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2001]

MORE THAN JUST BAD BLOOD:
REASONABLY ASSESSING FEAR OF AIDS CLAIMS

I. INTRODUCTION

Acquired Immunodeficiency Syndrome (AIDS) is a devastating terminal disease that has most likely impacted our culture and legal system more than any other disease over the last two decades.¹ AIDS, which is caused by the human immunodeficiency virus (HIV),² is responsible for

1. See, e.g., SUSAN PALMER, AIDS AS AN APOCALYPTIC METAPHOR IN NORTH AMERICA 11-12 (1997) (stating that fundamentalist groups viewed HIV/AIDS as "divine punishment" for immoral lifestyle); DARRELL E. WARD, THE AMFAR AIDS HANDBOOK 18 (1999) (noting that Americans with Disabilities Act protects people that are HIV-positive or have AIDS); Mark G. Winiarski, *Understanding HIV/AIDS Using the Biopsychosocial/Spiritual Model*, in HIV MENTAL HEALTH FOR THE 21ST CENTURY 4 (Mark G. Winiarski ed., 1997) (stating that AIDS is taboo topic for many and that victims are subjected to condemnation); Karen L. Chadwick, *Fear of AIDS: The Catalyst for Expanding Judicial Recognition of a Duty to Prevent Emotional Distress Beyond Traditional Bounds*, 25 N.M. L. REV. 143, 143 (1995) (stating that public's awareness of effects of HIV/AIDS has led to generalized fear of its contraction); Matthew Warren Grill, Comment, *Recovery for Emotional Distress Due to Fear of AIDS: Exposing AIDSphobia in Alabama*, 49 ALA. L. REV. 1009, 1011 (1998) (stating that HIV/AIDS has "reached epidemic proportions").

2. See Center for Disease Control and Prevention, *Frequently Asked Questions, What is AIDS? What Causes Aids?*, available at <http://www.cdc.gov/hiv/pubs/faq/faq2.htm> (last visited Sept. 22, 2000) (stating that HIV weakens immune system to condition known as AIDS). HIV was first detected in serum samples collected in Central Africa in 1959. See GERALD J. STINE, AIDS UPDATE 1999, at 198 (David Kendrick Brake ed., Prentice Hall, Inc. 1998) (stating where and when HIV was first discovered). During the 1960s and 1970s, the virus spread most widely in Central Africa and Haiti. See *id.* at 190 (describing spread of AIDS). It is speculated that tourists returning from Haiti accounted for the transmission of the virus to the United States. See *id.* (noting belief that tourists carried virus to America). The first AIDS cases reported by the Center for Disease Control were in New York, Los Angeles and San Francisco in 1981, which is the year widely considered to be the date that AIDS was discovered. See *id.* (recounting disease's arrival to America); see also KENNETH J. DOKA, AIDS, FEAR, AND SOCIETY: CHALLENGING THE DREADED DISEASE 62 (1997) (noting that first case of AIDS was reported by Center for Disease Control on June 5, 1981). Nevertheless, conflicting information suggests that AIDS was present in the United States much earlier. See STINE, *supra*, at 198 ("According to the CDC's first clinical AIDS definition, at least one case of AIDS occurred in New York City in 1952 and another in 1959."). A person is diagnosed with AIDS if their immune system reaches such a weakened condition that they succumb to one or multiple viral caused infections, also known as "opportunistic infections," or their T4 cell count drops below a certain level. See *id.* at xvii (describing AIDS as "an umbrella term for any or all of 26 known diseases and their symptoms An AIDS diagnosis is also given to HIV-positive people with a T4 cell count of less than 200/ μ L of blood."); see also *Faya v. Almaraz*, 620 A.2d 327, 329 (Md. 1993) (listing prevalent opportunistic infections); DOKA, *supra*, at 68 (stating that T4 cells "orchestrate attacks on invading microorganisms"); STEDMAN'S MEDICAL DICTIONARY 1255 (26th ed. 1995) (defining an "opportunistic" infection as an "organism capable of causing disease only in host whose resistance

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approximately 46,000 new victims per year in the United States alone.³ Current estimates show that 403,544 people are now living with the disease in the United States.⁴ Nonetheless, America represents only a small percentage of the tragedy.⁵ Moreover, the ultimate future of the disease remains unclear.⁶

On a social level, however, AIDS has brought out the best and worst in human nature.⁷ It has forced Americans to face new political issues, sometimes with surprising bravery and courage.⁸ Conversely, fear and mis-

is lowered, e.g., by other diseases or drugs"); Mandana Shahvari, Comment, *AfrAIDS: Fear of AIDS as a Cause of Action*, 67 TEMP. L. REV. 769, 774 (1994) (explaining how HIV infects immune system); Larry Thompson, *Like No Other Human Disease: The AIDS Virus Attacks the Body's Defenses*, WASH. POST, Sept. 4, 1985, at Health 12 (detailing HIV's destruction of immune system).

3. See Center for Disease Control and Prevention, *Basic Statistics*, available at <http://www.cdc.gov/hiv/stats/cumulati.htm> (last visited Oct. 2, 2000) (stating annual infection rate of HIV/AIDS in United States). All told, 430,441 people have died of AIDS. See *id.* (stating statistics). "[L]atest statistics . . . suggest an eventual leveling off of the death rate at many thousands per year unless there is further progress against the disease." Marlene Cimon, *New Data Suggest Limits to AIDS Drugs*, L.A. TIMES, Aug. 31, 1999, at A1. Although AIDS deaths dropped forty-two percent in 1997 due to powerful drug cocktails, it is just taking longer for people to succumb to the ravages of AIDS. See *id.* at A1, A12 (noting effect of drugs on AIDS statistics).

4. See Center for Disease Control and Prevention, *HIV Surveillance Report*, Tbl. 1, available at <http://www.cdc.gov/hiv/stats/hasr1102/table1.htm> (last visited Oct. 2, 2000) (stating number of people with HIV or AIDS in United States). The Center for Disease Control estimates that this number may be as high as 900,000. See Cimon, *supra* note 3, at A1 (stating that Center for Disease Control estimates that 900,000 people are living with HIV or AIDS). This represents approximately one-third of one percent of America's population. See United States Census Bureau, *Population Clocks*, available at <http://www.census.gov> (last visited Sept. 30, 2000) (stating that population of United States stands at 275,843,150).

5. See HIVinsite, *Global Summary of HIV/AIDS Epidemic, December 1999*, available at <http://hivinsite.ucsf.edu/social/un/2098.44d3.html#1> (last visited Oct. 9, 2000) (summarizing global statistics as of December 1999). In 1999, 5.6 million people were newly infected with HIV. See *id.* (stating statistic as of December 1999). Presently, 33.6 million people in the world are living with HIV/AIDS. See *id.* (same). There were also 2.6 million AIDS deaths. See *id.* (same).

6. See STINE, *supra* note 2, *preface* at xviii-xix (describing worst-case scenario as exponential amount of infections unless cheap, preventive and effective vaccine is created); Shahvari, *supra* note 2, at 769 ("[T]he medical and scientific community can offer the public few absolute guarantees relating to the disease.").

7. See, e.g., DOKA, *supra* note 2, at 80 ("The victim [of AIDS] is identified with socially defined deviant groups such as homosexuals or drug addicts. Hence the disease carries a strong moral connotation in which victims are blamed for their fate."); PALMER, *supra* note 1, at 20-43 (examining negative and positive responses to AIDS by Christian establishments); WARD, *supra* note 1, at 18 (noting that prevalence of AIDS has spawned multiple legal defense services).

8. See, e.g., DOKA, *supra* note 2, at 106 (debating whether needle exchange programs effectively combat spread of HIV or if they indirectly condone drug use). Commentators also debate whether prostitution should be legalized or pornography should be more restricted, as measures to combat the spread of the disease. See *id.* at 107 (summarizing debates). Another peripheral debate has been about whether to allow same-sex marriages. Compare *Baker v. State*, 744 A.2d 864, 867

perception about AIDS has invaded society since the disease's inception.⁹ Ignorantly termed the "gay plague" in the early 1980s, AIDS continues to unleash hatred and fear even today.¹⁰

As a result of the foregoing factors, AIDS-based claims have spilled into our courtrooms in various forms.¹¹ One such example is the topic of this Note, namely the "fear of AIDS" claim based on negligent infliction of emotional distress.¹² In a fear of AIDS claim, the plaintiff was potentially or actually exposed to a person or object capable of carrying the disease

(Vt. 1999) ("[T]he State is constitutionally required to extend to same-sex couples the common benefits and protections that flow from marriage under Vermont law."), *with Posik v. Layton*, 695 So. 2d 759, 761 (Fla. Dist. Ct. App. 1997) (noting that Florida prohibits same-sex marriage). "[O]thers vehemently oppose anything that would legitimize gay relationships as conducive to the spread of HIV." *DOKA*, *supra* note 2, at 107. The legitimacy of same-sex marriage must overcome great obstacles to be recognized. See John G. Culhane, *Uprooting the Arguments Against Same-Sex Marriage*, 20 CARDOZO L. REV. 1119, 1124 (1999) ("[A]rguments advanced against same-sex marriage . . . stem from . . . deeply held beliefs about what is thought to be the necessary relationship between biological sexual identity and gender and its appropriate expression.").

9. See Mary McGrory, *The Spread of Fear*, WASH. POST, Sept. 17, 1985, at A2 (stating that parents of public school children in Queens protested admission of HIV infected child by having their children stay at home). Probably the most infamous infected child, Ryan White, was banned from the schools in his hometown of Kokomo, Indiana. See *id.* (noting that focus of article is whether AIDS victims have right to "mingle with their peers"). Others have noted that AIDS was at one time "dismissed . . . as a disease limited to homosexuals, hemophiliacs, Haitians and drug abusers." *AIDS Doctors Hope for the Best, Prepare for Worst*, SAN DIEGO UNION-TRIBUNE, Apr. 14, 1985, at AA-7; see also Ann Japenga, *Gay Women and the Risk of AIDS; Lesbians Oppose Misperception That They're All Diseased*, L.A. TIMES, Apr. 2, 1986, at View, pt. 5, p.1 (noting that lesbians suffered assumption that they were all AIDS carriers).

10. See McGrory, *supra* note 9, at A2 (noting that religious leader Reverend Jerry Falwell termed AIDS as "gay plague" and others believed it to be "behaviorally induced"). Some of the responses to HIV-positive individuals have been severe. See Associated Press, *Fear Increases As AIDS Epidemic Spreads Around the World*, SAN DIEGO UNION-TRIBUNE, Nov. 28, 1985, at AAA-18 (noting that British tattoo artists turned away gay customers); Lynn Simross, *13 Random Victims of an Indiscriminate Killer—AIDS; Some of the Stories Behind the Death Toll Include a Businessman, Wife and Mother, Former Priest, Child and Ballet Dancer*, L.A. TIMES, May 24, 1987, at View 1 (detailing experience of family of father who died of AIDS, which included threats left in mailbox and poisoning of dog).

11. See, e.g., *Bragdon v. Abbott*, 524 U.S. 624, 630-47 (1998) (addressing whether AIDS is disability under Americans with Disabilities Act of 1990); *Sierakowski v. Ryan*, 223 F.3d 440, 445 (7th Cir. 2000) (denying injunctive relief to plaintiff who claimed Illinois AIDS Confidentiality Act was unconstitutional because Act allowed doctors to test patients without their knowledge); *Herring v. Keenan*, 218 F.3d 1171, 1175 (10th Cir. 2000) (addressing whether plaintiff's right to privacy was breached when probation officer told plaintiff's sister and employer that he was HIV-positive); *Williamson v. Waldman*, 696 A.2d 14, 22 (N.J. 1997) (suing for fear of AIDS); *Heiner v. Moretuzzo*, 652 N.E.2d 664, 670 (Ohio 1995) (denying right to sue for emotional distress based on negligent misdiagnosis of AIDS).

12. For a further discussion of fear of AIDS claims, see *infra* notes 76-162 and accompanying text.

and, as a result, sues for his or her present emotional distress for fear of contracting HIV.¹³ The claim is unique in that it explores the edge of tort liability while simultaneously forcing judges and juries to cope with the policy issues that surround the disease.¹⁴ At the heart of this debate is whether a plaintiff must demonstrate actual exposure to HIV/AIDS or, more simply, that his or her fear of contracting AIDS is reasonable considering the circumstances.¹⁵

This Note argues that an enhanced reasonableness standard, adopted in *Williamson v. Waldman*,¹⁶ should govern fear of AIDS claims.¹⁷ The enhanced reasonableness standard is consistent with the liberalization of negligent infliction of emotional distress and adequately addresses the public policy concerns that affect tort recovery.¹⁸ Part II of this Note discusses the development of negligent infliction of emotional distress and its acceptance as a legal concept through bystander and fear of cancer claims.¹⁹ Part III explains the factors that influence fear of AIDS claims and presents the actual exposure requirement and enhanced reasonableness standard, both of which are used to evaluate the foreseeability of emotional distress.²⁰ Part IV contends that an enhanced reasonableness standard in fear of AIDS claims is consistent with the liberalization of neg-

13. See, e.g., *Marriott v. Sedco Forex Int'l Res., Ltd.*, 827 F. Supp. 59, 72 (D. Mass. 1993) (claiming emotional distress damages after receiving HIV-positive vaccine inoculation); *Coca-Cola Bottling Co. v. Hagan*, 750 So. 2d 83, 84-85 (Fla. Dist. Ct. App. 1999) (bringing claim for fear of AIDS after ingesting bottle of Coca-Cola which apparently contained used condom). But see *Chizmar v. Mackie*, 896 P.2d 196, 205 (Alaska 1995) (holding that plaintiff stated valid negligent infliction of emotional distress claim based on negligent false HIV-positive diagnosis); *Heiner*, 652 N.E.2d at 670 (holding that plaintiff did not state valid negligent infliction of emotional distress claim based on false HIV-positive diagnosis). In *Heiner*, the Ohio Supreme Court held that a negligent infliction of emotional distress claim is compensable when the plaintiff witnesses, experiences or appreciates real physical peril. See *Heiner*, 652 N.E.2d at 669-70 (stating that to recover under negligent infliction of emotional distress, plaintiff must witness, experience or appreciate real physical peril). Because the plaintiff was misdiagnosed as HIV-positive she feared a nonexistent physical peril and could not recover. See *id.* at 670 (stating that plaintiff's misdiagnosis represented nonexistent physical peril).

14. See, e.g., *Majca v. Beekil*, 701 N.E.2d 1084, 1090 (Ill. 1998) (reviewing policy arguments in favor of actual exposure requirement).

15. For a further discussion of negative and positive attributes of each standard of recovery, see *infra* notes 163-219 and accompanying text.

16. 696 A.2d 14 (N.J. 1997).

17. For a further discussion of the strengths of the enhanced reasonableness standard, see *infra* notes 163-219 and accompanying text.

18. For a further discussion of the evolution of negligent infliction of emotional distress and the reasonableness standard, see *infra* notes 23-75 and accompanying text.

19. For a further discussion of the evolution of negligent infliction of emotional distress and the reasonableness standard, see *infra* notes 23-75 and accompanying text.

20. For a further discussion of the factors that influence fear of AIDS decisions, see *infra* notes 76-98 and accompanying text.

ligent infliction of emotional distress.²¹ Additionally, Part IV asserts that an enhanced reasonableness standard more readily addresses legitimate fear of AIDS claims, promotes reasonable care and combats ignorance about the disease.²²

II. EVOLUTION OF NEGLIGENT INFLECTION OF EMOTIONAL DISTRESS

Fear of AIDS claims ordinarily are brought under the theory of negligent infliction of emotional distress because the theory permits recovery for purely emotional damages based on a negligent level of culpability.²³ Nonetheless, courts have long evaluated purely emotional damages with suspicion.²⁴ Only recently have the courts become more liberalized in recognizing purely emotional distress damages.²⁵ It is important to understand the rationales for this evolution in order to evaluate when compensation for fear of AIDS claims is appropriate.

Throughout the twentieth century, concerns that emotional distress claims were ingenuine and frivolous have influenced judicial opinions.²⁶

21. For a further discussion of negative and positive attributes of each standard of recovery, see *infra* notes 163-219 and accompanying text.

22. For a further discussion of negative and positive attributes of each standard of recovery, see *infra* notes 163-219 and accompanying text.

23. See, e.g., *Consol. Rail Corp. v. Gottshall*, 512 U.S. 532, 544 (1994) (stating that negligent infliction of emotional distress claim based on zone of danger rule is for "mental or emotional injury, apart from the tort law concepts of pain and suffering"); *Marchica v. Long Island R.R.*, 810 F. Supp. 445, 453 (E.D.N.Y. 1993) (permitting recovery for purely emotional distress damages in fear of AIDS claim when plaintiff pricked his finger on discarded hypodermic needle). Commentators have described the existence of emotional distress damages as a severe invasion of an individual's rights. See DAN B. DOBBS, *THE LAW OF TORTS* § 302, at 821 (2000) (stating that emotional harm "represent[s] the antithesis of happiness or enjoyment of life which everyone pursues").

24. See Terry Morehead Dworkin, *Fear of Disease and Delayed Manifestation Injuries: A Solution or a Pandora's Box?*, 53 *FORDHAM L. REV.* 527, 529-30 (1984) (explaining that emotional damages were viewed with suspicion and were subject to judicial checks); Leslie B. Sandor & Carol Berry, *Recovery for Negligent Infliction of Emotional Distress Attendant to Economic Loss: A Reassessment*, 37 *ARIZ. L. REV.* 1247, 1251-53 (1995) (recounting judicial system's reluctance to permit recovery for emotional distress); Grill, *supra* note 1, at 1014 (stating that suspicion of emotional distress claims was based on their trivial nature).

25. See generally *Molien v. Kaiser Found. Hosps.*, 616 P.2d 813, 821 (Cal. 1980) (permitting recovery for emotional distress based on defendant physician's negligently misdiagnosing plaintiff's wife with sexually transmitted disease); *Rodrigues v. State*, 472 P.2d 509, 520 (Haw. 1970) (permitting recovery of emotional distress based on extensive flood damage to home); *Bass v. Nooney Co.*, 646 S.W.2d 765, 772-73 (Mo. 1983) (en banc) (allowing purely emotional distress damages for plaintiff stuck in elevator).

26. See *Dillon v. Legg*, 441 P.2d 912, 917 (Cal. 1968) (noting that fear of fraudulent and indefinable claims are "twin fears" of courts declining to impose duty to refrain from negligently inflicting emotional distress); *Knierim v. Izzo*, 174 N.E.2d 157, 164 (Ill. 1961) ("Indiscriminate allowance of actions for mental anguish would encourage neurotic overreactions to trivial hurts, and the law should aim to toughen the psyche of the citizen rather than pamper it."); *Gardner v. Cumberland Tel. Co.*, 268 S.W. 1108, 1110 (Ky. 1925) (stating that it is easy to

As a result, courts created pre-requisites to recovery, beginning with a physical impact requirement.²⁷ Under the physical impact requirement, a defendant was responsible only for “parasitic” emotional damages that flowed naturally from a physical impact.²⁸ These parasitic emotional damages ensured the genuineness of the plaintiff’s claim.²⁹

Many courts revised the physical impact requirement in light of the harsh results that it produced.³⁰ Some jurisdictions allowed recovery

feign emotional distress, yet difficult to disprove); *Carey v. Lovett*, 622 A.2d 1279, 1286 (N.J. 1993) (stating that limitations on foreseeability requirement were enacted because of concerns with genuineness of claims); *cf. Bosch v. St. Louis Healthcare Network*, No. 76044, 2000 Mo. App. LEXIS 500, at *13 (Mo. Ct. App. Apr. 11, 2000) (stating that difficulty proving causal connection between claimed emotional damages and act by defendant is additional reason for physical impact requirement); Chadwick, *supra* note 1, at 143 (stating that courts disfavor recovery for emotional distress because emotional distress alone is trivial and difficult to prove); Nancy Levit, *Ethereal Torts*, 61 GEO. WASH. L. REV. 136, 145-46 (1992) (“Although courts gradually have expanded those emotional injuries for which compensation will be afforded, the law of . . . negligent infliction of emotional distress remains a patchwork. Compensable injuries still are, in large part, tied to either physical impacts, physical manifestations of injury, or other proxies for emotional distress.”); Michael Phillips, Note, *Drawing the Line: Missouri Adopts the Zone of Danger Rule for Bystander Emotional Distress*, 56 MO. L. REV. 1183, 1188 (1991) (stating four rationales for physical impact requirement).

27. Compare RESTATEMENT (SECOND) OF TORTS § 436A (1965) (holding that claims for emotional distress without physical injury should be disallowed), with DOBBS, *supra* note 23, § 308, at 837 (“[O]nce a personal injury is inflicted, emotional harm would not be stand-alone harm but would instead represent an element of the damages for the physical injury.”), and W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 54, at 362-63 (5th ed. 1984) (stating that courts recognize emotional distress when accompanied by physical injury).

28. See *R.J. v. Humana of Fla., Inc.*, 652 So. 2d 360, 364-65 (Fla. 1995) (Kogan, J., concurring) (stating that if there is contemporaneous physical impact, defendant is responsible for injury and resulting emotional distress).

29. See *Chizmar v. Mackie*, 896 P.2d 196, 201 (Alaska 1995) (“The basic assumption underlying the traditional rule is that emotional distress without physical injury is . . . easily feigned.”). Nevertheless, in *Chizmar*, the traditional rule was rejected in favor of a foreseeability test in the context of a negligent infliction of emotional distress claim based on a false HIV-positive diagnosis of the plaintiff. See *id.* at 202-03 (stating that severe emotional distress is foreseeable result of misdiagnosis of AIDS). The court also relied on the fact that the misdiagnosis arose out of the doctor-patient relationship, which carries a pre-existing duty. See *id.* at 203-04 (finding that doctor-patient relationship carries duty in tort); see also *Humana*, 652 So. 2d at 363 (stating that impact rule assures validity of claims for emotional distress); KEETON ET AL., *supra* note 27, § 54, at 363 (“With a cause of action established by the physical harm, ‘parasitic’ damages are awarded, and it is considered that there is sufficient assurance that the mental injury is not feigned.”). But see *Payton v. Abbott Labs*, 437 N.E.2d 171, 193 (Mass. 1982) (Wilkins, J., dissenting) (stating that physical harm requirement does not necessarily ensure genuineness of emotional distress damages; trier of fact must resolve validity of claim).

30. See, e.g., *Deutsch v. Shein*, 597 S.W.2d 141 (Ky. 1980) (accepting x-rays of pregnant woman as physical impact); *Porter v. Delaware, Lackawanna W. R.R. Co.*, 63 A. 860 (N.J. 1906) (accepting dust in eye as physical impact); *Morton v. Stack*, 170 N.E. 869 (Ohio 1930) (accepting smoke inhalation as physical impact).

when the claim ensured its own genuineness,³¹ while others required the plaintiff to demonstrate physical manifestations of the emotional distress.³² In other jurisdictions, a slight or trivial physical impact sufficiently supported the distress.³³ For example, in a fear of AIDS claim, a needle wound to the hand of the plaintiff constituted sufficient physical impact to support a \$250,000 award of emotional distress damages.³⁴ Courts rea-

31. See, e.g., *Brown Funeral Homes & Ins. Co. v. Baughn*, 148 So. 154, 154 (Ala. 1933) (stating that jury reasonably inferred negligence to defendant for improperly embalming body of plaintiff's husband when body "gave off offensive odors"). Negligent mishandling of a corpse or negligent delivery of a telegram decreasing a relative's death typified these claims. See *Rodrigues v. State*, 472 P.2d 509, 519 (Haw. 1970) (noting that "negligent infliction of emotional distress has been treated as an independent tort . . . in negligent handling of corpses and the negligent transmission of telegrams likely to cause emotional distress"). But see *Gardner v. Cumberland Tel. Co.*, 268 S.W. 1108, 1110 (Ky. 1925) (noting that courts generally ground negligently delivered death telegrams claims in breach of contract actions).

32. See *Chadwick*, *supra* note 1, at 145-46 (stating that "where the actor's conduct created a risk of physical harm to the plaintiff that fell short of actually causing physical harm but did cause emotional injury which, in turn, manifested itself in physical injury, the plaintiff could recover for both the emotional and physical injuries"). Requiring physical manifestation of emotional distress validates the harm. See *DOBBS*, *supra* note 23, § 308, at 838 (stating that requiring manifestation of distress proves that distress is real). Furthermore, some commentators contend that harm that does not rise to the level of physical manifestations should not be compensated. See *id.* (stating that physical manifestation requirement implies that "purely mental disturbance is not worth compensating for mere negligence").

33. See *KEETON ET AL.*, *supra* note 27, § 54, at 363-64 (collecting examples of slight physical injuries, including dust in eye). Nevertheless, the physical impact rule remains in use. See *Gottshall v. Consol. Rail Corp.*, 988 F.2d 355, 361 (3d Cir. 1993) (noting that minority of jurisdictions presently use physical impact rule); *Laxton v. Orkin Exterminating Co.*, 639 S.W.2d 431, 434 (Tenn. 1982) (stating that ingestion of indefinite amount of toxically contaminated drinking water constituted physical injury); Dennis G. Bassi, Note, *It's All Relative: A Graphical Reasoning Model for Liberalizing Recovery for Negligent Infliction of Emotional Distress Beyond the Immediate Family*, 30 VAL. U. L. REV. 913, 922 (1996) (noting that because physical impact requirement has been interpreted broadly it has not funneled out fraudulent or trivial claims); see also *Metro-North Commuter R.R. Co. v. Buckley*, 521 U.S. 424, 432 (1997) (finding that plaintiff's exposure one hour per working day to insulation dust containing asbestos, which did not result in symptoms of cancer, did not constitute physical impact within meaning of Federal Employers' Liability Act); *Brown v. Phila. Coll. of Osteopathic Med.*, No. 2880, 2000 Pa. Super. LEXIS 2464, at *21 (Pa. Super. Ct. Aug. 30, 2000) (stating that injection to treat nonexistent and negligently misdiagnosed syphilis did not constitute physical impact because it was relatively painless).

34. See *Dollar Inn, Inc. v. Slone*, 695 N.E.2d 185, 189 (Ind. Ct. App. 1998) (holding that plaintiff succeeded on general negligence claim that demonstrated physical impact and included parasitic mental distress damages). In *Dollar*, the plaintiff, while residing in a room rented from the defendant, punctured her hand on a discarded hypodermic needle inside a roll of toilet paper in the bathroom. See *id.* at 186 (stating facts). A motel employee told the plaintiff that the needle "probably was from an intravenous drug user on the hotel staff." *Id.*

soned that these barriers grounded the speculative nature of emotional damages and ensured the genuineness of the distress.³⁵

Although many jurisdictions still rely on one of the aforementioned barriers or exceptions to recovery, many other jurisdictions now recognize an independent tort for the negligent infliction of emotional distress.³⁶ This progression is credited to the development of psychological science³⁷ and the realization that these barriers to recovery amounted to nothing more than mechanical limitations to authentic injury.³⁸ Prime examples

35. See DOBBS, *supra* note 23, § 308, at 837 (stating that some courts required physical injury or impact be actionable to recover emotional damages).

36. Compare *Tanner v. Hartog*, 696 So. 2d 705, 708 (Fla. 1997) (maintaining physical impact requirement but allowing exception for father's emotional distress over wife's stillbirth), *Chambley v. Apple Rests., Inc.*, 504 S.E.2d 551, 553 (Ga. Ct. App. 1998) (requiring that physical impact rule be met before woman who found condom in Santa Fe chicken salad could recover emotional distress damages), and *Brown*, 2000 Pa. Super. LEXIS 2464, at *22 (stating that recovery for negligent infliction of emotional distress is inappropriate without contemporaneous physical harm), with *In re Haw. Fed. Asbestos Cases*, 734 F. Supp. 1563, 1569 (D. Haw. 1990) ("[T]he recovery of emotional distress damages is an independent cause of action in Hawaii."), *Faya v. Almaraz*, 620 A.2d 327, 338-39 (Md. 1993) (stating that plaintiffs can recover emotional distress for fear of AIDS if they objectively demonstrate its existence), and *Fairfax Hosp. v. Curtis*, 492 S.E.2d 642, 647 (Va. 1997) (stating that physical harm or wanton and willful misconduct by defendant generally is required to recover emotional distress, but allowing exception for hospital's wrongful disclosure of plaintiff's medical records). See *R.J. v. Humana of Fla., Inc.*, 652 So. 2d 360, 363 (Fla. 1995) (refusing to make exception to physical impact rule for negligent misdiagnosis of HIV). Although the plaintiff in *Humana* believed that he was HIV-positive for nineteen months, the Florida Supreme Court refused to make an exception to the physical impact requirement because it would raise the cost of medical care and open the floodgates to negligent misdiagnosis of all diseases. See *id.* at 363-64 (stating reasons to maintain physical impact rule in HIV misdiagnosis claims). Nevertheless, the court noted that presenting evidence of "unnecessary and harmful medical treatment" could possibly have satisfied the physical impact requirement. See *id.* at 364 (identifying evidence sufficient to satisfy impact requirement in case involving negligent misdiagnosis of HIV).

37. See *Fogarty v. Campbell 66 Express, Inc.*, 640 F. Supp. 953, 962 (D. Kan. 1986) (stating that modern medicine has decreased potential for fraudulent claims); *Molien v. Kaiser Found. Hosps.*, 616 P.2d 813, 821 (Cal. 1980) (noting that modern psychology is more precise method to evaluate genuineness of emotional distress than physical impact requirement); David J. Leibson, *Recovery of Damages for Emotional Distress Caused by Physical Injury to Another*, 15 J. FAM. L. 163, 190-201 (1977) (discussing development of medical evidence of emotional distress); Levit, *supra* note 26, at (1992) (noting that psychology has advanced significantly); Kenneth W. Miller, Note, *Toxic Torts and Emotional Distress: The Case for an Independent Cause of Action for Fear of Future Harm*, 40 ARIZ. L. REV. 681, 693 (1998) ("[W]hile the physical injury rule as a filter against frivolous claims may have been reasonable a century ago, the current state of medical science and technology, as well as the modern advances in human psychology make the physical injury rule unnecessary as a screen for genuineness.").

38. See, e.g., *Marriott v. Sedco Forex Int'l Res., Ltd.*, 827 F. Supp. 59, 75-76 (D. Mass. 1993) (permitting recovery of emotional distress because plaintiff's direct exposure to HIV-positive vaccine inoculation provided genuineness of emotional damages); *Bass v. Nooney Co.*, 646 S.W.2d 765, 772-73 (Mo. 1983) (en banc) (liberalizing recovery for emotional distress by permitting claims absent physical im-

of recovery for purely emotional distress are “bystander” and “fear of cancer” claims.³⁹

A. *Bystander Recovery—Evolving from Zone of Danger to Foreseeability*

Bystander claims illustrate how courts revise standards of liability to meet the demands of legitimate claims.⁴⁰ Ordinarily, a bystander claim based on negligent infliction of emotional distress means that the plaintiff perceived a serious injury to a close relative and, as a result, suffered severe emotional distress.⁴¹ Because bystander plaintiffs ordinarily pursue

pact). In *Bass*, the Missouri Supreme Court created the following guidelines for recovery: “(1) the defendant should have realized that his conduct involved an unreasonable risk of causing the distress; and (2) the emotional distress or mental injury must be medically diagnosable and must be of sufficient severity so as to be medically significant.” *Bass*, 646 S.W.2d at 772-73.

By not compensating emotional harm, the judicial system implicitly sends the message that the plaintiff's own mental defect causes the emotional distress. See *Levit*, *supra* note 26, at 175 (stating that denial of emotional distress claims reinforces view that plaintiffs are mentally weak). Nevertheless, the establishment of right to privacy and intentional infliction of emotional distress torts represent the movement of the judicial system towards recognizing the validity of emotional distress. Compare *Thing v. La Chusa*, 771 P.2d 814, 817 (Cal. 1989) (“With recognition of intentional infliction of emotional distress as discrete tort cause of action, this court accepted . . . freedom from emotional distress as an interest worthy of protection . . .”), and *State Rubbish Collectors Ass'n v. Siliznoff*, 240 P.2d 282, 284-86 (Cal. 1952) (formulating tort of intentional infliction of emotional distress), with Samuel D. Warren & Louis D. Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193, 193-200 (1890) (advocating intangible right to privacy). In *Right to Privacy*, the authors termed the now widely accepted right to privacy a “right to be let alone.” See *id.* at 193 (stating that “scope of . . . legal rights [has] broadened; and now the right to life has come to mean the right to enjoy life,—the right to be let alone . . .”). Another commentator further credits American courts' increased recognition of emotional distress to our rapid industrialization and advancement of psychology. See *Levit*, *supra* note 26, at 159-60 (suggesting that increased technology and industrialization, and its broad effect on people, was responsible for judicial theory that was more receptive to intangible harm); see also *Taylor v. Baptist Med. Ctr., Inc.*, 400 So. 2d 369, 374 (Ala. 1981) (stating that “to continue to require physical injury . . . 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”); *Bass*, 646 S.W.2d at 769 (noting that refinement of psychiatric tests enables science to establish existence and severity of psychic harm with reasonable certainty).

39. For a further discussion of bystander and fear of cancer claims, see *infra* notes 40-75 and accompanying text.

40. See generally *Thing*, 771 P.2d at 816-30 (explaining development of negligent infliction of emotional distress case law to permit recovery for bystanders).

41. See, e.g., *Barnhill v. Davis*, 300 N.W.2d 104 (Iowa 1981) (adopting bystander recovery for plaintiff who witnessed defendant's vehicle strike mother's vehicle); *Corso v. Merrill*, 406 A.2d 300, 308 (N.H. 1979) (permitting recovery of emotional distress for parents that contemporaneously perceived daughter's accident); *Portee v. Jaffee*, 417 A.2d 521, 526-28 (N.J. 1980) (relying on *Dillon* factors to award emotional distress damages to mother who watched unsuccessful efforts to rescue her seven-year-old son trapped in elevator shaft). “No loss is greater than the loss of a loved one, and no tragedy is more wrenching than the helpless apprehension of the death or serious injury of one whose very existence is a precious

purely emotional distress damages, many courts limit liability by applying the “zone of danger” rule.⁴² The zone of danger rule allows the bystander plaintiff to recover only if he or she is endangered by the same physical harm that caused physical injury to a third party.⁴³ The zone of danger rule theorizes that the defendant breaches a duty to the plaintiff when the defendant endangers the plaintiff with physical harm.⁴⁴ Courts and commentators believe that the zone of danger rule deters unlimited liability, ensures the genuineness of the claim and provides courts and juries with an objective standard that can be consistently applied.⁴⁵

1. *Dillon v. Legg Recognizes Legitimate Claims*

Nevertheless, the zone of danger rule was rejected by the California Supreme Court in the landmark tort case, *Dillon v. Legg*,⁴⁶ in favor of general guidelines of foreseeability.⁴⁷ In *Dillon*, plaintiffs, a mother and

treasure.” *Portee*, 417 A.2d at 526; *see also* *Leong v. Takasaki*, 520 P.2d 758, 767 (Haw. 1974) (permitting recovery of emotional distress for ten-year-old who witnessed his step-grandmother struck and killed by defendant’s automobile); *Sinn v. Burd*, 404 A.2d 672, 686 (Pa. 1979) (permitting recovery of emotional distress for mother who saw her daughter struck and killed by defendant’s vehicle); *D’Ambra v. United States*, 338 A.2d 524, 531 (R.I. 1975) (permitting recovery of emotional distress for mother who witnessed her daughter struck and killed by negligently driven mail truck); *Hunsley v. Giard*, 553 P.2d 1096, 1103 (Wash. 1976) (allowing recovery of emotional distress when plaintiff’s neighbor drove her vehicle into plaintiff’s back porch and plaintiff suffered heart ailment thereafter).

42. *See generally* Richard N. Pearson, *Liability to Bystanders for Negligently Inflicted Emotional Harm—A Comment on the Nature of Arbitrary Rules*, 34 U. FLA. L. REV. 477 (1982) (arguing that recovery for emotional distress should be limited to zone of danger rule).

43. *See* J. Mark Appleberry, Note, *Negligent Infliction of Emotional Distress: A Focus on Relationships*, 21 AM. J.L. & MED. 301, 305-09 (1995) (describing parameters of zone of danger rule).

44. *See, e.g.*, *Asaro v. Cardinal Glennon Mem’l Hosp.*, 799 S.W.2d 595, 599-600 (Mo. 1990) (adopting variation of zone of danger test); *Bovsun v. Sanperi*, 461 N.E.2d 843, 844 (N.Y. 1984) (stating theory of zone of danger). The Court of Appeals of New York stated:

Where a defendant’s . . . negligenc[ce] . . . creat[es] an unreasonable risk of bodily harm to a plaintiff and such conduct is a substantial factor in bringing about injuries to the plaintiff . . . of shock or fright resulting from his or her contemporaneous observation of serious physical injury or death inflicted . . . on a member of the plaintiff’s immediate family in his or her presence, the plaintiff may recover damages for such injuries.

Bovsun, 461 N.E.2d at 844.

The zone of danger test also may require that the plaintiff demonstrate physical manifestations of distress. *See* *DOBBS*, *supra* note 23, § 309, at 840 (describing requirements under zone of danger test).

45. *See* *Stadler v. Cross*, 295 N.W.2d 552, 554 (Minn. 1980) (stating that zone of danger rule limits liability and promotes consistent application); *Bovsun*, 461 N.E.2d at 848 (stating that zone of danger rule stops unlimited liability and provides objective test).

46. 441 P.2d 912 (Cal. 1968).

47. For a discussion of the foreseeability guidelines adopted in *Dillon*, *see infra* notes 48-53 and accompanying text.

daughter, witnessed the defendant negligently strike and kill the mother's other daughter with his vehicle.⁴⁸ At the time of the accident, the mother was outside of the zone of danger, while the witnessing daughter was close enough to be inside the zone.⁴⁹ Therefore, the trial court denied the mother recovery for her emotional distress but permitted the daughter to recover for hers.⁵⁰

Finding the distinction of distance arbitrary, the California Supreme Court adopted general guidelines of foreseeability.⁵¹ The court explained that judges and juries should distinguish between genuine and fraudulent claims, which makes a *per se* rule like the zone of danger rule unnecessary.⁵² The court also encouraged courts to make their own "case by case analysis" while using their foreseeability factors as a "guide."⁵³

2. *Current State of Bystander Claims*

Bystander recovery still varies from jurisdiction to jurisdiction.⁵⁴ Nevertheless, courts credit *Dillon*, described as a "pebble cast in the pond," with liberalizing recovery of emotional distress.⁵⁵ Many other jurisdictions adopted the *Dillon* requirements, albeit with some modifications and ex-

48. See *Dillon*, 441 P.2d at 914 (stating facts).

49. See *id.* at 915 (explaining trial court's basis for summary judgment).

50. See *id.* (stating facts).

51. See *id.* at 920 (adopting foreseeability guidelines). The guidelines adopted by the California Supreme Court are:

Whether [a] plaintiff was located near the scene of the accident as contrasted with one who was a distance away from it. (2) Whether the shock resulted from a direct emotional impact upon a plaintiff from the sensory and contemporaneous observance of the accident, as contrasted with learning of the accident from others after its occurrence. (3) Whether plaintiff and the victim were closely related, as contrasted with an absence of any relationship or the presence of only a distant relationship.

Id. Nevertheless, courts have, at times, applied the guidelines fairly strictly. See *Maldonado v. Nat'l Acme Co.*, 73 F.3d 642, 645 (6th Cir. 1996) (denying plaintiff's bystander claim in which he witnessed in close proximity, fatal injury to co-worker, because he was not member of immediate family); *Burgess v. Sup. Ct.*, 831 P.2d 1197, 1200-01 (Cal. 1992) (stating that claim in which plaintiff's baby was negligently misdelivered, causing brain damage to baby, was not bystander claim because plaintiff-mother did not perceive delivery complications until after delivery).

52. See *Dillon*, 441 P.2d at 917 n.3 (stating that "courts are responsible for dealing with cases on their merits . . ."). Furthermore, the court announced that the legal system should never erect *per se* rules at the expense of legitimate claims. See *id.* at 917-18 (stating that argument for zone of danger rule rests on assumption that judges and juries cannot distinguish fraudulent and genuine claims).

53. See *id.* at 919-25 (explaining that claims should be evaluated on case by case basis). The court concluded by stating that "[t]he test that we have set forth will aid in the proper resolution of future cases." *Id.* at 925.

54. For a further discussion of the jurisdictional acceptance of *Dillon*, see *infra* note 56 and accompanying text.

55. See *Thing v. La Chusa*, 771 P.2d 814, 819 (Cal. 1989) (describing *Dillon* as pebble cast into pond because it caused ripples in tort recovery); *Amodio v. Cunningham*, 438 A.2d 6, 9-10 (Conn. 1980) (crediting *Dillon* with directly affecting courts in their respective decisions to permit recovery in bystander claims).

ceptions.⁵⁶ Nevertheless, many reiterate the fundamental goal of bystander recovery, addressing legitimate emotional distress claims.⁵⁷

B. *Fear of Cancer Claims—Continuing Recognition of Legitimate Emotional Distress Claims*

Fear of cancer claims are a relatively new phenomenon that exemplify the progress that tort law has made in recognizing emotional distress dam-

56. See *Tommy's Elbow Room v. Kavorkian*, 727 P.2d 1038, 1041-43 (Alaska 1986) (adopting *Dillon* foreseeability factors and permitting recovery for plaintiff that learned of accident immediately after it occurred); *Thing*, 771 P.2d at 815 (limiting eligible plaintiffs to closely related persons and those who were actually present at scene and aware of accident); *Clohessy v. Bachelor*, 675 A.2d 852, 855 (Conn. 1996) (citing *Dillon* and adopting foreseeability test for bystander claims); *Champion v. Gray*, 478 So. 2d 17, 20 (Fla. 1985) (adopting foreseeability factors but holding that plaintiff must demonstrate physical manifestations of psychic trauma); *Leong v. Takasaki*, 520 P.2d 758, 765 (Haw. 1974) (adopting foreseeability factors and permitting recovery for emotional distress absent physical impact or physical manifestations); *Fineran v. Pickett*, 465 N.W.2d 662, 664 (Iowa 1991) (denying recovery because plaintiffs witnessed only aftermath of relative's bicycle accident); *Lejeune v. Rayne Branch Hosp.*, 556 So. 2d 559, 570 (La. 1990) (adopting foreseeability factors similar to those in *Dillon* without attempting to establish concrete rules); *Cameron v. Pepin*, 610 A.2d 279, 284-85 (Me. 1992) (adopting foreseeability factors and denying recovery to plaintiffs who did not see son's injuries until son was at hospital); *Stockdale v. Bird & Son, Inc.*, 503 N.E.2d 951, 953-54 (Mass. 1987) (adopting foreseeability factors); *Nugent v. Bauermeister*, 489 N.W.2d 148, 150 (Mich. Ct. App. 1992) (same); *Entex, Inc. v. McGuire*, 414 So. 2d 437, 444 (Miss. 1982) (permitting recovery for emotional distress after witnessing fire to home and pulling wife from wreckage); *Versland v. Caron Transport*, 671 P.2d 583, 585-87 (Mont. 1983) (citing *Dillon* and adopting foreseeability factors); *James v. Lieb*, 375 N.W.2d 109, 114-15 (Neb. 1985) (adopting foreseeability factors); *Buck v. Greyhound Lines, Inc.*, 783 P.2d 437, 443 (Nev. 1989) (same); *Wilder v. City of Keene*, 557 A.2d 636, 638 (N.H. 1989) (same); *Dunphy v. Gregor*, 642 A.2d 372, 375-76 (N.J. 1994) (adopting foreseeability factors and permitting bystander recovery for fiancée); *Frame v. Kothari*, 560 A.2d 675, 678 (N.J. 1989) (adopting foreseeability factors); *Folz v. State*, 797 P.2d 246, 257-58 (N.M. 1990) (same); *Johnson v. Ruark Obstetrics & Gynecology Assocs.*, 395 S.E.2d 85, 98 (N.C. 1990) (same); *Paugh v. Hanks*, 451 N.E.2d 759, 766 (Ohio 1983) (adopting elastic version of *Dillon* foreseeability factors); *Sinn v. Burd* 404 A.2d 672, 685-86 (Pa. 1979) (adopting foreseeability factors); *Reilly v. United States*, 547 A.2d 894, 895-97 (R.I. 1988) (same); *Kinard v. Augusta Sash & Door Co.*, 336 S.E.2d 465, 466-67 (S.C. 1985) (same); *Freeman v. City of Pasadena*, 744 S.W.2d 923, 923-24 (Tex. 1988) (same); *Gain v. Carroll Mill Co.*, 787 P.2d 553, 556-57 (Wash. 1990) (same); *Heldreth v. Marrs*, 425 S.E.2d 157, 162 (W. Va. 1992) (same); *Contreras v. Carbon County Sch. Dist. No. 1*, 843 P.2d 589, 593-94 (Wyo. 1992) (same). Nevertheless, the *Restatement (Second) of Torts* adopts the zone of danger rule. See RESTATEMENT (SECOND) TORTS § 436(A) (1965) (limiting exception to physical impact requirement for zone of danger rule).

57. See, e.g., *Paugh*, 451 N.E.2d at 767 (explaining that *Dillon* foreseeability factors should be elastic so all legitimate claims will be heard); *Sinn*, 404 A.2d at 677 (stating that zone of danger rule is unfair because legitimate emotional distress is as likely to occur when parent witnesses death of child as when someone is in zone of danger).

ages.⁵⁸ A fear of cancer claim arises when the plaintiff was exposed to a known carcinogen and sues for the present emotional distress stemming from the fear that he or she will develop cancer.⁵⁹ Fear of cancer claims resemble fear of AIDS claims in some respects.⁶⁰ Both claims pursue recovery for the present emotional distress suffered over the fear of developing a disease in the future.⁶¹ Additionally, in both claims plaintiffs often cannot demonstrate any physical effects from exposure, and thus, courts are often skeptical as to whether or not a plaintiff has suffered a compensable injury.⁶² The similarities have led courts to extend fear of cancer principles to fear of AIDS claims.⁶³

58. See, e.g., Richard A. Nagareda, *In the Aftermath of the Mass Tort Class Action*, 85 GEO. L.J. 295, 315 n.91 (1996) (noting that common law courts have begun to recognize new causes of action relating to disease exposure, such as fear of cancer, over the past decade).

59. See Chadwick, *supra* note 1, at 153-56 (describing development of cancerphobia claim). Chadwick noted:

The typical cancerphobia case arises when the plaintiff is exposed to a known carcinogen. Because of long latency periods, idiosyncratic responses to exposure, and the inability of medical science to predict the probability of cancer actually developing, the plaintiff may not have suffered a compensable physical injury at the time the suit is initiated. Nonetheless, the plaintiff may allege emotional distress at the possibility that an exposure to a carcinogen might result in cancer.

Id. at 153; see also *Temple-Inland Products Corp. v. Carter*, 993 S.W.2d 88, 89-90 (Tex. 1999) (stating that plaintiffs who feared developing cancer and who alleged that their chances of developing cancer increased from one in 1,000,000 to one in 500,000 over next ten to fifteen years because of exposure to asbestos, did not state cause of action because, absent physical injury, Texas does not generally recognize negligent infliction of emotional distress).

There are two other claims based on exposure to carcinogens: increased risk of disease and medical monitoring. See Symposium, *Evolving Standards for Fear of Future Disease Claims in the Post-Potter Era*, 10 TUL. ENVTL. L.J. 307, 311-14 (1997) (describing different causes of action). In an increased risk cause of action, the plaintiff sues for the enhanced risk of contracting a disease after toxic exposure, not for the present emotional injury for fear of the disease. See *id.* at 311-12 (describing increased risk of disease cause of action). Medical monitoring claims seek compensation for the out-of-pocket expenses plaintiffs incur because of diagnostic tests and exams after exposure. See *id.* 312-14 (describing medical monitoring cause of action).

60. For further discussion of the similarities between the diseases, see *infra* notes 61-62 and accompanying text.

61. Compare *Temple-Inland*, 993 S.W.2d at 89 (stating that claim is for present fear of developing cancer because of asbestos exposure), with *Coca-Cola Bottling Co. v. Hagan*, 750 So. 2d 83, 84 (Fla. Dist. Ct. App. 1999) (bringing claim for fear of developing AIDS after drinking bottle of Coca-Cola that apparently contained used condom). The object later turned out to be mold. See *id.* at 85 (stating that object in Coca-Cola bottle was mold).

62. See *Temple-Inland*, 993 S.W.2d at 93 (stating that it is difficult to distinguish genuine claims from false claims when court is forced to predict whether plaintiff will develop cancer after exposure to asbestos).

63. See *Kerins v. Hartley*, 27 Cal. App. 4th 1062, 1074 (Ct. App. 1994) (applying *Potter's* more likely than not standard to fear of AIDS claim); *Lubowitz v. Albert Einstein Med. Ctr.*, 623 A.2d 3, 5 (Pa. Super. Ct. 1993) (stating that court is "guided by decisions which involve similar 'risk of contracting disease' claims")

1. *Potter v. Firestone & Rubber Co. Sets Strict Standard of Recovery*

In the seminal case of *Potter v. Firestone Tire & Rubber Co.*,⁶⁴ the California Supreme Court addressed the standard of recovery for fear of cancer claims and created the highest barrier to recovery of the jurisdictions that recognize an independent cause of action for fear of cancer claims.⁶⁵ The *Potter* court held that a plaintiff could recover emotional distress damages if “it is more likely than not that the plaintiff will develop the cancer in the future due to the toxic exposure.”⁶⁶ The four plaintiffs in *Potter* claimed that the defendant, Firestone, illegally disposed of toxic waste in the landfill that abutted their homes.⁶⁷ As a result, the plaintiffs alleged fear of cancer because trace elements of the toxic chemicals seeped into their drinking water.⁶⁸ The court ultimately remanded the case to the appellate level to determine if the plaintiffs’ claims of emotional distress met the more likely than not standard.⁶⁹ The court’s primary concern was that an infinite class of plaintiffs would result because of the exposure to carcinogens that people experience everyday.⁷⁰

when evaluating fear of AIDS claims); Vance A. Fink, Jr., Comment, *Emotional Distress Damages for Fear of Contracting AIDS: Should Plaintiffs Have to Show Exposure to HIV?*, 99 DICK. L. REV. 779, 785-86 (1995) (stating that courts look to fear of cancer cases for guidance in addressing fear of AIDS claims); Grill, *supra* note 1, at 1015-18 (1998) (relating fear of AIDS claims to fear of cancer claims).

64. 863 P.2d 795 (Cal. 1993).

65. *See Potter*, 863 P.2d at 816 (setting out requirements for recovery under negligent infliction of emotional distress in fear of cancer claims).

66. *Id.* at 816 (emphasis added). The court relaxed the more likely than not standard if the exposure was a result of the defendant’s oppression, fraud or malice. *See id.* at 817-18 (discussing recovery when defendant’s culpability rises to level of oppression, fraud or malice). The court stated:

Once the plaintiff establishes that the defendant has acted with oppression, fraud or malice, the plaintiff must still demonstrate that his or her fear of cancer is reasonable, genuine and serious in order to recover damages In addition, the plaintiff must show that his or her actual risk of cancer is significant before recovery will be allowed. Under this reasoning, a plaintiff’s fear is not compensable when the risk of cancer is significantly increased, but remains a remote possibility.

Id. at 818.

67. *See id.* at 801 (stating facts).

68. *See id.* (stating facts).

69. *See id.* at 827 (remanding case).

70. *See id.* at 811 (“As a starting point in our analysis, we recognize the indisputable fact that all of us are exposed to carcinogens every day.”). The court theorized that a low standard for recovery would result in higher insurance costs for toxic tort risks, which would ultimately be borne by the public in the form of higher costs for goods and services. *See id.* at 812 (explaining that cost of infinite class of plaintiffs would be borne by consumers).

2. *Current State of Fear of Cancer Claims*

Similar to bystander claims in recent years, courts have liberalized standards for recovery of fear of cancer damages.⁷¹ Like the *Potter* court, many of the courts that recognize a stand-alone cause of action for fear of cancer have departed from the more likely than not standard.⁷² These courts instead look to factors such as expert testimony and the likelihood of the plaintiff's possibility of developing the disease.⁷³ Nevertheless, other jurisdictions retain a physical injury requirement to establish a viable claim for fear of cancer.⁷⁴ Although recovery varies by jurisdiction, a progression toward wider recovery persists.⁷⁵

71. See, e.g., Scott D. Marrs, *Mind Over Body: Trends Regarding the Physical Injury Requirement in Negligent Infliction of Emotional Distress and "Fear of Diseases" Cases*, 28 TORT & INS. L.J. 1,4 (1992) (stating that Alabama, California, Connecticut, Hawaii, Maine, Missouri, Montana, Nebraska, New Jersey, North Carolina, Ohio, Oregon, Texas and Washington have removed physical injury requirement in fear of disease claims). Nevertheless, of the jurisdictions that retain a physical injury requirement, some require only physical manifestations of the emotional distress. See *id.* at 1 (stating that some courts require only physical manifestations of emotional distress); see also *Slaymaker v. Archer-Daniels-Midland Co.*, 540 N.W.2d 459, 461 (Iowa 1995) (creating two-prong test that requires increased statistical likelihood of developing cancer and manifestations of emotional distress).

72. See, e.g., *Watkins v. Fibreboard Corp.*, 994 F.2d 253, 257 (5th Cir. 1993) (permitting recovery for fear of cancer on showing of reasonableness of anguish and compensation sought); *Day v. Natl. Lead of Ohio*, 851 F. Supp. 869, 878 (S.D. Ohio 1994) (holding that exposure alone could constitute physical injury making resulting emotional distress reasonable); *Thomas v. FAG Bearings Corp.*, 846 F. Supp. 1400, 1408 (W.D. Mo. 1994) (recognizing emotional distress for fear of cancer that is medically significant); *Leaf River Forest Prods., Inc. v. Ferguson*, 662 So. 2d 648, 658 (Miss. 1995) (requiring that there must be proof of exposure to a dangerous substance and medical evidence of potential future illness to recover for fear of future illness).

73. See Mark A. Koppel, Note, *Gilliam v. Roche Biomedical Laboratories: An Introduction to Fear-of-Disease Damages in Arkansas*, 48 ARK. L. REV. 555, 560-63 (1995) (explaining factors applied to fear of cancer claims).

74. See, e.g., *Triche v. Overnite Transp. Co.*, 1996 U.S. Dist. LEXIS 10168, at *43 (E.D. La. July 15, 1996) (requiring that plaintiff demonstrate actual injury); *In re Asbestos Litig.*, 1995 Del. LEXIS 323, at *8 (Del. Sept. 5, 1995) (implying that pleural thickening could establish requisite physical injury requirement); *Capital Holding Corp. v. Bailey*, 873 S.W.2d 187, 194 (Ky. 1994) (requiring physical injury for fear of cancer claim); *Payton v. Abbott Labs.*, 437 N.E.2d 171, 174 (Mass. 1982) (denying recovery because plaintiff failed to establish physical injury); *Wolff v. A-One Oil, Inc.*, 627 N.Y.S.2d 788, 789 (App. Div. 1995) (requiring evidence of asbestos-related injury to recover for fear of cancer); *Simmons v. Pacor, Inc.*, 674 A.2d 232, 238-39 (Pa. 1996) (requiring physical injury for fear of cancer claim).

75. For a further discussion of jurisdictions discarding physical injury requirement, see *supra* notes 72-73 and accompanying text.

III. COMPOSITION OF FEAR OF AIDS CLAIMS

A. *Influential Factors in Fear of AIDS Claims*

In light of fear of cancer claims and the prevalence of fear of disease claims in general, plaintiffs have brought fear of AIDS claims.⁷⁶ Before examining the legal standards of recovery for fear of AIDS claims, it is important to understand first how HIV/AIDS is transmitted, as well as some additional influential factors.⁷⁷ Because most fear of AIDS claims are based on a brief event of potential or actual exposure to HIV/AIDS, the reasonableness of the plaintiff's fear of contracting HIV/AIDS relies heavily on the circumstances of the transmission.⁷⁸ Furthermore, judges and juries should consider the dynamics of the testing period and the disease's physical and mental effects before drawing conclusions about the claim's validity.⁷⁹

1. *Transmission of AIDS*

Although the methods of transmission of AIDS are fairly well established, a degree of uncertainty still remains.⁸⁰ Transmission generally requires an exchange of bodily fluids.⁸¹ The three most prevalent modes of HIV transmission are: (1) sexual intercourse with an infected person; (2) injection with HIV-positive fluid in the form of drugs, needles, syringes or blood; and (3) transmission from an HIV-infected mother to her fetus in utero, during childbirth, from mother to infant or during breast-feed-

76. See Fink, *supra* note 63, at 785-86 (stating that fear of cancer claims widened recovery for fear of AIDS claims).

77. For a further discussion of the factors that influence fear of AIDS decisions, see *infra* notes 78-98 and accompanying text.

78. See Jill Trachtenberg, *Living in Fear: Recovering Negligent Infliction of Emotional Distress Damages Based on the Fear of Contracting AIDS*, 2 DEPAUL J. HEALTH CARE L. 529, 543 (1999) (stating that courts consider mode of transmission in making decisions).

79. For a further discussion of the influential factors in fear of AIDS claims, excluding mode of transmission, see *infra* notes 88-96 and accompanying text.

80. See Chadwick, *supra* note 1, at 157 ("Although the process of HIV transmission and infection has been studied in depth, much is still unknown."); cf. Harold Jaffe, *The Application of Medical Facts to the Courts*, in AIDS AND THE COURTS 16 (Clark C. Abt & Kathleen M. Hardy eds., 1990) (explaining that cases that are initially categorized as unknown mode of transmission "largely represent incomplete information"). Many of the victims in this category either do not want to be interviewed or die before the interview may be conducted. See *id.* (identifying victims that fall into category of unknown mode of transmission). When these victims are ultimately interviewed, the majority of them are reclassified into an alternate category of transmission. See *id.* (stating that people this category of transmissions are generally assigned to a different category).

81. See Faya v. Almaraz, 620 A.2d 327, 329 (Md. 1993) (noting that HIV is commonly transmitted through genital fluids and blood). HIV/AIDS is a communicable disease because the causative agent can be transmitted from one person to another. See STINE, *supra* note 2, at 187 (defining HIV). HIV/AIDS can incubate in a person's system symptom-free for up to a decade. See Faya, 620 A.2d at 329 (stating that HIV can reside in person symptom-free for up to ten years).

ing.⁸² It is well documented that HIV is not transmitted through the air, tears, phones, toilet seats, eating utensils, drinking glasses, a person's clothes or insects.⁸³

Statistically, if a person is exposed to HIV, the chances of transmission are relatively low.⁸⁴ The chances of infection through a needlestick in which the hypodermic needle contains HIV-positive blood are one in 300.⁸⁵ The risk of contracting HIV/AIDS through the nose, mouth or skin is one in 1000.⁸⁶ Of course, both of these levels of risk could increase or decrease depending on the circumstances of exposure.⁸⁷

82. See STINE, *supra* note 2, at 187 (listing most prevalent modes of transmission). Although sexual intercourse is the most prevalent mode of transmission, it is considered inefficient because exposure will most likely not produce infection. *See id.* at 187 (stating that sexual intercourse does not always transmit HIV). "HIV is transmitted more efficiently through intravenous . . . routes." *Id.* at 187. Other documented cases of HIV transmitted through means other than the three most often modes include: three cases of home nursing care where there was skin to bodily secretion contact, a mother that became infected through extensive unprotected exposure to her child's blood and secretions, and two adolescent brothers with hemophilia that shared a razor. *See id.* at 194-96 (detailing cases where HIV was transmitted through rare method along with table). In one rare documented case, a man contracted HIV from his brother after a bloody fight. *See id.* at 196 (noting that newly infected brother denied all other means of viable transmission and that strand of virus found in newly infected brother was identical to that in already infected brother).

83. *See id.* at 187 (listing ways HIV is not transmitted). Generally, HIV is not transmitted through casual contact, although one case of HIV was traced to deep kissing. *See id.* (stating that one case of HIV transmission through deep kissing has been documented). Moreover, in one study, no family members that shared a toothbrush with an infected person contracted the virus. *See id.* at 193 (describing this particular result of the study).

84. For a discussion of statistical chances of contracting HIV, see *supra* notes 82-83 and accompanying text.

85. See Center for Disease Control, *Occupational Exposure to HIV: Information for Healthcare Workers*, available at <http://www.cdc.gov/ncidod/hip/faq.htm> (last visited Jan. 7, 2000) [hereinafter *Occupational Exposure to HIV*] (stating that risk of infection is about three-tenths of one percent).

86. *See id.* (stating that risk of HIV infection after exposure to HIV-infected blood of the eye, nose or mouth is about one-tenth of one percent).

87. *See id.* (stating that risk through skin contact varies depending on amount of blood and condition of skin). Moreover, the risk of infection for an uninfected female through unprotected vaginal intercourse with an infected male is one in 100, while risk of infection for an uninfected male through vaginal intercourse with an infected female is one in 1000. *See* WARD, *supra* note 1, at 38 (stating statistics).

2. *The Testing Period and Physical and Mental Effects*

AIDS is also devastating in other ways.⁸⁸ First, it is incurable.⁸⁹ Second, AIDS causes victims to deteriorate physically.⁹⁰ Third, and most importantly, in the context of fear of AIDS claims, potential exposure to HIV/AIDS is treated the same as actual exposure.⁹¹ HIV test results are not conclusive for six months.⁹² As a result, someone that is potentially exposed to HIV/AIDS must take identical precautions as someone that is actually exposed to ensure that he or she does not transmit the disease.⁹³ This includes limiting association with family and friends to casual contact.⁹⁴ This six-month period can have deep psychological effects on a person.⁹⁵

88. See Shahvari, *supra* note 2, at 769 (noting unique characteristics of AIDS).

89. See *Kerins v. Hartley*, 27 Cal. App. 4th 1062, 1068 (Ct. App. 1994) (noting that AIDS is 100% fatal); *Faya v. Almaraz*, 620 A.2d 327, 329 (Md. 1993) ("AIDS is invariably fatal."). Even though "drug cocktails" have prolonged victims' lives longer than ever before, the doses are physically difficult to ingest and the regimen is difficult to follow. Drug cocktails represent the regimen of drugs HIV-positive persons take to slow the development of HIV to AIDS. See *WARD*, *supra* note 1, at 68-103 (describing drug therapy). Moreover, physicians fear that HIV/AIDS will build up a tolerance to the cocktails, forcing victims to either ingest more or forfeit the benefits. See *id.* (noting possible diminishing efficacy of drug cocktails). Another impediment to care for victims is that the drugs cost \$2000 to \$7000 annually, with most people taking three types of pills simultaneously. See *id.* at 69 (stating cost of drugs).

90. See SUZANNE LEGO, FEAR AND AIDS/HIV: EMPATHY AND COMMUNICATION 5 (1994) (stating that "HIV-infected persons may . . . fear . . . physical and mental deterioration"); *WARD*, *supra* note 1, at 60-63 (describing physical effects of HIV/AIDS). About sixty percent of victims experience gastrointestinal disorders, which, for example, can result in wasting. See *id.* at 62 (describing wasting). Wasting is defined as ten percent baseline weight loss coupled with diarrhea over a span of thirty days. See *id.* (same). About thirty to fifty percent of the victims develop neurological problems. See *id.* at 62-64 (describing neurological disorders that many victims develop). For example, AIDS dementia complex, which affects brain tissue, can result in loss of memory. See *id.* at 63 (describing AIDS dementia complex).

91. See *Hartwig v. Or. Trail Eye Clinic*, 580 N.W.2d 86, 92 (Neb. 1998) ("[M]odern medicine treats a *potential exposure* to HIV virtually the same as it treats an *actual exposure* to HIV."); Shahvari, *supra* note 2, at 800 (outlining CDC requirements when someone is potentially exposed to HIV/AIDS).

92. See *Kerins*, 27 Cal. App. 4th at 1068 (stating that HIV test is ninety-five percent accurate six months after exposure).

93. For a further discussion of the precautions that a person potentially exposed to HIV/AIDS must take, see *infra* note 182 and accompanying text.

94. For a further discussion of these precautions and others a person potentially exposed to HIV/AIDS must take, see *infra* note 182 and accompanying text.

95. See LEGO, *supra* note 90, at 13-23 (explaining that infected individuals may experience loss of control, helplessness, feeling of victimization, reduction in self-esteem, changes in physical appearance, sense of isolation, guilt over lifestyle, anger, depression, paranoia, fear of violence against them, sense of betrayal and escape into drugs); John Schieszer, *The Down Side of Home HIV Tests*, ST. LOUIS POST-DISPATCH, Nov. 13, 1995, at 1E (stating that people must psychologically prepare for positive result and that negative of home testing is lack of counseling); see also

Finally, people with AIDS are subject to negative stigmatization by society.⁹⁶ Although AIDS has been around for two decades, society still ostracizes people with HIV/AIDS.⁹⁷ The disease stirs strong feelings of fear, which erupt in discrimination and violence.⁹⁸ Thus, a part of the “fear” generating a fear of AIDS claim must incorporate all of the aforementioned factors.

B. *Establishing Proximate Cause*

Because fear of AIDS claims are brought under negligent infliction of emotional distress, the plaintiff must demonstrate duty, breach, causation and damages.⁹⁹ Proximate causation evaluates whether the plaintiff’s harm, in the form of emotional distress, was a foreseeable result of the defendant’s negligence.¹⁰⁰ Here, courts disagree over whether the plaintiff must demonstrate actual exposure or only that the fear is reasonable to establish proximate cause.¹⁰¹

Sandor & Berry, *supra* note 24, at 1255 (noting that mental trauma can be more devastating than physical trauma).

96. See Ellen L. Luepke, Note, *HIV Misdiagnosis: Negligent Infliction of Emotional Distress and the False-Positive*, 81 IOWA L. REV. 1229, 1229 (1996) (“Because AIDS is a terminal illness, and because modern American culture still stigmatizes HIV-positive and AIDS-inflicted individuals as unclean or dangerous, any positive diagnosis, including a false-positive HIV test result, can be an emotionally taxing experience.”).

97. See, e.g., Winiarski, *supra* note 1, at 4 (noting that White House guards wore rubber gloves in 1995 to receive gay guest).

98. See, e.g., DOKA, *supra* note 2, at 64 (suggesting that Reagan administration responded slowly with funding to combat AIDS in early 1980s because AIDS was associated with homosexuals and fundamental religious right sect of Republicans was strongly opposed to gay lifestyle). Leaders of the religious right boldly voiced their negative opinions about the homosexual lifestyle. See *id.* at 64 (quoting religious right leader, Pat Buchanan, “the poor homosexuals—they have declared war on nature and now nature is exacting an awful retribution”). Conservative columnist, William F. Buckley, suggested that persons with AIDS be tattooed to control its spread. See *id.* at 68 (noting Buckley’s proclamation).

99. See, e.g., Corgan v. Muehling, 574 N.E.2d 602, 604 (Ill. 1991) (stating that plaintiff must prove duty, breach, causation and damages to succeed on claim of negligent infliction of emotional distress).

100. See KEETON ET AL., *supra* note 27, at 273 (explaining proximate causation in negligent infliction of emotional distress cases).

101. Compare *Burk v. Sage Prods., Inc.*, 747 F. Supp. 285, 288 (E.D. Pa. 1990) (noting that plaintiff must show actual exposure to AIDS), *Neal v. Neal*, 873 P.2d 881, 886-89 (Idaho Ct. App. 1993) (same), *Hare v. State*, 570 N.Y.S.2d 125, 127 (App. Div. 1991) (denying recovery for fear of AIDS because plaintiff could not demonstrate that he was infected with AIDS), *Carroll v. Sisters of St. Francis Health Servs., Inc.*, 868 S.W.2d 585, 594 (Tenn. 1993) (same), *Funeral Servs. by Gregory, Inc. v. Bluefield Cmty. Hosp.*, 413 S.E.2d 79, 84 (W. Va. 1991) (same), and *Johnson v. W. Va. Univ. Hosps., Inc.*, 413 S.E.2d 889, 893 (W. Va. 1991) (same), with *Marchica v. Long Island R.R.*, 810 F. Supp. 445, 452 (E.D.N.Y. 1993) (requiring reasonableness of fear), *Faya v. Almaraz*, 620 A.2d 327, 336-37 (Md. 1993) (same), and *Williamson v. Waldman*, 696 A.2d 14, 22-23 (N.J. 1997) (same). But see *Marriott v. Sedco Forex Int’l Res., Ltd.*, 827 F. Supp. 59, 75 (D. Mass. 1993) (stating that plaintiff who was inoculated with HIV-positive vaccine established

1. *Majority Position—Actual Exposure*

A majority of jurisdictions find that the plaintiff can establish actual exposure and, therefore, that his or her fear is reasonable if there is “exposure to tissue, blood, or body fluid infected with HIV, and . . . the exposure to the infected tissue, blood, or body fluid . . . [is] by way of a channel of communication or transmission deemed medically or scientifically sufficient to cause an HIV infection.”¹⁰² If the plaintiff fails to demonstrate actual exposure then the claim for emotional distress is unreasonable as a matter of law because the plaintiff’s emotional damages are deemed an unforeseeable result of the defendant’s negligent act.¹⁰³ Most courts were influenced by fear of cancer claims in creating this standard.¹⁰⁴ The actual exposure requirement purports to ensure the genuineness of the claim and objectify results.¹⁰⁵

For example, in *Majca v. Beekil*,¹⁰⁶ the Illinois Supreme Court denied recovery in two fear of AIDS claims because the plaintiffs failed to demonstrate actual exposure.¹⁰⁷ In the first cause of action, the plaintiff, Majca, was an office worker for a physician.¹⁰⁸ Her responsibilities included emptying the trash receptacles.¹⁰⁹ The plaintiff cut her hand on a discarded scalpel when she pressed down on the trash to compact it.¹¹⁰ The scalpel

cause of action under actual exposure requirement and reasonableness standard because of direct exposure); *Transamerica Ins. Co. v. Doe*, 840 P.2d 288, 290-92 (Ariz. Ct. App. 1992) (holding that paramedics who were actually exposed to HIV-positive blood when they performed life-saving procedures on infected person could not recover for emotional distress under terms of insurance policy until they demonstrated physical impairment or harm caused by exposure); Chadwick, *supra* note 1, at 170-71 (advocating alternative in which court addresses validity of claim under duty analysis). The Missouri and Nebraska Supreme Courts kept an actual exposure requirement, but made exceptions because the modes of transmission were unavailable for testing. *See generally* S. Cent. Reg’l Med. Ctr. v. Pickering, 749 So. 2d 95 (Miss. 1999) (finding difficulty in applying either standard); Hartwig v. Or. Trail Eye Clinic, 580 N.W.2d 86, 91 (Neb. 1998) (same). For a further discussion of *Hartwig* and *Pickering*, see *infra* notes 196-202 and accompanying text.

102. *Hartwig*, 580 N.W.2d at 91.

103. *See, e.g.*, *Russaw v. Martin*, 472 S.E.2d 508, 512 (Ga. Ct. App. 1996) (stating that plaintiff’s fear of AIDS was unreasonable and unforeseeable due to lack of actual exposure).

104. *See generally* *Harper v. Ill. Cent. Gulf R.R.*, 808 F.2d 1139 (5th Cir. 1987) (indicating that plaintiff may not recover for emotional distress unless there is sufficient evidence of exposure to potentially harmful agent); *Maddy v. Vulcan Materials Co.*, 737 F. Supp. 1528 (D. Kan. 1990) (noting that plaintiff must demonstrate actual exposure to harmful substance).

105. *See Carroll*, 868 S.W.2d at 594 (noting that actual exposure requirement is objective standard for recovery).

106. 701 N.E.2d 1084 (Ill. 1998).

107. *See Majca*, 701 N.E.2d at 1091 (discussing failure of claims due to lack of actual exposure).

108. *See id.* at 1085 (stating facts).

109. *See id.*

110. *See id.*

was covered with dry blood and a mucus-like substance.¹¹¹ Majca immediately went to a hospital where she received six stitches for the cut and took an HIV test.¹¹² Majca failed to confront the responsible physician about the carelessly discarded scalpel.¹¹³ The physician died of an AIDS-related illness eight months later.¹¹⁴

In the second cause of action, the unnamed plaintiffs were patients of a dental student at Northwestern University.¹¹⁵ Some time after treatment, the plaintiffs received a letter from the University stating “[W]e [have] learned that a dental student involved in providing care to you in the Dental Clinic has tested positive for HIV”¹¹⁶ Although the letter stated that the chances of any of the plaintiffs contracting the virus were remote, the University still recommended that all the patients be tested for HIV.¹¹⁷

Majca’s claim failed because the scalpel that cut her was unavailable for testing, and as a result, she could not demonstrate that the dried blood on the scalpel was infected with HIV.¹¹⁸ The court surmised that “[a]t most, [Majca has] established that [she] cut her hand on a scalpel that may have been used by an HIV-infected podiatrist.”¹¹⁹ Similarly, the second cause of action failed because the plaintiffs did not point to an incident where their blood or fluids came into contact with the dental student’s blood or fluids.¹²⁰ Therefore, the plaintiffs’ emotional distress damages, genuine or not, were unreasonable as a matter of law.¹²¹

The Minnesota Supreme Court also held that the plaintiff failed to demonstrate actual exposure in *K.A.C. v. Benson*.¹²² In *K.A.C.*, the defendant, Dr. Benson, performed two gynecological procedures on the plaintiff, T.M.W., while he was HIV-positive and suffered from open sores on his

111. *See id.*

112. *See id.* at 1086.

113. *See id.*

114. *See id.*

115. *See id.* at 1087.

116. *Id.*

117. *See id.* But see *Kerins v. Hartley*, 27 Cal. App. 4th 1062, 1068 (Ct. App. 1994) (noting that colleagues of defendant HIV-positive physician said that physicians frequently cut and poke themselves with needles and knives during surgery). Nonetheless, in *Kerins*, the operative report and defendant’s testimony support the contention that he did not cut himself during surgery. *See id.* at 1067-68 (noting results of operative report).

118. *See Majca*, 701 N.E.2d at 1090-91 (collecting facts that demonstrate Majca failed to meet actual exposure requirement).

119. *Id.* at 1091.

120. *See id.* at 1091 (“For example, it was never alleged that: [the defendant] bled into a plaintiff’s mouth by accidentally cutting himself during a dental procedure; [the defendant] pricked himself with a needle prior to using the needle on a plaintiff; or [the defendant] otherwise exposed a plaintiff to HIV.”).

121. *See id.* (noting that, without actual exposure, plaintiffs failed to state cause of action).

122. 527 N.W.2d 553 (Minn. 1995).

hands and forearms.¹²³ The court applied the zone of danger rule because it is the prevailing standard of recovery for emotional distress in Minnesota.¹²⁴ Thus, T.M.W. could only recover if she demonstrated that she was in danger of physical harm.¹²⁵ In fear of AIDS claims, the court explained, only actual exposure to HIV/AIDS shows physical danger.¹²⁶ Hence, T.M.W. was denied recovery because she did not allege that the open sores on Benson's hands or forearms came into contact with her skin or blood.¹²⁷

The actual exposure requirement is based on public policy rationales.¹²⁸ Because of the inherent speculation involved in fear of AIDS claims, courts feel that the actual exposure requirement "ensure[s] the genuineness of the . . . claim."¹²⁹ Furthermore, the actual exposure requirement purports to prevent a flood of litigation.¹³⁰ Similar to the function of the physical injury requirement, courts substitute the actual exposure requirement to objectify the emotional injury.¹³¹

2. *Minority Position—Reasonableness*

a. Defining a Reasonableness Standard

The reasonableness standard permits recovery of purely emotional distress damages for fear of AIDS claims if the plaintiff can prove that a specific occurrence of potential exposure was sufficient to create a reason-

123. See *K.A.C.*, 527 N.W.2d at 555 (stating facts).

124. See *id.* at 559 (stating that Minnesota limits recovery for emotional distress to instances in which plaintiff was placed in physical danger).

125. See *id.* (stating that plaintiff must prove that she was reasonably endangered with physical harm).

126. See *id.* ("[W]e hold that a plaintiff who fails to allege actual exposure to HIV is not, as a matter of law, in personal physical danger of contracting HIV, and thus not within the zone of danger . . .").

127. See *id.* at 560 (noting that plaintiff did not demonstrate any instance in which defendant's skin came into contact with her blood).

128. See, e.g., *Shahvari*, *supra* note 2, at 796 ("[B]y requiring proof of exposure . . . courts seek to ensure the genuineness of the [fear of] AIDS . . . claim.").

129. See *id.* (noting policy behind courts' requirement of proof of exposure); see also *Roes v. FHP, Inc.*, 985 P.2d 661, 667 (Haw. 1999) (stating that "actual exposure to HIV-positive blood . . . pose[s] a direct, immediate, and serious threat to an individual's safety, [and] such exposure would foreseeably engender serious mental distress in a reasonable person" (footnote omitted)). In *Roes*, the court found that the actual exposure requirement was an adequate replacement for the physical harm requirement in measuring the genuineness of a plaintiff's claim. See *Roes*, 985 P.2d at 664-68 (discussing evolution of Hawaii's negligent infliction of emotional distress cause of action from physical injury to actual exposure).

130. See *Shahvari*, *supra* note 2, at 796 (stating that actual exposure requirement discourages others from instituting suits based on less demanding standards).

131. See, e.g., *Carroll v. Sisters of St. Francis Health Servs.*, 868 S.W.2d 585, 594 (Tenn. 1993) ("Because . . . we have never deviated from an objective standard for negligent infliction of emotional distress claims, but have merely employed a different type of objective standard because of the changed nature of the actions, we hereby formally adopt the 'actual exposure' approach.").

able fear of having contracted HIV/AIDS.¹³² The Maryland Court of Appeals adopted the reasonableness standard in *Faya v. Almaraz*.¹³³ In *Faya*, the defendant, Dr. Rudolf Almaraz, performed invasive surgery on the two plaintiffs at a time when he knew he was HIV-positive.¹³⁴ After nearly two years had passed, and Almaraz had succumbed to the disease, the plaintiffs discovered Almaraz's HIV-positive status through a local newspaper article.¹³⁵ Both plaintiffs tested HIV-negative within weeks of reading the article.¹³⁶ Nonetheless, the plaintiffs brought fear of AIDS claims against Almaraz's estate.¹³⁷

The court reasoned, in deciding proximate cause, that the actual exposure requirement produced harsh results.¹³⁸ Thus, the court overturned Almaraz's motion to dismiss and explained that the "actual transmission [requirement] . . . unfairly punish[es] [plaintiffs that] lack [] the requisite information. . . ."¹³⁹

132. *See, e.g.*, *Williamson v. Waldman*, 696 A.2d 14, 22 (N.J. 1997) (adopting standard of reasonableness over actual exposure requirement).

133. 620 A.2d 327 (Md. 1993). Although the court adopted the reasonableness standard, the plaintiff must demonstrate manifestations of the emotional distress. *See id.* at 338-39 (stating that plaintiffs may recover for emotional injuries that can be objectively demonstrated).

134. *See Faya*, 620 A.2d at 329 (stating that Almaraz removed axillary hematoma and benign lump from plaintiffs, respectively).

135. *See id.* (stating facts).

136. *See id.* at 329 (stating that plaintiffs learned of newspaper article around December 6, 1990 and immediately sought testing for HIV).

137. *See id.* (stating that plaintiffs also filed suit against Almaraz's hospital, where he had operative privileges). Although the court never expressly stated that the claim was for negligent infliction of emotional distress, the claim was for only emotional damages and the court used the actual exposure/reasonableness proximate cause analysis. *See id.* at 335-39 (examining what standard applies to plaintiffs' emotional injuries in context of fear of AIDS claim based on negligence). The complaints also included counts of negligent failure to obtain informed consent, fraud, intentional infliction of emotional distress, negligent misrepresentation and breach of contract. *See id.* at 330 (stating counts of complaints).

138. *See id.* at 333-35 (explaining that Almaraz had duty to plaintiff to obtain her consent before operating). The court appeared to find the duty analysis persuasive in ultimately permitting the plaintiffs to overcome the motion to dismiss their fear of AIDS claim. *See id.* (discussing duty).

139. *Id.* at 337. The court took judicial notice of verifiable facts about AIDS. *See id.* at 331 ("[I]n order to place a complaint in context, we may take judicial notice of additional facts that are either matters of common knowledge or [are] capable of certain verification."). This was to dispute the contention by plaintiffs that the lower court improperly took judicial notice of facts that were open to dispute through expert testimony. *See id.* at 332-33 (noting plaintiffs' contention). *But see Dollar Inn, Inc. v. Slone*, 695 N.E.2d 185, 187-88 (Ind. Ct. App. 1998) (refusing to take judicial notice of facts on appeal that pertained to transmission of AIDS because they were not raised at trial and would be utilized to fill "evidentiary gaps").

b. The *Williamson* Decision—Setting a New Standard

Four years later, the New Jersey Supreme Court agreed that the reasonableness standard effectively addressed the issue of proximate cause in *Williamson v. Waldman*.¹⁴⁰ Nevertheless, because of the public policy concern that neither standard effectively combated ignorance about AIDS, the court enhanced the standard by holding that:

[A] person claiming damages for emotional distress based on the fear that she has contracted HIV must demonstrate that the defendant's negligence proximately caused her genuine and substantial emotional distress that would be experienced by a reasonable person of ordinary experience *who has a level of knowledge that coincides with then-current, accurate, and generally available public information about the causes and transmission of AIDS*.¹⁴¹

In *Williamson*, the plaintiff, Karen Williamson, worked for her husband's cleaning business and was assigned to clean the examining room that the defendant physicians maintained.¹⁴² In the process of emptying a common-trash receptacle, Williamson pricked her hand on an improperly discarded lancet.¹⁴³ As a result, she instituted a claim of negligent infliction of emotional distress, asserting that the lancet-stick incident caused her to suffer severe emotional distress due to her fear of contracting HIV/AIDS.¹⁴⁴ The plaintiff tested negative for HIV on every occasion after the incident and therefore suffered purely emotional damages.¹⁴⁵

140. 696 A.2d 14 (N.J. 1997). For a further discussion of how the reasonableness standard addresses proximate cause, see *infra* notes 141-62 and accompanying text.

141. *Williamson*, 696 A.2d at 22 (emphasis added).

142. *See id.* at 16 (stating facts).

143. *See id.* at 15-16 (stating facts). Under New Jersey law, waste must be disposed of in appropriate, correctly labeled, medical-waste receptacles. *See id.* at 17 n.1 (citing New Jersey statutes that govern waste disposal). Williamson was attempting to remove EKG stickers from the trash can when the lancet-stick incident took place. *See Williamson v. Waldman*, 677 A.2d 1179, 1180 (N.J. Super. Ct. App. Div. 1996) (stating facts), *aff'd*, 696 A.2d 14 (N.J. 1997).

144. *See Williamson*, 696 A.2d at 15-16 (stating facts). Williamson asserted that the incident forced her to make "lifestyle changes," which included a decision not to have another baby or engage in unprotected sexual relations with her husband. *See id.* at 16 (stating facts). Nonetheless, Williamson was not alarmed by the incident until she spoke with an acquaintance who was a nurse and who informed her that she was potentially exposed to hepatitis and AIDS. *See id.* (noting that plaintiff became particularly alarmed about contracting hepatitis and AIDS and that nurse told her to go to emergency room). Conversely, Williamson's physician characterized her as a nervous person and had referred her to other doctors for professional treatment of depression prior to the incident. *See id.* at 17 (stating facts).

145. *See id.* at 16 (noting that plaintiff tested negative in July 1992, 1993 and 1994). "After the second negative test result, [plaintiff's physician] informed [her] that her chances of having contracted HIV from the incident were 'slim or remote.'" *Id.* Although it is not addressed in either the appellate or supreme court opinion, it appears that the lancet responsible for Williamson's wound was no

i. Choosing Reasonableness Over Actual Exposure for Proximate Cause

The *Williamson* court reviewed the case law and policy arguments that supported both the actual exposure standard and reasonableness standard to decide which standard was most appropriate.¹⁴⁶ The court noted that, absent an actual exposure standard, a flood of litigation could ensue.¹⁴⁷ In addition, “the strict objective standard . . . [is needed] to counteract general ignorance about AIDS Thus, a low threshold for establishing proximate cause, such as the reasonableness standard, will not discourage misleading and inaccurate information or counteract ignorance”¹⁴⁸ Although the court appeared to agree that the actual exposure standard combats ignorance concerning AIDS, it nonetheless noted articles that contend that the majority standard accomplishes the exact opposite.¹⁴⁹ Presumably, this was to foreshadow the unveiling of their forthcoming enhanced reasonableness standard.¹⁵⁰

First, though, the court reviewed policy considerations in support of the reasonableness standard.¹⁵¹ The court noted that the actual exposure requirement produced harsh results.¹⁵² Moreover, the court determined that the reasonableness standard effectively promoted reasonable care and could ensure the genuineness of the claim.¹⁵³ Finally, the court noted

longer available for testing. *See id.* at 14-24 (failing to address lancet’s availability for testing); *Williamson*, 677 A.2d at 1179-82 (same).

146. *See Williamson*, 696 A.2d at 18-20 (reviewing majority case law). The court explained that some majority jurisdictions have “expressly . . . added the further requirement that a plaintiff prove a medically sound channel of transmission of the HIV virus.” *Id.* at 18. The courts that adopt the channel of transmission requirement are considered to be the majority and normally umbrella the medically sound channel requirement under one rule with actual exposure to HIV. *See id.* at 18-19 (discussing overall majority view including discussion of channel of transmission as part of majority’s view of actual exposure). The *Williamson* court also recognized some of the public policy arguments behind the actual exposure requirement. *See id.* at 19-20 (noting that actual exposure requirement ensures courts will not be flooded with fraudulent claims and combats ignorance about the disease). The court also cited commentators who believed that the actual exposure requirement did not address ignorance about AIDS. *See id.* at 20 (collecting articles).

147. *See id.* at 19 (stating that one policy rationale of actual exposure requirement is to deter flood of litigation).

148. *Id.*

149. *See id.* at 20 (“[T]he inference is that a reasonable person of ordinary intelligence would not fear that he would develop AIDS unless he had proof that he had actually been exposed to the virus. This is contrary to common experience, however.” (quoting Edward M. Slaughter, *AIDS Phobia: The Infliction of Emotional Distress and the Fear of AIDS*, 16 U. HAW. L. REV. 143, 160 (1994))).

150. *See generally Williamson*, 696 A.2d at 21-22 (discussing enhanced reasonableness standard).

151. For a further discussion of the court’s review of the reasonableness standard, see *infra* notes 152-55 and accompanying text.

152. *See Williamson*, 696 A.2d at 20 (stating that actual exposure requirement can produce harsh results).

153. *See id.* at 20 (stating that reasonableness standard promotes reasonable care and can assure genuineness of claims).

that the reasonableness standard more readily provided redress for legitimate claims.¹⁵⁴ The court concluded that the policy arguments in support of the reasonableness standard outweighed those in support of the actual exposure requirement.¹⁵⁵

ii. Unveiling a New Standard—The Enhanced Reasonableness Standard

Because public policy plays such a strong role in the debate over which standard to apply in the context of a fear of AIDS claim, the *Williamson* court cited the greatest policy concern regarding AIDS, education about the disease, to enhance the reasonableness standard.¹⁵⁶ The enhanced reasonableness standard, the court explained, imputes a “level of knowledge that coincides with then-current, accurate, and generally available public information about the causes and transmission of AIDS” to the plaintiff.¹⁵⁷ The court hoped that the enhancement would promote education, which would, in turn, calm the irrational fears that confront the disease and fight the prejudice and discrimination that surround it.¹⁵⁸ Additionally, because no other standard took an affirmative approach, the court noted that alternative standards indirectly encourage ignorance.¹⁵⁹

Turning to the validity of Williamson’s claim, the court held that she could recover for the emotional distress suffered during the window of

154. *See id.* at 20 (“[T]he reasonableness standard accommodates the tort policy of providing redress for harm suffered at the hands of another.”).

155. *See id.* at 20-21 (stating that reasonableness standard effectively fulfills basic goals of tort doctrine).

156. *See id.* at 21-22 (discussing enhancement of reasonableness standard in fear of AIDS claims). Imputation of this knowledge is applied in the latter portion of the opinion. *See id.* at 23 (applying enhanced reasonableness standard to circumstances of Williamson’s claim). The plaintiff’s physician originally told her that she needed to be tested annually for a period of seven to ten years. *See id.* at 16 (noting physician’s recommendation). Normally, a nearly mathematically conclusive test can be administered six months after the exposure. *See Kerins v. Hartley*, 33 Cal. Rptr. 2d 172, 175 (Ct. App. 1994) (stating that HIV test is ninety-five percent accurate six months after exposure). Because the imputation of knowledge applied in *Williamson* requires the plaintiff to know about the available facts on AIDS, the court found that it was illogical to hold the original tortfeasor responsible for the plaintiff’s physician’s misinformation. *See Williamson*, 696 A.2d at 24 (“The circumstances of this case . . . militate against holding the initial tortfeasors liable for the consequences of the subsequent incorrect medical advice Our adoption of the enhanced reasonableness standard . . . is based . . . on the policy consideration that ignorance concerning HIV and AIDS ought to be discouraged”).

157. *Williamson*, 696 A.2d at 22.

158. *See id.* at 21-22 (stating that reasonableness standard that requires only common knowledge about AIDS actually encourages misperceptions about the disease); *cf. WARD*, *supra* note 1, at 18 (stating that education about HIV/AIDS has lessened pervasiveness of negative stigma).

159. *See Williamson*, 696 A.2d at 21-22 (noting that alternative standards do not adequately address education about HIV/AIDS).

anxiety.¹⁶⁰ The window of anxiety runs from the time that the plaintiff discovers that he or she may have been exposed to HIV until he or she receives a test that conclusively demonstrates his or her status.¹⁶¹ The court concluded that any person would reasonably be distressed after puncturing their hand on medical waste, or at least until he or she could obtain HIV test results.¹⁶²

IV. ADOPTING THE ENHANCED REASONABLENESS STANDARD

In light of the progress in negligent infliction of emotional distress and the devastating characteristics of HIV/AIDS, fear of AIDS claims are worthy of individual evaluation.¹⁶³ Consequently, the enhanced reasonableness standard formulated in *Williamson* effectively undertakes this individual evaluation by permitting recovery through a standard of reasonableness that imputes accurate knowledge of the disease to the plaintiff.¹⁶⁴ Moreover, the enhanced reasonableness standard adequately addresses the policy considerations of tort law.¹⁶⁵

A. *Progress in Recognizing Emotional Distress*

Over the past century, tort law has expanded its recognition of emotional distress damages through the tort of negligent infliction of emotional distress.¹⁶⁶ Tort law was established, in part, to assign liability to those who have committed a wrong.¹⁶⁷ In this pursuit, tort law has recognized that stand-alone emotional distress damages are worthy of redress in certain circumstances.¹⁶⁸ Most strikingly, *Dillon* rejected the zone of danger rule in bystander claims because the emotional trauma suffered was

160. See *id.* at 23 (stating that damages should be constricted to window of anxiety).

161. See *id.* (stating that window of anxiety is "the period from the time of possible exposure to that point when a plaintiff knows or should know that [he or] she was not infected with HIV").

162. See *id.* at 24 (permitting recovery of *Williamson*'s reasonable emotional distress).

163. For a further discussion of the reasons to adopt the enhanced reasonableness standard, see *infra* notes 188-219 and accompanying text.

164. For a further discussion of the enhanced reasonableness standard adopted by *Williamson*, see *supra* notes 140-62 and accompanying text.

165. For a further discussion of how the enhanced reasonableness standard addresses policy considerations, see *supra* notes 146-62 and accompanying text.

166. For a further discussion of the evolution of negligent infliction of emotional distress, see *supra* notes 23-75 and accompanying text.

167. See John A. Turcotte, *When You Should Have Known: Rethinking Constructive Knowledge in Tort Liability for Sexual Transmission of HIV*, 52 ME. L. REV. 261, 262 (2000) (noting that purpose of tort law is to apportion responsibility).

168. For a further discussion of stand-alone emotional distress damages, see *supra* notes 23-75 and accompanying text.

both foreseeable and worthy of redress.¹⁶⁹ There, the court reasoned that the “interests of meritorious plaintiffs should prevail over . . . administrative difficulties.”¹⁷⁰ As a result, many jurisdictions adopted *Dillon’s* foreseeability factors to address legitimate claims.¹⁷¹

Continuing this evolution, courts have widely recognized emotional distress damages in fear of cancer claims.¹⁷² In doing so, courts discarded the physical injury requirement in favor of standards of recovery that varied in the burden placed on the plaintiff.¹⁷³ One of the most strict applications was the more likely than not standard set forth in *Potter*.¹⁷⁴

Nevertheless, by comparing the primary rationale for the strict standard in *Potter* and the fundamental characteristics of the diseases, it is apparent that fear of AIDS claims warrant a broader standard of recovery than fear of cancer claims.¹⁷⁵ In creating its more likely than not standard, *Potter* relied heavily on the possibility of opening the floodgates of litigation.¹⁷⁶ Logically, a floodgates argument may apply to fear of cancer

169. See *Dillon v. Legg*, 441 P.2d 912, 915 (Cal. 1968) (stating that rejecting mother’s distress because of distance exposes arbitrary nature of zone of danger rule).

170. *Id.* at 918. The *Dillon* court also encouraged courts to use the foreseeability factors as a guide in performing a case-by-case analysis of bystander emotional distress claims. See *id.* at 921 (“Such reasonable foreseeability does not turn on whether the particular defendant . . . would have in actuality foreseen the exact accident and loss; it contemplates that courts, on a case-to-case basis, analyzing all the circumstances, will decide what the ordinary man under such circumstances should reasonably have foreseen.”); see also Leibson, *supra* note 37, at 195 (explaining that emotional distress damages should be evaluated on case-by-case basis).

171. For a further discussion of jurisdictions adopting the foreseeability factors, see *supra* note 56 and accompanying text.

172. See *Fink, supra* note 63, at 782-86 (analyzing bystander claims as lead-in to fear of disease claims).

173. See, e.g., *Wisniewski v. Johns-Manville Corp.*, 759 F.2d 271, 274 (3d Cir. 1985) (requiring physical injury requirement); *DeStories v. City of Phoenix*, 744 P.2d 705, 711 (Ariz. Ct. App. 1987) (requiring physical injury to succeed on asbestos exposure claim); *Eagle-Picher Indus., Inc. v. Cox*, 481 So. 2d 517, 528-29 (Fla. Dist. Ct. App. 1985) (requiring physical injury in enhanced risk of cancer claim after exposure to asbestos); *Wetherhill v. Univ. of Chi.*, 565 F. Supp. 1553, 1559-60 (N.D. Ill. 1983) (requiring plaintiffs exposed to DES to demonstrate reasonableness of fear of cancer and physical impact).

174. See *Macy’s Cal., Inc. v. Sup. Ct.*, 48 Cal. Rptr. 2d 496, 501 (Ct. App. 1995) (describing standard created in *Potter* as strict).

175. See *Temple-Inland Prod. Corp. v. Carter*, 993 S.W.2d 88, 95 (Tex. 1999) (stating that “[t]he principles we have used to deny recovery of mental anguish damages for fear of the possibility of developing a disease as a result of an exposure to asbestos may not yield the same result when the exposure is to some other dangerous or toxic element”).

176. See *Potter v. Firestone Tire & Rubber Co.*, 863 P.2d 795, 811-14 (Cal. 1993) (citing floodgates rationale for promulgating more likely than not standard). In *Potter*, the court stated:

[A]ll of us are potential fear of cancer plaintiffs, provided we are sufficiently aware of and worried about the possibility of developing cancer from exposure to or ingestion of a carcinogenic substance. The enormity of the class of potential plaintiffs cannot be overstated; indeed, a single

claims because of society's mass exposure to carcinogens.¹⁷⁷ On the contrary, exposure to AIDS occurs in limited circumstances.¹⁷⁸ The factual circumstances of most cases demonstrate that even potential exposure to AIDS is rather limited.¹⁷⁹ Fear of AIDS claims find their genesis in improperly disposed needles, surgeons with AIDS and unsterile surgical tools.¹⁸⁰ Thus, a strict standard of recovery is unnecessary to restrict floodgates in fear of AIDS claims.¹⁸¹

Moreover, there are fundamental differences between the two diseases. Unlike cancer, potential exposure to HIV/AIDS is treated medically the same as actual exposure.¹⁸² Potentially exposed persons must conduct themselves as if they are infected in their contact with family and friends.¹⁸³ It appears inequitable to leave potentially exposed plaintiffs

class action may easily involve hundreds, if not thousands, of fear of cancer claims.

Id. at 812. See also Symposium, *supra* note 59, at 308-09 (stating that class of potential plaintiffs could be never ending because of everyday exposure).

177. See *Jackson v. Johns-Manville Sales Corp.*, 750 F.2d 1314, 1323 (5th Cir. 1985) (estimating that over twenty-one million Americans have experienced significant exposure to asbestos fibers).

178. See Lauren J. Camillo, Note, *Adding Fuel to the Fire: Realistic Fears or Unrealistic Damages in AIDS Phobia Suits?*, 35 S. TEX. L. REV. 331, 350 (1994) (noting that there are limited modes of transmission). For a further discussion of the modes of transmission, see *supra* notes 80-87 and accompanying text.

179. See generally *Faya v. Almaraz*, 620 A.2d 327 (Md. 1993) (HIV-positive surgeon performed operations on plaintiffs); *Williamson v. Waldman*, 696 A.2d 14 (N.J. 1997) (exposure through improperly discarded lancet); *Hinote v. Rio Grande Surgery Ctr. Assocs.*, No. 13-99-489-6V, 2000 Tex. App. LEXIS 6011 (App. Aug. 31, 2000) (same anesthesia kit that was used on patient with hepatitis C was used on plaintiff). Cf. *DOBBS*, *supra* note 23, § 312, at 849 ("When the defendant owes an independent duty of care to the plaintiff, there is no risk of unlimited liability to an unlimited number of people.").

180. For examples of these claims, see sources cited in *supra* note 179.

181. See, e.g., *Dillon v. Legg*, 441 P.2d 912, 917 n.3 (Cal. 1968) (stating that "courts are responsible for dealing with cases on their merits, whether there be few suits or many"). Thus, if the courts can not handle the claims then there should be more courts. See *id.* at 917 n.3 (stating that multitude of claims exemplifies need for redress).

182. See *Hartwig v. Or. Trail Eye Clinic*, 580 N.W.2d 86, 92 (Neb. 1998) (stating that person potentially exposed to HIV must conduct his or her life as if they were actually exposed); *Occupational Exposure to HIV*, *supra* note 85 (outlining CDC's precautions for health-care workers exposed to HIV-positive blood). The CDC states that:

During the follow-up period, especially the first 6-12 weeks when most infected persons are expected to show signs of infection, you should follow recommendations for preventing transmission of HIV. These include refraining from blood, semen, or organ donation and abstaining from sexual intercourse. If you choose to have sexual intercourse, using a latex condom consistently and correctly may reduce the risk of HIV transmission. In addition, women should not breast-feed infants during the follow-up period to prevent exposing their infants to HIV in breast milk.

Id.

183. See *id.* (stating that persons potentially exposed should abstain from intimate contact).

uncompensated for the six-month testing period when, in most instances, the cost of preventing the negligent conduct was slight.¹⁸⁴ Additionally, negative stigma attaches to an HIV-positive diagnosis, which may increase the emotional distress suffered by a fear of AIDS plaintiff.¹⁸⁵ Finally, AIDS is incurable.¹⁸⁶ Conversely, someone who is exposed to a carcinogen and ultimately develops cancer maintains a fifty-nine percent overall survival rate.¹⁸⁷ Hence, a broader standard of recovery is appropriate in fear of AIDS claims.

B. *Enhanced Reasonableness Versus Actual Exposure*

The broader standard of recovery that this Note adopts is the enhanced reasonableness standard formulated in *Williamson*.¹⁸⁸ It effectively addresses fear of AIDS claims by more readily recognizing legitimate claims, promoting reasonable care and affirmatively combating ignorance about AIDS.¹⁸⁹

A main utility of the actual exposure requirement is that it promotes predictability in the adjudication of fear of AIDS claims.¹⁹⁰ Nevertheless,

184. See, e.g., Levit, *supra* note 26, at 157-58 (“[T]his departure from the previous all-or-nothing approach to recovery reaffirms ‘the loss-assigning role of [tort] law,’ properly placing on the defendant the burden of ‘grappl[ing] with imponderables of chance.’” (quoting Joseph H. King, Jr., *Causation, Valuation, and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences*, 90 YALE L.J. 1353, 1377, 1378 (1981))).

185. For a further discussion of the negative treatment AIDS victims have received, see *supra* notes 96-98 and accompanying text.

186. See *Doe v. Wash. Univ.*, 780 F. Supp. 628, 632 (E.D. Mo. 1991) (noting that AIDS is incurable); Amy L. McGuire, Comment, *AIDS as a Weapon: Criminal Prosecution of HIV Exposure*, 36 Hous. L. Rev. 1787, 1793 (1999) (noting that AIDS remains incurable).

187. See American Cancer Society, *What Percentage of People Survive Cancer?*, available at <http://www3.cancer.org/cancerinfo/sitecenter> (last visited Oct. 21, 2000) (stating that overall survival rate is fifty-nine percent). The percentage is measured by the five-year survival rate, which compares survival rate of cancer victims to those in general population who are the same age, gender and race. See *id.* (noting calculation of percentage); see also Suzanne V. Cocca, Note, *Who's Monitoring the Quality of Mammograms? The Mammography Quality Standards Act of 1992 Could Finally Provide the Answer*, 19 AM. J.L. & MED. 313, 314 (1993) (noting that if breast cancer is detected early, five-year survival rate is ninety-one percent).

188. See *Williamson*, 696 A.2d at 21-22 (discussing enhanced reasonableness standard).

189. For a further discussion of how the enhanced reasonableness standard addresses these public policy issues, see *supra* notes 156-62 and accompanying text.

190. See generally Levit, *supra* note 26, at 136-37 (noting that courts seek order and predictability). The author notes that the “individualized goal of compensatory justice” confronts courts’ desire to formulate predictable rules. See *id.* at 139 (stating that development of intangible harm clashes with recognition of legitimate claims). “If emphasis is placed on predictability of outcomes, compensation of individual harms will suffer.” *Id.* at 164; see also *Majca v. Beekil*, 701 N.E.2d 1084, 1090 (Ill. 1998) (stating that objective actual exposure standard ensures stability, consistency and predictability). “[A]n actual exposure requirement prevents an individual from recovering damages for a fear of contracting AIDS when that fear

choosing form over substance readily disposes of legitimate claims as compared to a standard of reasonableness.¹⁹¹ The mechanical nature of the actual exposure requirement was demonstrated in *Majca*.¹⁹² In *Majca*'s first cause of action, the plaintiff was unable to prove actual exposure because the scalpel was no longer available for testing.¹⁹³ As the *Faya* court concluded, it is inequitable to punish plaintiffs for lacking the requisite information to prove actual exposure.¹⁹⁴ Fortunately, some courts that favor the actual exposure requirement have made exceptions to it.¹⁹⁵

In *Hartwig v. Oregon Trail Eye Clinic*,¹⁹⁶ the Nebraska Supreme Court refused to apply the actual exposure requirement when the needle that pricked the plaintiff was unavailable for testing.¹⁹⁷ The court recognized that when a plaintiff has been potentially exposed to HIV/AIDS through a medically recognized channel of transmission and it is impracticable to determine whether the product of transmission was HIV-positive, then her or his fear of AIDS is not unreasonable as a matter of law.¹⁹⁸ Likewise, in *South Central Regional Medical Center v. Pickering*,¹⁹⁹ the plaintiff was pricked with a lancet that the defendant's nurse used on other unknown patients.²⁰⁰ Unfortunately, the lancet kit was disposed of before it could be tested.²⁰¹ The court, determined not to abandon the actual exposure re-

is based on lack of information or inaccurate information regarding the transmission of HIV." *Majca*, 701 N.E.2d at 1090.

191. See, e.g., *Chester v. Mustang Mfg. Co.*, 998 F. Supp. 1039 (N.D. Iowa 1998) (resolving bystander liability by determining whether plaintiff's husband was dead when she arrived on scene of accident, rather than evaluating legitimacy of plaintiff's emotional distress).

192. See *Majca*, 701 N.E.2d at 1091-92 (applying actual exposure requirement).

193. See *id.* at 1091 (noting that scalpel was no longer available for testing).

194. See *Faya v. Almaraz*, 620 A.2d 337, (Md. 1993) (stating that it is unfair to punish plaintiffs who cannot prove actual exposure because they lack information to do so).

195. See *S. Cent. Reg'l Med. Ctr. v. Pickering*, 749 So. 2d 95, 102 (Miss. 1999) (making exception to strict actual exposure requirement); *Hartwig v. Or. Trail Eye Clinic*, 580 N.W.2d 86, 92 (Neb. 1998) (same).

196. 580 N.W.2d 86 (Neb. 1998).

197. See *Hartwig*, 580 N.W.2d at 89 (noting that needles that pricked plaintiff were never tested and presumably no longer available).

198. See *id.* at 94 (describing when plaintiff can recover for fear of AIDS in absence of key evidence).

199. 749 So. 2d 95 (Miss. 1999).

200. See *Pickering*, 749 So. 2d at 97 (stating facts). *Pickering* was tested for HIV while at the hospital and five more times thereafter. See *id.* at 97-98 (noting that *Pickering* was later tested in November 1987, January 1988, March 1988, September 1988 and once by another institution in August 1990). The same kit was used on at least eleven other patients. See *id.* at 97 (stating facts).

201. See *id.* at 97 (stating facts). The nurse claimed that she had not disposed of them sooner because the receptacle was new to the room and she was unfamiliar with its presence. See *id.* ("Pickering claims that the nurse responded that the receptacle was only implemented two weeks earlier and that she had not grown accustomed to using it.").

quirement, created an elaborate pleading system, where a rebuttable presumption of actual exposure arose in favor of the plaintiff in a fear of AIDS claim when the defendant had caused the best evidence to be destroyed.²⁰²

Application of the actual exposure requirement in such circumstances begs the question as to why courts need apply it at all. These decisions appear to destroy consistency by mutating the standard.²⁰³ Moreover, a per se barrier to recovery can only be appropriate when the judicial system adopts a presumption that many plaintiffs inherently bring false suits and that such a barrier is required to weed out false claims before they make it to the courts.²⁰⁴ Nevertheless, the function of evaluation should be left to the fact-finder and, as a result, fear of AIDS claims should be individually evaluated with the enhanced reasonableness standard.²⁰⁵

The enhanced reasonableness approach will also promote a greater degree of reasonable care. Tort law was also established to "mold[] behavior."²⁰⁶ Presumably, when liability is imposed on defendants, a higher degree of care will result.²⁰⁷ For example, *Majca, Pickering, Hartwig and Williamson* resulted, in part, because of unsterile instruments.²⁰⁸ Weighing the slight cost of properly sterilizing the instruments against the gravity of the harm, it appears equitable for the defendants to bear the cost of their negligence.²⁰⁹

202. See *id.* at 102 ("[W]here the defendant allowed or caused the best evidence to be destroyed . . . a rebuttable presumption of actual exposure would arise in favor of the plaintiff.").

203. See, e.g., *id.* (creating rebuttable presumption test, which is unique to that jurisdiction).

204. See, e.g., Jeffrey B. Greenstein, Note, *New Jersey's Continuing Expansion of Tort Liability: Williamson v. Waldman and the Fear of AIDS Cause of Action*, 30 RUTGERS L.J. 489, 489 (1999) (noting that if person is stuck with discarded needle in New Jersey, they should "put [a] band-aide on, hire a lawyer, and immediately file suit").

205. See DOBBS, *supra* note 23, § 308, at 836 (noting that, in addition to trials, judicial review of excessive awards also serves as a check on fraudulent claims); Miller, *supra* note 37, at 693 (stating that determination of claim's genuineness should be left to fact-finder).

206. Levit, *supra* note 26, at 179.

207. See, e.g., *Madrid v. Lincoln County Med. Ctr.*, 923 P.2d 1154, 1162 (N.M. 1996) ("In light of the deadly nature of the AIDS virus, reasonable care should be encouraged, for example, in the handling of potential disease-transmitting agents such as blood products. The potential for liability encourages those engaged in conduct that may result in an exposure incident to use reasonable care.").

208. See *Majca v. Beekil*, 701 N.E.2d 1084, 1085 (Ill. 1998) (improperly disposed needle); *S. Cent. Reg'l Med. Ctr. v. Pickering*, 749 So. 2d 95, 97 (Miss. 1999) (lancets used on other patients); *Hartwig v. Or. Trail Eye Clinic*, 580 N.W.2d 86, 96 (Neb. 1998) (improperly disposed needle); *Williamson v. Waldman*, 696 A.2d 14, 16 (N.J. 1997) (improperly disposed needle).

209. See DOBBS, *supra* note 23, at 340 (explaining Judge Learned Hand's classic negligence formula).

The additional feature of imputing then-current knowledge about HIV/AIDS to the plaintiff should dispel any remaining reservations about its appropriateness. By imputing then-current knowledge to plaintiffs, the enhanced reasonableness standard is the only standard that affirmatively combats ignorance.²¹⁰ Education about AIDS is more important than ever before.²¹¹ Commentators report that many people have become apathetic about the disease.²¹² The majority of jurisdictions contend that an actual exposure requirement promotes education about the disease and ensures that the plaintiff's claim is not based on misconceptions.²¹³ Nevertheless, it is generally not explained how the standard does this.²¹⁴ On the other hand, the enhanced reasonableness standard affirmatively combats ignorance.²¹⁵

In all tort claims, it is appropriate to impute a duty to mitigate damages upon the plaintiff.²¹⁶ Now, more than ever before, information about AIDS is readily available through multiple channels and needs to be disseminated to the public.²¹⁷ As a result of the plaintiff's investigation, he or she may discover that the mathematical chances of transmission are, in fact, extremely low. As a result, the distress or damages are effectively mitigated.²¹⁸ Nevertheless, if a potential plaintiff foregoes the investiga-

210. See *Williamson*, 696 A.2d at 22 (describing enhanced reasonableness standard).

211. See Chadwick, *supra* note 1, at 143 ("As the prevalence of AIDS cases has increased, so has the public's awareness of the dire consequences of infection with the virus causing AIDS. For many, the omnipresence of AIDS has led to fear; in some cases, the fear has reached the level of hysteria.").

212. See Karyn Miller-Medzon, *Risky Behavior Spurs AIDS Threat; New Therapies Lead to Infection Apathy*, BOSTON HERALD, July 30, 2000, at O63 (stating that because of effectiveness of new drug therapies small part of Massachusetts population figures they will be able to adequately treat HIV if infected).

213. See *Brzoska v. Olson*, 668 A.2d 1355, 1363 (Del. 1995) (stating that AIDS "spawns widespread public misperception" and absence of actual exposure requirement would encourage paranoia about the disease).

214. See *Carroll v. Sisters of St. Francis Health Servs., Inc.*, 868 S.W.2d 585, 594 (Tenn. 1993) (noting that opinions in favor of actual exposure requirement rarely explain rationale).

215. For a further discussion of the enhanced reasonableness standard, see *supra* notes 156-62 and accompanying text.

216. See, e.g., *Burns v. Hanson*, 734 A.2d 964, 975 (Conn. 1999) (noting that plaintiff has duty to mitigate damages in negligence claims).

217. One can simply explore the Internet for HIV/AIDS informational websites. Examples include the Center for Disease Control (<http://www.cdc.gov/>), National Institutes of Health (<http://www.nih.gov/>), AIDS: Education and Prevention from the Growing Epidemic (<http://library.thinkquest.org/10631/>), Johns Hopkins AIDS Service (<http://www.hopkins-aids.edu/educational/index.edu.html>), YouthHIV.org (<http://www.youthhiv.org/>) and HIV Insite (<http://hivinsite.ucsf.edu/>). Furthermore, the CDC provides an informational hotline at 1-800-342-2437 and a treatment information service at 1-800-448-0440.

218. See, e.g., *Kerins v. Hartley*, 27 Cal. App. 4th 1062, 1068 n.3 (Ct. App. 1994) (relying on methodical analysis to demonstrate that plaintiff who was patient of HIV-positive physician and already received one HIV-negative result, stood, at most, one in 300,000 chance of contracting HIV). *Kerins* is one of the rare opin-

tion then *Williamson* imputes to him or her what a reasonable investigation would uncover.²¹⁹

V. CONCLUSION

This Note finds that the enhanced reasonableness standard, formulated in *Williamson*, should govern fear of AIDS claims. It is consistent with the evolution of negligent infliction of emotional distress, in which courts have liberalized their recovery for emotional distress damages. Furthermore, the enhanced reasonableness standard effectively addresses the unique characteristics of HIV/AIDS and the basic policy concerns that influence tort liability.

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ions that relied on statistical analysis to address a fear of AIDS claim. *See also* Shahvari, *supra* note 2, at 798 (encouraging courts to assess statistical probabilities of contracting HIV/AIDS when evaluating fear of AIDS claims).

219. *See Williamson v. Waldman*, 696 A.2d 14, 21-22 (N.J. 1997) (discussing enhanced reasonableness standard).