent Tort*, 59 GEO. L.J. 1237, 1248-63 (1971) (illustrating that the physical impact and physical manifestation rules are arbitrary and unnecessary because of the advancements of modern science); Bell, *supra* note 60, at 333-40, 412 (arguing that the physical impact and physical manifestation rules should be abandoned in favor of full recovery for psychic injury); Frances L. Edwards & Al H. Ringleb, *Exposure to Hazardous Substances and the Mental Distress Tort: Trends, Applications, and a Proposed Reform*, 11 COLUM. J. ENVTL. L. 119, 122, 126-38 (1986) (arguing that it is illogical to maintain the physical impact and physical manifestation rules, given that the rules are no longer consistently applied). *But see* Brown, *supra* note 63, at 367 (arguing that the solution to inconsistent case law is to keep the physical manifestation rule, but make its application consistent).

92. See *Taylor v. Baptist Medical Ctr., Inc.*, 400 So. 2d 369, 374 (Ala. 1981) (reasoning that "to continue to require physical injury caused by culpable tortious conduct, when mental suffering may be equally recognizable standing alone, would be an adherence to procrustean principles which have little or no resemblance to medical realities"); see also Edwards & Ringleb, *supra* note 91, at 133-38 (exposing the physical injury requirement as unnecessary in light of medical advancements); Herring, *supra* note 76, at 487 (presenting evidence of medical science's ability to determine whether mental suffering is legitimate).

93. *James v. Lieb*, 375 N.W.2d 109, 116 (Neb. 1985). The court reasoned that the physical manifestations requirement is flawed because "[i]t encourages extravagant pleadings and distorted testimony" and is unnecessary given the current understanding of psychological injuries in medical science and psychology. *Id.*

physical manifestation rule is under-inclusive because serious claims are rejected if they are not accompanied by physical symptoms.⁹⁴

Jurisdictions retain the physical manifestation rule because they fear its absence will lead to a flood of fraudulent claims. However, advancements in medical science and psychology now enable experts to distinguish fraudulent claims from legitimate claims.⁹⁵ In addition to the ability of experts to

94. *Id.* The court reasoned that the physical manifestation rule is "under inclusive, since serious distress is arbitrarily deemed not compensable if not accompanied by physical symptoms." *Id.*

95. "The study of psychiatry is now an integral and respected part of medical science." Leibson, *supra* note 73, at 164. See *Hagerty v. L & L Marine Servs., Inc.*, 788 F.2d 315, 318 (6th Cir. 1988) (holding that plaintiffs do not have to allege a contemporaneous physical injury, but instead must only plead that the emotional distress is "reasonably and causally related to the plaintiff's negligence"). See also *Rodrigues v. State*, 472 P.2d 509, 519-20 (1970) (holding that in evaluating the genuineness of plaintiffs' claims, "courts and juries may look to the quality and genuineness of proof and rely to an extent on the contemporary sophistication of the medical profession and the ability of the court and jury to weed out dishonest claims"); *Corgan v. Muehling*, 574 N.E.2d 602, 608-09 (Ill. 1991) (holding that pure psychic emotional injury claims are legitimate given science's ability to judge the claim's merit); *Gammon v. Osteopathic Hosp. of Maine, Inc.*, 534 A.2d 1282, 1285 (Me. 1987) (reasoning that "[t]he analysis of commentators and the developing trend in case law encourage us to abandon these artificial devices [the physical manifestation requirement] in this and future tort actions and to rely upon the trial process for protection against fraudulent claims"); *Zelinsky v. Chimics*, 175 A.2d 351, 354 (Pa. Super. Ct. 1961) (holding that the expert witness's testimony that the plaintiff's neurosis was caused by an automobile accident was sufficient proof of emotional distress); *Schultz v. Barberton Glass Co.*, 447 N.E.2d 109, 112 (Ohio 1983) (holding that the physical manifestation rule is unjust and contrary to experience); *Sinn v. Burd*, 404 A.2d 672, 678-79 (Pa. 1979) (holding that medical science could establish a causal link between psychic injury and the plaintiff's viewing of a grisly accident). See also *St. Elizabeth Hosp. v. Garrard*, 730 S.W.2d 649, 654 (Tex. 1987) (holding that the distinction between physical injury and emotional distress is no longer valid). The court in *St. Elizabeth* reasoned:

The problem is one of proof, and to deny a remedy in all cases because some claims may be false leads to arbitrary results which do not serve the best interests of the public.

Jurors are best suited to determine whether and to what extent the defendant's conduct caused compensable mental anguish by referring to their own experience.

Id. See also *Calvert Magruder, Mental and Emotional Disturbance in the Law of Torts*, 49 HARV. L. REV. 1033, 1035 (1936) (arguing that courts have the ability to redress infliction of mental pain).

"Mental suffering is no more difficult to estimate in financial terms, and no less a real injury, than 'physical' pain . . ." KEETON ET AL., *supra* note 61, at 360. See generally *Dworkin, supra* note 58 (arguing that juries possess the ability to assess emotional injuries); *Davies, supra* note 76, at 13 (analyzing the various methods employed by courts to determine whether the plaintiff's emotional distress is legitimate); *Daley v. LaCroix*, 179 N.W.2d 390, 396 (Mich. 1970) (illustrating the different tests that physicians can use to determine emotional distress and its cause); *Devlin v. Johns-Manville Corp.*, 495 A.2d 495, 497 (N.J. Super. Ct. App. Div. 1985) (recognizing that emotional distress is as real as physical pain and therefore, its estimation is not more difficult than physical pain).

After interviewing the plaintiff about the emotional distress, physicians have a variety of methods to distinguish fraudulent claims from those that are legitimate. Comment, *supra* note 91, at 1248-53, 1258-62. "[M]edical science is capable of satisfactorily establishing the existence,

determine the legitimacy of the plaintiff's emotional distress, the circumstances surrounding the incident which caused the plaintiff's fear can supply a sufficient guarantee of the genuineness of the plaintiff's emotional distress.⁹⁶ Therefore, the courts can evaluate the circumstances that caused the plaintiff's emotional distress and determine whether a reasonable person would also suffer emotional distress.⁹⁷

Psychic injuries are already recognized in a variety of non-parasitic situations, including the intentional torts of invasion of privacy⁹⁸ and false imprisonment,⁹⁹ as well as in workers' compensation cases.¹⁰⁰ Therefore,

seriousness, and ramifications of emotional harm." *Id.* at 1253. *See also* Edwards & Ringleb, *supra* note 91, at 133-38 (asserting that medical science is able to establish the magnitude of the plaintiff's emotional injury); Herbert F. Goodrich, *Emotional Disturbance as Legal Damage*, 20 MICH. L. REV. 497, 513 (1922) (concluding that although medical science may help the courts with facts about human emotions, the legal effects of the facts are ultimately based on rules of policy established by the courts and legislatures); Moses Keschnor, *Simulation of Nervous and Mental Disease*, 44 MICH. L. REV. 715 (1946) (analyzing the tests employed in determining whether a plaintiff's emotional distress is legitimate); Paul D. Rheingold, *The Basis of Medical Testimony*, 15 VAND. L. REV. 473, 482-88 (1962) (arguing that physicians should be allowed to freely rely upon medical material that they believe is crucial to the opinion they are asked to offer); Hubert Winston Smith, *Cross-Examination of Neuropsychiatric Testimony in Personal Injury Cases*, 4 VAND. L. REV. 1, 61-62 (1950) (providing a rationale to test expert medical testimony in emotional distress claims).

96. *Hagerty v. L & L Marine Servs., Inc.*, 788 F.2d 315, 318 (5th Cir. 1986), *aff'd on reconsideration*, 797 F.2d 256 (5th Cir. 1986). The *Hagerty* court reasoned:

The physical [manifestation] requirement, like its counterpart, the physical impact requirement, was developed to provide courts with an objective means of ensuring that the alleged mental injury is not feigned. We believe that notion to be unrealistic. It is doubtful that the trier of fact is any less able to decide the fact or extent of mental suffering in the event of physical [manifestation] or impact.

Id. at 318 (citations omitted).

By combining the plaintiff's testimony and the context in which the plaintiff's trauma occurred with knowledge of the amount of emotional harm likely to result from such a trauma, a psychiatrist can determine whether the plaintiff's emotional distress is legitimate. Comment, *supra* note 91, at 1252.

97. *See, e.g., Hagerty*, 788 F.2d at 318; *Rodriguez v. State*, 472 P.2d 509, 520 (Haw. 1970); *Alevizos v. Metropolitan Airports Comm'n*, 216 N.W.2d 651, 662 (Minn. 1974) (requiring the plaintiffs to prove that a reasonable person would have suffered emotional distress from the defendant's actions).

98. *See, e.g., Gertz v. Robert Welch, Inc.*, 418 U.S. 323 (1974); *Hampton v. Morrissey*, 1993 WL 358209 (Conn. Super. Ct. 1993); *Guthridge v. Pen-Mod, Inc.*, 239 A.2d 709 (Del. Super. Ct. 1967); *Macon Tel. Pub. Co. v. Tatum*, 436 S.E.2d 655 (Ga. 1993) (illustrating that there is no requirement under the tort of invasion of privacy that the plaintiff's emotional distress manifest itself physically).

99. *See, e.g., Altman v. Knox Lumber Co.*, 381 N.W.2d 858, 863-65 (Minn. Ct. App. 1986); *K-Mart Corp. v. Washington*, 866 P.2d 274, 285 (Nev. 1993); *Fields v. Victory Chain Store, Inc.*, 300 N.Y.S.2d 688 (1969); *Bean v. Best*, 93 N.W.2d 403, 407-09 (S.D. 1958); *Lane v. Collins*, 138 N.W.2d 264, 268-70 (Wis. 1965) (illustrating that physical manifestation of the plaintiff's emotional distress was not required in false imprisonment claims).

if the courts are able to evaluate emotional distress claims in these situations, they should be able to evaluate emotional distress claims in *any* non-parasitic situations.¹⁰¹ The HIV-fear cases are psychological claims and must be viewed in light of the various ways that states have dealt with other psychological torts.¹⁰² The same limitations imposed in other emotional distress claims¹⁰³ threaten to stifle the claims of plaintiffs legitimately injured in HIV-fear cases solely because their emotional distress is not attached to, or manifested in, physical injuries.¹⁰⁴

III. THE NEW FRONTIER—RECOVERY FOR EMOTIONAL DISTRESS IN HIV-FEAR CASES

The HIV-fear cases appeared in the midst of a debate over fear of illness cases.¹⁰⁵ According to commentators, the risk of exposure to toxic substances has become the most significant health issue of the century.¹⁰⁶ Courts generally recognize emotional distress that is caused by a fear of developing an

100. Bell, *supra* note 60, at 407-08. See *Todd v. Goostree*, 493 S.W.2d 411, 420-21 (Mo. Ct. App. 1973), *aff'd*, 528 S.W.2d 470 (1975) (allowing an employee's recovery for severe anxiety resulting from the discovery of a co-worker's crushed body); *Wolfe v. Sibley, Lindsay & Curr, Co.*, 330 N.E.2d 603, 606-07 (N.Y. 1975) (allowing workers' compensation for depression caused by the employee's discovery of boss after his suicide). Although these cases were brought under the rules of workers' compensation rather than the general tort compensation system, they are important because they illustrate that "one significant branch of compensation law in this country rejects some of the arguments that are advanced to bar full recognition of psychic injury in the courts." Bell, *supra* note 60, at 408 n.309.

101. Bell, *supra* note 60, at 92-104.

102. See *supra* notes 86-100 and accompanying text.

103. See *supra* notes 71-76, 86-94 and accompanying text.

104. See *infra* note 119 and accompanying text (describing cases denying compensation to plaintiffs who were legitimately injured in HIV-fear cases because they did not satisfy either the physical impact or the physical manifestation rule). See *infra* notes 116-30 and accompanying text (examining the imposition of the physical impact and physical manifestation rules to HIV-fear claims).

105. See generally Brian R. Garves, *Fear of AIDS*, 3 J. PHARM. & L. 29 (1994) (providing an overview of HIV-fear cases); Lauren J. Camillo, Comment, *Adding Fuel to the Fire: Realistic Fears or Unrealistic Damages in AIDS Phobia Suits*, 35 TEX. L. REV. 331 (1994) (presenting a legal analysis of *Faya v. Almaraz*, 620 A.2d 327 (Md. 1993)); Kevin B. Flynn, *Marchica v. Long Island RR: AIDS Phobia as a Cause of Action Under the Federal Employers' Liability Act*, 3 J. PHARM. & L. 217 (1994) (analyzing the court's holding and reasoning in the *Marchica* case).

106. Richard H. Krochok & Mark A. Solheim, *Psychological Damages from Toxic Substances: Problems and Solutions*, 60 DEF. COUNS. J. 80, 80 (1993).

It is difficult to go a week without news of toxic exposure. Virtually everyone in society is conscious of the fact that the air they breathe, [the] water, food and drugs they ingest, [the] land on which they live, or [the] products to which they are exposed are potential health hazards. Although few are exposed to all, few also can escape exposure to any.

Id. at 81.

illness after potential exposure to a toxic substance.¹⁰⁷ Courts readily recognize claims based on fear of cancer,¹⁰⁸ but are more skeptical about allowing recovery for fear of other diseases, such as HIV.¹⁰⁹

In a 1993 decision,¹¹⁰ the Superior Court of Pennsylvania ignored the true basis of a fear-of-illness claim based upon potential exposure to HIV. The court held that emotional distress recovery will only be allowed if the plaintiff eventually tests positive for HIV, reasoning that only existing diseases are compensable.¹¹¹ The court's rejection of the plaintiff's claim completely ignores the purpose of HIV-fear suits, which is recovery for the plaintiffs' fear during the time period in which they do not know whether they have been

107. See Marrs, *supra* note 75, at 2 (thoroughly analyzing the leading fear-of-illness cases of each state). See generally Brown, *supra* note 63 (analyzing the recognition of claims based upon a fear of developing a future illness); Whiteman, *supra* note 59 (analyzing the history of toxic emotional distress claims); Krochock & Solheim, *supra* note 106, at 80 (analyzing the fear-of-illness case law in all 50 states); Bill Charles Well, *The Grin Without the Cat: Claims for Damages from Toxic Exposure Without Present Injury*, 18 WM. & MARY J. ENVTL. L. 285 (1994) (analyzing the evolution of toxic torts, medical monitoring, fear of future disease claims, and claims for increased risk of future disease).

108. See Smith v. A. C. & S., Inc., 843 F.2d 854 (5th Cir. 1988) (holding that plaintiffs may recover for their fear of developing cancer if they present evidence of their fear of developing cancerous conditions in the future); Devlin v. Johns-Manville Corp., 495 A.2d 495, 499 (N.J. 1985) (holding that plaintiffs can recover for their fear of developing cancer if the plaintiffs' fears are reasonable, proximately caused by exposure to a carcinogen (here asbestos), and the defendants were legally responsible for the plaintiffs' exposure to the carcinogen); NC-Alley v. Charlotte Pipe & Foundry Co., 74 S.E. 885, 886 (N.C. 1912) (recognizing that the fear of cancer is a present injury of mental anxiety and distress); Lavelle v. Owens-Corning Fiberglas, 507 N.E.2d 476, 478, 480-81 (Ohio Comm. Pl. 1987) (holding that neither physical impact nor physical manifestation are required to recover for fear of cancer); Laxton v. Orkin Exterminating Co., Inc., 639 S.W.2d 431, 434 (Tenn. 1982) (holding that the plaintiffs could recover for their fear of developing cancer because drinking contaminated water constituted a physical injury).

109. JACOB A. STEIN, *STEIN ON PERSONAL DAMAGES* 77-78 (2d ed. 1991). Courts are skeptical of allowing recovery in HIV cases because of the social stigmas and phobias surrounding the disease. Garves, *supra* note 32, at 30-32. Despite the fact that HIV now affects both sexes and all races and is not solely transmitted through sexual activity, many in society view HIV as a disease that only plagues homosexuals or sexually promiscuous individuals. Braden, *supra* note 12, at 278. In fact, most people are confident that they will never test positive for the disease. RANDY SHILTS, *AND THE BAND PLAYED ON: POLITICS, PEOPLE, AND THE AIDS EPIDEMIC* 589 (1987).

110. Lubowitz v. Albert Einstein Med. Ctr., 623 A.2d 3 (Pa. Super. Ct. 1993).

111. *Id.* at 5. The court held that if "Robyn Lubowitz eventually were to contract AIDS as the result of the events outlined in this case, she would have a cause of action for a compensable injury at that time." *Id.* Therefore, in Pennsylvania, plaintiffs can only recover compensation for diseases that presently exist or existed at or before the time of trial. *Id.* See also J.B. v. Bohonovsky, 835 F. Supp. 796, 800 (D. N.J. 1993) (holding that "in the absence of any indicia that the plaintiff is actually infected [with HIV], the court concludes that the plaintiff has failed to demonstrate that the [defendant's] conduct caused him any physical injury").

exposed to HIV.¹¹² Critics of HIV-fear claims argue that the claims will merely increase litigation for an already over-burdened judiciary.¹¹³ Although recognition of the claims could increase litigation, this is not a legitimate argument to deny recovery to injured plaintiffs, because the courts were created to dispense justice and not merely to promote judicial efficiency.¹¹⁴

Currently, confusion exists among the courts in fear-of-illness cases as to whether plaintiffs should be allowed to recover for their fear of future illness in the absence of any physical injury¹¹⁵ and regardless of whether they develop the disease.¹¹⁶ Unfortunately, because of the confusion, the HIV-fear cases have been limited by the archaic rules present in other emotional distress claims.¹¹⁷ As in other emotional distress claims,¹¹⁸ courts attempt to restrict liability and insure legitimate claims by requiring a physical injury through either a physical impact¹¹⁹ that accompanies the fear or a physical

112. Skiver, *supra* note 5, at 844. See, e.g., *Tischler v. Dimenna*, 609 N.Y.S.2d 1002, 1009 (N.Y. 1994) (holding that although the plaintiff tested negative for HIV on three separate occasions, she established a prima facie case of emotional distress from possible exposure to HIV against her former boyfriend who had died from AIDS and with whom she had engaged in unprotected sex from 1980 until 1989).

113. Goldberg, *supra* note 30, at 88.

114. Smith, *supra* note 56, at 193, 197; Comment, *supra* note 91, at 1245 (arguing that the courts' continual arguments about the flood of litigation that will occur and the inability to filter out false claims illustrate the "arbitrariness of public policy decisions and raise questions concerning the wisdom of cutting off liability on a per se basis"). See also Merton E. Marks & James T. Acuff, Jr., *Legal Issues in the Recovery for Fear of Future Disease Without Present Physical Injury*, FED. INS. C.C.Q., Winter 1991, at 239 (disclaiming the various arguments by courts that expanded recovery in fear-of-illness cases will overwhelm the courts with fraudulent claims).

115. John R. Allison, *Evidence Supporting Recoverable Damages for Potential Disease*, 24 TORT & INS. L.J. 39 (1988). The courts are split over whether a plaintiff must suffer a physical harm (either impact or manifestation) in order to recover for damages for a potential disease. The arguments are repetitious of the arguments made in negligent infliction of emotional distress claims. G. Marc Whitehead & Larry D. Espel, *Damages for Speculative Toxic Tort Consequences?: Wait and See*, in 363 PRACTICING L. INST. LITIG. J. 443-46 (Practicing Law Inst. 1988). See also Adam P. Rosen, Comment, *Emotional Distress Damages in Toxic Tort Litigation: The Move Towards Foreseeability*, 3 VILL. ENVTL. L.J. 113, 117 (1992) (arguing that a foreseeability analysis in fear-of-illness claims provides redress for plaintiffs and deters the negligent management of toxic hazards). See also *supra* notes 86-100 and accompanying text.

116. See *supra* notes 110-14 and accompanying text.

117. See *supra* notes 73-91 and accompanying text.

118. See *supra* notes 73-91 and accompanying text.

119. See, e.g., *Doe v. Doe*, 519 N.Y.S.2d 595 (1987), where the wife claimed emotional distress from the fear that she had been exposed to HIV by her husband who had, without her knowledge, engaged in homosexual activity. *Id.* at 597. The court dismissed the wife's claim as too tenuous because she did not allege that either she or her husband had contracted HIV, and therefore she did not satisfy the jurisdiction's physical injury requirement. *Id.* Since the *Doe* case, the courts have witnessed an emergence of HIV-fear cases and have adopted various standards of recovery. See, e.g., *Marchica v. Long Island R.R.*, 810 F. Supp. 445, 449 (E.D.N.Y. 1993) (holding that a puncture wound from a hypodermic needle satisfied the jurisdiction's physical injury

manifestation of the fear.¹²⁰ The result is diverse approaches in fear-of-illness

rule); *Castro v. New York Life Ins. Co.*, 588 N.Y.S.2d 695, 697 (1991) (holding that a cleaning worker's puncture from a hypodermic needle in a waste container at an insurance office constituted a physical injury); *Burk v. Sage Products, Inc.*, 747 F. Supp. 285, 287 (E.D. Pa. 1990) (holding that absent an injury stemming from his alleged exposure to HIV, a paramedic who was stuck by a needle protruding from a disposal container of used medical syringes could not recover damages for his fear of HIV). See also *Johnson v. West Virginia Univ. Hosps., Inc.*, 413 S.E.2d 889, 891 (W. Va. 1991), in which a hospital patient who was suffering from AIDS bit his own arm and then, with his own blood in his mouth, bit the plaintiff, a security officer, on the arm. The plaintiff sued for emotional distress based on his fear that he had been exposed to HIV/AIDS, and the court held that the bite on the plaintiff's arm satisfied the physical impact rule. See also *Doe v. Surgicare of Joliet, Inc.*, 643 N.E.2d 1200, 1202 (Ill. App. Ct. 1994) (holding that a needle stick satisfied the jurisdiction's physical impact requirement but ultimately holding that the plaintiff's claim was too speculative to allow recovery). See *supra* notes 73-87 and accompanying text (analyzing the physical impact rule).

120. *STEIN, supra* note 109, at 79. See *Poole v. Alpha Therapeutic Corp.*, 698 F. Supp. 1367, 1372 (N.D. Ill. 1988) (holding that the wife of a hemophiliac who contracted AIDS through contaminated blood sufficiently established that she was in the zone of danger, but failed to allege any physical injury or illness resulting from her emotional distress); *In re Hawaii Federal Asbestos Cases*, 734 F. Supp. 1563, 1570 (D. Hawaii 1990) (holding that a compensable physical harm must exist that accompanies the fear of illness based on toxic exposure); *Ordway v. County of Suffolk*, 583 N.Y.S.2d 1014, 1016 (1992) (holding that because the plaintiff stated only that he lived in fear that he contracted HIV and did not allege any physical manifestations of his fear, the plaintiff's allegations of subsequent injury did not give a guarantee of genuineness); *Rittenhouse v. St. Regis Hotel Joint Venture*, 579 N.Y.S.2d 100, 101 (1992) (holding that the plaintiff could not recover because she had not demonstrated any physical manifestation of the emotional distress of being exposed to asbestos); *Ball v. Joy Technologies, Inc.*, 755 F. Supp. 1344, 1367 (S.D. W.Va. 1990) (holding that under West Virginia law, mere exposure to a toxic substance is not enough to support a claim for emotional distress). See also *Arvin Maskin & Peter A. Antonucci, Overview and Update of Emerging Damage Theories in Toxic Tort Litigation*, C837 ALI-ABA 629, 650-657 (1993) (discussing cases that illustrate the practice of only allowing recovery where there is a physical impact or physical manifestation).

Some courts have found the existence of physical manifestation. See, e.g., *M.M.H. v. United States*, 966 F.2d 285 (7th Cir. 1992). While in the Army, the plaintiff was notified that she was HIV positive and was not notified to the contrary when it was discovered two months later that she did not have HIV. The court held that the plaintiff's sleeplessness, diarrhea, and suicide attempts after notification that she had HIV satisfied the physical manifestation requirement. *Id.* at 287; See also *Faya v. Almaraz*, 620 A.2d 327, 338 (Md. 1993) (holding that the plaintiffs' headaches and sleeplessness were physical manifestations of emotional distress); *Howard v. Alexandria Hospital*, 429 S.E.2d 22, 23 (Va. 1993). After surgery, the plaintiff was advised by her surgeon that there was a possibility that unsterile instruments had been used during her operation, and the surgeon was afraid that the plaintiff could develop HIV and other infectious diseases. The court held that, although the plaintiff did not sustain an injury as a result of infection from such injuries, she was forced to undergo treatments of pain shots every four to six hours that caused her migraine headaches, nausea, and vomiting and therefore had suffered physical manifestations. *Howard*, 429 S.E. 2d at 25. See also *Edward Benedict Lumpkin, Note, Recovery of Emotional Distress Damages in AIDS-Phobia Cases: A Suggested Approach for Virginia*, 51 WASH. & LEE L. REV. 717 (1994) (arguing that Virginia's requirement of physical manifestations and proximate cause through clear and convincing evidence should be maintained to insure the genuineness of plaintiff's claims). See generally *Harry H. Lipsig, AIDS Phobia and Negligent Infliction of Emotional Distress*, N.Y. L.J., Mar. 26, 1992, at 3 (analyzing the physical manifestation requirement in HIV-fear cases).

cases because some courts treat the exposure as a form of physical impact.¹²¹

Just as in other emotional distress claims,¹²² the physical injury requirement in fear-of-illness cases reflects the proposition that physical security is valued more than emotional security in tort law.¹²³ The reality is that emotional security is valid and deserves the same respect as physical security.¹²⁴ Individuals have the right to physical *and* mental tranquility because both are important to human existence.¹²⁵ Therefore, many courts recognize pure psychic emotional claims by holding that exposure alone is a sufficient basis for recovery.¹²⁶

121. Krochock & Solheim, *supra* note 106, at 105-10. See *Gideon v. Johns-Manville Sales Corp.*, 761 F.2d 1129, 1137 (5th Cir. 1985) (holding that the inhalation of asbestos fibers was a physical impact); *Herber v. Johns-Manville Corp.*, 785 F.2d 79, 83 (3d Cir. 1986) (holding that a physical injury that resulted from the plaintiff's fear of cancer was not required, but instead that the infiltration of asbestos fibers into the plaintiff's lungs was a physical impact); *Laxton v. Orkin Exterminating Co.*, 639 S.W.2d 431, 434 (Tenn. 1982) (holding that the plaintiff's ingestion of water contaminated with toxic chemicals constituted a physical impact). See also *Maskin & Antonucci*, *supra* note 120, at 629, 657-59 (analyzing cases in which courts have held that exposure to a toxic substance is a sufficient physical impact or physical injury).

122. See *supra* notes 73-91 and accompanying text.

123. See *supra* notes 55-76, 86-91 and accompanying text.

124. See Comment, *supra* note 91, at 1263 (arguing that mental injuries are real and should be recompensed); *Bell*, *supra* note 60, at 314 (arguing that individuals have the right to freedom of mental tranquility).

125. *Bell*, *supra* note 60, at 341. See also *Cornelius J. Peck, Compensation for Pain: A Reappraisal in Light of New Medical Evidence*, 72 MICH. L. REV. 1355, 1386-95 (1974) (arguing that both physical and emotional pain are compensable); *David J. Leibson*, *supra* note 73, at 164 (concluding that emotional injuries are legitimate and deserve compensation).

126. The jurisdictions have adopted either all or part of the following principles:

(1) The plaintiff must establish the elements of a *prima facie* case for negligence, (2) Negligent Infliction of Emotional Distress is an independent cause of action, (3) the fear of future disease is a type of compensable emotional distress, (4) the plaintiff must establish proof of exposure to the toxic substance, (5) the emotional distress must be serious, (6) the plaintiff's claim must be for fear of a specific disease and not just a fear for the plaintiff's general health, (7) the fear of illness must be reasonable, (8) the plaintiff may enter evidence of the plaintiff's likelihood of developing the illness to illustrate the reasonableness of the plaintiff's fear, and (9) it must be reasonably foreseeable that the conduct would cause severe emotional distress in the plaintiff.

Marrs, *supra* note 75, at 2. See generally *Krochock & Solheim*, *supra* note 106 (analyzing the jurisdictions that recognize pure psychic claims for emotional distress).

See *Sterling v. Velsicol Chemical Corp.*, 855 F.2d 1188, 1199 (6th Cir. 1988) (recognizing that the plaintiff's fear of contracting cancer as a result of ingesting water contaminated by the chemical corporation without anything more was enough to maintain a claim for emotional distress); *Hagerty v. L & L Marine Servs., Inc.*, 788 F.2d 315, 318 (5th Cir. 1986) (holding that a seaman who was doused with toxic chemicals may proceed with his claim with or without physical impact or physical manifestations because his fear was reasonable and causally related to the defendant's negligence); *Marriott v. Sedco Forex Int'l Resources*, 827 F. Supp. 59, 75 (D. Mass. 1993) (holding that plaintiffs who were inoculated with a vaccine that tested positive for HIV could recover for their fear of developing HIV absent physical manifestations); *Merry v. Westinghouse Elec. Corp.*, No.

The courts that continue to retain the physical injury requirement in fear-of-illness cases represent a tradition of denying full recovery for emotional injury in all tort categories.¹²⁷ Although the debates over the retention of the physical impact¹²⁸ and physical manifestation rules¹²⁹ play an important part in the HIV-fear cases, currently the greatest focus is upon whether the plaintiff should be required to prove the actual channel of exposure.¹³⁰

A. *The Debate Over the Channel of Exposure*

Adding to the complexity of the HIV-fear cases is the current debate over whether a plaintiff should be required to prove the actual channel of potential HIV exposure, meaning the exact means by which HIV exposure potentially occurred.¹³¹ In their struggle to avoid the overly anticipated flood of HIV-fear cases, some courts have established an additional barrier separate from the physical injury and physical manifestation rules that requires the plaintiff to prove the actual channel of HIV exposure.¹³² Requiring proof of actual

86-1673, slip op. (M.D. Pa. Mar. 14, 1988) (holding that the plaintiffs could recover for their fear of illness from contaminated water in their wells even absent medical evidence that they had retained any chemicals in their bodies); *Maskin & Antonucci*, *supra* note 120, at 629 (discussing other cases where the courts have held that exposure alone is sufficient for recovery).

See also *Whiteman*, *supra* note 59, at 1005, 1013-14 (arguing that both the physical requirements should be abandoned in favor of a reasonable fear test in fear of cancer cases). Under *Whiteman's* proposed test, plaintiffs must prove that their fear is specific, reasonable, serious, causally related to and a foreseeable result of the defendant's negligence, and that cancer may result from the toxic exposure. *Id.*

See also *Kaufman v. Physical Measurements, Inc.*, 615 N.Y.S.2d 508, 509 (N.Y. App. Div. 1994) (holding that New York does recognize pure psychic emotional claims but that the plaintiff who was accidentally pricked by a needle had no medical evidence to support his claim of exposure to HIV, for both the needle and the individual whose blood was in the needle tested negative for HIV).

127. Jane E. Larson, "Women Understand So Little, They Call My Good Nature 'Deceit'": *A Feminist Rethinking of Seduction*, 93 COLUM. L. REV. 374, 460 (1993).

128. See *supra* notes 73-86 and accompanying text.

129. See *supra* notes 64-68, 73-75, 87-90, 94-96 and accompanying text.

130. *Garves*, *supra* note 32, at 30.

131. Two categories of cases exist because the alleged contact is either too tenuous to establish potential exposure, or is sufficient to establish that something occurred that might constitute exposure. *Goldberg*, *supra* note 30, at 90.

132. See *Doe v. Surgicare of Joliet, Inc.*, 643 N.E. 2d 1200, 1203-04 (Ill. App. Ct. 1994) (holding that the plaintiff must allege and prove actual exposure to HIV and that recovery should be based upon the likelihood of contracting the disease and not the fear that exposure could have happened, but did not); *Neal v. Neal*, 873 P.2d 881, 888 (Idaho Ct. App. 1993) (holding that proof of actual exposure is required to recover for fear of HIV exposure); *Seimon v. Becton Dickinson & Co.*, 632 N.E.2d 603, 605 (Ohio App. Ct. 1993) (holding that absent proof of actual exposure to HIV, the plaintiffs could not recover); *Burk v. Sage Products*, 747 F. Supp. 285, 288 (E.D. Pa. 1990) (holding that fear of exposure to HIV was not a compensable injury because the plaintiff could not prove actual exposure to HIV); *Gregory, Inc. v. Bluefield Community Hospital*, 413 S.E.2d 79 (W. Va. 1991) (holding that absent proof of actual exposure to HIV, the plaintiff's fear was

exposure reassures the court that the emotional distress is not fraudulent by providing tangible proof that justifies the plaintiff's fear of developing HIV.¹³³

The social and economic stigmas surrounding the HIV-fear cases merely reinforce the idea that emotional distress claims are somehow not as compensable as claims for physical ailments.¹³⁴ The requirement of proof of the actual channel of exposure creates legitimacy for the courts that the plaintiff's fear is reasonable, justifiable, and therefore, compensable.¹³⁵ The reality, however, is that counterfeited HIV claims based on erroneous beliefs of HIV transmission already exist.¹³⁶

For example, in *Johnetta v. Municipal Court*,¹³⁷ the court ordered the defendant to submit to AIDS blood testing after the defendant bit a sheriff's deputy.¹³⁸ The trial court found no evidence that the bite transferred any blood to the deputy.¹³⁹ Therefore, the defendant's saliva contained the only

unreasonable and not legally compensable).

133. Proof of exposure has consistently been the plaintiff's greatest burden in HIV-fear cases. Garves, *supra* note 32, at 27.

134. The reality is that the "law is not for the protection of the physically sound alone." KEETON ET AL., *supra* note 61, at 360.

135. Debbie E. Lanin, Note, *The Fear of Disease As a Compensable Injury: An Analysis of Claims Based on AIDS Phobia*, 67 ST. JOHN'S L. REV. 77 (1993) (arguing that proof of actual exposure is a decisive element of the plaintiff's fear of AIDS claim, and abandonment of this requirement would lead to a flood of cases based on unsubstantiated fears of developing AIDS); James E. Maroulis, *Can HIV-Negative Plaintiffs Recover Emotional Distress Damages for Their Fear of AIDS?*, 62 FORDHAM L. REV. 225, 263 (1993) (arguing that proof of the actual channel of exposure is the only means available to validate the plaintiff's claims); Harris J. Zakarin, *Scared to Death: A Cause of Action for AIDS Phobia*, 10 Touro L. REV. 263, 273 (1993) (analyzing New York HIV-fear cases and concluding that plaintiffs must show actual exposure to HIV).

136. See *infra* notes 137-50 and accompanying text. See also *Weeks v. State*, 834 S.W.2d 559 (1992), in which the defendant, a prison inmate, twice spit upon a prison guard's face. At the time of the incident, the defendant was HIV-positive. The first medical expert testified that "[i]f [HIV] was transmitted by casual contact with saliva or with kissing, we would have many more documented cases than we do now We would have seen an explosion outside the risk group, which has not happened." *Id.* at 564. The court chose to ignore the first expert's testimony and relied upon another medical expert who testified that there had been a case where an elderly couple allegedly only engaged in kissing and HIV transmission occurred. *Id.* at 563. Despite contradictory medical testimony that it is almost impossible to get all relevant information about sexual practices and conduct and that the case is not "precedent for transmission in general," the court held that there was sufficient evidence to support the finding that the defendant could have transmitted HIV to the prison guard through his saliva. *Id.* at 565.

137. 267 Cal. Rptr. 666 (Cal. Ct. App. 1990).

138. *Id.*

139. *Id.* at 670. "There was no blood in the mouth of the defendant at the time; but certainly saliva was transferred." *Id.* at 669.

possible transfer agent of HIV.¹⁴⁰ Despite expert medical testimony that HIV cannot be transferred through saliva that does not contain HIV-infected blood, the California Court of Appeals held that it was reasonable to require the defendant to undergo an HIV test.¹⁴¹ The court reasoned that a theoretical possibility existed that HIV transmission could occur through mere saliva; and therefore, it was reasonable to test for HIV.¹⁴²

The *Johnetta* case is dangerous, for it opens doors to claims of HIV exposure that are too tenuous and that are not recognized by HIV researchers.¹⁴³ By requiring defendants to undergo HIV tests when no blood-to-blood exposure occurs, the court condones cases based upon erroneous beliefs of HIV transmission.

In a similar case, *Syring v. Tucker*,¹⁴⁴ the court also required the defendant who bit the plaintiff to undergo HIV testing.¹⁴⁵ The court agreed with the *Johnetta* court,¹⁴⁶ reasoning that there is a theoretical possibility that HIV could be transmitted through saliva.¹⁴⁷ By allowing claims such as

140. *Id.* The court accepted the observations of medical experts that none of the defendant's blood entered the plaintiff's bloodstream. *Id.* at 670.

141. *Id.* at 685. The court based its decision upon medical testimony that all bodily fluids of an HIV-infected individual have a concentration of HIV, and even though saliva has a low HIV-concentration, it could possibly transmit the disease. *Id.* at 670. *But see supra* note 6 (explaining that saliva which does not contain HIV-infected blood does not possess enough concentration of HIV for possible transmission).

142. *Johnetta v. Municipal Court*, 267 Cal. Rptr. 666, 674 (Cal. Ct. App. 1980). The court reached its conclusion by discounting the testimony of the majority of experts who stated that, "Researchers have found HIV in saliva in low concentrations, but these low concentrations, together with the studies described above and the absence of a single documented case of transmission are strong evidence that HIV cannot be transmitted through saliva." *Id.* at 670.

143. Although there is much about the disease that medical experts do not know, HIV researchers assert that HIV cannot be transmitted through casual contact or saliva that does not contain HIV-infected blood. Therefore, HIV-infected blood must be present in the saliva. *See supra* note 6 (describing the HIV transmission case of two sisters). One of the possible modes of transmission was a shared toothbrush because the HIV-infected sister had bleeding gums. Therefore, the HIV-infected blood possibly came in contact with the younger girl's blood through her own gums which may have had lesions from rough brushing. The older girl's saliva contained her HIV-infected blood, but the mode of transmission was still blood-to-blood exposure, and not mere saliva.

144. 498 N.W.2d 370 (Wis. 1993).

145. *Id.* at 378. The defendant was a Department of Social Services' (DSS) client who went to the department's offices for a hearing, became disruptive, and was asked to leave. *Id.* at 371. The plaintiff, a DSS employee, attempted to restrain the defendant, and the defendant bit him on the left forearm. *Id.* The defendant then yelled at the plaintiff that she had AIDS. *Id.*

146. *Johnetta v. Municipal Court*, 267 Cal. Rptr. 666, 666 (Cal. Ct. App. 1990). *See supra* notes 137-43 and accompanying text (analyzing the *Johnetta* decision).

147. *Syring v. Tucker*, 498 N.W.2d 370, 373 (Wis. 1993). The court acknowledged that "[i]t may be that the greater weight of current scientific opinion holds that HIV cannot be transmitted via saliva," but then proceeded to hold that the defendant theoretically transmitted HIV to the plaintiff

Johanna and *Syring*, where no blood-to-blood exposure to HIV occurred, the courts are already perpetuating hysteria about how HIV is transmitted. Therefore, the argument that abandoning the actual channel of exposure requirement will open the courts to irrational claims is invalid, because irrational claims already exist under the standard of recovery that requires the plaintiff to prove the actual channel of exposure.¹⁴⁸ No reason exists to maintain a rule that does not fulfill its function of preventing claims based on erroneous beliefs that exposure to HIV possibly occurred.¹⁴⁹ Consequently, some courts do not require the plaintiff to prove the actual channel of HIV exposure.¹⁵⁰

In *Marriott v. Sedco Forex Int'l Resources*,¹⁵¹ rather than requiring the plaintiffs to prove the actual channel of exposure, the court required the plaintiffs to tie their claim to a distinct event that would cause a reasonable

through her non-HIV-tainted saliva. *Id.*

148. See *supra* notes 137-47 and accompanying text. See, e.g., *United States v. Moore*, 846 F.2d 1163, 1164 (8th Cir. 1988) (holding that an HIV positive inmate who bit two federal correctional officers could be convicted of assault with a deadly or dangerous weapon (mouth and teeth)). The court held that even if the inmate was not HIV positive, the decision would be the same, reasoning that a bite is an assault with a deadly weapon. *Id.* The court added that the reference to HIV in the indictment was "mere surplusage," but by allowing the government to pursue the theory that the defendant possibly transmitted HIV through saliva, the court affirmed the erroneous belief that exposure to HIV can occur through saliva that does not carry HIV-infected blood. *Id.* But see *Hare v. State*, 570 N.Y.S.2d 125, 127 (N.Y. App. Div. 1991) (refusing recovery for fear of HIV to an x-ray technician who was bitten by an inmate, reasoning that there was no evidence that the inmate was infected with HIV). However, the *Hare* court did not address whether the plaintiff would have a claim for the bite if it were shown that the inmate was HIV positive. The plaintiff in *Hare* would be denied recovery under this note's modified distinct event approach because he would not be able to trace his fear to a distinct event that potentially exposed him to HIV given that no evidence existed that the inmate was HIV positive. However, the plaintiff would also be denied recovery under this note's modified distinct event approach even if the inmate were shown to be HIV positive. The inmate's saliva did not contain any blood and transmission of HIV cannot occur through saliva that does not contain HIV-infected blood. See *infra* Section IV, notes 226-52 and accompanying text (discussing this note's modified distinct event approach) and *supra* note 6 (discussing the modes of HIV transmission).

149. Another argument against the actual exposure requirement is that courts which use it are careless in establishing an AIDS/HIV policy for its jurisdiction. Mandana Shahvari, Comment, *Afraid: Fear of AIDS as a Cause of Action*, 67 TEMP. L. REV. 769, 803 (1994).

150. See, e.g., *Faya v. Almaraz*, 620 A.2d 327 (Md. 1993); *Castro v. New York Life Ins. Co.*, 588 N.Y.S.2d 695 (N.Y. Sup.Ct. 1991) (abandoning the requirement of proof of the actual channel of exposure, reasoning that it was an impossible burden). See also Louise Feffer, *AIDSphobia, A New Entity*, N.Y.B.J., Feb. 1993, at 14 (discussing the courts that have abandoned the actual channel requirement).

151. 827 F. Supp. 59 (D. Mass. 1993). In *Marriott*, the plaintiffs were inoculated against hepatitis with a vaccine that subsequently tested positive for HIV. *Id.* at 63. The plaintiffs' employer notified the plaintiffs about the virus, and the plaintiffs sued for their severe emotional distress caused by their fear that they would develop HIV. The court held that the plaintiffs could recover for their fear of developing HIV absent physical manifestations. *Id.* at 75.

person to fear developing HIV.¹⁵² Therefore, under the reasoning of *Marriott*, a plaintiff must allege an injury that stems from exposure to HIV.¹⁵³ Injuries stemming from a fear of developing the illness *after* exposure are compensable, but fear of exposure alone is not compensable.¹⁵⁴ Therefore, under *Marriott*, plaintiffs can recover for their fear of developing HIV if they show that it is reasonably probable that they will develop HIV, but cannot recover for their fear over whether exposure occurred.¹⁵⁵ The *Marriott* court correctly abandoned the actual exposure rule,¹⁵⁶ but did not address the fact that in most cases the plaintiff's emotional distress is fear over *whether* exposure occurred. Most plaintiffs do not possess the same certainty of actual exposure to HIV that the plaintiffs possessed in *Marriott*.¹⁵⁷

In *Marriott*,¹⁵⁸ the plaintiffs did not have the burden of proving that HIV exposure occurred because their employer notified them that they had been inoculated with a virus that subsequently tested positive for HIV.¹⁵⁹ Recovery for plaintiffs' fear after exposure is proven does not account for plaintiffs who may be unable to prove actual exposure,¹⁶⁰ but who legitimately fear that they

152. The *Marriott* court reasoned that there was a sufficient guarantee of genuineness of the claim so long as plaintiffs tied their claims to a "distinct event which could cause a reasonable person to develop a fear of developing a disease like AIDS." *Id.*

153. The court held that "[i]f a claim can be tied to a distinct event which could cause a reasonable person to develop a fear of contracting a disease like HIV, there is a guarantee of genuineness of the claim." *Id.* at 75.

154. *Id.* The court reasoned that the plaintiffs' claim fell within the group of cases that allow recovery absent physical manifestation because they traced their fear of developing HIV to a single traumatic occurrence where they were directly exposed to HIV (the inoculation). *Id.* at 75-76.

155. Therefore, the plaintiffs must allege a reasonable fear that they have contracted HIV. *Marriott v. Sedco Forex Int'l Resources*, 827 F. Supp. 59, 75-76 (D. Mass. 1993). See also *Herbert v. Regents of Univ. of Cal.*, 31 Cal. Rptr. 2d 709, 712 (Cal. Ct. App. 1994) (holding that the plaintiff must show that the risk of contracting HIV is significant).

156. *Marriott*, 827 F. Supp. at 75 (holding that the plaintiffs must allege a single traumatic occurrence in which they were exposed to HIV).

157. See *supra* note 151 (establishing the facts of *Marriott*).

158. 827 F. Supp. 59 (D. Mass. 1993).

159. *Id.* at 63.

160. For example, proof of whether exposure actually occurred will be more difficult, if not impossible, for a plaintiff who is unconscious during surgery. See *Faya v. Almaraz*, 620 A.2d 327, 337 (Md. 1993) (reasoning that to require plaintiffs to "allege actual transmission would unfairly punish them for lacking the requisite information to do so" because the plaintiffs were unconscious during their respective surgeries and discovered months later that the physician who performed the surgery was HIV positive at the time of the surgery). See *infra* notes 242-50 and accompanying text, in which this note proposes that *Res Ipsa Loquitur* should be applied in HIV-fear cases to plaintiffs who are unable to prove the actual channel of exposure. See also *Shahvari, supra* note 149, at 804 (arguing that courts must not characterize all plaintiffs as unreasonable AIDS phobics merely because they cannot prove the actual channel of exposure). Instead, *Shahvari* proposes that courts must examine the significance of the risk of exposure to HIV. *Id.* However, *Shahvari* does not define what constitutes a significant risk and instead leaves that question for courts to answer.

have been exposed to the virus. A better standard is this Note's modification of *Marriott's* distinct event approach which requires plaintiffs to trace their fear to a distinct event that would cause a reasonable person to fear that *exposure* to HIV occurred.¹⁶¹ If the plaintiffs can allege a specific incident of potential exposure to HIV, recovery should be allowed.¹⁶² Therefore, this Note's proposed judicial approach focuses on the reasonableness of the plaintiffs' claims that they were potentially exposed to HIV.¹⁶³

Proof of the actual channel of exposure is the greatest burden for plaintiffs in HIV-fear cases,¹⁶⁴ particularly in cases where it is impossible for the plaintiff to prove actual exposure.¹⁶⁵ Because of the impossible burden on many plaintiffs, the court in *K.A.C. v. Benson*¹⁶⁶ circumvented the rule and held that proof of actual exposure does not require proof of direct contact with

Id. at 803-04.

161. See *infra* notes 234-41 and accompanying text.

162. See *infra* notes 242-43 and accompanying text.

163. Susan J. Zook, Note, *Under What Circumstances Should Courts Allow Recovery for Emotional Distress Based Upon the Fear of Contracting AIDS?*, 43 WASH. U. J. URB. & CONTEMP. L. 481 (1993); *Johnson v. West Virginia University Hospitals Inc.*, 413 S.E.2d 889 (W. Va. 1991) (arguing that the reasonableness of the plaintiff's fear is based upon proof of exposure and the statistical likelihood of contracting the disease). This argument fails to take into the account that the recovery is sought regardless of whether the plaintiff ever develops HIV and therefore, a standard based upon the statistical likelihood of contracting the disease defeats the purpose of claims based on fear of exposure. See Goldberg, *supra* note 30, at 92 (quoting Chicago Torts professor Richard Epstein, who states: "Cancerphobia plaintiffs have not been uniformly required to demonstrate a probability of developing cancer, . . . so why require it in AIDS phobia cases, especially given the disease's high fatality rate?").

Instead of a standard based upon the statistical likelihood of contracting the disease, the standard should be one based upon the likelihood that exposure potentially occurred. By focusing upon the likelihood of contracting the disease, the courts would again ignore the reality of psychic claims and would compensate only claims that have a high probability of resulting in physical illness. However, regardless of whether the plaintiff develops HIV, the fear is the same during the period in which a plaintiff does not know whether he or she will develop HIV. Instead, the focus should be on whether the plaintiff has a legitimate claim for fear that potential exposure occurred. Zook's standard is based on the probability of contracting the disease, and therefore requires the plaintiff to prove the actual channel of exposure, for without actual proof, Zook sees the probability of exposure as non-existent. See Zook, *supra*. The standard that should be employed is one that measures whether there has been a substantial likelihood of *exposure* to HIV-infected blood or fluids. Exposure does not necessarily guarantee development of the disease, and whether the plaintiff ever actually develops the disease, the fear from potential exposure is equally harrowing. See *infra* Section IV, notes 226-52 and accompanying text (presenting this note's modified distinct event approach that focuses on the likelihood of exposure to HIV-infected blood or fluids).

164. Garves, *supra* note 32, at 27.

165. See, e.g., *Faya v. Almaraz*, 620 A.2d 327 (Md. 1993); *Rossi v. Almaraz*, 1991 WL 166924 (Md. Cir. Ct. 1991) (holding that it was virtually impossible for the plaintiffs to prove the actual channel of exposure, given that they were all unconscious during the surgery).

166. 1993 WL 515825, *2 (Minn. Ct. App. 1993).

HIV-infected blood or bodily fluids.¹⁶⁷ The *K.A.C.* court applied the proof of exposure rule and held that the plaintiffs met the requisite showing of actual exposure through their allegations that the HIV infected physician who was suffering from oozing open sores on his arms, had placed his fingers, (either singly or doubly gloved) inside the plaintiffs' body cavities.¹⁶⁸ The court reasoned that the physician's performance of invasive procedures while he suffered from open sores was an exposure to HIV.¹⁶⁹ While the *K.A.C.* court correctly abandoned proof of actual blood-to-blood contact,¹⁷⁰ it did so by expanding the exposure rule and holding that the defendant-physician's actions constituted exposure to HIV.¹⁷¹

Courts should abandon all forms of the exposure rule in favor of a judicial approach that requires plaintiffs to trace their fear to an event that potentially exposed them to HIV.¹⁷² The form of the exposure rule is irrelevant.¹⁷³ The *K.A.C.* court's decision is a move in the right direction, but it does not quite go far enough. Although it broadens the definition of exposure, it still clings to the notion that plaintiffs must show actual exposure to recover.¹⁷⁴

The motive behind abandoning proof of actual exposure recognizes that the requirement essentially punishes plaintiffs who lack the requisite information to prove actual exposure.¹⁷⁵ Regardless of whether they can prove the actual channel of exposure, many plaintiffs can still prove the legitimacy of their fears through other means, but the courts in *K.A.C.* and *Marriott* failed to consider alternative means to test the legitimacy of the plaintiffs' claims.¹⁷⁶ As the modified distinct event approach of this Note establishes, plaintiffs should be

167. *Id.* at *4. The court reasoned that proof of direct contact with HIV-infected blood was a form of the physical impact rule, which was no longer applied in Minnesota. *Id.*

168. *Id.* at *4. The court reasoned that requiring the plaintiffs to show contact with the physician's blood or bodily fluids would place "an unduly difficult, if not insurmountable, burden of proof on plaintiffs." *Id.*

169. *Id.* at *1. The court concluded that exposure may also occur when the object of danger is "near or accessible to anything which may affect it detrimentally." *Id.* at *4.

170. *K.A.C. v. Benson*, 1993 WL 515825, *1 (Minn. Ct. App. 1993).

171. *Id.* at *2. The court stated that "Dr. Benson's performance of invasive procedures while suffering from exudative dermatitis, regardless of whether he wore one or two pairs of gloves, constituted an exposure to HIV." *Id.* Therefore, the court still required proof of actual exposure, but held that proof of direct blood-to-blood exposure was not necessary to fulfill this proof requirement. *Id.* at *3.

172. *See infra* notes 226-41 and accompanying text.

173. *See infra* notes 226-41 and accompanying text.

174. *K.A.C.*, 1993 WL 515825 at *2-3.

175. *Faya v. Almaraz*, 620 A.2d 327, 336 (Md. 1993). *See also supra* note 150 (presenting cases which have held that proof of the actual channel of exposure is virtually impossible for plaintiffs).

176. *See supra* notes 151-74 and accompanying text.

required to link their proof to a distinct event that shows that a substantial likelihood exists that exposure to HIV-infected blood or fluids potentially occurred at a specific point in time.¹⁷⁷

B. *The Debate Over the Time Period of Allowable Recovery*

If a court determines that the plaintiff can recover for emotional distress for potential HIV exposure, the court then faces the challenge of determining the time period of allowable recovery. The majority of courts that allow recovery in HIV-fear cases follow the six month "window of anxiety" approach.¹⁷⁸ This approach defines the time period of allowable recovery as the six month period between discovery of potential exposure and receipt of information that indicates the plaintiff's freedom from infection with reasonable medical certainty.¹⁷⁹ The window of anxiety approach is based on the acceptance of medical research results that ninety-five percent of individuals who develop HIV will test positive for HIV within six months of exposure.¹⁸⁰ The rationale is that it is unjust to allow the plaintiff to recover for the fear of developing HIV after they have had sufficient opportunity to determine with medical certainty that they did not contract HIV.¹⁸¹

Given that it may take several years before an individual manifests signs of HIV infection, plaintiffs should be allowed to recover for their fear until they know their HIV status with medical certainty.¹⁸² For example, consider the hypothetical case of a plaintiff who discovers two years after her kidney transplant that the surgeon who performed the operation was HIV positive at the time of her surgery. The plaintiff is tested for HIV and the results are negative. Although the plaintiff brings her cause of action after the six month window of anxiety period, she would still be able to recover for the time period in which her HIV status is medically uncertain.

In 1991, the West Virginia Supreme Court allowed a plaintiff to recover damages for emotional distress for the rest of his life, not just for the six month

177. See *infra* Section IV, notes 226-52 and accompanying text (proposing that instead of proving the actual channel of exposure, plaintiffs should be required to trace their fear to a distinct event that potentially exposed them to HIV). But see Maroulis, *supra* note 135, at 263; Zakarin, *supra* note 135, at 273 (arguing that courts should uniformly require plaintiffs to present evidence of the actual channel of exposure).

178. Goldberg, *supra* note 30, at 88.

179. *Id.*

180. See *supra* note 38 and accompanying text.

181. Faya v. Almaraz, 620 A.2d 327, 337 (Md. 1993).

182. See *supra* note 38 and accompanying text.

window of anxiety period.¹⁸³ The rationale behind the extended recovery was that, because of the controversy surrounding the HIV tests, a negative test result may not sufficiently erase the plaintiff's fear of one day developing HIV.¹⁸⁴ Proponents of the extended recovery period are not confident in the majority of medical researchers' six month window of anxiety period because of the uncertainty that surrounds HIV and AIDS.¹⁸⁵

Extending recovery beyond the period of medical uncertainty about a plaintiff's HIV status ignores the premise that plaintiffs should only be compensated for the period in which they are uncertain about their HIV status.¹⁸⁶ Plaintiffs' recovery should be limited to the period of uncertainty because their claims are based on their fear of the unknown. Allowing plaintiffs to recover after the period of uncertainty compensates plaintiffs for a period in which their fear is unreasonable.¹⁸⁷ Consequently, instead of allowing recovery beyond the period of medical uncertainty, courts should only allow recovery for the period in which plaintiffs do not know with medical certainty whether they have contracted HIV.¹⁸⁸ However, a plaintiff's recovery may be reduced or barred if the defendant can establish that the plaintiff contributed to or assumed the risk of HIV exposure.¹⁸⁹

C. *Questions of Assumption of the Risk and Comparative Negligence in HIV-Fear Cases*

As in other tort cases, in HIV-fear cases courts must address the issues of contributory¹⁹⁰ or comparative negligence,¹⁹¹ assumption of the risk,¹⁹² and

183. See *Johnson v. West Virginia Univ. Hosps.*, 413 S.E.2d 889, 893 (W.Va. 1991) (holding that the plaintiff could recover not just for the window of anxiety period, but for the rest of his life).

184. Goldberg, *supra* note 30, at 88.

185. See Popadopulos-Eleopoulos, *supra* note 13 (discussing the skepticism surrounding the tests that are supposed to determine if an individual is infected with HIV).

186. Maroulis, *supra* note 135, at 228-59. The author argues that although the AIDS tests are not always accurate, they still offer a strong probability of whether infection has occurred. *Id.* at 258. Therefore, recovery should not be allowed when a plaintiff tests negative for HIV after testing becomes viable. *Id.* at 258-59.

187. *Id.* In addition, the author argues that emphasizing negative test results as strong indicators that the plaintiff has not contracted HIV is harmonious with traditional emotional distress policies that have denied recovery for damages that were not in close proximity to the tortious conduct. *Id.* at 259.

188. See generally Zook, *supra* note 163, at 489-91; Lanin, *supra* note 135, at 84; Maroulis, *supra* note 135, at 259-63 (arguing that recovery should be limited to the time period of medical uncertainty about the plaintiff's HIV status).

189. See *infra* notes 190-217 and accompanying text.

190. Contributory negligence occurs when plaintiffs fail to exercise due care. PROSSER, *supra* note 70, at 427.

191. Under a comparative negligence standard, the plaintiff's recovery is reduced in proportion to the plaintiff's fault. *Id.* at 443-44.

the existence of a duty.¹⁹³ An examination of how the courts address these issues in suits for the sexual transmission of HIV predicts how the courts will probably deal with them in HIV-fear suits. In claims for sexual transmission of HIV, plaintiffs may argue that it is the defendant's duty to disclose HIV infection to the plaintiff.¹⁹⁴ In response to suits for the sexual transmission of AIDS, defendants may raise a comparative negligence defense in which they argue that the plaintiff impliedly assumed the risk of HIV infection by engaging in sexual intercourse.¹⁹⁵ If the defendant's argument is successful, all claims,

192. Assumption of the risk occurs when the plaintiff knowingly and voluntarily assumes future risks inherent in a particular activity or situation. COMPARATIVE NEGLIGENCE MANUAL 14 (1993).

193. To recover in a negligence action, the plaintiff must establish that: (1) the defendant had a legal duty toward the plaintiff, (2) the defendant breached that duty, (3) the defendant's breach of duty was the proximate cause of the plaintiff's injury, and (4) the plaintiff suffered damages as a result of the injury. WILLIAM L. PROSSER, ET AL., CASES AND MATERIALS ON TORTS 136 (8th ed. 1988).

194. Before HIV became a significant issue, there were court decisions involving other sexually transmitted diseases that held defendants liable for their failure to warn sexual partners of their infection. HERMANN & BURRIS, *supra* note 31, at 340. See, e.g., R.A.P. v. B.J.P., 428 N.W.2d 103, 107-08 (Minn. Ct. App. 1988) (holding that the defendant had a duty to warn his sexual partner about his herpes infection); Maharam v. Maharam, 123 A.D.2d 165, 169 (N.Y. App. 1986) (holding that a husband had a duty to inform his wife about his genital herpes infection); Duke v. Housen, 589 P.2d 334, 340 (Wyo. 1979) (reversing the plaintiff's claim against her sex partner for infecting her with gonorrhea due to the statute of limitations, but reasoning that "one who negligently exposes another to an infectious or contagious disease, which such other person thereby contracts, can be held liable in damages").

See also *Mussivand v. David*, 544 N.E.2d 265, 270 (Ohio 1989) (holding that individuals with venereal diseases have a duty to use reasonable care to avoid infecting their sexual partners); Louis A. Alexander, Note, *Liability in Tort for the Sexual Transmission of Disease: Genital Herpes and the Law*, 70 CORNELL L. REV. 101, 102 (1984) (arguing that a legally enforceable duty exists in sexual relationships to protect against the transmission of genital herpes, and therefore, an infected partner has an affirmative obligation to reveal the infection before engaging in sexual intercourse). The same argument can be made in AIDS cases. Plaintiffs can argue that the same duty imposed by courts in other sexually transmitted disease cases should be imposed in cases for sexual transmission of HIV. See Julia A. Galgen, Case Note, *Doe v. Johnson: Wrongful Transmission of HIV Based on Traditional Tort Concepts*, 3 J. PHARM. & L. 209 (1994).

See *supra* note 21 (discussing two commentators who propose that the standard of duty imposed in cases for the transmission of other sexually transmitted diseases should be applied to HIV transmission cases). See also *C.A.U. v. R.L.*, 438 N.W.2d 441, 444 (Minn. Ct. App. 1989) (holding that the defendant did not have a duty to warn the plaintiff because at the time of their sexual encounter (1985), it was not known that HIV transmission could occur through heterosexual sex). The court determined that the key in cases for transmission of the AIDS virus is whether it is reasonable for the defendant to have constructive knowledge of the defendant's capability of transmitting the AIDS virus. *Id.* The court reasoned that at the time in which the parties engaged in sexual contact, the general societal notion was that AIDS could not be transmitted heterosexually. *Id.* Therefore, it was unreasonable for the defendant to constructively know that he could transmit the AIDS virus. *Id.*

195. See *Doe v. Johnson*, 817 F. Supp. 1382, 1386 (W. D. Mich. 1993) (involving a defendant who argued that the plaintiff assumed the risk of a sexually transmitted disease by engaging in sex with the defendant).

including negligent infliction of emotional distress, are barred.¹⁹⁶ Other defendants may argue that it is the duty of the plaintiff to inquire as to whether the defendant is infected with HIV.¹⁹⁷

Defendants also argue that if the plaintiff engages in sexual activity after being warned by the defendant that the defendant has HIV, contributory negligence should completely bar recovery¹⁹⁸ or comparative negligence should reduce recovery.¹⁹⁹ In jurisdictions that recognize the affirmative defense of assumption of the risk, the defendant must show that the plaintiff had knowledge of the defendant's risk of infection, fully understood and appreciated the consequences, and voluntarily engaged in the risky sexual activity.²⁰⁰ Some commentators find the sexual liability cases troubling because most adults now know how to avoid contracting HIV and should take precautions instead of

196. *Id.* at 1386. The defendant argued that he did not have a legal duty toward the plaintiff because he did not know that he was infected with HIV at the time of their sexual encounter. *Id.*

197. *See, e.g., Doe*, 817 F. Supp. at 1386; *C.A.U. v. R.L.*, 438 N.W.2d 441, 444 (Minn. Ct. App. 1989) (examining arguments by the defendants that the plaintiff had a duty to ask whether the defendant could possibly be HIV positive).

198. Deane Kenworthy Corliss, Comment, *AIDS-Liability for Negligent Sexual Transmission*, 18 CUMB. L. REV. 691, 719-20 (1988) (arguing that all sexually active persons have a duty to protect themselves from the risk of contracting HIV). However, the author also argues that because of society's interest in ending the spread of HIV, it is reasonable for the courts to impose a duty upon "at-risk sexually active individuals" to warn their partners. If the at-risk individuals fail to warn, they should be held liable for damages. *Id.* at 721-22.

See also Linda K. Burdt & Robert S. Caldwell, Note, *The Real Fatal Attraction: Civil and Criminal Liability for the Sexual Transmission of AIDS*, 37 DRAKE L. REV. 657, 679 (1987-88) (arguing that the determination of contributory negligence should be based upon whether the plaintiff asked the defendant if he or she had HIV/AIDS). The authors further argue that if the defendant did not manifest any outward signs of HIV infection and the plaintiff had no knowledge that the defendant engaged in high-risk activity, then the plaintiff does not have a duty to ask about the defendant's sexual health. *Id.* at 679-80. *But see* Goldberg, *supra* note 30, at 90 (arguing that all sexually active individuals have a responsibility to question their sexual partners about their sexual health).

199. Burdt & Caldwell, *supra* note 198, at 680. *See also* Schoenstein, *supra* note 78, at 78-79 (arguing that comparative negligence should reduce the plaintiff's recovery in proportion to the plaintiff's fault if any or all of the following are shown: (1) the plaintiff engaged in high risk activity; (2) did not ask about the defendant's sexual health; and/or (3) did not use a condom). *See* Elber, *supra* note 21, at 924-27 (arguing that when plaintiffs have knowledge that the defendant may have HIV, the fact finder must decide whether the plaintiffs' actions contributed to their injury). Elber further contends that defendants may argue contributory negligence if the plaintiff did not use or insist upon the defendant's use of a condom. *Id.*

200. Corliss, *supra* note 198, at 719-20. The logic behind assumption of the risk in HIV transmission cases is that no wrong is done to one who consents to the risks accompanying sexual intercourse. Burdt & Caldwell, *supra* note 198, at 678. A plaintiff may expressly or impliedly assume the risk of HIV infection. *Id.* If the defendant can show that the defendant warned the plaintiff and the plaintiff fully appreciated the extent of the risk of transmission from engaging in sexual activity with the defendant, the plaintiff will be barred from recovery. *Id.*

blaming the other participant.²⁰¹

Generally, assumption of the risk has not been a successful defense in sexual disease cases because courts are reluctant to accept the idea that individuals assume the risk of contracting sexual diseases whenever they enter into a sexual relationship.²⁰² Part of this reluctance is attributed to a public policy interest in protecting the health, safety, and welfare of society.²⁰³ If courts allow defendants to claim assumption of the risk, the courts may effectively contribute to the spread of HIV by giving immunity to individuals who pass the disease through sexual contact.²⁰⁴ Instead of giving immunity to those who negligently spread the disease, the court should impose liability on them for their actions to deter similar behavior in others and effectively restrain the spread of HIV.²⁰⁵ The fact that assumption of the risk arguments have not been successful in cases for the sexual transmission of herpes²⁰⁶ has led many commentators to conclude that this defense will not be particularly successful in cases for actual or feared sexual transmission of HIV.²⁰⁷

201. Goldberg, *supra* note 30, at 90 (quoting Elizabeth Cooper, staff counsel for the ACLU's AIDS Project). See also Martha Chamallas, *Consent, Equality, and the Legal Control of Sexual Conduct*, 61 S. CAL. L. REV. 777, 784 (1988) (arguing that all sex is consensual unless there is inducement by physical force, economic pressure, or deception).

202. Papelian, *supra* note 21, at 662. See *Christian v. Sheft*, No. C574 (Los Angeles County Super. Ct. Feb. 15, 1989), (holding that the plaintiff did not assume the risk of AIDS because the plaintiff only knew the defendant was ill and did not know that the defendant had AIDS); *Kathleen K. v. Robert B.*, 198 Cal. Rptr. 273, 276 (Cal. Ct. App. 1984) (holding that consent to sexual intercourse is vitiated by a partner's fraudulent concealment of the risk of infection of venereal disease (in this case, herpes)).

See Brigham, *supra* note 80, at 545-46 (arguing that the individual infected with HIV is in the best position to warn potential sexual partners of the risks involved with their sexual activity). However, Brigham also argues that because there is no guarantee that HIV-infected individuals will be honest about their infection, the only solution is to impose a legal duty upon the HIV-infected individuals to honestly disclose their infection to all potential sexual partners. *Id.* at 546.

203. Elber, *supra* note 21, at 928-30.

204. *Id.*

205. See Papelian, *supra* note 21, at 649 (arguing that holding individuals liable for negligent transmission of HIV will deter negligent behavior); Schoenstein, *supra* note 78, at 79 (arguing that the courts must impose a duty upon HIV-infected individuals to curb the spread of HIV).

206. See *Kathleen K. v. Robert B.*, 198 Cal. Rptr. 273, 276 (Cal. Ct. App. 1984); *Berner v. Caldwell*, 543 So. 2d 686, 687 (1989) (rejecting the defendant's claims that the plaintiff assumed the risk of contracting a venereal disease by engaging in a sexual relationship with the defendant).

207. Goldberg, *supra* note 30, at 90. Goldberg quotes Michael L. Closen of John Marshall Law School who notes that assumption of the risk is unlikely to succeed in AIDS cases. Instead, Closen believes, courts will more likely employ a comparative negligence standard. *Id.* See *Burd & Caldwell*, *supra* note 198, at 678-79 (arguing that it is illogical to assert that individuals assume the risk of contracting HIV every time they engage in sexual intercourse because such an assertion contradicts the purpose of various state statutes that were enacted to prohibit the transmission of venereal diseases). *Id.* The purpose of these statutes is to protect the public from further spread of venereal diseases. *Id.*

The issues of duty, assumption of the risk, and comparative negligence also raise questions as to what responsibilities exist for individuals who may be liable for actual or feared non-sexual transmission of HIV.²⁰⁸ One clear proposition is that individuals do not impliedly assume the risk of infection from health care workers, for society insists that hospitals must take precautions to prevent the spread of all diseases.²⁰⁹ This recognition of responsibility on the part of hospitals is important in both AIDS transmission and HIV-fear cases, because it raises questions as to what steps hospitals must take to prevent HIV exposure to both health care workers and patients.

Although the risk of exposure from health care worker to patient is extremely low, the case of Kimberly Bergalis,²¹⁰ who contracted HIV from her

208. See *Marchica v. Long Island R.R.*, 810 F. Supp. 445 (E.D.N.Y. 1993) (holding the defendant liable for not providing a safe work environment for the plaintiff who was stuck by a contaminated needle); *Marriott v. Sedco Forex Int'l Resources*, 827 F. Supp. 59 (D. Mass. 1993) (holding that the defendants were liable for the plaintiffs' fear of HIV exposure that stemmed from the defendant's negligence in inoculating the plaintiffs with a vaccine that subsequently tested positive for HIV). See also *Castro v. New York Life Ins. Co.*, 588 N.Y.S.2d 695, 696 (N.Y. Sup. Ct. 1991) where the defendant failed to properly dispose of used hypodermic needles and syringes in a manner provided by statutory laws, regulations, and local ordinances and as a result of the defendant's negligence, an employee was stuck by a contaminated needle. See also *Howard v. Alexandria Hosp.*, 429 S.E.2d 22, 24 (Va. 1993) (holding that the hospital was negligent in using unsterilized instruments during the plaintiff's surgery). After surgery, the plaintiff's doctor informed her that unsterilized instruments were used during her surgery and he feared that exposure to HIV or other viruses occurred during the surgery. *Id.* As a result of this information, the plaintiff had to undergo extremely painful antibiotic therapy and suffered severe anxiety of contracting HIV. *Id.*

209. *Keyes*, *supra* note 16, at 603.

210. Thomas E. Margolis, Commentary, *Health Care Workers and AIDS—HIV Transmission in the Health Care Environment*, 13 J. LEGAL MED. 357 (1992). Kimberly Bergalis, who died in 1991 from AIDS, was the first documented patient to receive HIV from a health care worker (her dentist). Bergalis' case sparked significant controversy over whether health care workers should be required to undergo HIV testing and disclose their test results to their patients. See Marjorie H. Lawyer, *HIV and Dentistry*, 29 VAL. U. L. REV. 297, 297-98, 307-19 (discussing the Bergalis case and proposing a federal statute that balances the competing interests of HIV carriers and the public).

Out of the Bergalis controversy emerged almost unanimous agreement on one method of controlling the spread of HIV in medical facilities. *Margolis*, *supra*, at 392. The method was the "implementation and enforcement of strict infection control guidelines and universal precaution standards." *Id.* at 387-88. The CDC proposed guidelines for the protection of patients from transmission of HIV and recommended that all health care workers "should adhere to universal precautions and . . . should refrain from performing exposure-prone procedures or seek counsel from a review panel." *Id.* at 375. The CDC guidelines also suggested that if allowed by the review panel to continue certain procedures, the health care workers should be required to inform patients prior to the procedure because disclosure is vital when procedures will put the patient at risk of exposure. *Id.* at 391.

While the CDC guidelines are primarily for the protection of patients, health care professionals have lobbied for guidelines to prevent the infection of health care workers from HIV-infected patients because by February of 1992, 47 health care workers had been infected with HIV by patients. *Id.* at 383. Since the CDC's guidelines are only advisory, medical facilities do not have

infected dentist, illustrates that it is a possibility.²¹¹ Therefore, it is not surprising that HIV-fear claims against HIV-infected health care workers have emerged.²¹²

Paramount in the HIV-fear cases is the fact that many times someone's negligence causes the plaintiff's fear of HIV exposure.²¹³ Therefore, the HIV-fear cases are important because plaintiffs who have been the victims of negligence deserve compensation. It is in society's interest to curb negligent behavior and prevent the spread of HIV²¹⁴ by encouraging responsible

to strictly enforce universal precautions or routinely train their health care workers in infection control. *Id.* at 382-83, 391-94.

In March 1992, the Occupational Safety and Health Administration compulsory regulations became effective and in part require employers to: "(1) develop a written infection control plan; (2) provide appropriate personal protective equipment; (3) observe universal precautions; and (4) give workers information and training on bloodborne infectious diseases within 90 days of hire and at least annually thereafter." *Id.* at 383. The best way to prevent transmission is through precautionary measures, but consensus is greatly needed as to what precautionary measures should be enforced in health care facilities. The determination of what precautionary measures should be taken by health care facilities is beyond the scope of this note.

211. Margolis, *supra* note 210, at 359. Margolis quotes medical authorities who state that there is a possibility of HIV transmission during invasive, exposure-prone procedures. In addition, a surgeon:

will cut a glove in approximately one out of every four cases and probably sustain a significant skin cut in one out of every forty cases Assuming that the surgical patient's risk is exceedingly low . . . the risk that one of [the surgeon's] patients will contract HIV becomes more realistic the more operations he performs Patients, of course, cannot expect a wholly risk-free environment in a hospital. But there does come a point where the risk of a detrimental outcome becomes sufficiently real

Id. at 372.

See *Estate of Behringer v. Medical Ctr. at Princeton*, 592 A.2d 1251, 1283 (N.J. Super. Ct. Law Div. 1991) (applying a "no risk" standard and holding that an AIDS-infected surgeon could be prohibited from performing invasive procedures). The court reasoned that "where the ultimate harm is death, even the presence of a low risk of transmission justifies the adoption of a policy which precludes invasive procedures when there is 'any' risk of transmission." *Id.* See also *supra* note 16 (discussing restrictions on health care workers); *supra* notes 192, 202-09 and accompanying text (discussing the assumption of the risk doctrine).

212. See, e.g., *Kerins v. Hartley*, 33 Cal. Rptr. 2d 172 (Cal. Ct. App. 1994); *Faya v. Almaraz*, 620 A.2d 327 (Md. 1993); *Howard v. Alexandria Hosp.*, 429 S.E.2d 22 (Va. 1993); *K.A.C. v. Benson*, 1993 WL 515825 (Minn. Ct. App. 1993) (bringing claims against HIV-infected health care workers).

213. See *supra* note 208 and accompanying text.

214. Consensus is greatly needed as to whether health care workers should be allowed to perform invasive exposure-prone procedures. See *supra* notes 16-17. The current scientific evidence and CDC guidelines indicate that if universal precautions are followed, risk of HIV infection is only present when HIV-positive health care workers perform exposure-prone procedures. R. Bradley Prewitt, Comment, *The "Direct Threat" Approach to the HIV-Positive Health Care Employee Under the ADA*, 62 MISS. L.J. 719, 741 (1993). Prewitt argues that the job restructuring solution proposed by the Americans with Disabilities Act of 1990 (ADA) is a just solution because it "employs an individual, objective assessment of each HIV-positive worker and his role in the

behavior both by those who are HIV-positive and those who are not infected with the disease.²¹⁵ The imposition of a duty to prevent the negligent spread of HIV is important because without it, the courts will effectively grant immunity to defendants who negligently expose someone to HIV.²¹⁶ At the same time, all individuals have a responsibility to protect themselves against HIV infection; consequently, it is important to determine whether the plaintiffs negligently contributed to or assumed the risk of their actual or feared HIV exposure.²¹⁷

D. *The Impact of HIV-Fear Cases*

Given that HIV-fear cases are highly emotional and controversial, they have the potential to perpetuate hysteria. Critics worry that these cases will increase discrimination against employees or potential employees known to be HIV-positive.²¹⁸ By continuing to educate society that HIV is not casually transmitted,²¹⁹ the risk of discrimination against HIV-positive individuals will diminish.²²⁰ The model AIDS discrimination units which are successfully

workforce rather than a hasty, generalization-based analysis." *Id.* Therefore, all HIV-positive employees will be individually evaluated to determine whether they pose a risk of HIV transmission in their job. *Id.* at 741-42.

215. Margolis, *supra* note 210, at 394-96.

216. See *supra* notes 202-05 and accompanying text (establishing the premise that allowing the defense of assumption of the risk in sexually transmitted HIV cases grants immunity to defendants who transmit the disease). This premise can be argued in all HIV transmission cases because if courts do not impose liability upon individuals who negligently expose others to HIV, they will effectively condone such negligent behavior.

217. If individuals contribute to or assume the risk of their actual or feared HIV exposure, their recovery should be barred or reduced under contributory negligence, comparative negligence, or assumption of the risk. The affirmative defense employed will depend upon which defense is recognized in the jurisdiction.

218. Goldberg, *supra* note 30, at 88.

219. See *supra* note 6 (discussing the various modes of HIV transmission).

220. Michele A. Zavos, *Right to Work: Job Protections for People with HIV*, TRIAL, July 1993, at 41. The court can play a crucial role through these cases in preventing discrimination against HIV-infected individuals who do not pose a direct threat of infection to others. *Id.* at 41-42. See *School Board of Nassau County v. Arline*, 480 U.S. 273, 274 (1987). The *Arline* Court established four factors that are to be considered in determining whether someone with a transmittable disease can safely perform a job: 1) the nature of the risk (how the disease is transmitted); 2) the duration of the risk (how long the carrier is infectious); 3) the severity of the risk (the amount of potential harm to third parties); and 4) the probability that the disease will be transmitted and will cause harm. *Id.* at 275. By employing these standards, courts can determine whether individuals should be allowed to continue in their jobs or whether the risk they pose is outweighed by concern for the safety of others. *Id.* See also *supra* notes 15-17 and accompanying text.

decreasing HIV/AIDS discrimination illustrate the power of education.²²¹

Consequently, the HIV-fear cases can be viewed as useful tools to educate the general public about HIV transmission. The courts are fearful of an overflow of HIV-fear cases, but they can prevent fraudulent claims through education about the facts and the science of HIV and refuse to entertain claims based on misconceptions about HIV transmission.²²² Through legitimate claims, the judiciary can inform society that it will not tolerate activity that potentially contributes to the spread of HIV.²²³ AIDS has already claimed two hundred thousand lives,²²⁴ and currently over one million individuals are infected with HIV.²²⁵ Therefore, society should use every available means, including legal liability, to combat the further spread of HIV.

221. Schulman, *supra* note 18, at 1117. AIDS discrimination units in Los Angeles have discovered that prejudices against HIV or AIDS-infected individuals can be dramatically reversed with education about the medical facts of HIV and AIDS. *Id.* at 1133-34. The units have learned that before the fight against HIV and AIDS discrimination will be truly successful, fears about AIDS as a disease must be eradicated. *Id.* The AIDS education program established by the city of Los Angeles requires education for city employees about preventing further spread of HIV and how to ensure confidentiality in the workplace, prevent discrimination, and protect against liability. *Id.* at 1134.

The first step of the program is a series of special briefing sessions for elected officials and department heads to insure that these leaders will be knowledgeable. *Id.* Task forces are then created within each department to coordinate workplace education and to solve problems. *Id.* Every department must accomplish three objectives: "educate its employees; review and revise all policies and procedures in light of AIDS and medical and legal information; and adapt daily department interactions with the community to further public education about AIDS." *Id.* The employees have learned that it does not matter who has HIV and who does not, because if their job entails possible exposure to HIV, their lawful and medically safe action should be the same in either case: use gloves. *Id.* "[G]loves are a reasonable response to just that tiny theoretical possibility some have urged as justification for more tyrannical measures against people with HIV. Everyone learns that protection of an individual's rights and the public's health adds up to the same thing—reason and fairness." *Id.*

222. Through education about HIV, the judiciary will more ably distinguish legitimate claims from tenuous claims of potential HIV exposure, and will play a major role in preventing HIV-fear cases from perpetuating AIDS hysteria. Goldberg, *supra* note 30, at 88. See *Johnson v. West Virginia Univ. Hosps.*, 413 S.E.2d 889 (W. Va. 1991) in which the court allowed the plaintiff to recover after an inmate with AIDS bit the plaintiff on the arm. Goldberg states that almost every medical authority asserts that AIDS is not transmitted by biting, yet the court allowed recovery. Goldberg, *supra* note 30, at 88. The distinction for the *Johnson* court was the fact that the inmate bit himself first, and had his own blood in his mouth when he bit the plaintiff, and therefore, the court reasoned that there was blood-to-blood exposure. Even with the inmate's own blood in his mouth, almost every medical authority would still assert that the AIDS virus cannot be transmitted in this manner. *Id.*

223. See *supra* note 207 and accompanying text.

224. See *supra* note 9.

225. See *supra* note 9.

IV. A PROPOSED SOLUTION—THE DISTINCT EVENT APPROACH

Currently, the issue of toxic torts is the primary health fear for Americans.²²⁶ Regardless of whether it is classified as a toxic tort, HIV is also terrifying, and those who legitimately fear that they have been exposed to HIV deserve compensation for their emotional distress. As the scientific community's knowledge of the human mind has continued to grow, the judiciary has increasingly recognized claims for mental injuries.²²⁷ However, many courts continue to establish limits on claims for emotional injuries in an effort to prevent a flood of fraudulent claims.²²⁸

These outdated limitations on emotional distress claims are no longer justified in the face of scientific advancements concerning the legitimacy of mental injuries.²²⁹ Also, the physical impact and physical manifestation rules propose that only those claims alleging tangible physical injuries are worthy of compensation.²³⁰ Similar to the physical impact and physical manifestation rules, the majority of courts' standard of proof of the actual channel of exposure is unfair and places an impossible burden on plaintiffs.²³¹ While courts believe that these rules are the solution to preventing a flood of HIV-fear cases, the courts' limitations actually do not prevent frivolous claims.²³² Instead, the limitations create more inconsistent case law because the courts define the rules differently.²³³

The solution to the current lack of uniformity in HIV-fear cases is this Note's proposed judicial approach which is a modification of the distinct event approach developed in *Marriott v. Sedco Forex Int'l Resources*.²³⁴ The modified distinct event approach consists of a five prong analysis that the courts should consider:

226. See *supra* note 106 and accompanying text.

227. See *supra* notes 92-104 and accompanying text (discussing pure psychic claims for emotional distress).

228. See *supra* notes 64-91, 95-97 and accompanying text.

229. See *supra* notes 92-104 and accompanying text.

230. Levit, *supra* note 63, at 136 (arguing that emotional injuries deserve compensation because emotional distress claims protect individuals' privacy and emotional well-being interests). See also *supra* notes 92-104 and accompanying text.

231. See *supra* notes 131-74 and accompanying text.

232. See *supra* notes 136-48.

233. See *supra* notes 86-88, 151-74 and accompanying text. *But see* Maroulis, *supra* note 135, at 263. Maroulis argues that uniformity among the courts is not necessary because each jurisdiction is free to decide whether it will apply the physical impact or the physical manifestation rule. *Id.* By maintaining inconsistencies among the jurisdictions, the courts perpetuate divergent standards of recovery and in many cases, deny recovery to plaintiffs who legitimately fear that they have been exposed to HIV. See *supra* note 120 and accompanying text.

234. See *supra* notes 151-63 and accompanying text.

- 1) whether the plaintiff is legitimately suffering from a fear of exposure to HIV;
- 2) if so, whether the plaintiff can trace his or her fear to a distinct event of potential exposure;
- 3) if so, the burden shifts to the defendant who must prove that exposure to HIV could not have occurred during that distinct event;
- 4) if the defendant is unable to prove that HIV exposure could not have occurred, the court must then examine whether the plaintiff negligently contributed to or assumed the risk of HIV exposure and whether;
- 5) the plaintiff's period of recovery is based upon the time period in which the plaintiff did not know with medical certainty his or her HIV status.

The modified distinct event approach is illustrated using the following fact pattern.²³⁵

While emptying waste baskets at an insurance company, a contaminated needle stuck a cleaning woman.²³⁶ The company administered HIV tests and failed to properly dispose of used hypodermic needles and syringes in a manner provided by state law, regulations, and local ordinances.²³⁷ The cleaning woman developed a fear that she had been exposed to HIV and consequently sued the company.²³⁸ Under this Note's modified distinct event approach, the court must first consider whether the cleaning woman legitimately suffers from emotional distress based upon a fear of exposure to HIV. In determining whether the plaintiff's emotional distress is legitimate, the court should not apply either the physical impact or physical manifestation rule. Uniformity is greatly needed in HIV-fear cases, and both rules perpetuate inconsistent case law due to different definitions of what constitutes a physical impact or manifestation.²³⁹ Instead, the court should investigate whether the cleaning woman's emotional distress is legitimate by examining whether a reasonable person in the cleaning woman's situation would also suffer emotional distress.²⁴⁰ The court should also determine the legitimacy of the cleaning woman's emotional distress by employing the various tests developed by psychiatrists to evaluate the validity of an individual's emotional distress.²⁴¹

235. The fact pattern is based upon the facts of *Castro v. New York Life Ins. Co.*, 588 N.Y.S.2d 695 (N.Y. Sup. Ct. 1991). See *supra* note 208.

236. *Castro*, 588 N.Y.S.2d at 695.

237. *Id.* at 695-96.

238. *Id.* at 696.

239. See *supra* notes 86-91 and accompanying text (illustrating the inconsistent case law perpetuated by the physical impact and physical manifestation rules).

240. See *supra* notes 95-101 and accompanying text (discussing the various methods employed by psychiatrists to determine the legitimacy of the plaintiff's emotional distress claim).

241. *Id.*

If the court determines that the cleaning woman's emotional distress is legitimate, the court should then address the question of the channel of exposure. As with the physical injury rules, the court should abandon the actual channel requirement in favor of another standard that is more uniform. Abandoning the proof requirement of actual exposure is justified because the requirement imposes an impossible burden on many plaintiffs.²⁴² Instead, the court should require the cleaning woman to tie her fear to a distinct event that potentially exposed her to HIV. Applying the distinct event approach, the cleaning woman would trace her fear to the distinct event of the contaminated needle that stuck her. Because the company was conducting blood tests and because contaminated needles actually have the proven potential to transmit HIV,²⁴³ the cleaning woman would fulfill her burden of proof that she was potentially exposed to HIV. The burden then shifts to the company to prove that exposure to HIV did not occur. The burden of persuasion in HIV-fear cases should be shared by both plaintiffs and defendants because in most situations the defendant will have greater knowledge as to whether exposure occurred.²⁴⁴

This burden shifting employs the logic of the doctrine of *res ipsa loquitur*²⁴⁵ in which the chief evidence of the case is practically accessible to the person charged with negligence, but is inaccessible to the injured

242. See *supra* note 174 and accompanying text.

243. See *supra* note 6 (discussing the various modes of HIV transmission).

244. For example, in a surgery situation where the plaintiff was unconscious, the plaintiff will have a difficult time proving whether exposure to HIV actually occurred. See, e.g., *Barrett v. Danbury Hosp.*, 1994 WL 76394 (Conn. Super. Ct. Mar. 3, 1994) (providing an example where the defendants possessed greater knowledge as to whether potential HIV exposure occurred). In *Barrett*, the plaintiff went to the defendant hospital's emergency room due to abdominal pain. *Id.* at *1. A doctor instructed the plaintiff to sit upon a gurney during the examination. *Id.* During the examination, the doctor suddenly realized that the plaintiff was sitting in blood and in an attempt to locate the blood's source, the doctor performed a rectal examination. *Id.* The doctor performed a second rectal examination and the plaintiff alleged that blood was introduced into the plaintiff's rectum during both examinations. *Id.* The doctor failed to locate the source of the blood, but the plaintiff examined the gurney and alleged that as he pressed upon it, blood seeped out. *Id.* At trial, the hospital submitted an affidavit of the hospital's Risk Manager who stated that after inspecting all of the emergency room records for treatment during the night that the plaintiff was in the emergency room, none of the cases revealed a medical history of AIDS, HIV-infection, or AIDS-related syndrome. *Id.* at *8. Thus, the defendant hospital had the capability to determine whether the plaintiff had been placed at risk for potential exposure to HIV during the time he spent in the emergency room and could present evidence that there was no risk. *Id.*

245. For *Res Ipsa Loquitur* to apply, the plaintiff must establish the following: 1) the incident was one which ordinarily does not happen unless someone was negligent; 2) the instrument which injured the plaintiff was under the exclusive control of the defendant; and 3) no indication exists in the circumstances that the injury was the result of the plaintiff's own voluntary act of negligence. *Ybarra v. Spangard*, 154 P.2d 687, 689 (Cal. 1944). If the plaintiff is able to establish the foregoing elements, then the burden shifts to the defendant to meet the inference of negligence and give an explanation of the defendant's conduct. *Id.* at 687, 689.

person.²⁴⁶ *Res Ipsa Loquitur* has always been applied to cases involving physical injuries.²⁴⁷ However, the rationale behind the doctrine is applicable in HIV-fear cases, because in most cases the defendant will have greater access to information of whether exposure to HIV potentially occurred.²⁴⁸ If the defendant is unable to prove that HIV exposure did not occur, then the plaintiff recovers. In situations where multiple individuals were present at the time of potential exposure,²⁴⁹ if it is unclear whether exposure to HIV occurred, all of the individuals will be held liable as in typical *Res Ipsa Loquitur* cases.²⁵⁰ This burden shifting standard encourages those who were not responsible for the potential exposure to reveal what happened in order to avoid liability.

Given that it was the insurance company who took the blood samples from the prospective life insurance applicants, the company will know whether the

246. *Id.* at 687-89.

247. *Id.*

248. For example, perhaps the surgeon was cut and the blood did or could have come in contact with the plaintiff's blood. *See, e.g.,* *Marriott v. Sedco Forex Int'l Resources*, 827 F. Supp. 59, 63 (D. Mass. 1993) (addressing the situation where the defendants possessed knowledge that the vaccine used on the plaintiffs subsequently tested positive for HIV); *Howard v. Alexandria Hosp.*, 429 S.E.2d 22, 24 (Va. 1993) (addressing the situation where the hospital possessed better knowledge of whether the instruments used during the plaintiff's surgery were unsterile).

249. For example, in a surgery situation the medical personnel are in a more advantageous position to know what occurred during the surgery, given that the plaintiff was unconscious. The medical personnel will be able to testify as to whether anything unusual happened during the surgery and whether there was potentially any blood-to-blood exposure. Given the fact that many defendants may not be very candid as to what occurred in the surgery, the other medical personnel who were present in the surgery will also be called to testify as to what happened. If the court finds that the other medical personnel are not candid either, then the court will hold all who were present during the surgery liable for the plaintiff's fear of exposure. *See infra* note 250 (discussing *Res Ipsa Loquitur* where everyone who was present was held liable for the plaintiff's injuries).

250. In medical *Res Ipsa Loquitur* cases, the courts hold all of the medical personnel liable if a clear picture of what transpired is not presented by the defendant(s). *See, e.g.,* *Ybarra v. Spangard*, 154 P.2d 687, 690 (Cal. 1944) (holding that where a plaintiff receives unusual injuries while unconscious during medical treatment, every defendant who had any control over the plaintiff's body or instrumentalities may be called upon under *Res Ipsa Loquitur* to rebut an inference of negligence by explaining their conduct); *Graham v. Thompson*, 854 S.W.2d 797, 799 (Mo. Ct. App. 1993) (stating that in medical malpractice cases, *Res Ipsa Loquitur* relieves the plaintiff of the burden of proving specific negligence and creates a rebuttable inference of general negligence); *Fiumefreddo v. McLean*, 496 N.W.2d 226, 230-32 (Wis. Ct. App. 1993) (holding that *Res Ipsa Loquitur* applied against two physicians in a medical malpractice action when it was not known which physician was guilty of the negligent act because the physicians were in a better position than the patient to know the cause of the negligence).

See also *Whetstone v. Moravec*, 291 N.W. 425, 435-36 (Iowa 1940); *Lair v. Lancourt*, 734 S.W.2d 247, 249-50 (Mo. Ct. App. 1987); *Creemeens v. Kree Inst. of Electrolysis*, 689 S.W.2d 839, 842 (Mo. Ct. App. 1985); *Ross v. Double Shoals Cotton Mills*, 52 S.E. 121, 123 (N.C. 1905) (holding that under *Res Ipsa Loquitur* if it is unclear as to which defendant caused the plaintiff's injury, all defendants will be held liable).

needle was possibly tainted with HIV-infected blood.²⁵¹ Under this Note's modified distinct event approach, the company must prove that the needle was not used on an HIV-positive individual, and if the company cannot do so, the cleaning woman will recover.

After deciding whether the plaintiff's fear has been traced to a distinct event and whether the defendant can explain whether exposure occurred, the next step in the court's analysis is to determine whether the defendant has an affirmative defense that will reduce or bar the plaintiff's recovery. The defendant's argument will depend upon whether contributory negligence, comparative negligence, assumption of the risk, or a combination of these are accepted in the jurisdiction.

Applying this step to the cleaning woman's fact pattern, the company would have to convince the court that the cleaning woman contributed to her injuries. Given that the cleaning woman was routinely emptying the trash, it cannot be held that she contributed to her injury from the needle stick.²⁵² Because the cleaning woman was not negligent, she will recover for her fear of HIV exposure from the contaminated needle puncture unless the company can prove that the needle was not used on an HIV-positive individual. Given that the company conducts the HIV tests, it has greater access to information about whether the needle was used on an HIV-positive individual, and therefore, it is appropriate to place the burden of proof upon the company. Because the cleaning woman's fear of exposure is legitimate and can be traced to a distinct event that potentially exposed her to HIV, the burden shifts from her to the company to prove that exposure did not occur. If the company is unable to do so, the cleaning woman will recover.

The last step in the court's analysis is to determine the period of allowable recovery. The courts should allow recovery for the period during which plaintiffs do not know whether they are infected with HIV. The plaintiffs' suits are based upon a fear of exposure, and recovery after it is medically certain that they are not HIV-positive would compensate plaintiffs beyond the period in which their fear of exposure is reasonable. Consequently, the courts should allow recovery until the point that plaintiffs know with medical certainty whether they are infected with HIV. While HIV-positive plaintiffs will have an additional cause of action for actual transmission of HIV, plaintiffs who are

251. In the actual case, *Castro v. New York Life Ins. Co.*, 588 N.Y.S.2d 695 (N.Y. Sup. Ct. 1991), the court never shifted the burden of proof to the defendant to prove that the needle was not used on an HIV-infected individual. *Id.* at 697. Instead, the court held that the cleaning woman could recover for her fear of HIV exposure because all contaminated needles are potentially infected with HIV. *Id.* at 697-98.

252. *Id.* at 695.

HIV-negative will only be able to recover for the time period in which they did not know their HIV status. Therefore, in applying this step to the cleaning woman's fact pattern, she will be able to recover for the period in which she did not know whether she was infected with HIV.

This Note's modified distinct event approach embraces modern advancements in medical science as to the legitimacy of mental injury claims, and although it requires the abandonment of the channel of exposure, it establishes other legitimate means of monitoring fraudulent claims. More importantly, this Note's modified distinct event approach establishes uniformity, which is greatly needed to end the current diverse approaches in HIV-fear cases.

V. CONCLUSION

Currently, a lack of uniformity exists on every issue related to HIV, except the fact that it is a deadly virus which crosses economic, racial, and gender boundaries. Uniformity is needed to end the uncertainty and foster an approach to prevent further spread of HIV. Through uniformity in HIV-fear cases, courts will inform society that they will not tolerate negligent behavior that potentially exposes another to HIV. Uniformity in HIV-fear cases will be achieved through this Note's modified distinct event approach which eliminates the arbitrary physical impact, physical manifestation, and actual channel of exposure standards that have perpetuated inconsistent case law.²⁵³

Eliminating these standards will not open the courts to a flood of claims based upon unreasonable fears of contracting HIV because the modified distinct event approach imposes an alternative burden of proof on plaintiffs. In addition, the modified distinct event approach allows defendants to prove that HIV exposure could not have occurred, thus adding another test to determine whether the plaintiff's fear is reasonable. Imposing unnecessary restrictions upon plaintiffs in HIV-fear claims is not the best way to prevent fraudulent claims. Education is the best cure for unreasonable fears of contracting HIV.²⁵⁴ Through education about HIV, the courts will be better able to recognize legitimate claims, and by refusing to entertain claims where exposure to HIV could not have occurred, the courts will in turn educate society about HIV.

Amy L. Hansen

253. See *supra* Section IV, notes 226-52 and accompanying text.

254. See *supra* note 221.