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AIDSphobia and the "Window of Anxiety": Enlightened Reasoning or Concession to Irrational Fear?

Ivan Yip

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AIDSPHOBIA* AND THE "WINDOW OF ANXIETY":** ENLIGHTENED REASONING OR CONCESSION TO IRRATIONAL FEAR?

[T]he average person has a profound negative bias toward AIDS. . . . "They'll be asked, 'Well, do you think you can really contract HIV this way?' They'll say 'no,' but it brings to mind things they just don't want to think about—homosexuality, death, drugs." . . . [A] key factor in the bias is "sympathetic magic"—the belief, commonly found in traditional cultures, that when two objects meet, the characteristics of one can be transmitted to the other.¹

INTRODUCTION

Acquired immunodeficiency syndrome ("AIDS") is a fatal disease for which there is still no cure.² Thirteen years after the beginning of the AIDS epidemic, however, more is known about the causative agent, human immunodeficiency virus ("HIV"), than about any other virus.³ In addition, there are methods proven to help prevent the transmission of HIV.⁴ Yet, despite both the widespread availability of this information and efforts on the part of educators to disseminate it, there remains an "obdurate ignorance surrounding the subject" and "many people remain confused about how the disease is transmitted."⁵

Not surprisingly, in the United States there is a growing

* The term "AIDSphobia" refers to the fear of contracting HIV or developing AIDS. See, e.g., *Ordway v. County of Suffolk*, 154 Misc. 2d 269, 271-72, 583 N.Y.S.2d 1014, 1015-16 (Sup. Ct. 1992); *Castro v. New York Life Ins. Co.*, 153 Misc. 2d 1, 4, 588 N.Y.S.2d 695, 697 (Sup. Ct. 1991).

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

¹ David Gelman, *A Resistance to Reason*, NEWSWEEK, Nov. 29, 1993, at 79.

² See *infra* notes 22-35 and accompanying text for a discussion of HIV and AIDS.

³ Michael H. Merson, *Slowing the Spread of HIV: Agenda for the 1990s*, 260 SCI. 1266 (1993).

⁴ For example, because AIDS is "essentially a sexually transmitted disease," using condoms during sex, having fewer sex partners and choosing non-penetrative forms of sex can slow the spread of the AIDS epidemic. *Id.* at 1266-67.

⁵ Gelman, *supra* note 1, at 79.

body of litigation generated both by the fear of contracting HIV or developing AIDS and by the fear of those who are, indeed, infected with HIV or who have AIDS.⁶ Because HIV is spread through sexual contact and the exchange of bodily fluids, cases involving HIV/AIDS have arisen in a variety of contexts. Claims have been based on the sexual transmission of HIV⁷ and the transmission of HIV from contaminated blood⁸ and blood components.⁹ Still other actions have involved employment discrimination,¹⁰ the segregation of HIV-infected indi-

⁶ See *infra* notes 22-32 and accompanying text for a discussion of the distinction between HIV and AIDS.

⁷ See, e.g., *Doe v. Johnson*, 817 F. Supp. 1382 (W.D. Mich. 1993) (tort action against sex partner for wrongful transmission of HIV); *Virgin Islands v. Roberts*, 756 F. Supp. 898 (D.V.I. 1991) (government sought order compelling defendant in criminal rape trial to undergo HIV-antibody testing); *People v. Dempsey*, 610 N.E.2d 208 (Ill. App. Ct. 1993) (defendant convicted of criminal transmission of HIV).

⁸ See, e.g., *Kirkendall v. Harbor Ins. Co.*, 698 F. Supp. 768 (W.D. Ark. 1988) (action against blood bank after patient received transfusion of HIV-contaminated blood), *aff'd*, 887 F.2d 857 (8th Cir. 1989); *Kozup v. Georgetown Univ.*, 663 F. Supp. 1048 (D.D.C. 1987) (action brought by the parents of a child who died as a result of receiving HIV-contaminated blood transfusion), *aff'd in relevant part*, 851 F.2d 437 (D.C. Cir. 1988); *Belle Bonfils Memorial Blood Ctr. v. District Ct.*, 763 P.2d 1003 (Colo. 1988) (action brought by patient who had contracted HIV through blood transfusion); *Rasmussen v. South Fla. Blood Servs.*, 500 So. 2d 533 (Fla. 1987) (action seeking the identities of blood donors after plaintiff received HIV-contaminated blood transfusion); *Krygier v. Airweld, Inc.*, 137 Misc. 2d 306, 520 N.Y.S.2d 475 (Sup. Ct. 1987) (same); *Tarrant County Hosp. Dist. v. Hughes*, 734 S.W.2d 675 (Tex. Ct. App. 1987) (action seeking names and addresses of blood donors after plaintiff's daughter had contracted HIV through a blood transfusion).

⁹ See, e.g., *Seitzinger v. American Red Cross*, No. 90-0046, 1991 WL 88023 (E.D. Pa. May 21, 1991) (action against supplier after transfusion of HIV-contaminated clotting factor for hemophiliacs); *Doe v. Travenol Lab., Inc.*, 698 F. Supp. 780 (D. Minn. 1988) (action against manufacturer of anti-hemophilic factor after infection with HIV); *Poole v. Alpha Therapeutic Corp.*, 698 F. Supp. 1367 (N.D. Ill. 1988) (hemophiliac patient claiming to have been infected with HIV after receiving an anti-hemophilic factor brought an action against those in the factor's distribution chain).

Hemophiliacs are more susceptible to HIV infection because the blood clotting protein (factor VIII) is chemically unstable and cannot be put through the usual purification process without being destroyed. RONALD MUNSON, INTERVENTION AND REFLECTION: BASIC ISSUES IN MEDICAL ETHICS 214 (4th ed. 1992). In addition, a single injection of factor VIII may contain the protein from as many as 2500 people. *Id.*

¹⁰ See, e.g., *Doe v. Attorney Gen. of United States*, 941 F.2d 780 (9th Cir. 1991) (physician with AIDS brought breach of contract action for FBI's refusal to send agents and applicants for physical exams allegedly because he was HIV-infected); *Doe v. District of Columbia*, 796 F. Supp. 559 (D.D.C. 1992) (HIV-positive firefighter applicant brought an employment discrimination claim when offer of

viduals,¹¹ the confidentiality of an individual's HIV-positive status,¹² and the denial of medical treatment to HIV-infected individuals.¹³

employment was withdrawn); *Cain v. Hyatt*, 734 F. Supp. 671 (E.D. Pa. 1990) (regional partner of law firm brought action against firm claiming he was discharged because of his HIV-infected status); *Plowman v. United States Dep't of Army*, 698 F. Supp. 627 (E.D. Va. 1988) (HIV-infected civilian employee's action against former supervisor who allegedly forced him to resign because he was HIV-positive); *see also Doe v. Washington Univ.*, 780 F. Supp. 628 (E.D. Mo. 1991) (action by dental student who was disenrolled by a university committee because of his HIV-positive status).

Other employment based actions have concerned mandatory testing policies. *See, e.g., Anonymous Fireman v. City of Willoughby*, 779 F. Supp. 402 (N.D. Ohio 1991) (challenging city's policy of mandatory HIV-status testing for firefighters and paramedics as part of annual physical exam); *Glover v. Eastern Neb. Community Office*, 686 F. Supp. 243 (D. Neb. 1988) (enjoining enforcement of an infectious disease policy requiring mandatory HIV testing of health services employees), *aff'd*, 867 F.2d 461 (8th Cir.), *cert. denied*, 493 U.S. 932 (1989).

¹¹ *See, e.g., Harris v. Thigpen*, 941 F.2d 1495 (11th Cir. 1991) (action challenging the uniform segregation of prisoners testing positive for HIV); *Chalk v. United States Dist. Ct.*, 840 F.2d 701 (9th Cir. 1988) (action brought by HIV-infected teacher after being removed from the classroom and assigned administrative duties); *Doe v. Dolton Elementary Sch.*, 694 F. Supp. 440 (N.D. Ill. 1988) (action challenging school's refusal to allow HIV-infected student to attend); *Thomas v. Atascadero Unified Sch. Dist.*, 662 F. Supp. 376 (C.D. Cal. 1987) (same); *Ray v. School Dist.*, 666 F. Supp. 1524 (M.D. Fla. 1987) (action seeking injunction against plan to segregate three HIV-infected school children from the rest of the student body); *District 27 Community Sch. Bd. v. Board of Educ.*, 130 Misc. 2d 398, 502 N.Y.S.2d 325 (Sup. Ct. 1986) (action by local school boards and community to prohibit an HIV-infected student from attending public school).

¹² *See, e.g., Leckelt v. Board of Comm'rs*, 909 F.2d 820 (5th Cir. 1990) (action by HIV-positive employee after being terminated for failing to comply with hospital's disclosure requirements); *Doe v. Borough of Barrington*, 729 F. Supp. 376 (D.N.J. 1990) (action brought after a police officer publicly disclosed a citizen's HIV-positive status to community residents); *Estate of Behringer v. Medical Ctr.*, 592 A.2d 1251 (N.J. Super. Ct. Law Div. 1991) (action by HIV-infected physician against hospital for failing to keep his diagnosis and test results confidential); *In re Milton S. Hershey Med. Ctr.*, 595 A.2d 1290 (Pa. Super. Ct. 1991) (action by HIV-positive physician to prevent hospital from disclosing his status to colleagues and patients), *aff'd*, 634 A.2d 159 (Pa. 1993); *Hillman v. Columbia County*, 474 N.W.2d 913 (Wis. Ct. App. 1991) (action by inmate of county jail when information regarding his HIV-positive status was publicized among jail employees and other inmates); *see also McBarnette v. Feldman*, 153 Misc. 2d 627, 582 N.Y.S.2d 900 (Sup. Ct. 1992) (estate of deceased HIV-infected dentist asserting physician-patient privilege and confidentiality of HIV and AIDS-related information to challenge a state action seeking the dentist's patient records).

¹³ *See, e.g., Miller v. Spicer*, 822 F. Supp. 158 (D. Del. 1993) (patient was refused medical treatment based upon his perceived sexual preference and HIV status); *Glanz v. Vernick*, 756 F. Supp. 632 (D. Mass. 1991) (physician and clinic refused to perform elective ear surgery because patient tested positive for HIV).

Courts also have been presented with "AIDSphobia" claims by plaintiffs seeking to recover damages for their fear of developing AIDS, allegedly suffered after a potential exposure to HIV.¹⁴ These AIDSphobia claims have been raised where the plaintiff either has established that the object or person causing the fear was contaminated or infected with HIV,¹⁵ or does not know or is unable to determine if the alleged source of infection was contaminated with HIV.¹⁶

¹⁴ See generally Harry H. Lipsig, *AIDS Phobia and Negligent Infliction of Emotional Distress*, N.Y. L.J., Mar. 26, 1992, at 3.

Courts also have faced the question of whether to allow damages for emotional distress where the plaintiff receives a false positive test result for HIV. See, e.g., *M.M.H. v. United States*, 966 F.2d 285 (7th Cir. 1992) (suggesting that recovery for emotional distress may be allowable where the plaintiff is not immediately informed that a second blood test indicates that she is not infected with HIV); *Lubowitz v. Albert Einstein Med. Ctr.*, 623 A.2d 3 (Pa. Super. Ct. 1993) (denying recovery for emotional distress when plaintiff's fear of developing AIDS was based on a false positive test result).

False positive results may occur because of "laboratory error, either labeling errors or technical errors, previous illness, pregnancy, and because other retroviruses have the same molecular weight as the AIDS virus and can mimic a positive finding." *Glover*, 686 F. Supp. at 248 (discussing testing procedures for HIV antibodies).

¹⁵ See *Marriott v. Sedco Forex Int'l Resources*, 827 F. Supp. 59 (D. Mass. 1993) (plaintiffs sought recovery for emotional distress after learning that a hepatitis inoculation they received was contaminated with HIV); *Transamerica Ins. Co. v. Doe*, 840 P.2d 288 (Ariz. Ct. App. 1992) (rescuers were exposed to blood while assisting the victims of a car accident and suffered fear of developing AIDS after learning that one of the victims was HIV-infected); *Ordway v. County of Suffolk*, 154 Misc. 2d 269, 583 N.Y.S.2d 1014 (Sup. Ct. 1992) (surgeon brought action after he learned that his patient was HIV-infected); *Funeral Servs. by Gregory, Inc., v. Bluefield Community Hosp.*, 413 S.E.2d 79 (W. Va. 1991) (mortician alleged fear of developing AIDS after he unknowingly embalmed an HIV-infected corpse), *overruled by Courtney v. Courtney*, 437 S.E.2d 436 (W. Va. 1993); *Johnson v. West Va. Univ. Hosps.*, 413 S.E.2d 889 (W. Va. 1991) (security guard suffered fear after being bitten by a hospital AIDS patient where the patient bit himself and drew blood before biting the guard).

¹⁶ See *Marchica v. Long Island R.R.*, 810 F. Supp. 445 (E.D.N.Y. 1993) (railroad worker was stuck by a hypodermic needle while he was cleaning refuse left in area where drug addicts loitered), *aff'd*, No. 93-7521, 1994 WL 401512 (2d Cir. July 29, 1994); *Burk v. Sage Prods., Inc.*, 747 F. Supp. 285 (E.D. Pa. 1990) (paramedic stuck by needle sticking out of a disposal container for needles and other disposable sharp objects); *Hare v. State*, 173 A.D.2d 523, 570 N.Y.S.2d 125 (2d Dep't 1991) (plaintiff developed fear of developing AIDS after he was bitten by a prison inmate), *appeal denied*, 78 N.Y.2d 859, 580 N.E.2d 1058, 575 N.Y.S.2d 455 (1991); *Castro v. New York Life Ins. Co.*, 153 Misc. 2d 1, 588 N.Y.S.2d 695 (Sup. Ct. 1991) (cleaning worker stuck by needle that was left in an office waste container); *Doe v. Doe*, 136 Misc. 2d 1015, 519 N.Y.S.2d 595 (Sup. Ct. 1987) (wife alleged that her husband had had homosexual affairs that put her at risk of de-

In trying to resolve these AIDSphobia claims, some courts have sought guidance from "cancerphobia" claims, which involve plaintiffs who were exposed to cancer-causing materials.¹⁷ These courts reason that guidance can be gained from cancerphobia cases because of the similarities between cancer and AIDS. Both diseases are incurable and fatal. Also, just like cancer, AIDS takes several years to develop after one is exposed to the disease-causing agent.¹⁸

Recently, courts have tried a new approach in resolving AIDSphobia claims. In AIDSphobia claims brought by patients of HIV-infected surgeons, two state courts allowed the plaintiffs to recover damages. In both cases, the plaintiffs brought their claims after learning that their surgeons were HIV-infected. They alleged fear that they contracted HIV and will develop AIDS because their surgeon performed an invasive procedure during which there was a potential that HIV could have been transmitted.¹⁹ Based on the theory that their HIV-infected surgeons had a duty to disclose their HIV status before performing any invasive procedures, the patients brought claims for, inter alia, negligent infliction of emotional distress.²⁰ The courts, however, limited recovery to a "reasonable window of anxiety" period: from the time the patients learned of their surgeon's HIV infection to the point at which they learned with a reasonable medical certainty that they were not exposed to HIV.²¹

In examining the compensability of AIDSphobia, this Note

veloping AIDS).

¹⁷ See, e.g., *Burk*, 747 F. Supp. at 287 (deciding compensability of an AIDS-phobia claim and analogizing to cases involving the fear of developing cancer or asbestosis from exposure to asbestos); *West Va. Univ. Hosps.*, 413 S.E.2d at 893 ('Another area that is relevant to our consideration of this [AIDSphobia] case is 'cancerphobia,' arising from asbestos-related torts.');

see also John P. Darby, Note, *Tort Liability for the Transmission of the AIDS Virus: Damages for Fear of AIDS and Prospective AIDS*, 45 WASH. & LEE L. REV. 185 (1988) (arguing that courts should apply the same analysis from case law involving carcinogen exposure to claims involving HIV transmission).

¹⁸ See *infra* text accompanying notes 29-31.

¹⁹ For a definition of invasive procedures, see *infra* note 45.

²⁰ *Kerins v. Hartley*, 21 Cal. Rptr. 2d 621 (Ct. App.) (plaintiff brought action against her surgeon after learning that he was HIV-infected during the time he operated on her), *opinion superseded by* 860 P.2d 1182 (Cal. 1993); *Faya v. Almaraz*, 620 A.2d 327 (Md. 1993) (same); see also *infra* note 84.

²¹ See *Kerins*, 21 Cal. Rptr. 2d at 632; *Faya*, 620 A.2d at 337.

first outlines the current state of knowledge regarding HIV and AIDS and briefly surveys how courts have treated cancerphobia and AIDSphobia claims, including a look at the "window of anxiety" cases. This Note argues that limited guidance can be gained from an analysis of cancerphobia cases in attempting to resolve AIDSphobia claims. The analogy between cancerphobia and AIDSphobia claims may seem attractive because of the similarities between carcinogens and HIV: both cause deadly and incurable diseases that require a latency period to develop fully. But with cancerphobia claims, the question at issue is whether the plaintiff will develop cancer after being exposed to a cancer-causing agent. The question of whether the plaintiff was initially exposed to the cancer-causing agent is *not* at issue. With AIDSphobia claims, however, the issue is whether the plaintiff, in fact, was exposed to HIV in the first place.

This Note also argues that the fear of AIDS should not be a legally compensable injury unless the plaintiff satisfies a two-prong test to prove that there was exposure to HIV by either: (1) testing positive for HIV antibodies; or (2) showing that the alleged source of HIV is itself contaminated or infected with HIV *and* establishing an explicit channel through which the exchange of bodily fluids could have taken place. Allowing plaintiffs to recover damages for claims based purely on the fear of developing AIDS, when the plaintiff cannot demonstrate actual exposure to HIV and when there is no possibility that the plaintiff will develop AIDS, is not sound public policy and is likely to lead to a flood of speculative and frivolous litigation.

Finally, this Note argues that the application of the "window of anxiety" approach to limiting damages in AIDSphobia claims should be confined to health care settings where the plaintiffs are patients who were rendered unconscious during an invasive procedure performed by their health care worker ("HCW"). Plaintiffs who were unconscious during invasive procedures are at a disadvantage because they cannot know if there was an accident during the procedure that may have led to the transmission of HIV from their HIV-infected HCW. Consequently, they would be unable to satisfy this Note's proposed two-prong test. This limited application will prevent many frivolous claims that would otherwise be rewarded if the

"window" were opened up to general AIDSphobia claims.

I. BACKGROUND

A. *Facts about HIV and AIDS*

1. The Disease, its Transmission, and Testing

In the spring of 1981, the Centers for Disease Control ("CDC")²² focused attention on New York and California where physicians were reporting unusual cases of patients with weakened immune systems and various opportunistic infections.²³ This was the beginning of the AIDS epidemic.²⁴ As of mid-1993 the World Health Organization ("WHO") estimated that over thirteen million adults world-wide have been infected with HIV, the retrovirus that causes AIDS.²⁵ More

²² The CDC is an agency of the U.S. Department of Health & Human Services that provides health information and conducts research to track down the sources of epidemics. 3 WORLD BOOK ENCYCLOPEDIA 261 (World Book-Childcraft Int'l, Inc. 1981). In 1992, the CDC changed its name to the "Centers for Disease Control and Prevention." See *Prevention Added to CDC's Name*, CHI. TRIB., Oct. 30, 1992, at 3. The initials "CDC" were retained, however, because of their recognizability. *Id.*

²³ MUNSON, *supra* note 9, at 214. Opportunistic infections take advantage of the body's weakened immune system and are caused by organisms that usually do not cause disease in healthy people. AMERICAN FOUND. FOR AIDS RESEARCH, 6 AIDS/HIV TREATMENT DIRECTORY 173 (1993). *Pneumocystis carinii* pneumonia ("PCP"), a parasitic infection affecting the lungs, is "the most common life-threatening opportunistic infection in AIDS patients." *Id.* at 174. Other opportunistic infections can include: candidiasis (fungal infection of mucous membranes lining the mouth or respiratory tract); cytomegalovirus ("CMV") (a herpes virus most frequently infecting the retina and colon of AIDS patients); Kaposi's sarcoma (a rare cancer that is the most commonly diagnosed malignancy in HIV-infected people); salmonellosis and sinusitis (bacterial infections); extra-pulmonary tuberculosis (a mycobacterial infection); and wasting syndrome (profound involuntary weight loss). *Id.* at 55-93. These various cancers and infections are what actually kills people with AIDS.

²⁴ When the CDC checked its records it found cases that were reported as early as 1978 and 1979. Initially, all of the cases involved homosexual men. When later reports of those infected began to include intravenous drug users and Haitian immigrants, however, the cases ceased falling into any specific pattern. MUNSON, *supra* note 9, at 213.

²⁵ Merson, *supra* note 3, at 1266. In addition, as of mid-1993, approximately one million children world-wide have been infected with HIV at or around the time of birth. *Id.* Retroviruses copy genetic material using the ribonucleic acid ("RNA") of a cell as a guide for making viral deoxyribonucleic acid ("DNA") to rep-

than two million of those infected have developed AIDS, and most of them have died.²⁶ In North America, where the epidemic is the oldest, more than one million adults are infected with HIV.²⁷

HIV is found in blood, semen, vaginal secretions, and possibly breast milk,²⁸ and is spread through vaginal, anal, or oral sexual contact, subcutaneous exposure to infected blood or blood components, sharing of hypodermic needles, and during pregnancy or the birthing process. Once infected with HIV, the immune system's response is to produce antibodies to ward off the infectious invader. Current estimates are that seroconversion, the production of antibodies, takes place within 6 to 12 weeks after infection.²⁹

Once infected with HIV there may be no symptoms, or only minor ones, for an average of 10 years.³⁰ AIDS is the

licate itself. AMERICAN FOUND. FOR AIDS RESEARCH, *supra* note 23, at 171-74.

Although HIV is necessary to develop AIDS, "our lack of understanding has led some commentators to query whether HIV infection is sufficient to cause AIDS or whether HIV may be essentially harmless in the absence of other cofactors." Robin A. Weiss, *How Does HIV Cause AIDS?*, 260 SCI. 1273, 1273 (1993) (citing ROBERT S. ROOT-BERNSTEIN, *RETHINKING AIDS: THE TRAGIC COST OF PREMATURE CONSENSUS* (1993)).

²⁶ Merson, *supra* note 3, at 1266. Only three years earlier, in mid-1990, WHO's world-wide estimates were that six million to eight million people were infected with HIV and 700,000 had developed AIDS. Geoffrey Cowley et al., *AIDS: The Next Ten Years*, NEWSWEEK, June 25, 1990, at 20. In 1990, WHO projected that twenty million people world-wide would be infected with HIV and five million to six million people would develop AIDS by the year 2000. *Id.* If current rates of infection continue at their present pace, the AIDS epidemic will quickly surpass these estimates.

²⁷ Merson, *supra* note 3, at 1266. More than 8 million people in sub-Saharan Africa, 1.5 million in Latin America and the Caribbean, and 1.5 million in south and southeast Asia are infected with HIV. The majority of those HIV-positive persons became infected through heterosexual intercourse. *Id.*

²⁸ HIV has also been found in low concentrations in saliva, tears and urine. However, only blood, semen vaginal fluids and possibly breast milk have been implicated in HIV transmission. Centers for Disease Control, *Recommendations for Prevention of HIV Transmission in Health-Care Settings*, 36 MMWR 2S, 3S (Supp. Aug. 21, 1987) [hereinafter *Prevention of HIV Transmission*].

²⁹ *Id.* at 13S. During this period there is a depletion of T-4 lymphocytes ("helper T-cells"), white blood cells that are crucial to making the antibodies effective. There is also an increase in the number of T-8 lymphocytes ("suppressor T-cells") that inhibit the antibody system. This severely cripples the body's immune system. MUNSON, *supra* note 9, at 214. A current model of how HIV works is that the virus enters a T-cell and becomes incorporated into its DNA. When another infectious agent (e.g., a cold virus) activates the T-cell, the HIV reproduces itself, kills the T-cell, and releases new HIV to infect other T-cells. *Id.* at 215.

³⁰ CENTERS FOR DISEASE CONTROL & PREVENTION, SURGEON GENERAL'S REPORT

end-stage of HIV infection and takes a varied but generally long time to develop.³¹ As a result of their weakened immune systems, victims of AIDS are susceptible to opportunistic infections.³² These infections eventually cause death.

Blood tests can accurately determine whether an individual has been infected with HIV by testing for HIV antibodies.³³

TO THE AMERICAN PUBLIC ON HIV INFECTION AND AIDS 1 (1993) [hereinafter SURGEON GENERAL'S REPORT].

The distinction between HIV and AIDS is important because "most people do not have any symptoms when they are first infected with HIV." *Id.* at 5. Consequently, most people infected with HIV do not know they are infected because they may look and feel healthy. People with AIDS, in contrast, often suffer from "many types of infections, and those infections happen more often and get worse." *Id.* Early detection of HIV can delay the onset of AIDS with the use of medication and other treatment and lead to a longer life for people infected with HIV.

In current legal and popular literature regarding HIV and AIDS, there are references to "the HIV virus," "contracting AIDS" or "transmitting AIDS," and "blood tests for AIDS." These flawed phrases are some of the more common carry-overs from early writings and continue to add to the confusion surrounding the HIV/AIDS crisis. HIV is an acronym for human immunodeficiency *virus*. To add the term "virus" after HIV is unnecessary. More appropriate would be the term "AIDS virus" or simply "HIV." The phrases "contracting AIDS" and "transmitting AIDS" are similarly defective. "AIDS" is the acronym for acquired immunodeficiency syndrome. A syndrome is "a group of signs and symptoms that collectively indicate or characterize a disease." AMERICAN HERITAGE DICTIONARY 1233 (2d ed. 1991). Symptoms cannot be contracted nor transmitted. A virus like HIV, however, can be contracted or transmitted.

Finally, "blood tests for AIDS" do not exist. Tests currently in use detect antibodies to HIV or HIV itself. The presence of antibodies indicates infection with HIV but does not mean that the infected person has AIDS. AIDS can be characterized by a number of defining diagnoses of symptoms like PCP, cytomegalovirus retinitis (eye infection) with loss of vision, or Kaposi's sarcoma (a rare cancer). See *supra* note 23 for a discussion of opportunistic infections.

³¹ Weiss, *supra* note 25, at 1273. "[G]enetic, behavioral, and environmental factors [may] influence the rate of progression to AIDS among individuals." *Id.* at 1274.

³² See *supra* note 23 and accompanying text for a discussion of opportunistic infections.

³³ Testing of the nation's blood supply began in mid-1985. Donors are pre-screened for risk factors that may make them susceptible to HIV infection. People at increased risk are not allowed to donate blood. In addition, blood samples are put through seven different tests for exposure to HIV and other viruses. The blood supply in the United States is now considered among the safest in the world. Cases involving pre-1985 transfusions, however, continue to arise. See, e.g., *Smith v. Paslode Corp.*, 7 F.3d 116 (8th Cir. 1993) (transfusions during surgery of HIV-contaminated blood); *Barton v. American Red Cross*, 829 F. Supp. 1290 (M.D. Ala. 1993) (HIV-contaminated blood transfusion); *Estate of Doe v. Vanderbilt Univ. Inc.*, 824 F. Supp. 746 (M.D. Tenn. 1993) (HIV-contaminated blood transfusion from 1984); *Doe v. United States*, 805 F. Supp. 1513 (D. Haw. 1992) (army medical center transfusion in 1985 caused HIV infection); *Doe v. American Nat'l Red Cross*,

If the test results are negative for HIV antibodies there is a relative certainty that there has been no exposure to HIV. Since 1987, tests for HIV antibodies have been estimated to be at least 99% accurate when performed on blood samples of individuals infected for twelve weeks or more.³⁴ A second negative test after 3 to 6 months confirms that there has been no exposure, as long as the individual being tested has not engaged in any behaviors that risk exposure to HIV in the interim. Experts now estimate that the two tests together are more than 99.9% accurate in detecting the presence of HIV antibodies.³⁵

2. CDC Recommendations for the Prevention of HIV Transmission from HCW to Patient

Prior to 1990, people in health care settings feared that HIV-infected patients posed the risk of transmitting HIV to the HCWs who treated them, and that these HCWs would then transmit the disease to other patients.³⁶ These fears were

798 F. Supp. 301 (E.D.N.C. 1992) (HIV-contaminated blood transfusions during 1985 surgeries).

The enzyme-linked immunosorbent assay ("ELISA") and Western Blot tests are most commonly used. The ELISA test is highly sensitive—it rarely fails to detect the presence of HIV antibodies—but not specific (it shows many false positives). Thus, after a positive reading the test is repeated. If it shows positive again the Western Blot, a highly specific test, is used to confirm the results. MUNSON, *supra* note 9, at 217.

³⁴ *Prevention of HIV Transmission*, *supra* note 28, at 13S.

³⁵ CENTERS FOR DISEASE CONTROL AND PREVENTION, VOLUNTARY HIV COUNSELING AND TESTING: FACTS, ISSUES AND ANSWERS 18 (1993).

³⁶ HCWs caring for HIV-infected patients are faced with the threat of a fatal disease with any type of procedure performed. For example, in *Estate of Behringer v. Medical Ctr.*, 592 A.2d 1251 (N.J. Super. Ct. Law Div. 1991), Behringer was a staff physician practicing as an ear-nose-throat specialist. After he was diagnosed with AIDS, Behringer believed that he was infected with HIV when he failed to wear a mask as he performed an emergency tracheotomy on an infected patient. MUNSON, *supra* note 9, at 221. In *Prego v. City of New York*, 147 A.D.2d 165, 541 N.Y.S.2d 995 (2d Dep't 1989), a hospital extern tested positive for HIV infection after two separate incidents of being stuck by needles used on AIDS patients. During one occasion she was stuck by a needle left among refuse on a patient's bed. The other needle stick occurred while she was drawing blood from an AIDS patient.

In 1988, the American Medical Association ("AMA") addressed the concerns of physicians over treating HIV-infected patients and stated that "[a] physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive." Council on

based on the possibility of an accidental transmission of HIV and on the number of infections that were actually acquired on the job.³⁷ Then, in 1990, the CDC received a report of a young woman with AIDS who apparently was not infected through any of the established channels for HIV infection (i.e., receipt of a contaminated blood transfusion or any documented behavioral risk factors, including intravenous drug use or sex with a HIV-infected person).³⁸ After it was determined that the woman, Kimberly Bergalis, had had two teeth extracted by a dentist who was HIV-positive, the CDC compared blood samples from Bergalis and the dentist to determine the relatedness of the HIV DNA sequences of both persons.³⁹ When the results showed a similarity between the viral DNA sequences of Bergalis and her dentist, the CDC concluded that the case was "consistent with transmission of HIV to a patient during an invasive dental procedure, although [the] possibility of another source of infection cannot be entirely excluded."⁴⁰

Ethical and Judicial Affairs, *Ethical Issues Involved in the Growing AIDS Crisis*, 259 JAMA 1360 (1988) (promoting guidelines for the treatment and care of AIDS victims). Physicians, however, are not bound to act in the way the AMA mandates, as evidenced by the continuing refusal of some physicians to treat HIV-infected individuals, e.g., *Miller v. Spicer*, 822 F. Supp. 158 (D. Del. 1993) (surgeon refused to perform required surgery because he suspected his patient had AIDS), and by physicians arguing that they have a right to know the HIV status of their patients. See e.g., *Ordway v. County of Suffolk*, 154 Misc. 2d 269, 583 N.Y.S.2d 1014 (Sup. Ct. 1992) (surgeon's action against county for its failure to inform him that patient/arrestee had HIV).

³⁷ As of July 1993, the CDC has confirmed that thirty-seven HCWs were occupationally infected with HIV. CENTERS FOR DISEASE CONTROL & PREVENTION, HIV/AIDS SURVEILLANCE REP., July 1993, at 13 (Table 11). Thirty-two of those HCWs occupationally infected were infected by a needlestick injury or cut by a scalpel or other sharp object. Michele Turk, *High Anxiety*, NEW PHYSICIAN, Sept. 1993, at 17, 17. HCWs suffer an estimated 800,000 needlestick injuries each year. *Id.* Surgeons are thought to be at the greatest risk of occupationally acquired HIV infection because they come into direct contact with a patient's blood in an estimated one of every five invasive procedures. *Id.* In addition, between 25% to 80% of medical students and residents are injured during the first year of clinical training. *Id.* at 17-18. The actual number of occupationally infected workers is probably much higher, but fears of losing jobs and insurance may inhibit the reporting of transmission incidents. *Id.* at 19.

³⁸ Centers for Disease Control, *Possible Transmission of Human Immunodeficiency Virus to a Patient During an Invasive Dental Procedure*, 264 JAMA 1092 (1990).

³⁹ *Id.* at 1093.

⁴⁰ *Id.* at 1092. The precise mechanism of transmission has still not been determined.

The Bergalis case lent credence to the fears that HIV-infected HCWs can transmit HIV to their patients.⁴¹ These fears were heightened when five other persons were reported to have been infected by the same dentist.⁴² In response to the heightened concerns, in July 1991, the CDC released updated guidelines regarding the prevention of HIV transmission in health care settings.⁴³ In addition to emphasizing the use of universal precautions as the primary technique for preventing HIV transmission,⁴⁴ the guidelines suggest that HCWs who

⁴¹ Before the Bergalis case, HCWs feared being infected by their patients because the transmission of HIV from infected patients to their HCWs was documented. See *supra*, notes 36-37 and accompanying text.

⁴² Centers for Disease Control & Prevention, *Update: Investigations of Persons Treated by HIV-Infected Health-Care Workers—United States*, 41 MMWR 329 (1993). These six cases, however, remain the only documented cases of HIV transmission from HCW to patient. According to the CDC, as of March 1993, reports of investigations on 19,036 patients of 57 HIV-infected HCWs in the United States have revealed no other cases of HIV transmission. 41 MMWR 329 (1993); see also Gordon M. Dickinson et al., *Absence of HIV Transmission From an Infected Dentist to His Patients: An Epidemiological and DNA Sequence Analysis*, 269 JAMA 1802 (1993) (study of 1,192 patients who had undergone 9,267 procedures performed by HIV-infected dentist indicated that there was no documented case of HIV transmission from dentist to patient); Ban Mishu et al., *A Surgeon With AIDS: Lack of Evidence of Transmission to Patients*, 264 JAMA 467 (1990) (finding no cases of HIV transmission in 616 patients of HIV-infected surgeon); Audrey S. Rogers et al., *Investigation of Potential HIV Transmission to the Patients of an HIV-Infected Surgeon*, 269 JAMA 1795 (1993) (finding no HIV transmission in 369 person-hours of surgical exposure); C. Fordham von Reyn et al., *Absence of HIV Transmission From an Infected Orthopedic Surgeon: A 13-Year Look-Back Study*, 269 JAMA 1807 (1993) (finding no cases of HIV infection among 1,174 former patients on whom invasive procedures were performed during a 13.5-year period).

⁴³ Centers for Disease Control, *Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures*, 40 MMWR 1 (1991) [hereinafter *Recommendations for Preventing Transmission*].

⁴⁴ In light of the Bergalis case and the ensuing public fears about the possibility that an HIV-infected HCW can transmit HIV to a patient, there were concerns on the part of HCWs that the new CDC guidelines would require mandatory testing of HCWs. Lawrence K. Altman, *AIDS Testing of Doctors is Crux of Thorny Debate*, N.Y. TIMES, Dec. 20, 1990, at A1. Instead, they require disclosure of an HIV-infected HCW's status to patients before performance of invasive procedures or withdrawal from performing those procedures. *Recommendations for Preventing Transmission*, *supra* note 43, at 4. Similarly, in 1991, perhaps in response to increased fear concerning HIV-infected HCWs, the AMA and American Dental Association (ADA) both recommended that HIV-infected HCWs inform their patients or give up performing invasive procedures. MUNSON, *supra* note 9, at 221.

Universal precautions emphasize the need to treat blood and other body fluids from all patients as potentially infective. *Recommendations for Preventing Transmission*, *supra* note 43, at 1. The precautions include: the routine use of appropriate

perform invasive procedures that can lead to contact with blood "should know their own HIV antibody status," and if HIV-positive, refrain from "exposure-prone" procedures.⁴⁵ It is also recommended that they seek the counsel of an expert review panel for advice on what circumstances would permit them to continue to perform, and what procedures they should be allowed to carry out.⁴⁶

barrier precautions to prevent skin and mucous-membrane exposure (e.g., gloves, masks, protective eyewear or face shields, gowns, aprons, etc.); the requirement that hands and other skin surfaces are washed immediately and thoroughly after gloves are removed; proper use and disposal of needles, scalpels and other sharp instruments; the use of proper disinfection and sterilization techniques for instruments and other reusable equipment and; refraining from direct contact with patients where the HCW's skin is open (e.g., due to dermatitis or cuts), until the skin is healed. *Id.* at 1-4.

An examination of hepatitis-B virus ("HBV") transmission in health care settings emphasizes the importance of using universal precautions and proper barrier techniques to reduce the risk of HIV transmission. Since the early 1970s, when blood testing for HBV began, there have been reports of over 300 patients infected with HBV by an HBV-infected HCW. *Id.* at 2. These cases of HBV transmission have been attributed to either the HCW's failure to use proper barrier techniques (e.g., not wearing gloves during an invasive procedure) or to an accident occurring during an invasive procedure. *Id.* at 3. The risk of HBV transmission to an HCW after percutaneous exposure to HBV-infected blood is estimated at 30%. *Id.* By contrast, the risk of HIV transmission to an HCW after percutaneous exposure to HIV-infected blood is estimated to be 0.3%. *Id.* at 3. Because HBV is one hundred times more infectious than HIV, the risk of HIV transmission from an HIV-infected HCW is proportionately lower as long as proper barrier techniques are used. *Id.* Conversely, the risk that HIV-infected patients pose to their HCWs is much higher. See *supra* notes 36-37 and accompanying text.

Prior to 1991, the CDC's guidelines for preventing HIV transmission in health care settings emphasized the use of universal precautions and reflected only concern over the risks that HIV-infected patients posed to their HCWs. *Prevention of HIV Transmission*, *supra* note 28, at 4S. Many HCWs, however, were calling for mandatory testing of patients and argued that the guidelines were too vague and difficult to interpret. Altman, *supra*, at A17.

⁴⁵ Exposure-prone invasive procedures include situations where the "fingers and a needle or other sharp instrument or object [are] in a poorly visualized or highly confined anatomic site." *Recommendations for Preventing Transmission*, *supra* note 44, at 3. The CDC defines invasive procedures as:

surgical entry into tissues, cavities, or organs or repair of major traumatic injuries 1) in an operating or delivery room, emergency department, or outpatient setting, including both physicians' and dentists' offices; 2) cardiac catheterization and angiographic procedures; 3) a vaginal or cesarean delivery or other invasive obstetric procedure during which bleeding may occur; or 4) the manipulation, cutting, or removal of any oral or perioral tissues, including tooth structure, during which bleeding occurs or the potential for bleeding exists.

Prevention of HIV Transmission, *supra* note 28, at 6S-7S.

⁴⁶ *Recommendations for Preventing Transmission*, *supra* note 43, at 4. The

B. *Cancerphobia and AIDSphobia Cases*

1. General Principles of Emotional Distress Claims

When a defendant's negligence is the cause of a plaintiff's emotional distress, and when there has been no physical impact upon the plaintiff, courts analyze the defendant's liability under traditional negligence principles of duty and proximate cause. Under a duty analysis, the relevant inquiry is whether a defendant has a duty to guard against the occurrence of emotional distress.⁴⁷ Under a proximate cause analysis, the question is whether the emotional distress is sufficiently foreseeable to be considered the proximate result of the defendant's conduct.⁴⁸

Courts traditionally have been reluctant to allow recovery for emotional distress without any accompanying physical impact on the plaintiff.⁴⁹ Most courts, however, now allow recovery for emotional distress without a showing of harm caused by impact or trauma, so long as there are physical symptoms of the emotional distress (e.g., nightmares, shock, pain, sleeplessness, etc.).⁵⁰ The rationale underlying this rule is that objective physical symptoms provide a minimum guar-

panel of experts could include the infected HCW's personal physician(s) in conjunction with the medical directors and personnel health services staff of their employing institution or hospital. *Id.*

⁴⁷ See, e.g., *McCance v. Lindau*, 492 A.2d 1352, 1358 (Md. Ct. Spec. App. 1985) ("When a reasonable person knows or should have known that certain types of conduct constitute an unreasonable risk of harm to another, he or she has the duty to refrain from that conduct."); see also RESTATEMENT (SECOND) OF TORTS § 435(2) (1965) (a duty is imposed if it appears highly likely that the conduct in question should have brought about the harm).

⁴⁸ See, e.g., *Wetherill v. University of Chicago*, 565 F. Supp. 1553, 1559 (N.D. Ill. 1983) (noting that the traditional notion of proximate cause requires that the emotional distress be reasonably foreseeable); see also RESTATEMENT (SECOND) OF TORTS, *supra* note 47, at § 435 (stating that a defendant's negligent conduct is the legal cause of the plaintiff's harm unless the harm is so "highly extraordinary" that liability should not be imposed).

⁴⁹ See generally *Payton v. Abbott Labs*, 437 N.E.2d 171 (Mass. 1982) (reviewing the evolution of emotional distress as a theory of recovery); *Ordway v. County of Suffolk*, 154 Misc. 2d 269, 583 N.Y.S.2d 1014 (Sup. Ct. 1992) (same).

⁵⁰ See *Payton*, 437 N.E.2d at 178; see also RESTATEMENT (SECOND) OF TORTS, *supra* note 47, at § 436A ("If the actor's conduct is negligent as creating an unreasonable risk of causing either bodily harm or emotional disturbance to another, and it results in such emotional disturbance alone, without bodily harm or other compensable damage, the actor is not liable for such emotional disturbance.").

antee of the genuineness of the claim and reduce the risk of fraudulent claims.⁵¹ Also, any "emotional disturbance which is not so severe and serious as to have physical consequences is normally in the realm of the trivial, and so falls within the maxim that the law does not concern itself with trifles."⁵² Finally, in those cases where the defendant's conduct has been merely negligent without any intention to cause harm, the defendant's fault does not rise to the level of requiring the imposition of liability for a purely mental disturbance.⁵³

2. Cancerphobia Cases

The question of whether a plaintiff can recover for negligent infliction of emotional distress where there is only the possibility of the plaintiff developing a disease in the future, after being exposed to some disease-causing agent, has been addressed in claims for fear of developing cancer. Many plaintiffs have brought cancerphobia claims after being exposed to asbestos fibers. For example, in *Jackson v. Johns-Manville Sales Corp.*,⁵⁴ a shipyard worker was exposed to asbestos and sought recovery for his emotional distress against the manufacturers of asbestos products used at his work-site. Because the plaintiff was suffering from asbestosis, the court reasoned that his emotional distress was recoverable.⁵⁵ Similarly, the plaintiff in *Herber v. Johns-Manville Corp.*⁵⁶ was exposed to asbestos while on the job. The court allowed him to recover for his emotional distress and fear of developing cancer because his exposure to asbestos led to pleural thickening of his lungs.⁵⁷

Plaintiffs have also brought cancerphobia claims after exposure to toxic chemicals found in their water supply. In *Laxton v. Orkin Exterminating Co.*,⁵⁸ the plaintiffs drinking water was contaminated with chlordane, a possible carcinogen, after the defendant sprayed for termites in the area surround-

⁵¹ *Payton*, 437 N.E.2d at 178.

⁵² RESTATEMENT (SECOND) OF TORTS, *supra* note 47, at 436A cmt. b.

⁵³ RESTATEMENT (SECOND) OF TORTS, *supra* note 47, at 436A cmt. b.

⁵⁴ 781 F.2d 394 (5th Cir.), *cert. denied*, 478 U.S. 1022 (1986).

⁵⁵ *Id.* at 414-15.

⁵⁶ 785 F.2d 79 (3d Cir. 1986).

⁵⁷ *Id.* at 88-89.

⁵⁸ 639 S.W.2d 431 (Tenn. 1982).

ing the plaintiffs' underground water spring. The chemical seeped into the water supply after heavy rains in the area. The court found that plaintiffs could recover for their fear of developing cancer in the future because they ingested an unknown amount of the toxic chemical.⁵⁹ The court, however, limited the plaintiffs' recovery for emotional distress to the period between when they first learned that they ingested the chemical, to the time they were advised by a physician that they need not get further testing for effects of the exposure.⁶⁰

Skin contact with toxic chemicals has also led to cancer-phobia claims. For example, in *Hagerty v. L & L Marine Services*,⁶¹ a seaman was loading a barge when he was completely soaked with dripolene, a carcinogenic chemical compound. The court allowed the plaintiff to recover for his fear of developing cancer, stating that his fear was reasonable and causally related to the defendant's negligence.⁶²

3. AIDSphobia Cases⁶³

Courts have been divided over the compensability of AIDSphobia. Some courts have denied recovery when the plaintiff cannot demonstrate infection with HIV in the form of a positive test for HIV antibodies.⁶⁴ Other courts will find the requirement that the plaintiff prove infection satisfied, however, if the plaintiff can establish a channel of blood-to-blood exposure that would have allowed transmission of HIV.⁶⁵ For

⁵⁹ *Id.* at 434.

⁶⁰ *Id.*

⁶¹ 788 F.2d 315 (5th Cir. 1986).

⁶² *Id.* at 319.

⁶³ See *supra* notes 14-16.

⁶⁴ See, e.g., *Burk v. Sage Prods., Inc.*, 747 F. Supp. 285 (E.D. Pa. 1990) (denying recovery to paramedic stuck by a needle protruding from a waste disposal container for needles and sharp objects because the paramedic was unable to show the needle was used on an AIDS patient and because the paramedic tested negative for HIV); *Hare v. State*, 173 A.D.2d 523, 570 N.Y.S.2d 125 (2d Dep't 1991) (in an AIDSphobia claim brought by a hospital technician who was bitten by a prison inmate, recovery was denied because plaintiffs fear was based on rumors that the inmate had AIDS and plaintiff tested negative for HIV infection).

⁶⁵ See, e.g., *Marchica v. Long Island R.R.*, 810 F. Supp. 445 (E.D.N.Y. 1993) (allowing an emotional distress claim by a railroad worker who was stuck by a used hypodermic needle left in an area where drug addicts loitered), *aff'd*, No. 93-7521, 1994 WL 401512 (2d Cir. July 29, 1994); *Castro v. New York Life Ins. Co.*, 153 Misc. 2d 1, 588 N.Y.S.2d 695 (Sup. Ct. 1991) (allowing claim for fear of devel-

example, in *Ordway v. County of Suffolk*,⁶⁶ the New York Supreme Court denied the AIDSphobia claim of a surgeon who performed two operations on an HIV-infected patient. For each surgical procedure, the surgeon wore "a surgical scrub suit consisting of pants, a shirt, sterile gown, sterile mask and surgical gloves."⁶⁷ In denying the claim, the court reasoned that the plaintiff had tested negative for HIV antibodies and had not shown a channel of transmission that would have allowed HIV to be passed from the patient, such as "[a] broken glove, pierced skin, patient bite, etc."⁶⁸

Similarly, in *Funeral Services by Gregory, Inc. v. Bluefield Community Hospital*,⁶⁹ the West Virginia Supreme Court of Appeals rejected a claim by a mortician who embalmed a corpse unaware that it was HIV-infected.⁷⁰ Because the plaintiff had tested negative for HIV antibodies and had not offered proof that he "punctur[ed] his gloves during the embalming procedure" nor proof of other events with the potential for exposure, the court reasoned that he was "merely hypothesiz[ing] as to how a potential exposure to the virus may have occurred."⁷¹

Where it is not known if the alleged HIV source was actually contaminated with HIV, some courts have held that the showing of a channel of transmission is sufficient to allow recovery for AIDSphobia. In *Marchica v. Long Island R.R.*,⁷² while the plaintiff was clearing away litter that was left in a work area, a hypodermic needle stuck his finger. The plaintiff suffered fear of developing AIDS because the needle was left in an area where "homeless people and drug addicts" loitered.⁷³ The court found that "the plaintiff . . . sustained sufficient physical injury to support an award" for his fear of developing

oping AIDS by a cleaning woman whose thumb was stuck by a used hypodermic needle that was left in an office waste container).

⁶⁶ 154 Misc. 2d 269, 583 N.Y.S.2d 1014 (Sup. Ct. 1992).

⁶⁷ *Id.* at 270, 583 N.Y.S.2d at 1015.

⁶⁸ *Id.*

⁶⁹ 413 S.E.2d 79 (W. Va. 1991), *overruled by* Courtney v. Courtney, 437 S.E.2d 889 (W. Va. 1993).

⁷⁰ *Id.* at 84.

⁷¹ *Id.* at 82.

⁷² 810 F. Supp. 445 (E.D.N.Y. 1993), *aff'd*, No. 93-7521, 1994 WL 401512 (2d Cir. July 29, 1994).

⁷³ *Id.* at 446.

AIDS, even though there was no proof at the time that he had contracted HIV.⁷⁴

Similarly, in *Castro v. New York Life Ins. Co.*,⁷⁵ the plaintiff was a cleaning worker whose thumb was stuck by a used hypodermic needle that was left in an office waste container.⁷⁶ The hypodermic needle was allegedly used to draw blood samples from the defendant's prospective life insurance applicants. The court reasoned that because a needlestick provides a channel of transmission the plaintiff could recover for her fear of developing AIDS.⁷⁷

In contrast, some courts have denied recovery if the plaintiff does not show that the claimed source of infection is itself infected with HIV, even if the plaintiff is able to show a channel of transmission. These courts reason that recovery for emotional distress that arises out of a fear of contracting a disease cannot be allowed if the plaintiff cannot prove exposure to the agent that causes the feared disease.⁷⁸ For example, in *Burk v. Sage Products, Inc.*,⁷⁹ the plaintiff was a paramedic who was stuck by a needle protruding from a disposal container for used needles and syringes.⁸⁰ The plaintiff feared contracting HIV as a result of the needle stick because he saw several AIDS patients on the hospital floor where he was using the disposal container. The court denied recovery because the plaintiff was unable to show that the needle that pricked him was used on an AIDS patient. Consequently, he failed to demonstrate exposure to the virus. Since the damages that he was claiming were based on his fear of contracting HIV and developing AIDS, the court reasoned that his action must fail because he will never get the disease that he feared developing.⁸¹

⁷⁴ *Id.* at 453.

⁷⁵ 153 Misc. 2d 1, 588 N.Y.S.2d 695 (Sup. Ct. 1991).

⁷⁶ *Id.* at 2, 588 N.Y.S.2d at 695.

⁷⁷ *Id.* at 6, 588 N.Y.S.2d at 698.

⁷⁸ *Burk v. Sage Prods., Inc.*, 747 F. Supp. 285 (E.D. Pa. 1990); *see also* *Hare v. State*, 173 A.D.2d 523, 570 N.Y.S.2d 125 (2d Dep't 1991) (denying recovery to plaintiff who had fear of developing AIDS after he was bitten by a prison inmate who was only rumored to have had AIDS); *Doe v. Doe*, 136 Misc. 2d 1015, 519 N.Y.S.2d 595 (Sup. Ct. 1987) (denying recovery for AIDSphobia in wife's claim that her husband had had homosexual affairs and put her at risk of developing AIDS).

⁷⁹ 747 F. Supp. at 285.

⁸⁰ *Id.* at 286.

⁸¹ *Id.* at 288.

4. The "Window of Anxiety" Cases

In the wake of the well-publicized Bergalis case, two courts recently decided AIDSphobia claims by plaintiffs whose surgeons were HIV-infected. *Faya v. Almaraz*,⁸² involved two companion cases brought by former patients of Dr. Rudolph Almaraz, a surgical oncologist who specialized in breast cancer and who performed invasive procedures on both patients.⁸³

More than one year after their surgeries, the plaintiffs learned of Dr. Almaraz's HIV infection and they immediately had a blood test for HIV infection. The test results for both were negative. Subsequently, both plaintiffs filed separate actions against Dr. Almaraz seeking to recover damages for their fear of developing AIDS based on, inter alia, negligent failure to obtain the patient's informed consent and negligent infliction of emotional distress.⁸⁴

⁸² 620 A.2d 327 (Md. 1993).

⁸³ See *supra* note 45 for a definition of invasive procedures.

⁸⁴ This Note will address only the negligent infliction of emotional distress claim as the basis of recovery for AIDSphobia and assumes that the informed consent doctrine imposes a duty on HIV-infected HCWs to disclose that status to their patients before performing invasive procedures. Under the doctrine of informed consent, a physician has a duty to disclose medical information and "those risks which a reasonably prudent patient would consider material or significant in making the decision about what course of treatment, if any, to accept." *Estate of Behringer v. Medical Ctr.*, 592 A.2d 1251, 1278 (N.J. Super. Ct. Law Div. 1991) (discussing the development of the informed consent doctrine). The medical information or risks of a procedure are material when "a reasonable patient would be likely to attach significance to it in deciding whether or not to submit to the treatment." *Id.*; see also *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.) (adopting the "reasonable patient" standard), *cert. denied*, 409 U.S. 1064 (1972). *But see* *Natanson v. Kline*, 350 P.2d 1093, 1106 (Kan. 1960) (adopting a "professional community" standard which dictates that physicians need only disclose that which a "reasonable medical practitioner" would disclose in the same or similar circumstances).

The question of whether HIV-infected HCWs have a duty to disclose their HIV-status to their patients has generated much commentary. According to a 1991 survey, 90% of Americans think all HIV-infected HCWs should be required to tell patients if they are infected with HIV. Bill Gentile, *Doctors and AIDS*, NEWSWEEK, July 1, 1991, at 48, 51. Consistent with this belief, if they knew that their HCW was HIV-infected, 65% of those responding to the survey stated that they would discontinue all treatment with their HCW. *Id.* at 52. Another 13% said they would continue treatment but exclude surgery or other invasive procedures, and 15% said they would continue treatment as long as stringent protective measures were used. *Id.* The 1991 CDC guidelines, see *supra* note 43, require HIV-infected HCWs to either disclose their status to their patients before performing any invasive procedure or refrain from performing those procedures. See *supra* notes 43-46 and ac-

The Maryland Court of Appeals found that Dr. Almaraz had a duty to either inform his patients that he was HIV-infected or to refrain from performing the procedures.⁸⁵ Ultimately the court held that although the plaintiffs tested negative for the virus and were unable to show actual transmission of HIV into their bodies during their surgical procedures, their fear of developing AIDS was a legally compensable injury.⁸⁶ The court, however, limited their recovery for emotional distress to a "reasonable window of anxiety" period: the time they learned that their physician was HIV-infected to the point they learned that they were not infected with HIV.⁸⁷

companying text. Because of the small possibility of HIV transmission from HIV-infected HCWs to their patients, *see supra* note 37, and because of the fatal nature of AIDS, some commentators have argued that HIV-infected HCWs have a duty to disclose their status to their patients under the informed-consent doctrine. *See, e.g.,* Karen C. Lieberman & Arthur R. Derse, *HIV-Positive Health Care Workers and the Obligation to Disclose: Do Patients Have a Right to Know?*, 13 J. LEGAL MED. 333, 356 (1992) (arguing that the "obligations of society" to protect HIV-positive HCWs "from unjust discrimination and unnecessary infringements on privacy . . . cannot legally be transferred to unconsenting individual patients by placing them at risk, even if remote, of death or serious harm without their knowledge and consent"); Jeffery W. Cavender, Note, *AIDS in the Health Care Setting: The Congressional Response to the Kimberly Bergalis Case*, 26 GA. L. REV. 539 (1992) (reviewing several congressional proposals designed to prevent HIV transmission from infected HCWs to their patients and arguing that a duty to disclose their HIV status is necessary, but recognizing that some protections must be included to minimize intrusion on HCWs' privacy interests). *But cf.* Larry Gostin, *Hospitals, Health Care Professionals, and AIDS: The "Right to Know" the Health Status of Professionals and Patients*, 48 MD. L. REV. 12, 54 (1989) (suggesting that universal precautions are a better alternative to reduce HIV transmission in health care settings, and that the risk of transmission is too low to warrant imposing a duty, which would only serve to "undermine trust in our health care institutions without any public health utility"); Thomas E. Margolis, Commentary, *Health Care Workers and AIDS: HIV Transmission in the Health Care Environment*, 13 J. LEGAL MED. 357 (1992) (suggesting that adherence to universal precautions and modification of medical instruments and techniques will reduce or eliminate the need for practice restrictions or disclosure).

Some courts also have addressed the issue of whether HIV-infected HCWs have a duty to inform their patients of that status under the informed consent doctrine. *See, e.g.,* *Faya v. Almaraz*, 620 A.2d 327, 333 (Md. 1993) (stating that because an HIV-infected HCW "might transmit the AIDS virus to his patients during invasive [procedures], . . . the seriousness of potential harm, as well as its probability, contributes to a duty to prevent it"); *Estate of Behringer*, 592 A.2d at 1280 ("[T]he difficulties created by the public reaction to AIDS cannot deprive the patient of making the ultimate decision where the ultimate risk is so significant.").

⁸⁵ 620 A.2d at 333.

⁸⁶ *Id.* at 339.

⁸⁷ *Id.* at 337.

Following *Faya*, the California Court of Appeal in *Kerins v. Hartley* also limited a plaintiff's recovery for her fear of developing AIDS to a "reasonable window of anxiety" period.⁸⁸ The facts of *Kerins* were very similar to those of *Faya*. Plaintiff Kerins filed a claim against her surgeon, Dr. Gordon, more than seventeen months after her surgery, for her fear of developing AIDS after she learned that he was HIV-infected.⁸⁹ In allowing Kerins's AIDSphobia claim, the California Court of Appeal held that her emotional distress became unreasonable only when: (1) she received access to the report documenting the operation procedures (because it would contain notations of any accidents that might have occurred during the surgical procedure) and/or some assurance that the surgeon did not cut himself nor expose his blood in any way during the surgery; (2) she received negative test results for HIV infection; and (3) she received counseling regarding the accuracy and reliability of the test methods and the improbability of being HIV-infected when tests are negative eighteen months after the alleged exposure.⁹⁰

II. ANALYSIS

AIDS continues to be considered "a mysterious and stigmatizing disease" despite the efforts of educators and health organizations to educate the general public.⁹¹ The public hysteria in response to the Bergalis case, and the resultant pressure on the CDC that led to calls for restrictions on HIV-infected HCWs,⁹² are evidence of the strong emotions that HIV and AIDS can cause. Strong emotions that are not tempered by

⁸⁸ 21 Cal. Rptr. 2d 621, 631 (Ct. App. 1993) (quoting *Faya*, 620 A.2d at 337).

⁸⁹ Kerins was watching a newscast publicizing Dr. Gordon's legal battle with his partners, who were refusing to allow him to return to his surgical practice. During the television report Kerins heard Dr. Gordon's partners explain that they were protecting their patients from exposure to HIV and AIDS. *Id.* at 623 n.1.

⁹⁰ *Id.* at 632. The court of appeals reversed the trial court, which found that Kerins's fear of developing AIDS was unreasonable because there was no proof that she was exposed to Dr. Gordon's blood during surgery, nor proof that there was a reasonable likelihood that she would develop AIDS. *Id.* at 627-28.

⁹¹ *M.M.H. v. United States*, 966 F.2d 285, 289 (7th Cir. 1992); see also *Doe v. American Red Cross Blood Servs.*, 125 F.R.D. 646, 652 (D.S.C. 1989) ("[AIDS is] a disease that is widely thought of as the modern day equivalent of leprosy.").

⁹² See *supra* note 44 and accompanying text.

objective information, however, should not form the basis of public policy or dictate judicial decisions.

In AIDSphobia claims the actual injury at issue is the fear of developing AIDS. There is a danger inherent in AIDSphobia claims that the negative associations connected with HIV and AIDS⁹³ will blind both judge and jury from determining whether the plaintiff was exposed to HIV. Because HIV causes AIDS,⁹⁴ the plaintiff's exposure is the crucial question. Where a plaintiff can prove actual exposure to HIV, in the form of a positive test for HIV antibodies,⁹⁵ there should be no hesitancy in assigning liability to the defendant—as long as the plaintiff can prove that the defendant caused the exposure to HIV. A difficulty in AIDSphobia claims arises when the plaintiff can only speculate as to whether there was exposure to HIV. This speculation occurs when a person or object is either known or suspected to be carrying HIV. Courts should not compensate this speculation without requiring some form of objectivity by which it can be determined that the plaintiff was exposed to HIV.

A. *Guidance from Cancerphobia cases*

Because of the similarities between cancer and AIDS,⁹⁶ courts faced with the question of whether to allow recovery for AIDSphobia may find some guidance from cancerphobia cases, which involve a fear of developing cancer and the emotional distress resulting from exposure to a cancer-causing agent. Such guidance can come in the form of how courts deciding cancerphobia cases have resolved the issue of whether plaintiffs can recover damages for their fear of developing a future disease. Courts have required that the plaintiffs meet two requirements: (1) there must be a reasonable and genuine fear that the plaintiff will develop cancer; and (2) there must be some physical injury suffered from exposure to carcinogens.⁹⁷

⁹³ See Gelman, *supra* note 1.

⁹⁴ See *supra* notes 28-32 and accompanying text.

⁹⁵ See *supra* notes 33-35 and accompanying text.

⁹⁶ See *supra* notes 17-18 and accompanying text.

⁹⁷ See, e.g., *Herber v. Johns-Manville Corp.*, 785 F.2d 79, 85 (3d Cir. 1986) (allowing cancerphobia claim because plaintiff's inhalation of asbestos fibers and the resulting pleural thickening of his lungs could reasonably lead to a fear of

Cancerphobia claims have been premised on a fear of developing cancer where there is no question that the plaintiffs have been exposed to a cancer-causing agent. Consequently, the question arising from cancerphobia cases is not whether the plaintiffs were exposed to a cancer-causing agent in the first place. Rather, the question is whether plaintiffs can recover emotional distress damages arising from their fear that they will develop cancer in the future, knowing that they were exposed to a cancer-causing agent.

AIDSphobia claims, on the other hand, must first resolve the question of whether the plaintiff was exposed to HIV in the first place. Where there has been an exchange of bodily fluids between a HIV-infected individual and a non-infected individual, there is no question that the uninfected person has been exposed to HIV.⁹⁸ This exposure to HIV leads to a greater likelihood that the non-infected individual may develop AIDS in the future. Thus, where the plaintiff has actually been exposed to HIV there is a close analogy to cancerphobia cases because the exposure provides a rational basis for the belief that AIDS will develop. With AIDSphobia claims, however, there is usually only the *potential* that an exchange of bodily fluids occurred through which HIV could have been transmitted. Consequently, the analogy between cancerphobia and AIDSphobia weakens because the recovery for emotional distress in cancer cases is dependent on the plaintiff actually having been exposed to a cancer-causing agent, not on a potential exposure.⁹⁹

developing cancer); *Jackson v. Johns-Manville Sales Corp.*, 781 F.2d 394, 414 (5th Cir. 1986) (same). See *supra* notes 47-62 and accompanying text.

⁹⁸ See *supra* note 28 and accompanying text.

⁹⁹ For example, consider a plaintiff who was working in a building where different sections of the building were sealed off for an asbestos removal project. Despite the remote possibility that there was a leak in the barriers between the asbestos removal area and the non-removal area, it is unlikely that many would consider the plaintiff's claim of fear of developing cancer to be reasonable. See *Rittenhouse v. St. Regis Hotel*, 149 Misc. 2d 452, 453, 565 N.Y.S.2d 365, 366 (Sup. Ct. 1990) (rejecting the "asbestosphobia" claim of the plaintiff, who was temporarily working in a building at the same time that there was an asbestos removal project in progress in the building, because the plaintiff did not have any clinical manifestations of asbestos-related disease).

B. *AIDSphobia Based on Speculation*

Plaintiffs in AIDSphobia claims should be required to prove exposure to HIV before being allowed to recover for their fear of developing AIDS. The *Burk* rationale provides an appropriate standard which courts should follow when evaluating AIDSphobia claims.¹⁰⁰ *Burk* required that plaintiffs in AIDSphobia cases prove both exposure to HIV and that there is a substantial likelihood that they will develop AIDS in the future.¹⁰¹ This requirement of proving exposure can be met by either (1) a positive blood test for HIV antibodies; or (2) proof that the alleged source of HIV is itself infected or contaminated with HIV *and* that an explicit channel existed through which HIV could have passed into the plaintiff's body.

It is common knowledge that HIV can be spread through sexual contact, exchange of bodily fluids, sharing needles and sometimes during birth or pregnancy.¹⁰² Also well known is the fact that one cannot develop AIDS unless infected with HIV. Despite this information, however, in most AIDSphobia cases the plaintiffs do not even know if they actually came into contact with HIV. The two-prong test does not deny that a plaintiff feels fear. Where there is no rational basis to fear developing AIDS, however, that fear should not be compensated. The two-prong test eliminates the problems inherent with claims involving this undefined fear of developing AIDS.

A positive test for HIV antibodies, which indicates infection with HIV,¹⁰³ automatically eliminates the question of whether the plaintiff had been exposed to HIV.¹⁰⁴ A negative test, however, means it is more likely than not that the plaintiff was not exposed to HIV.¹⁰⁵ Where the tests for antibodies are negative more than one year from the time of the alleged exposure, there is a certainty that there was no exposure to

¹⁰⁰ *Burk v. Sage Prods., Inc.*, 747 F. Supp. 285 (E.D. Pa. 1990); *see supra* notes 79-81 and accompanying text.

¹⁰¹ 747 F. Supp. at 288.

¹⁰² *See supra* note 28.

¹⁰³ *See supra* notes 33-35 and accompanying text.

¹⁰⁴ The plaintiff must still prove that the defendant was the source of the HIV exposure.

¹⁰⁵ *See supra* notes 33-35 and accompanying text.

HIV.¹⁰⁶ Thus, requiring that a plaintiff prove exposure to HIV in the form of a positive test for HIV antibodies ensures that the AIDSphobia claim is reasonable and eliminates the speculative nature of the claim.

The second prong of the test also provides guarantees of the reasonableness of the claim by requiring proof that the alleged source of HIV is itself infected or contaminated with HIV and that an explicit channel existed through which HIV could have passed into the plaintiff's body. First, a requirement that the alleged source be shown to be HIV-infected provides a minimum guarantee that there was at least a possibility that HIV could have been transmitted; if the alleged source is not HIV-infected, the source cannot transmit HIV. Moreover, requiring that there be a showing of an explicit channel through which HIV could have been passed legitimates the concern that HIV was transmitted. Since external contact with HIV-contaminated bodily fluids is not sufficient to transmit HIV,¹⁰⁷ there must be a route through which contaminated fluids can be exchanged. It is only by this exchange of body fluids that HIV will be transmitted.¹⁰⁸ Thus, the requirement that the plaintiff in an AIDSphobia claim show an explicit channel through which HIV could have been transmitted ensures that there is a definite route by which the plaintiff could have been infected. Without this explicit channel, the plaintiff could not have been infected with HIV.

The requirements for an explicit channel through which HIV transmission could take place, and proof that the source of fear is itself HIV-infected or contaminated, will also reduce the highly speculative nature of AIDSphobia claims. Under the second prong, *Marchica*¹⁰⁹ and *Castro*¹¹⁰ were wrongly decided. There was a failure to show that the needles causing the plaintiffs' fear were contaminated with HIV. Consequently, there was no showing that the plaintiffs' were ever exposed to HIV. A better justification for allowing recovery in *Marchica*

¹⁰⁶ See *supra* notes 33-35 and accompanying text.

¹⁰⁷ See *supra* note 28 and accompanying text.

¹⁰⁸ See *supra* note 28 and accompanying text.

¹⁰⁹ 810 F. Supp. 445 (E.D.N.Y. 1993). See *supra* notes 72-74 and accompanying text.

¹¹⁰ 153 Misc. 2d 1, 588 N.Y.S.2d 695 (Sup. Ct. 1991). See *supra*, notes 75-77 and accompanying text.

would have been the negligent failure of the plaintiff's employer to provide a safe and secure working environment. Similarly, a pure negligence-based claim for the defendant's failure to properly dispose of a used hypodermic needle would have justified recovery. By basing recovery in these cases on AIDSphobia, however, the courts have left open the gates to a flood of potentially frivolous litigation and perhaps contributed to irrational hysteria about HIV and AIDS.

Ultimately, if emotional distress results from the possibility that AIDS will develop, AIDSphobia claims should not succeed unless the "possibility" manifests itself. Since AIDS cannot develop if there has been no exposure to HIV, and the only way that HIV can be spread is through the exchange of bodily fluids, there must be a channel through which the exchange of body fluids could have taken place.

C. *"The Window of Anxiety" as a Limitation on Recovery for Emotional Distress*

A difficulty arises in health care settings where patients of HIV-infected HCWs are rendered unconscious during an invasive procedure. Unconscious patients cannot satisfy the second prong of the proposed test because they were unconscious and are unable to show whether there was a break in the barriers that are designed to prevent HIV transmission. Consequently, patients who were unconscious during an invasive procedure would not be able to recover for their fear, despite the potential that they were exposed to HIV during the procedure.¹¹¹

The *Faya*¹¹² and *Kerins*¹¹³ decisions offer a novel approach to resolving the question of whether plaintiffs who were unconscious during an invasive surgical procedure should be allowed to recover for AIDSphobia after they learn that their surgeon was HIV-infected. The *Faya* and *Kerins* courts limited the period of recovery for AIDSphobia to the period when the patients learned that their HCW was HIV-infected to the time the patients learned that they were not infected. This approach

¹¹¹ Assuming they test negative for HIV antibodies and do not manifest symptoms of HIV infection for several months.

¹¹² See *supra* notes 82-87 and accompanying text.

¹¹³ See *supra* notes 88-90 and accompanying text.

offers a method that is an attractive compromise between allowing plaintiffs to recover for their emotional distress and the competing interest in limiting the amount of frivolous litigation to prevent overburdening the judicial system. The rationale underlying the decisions is that, given its fatal nature, even a remote risk that HIV could have been transmitted is sufficient to allow recovery for fear of developing AIDS.

There are several weaknesses, however, to the "window of anxiety" approach of limiting damages in AIDSphobia claims. First, the approach only limits the time for which damages can be recovered, without providing courts with guidance for determining how much recovery should be limited, if at all.¹¹⁴ A danger occurs if the trier of fact is left to determine how much recovery the plaintiff should be allowed in an AIDSphobia case. Given the fear and hysteria that surrounds the subject of HIV and AIDS and their "negative" associations—death, homosexuality and drug abuse¹¹⁵—it is likely that juries would allow an unreasonably large recovery for plaintiffs who allege that their HCWs might have "given them AIDS."

Second, the plaintiffs in *Faya* and *Kerins* both learned of their surgeon's HIV-infection more than one year after undergoing invasive procedures. Thus, their "window" was limited to the two week period, during which they were waiting to get their test results. This short time period might have served as a deterrent to other similar claims because the short time period may be perceived as resulting in a negligible compensation, and thus not worth the costs of litigating the claim.¹¹⁶ The applicability of the "window" limitation is less clear, however, when a patient learns of their HCW's HIV-infection less than one year after undergoing an invasive procedure. If seroconversion occurs within six to twelve weeks,¹¹⁷ and a patient learns of their HCW's HIV-infection within two or three weeks or months after an invasive procedure, and suffers fear of developing AIDS as a result, it is not clear how long the

¹¹⁴ See, e.g., *Becker v. Schwartz*, 46 N.Y.2d 401, 386 N.E.2d 807, 413 N.Y.S.2d 895 (1978) (suggesting that recovery should not be allowed where there is an inability to measure damages in terms of dollars).

¹¹⁵ See Gelman, *supra* note 1, at 79.

¹¹⁶ If plaintiffs are awarded a large sum of money, however, the deterrent factor of a limited time period of recovery disappears.

¹¹⁷ See *supra* note 29 and accompanying text.

"window" would stay open. Exactly when a "reasonable medical certainty" is established is not clear given the variability of individuals in developing antibodies.¹¹⁸ Certainly, the "window" should not remain open longer than one year after the alleged exposure incident (allowing for the variability in developing antibodies).

Third, there is an inherent difficulty in establishing causation with the "window of anxiety" approach. If a patient does receive a positive test result for HIV infection after undergoing an invasive procedure performed by a HIV-infected HCW, it would be difficult to determine if the invasive procedure was the source of HIV-infection.¹¹⁹ The patient is likely to claim that the invasive procedure was the source. Of course, the patient might have been infected through another source (either knowingly or unknowingly), before or after the procedure. There is a danger, however, that the trier of fact will automatically give the utmost deference to the plaintiff's claim that the defendant HIV-infected HCW was the source of the infection. Because of negative associations, and because the plaintiff's body was "exposed" to the environment, was under the defendant-HCW's control, and because blood was exposed during the procedure, the trier of fact might mistakenly conclude that the defendant-HCW was liable despite a lack of evidence. Thus, in the event of a positive HIV antibody test, it will be necessary for a plaintiff to prove that there was no other source of HIV infection, but difficult for a defendant-HCW to rebut the allegation.

All of these weaknesses in the "window of anxiety" approach dictate that its application be limited to situations similar to those of the plaintiffs in *Faya* and *Kerins*: where the plaintiffs are unconscious during an invasive procedure performed by a HIV-infected HCW. To otherwise allow recovery

¹¹⁸ See *supra* notes 29 and accompanying text.

¹¹⁹ Genetic testing of viral DNA samples is a method that could be used to compare samples from the infected HCW and the patient. These tests, however, would serve as a further drain on the court's time and resources. In addition, the tests are subject to different interpretations and questions of accuracy. See, e.g., *United States v. Martinez*, 3 F.3d 1191, 1195 (8th Cir. 1993) ("concerns persist over possible error and ambiguity"); CHARLES T. MCCORMICK, MCCORMICK ON EVIDENCE § 205, at 900-01 (John W. Strong ed., 4th ed. 1992) ("The problems arise at two levels: controlling the experimental conditions of the analysis, and interpreting the results.").

based on the "window of anxiety" approach in AIDSphobia claims that do not meet these criteria will promote a large number of speculative claims that would increase the hysteria surrounding HIV and AIDS. Furthermore, allowing recovery under the "window of anxiety" approach without requiring these *Faya* and *Kerins* requirements would allow patients to act on the basis of irrational fears and on the desire to avoid anyone who is HIV-infected. It would also promote a large number of claims that are based on rumor, innuendo, or the perceived sexual preference or HIV-status of HCWs. Finally, to allow these claims would perpetuate the mistaken belief that the risk posed by HIV-infected HCWs is great enough to justify their exclusion from practice of any kind.

CONCLUSION

As the AIDS epidemic continues to spread, courts must be prepared to face an increasing amount of litigation that is caused by people's fear of the disease. Given the continued spread of HIV and AIDS, it seems inevitable that more AIDSphobia claims will be brought in the foreseeable future, especially in health care settings. By establishing a principle by which recovery for AIDSphobia will be allowed, courts will be able to minimize the number of frivolous lawsuits, and at the same time provide predictability for those who are considering an AIDSphobia claim. A two-prong test that requires proof of actual exposure to HIV provides such a principle. Requiring either a positive blood test for HIV antibodies or a showing that the source of fear was contaminated with HIV and that there was an explicit channel of transmission will ensure that only those plaintiffs whose claims are reasonable and genuine will recover.

In addition, application of the "window of anxiety" approach to limiting damages will provide guidance to courts deciding whether and how compensation for AIDSphobia should be allowed. Its application, however, should be limited in scope to situations where the plaintiff is a patient of an HIV-infected HCW, the patient was unconscious during an invasive procedure performed by the HCW and the patient tests negative for HIV infection. Where the patient tests positive after undergoing an invasive procedure, the plaintiff

should be required to prove that the invasive procedure was the source of infection.

Ivan Yip