Fear of AIDS

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When is it Unreasonable as a Matter of Law

I. Background

There are presently five Illinois appellate court opinions addressing the issue of emotional distress damages for the fear of contracting HIV. These five opinions have created three different standards for recovery.1 The Illinois Supreme Court has recently accepted consolidated appeals on this issue, and will ultimately render the final opinion as to the standard plaintiffs must meet to recover monetary damages for the fear of contracting HIV.

It should first be made clear that the fear of contracting a communicable disease, such as HIV, is not itself supportive of a legal cause of action. Rather, this fear, if other elements of a cause of action are plead correctly, is simply a type of legal damage for which a monetary judgment may be taken. This fear, like any legally recognized injury, must stem from wrongful conduct by the defendant. Typically, the wrongful conduct is either pled as the negligent or intentional infliction of emotional distress. Both are recognized causes of action in Illinois.

This article will focus on the cause of action for negligent infliction of emotional distress for the fear of contracting AIDS, rather than its “intentional” counter-part, as the former is more typically a basis of “AIDS phobia” litigation.

II. Negligent Infliction of Emotional Distress

To state a cause of action for negligent infliction of emotional distress, the complaint must first allege the basic elements supportive of a negligence claim: 1) the defendant owed a legal duty to the plaintiff; 2) that duty was breached by the defendant’s conduct; 3) the defendant’s conduct was the direct and proximate cause of 4) injury to the plaintiff in the form of emotional distress.2

In most “AIDS phobia” cases, the first two elements are not primarily at issue. Rather, the defendant’s motion to dismiss will assert that the plaintiff failed to plead a compensable injury proximately caused by the defendant’s negligent conduct.3

Illinois case law is not clear as to what plaintiff must plead and prove to have his case heard by the trier of fact. Confusion is added by those appellate opinions which analyze distinctions between “zone of danger” and “direct victim” plaintiffs. Within these subtopics comes further confusing dialogue as to requirements of “physical impact” and “physical manifestations” of emotional distress. All of these terms are used too frequently and unnecessarily in “AIDS phobia” appellate court opinions. The net result is a lack of clarity and guidance for plaintiff and defense counsel, alike.

A. “Zone of Danger” v. “Direct Victim” Plaintiffs

There is a distinction in negligent infliction of emotional distress cases between a plaintiff who is within the “zone of physical danger,”4 and a “direct victim.” The distinction is important as it determines what plaintiff must plead and prove to maintain a cause of action.
The “zone of danger” plaintiff must prove that he was a bystander to defendant’s negligent conduct directed at a third-person, and within such proximity that there existed a high risk of physical impact to the plaintiff himself.5

The “direct victim” plaintiff must either suffer a “physical impact” resulting from defendant’s negligent conduct or suffer “physical manifestations” of emotional distress.6 The key distinction between the two, is that the former must prove a “high risk of physical impact” and “physical manifestations,” while the latter must either prove a “physical impact” or “physical manifestations.”7

In “AIDS phobia” litigation, the plaintiff will almost always be a “direct victim” plaintiff. For example, a physical impact occurs when the plaintiff is stuck with a contaminated needle negligently disposed of by the defendant; where the plaintiff is operated on by an HIV-infected physician-defendant; where the plaintiff is the sexual partner of an HIV-infected defendant, etc. In each case, the plaintiff actually suffered a physical impact. Thus, there is no need to analyze the “zone of danger” rule in such “AIDS phobia” cases.

B. The Physical Manifestation Requirement

Most “AIDS phobia” plaintiffs need not allege physical manifestations of emotional distress (i.e. headaches, weight loss, insomnia, vomiting, etc.).9 Nearly all plaintiffs are direct victims who have suffered a physical impact.10

Two recent “AIDS phobia” decisions, however, have confused Illinois law on this point. The First District in Majca v. Beekil11 and Doe v. Northwestern University,12 opinions issued on the same date, stated that Illinois courts require emotional distress plaintiffs to prove “medically verifiable manifestations” of severe emotional distress. However, the Supreme Court in Corgan v. Meuhling held just the opposite: “Therefore, this court finds that the trial court acted properly in not dismissing the plaintiff’s cause of action for failure to allege physical symptoms of emotional distress.”13

III. Illinois “AIDS phobia” Case Law

In Doe v. Surgicare of Joliet, Inc.,14 plaintiff sought damages for negligent infliction of emotional distress after she learned that a medical technician stuck herself with a needle which was subsequently used to administer anesthetic during the course of her surgery. Plaintiff further alleged that she was notified of the incident two months post-surgery, but the technician refused to undergo a test for HIV.

The trial court dismissed the complaint, finding that the alleged fear of contracting HIV was unreasonable as a matter of law.15 The appellate court affirmed. The court, following the majority of other jurisdictions, held that Illinois courts require emotional distress plaintiffs to prove “actual exposure” to HIV; otherwise, her fear of contracting HIV was “too speculative” as a matter of law.16 The court concluded that “[r]ecovery in this situation should be based on the likelihood of contracting AIDS, not the fear that it could have happened, but did not.”17

Justice Barry wrote a strong dissenting opinion, finding that the plaintiff’s inability to meet the “actual exposure” requirement was a result of the technician’s refusal to be tested for HIV.18 Justice Barry would have applied the minority adopted “reasonableness” standard to the facts of this case, where “plaintiff cannot prove or disprove actual exposure to the HIV virus due to the defendant withholding information.”19

In Doe v. Northwestern Univ.,20 six fictitiously named plaintiffs were treated at defendant’s dental school between 1990 and 1991. On July 22, 1991, defendant sent letters advising plaintiffs that the dental student who was responsible for their treatment tested positive for HIV. The letter further advised that the likelihood of transmission was “extremely low,” but that each plaintiff should be tested for HIV.21
The complaint alleged that the defendant knew that the dental student was HIV positive before the treatment of at least one plaintiff. It further alleged that “accidental blood trauma to the hands and fingers of dental practitioners can occur during the performance of invasive dental procedures,” but the complaint did not allege “any particular level of probability of transmission.” Defendants, on the other hand, presented studies showing a very small chance of transmission during the course of medical treatment which was properly before the court pursuant to their 2-619 motion.

The trial court dismissed the complaint finding that plaintiffs failed to allege “actual exposure.” The appellate court affirmed, but on different grounds as discussed below.

In Majca v. Beekil, plaintiff brought a claim for negligent disposal of a scalpel against the estate of Dr. Latcher, a physician who died following AIDS complications. The complaint alleged that Majca was employed as Dr. Latcher’s office manager, and that her responsibilities included office cleaning. While cleaning the office, plaintiff placed her hand in a trash can and was cut by a discarded scalpel. Plaintiff observed dried blood and mucus on the blade. She further alleged that Dr. Latcher was known to spit and blow his nose on tissues which were then placed in the trash cans. The incident occurred on March 1, 1991 and Dr. Latcher died following AIDS complications on November 1, 1991. Plaintiff was tested for HIV in March and June of 1991; both tests were negative for HIV. Plaintiff first learned that Dr. Latcher was HIV positive on the date of his death.

The trial court granted summary judgment for the estate of Dr. Latcher, finding that the plaintiff failed to prove “actual exposure” per Surgicare. The appellate court affirmed, but on different grounds as discussed below.

The First District in Majca and Northwestern, adopted a new standard for determining whether a plaintiff’s fear of future illness, such as AIDS, is compensable:

A plaintiff who fears that she has contracted AIDS because of a defendant’s negligence should recover damages for the time in which she had a reasonable fear of a substantial, medically verifiable possibility of contracting AIDS.

In Northwestern, the court found that plaintiffs’ fears, although reasonable, were not compensable because “they alleged no reason for disbelieving defendants’ statement that the likelihood of infection was extremely low.” Specifically, plaintiffs did not allege that the dental student bled while treating them or failed to use adequate precautions to prevent the transmission of HIV.

In Majca, plaintiff did not know that Dr. Latcher was HIV positive until his death: eight months after she was cut by the used scalpel. Therefore, according to the court, she did not know that the scalpel “probably held bodily fluids of a person who had HIV.” The court stated that plaintiff’s fear, although reasonable, “could not be sufficiently serious so as to be compensable until plaintiffs learned that Dr. Latcher had HIV, which gave them reason to believe that Eileen faced a particular substantial risk of HIV infection.”

Justice DiVito, in both cases, wrote a special concurring

opinion holding in favor of the “actual exposure” standard adopted by the Third District in Surgicare. Justice DiVito found the standard “easier to understand and apply” than that of the majority. DiVito stated that “[t]o establish actual exposure, a plaintiff must show that HIV was present in the alleged disease-transmitting agent and that a medically-accepted channel of transmission for the virus existed.” He expressed concern with the majority’s test in that “differing opinions as to what is a “substantial possibility” of HIV infection will lead to increased litigation and divergent results in cases involving a fear of HIV infection.”

In Natale v. Gottlieb Memorial Hospital, et al., the plaintiff sued a surgeon and hospital for medical negligence resulting in the fear of AIDS following surgery wherein it was alleged that the
plaintiff was “invaded by a non-sterile, contaminated scope.”

The circuit court dismissed the complaint after finding that the plaintiff failed to allege “actual exposure” as required by Surgicare.

The appellate court reversed, after first considering the standards applied in Surgicare and Northwestern/Majca. The court stated that “[t]his case does not require us to choose between these two standards, however, as actual exposure to HIV clearly satisfies the condition precedent to recovery as articulated by the majority in Northwestern.” The court did not offer any reasoning in arriving at its holding. However, it appears that the court found the Third District’s standard to be the more stringent standard for recovery.

Finally, in Doe v. Noe, the appellate court recognized a cause of action for negligent failure of a physician to disclose his HIV-positive status before performing an invasive medical procedure on a patient. The physician performed two gynecological procedures on the plaintiff. Plaintiff filed an 18 count complaint, asserting various theories of recovery against various defendants associated with the physician. The trial court dismissed all counts, except those against the physician and his corporation, based on negligent infliction of emotional distress. The appellate court affirmed after first addressing two certified questions. In answering those questions in the affirmative, the court held that a physician owes a duty to disclose his HIV-status before performing an invasive procedure and that the patient may recover damages for emotional distress based on such conduct.

The court went further, however, and found that plaintiff need not allege “actual exposure” as required by Surgicare. The court did not establish any particular test. Rather, the court followed the rationale advocated by the Supreme Court of Maryland in relaxing plaintiff’s pleading and proof requirements. Specifically, the court adopted the “reasonable window of anxiety test” adopted by the Supreme Court of Maryland. The court reasoned that to allow liability within this time frame provides the defendant practitioner with a reason to disclose the possibility of HIV transmission and to thereby avoid liability.

The court noted that its test is at odds with Surgicare and Majca/Northwestern. Notwithstanding the “high standards” established by those courts, the Noe court found that their tests “would discourage notification to a person who may have been exposed to HIV because there would be no reason for such disclosure if no liability obtained in the future.”

IV. Analysis

The Illinois Supreme Court has recently accepted consolidated appeals in Majca and Northwestern. The Court faces a difficult challenge in choosing a standard to determine whether a fear of future illness, such as AIDS, is compensable in Illinois. The Second, Fourth and Fifth Appellate Districts have not addressed this issue. There is a three way conflict between the First and Third Districts. The Court may follow its earlier reasoning in Corgan, as advocated by Justice Barry’s dissenting opinion in Surgicare. If so, will it apply that standard to fears concerning every type of future illness? For example, the fear of cancer from inhalation of carcinogens; the fear of arthritis following surgical repair resulting from an orthopedic injury; the fear of disc disease following a traumatically induced back injury, etc.

In Corgan, the Court emphasized the jury’s role as fact finder and “its faith in the ability of jurors to fairly determine what is, and is not, emotional distress.” Should this reasoning apply equally to fears of future illness across the board? Specifically, should it apply to the fear of AIDS, a condition which has received widespread media attention and provoked unjustified and unproven, but widely believed conclusions as to its causes and effects?
Should the Supreme Court create special standards specifically addressed to the concerns surrounding AIDS and create a judicial barrier at the pleading stage to weed out unfounded or speculative fears? If so, what standard is appropriate to provide guidance to the lower courts? These are some of the difficult issues facing the court.

A relaxed standard may very well open the flood gates to litigation and an overly stringent standard may effectively eliminate all causes of action for fear of contracting HIV. The court must balance these concerns.

Actual exposure, as advocated by the majority of jurisdictions and the Third District is more easily understood as pointed out by Justice Divito. However, it is susceptible to imprecise application as noted by Justice McNulty. Justice McNulty’s test speaks of a “substantial, medically verifiable possibility” of contracting HIV. Does this test require a substantial risk of infection or a possibility of infection; or does it require a substantial possibility of infection? If the latter, how is such a standard applied outside the facts of Majca and Northwestern? Actually, it remains unclear what the plaintiffs were required to plead and prove in both cases.

In Majca, it would appear that the plaintiff needed to allege and prove that she was aware that Dr. Lacher had AIDS at the time when she was cut by the scalpel. If so, why would this be sufficient to meet the majority’s standard? The scalpel was discarded and never tested for the presence of HIV. There were no facts pled to suggest that Dr. Latcher’s blood or mucus was on the scalpel. What did the plaintiffs have to plead?

In Northwestern, the defendants notified the plaintiffs that they faced an “extremely low” risk of infection. At least one plaintiff alleged that defendants were aware that the student was infected with HIV prior to performing surgery. It would appear that the plaintiff was required to allege and prove that the student actually bled inside the plaintiff’s mouth during the course of surgery. If this is true, why wasn’t the plaintiff in Majca required to plead and prove that the scalpel bore the presence of HIV? In both opinions filed on the same date, the First District majority’s new test failed to achieve consistent application.

Surgicare’s “actual exposure” requirement likewise suffers from inconsistent application. Some courts apply a very relaxed definition to the term “exposure.” For example, one court held that the plaintiff was exposed to HIV when the blood of an HIV-positive patient spilled on plaintiff’s hand after an intravenous needle became dislodged from the patient’s arm. Notably, there was no allegation that the plaintiff’s hand had any open wound.

In Natale, the court found that plaintiff pled exposure, without alleging that the defendant’s scope was used on an AIDS patient or that the scope tested positive for the presence of HIV. Compare this with Surgicare’s application of the exposure test wherein the plaintiff alleged she was stuck with a contaminated needle and her case was dismissed. Why should a contaminated scope and needle be treated differently?

The test adopted by the Supreme Court of Maryland, followed by Noe, appears to be limited to its facts: Where a physician fails to disclose his HIV-positive status prior to performing an invasive medical procedure. In those instances, the plaintiff may recover without alleging that a channel of transmission existed for which HIV may have entered the patient’s body. How far does Noe reach? Does it extend to a nurse who administers a shot or a physician that sutures a wound? Does it apply to dental cleaning? Without proof of a mode of transmission, there is no objective basis for weeding out speculative fears. For this reason, if Noe remains good law, its holding should be limited to medical or surgical procedures inside a patient’s body cavity where the patient would have no ability to learn that the physician was practicing without proper barrier techniques, such as double lined gloves, or that the surgeon cut himself during the course of surgery where the patient is unconscious. Under those circumstances, Noe’s test might very well address Justice Barry’s concerns where the “defendant’s actions have made it impossible for the plaintiff to prove actual exposure.”
V. Stating a Cause of Action for Fear of AIDS

Prior to the first AIDS phobia appellate case in Illinois, this author advocated a two-tier test, similar to what has been adopted by the Third and First Districts combined:

Whether defendant’s wrongful conduct has exposed the plaintiff to a medically verifiable increased risk of contracting HIV

This test represents a compromise between the standards adopted in *Surgicare* and *Majca/Northwestern*. Further it lessens the chance for inconsistent application of the exposure requirement by requiring medical verification of an increased risk of infection. The same test can be applied in all fear of future illness cases. In the “AIDS phobia” context, it would require that plaintiff prove that a mode of transmission existed for the virus to enter his body. The mode of transmission will be supported by the requirement of medical evidence of an increased risk of contracting HIV. The plaintiff must allege facts addressing the existence of medical evidence to support the claim. Of course, plaintiff must have knowledge that the defendant’s wrongful conduct exposed her to HIV. If plaintiff fails to take an HIV test within a reasonable time, typically six months from the date of initial exposure, than such facts may be raised by affirmative defense to defeat or limit plaintiff’s damages.

VI. Applying the Test in Simple Terms

To state and maintain a cause of action for the fear of contracting AIDS caused by the negligent conduct of another, plaintiff must allege and prove the following:

1) **Duty** - That the plaintiff and defendant were in such a relationship that a legal duty may be imposed upon the defendant to prevent the plaintiff from fearing the contraction of HIV (e.g. physician-patient).

2) **Negligence** - That the defendant acted or failed to act in such a manner that his conduct may be deemed unreasonable in causing the plaintiff to fear the contraction of AIDS (e.g. physician failed to disclose HIV-positive status to patient before performing an invasive surgical procedure).

3) **Causation** - That as a direct and proximate result of the Defendant’s negligent conduct, the plaintiff was exposed to HIV and became aware of that “exposure” which resulted in a fear of contracting AIDS (e.g. HIV-positive physician exposed the plaintiff to HIV by failing to utilize proper barrier techniques to prevent a “mode of transmission” through blood or other bodily fluids and the plaintiff became aware of this exposure).

   Inherent within the requirement of causation is that the plaintiff sustain a “physical impact” resulting from defendant’s negligent conduct. The “mode of transmission” of HIV is often a result of the physical impact (e.g. plaintiff stuck with HIV-contaminated needle). The physical impact and resulting mode of transmission will then establish “exposure” to HIV.

4) **Damages** - That the plaintiff’s fear of contracting AIDS was reasonable and not “too speculative” as a matter of law.

   Inherent within this requirement is the allegation of facts supporting a “medically verifiable increased risk” of contracting HIV. This is not a “more likely than not” test as adopted by the California Supreme Court and advocated by the Third District in *Surgicare*. However, the plaintiff’s fear must have some objective basis for the claim to survive the pleading stage. This requirement accomplishes that purpose without absolving defendants, and in particular, the medical community, from liability where negligent conduct has exposed the plaintiff to a “medically verified increased risk” of contracting HIV.
VII. Conclusion

Illinois courts are presently divided over what a plaintiff must plead and prove to maintain a cause of action supporting the fear of contracting HIV. The issue is now before the Illinois Supreme Court. This author advocates a test which strikes a balance between the differing standards adopted by the appellate court in this state. Further, it allows for consistency and fairness for plaintiffs and defendants alike.

Endnotes


3 Surgicare, 643 N.E.2d 1200.

4 The “zone of danger” plaintiff is also referenced as a “bystander” by the courts. Pasquale v. Speed Products Engineering, 166 Ill.2d 337, 654 N.E.2d 1365, 1372 (Ill 1995).

5 Corgan v. Muehling, 143 Ill.2d 296, 654 N.E.2d 602, 605 (Ill 1991)(citing Rickey v. Chicago Transit Auth., 98 Ill.2d 546, 457 N.E.2d 1 (Ill 1983). The “zone of danger” plaintiff need not prove a “physical impact” as a result of defendant’s negligent conduct, but must prove “physical injury or illness” resulting from the alleged emotional distress. Id.


8 Jarka, 637 N.E.2d at 1101.

9 Corgan, 574 N.E.2d at 609. The same rule applies to intentional infliction of emotional distress plaintiffs. Id.

10 The “zone of danger” plaintiff must allege physical manifestations, unlike the “direct victim” plaintiff.

11 289 Ill App 3d 760, 682 N.E.2d 253.

12 682 N.E.2d 145.

13 143 Ill.2d at 312, 574 N.E.2d at 609. The Third District in Surgicare correctly cited Corgan when it stated that “In Corgan, the Illinois Supreme Court held that a direct victim of psychologist’s negligence need not allege physical symptoms of emotional distress to sustain a cause of action.” 268 Ill.App.3d at 797, 643 N.E.2d at 1203.

14 268 Ill.App.3d 793, 643 N.E.2d 1200.

15 Id, 643 N.E.2d at 1203.

16 Id.

17 Id, 643 N.E.2d at 1204 (emphasis added). The court cited Potter v. Firestone Tire and Rubber, 6 Cal 4th 965, 863 P2d 795, 25 Cal Rptr 2d 550 (Cal 1993). Potter was a fear of cancer case in which the California Supreme Court adopted a very stringent test for recovery of emotional distress damages: (1) exposure to the carcinogens, corroborated by medical opinion, and (2) “it is more likely than not that the plaintiff will develop the cancer in the future ... ” Id, 25 Cal Rptr 2d at 571. California’s two-tier test “places a nearly insurmountable burden on “AIDS phobia” plaintiffs in their endeavor to recover for legitimate emotional harm.” Bollinger, “On the Road to Recovery for Emotional Harm: Is the Fear of AIDS a Legally Compensable Injury”, 16 The Journal of Legal Medicine 441 (1995).

18 Surgicare, 643 N.E.2d at 1204.

19 Id, 643 N.E.2d at 1206.

20 ___Ill.App.3d ___, 682 N.E.2d 145.

21 Id, 682 N.E.2d at 147.

22 Id, 682 N.E.2d at 148.

23 Id, 682 N.E.2d at 148.

24 289 Ill.App.3d 760, 682 N.E.2d 253.

25 Plaintiffs also sued another physician who shared office space with the deceased physician.

26 Majca, 682 N.E.2d at 253; Northwestern, 682 N.E.2d at 152.

27 Northwestern, 682 N.E.2d at 153.
28 Id.
29 Majca, 682 N.E.2d at 256 (emphasis added).
30 Id, 682 N.E.2d at 256-57.
31 Majca, 682 N.E.2d at 257; Northwestern, 682 N.E.2d at 154.
32 Majca, 682 N.E.2d at 257.
33 Northwestern, 682 N.E.2d at 154.
34 Id, 682 N.E.2d at 155.
36 Id at 1.
37 Id at 2 (emphasis added).
38 No. 1-96-3791 (1st D Dec 26, 1997).
39 Id, at 5.
40 Id at 7 (emphasis added).
41 Id (citing Faya v. Almarez, 620 A2d 327 (Md 1993)).
42 Id. The window of anxiety runs from the time plaintiff learned of the defendant’s HIV status until the time plaintiff receives negative HIV test results (typically six months from the date of exposure). Faya, 620 A2d at 338.
43 Id at 7.
45 630 So2d at 862.
48 It has been held that plaintiff may only recover damages during a “reasonable window of anxiety.” Faya, 620 A2d at 337 (the court noted a statement by the Centers for Disease Control suggesting that it may take persons up to six months following HIV-infection to test positive for HIV).
49 See IIA, supra, as to the requirement of physical impact and the distinction between “zone of danger” and “direct victim” plaintiffs.
50 These terms are frequently used by the courts in analyzing “AIDS phobia” claims.

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