Negligent HIV Testing and False-Positive Plaintiffs: Pardoning the Traditional Prerequisites for Emotional Distress Recovery

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I. INTRODUCTION

In December 1990, Vemelle Lowder tested HIV-positive.¹ Fearing she would infect others, she refused to let her children hug her and relinquished custody.

¹This Note uses the term "HIV" to refer to human immunodeficiency virus. HIV is the virus that has been identified as causing damage to the immune system, thus...
to her mother—who washed Lowder’s dirty dishes with bleach. Accepting her fate, she returned to live with an aunt in her hometown and planned to kill herself when she became seriously ill. In 1992, after being rejected and shunned by family and friends for two years, Lowder learned there had been an error. She was not infected with HIV after all. In 1994, a jury awarded Lowder $600,000 for needless anguish triggered by facing the devastating and stigmatizing consequences associated with HIV.2

"Mistakes" like Lowder’s are not uncommon. In 1993, Kathleen Murphy’s life came to a "screeching halt" after testing positive for the HIV virus.3 Horrified at the thought of inflicting her unborn child with the deadly disease, she underwent an abortion, only to find out her concern was unnecessary. The laboratory results were inaccurate.4 That same year, Charles Shires’s thoughts turned to suicide after friends had abandoned him when he was falsely diagnosed HIV-positive.5 According to Shires, friends refused to shake his hand, "treated him like nuclear waste," and "always had an excuse" not to see him.6 In 1992, Sue Gibson’s life had already "unraveled" before a health clinic counselor informed her that the positive test results were erroneous.7 The mistake carried fatal consequences for Gibson, a recovering alcoholic: "Thank God I didn’t kill myself, thank God I didn’t drink."8 In 1989, Charlene Riling’s life went on hold for three years after a New Haven Health Department counselor told her she tested positive for the AIDS virus.9 Riling wrote her will and planned her memorial service before finding out she had been misdiagnosed.10

Each of these individuals has been to hell and back. Not surprisingly, they have responded as most do when diagnosed HIV-positive: they experienced


4 Id.


6 Id.


9 Id. The Note uses the term "AIDS virus" to refer to human immunodeficiency virus."

10 Id.
fear, depression, and anxiety. However, they shared an additional grievance. They were victims of human error. Negligent HIV testing procedures are considered the primary cause of test inaccuracy. Although procedures to detect exposure to HIV are fairly trustworthy, human error can occur at every step—anywhere from mislabeling of vials when drawing blood to misinterpreting test results. Counseling errors are also a factor as many individuals mistakenly diagnosed HIV-positive are not told about the possibility of such error. The circumstances giving rise to false-positive results, as well as needless mental anguish, have provoked those misdiagnosed to seek recovery of damages based upon the theory of negligent infliction of emotional distress.

To date, the genuine emotional suffering of many false-positive plaintiffs remains unremedied. Unfortunately, the presence of mental anguish is often not determinative of the availability of relief. In some instances, courts require a showing that false-positive plaintiffs experienced some physical impact or have been "fortunate" enough to have sustained some physical injury aside from their extreme mental anguish before permitting recovery. These results have occurred, at least in part, because traditional tort law principles do not encourage courts to compensate purely emotional injuries. Although most courts acknowledge that emotional distress resulting from negligence may merit compensation, they place limits on recovery. Fearing fraudulent claims, courts historically required that the plaintiff sustain some physical impact as a result of the defendant's negligent conduct. Because there is often no correlation between impact and distress, many jurisdictions have adopted the physical-injury requirement, which requires that a plaintiff's emotional

11 See infra Part IV.A-B and accompanying notes 211-313.
13 See infra text accompanying notes 33-64.
15 This Note uses the phrases "mental anguish," "mental damages," "mental distress," and "emotional distress" synonymously.
17 See infra Part III.B.
19 See infra Part III.A.(1) and accompanying notes 114-32.
distress manifested itself in some form of physical injury before a defendant becomes liable for emotional distress.  

Although the traditional doctrines remain a substantial consideration in a majority of jurisdictions, most courts acknowledge exceptions to the historical barriers to emotional distress recovery. There is a developing trend to allow recovery for mental disturbance alone in two special groups of cases where there is a special likelihood that genuine and serious mental distress will result: cases involving the negligent transmission of a message announcing death and those involving the mishandling of a corpse. Recovery is permitted in these instances because the surrounding circumstances provide a guarantee that the resulting emotional distress claims are genuine. This rationale is equally applicable to cases involving claims regarding negligent HIV testing; therefore, false-positive cases also merit an exception.

Emotional distress is a guaranteed consequence of an HIV-positive test result. Medical studies indicate that nearly all HIV-infected individuals will eventually develop AIDS. AIDS is unusual in several respects. In addition to being fatal, the disease has serious stigmatizing and discriminatory aspects. In the United States, the greatest number of people infected by the virus is found among groups which are already marginalized: intravenous (IV) drug users, gay males, minorities, and women. Moreover, because HIV and AIDS are acquired, unlike many other fatalities, many people regard HIV-positive individuals as having "only themselves to blame." These

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20 See infra Part III.A.(2) and accompanying notes 133-39.

21 See infra Part III.A.(3) & (4) and accompanying notes 140-80.


24 See Harris J. Zakarin, Comment, Scared to Death: A Cause of Action for AIDS Phobia, 10 TOURO L. REV. 263, 263 (1993); see also Ordway v. County of Suffolk, 154 Misc.2d 269, 272 (Super. Ct. Suffolk County 1992) (recognizing that "AIDS... is ultimately fatal.").

25 See Anthony S. Fauci, NIH Conference - The Acquired Immune Deficiency Syndrome: An Update, 102 ANNALS INTERNAL MED. 800 (1985). At this point, it is helpful to distinguish between HIV and AIDS. HIV attacks the body's immune system and precludes it from fighting off other types of infections. Id. AIDS itself is defined by the existence of HIV in an individual and the presence of one or more opportunistic infections that subsequently germinate as a result of the individuals contaminated immune system. Id.

26 See infra Part IV.B.(1) & (2) and accompanying notes 246-313.


notions, combined with misconceptions about how HIV is transmitted, causes society to treat HIV-positive individuals in an irrational and often arbitrary manner.\textsuperscript{29} Fearing a slow and painful death, people with HIV must simultaneously bear the burdens of harassment, job discrimination, loss of health insurance, and social ostracism.\textsuperscript{30} The commingling of these burdens necessarily produces guilt, shame, anxiety, and humiliation. Thus, as could be expected, when an individual becomes aware of her own HIV-positive status such knowledge represents one of the strongest and most invariable connections with emotional distress to date.\textsuperscript{31}

This Note focuses upon the unique circumstances surrounding false-positive plaintiffs' claims. Part II examines the recent surge of litigation resulting from false-positive test results. The discussion begins by analyzing HIV antibody testing and procedure and concludes by noting that negligent testing is the prevailing factor in faulty diagnosis. Part III explores negligent infliction of emotional distress as a cause of action for false-positive plaintiffs. This section begins by tracing the historical development of the law on negligent infliction of emotional distress. The discussion focuses on both the development and abandonment of the traditional limitations placed upon emotional distress recovery. Part III concludes by criticizing the overall inconsistent and disparate effects of the application of these traditional doctrines to claims involving a false-positive diagnosis. Part IV asserts that false-positive results necessarily entail genuine emotional distress claims: the devastating and stigmatizing circumstances surrounding HIV and AIDS guarantees that severe emotional distress will follow in the wake of a positive test result. Part V analogizes these plaintiffs' claims (based on false-positive HIV test results) to two special groups of cases that the courts have deemed as "arising from special circumstances," and therefore exempt from the traditional barriers of emotional distress recovery. Recognizing the precise similarities shared by misdiagnosed plaintiffs' claims and those already excepted from the traditional doctrines, Part V concludes by proposing the abandonment of recovery limitations for false-positive plaintiffs in the HIV context.

II. FALSE-POSITIVE HIV TEST RESULTS SPARK LITIGATION

A. Analysis Of HIV Antibody Testing And Procedure

Determining whether a person has been infected with HIV involves complex laboratory testing procedures.\textsuperscript{32} The most commonly used method is

\textsuperscript{29}See infra Part IV.B.(2) and accompanying notes 281-313.

\textsuperscript{30}See Herek & Glunt, supra note 28, at 886, 887.


testing for antibodies created in response to an invasion by HIV.\textsuperscript{33} The threshold test is the enzyme-linked immunosorbent assay (ELISA), a blood screening test which indicates the presence of such antibodies.\textsuperscript{34} If an ELISA test fails to detect antibodies, the blood sample is presumed to be free from HIV infection and the test is typically not repeated.\textsuperscript{35} If the presence of antibodies is detected, however, the test is repeated at least once, and usually twice.\textsuperscript{36}

The ELISA is remarkably sensitive and often results in a large number of false-positives.\textsuperscript{37} Therefore, consistently positive results are cross-checked by an additional test: the Western Blot.\textsuperscript{38} This second test, although more reliable than the ELISA, similarly detects the presence of antibodies and does not detect the actual virus.\textsuperscript{39} Nonetheless, the Western Blot identifies antibodies more precisely regarding their relevance to HIV, thereby rendering itself less likely to produce false-positive results.\textsuperscript{40} The Western Blot is rarely used except to confirm positive ELISA results because it is significantly more costly, time-consuming, and difficult to perform.\textsuperscript{41}

Despite the follow-up techniques utilized in the HIV testing process, false-positive results occur with both types of tests.\textsuperscript{42} With respect to the ELISA, extreme sensitivity is not the only factor which may affect its accuracy. The initial screening test is prone to errors of timing, technical mishap, or biological ambiguity which can produce both false positives \textit{and} negatives:

\begin{itemize}
  \item \textsuperscript{34}Id. More specifically, to detect for the presence of antibodies using an ELISA, HIV is grown, purified, and broken down into its component parts, which are placed in some type of solid phase. \textit{Id}. When test serum is added, its color will change if antibodies to HIV are present. \textit{Id}.
  \item \textsuperscript{35}See Guidelines, supra note 12, at 510.
  \item \textsuperscript{36}See Lanin, supra note 33, at 94 n.136.
  \item \textsuperscript{37}See Donald H.J. Herman, AIDS: Malpractice and Transmission Liability, 58 U. COLO. L. REV. 63, 64 (1986-87); see generally Petricciani, Licensed Test for Antibody to Human T-Lymphotropic Virus Type III: Sensitivity and Specificity, 103 ANNALS INTERNAL MED. 726 (1985).
  \item \textsuperscript{38}Harold L. Hirsh, M.D., J.D., AIDS and the Law: A Summary and Conclusion, 10 J. LEGAL MED. 169, 177 (1989).
  \item \textsuperscript{39}See Herman, supra note 37, at 65; The Western Blot is significantly more reliable as it electrophoretically separates viral antigens. Hirsh, supra note 38, at 177. More specifically, the main proteins of a laboratory-grown HIV, called antigens, are electrically separated and placed into strips of a special paper. If the sample contains HIV it will align with the antigens on the strips. See Lanin, supra note 33, at 94 n.136.
  \item \textsuperscript{40}See Osborn, supra note 32, at 46.
  \item \textsuperscript{41}See Lanin, supra note 33, at 94 n.136.
  \item \textsuperscript{42}Phyllida Brown, \textit{Rushed HIV Testing Risks False Results}, NEW SCIENTIST, Sept. 18, 1993, at 5.
\end{itemize}
Timing comes into play if the infected person is tested before antibodies have time to be formed and appear, an interval of a relatively few weeks following the initial acquisition of the virus sometimes called the window period. Technical errors of many types can occur, such as mislabeling of test tubes or carry-over in pipetting of solution from a positive to a negative sample. And biologic ambiguity exists as in all medical indicator tests, since unrelated but functionally similar biologic substances can yield a falsely positive result.

Similarly, the Western Blot, is not altogether infallible. For instance, in Western Blots, it is not uncommon for individuals to yield slight reactions to HIV proteins even though they have never been exposed to the virus. These "indeterminate" results can be clarified by a later blood test as the immune response to the virus tends to become more active over a few weeks.

The HIV testing procedure exemplifies far more than just the presentation of laboratory results. As researchers have become increasingly skeptical regarding the reliability of the entire diagnostic process, both pretest and posttest counseling have become standard components of HIV antibody testing programs.

Pretest counseling is necessary to inform test recipients that a positive test result is not a genuine indication that one has been infected with the virus. Because HIV-positive test results stimulate significantly different emotional and physical responses than do standard or routine blood tests, counselors generally advise patients about the social and psychological impact of a posi-

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43 Osborn, supra note 32, at 45. When an individual is tested before the antibodies appear—during the window period—a false-negative HIV test result occurs. The legalities of a false-negative HIV test results are beyond the scope of this Note.

44 Brown, supra note 42, at 5.

45 See Levy, supra note 5, at D1. The Western Blot separates blood into HIV-positive, HIV-negative, and a third category, "indeterminate," or too ambiguous to finalize. Id. Those within the third category need to be retested a few months later to receive an accurate diagnosis. Id.

46 Brown, supra note 42, at 5.

47 See Elaine M. Sloand et al., HIV Testing: State of the Art, 266 JAMA 2861, 2862 (discussing the high false-positive rate and inability of HIV tests to achieve consistent results).


49 Id.

tive HIV test result prior to test implementation. In comparison, posttest counseling is often the starting point for medical evaluation and treatment. Follow-up counseling also contributes to the overall coping process, as the report of a positive antibody test often effectuates psychological distress, employment discrimination, social ostracism, and often determines the availability of both health and life insurance.

As it appears that no effective testing program exists, doctors or counselors who deliver an HIV-positive test result should warn the recipient that HIV tests are designed merely to detect antibodies showing exposure to the virus. More specifically, one legal scholar has suggested that test recipients be told that a positive result is indicative of numerous possibilities:

1) that one has been exposed to the HIV virus, and consequently that one has been infected at some time in the past but has now recovered, and is no longer in danger either of developing AIDS or of passing the virus to other people; or 2) that one is currently infected, and may transmit the virus or may come down with AIDS, or a related disease, at some unknown time in the future; or 3) that one has never been exposed to the virus since there is a possibility of a false-positive result.

Even the United States Congress has recognized the paramount importance behind adequate counseling in the HIV context. In 1990, Congress premised federal funding for public health care testing facilities upon pretest counseling regarding the accuracy and reliability of HIV tests in general. Furthermore, the statute obligated counselors to review the appropriateness of further testing when initial test results for HIV are positive.

51 Id.; see also Bernard Lo et al., Voluntary Screening for Human Immunodeficiency Virus (HIV) Infection: Weighing the Benefits and Harms, 110 ANNALS INTERNAL MED. 727 (1989) (discussing the ethical considerations involved in follow-up care and counseling).

52 Valdiserri et al., supra note 48, at 17.

53 Herman, supra note 37, at 71.


55 Herman, supra note 37, at 71.

56 Id.

57 42 U.S.C.A. § 300ff-62(c)(2) (West Supp. 1991). More specifically, this segment of the statute requires that:

(a) [t]he Secretary may not make a grant under this part unless the applicant for the grant agrees that, if the results of testing for HIV disease indicate that the individual has the disease, the applicant will provide to the individual appropriate counseling regarding such disease, including—(2) reviewing the appropriateness of further counseling, testing, and education of the individual regarding such disease[.]
No test is ever foolproof. Nonetheless, with more than 2.7 million individuals seeking HIV tests each year at public clinics alone, even a small margin of error will devastate many people. Because many test recipients may view initial positive results as conclusive for the presence of HIV, counselors are the bridge between misconceptions and diagnostic truths. The need for information regarding test accuracy makes counseling a critical element in the testing environment. Those surprised by a positive result must be advised to return for a second test. Failure to provide full information regarding both the nature and reliability of the results may give rise to a negligence suit.

B. Negligent Testing As A Common Factor In Faulty Diagnosis

As discussed above, human error is a real possibility in HIV testing. Although the tests are fairly accurate, they must be performed by "someone who knows what they are doing." Skilled staff in good laboratories can usually differentiate the false positives from genuine infection; testing of subsequent blood samples often clarifies ambiguous results. Considering the need to verify positive results with additional testing, it would appear that testing facilities would rarely fail to do so. One recent study, however, suggested that up to seventy percent of ELISA tests are not confirmed by a second ELISA. Furthermore, many individuals falsely diagnosed as HIV-positive were never informed about the possibility of erroneous test results. Some individuals who received false positives and subsequently began medical treatment never received confirmatory testing by their treating physicians. Consequently, the legal system has recently confronted a plethora of claims with respect to negligent HIV testing and false-positive diagnoses.

58 Cizik, supra note 54, at 15.
59 Levy, supra note 5, at D1.
60 See Herman, supra note 37, at 71.
61 See Levy, supra note 5, at D1.
62 Herman, supra note 37, at 70-71.
64 Levy, supra note 5, at D1 (quoting Dr. Sidney Wolfe, director of the Public Citizen Health Research Group, Washington, D.C.).
65 Brown, supra note 42, at 5.
66 Sloand, supra note 47, at 2861.
67 See Kranhold, supra note 8, at A1. More specifically, one test counselor urged an individual erroneously diagnosed HIV-positive to attend a fundamentalist church so that "Jesus Christ could heal her," instead of recommending additional testing. Id.
In *Ouverson v. Sitzman*, a woman falsely diagnosed HIV-positive filed suit against her doctors and the testing laboratory. The plaintiff claimed that she was put on AZT and treated as if she were HIV-infected for seven months before a second blood test, which showed she was free of infection, was performed. The suit, filed in 1992 and still pending, contends that doctors, including two HIV specialists, failed to perform regular follow-up testing. Furthermore, the lab apparently failed to perform an ELISA test, the standard initial HIV screen, prior to administering the Western Blot.

Recently, in *Lowder v. Economic Opportunity Family Health Services*, a Florida court awarded a woman $390,000 in damages because a state laboratory reported erroneous HIV-positive test results. Lowder, who was not immediately retested, was treated with anti-AIDS drugs for some 15 months. A second test was not administered until two years later. The suit alleged negligence on the part of the state lab. A medical malpractice claim against her treating physician for failing to seek a second HIV test was settled out of court.

Likewise, in *Bramer v. Dotson*, a fifty-four-year-old man filed a claim against his doctor and the testing lab for erroneously diagnosing him HIV-positive. One month after he was diagnosed—and without receiving confirmatory testing—the plaintiff began AIDS treatment. Knowing he was not among the groups of persons most at risk to develop AIDS, the plaintiff demanded repeat testing. This subsequent blood sample showed he was not HIV infected.

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69 No. 92-23888 (Jackson County Cir. Ct. filed Oct. 13, 1992); see also HIV-Free Woman Treated as Positive Sues Physician, Lab for Malpractice, 7 AIDS POL'Y & L. 5 (Oct. 30, 1992) [hereinafter HIV-Free].

70 Id. AZT refers to the drug azidothymidine, which slows the attack of AIDS. See Burroughs Wellcome’s AZT to be Standard Drug for AIDS Patients Who Have Had Pneumocystis Carinii Pneumonia: Four Month Mortality Results and Placebo Trials, 48 THE PINK SHEET 3 (1986).

71 See HIV-Free, supra note 69, at 5.

72 Id.

73 Lowder v. Economic Opportunity Family Health Services Inc., No. 93-16747 (Dade County Cir. Sept. 16, 1994).

74 See Faulty AIDS Test Nets $600,000, Woman Gave Up Kids, Planned Her Suicide, CHICAGO TRIBUNE, Sept. 23, 1994 at 8 [hereinafter AIDS Test Nets].

75 Id.; see also HIV-Negative Man Files Claim Against HMO That Treated Him, 7 AIDS POLY & L. 4, 5 (1992) [hereinafter HIV-Negative Man] (reporting $2 million dollar arbitration claim filed against Kaiser Permanente’s San Jose facilities for false-positive test results).


77 Id. at 774.

78 Id.

79 Id.
In another case, Kathleen Murphy brought a $1.2 million malpractice action against San Francisco's Kaiser Foundation Hospital after doctors misinformed her that she was HIV-positive.81 Three days after receiving the catastrophic news, Murphy underwent an unnecessary abortion.82 Because no follow-up testing procedure had been performed, the laboratory error on which the faulty diagnosis was based was not detected in time.83 Murphy's case, however, must be resolved out of court because her health plan requires arbitration of legal claims.84

Similarly, two men in San Francisco sought damages under arbitration when Kaiser doctors mistakenly diagnosed them as HIV-positive.85 John Kuivenhoven, fifty-four, who had never actually been tested for HIV, underwent AIDS treatment for six years before learning that he was not HIV-positive.86 Dante Paladorri, fifty-five, also received unnecessary AZT treatment prior to learning that he was free from HIV infection.87 In each case, the diagnosis was based on the fact that the individual belonged to a high risk group: Paladorri is a previous intravenous drug user and Kuivenhoven is gay.88

In Johnson v. Kaiser Foundation Health Plan,89 a fifty-one-year-old heterosexual mother of four children was diagnosed as HIV-positive based on a "weakly reactive" ELISA test and an "indeterminate" Western Blot.90 Her doctor, after ordering a second blood test which produced a similar "weakly reactive" result, told her there was no chance of error.91 Johnson sued the giant health maintenance organization for failing to administer subsequent testing "between three and six months of the initial testing."92

Finally, Charlene Riling filed a lawsuit against the New Haven Health Department and one of its health department counselors after she was

80 Id.
81 See McKee, supra note 3, at 6.
82 Id.
83 Id.
84 Id.
86 Id.
87 Id.
88 Id.
89 See HMO Liable, supra note 14, at 437.
90 Id.; see supra notes 38-44 and accompanying text (discussing the sensitivity of ELISA testing); supra notes 40-46 and accompanying text (defining "indeterminate" Western Blot test results).
91 See HMO Liable, supra note 14, at 437.
92 Id. at 438.
mistakenly informed that she had tested positive for the AIDS virus. The counselor who misinformed Riling of her HIV status never showed her the test results. Perhaps even worse, instead of urging her to receive additional testing and informing her about possible inaccuracies, the counselor prompted her to attend a fundamentalist church so that "Jesus Christ could heal her." The counselor assumed the test results were conclusive because the woman is lesbian and has a history of prior cocaine and alcohol addictions. That inaccurate test was the only one she received over a three year period, during which time she lived with both the stigma surrounding HIV and the severe side effects caused by some thirty-seven types of medication that her doctors prescribed as part of her AIDS treatment.

As the above cases indicate, negligence claims may arise from a variety of aspects of HIV testing. Many of the testing issues confronting the courts concern laboratory errors and/or the failure to provide appropriate counseling and treatment. Once it is established that an HIV test was not performed in accordance with accepted standards, an individual who is erroneously diagnosed with HIV may have a cause of action for negligent infliction of emotional distress. Despite the underlying soundness and the compelling nature of such claims, some courts deprive those suffering from emotional distress as a result of erroneous test results of any form of redress. Because false-positive plaintiffs' claims lie under the rubric of the general tort of negligent infliction of emotional distress, developments in the tort itself have contributed to the increasingly disparate treatment of these plaintiffs' claims. Therefore, before addressing the merits of false-positive plaintiffs' claims, it is necessary to review the historical development of negligent infliction of emotional distress as a form of redress.

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93 See Kranhold, supra note 8, at A1.
94 Id.
95 Id.
96 Id.; see also Kim Foltz, Testing Positive, N.Y. TIMES, Jan. 5, 1992, (Magazine), at 12 (discussing AZT's highly toxic components and dangerous side effects); Baker & Megan, supra note 51, at 3 (mentioning that erroneous positive results may result in damages for emotional distress, wrong treatment, and therapy).
97 Id. at 2-3; see supra note 58 and accompanying text.
98 See Herman, supra note 37, at 68-69. Herman also stated that:
[i]f a false diagnosis should trigger a response of 'AIDS anxiety' with debilitating effects on a patient, the physician whose negligence resulted in the erroneous diagnosis of AIDS may be liable. Further damages -apart from the emotional distress itself -may include the cost of necessary psychological therapy or counseling and even the loss of income to the extent that the psychological damage impaired the victim's ability to work.
Id.
III. NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS AS A CAUSE OF ACTION FOR FALSE-POSITIVE HIV DIAGNOSIS

A. Historical Analysis Of Tort Law Underlying Emotional Distress Claims For False-Positive Plaintiffs

A plaintiff who brings an action for negligent infliction of emotional distress must prove the same underlying elements of any negligence claim: duty, breach, causation, and injury. However, commentators note several problems in recognizing emotional distress as compensable even when such elements are satisfied. The first problem encountered in this context is whether temporary or minimal harm should be compensable. Second, these cases pose a danger that fraudulent claims, either imagined or falsified, will become commonplace. Third, a fairness issue arises regarding the imposition of heavy and disproportionate financial burdens upon negligent defendants for consequences far removed from the wrongful act. Fourth, these cases produce unusual proximate cause problems because many emotional injuries are not related to the physical consequences of the negligent act. Fifth, there is the question of how to measure emotional distress in dollar amounts. And finally, concern exists that emotional distress claims will lead to a vast increase in litigation. For these many reasons, courts established early barriers for liability premised upon negligent infliction of emotional distress.

100 KEETON ET AL., supra note 22, § 54, at 359. "No general agreement has yet been reached on many of the issues involving liability for negligence resulting in fright, shock, or other mental or emotional harm, and any resulting physical consequences." Id. at 359-60.

101 KEETON ET AL., supra note 22, 30, at 164. Duty is an "obligation, recognized by the law, requiring the person to conform to a certain standard of conduct, for the protection of others against unreasonable risks." Id.

102 Id. Breach is "[a] failure on the person's part to conform to the standard required." Id.

103 Id. at 165. Causation is a "reasonably close causal connection between the conduct and the resulting injury." Id.

104 Id. Injury is "[a]ctual loss or damage resulting to the interests of another." Id.

105 KEETON ET AL., supra note 22, § 55, at 361.

106 Id.

107 Id.; see RESTATEMENT (SECOND) OF TORTS, § 436A, cmr b.

108 KEETON ET AL., supra note 22, at 360.

109 Id.

110 Id.

1. Emotional Distress From Physical Impact

Originally, courts in England and the United States restricted recovery by awarding mental damages only when there was some type of contemporaneous physical impact.\(^{112}\) In 1888, in *Victorian Railways Commissioners v. Coultas*,\(^{113}\) the British Privy Council adopted what has generally become known as the "impact doctrine." The Council denied recovery for alleged injury to the plaintiff's nervous system induced when the defendant's truck nearly struck the plaintiff.\(^{114}\) Under this approach, the requirement of physical impact ties the plaintiff's injuries to the defendant's negligence.\(^{115}\) Otherwise, the court believed that the connection between the two would be marginal.\(^{116}\)

In 1896, New York became the first jurisdiction in the United States to adopt the impact rule.\(^{117}\) The court in *Mitchell v. Rochester Railway*\(^{118}\) barred emotional distress recovery when a negligently-driven team of horses came dangerously near the plaintiff, allegedly causing her miscarriage.\(^{119}\) Because the miscarriage was not the result of any physical impact, the court held that there could be no recovery for injuries resulting from mere fright.\(^{120}\) Although the court recognized that fright may have caused the plaintiff some physical injuries, the absence of an initial impact barred the suit.\(^{121}\) Similarly, a majority of courts in other states began to require that the plaintiff be physically touched by the defendant's tortious act prior to awarding mental damages.\(^{122}\) Supporters of the doctrine asserted that the occurrence of a physical impact created a presumption that emotional distress would result, thereby assuring the genuineness of the plaintiff's claim.\(^{123}\)

Nonetheless, the courts failed to acknowledge the fictitious aspect of the doctrine: the establishment of a physical impact bore no relationship to the

\(^{112}\) See Chesley, *supra* note 18, at 1018-19.

\(^{113}\) 13 App. Cas. 222 (P.C. 1888) (appeal taken from Supreme Court of Victoria).

\(^{114}\) Id. at 225-26.

\(^{115}\) Id.

\(^{116}\) See also Annotation, 64 A.L.R.2d 100, 134-43 (1959) (tracing the development and history of the theoretical basis behind the impact rule).

\(^{117}\) See Chesley, *supra* note 18, at 1020 n.18.

\(^{118}\) 45 N.E. 354 (N.Y. 1896).

\(^{119}\) Id. at 354.

\(^{120}\) Id. at 354-55.

\(^{121}\) Id.


\(^{123}\) See KEETON ET AL., *supra* note 22, § 54 at 363.
plaintiff's mental harm. For example, in *Interstate Life & Accident Co. v. Brewer*, the plaintiff suffered a heart attack when an insurance agent came to her home to question her regarding insurance benefits. The plaintiff claimed the questioning caused her to suffer emotional distress, which in turn led to the heart attack. Because the insurance agent had tossed a coin which struck her person, the court found the plaintiff met the impact requirement. Nonetheless, a few courts still apply the doctrine but will often go to similar lengths to fulfill the standard.

2. Emotional Distress Causing Physical Injury

As other courts became aware of the impact doctrine's artificial nature, a majority of jurisdictions recognized a new theory of recovery: the physical injury doctrine. Although less arbitrary in effect, the new requirement had limitations of its own. Under this new doctrine, definitive physical injuries resulting from the defendant's infliction of emotional distress had to be shown before the plaintiff could recover. While courts construed the doctrine liberally and allowed it to be met by "some physical injury, illness or other objective physical manifestation," considerable confusion arose regarding what symptoms or conditions were sufficient to satisfy such a requirement. On one hand, some courts allowed "unkempt hair, sunken cheeks and dark

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124 See Lanin, *supra* note 33, at 83-84.

125 See Maroulis, *supra* note 63, at 235; see, e.g., Plummer v. United States, 580 F.2d 72, 76 (3d Cir. 1978)(allowing impact of tubercle bacilli on lungs to satisfy the impact doctrine).


127 Id. at 463.

128 Id. at 463.

129 See KEETON ET AL., *supra* note 22, § 55 at 364 (recognizing that a majority of courts have abandoned the traditional impact doctrine).

130 See, Colla v. Mandella, 85 N.W.2d 345, 347 (Wis. 1957) (stating that minority of jurisdictions still applying the impact doctrine will go to absurd extremes to fulfill standard); Christy Bros. Circus v. Turnage, 144 S.E. 680 (____ 1928) (impact requirement satisfied when defendant's horses "evacuated his bowels" in the plaintiff's lap).


eyes” to satisfy the physical injury requirement. On the other hand, some courts denied plaintiffs recovery by requiring physical injuries such as death, paralysis, muscular impairment, or similar objectively discernible physical limitations. Regardless of such disparities in interpreting this requirement, a majority of courts still adhere to the physical injury doctrine. The major rationale underlying adherence to the doctrine suggests that mental anguish without physical injury is "so temporary, so evanescent, and so relatively harmless, that the task of compensating for it would unduly burden defendants and the courts.”

3. Emotional Distress Absent Physical Impact or Injury

While a majority of courts were straining to meet the traditional requirements, a trend developed of courts allowing emotional distress recovery without a showing of physical impact or injury. This trend was supported on a number of fronts, including acknowledgement by psychiatrists that mental injuries are often more harmful and debilitating than physical injuries. Similarly, judges began to speak in favor of such recovery finding that emotional distress was no more difficult to determine and quantify than physical injury. In addition, courts began to recognize that both the physical injury and impact requirements were inadequate in ferreting out false and trivial claims. Finally, many plaintiffs’ genuine emotional distress went unremedied merely because the facts had not played themselves out in such a manner so as to satisfy the requisite standard. Thus, some courts began to develop their own standards.

Three of these departures from the traditional doctrines deserve closer consideration: the "zone of danger rule"; the adoption of standards which appear to comply with the traditional concepts of foresseeability and negligence; and the creation of a general duty to avoid negligent infliction of emotional distress.

134 Vance v. Vance, 408 A.2d 728, 734 (Md. 1979).


136 Keeton et al., supra note 22, at 364; See Donovan, supra note 113, at 1395 (stating that majority of jurisdictions still adhere to the physical injury requirement).

137 Payton v. Abbott Labs, 437 N.E.2d 171, 178 (Mass. 1982); see Donovan, supra note 111, at 1354 n.66 (documenting the twenty-six jurisdictions which have adopted the subsequent physical injury doctrine).

138 See Chesley, supra note 18, at 1023.

139 Timothy M. Cavanaugh, Comment, A New Tort in California: Negligent Infliction of Emotional Distress (For Married Couples Only), 41 Hastings L.J. 447, 450.

140 See Donovan, supra note 111, at 1355.
First, several jurisdictions adopted the "zone-of-danger rule"\textsuperscript{141} to permit recovery for mental damages for the threat of impact or injury. In \textit{Rob v. Pennsylvania Railroad Co.},\textsuperscript{142} the plaintiff recovered mental damages after she barely escaped her car—which was caught on negligently-maintained railroad tracks—before a train ran into her car.\textsuperscript{143} Later, her emotional distress became so severe that she was unable to nurse her child. The court stated that for the plaintiff to recover the plaintiff's person must have been in danger of physical impact or in the immediate zone of physical risk,\textsuperscript{144} and the plaintiff must have suffered physical "consequences"\textsuperscript{145} from the emotional distress. This lead to the conclusion that the plaintiff should recover because "where results, which are regarded as proper elements of recovery as a consequence of physical injury, are proximately caused by fright due to negligence, recovery by one in the immediate zone of physical risk should be permitted."\textsuperscript{146}

In other factual scenarios, however, the zone-of-danger rule suffered from the same deficiency as both the physical impact and injury doctrines: genuine mental damages were not recoverable because of mere technicalities.\textsuperscript{147} In \textit{Levit v. General Motors Corp.},\textsuperscript{148} the court barred recovery for emotional distress resulting from a household fire because the plaintiffs were not present, or in the zone of danger, at the time of the fire.\textsuperscript{149} Similarly, in \textit{Kimelman v. City of Colorado Springs},\textsuperscript{150} the court barred recovery because the plaintiffs were not in

\begin{itemize}
  \item \textsuperscript{141} See \textit{Restatement (Second) of Torts} § 313 (1965). The Restatement sets out the rule as follows:
    \begin{enumerate}
      \item If the actor unintentionally causes emotional distress to another, he is subject to liability to the other for resulting illness or bodily harm if the actor
        \begin{enumerate}
          \item should have realized that his conduct involved an unreasonable risk of causing the distress, otherwise than by knowledge of the harm or peril of a third person, and
          \item from facts known to him should have realized that the distress, if it were caused, might result in illness or bodily harm.
        \end{enumerate}
      \item The rule stated in Subsection (1) has no application to illness or bodily harm of another which is caused by emotional distress arising solely from harm or peril to a third person, unless the negligence of the actor has otherwise created an unreasonable risk of bodily harm to the other.
    \end{enumerate}
  \item \textit{Id.}
  \item \textsuperscript{142} 210 A.2d 709 (Del. 1965).
  \item \textit{Id.} at 714-15.
  \item \textit{Id.}
  \item \textit{Id.}
  \item \textit{Id.}
  \item \textit{Id.}
  \item \textit{Id.}
  \item See Lanin, \textit{supra} note 33, at 85.
  \item 682 F. Supp. 386 (N.D. Ill. 1988).
  \item \textit{Id.} at 387.
\end{itemize}
a zone of danger when they watched as a family member's casket fell headlong into a grave.\textsuperscript{151}

Second, other jurisdictions adopted standards which appeared to comply with the traditional negligence concept of foreseeability. In Bass \textit{v. Nooney Co.},\textsuperscript{152} the plaintiff sued for negligent infliction of emotional distress after the defendant's elevator malfunctioned, trapping him inside. Although no physical injuries resulted, Bass fainted the following day in another elevator. Later, he was diagnosed as suffering from acute anxiety. After addressing some of the traditional concerns for precluding liability absent impact or injury,\textsuperscript{153} the court concluded that: 1) advancements in psychological testing permit the assessment of psychological harm with reasonable certainty; 2) judicial screening devices would preclude spurious claims from reaching final adjudication; and 3) the possible increase in litigation as a result is unimportant because the courts exist to remedy wrongs.\textsuperscript{154} Therefore, in Bass, the Supreme Court of Missouri set forth a two-pronged test to apply in lieu of the impact and injury requirements. First, the plaintiff could recover if the defendant should have foreseen that his conduct created an unreasonable risk of causing emotional distress.\textsuperscript{155} Second, the plaintiff's emotional distress must be medically diagnosable and significant.\textsuperscript{156} Applying this test to the facts of the case, the court concluded that the plaintiff's emotional distress was sufficient to submit to a jury and the case was remanded for a new trial.\textsuperscript{157}

Similarly, in \textit{Molein v. Kaiser Foundation Hospitals},\textsuperscript{158} the California Supreme Court awarded mental damages under a foreseeability theory. In Molein, the plaintiff's wife was incorrectly diagnosed with syphilis. After suffering severe emotional distress and dissolving his marriage, Molien obtained relief despite the fact that he could not prove physical harm. According to the court, emotional distress which is clear and capable of proof requires no showing of physical harm.\textsuperscript{159} Therefore, the court concluded it was "easily predictable that an erroneous diagnosis of syphilis and its probable source would produce marital discord and resultant emotional distress."\textsuperscript{160}

\textsuperscript{151}Id. at 52.
\textsuperscript{152}646 S.W.2d 765 (Mo. 1983).
\textsuperscript{153}Id. at 768-69.
\textsuperscript{154}Id. at 769-70.
\textsuperscript{155}Id. at 772.
\textsuperscript{156}Id. at 772-73.
\textsuperscript{157}646 S.W.2d 765, 774 (Mo. 1983).
\textsuperscript{158}616 P.2d 813 (Cal. 1980) (en banc).
\textsuperscript{159}Id. at 821.
\textsuperscript{160}Id. at 817.
Finally, the Hawaii Supreme Court was the first jurisdiction to create a general duty to avoid causing negligent infliction of emotional distress. In *Rodrigues v. State*, the court applied traditional tort principles and carved out elements for an independent cause of action, noting that freedom from mental distress was worthy of independent legal protection. However, the court placed some limitations on the use of this duty as a basis for a cause of action. First, the plaintiff's mental distress must have risen to a level that a reasonable person, in identical circumstances, would have been unable to bear. Second, the plaintiff's claim must be substantiated such that recovery was contingent upon a finding of genuine suffering on the part of the plaintiff. Finally, it must have been foreseeable that the plaintiff would be endangered by the defendant's conduct. The court concluded that these restrictions would make false or frivolous claims unlikely.

4. Exceptional Circumstances Likely to Result in Emotional Distress

In the vast majority of jurisdictions that still adhere to the traditional rule that recovery is not available without accompanying physical injury or impact, two special groups of cases are broadly recognized as "special exceptions". The first exception allows recovery for mental anguish alone when a negligently-delivered telegraph informs the plaintiff that a loved one had died. The other exception permits recovery for purely mental anguish caused by the negligent mishandling of a loved one's remains. The common ground of these exceptions is an "especial likelihood of genuine and serious mental distress, arising from the special circumstances, which serves as a guarantee that the claim is not spurious." Additionally, both cases involve a

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161 See Donovan, supra note 111, at 1356.
163 Id. at 520.
164 Id.
165 Id.
166 Id. at 521.
167 See Donovan, supra note 111, at 1359.
168 KEETON ET AL., supra note 22, at 362.
171 KEETON ET AL., supra note 22, at 362. "But cases will obviously be infrequent in which 'mental disturbance,' not so severe as to cause physical harm, will clearly be a serious wrong worthy of redress and sufficiently attested by the circumstances of the case." Id.
special relationship in which the defendant has agreed to perform duties upon which the plaintiff unequivocally relies. Courts infer that such defendants have a duty to refrain from "emotional risk conduct" because mental distress is a highly foreseeable result.

Certain jurisdictions go even further by carving out additional exceptions to the traditional doctrines. In Johnson v. State, the Superior Court of New York granted relief for mental anguish after a state hospital mistakenly informed the plaintiff that her mother had died. It was not until after attending the actual wake that the plaintiff realized the decedent was not her mother. Analogizing to the cases involving erroneous telegraphs and corpse mishandling, the court declared that hospitals owe a direct duty to a patient's relatives to refrain from negligently causing mental anguish. Similarly, in Martell v. Saint Charles Hospital, a plaintiff sued for emotional injuries after her doctors misinformed her that she had cancer. Again recognizing that a direct duty exists between the doctor and patient, the court found that a cognizable cause of action exists when erroneous information is communicated through negligence.

B. False-Positive Cases: Similar Claims Receive Dissimilar Treatment

Despite the movement toward allowing relief strictly for mental anguish, most jurisdictions appear to predicate recovery on the physical impact and injury doctrines, or one of the two recognized exceptions. To date, few courts have granted plaintiffs erroneously diagnosed with HIV a "pardon" from the traditional doctrinal prerequisites for emotional distress recovery. The courts faced with false-positive plaintiffs focused more upon the applicable tort standard instead of addressing the true heart of the matter—the plaintiff's actual distress. Consequently, false-positive plaintiffs with analogous emotional distress claims are the victims of inconsistent, and often illogical, results.

For example, in M.M.H. v. United States, the court required a woman erroneously diagnosed with HIV by the United States Army to show that she

172 See infra text accompanying notes 317-322.

173 For a definition of "emotional risk conduct" as it pertains to this Note, see infra note 316.

174 KEETON ET AL., supra note 22, at 362.

175 334 N.E.2d 590 (N.Y. 1975).

176 Id. at 593.

177 137 Misc.2d 980 (Sup. Ct. Suffolk County 1987).

178 Id. at 987.

179 See KEETON ET AL., supra note 22, at 364.

180 966 F.2d 285 (7th Cir. 1992).
suffered "sufficient physical injuries" to ensure genuine emotional damage.\textsuperscript{181} The plaintiff's claim was permitted to go forward only after the court concluded that her depressed cellular immunity, insomnia, and suicide attempts had satisfied the physical injury requirement.\textsuperscript{182} In contrast, in \textit{R.J. v. Humana of Florida, Inc.},\textsuperscript{183} another court barred a similar false-positive plaintiff's claim for emotional distress merely because the defendant's negligence had not resulted in some direct physical impact upon the plaintiff. The plaintiff was incorrectly led to believe that he was infected with HIV "causing him to suffer bodily injury including hypertension, pain and suffering, mental anguish, loss of capacity for the enjoyment of life and the reasonable expense of medical care and attention."\textsuperscript{184} Even though the plaintiff suffered from severe mental and physical injuries, the claim was dismissed with prejudice for failing to satisfy the impact rule.\textsuperscript{185} Acknowledging the fact that the Florida Supreme Court had relaxed the requirement of an impact on a case-by-case basis,\textsuperscript{186} the District Court of Appeals of Florida, Fifth District, reluctantly affirmed the lower court's ruling and certified the question to the Florida Supreme Court.\textsuperscript{187} On appeal, the Florida Supreme Court held that damages from a negligent HIV diagnosis did not fall squarely within one of the recognized exceptions to the impact doctrine.\textsuperscript{188}

In other jurisdictions, courts invented barriers in addition to the physical injury or impact requirements which deprive plaintiffs of relief for erroneous HIV-positive test results. Consider \textit{Heiner v. Moretuzzo},\textsuperscript{189} in which the Ohio Supreme Court affirmed summary judgment for the defendant because the plaintiff was not placed in "actual physical peril."\textsuperscript{190} The court recognized that state law does not require a plaintiff to suffer contemporaneous physical injuries prior to recovering for negligent infliction of emotional distress.\textsuperscript{191} However, the court stated that such recovery was limited to instances where one was a bystander to an accident or feared physical consequences to his own

\begin{itemize}
  \item \textsuperscript{181}Id. at 290-91.
  \item \textsuperscript{182}Id. at 291. Although the court upheld the physical injury requirement, the court acknowledged: "[t]he plaintiff was falsely diagnosed with a fatal disease . . . that disease is shrouded in mystery and stigma. We have little doubt that she suffered real emotional distress." \textit{Id.}
  \item \textsuperscript{183}625 So.2d 116 (Fla. Dis. Ct. App. 1993), \textit{aff’d} 1995 WL 81873 (Fla.) at *3.
  \item \textsuperscript{184}625 So.2d at 116-17.
  \item \textsuperscript{185}Id.
  \item \textsuperscript{186}Id. at 117.
  \item \textsuperscript{187}Id.
  \item \textsuperscript{188}652 So.2d at 363.
  \item \textsuperscript{189}73 Ohio St. 3d (1995).
  \item \textsuperscript{190}Id. at 87. (citations omitted).
  \item \textsuperscript{191}Id. at 85.
\end{itemize}
Because the plaintiff was never actually infected with HIV, the court concluded that he was never actually in real danger or placed in actual physical peril by the negligent diagnosis. The court held that, despite debilitating emotional injuries, the plaintiff could not recover as a matter of law. One dissenting judge, however, disagreed with a blanket prohibition of recovery in false-positive cases:

I recognize that any method of HIV testing will, on some occasions, inevitably yield false-positive results. I further recognize that to allow recovery on a claim for negligent infliction of serious emotional distress each time a false-positive test is reported would in effect be imposing strict liability on those who conduct and interpret the tests, when false-positive test results are produced at times without negligence. Thus, there can be no recovery for a plaintiff who can prove nothing more than that he or she received a report of a false-positive test, although that report understandable would induce anxiety to that recipient.

Having set forth my general agreement that some standards are necessary to govern recovery in a case such as this . . . the traditional tort law concepts of duty, breach of duty, proximate cause, and damages can serve to effectively limit recovery to those plaintiffs who deserve it, as in any other negligence case. . . . Additional limitations for recovery for negligent infliction of serious emotional distress ensure that the emotional distress must be both serious and foreseeable before recovery is allowed. Because adequate limits therefore already exist on the tort of negligent infliction of emotional distress, I see no reason to impose the additional "real danger" requirement established by the majority.

Unlike the foregoing examples, certain courts allow plaintiffs erroneously diagnosed with HIV to recover for negligent infliction of emotional distress without meeting the traditional doctrinal prerequisites. For example, in Bramer v. Dotson, the plaintiff claimed that the defendant's misdiagnosis negligently caused him to suffer major depression, anxiety, sleep disturbance, elevated concern for body functioning, and low self-esteem. The court held that a person misdiagnosed with the AIDS virus may recover for the negligent infliction of emotional distress upon showing that the claim for emotional damages is not spurious. The court, noting that AIDS, which has replaced cancer as the most feared disease in America and is essentially a death sentence,

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192 Id. at 88.
193 Id.
196 Id. at 774.
197 Id. at 774-75.
concluded that conventional wisdom mandates recognition that such circumstances elicit genuine, not spurious, claims of emotional distress. Moreover, the court recognized that "it is too late in the day medically" to assert that recognizable mental or emotional injuries stemming from severe emotional distress are not truly harmful.

As these cases indicate, the tension created between false-positive plaintiffs' claims and traditional tort law policies limiting recovery for emotional distress has led to inconsistent results. Instead of examining the plaintiff's mental distress as a consequence of false HIV diagnosis, the courts focus on whether the plaintiff was the victim of a physical impact, or whether the plaintiff's emotional distress manifests itself in some sort of physical injury. Continuing to apply these doctrines to false-positive plaintiffs' claims seems unjust because various false-positive plaintiffs, although all confronting HIV-related emotional distress in equal measures, are not equally recompensed.

Such arbitrary results are intolerable given the fact that the legal system has been far less reluctant to compensate for HIV-related emotional distress in a somewhat different context. Ironically, a number of courts allow emotional distress recovery resulting from what has become known as fear-of-AIDS. The cause of action for fear-of-AIDS is based upon the slight chance that the plaintiff may have contracted HIV from an HIV-infected individual. However, plaintiffs claiming emotional distress damages for fear-of-AIDS are not required to fulfill the traditional emotional distress standards. Under fear-of-AIDS claims, many courts allow plaintiffs to recover emotional distress damages for mere exposure to the virus. Some courts award fear-of-AIDS damages resulting from phobic reactions following casual contact with an HIV-infected individual even after plaintiffs have been tested for HIV and repeatedly yielded negative results.

In theory, false-positive plaintiffs indeed suffer from a genuine "fear of AIDS" as a result of their HIV-positive diagnosis. Nonetheless, fear-of-AIDS as a cause

198 Id. at 774-75; see also, Social Science and the Citizen, 25 SOCIETY 2 (Jan.- Feb. 1988) (according to a Gallup poll, 68 percent of Americans believe AIDS is the nation's most disturbing health problem).

199 437 S.E.2d at 775 (citation omitted).


202 Id. at 783-84.

203 Id.

204 See Maroulis, supra note 63, at 258-60. (noting that HIV-negative plaintiffs have been successful in recovering emotional distress damages).
of action, is not available to those mistakenly diagnosed HIV-positive because no actual exposure to HIV has occurred. In fear-of-AIDS cases, some courts have held that HIV-related emotional distress may be both severe and reasonable in spite of the fact that an individual plaintiff has received numerous HIV-negative test results. It is absurd not to recognize that an actual diagnosis of HIV (even an erroneous one) creates greater emotional distress than the fear of a potential diagnosis, especially in the light of numerous negative results.

In summary, many plaintiffs who are erroneously diagnosed HIV-positive have no form of redress unless they are "fortunate" to have sustained or suffered enough under the applicable doctrines. As discussed above, courts set aside such doctrines when the surrounding circumstances guarantee a genuine likelihood of emotional distress. Given HIV's unusual characteristics, a reasonable person would be likely to experience severe emotional distress upon receiving an HIV-positive test result. Therefore, the circumstances surrounding false-positive plaintiff's claims are akin to those already recognized as worthy of exception:

There are . . . a series of cases allowing recovery for negligent embalming, negligent shipment, running over the body, and the like . . . . There may perhaps be other cases. Where the guarantee can be found, and the mental distress is undoubtedly real and serious, there may be no good reason to deny recovery.

IV. FALSE-POSITIVE HIV TEST RESULTS MANDATE AN ESPECIAL LIKELIHOOD OF GENUINE EMOTIONAL DISTRESS CLAIMS

A. Testing Positive Is A Death Sentence

As a general matter, people find it extremely difficult to think about death. Many individuals believe that others will die, but not that it will happen to him or her. Consequently, being told that one is going to die is something that many individuals simply cannot bear. In the words of the United States Court of Appeals, Second Circuit:

Certain words when directed at a person deliver such a dread message as to strike terror in that person's heart. AIDS, a modern word, less

205 Id.
206 See infra Part IV.A-B and accompanying notes 211-314.
207 See infra Part V.
208 KEETON ET AL., supra note 22, at 362 (footnotes omitted).
than 20 years old, is accompanied by many myths and misconceptions; it also carries with it in the public's mind such an image of inevitable death as to bring home that terror.\textsuperscript{211}

Because AIDS is a new and unusual illness that is uniformly fatal,\textsuperscript{212} being diagnosed with HIV means that one must confront a long-term deteriorating illness "that leads to a slow and painful death."\textsuperscript{213} Not surprisingly, knowledge of an individual's own HIV infection brings about unavoidably adverse and intense psychological challenges.\textsuperscript{214} Individuals who are HIV-positive and asymptomatic\textsuperscript{215} live with constant fear of becoming ill.\textsuperscript{216} In addition, psychological research indicates that knowing one is HIV-positive represents the strongest, most consistent correlations with emotional distress to date.\textsuperscript{217} In fact, according to one study, fear of testing positive is so extreme that only sixty-three percent of those who receive testing return for their test results.\textsuperscript{218}

Therefore, it is foreseeable that a positive HIV test result can reasonably create psychological trauma for its recipients.\textsuperscript{219} Recognizing the devastating impact of a positive HIV diagnosis, police recently arrested a 13-year-old daughter of a hospital clerk for allegedly calling former patients and falsely informing them they had tested HIV-positive.\textsuperscript{220} The officer who arrested the youth charged her with making threats, assault, and aggravated assault after one of the unfortunate recipients of the phony test results became hysterical and tried to kill herself.\textsuperscript{221}

\begin{itemize}
\item \textsuperscript{211}Marchica v. Long Island R.R. Co., 31 F.3d 1197, 1199 (2d Cir. 1994).
\item \textsuperscript{212}Herek & Glunt, supra note 28, at 888; Maroulis, supra note 63, at 246; see also Federal Researcher Predicts HIV Vaccine Will Be Ready to Test Within Three Years, 7 AIDS POL'Y & L. 4 (July 24, 1992) (recognizing that AIDS is incurable and examining the potential uses and likelihood of a future vaccine).
\item \textsuperscript{213}Maroulis, supra note 63, at 260; see also Helena Brett-Smith, M.D. & Gerald H. Friedland, M.D., Transmission and Treatment, in AIDS LAW TODAY: A NEW GUIDE FOR THE PUBLIC 18, 23 (Scott Buris et al. eds., 1993); Faya v. Almaraz, 620 A.2d 327, 329 (Md. 1993) (recognizing that medical studies state that most carrying the AIDS virus will develop AIDS).
\item \textsuperscript{214}Perry, M.D., et al., supra note 23, at 775; cf., Martin & Dean, supra note 32 at 102-03 (stating that stressors associated with HIV testing diminish significantly when recipients are informed that they are HIV-negative).
\item \textsuperscript{215}All & Fried, supra note 27, at 8 (stating that those diagnosed HIV-positive without HIV-related symptoms must nonetheless deal with their own imminent death).
\item \textsuperscript{216}Id.
\item \textsuperscript{217}Martin & Dean, supra note 31, at 102.
\item \textsuperscript{218}Valdiserri, M.D. et al., supra note 48, at 13.
\item \textsuperscript{219}Baker & Arthur, supra note 50, at 4 (stating that post-test counseling may help HIV positives deal cope with their infection).
\item \textsuperscript{220}Ron Word, Girl Accused of Making False Calls About AIDS, CLEV. PLAIN DEALER, Mar. 1, 1995, at A8.
\end{itemize}
From the above example, it seems clear that one who is erroneously informed that they tested HIV-positive will confront the same psychological consequences as one who actually is HIV-positive. One aspect of psychological trauma regarding knowledge of an individual's HIV-infection is extreme depression. One recent study concluded that HIV-related depression is most overwhelming in the newly-diagnosed. Appreciating this fact, one judge mitigated a five-year prison sentence by two years because the defendant's conduct "was uncharacteristic and had resulted from his depression" following his discovery that he had contracted the AIDS virus.

The depression experienced by the many persons who are unable to cope with positive HIV test results has contributed to a high rate of suicide among them. For many HIV-positive men and women, suicide is often used as a coping method. As one commentator noted, the shocking news of a positive HIV test "has proved to be one of the most potent stimuli to suicide yet devised,

221 Id. Model Penal Code § 211 provides in pertinent part: Section 211.1 Assault.
(1) Simple Assault. A person is guilty of assault if he:
   (a) attempts to cause or purposely, knowingly or recklessly causes bodily injury to another; or
   (b) negligently causes bodily injury to another with a deadly weapon; or
   (c) attempts by physical menace to put another in fear of imminent serious bodily injury.

(2) Aggravated Assault. A person is guilty of aggravated assault if he:
   (a) attempts to cause serious bodily injury to another, or causes such injury purposely, knowingly or recklessly under circumstances manifesting extreme indifference to the value of human life: or
   (b) attempts to cause or purposely or knowingly causes bodily injury to another with a deadly weapon. Aggravated assault under paragraph (a) is a felony of the second degree; aggravated assault under paragraph (b) in a felony of the third degree.

222 See Lubowitz v. Albert Einstein Medical Center, 623 A.2d 3 (Pa. Super. Ct. 1993) (recognizing that plaintiff testing negative for the HIV virus confronted same mental anguish as one truly diagnosed HIV positive).

223 See All & Fried, supra note 27, at 8.


225 See Perry, M. D., et al., supra note 23, at 775.

226 Id.; Mindy Thompson Fullilove, M.D., Anxiety and Stigmatizing Aspects of HIV Infection, 50 J. CLINICAL PSYCHIATRY 5 (Nov. 1989); see Herman, supra note 38, at 70 n.34 (citing Illinois study crossing positive tests with suicide rates).

even more so than the diagnosis of AIDS itself, or of cancer.\textsuperscript{228} More importantly, it is mere knowledge of the HIV infection, not the effect of the AIDS virus itself, which is the source of such high suicide rates.\textsuperscript{229}

In addition to suicide, other aspects of HIV-related depression include sadness, hopelessness, and helplessness.\textsuperscript{230} Many HIV-positive individuals feel a loss of physical and sexual appeal as well.\textsuperscript{231} Perhaps even worse, because feelings of guilt, low self-esteem, and anticipatory grief are common responses to a positive HIV test result, many HIV-positive individuals withdraw from society.\textsuperscript{232} Some studies also show that the news of an HIV-positive test result often leads to alcohol or substance dependence—\textsuperscript{233} which likely develops as part of coping with HIV-related depression.

Moreover, HIV-related emotional distress encompasses far more than suicidal ideology and extreme depression. Other symptoms of such distress include what is known as "AIDS-related anxiety,"\textsuperscript{234} which is the fear of being subjected to a debilitating and fatal illness.\textsuperscript{235} This anxiety is characterized by panic attacks, insomnia, paranoia, hypochondrial concerns, and compulsive-obsessive behavior.\textsuperscript{236} AIDS-related anxiety can potentially lead to irrevocable life choices.\textsuperscript{237} Within six months of unnecessarily taking AZT, one woman gave away many of her personal possessions, wrote her will, quit her job, and set aside her true joy in life, bicycle racing.\textsuperscript{238} Coping with the

\textsuperscript{228}Osborn, supra note 32, at 47.

\textsuperscript{229}Id., see Stephen G. Schneider, et al., Factors Influencing Suicide Intent in Gay and Bisexual Suicide Ideators: Differing Models for Men With and Without Human Immunodeficiency Virus, 61 J. PERSONALITY & SOC. PSYCHOL. 776 (1991) (comparing suicidal behaviors between HIV positive and negative males); cf., R.J. Frances et al., Contracting AIDS as a Means of Committing Suicide, 142 AM. J. PSYCHIATRY 656 (discussing the deliberate contraction of the HIV virus as a form of suicide).

\textsuperscript{230}Fullilove, M.D., supra note 226, at 7.

\textsuperscript{231}Joyce Y. Chung, M.D. & Margie M. Magraw, L.I.S.C.W., A Group Approach to Psychosocial Issues Faced by HIV-Positive Women, 43 Hosp. & Community Psychiatry 891, 893.

\textsuperscript{232}See Fullilove, M.D., supra note 226, at 7.

\textsuperscript{233}See Chung & Magraw, supra note 231 (discussing psychosocial problems of women with AIDS and HIV infection); see also J. Atkinson, et al., Prevalence of Psychiatric Disorders Among Men Infected With Human Immunodeficiency Virus, 45 ARCHIVES GEN. PSYCHIATRY 859 (1988) (discussing the prevalence of psychosocial problems among HIV-infected males).

\textsuperscript{234}See Fullilove, supra note 226, at 8.

\textsuperscript{235}Id. at 6.

\textsuperscript{236}Id.


\textsuperscript{238}Kranhold, supra note 8, at A1.
threat of AIDS, another man remarked: "What have I changed? I've changed everything a hundred different times. I've also unchanged everything a hundred times. And then I start over somewhere else."\textsuperscript{239} Such radical shifts in life choices, made only as a result of being misdiagnosed as HIV-positive, provide yet another source of severe emotional distress.\textsuperscript{240}

Another consequence of a false-positive HIV test result is that many individuals undergo AIDS treatment, which leads to unnecessary physical side effects, high medical costs, and invasive medical procedures.\textsuperscript{241} For example, one man who was mistakenly informed that he was carrying the virus, and who was subsequently prescribed AZT "still suffers from headaches, chronic leg pains, hypertension and high blood pressure" as a result of such unnecessary medical treatment.\textsuperscript{242}

\textbf{B. HIV-Positive Individuals Are A Stigmatized Class}

As if impending doom were not enough to guarantee genuine emotional distress, HIV-related mental anguish has yet another root. The stressing aftermath of an HIV-positive test result is likely to be exacerbated by the isolation and guilt many experience as a result of the stigma\textsuperscript{243} attached to HIV and AIDS.

1. HIV-Positive Individuals are Often Members of Already Marginalized Groups.

AIDS is now perceived as a lethal disease that can be transmitted by specific behaviors and is most prevalent among gay men and users of intravenous drugs. This definition of the syndrome results in a dual stigma: first, from identification of AIDS as a serious illness; second, from the identification of AIDS with persons and groups already stigmatized prior to the epidemic.\textsuperscript{244}


\textsuperscript{240}Id.

\textsuperscript{241}See Bramer v. Dotson, 437 S.E.2d 773, 774 (guaranteeing genuine emotional distress claim for false HIV diagnosis and unnecessary AIDS treatment); HIV Negative Man, supra note 75, at 4-5.

\textsuperscript{242}Id. at 4.

\textsuperscript{243}See Herek & Glunt, supra note 28, at 886. "A stigma is a mark of shame or discredit. The focus of social psychological research on stigma is not on the mark itself, however, so much as on the social relationships in which a particular mark is defined as shameful or discrediting." Id.

\textsuperscript{244}Id. at 887; see also Gregory M. Herek, Beyond "Homophobia": A Social Psychological Perspective on Attitudes Toward Lesbians and Gay Men, 10(1) J. HOMOSEXUALITY 1 (1985); D.C. Des Jarlais, et al., \textit{Risk Reduction for the Acquired Immunodeficiency Syndrome Among Intravenous Drug Users}, 103 ANNALS INTERNAL MED. 755 (1985).
AIDS is both a deadly and stigmatized disease. Until a cure is found, those carrying the virus are almost 100% certain to develop AIDS and die from complications. Given the deadly consequences of HIV, AIDS most likely would have been stigmatizing regardless of whom it first infected. Through "an accident of history," however, the epidemic is linked with already stigmatized groups: gay males, IV-drug users, minorities, and women.

According to the National Research Council, these are "socially marginalized groups with little economic, political, and social power." Perhaps the biggest stigmatizing aspect of AIDS is its association with homosexuality, a controversial issue in today's society. AIDS, and its stigma, first surfaced in the United States in the late 1970s, when gay men began experiencing rare cancers and bizarre infections causing a deficiency in the body's immune-defense system. Originally called GRID, for Gay-Related Immune Deficiency, AIDS was not known to affect any other group until the early 1980s. The media contributed to the initial stigma associated with AIDS by labeling the illness as "the gay plague." Furthermore, the press provided little press coverage on AIDS until 1983 when it was discovered that other members of the population could become infected.

In 1982, GRID became known as "acquired immune deficiency syndrome" when a widespread channel of transmission was established through sharing

\[\text{245 See Martin & Dean, supra note 31, at 95.}\]
\[\text{246 See supra note 215 and accompanying text.}\]
\[\text{247 Herek & Glunt, supra note 28, at 887.}\]
\[\text{248 Id.; Despite the fact that minorities and women represent the fastest growing AIDS group, gay males and IV drug users continue to represent the majority of those who are either HIV infected or suffering from AIDS. See Chung & Magraw, supra note 231, at 891; see also All & Fried, supra note 28, at 8; 1993 Nat'l Commission on AIDS Rep., Report on HIV/AIDS Epidemic Among Communities of Color.}\]
\[\text{249 See Jaco, supra note 7, at 297.}\]
\[\text{250 All & Fried, supra note 27, at 8; cf., Julia Epstein, AIDS, Stigma, and Narratives of Containment, 49 AM. IMACO 293, 297 (1992) (noting the 1974 removal of homosexuality from a list of "mental disorders" by the American Psychiatric Association).}\]
\[\text{251 See AIDS: Deadly But Hard to Catch, CONSUMER REPORTS, Nov. 1986, at 724 [hereinafter Deadly].}\]
\[\text{252 Id.; cf., Thomas C. Quinn et al., AIDS in Africa: An Epidemiologic Paradigm, 234 SCIENCE 955 (1986) (noting the greater frequency of AIDS among heterosexuals in Africa where the ratio of males to females is 1:1).}\]
\[\text{253 M. VerMeulen, The Gay Plague, NEW YORK MAGAZINE, May 31, 1982. In fact, the New York Times published only six stories about AIDS during 1981 and 1982, none of which were highly emphasized or on the front page. Herek & Glunt, supra note 28, at 887.}\]
\[\text{254 Id.}\]
IV needles for illegal drug use.255 To some, IV-drug users—stigmatized largely because of their participation in a felonious activity—"represent[ed] the pivotal point for transmission of the HIV virus" as they were considered the main contributors to AIDS among children, women, and racial/ethnic minorities.256 Soon, another marginalized group became associated with the HIV virus: women. HIV-positive women, who often feel "guilty, sexually dirty, and ashamed,"257 became further stigmatized due to the universal assumption that they must have been promiscuous to have contracted the virus.258 Similarly, as a large number of minorities became infected by the AIDS virus, society attributed acquisition of the virus to being "poor and undereducated."259

It is apparent that many people believe that HIV-infected individuals are far afield from society at large and belong to the so-called "other."260 Reports on AIDS speak of "leakage" into a "decent" population.261 The frequent use of such phrases as "the general public" or "mainstream American" to counterbalance "bad" or "risky" groups further underlines this distinction.262 Moreover, the fact that HIV and AIDS are acquired as opposed to other fatal diseases such as cancer has caused many people to assume that individuals with the virus are being punished for their stigmatized behavior and thus, wholly responsible for their own infections.263 Other parochial attitudes have led to the demonizing of AIDS by nick-naming the disease the "WOG," which stands for "Wrath of God."264 In contrast, those individuals who acquire the virus through modes other than sexual behavior or drug use are referred to as "innocent victims" or "the most blameless victims."265

255 See Deadly, supra note 251, at 724.
256 All & Fried, supra note 27, at 8.
257 Id.
258 Chung & Magraw, supra note 231, at 892.
259 See Jaco, supra note 7, at 297.
260 See Epstein, supra note 250, at 307.
261 Id. at 293.
262 Herek & Glunt, supra note 28, at 888.
263 See L. Stevens & P. Muskin, Techniques for Reversing the Failure of Empathy Towards AIDS Patients, 15(4) J. AM. ACAD. OF PSYCHOANALYSIS 539 (1987); see also H. Chuang, et al., Psychosocial Distress and Well-Being Among Gay and Bisexual Men With Human Immunodeficiency Virus Infection, 146 AM. J. PSYCHIATRY 876 (concluding from study that anxiety, depression, and illness-related concerns of AIDS patients are similar to cancer patients). However, there have been less similarities between the two groups in the area of hope and survival. Id.
265 Herek & Glunt, supra note 28, at 888.
The stigma associated with AIDS continued to escalate as political and religious leaders exploited the illness for their own agendas. For example, one Houston mayoral candidate publicly stated that his solution to the AIDS epidemic would be to "shoot the queers." Similarly, Republican columnist, and presidential candidate Patrick Buchanan once attempted to politicize AIDS by tying the illness to the Democratic Party and to gay men exclusively:

There is one, and only one, cause of the AIDS crisis—the willful refusal of homosexuals to cease indulging in the immoral, unnatural, unsanitary, unhealthy, and suicidal practice of anal intercourse, which is the primary means by which the AIDS virus is being spread through the "gay" community, and, thence, into the needles of IV drug abusers [and to others] . . . [the] Democratic Party should be dragged into the court of public opinion as an unindicted coconspirator in America's AIDS epidemic . . . [for] seeking to make sodomy a protected civil right, . . . the sexual practice by which AIDS is spread.

Additionally, the Catholic Church responded to AIDS by linking the illness to homosexuals and using it as an excuse to stand against civil rights protection for gay people. In a remark that many commentators construed as referring to AIDS, the church argued that homosexual behavior seriously threatens "the lives and well-being of a large number of people" and charged those engaging in such behavior with "refus[ing] to consider the magnitude of the risks involved."

The stigma surrounding the AIDS virus has its own overt effects on those persons who are, or even are presumed to be, HIV-positive. Thus, many HIV-positive individuals fear that revealing their HIV status will subject them to a variety of discriminatory treatments. These expectations are realistic: children have been barred from classrooms, sick people have been refused medical care, insurance benefits have been denied, employment has been terminated, and tenants have been evicted. According to a 1990 study conducted by the American Foundation for AIDS Research, HIV-related dis-

268Herek & Glunt, supra note 28, at 888.
269Id. at 886; E. R. Shipp, Physical Suffering is Not the Only Pain That AIDS Can Inflict, N.Y. TIMES, Feb., 17, 1986, at A8.
270See Fullilove, M.D., supra note 226, at 5; see also Barbara Gerbert et al., Physicians and Acquired Immunodeficiency Syndrome: What Patients Think About Human Immunodeficiency Virus in Medical Practice, 262 JAMA 1969 (1989) (concluding from nationwide survey that more than half of respondents would change physicians if their physician were HIV positive).
271See Shipp, supra note 269, at 8.
Discrimination is on the rise. The study concluded that HIV- or AIDS-related discrimination reports increased by 50 percent nationwide in 1988, following an 88 percent increase in 1987. Recognizing that both AIDS patients and HIV-positive individuals face needless discrimination and social stigmatization, many states enacted HIV and AIDS confidentiality statutes which impose criminal liability for revealing an individual’s HIV status without their consent.

Similarly, the United States Congress recognized and attempted to minimize HIV-related discrimination. The Americans With Disabilities Act (ADA) passed by Congress in 1990, prohibits discrimination against all people with disabilities in both private and public settings, such as employment, education, business services, and governmental programs. Classifying HIV infection as a “disability,” the ADA protects individuals with any aspect of HIV, from asymptomatic HIV infection to full-blown AIDS, from discriminatory treatment.

2. Public Misconceptions Beget Irrational Fears

Side by side, needless discrimination and social ostracism “kill the human spirit and destroy human dignity.” Although efforts to forestall HIV-related discrimination are mandating that HIV-positive individuals be treated with fairness and compassion, many sufferers of HIV lose friends, families, and lovers. This, in part, is due to the reality that fear and misconception infect society faster than the disease itself.

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273 Id.
276 Herek & Glunt, supra note 28, at 886.
277 Id. The term “disability,” a legal term used to establish the basis for anti-discrimination protection, is used in the ADA to describe a broad range of medical conditions which are often inappropriately taken into account by employers and businesses. Id.; see also, Penn Lerblance, Legal Redress for Disability Discrimination: Bob, Carol, Ted and Alice Encounter AIDS, 24 GOLDEN GATE U. L. REV. 307, 332-33 (1994).
278 Lerblance, supra note 277, at 333.
279 Id. at 309.
281 See Deadly, supra note 251, at 724. Moreover, when fear and misconception are sharply joined, they generate bigotry and prejudice toward persons with HIV. Jane H. Barney, Comment, A Health Care Worker’s Duty To Undergo Routine Testing for HIV/AIDS and to Disclose Positive Results to Patients, 53 LA. L. REV. 933, 959 (1992); see also Maroulis,
As AIDS continues to represent one of Americans' darkest fears, such fear causes society to act irrationally toward HIV-positive individuals.\textsuperscript{282} Thus, it is important to reiterate the basic facts concerning AIDS. First and foremost, "AIDS ... knows no bounds and discriminates against no one."\textsuperscript{283} No group is individually responsible for HIV transmission.\textsuperscript{284} Notably, the worldwide epidemic is overwhelmingly heterosexual.\textsuperscript{285} HIV can be transmitted to anyone if infected blood, semen, or vaginal fluid enter the body.\textsuperscript{286} Although this happens mostly through sexual intercourse without a condom or when people inject drugs using shared needles, other routes exist. For example, HIV can be passed through inoculation or transfusion of infected blood or blood products.\textsuperscript{287} In addition, mothers with HIV can infect their babies during pregnancy, birth, or shortly after birth (perennial transmission).\textsuperscript{288}

While some members of the public fear that the virus can be transmitted through casual contact,\textsuperscript{289} HIV does not survive for long periods of time outside of the body.\textsuperscript{290} No known cases exist of HIV transmission from touching, hugging, kissing, sharing household utensils, or by being near someone carrying the virus who coughs or sneezes.\textsuperscript{291} Similarly, HIV cannot be transmitted from bug bites, toilets, telephones, or from attending school or working with someone who is infected.\textsuperscript{292} Other common myths now being debunked include that the virus may be transmitted through contact with tears, sweat, saliva, urine or feces.\textsuperscript{293} Although a small amount of the virus may exist...

\textsuperscript{282}See Shahvari, supra note 201, at 769.


\textsuperscript{284}Epstein, supra note 250, at 301.

\textsuperscript{285}Herek & Glunt, supra note 28, at 888.

\textsuperscript{286}Deadly, supra note 251, at 724.

\textsuperscript{287}Id.

\textsuperscript{288}Id.

\textsuperscript{289}Merle A. Sande, M.D., Transmission of AIDS: The Case of Casual Contagion, 314 NEW ENG. J MED. 380 (1986).

\textsuperscript{290}Id.

\textsuperscript{291}See What is the HIV Antibody Test?, TPA NEWS, June 1990, at 2 [hereinafter Antibody Test].

\textsuperscript{292}Id.

\textsuperscript{293}Id.; See Deadly, supra note 251, at 726 (recognizing the public scare in 1984 by the detection of HIV in saliva). However, subsequent research has indicated that the presence of the virus in saliva is to minuscule for transmission. Id.
in these bodily fluids, no known instances of transmission in this manner exist.294

Regardless of medical assurances that AIDS can be transmitted only through sexual contact or blood contamination, many people remain unconvinced and the hysteria regarding casual contagion continues.295 For example, police officers have repeatedly filed charges of attempted murder against AIDS victims who spat at them.296 Similarly, one Florida judge required all AIDS patients to wear masks while in his courtroom.297

Surprisingly, irrational fears also polluted the medical profession. In a recent study, the American Medical Association found that health-care providers share strong negative attitudes toward HIV-positive individuals.298 More than one-half of the physicians surveyed indicated that, given a choice, they would refuse to treat HIV-positive patients.299 According to another survey of employee attitudes, 75% of the employees expressed concerns about sharing restroom facilities with HIV-positive co-workers, 37% also indicated that they would refuse to share work equipment with infected individuals, and 40% stated that they would be uncomfortable eating in the same cafeteria with people who are HIV-positive.300

Thus, irrational fears continue to envelop HIV and AIDS, and the stigma associated with the phenomena is an ongoing problem.301 For example, one man was ordered by school officials to resign from his teaching position when rumors circulated that he was receiving AIDS treatment.302 After clarifying that his medical treatment was related to another blood disorder, he returned to work only to confront continual harassment and threatening telephone calls.303 One HIV-positive employee's co-workers even threatened to kill him if he ever returned to work.304 A mail carrier refused to deliver mail to an AIDS Task Force

294 See Antibody Test, supra note 291, at 2.


298 See Lerblance, supra note 277, at 310 (citing Gerbert et al., Primary Care Physicians and AIDS, 266 JAMA 2837 (1991).

299 Id.

300 The Corporate Counselor, Strong Negative Worker Attitudes Dictate Prompt Employer Action on AIDS Policy, 2 CORP. COUNS. 8 (Apr. 1988).

301 Fullilove, supra note 226, at 5.

302 Shipp, supra note 269, at A8.

303 Id.

fearing he could contract the virus. Similarly, after three brothers tested positive for HIV, their family barber refused to cut their hair, their minister requested they stay away from Sunday church services, and eventually their family's home was burned to the ground.

At the extreme, some individuals believe those with the virus should be "isolated compulsorily, immediately, and permanently," or that HIV carriers should be tattooed on the forearm "to protect common-needle users, and on the buttocks, to prevent the victimization of other homosexuals." Such illogical concerns come full circle as HIV-infected individuals feel ashamed for "cough[ing] too much in a crowd" or withhold hugs from their family and friends for fear of infecting them. People carrying the virus are therefore vulnerable to rejection, guilt, and emotional distress as the "emotions associated with harboring a contagious agent may cause the patient to feel like an outcast." Consequently, support groups increasingly develop to help reduce these adverse emotional effects for those with HIV.

V. PROPOSED SOLUTION

When negligent HIV testing leads to a false-positive diagnosis of HIV, emotional distress is an unavoidable consequence. Although a majority of jurisdictions still apply traditional doctrines in the context of negligent infliction of emotional distress, many courts developed exceptions and now allow recovery for mental suffering alone. Those exceptions, such as for the negligent transmission of a message announcing death and the mishandling of a corpse, permit recovery because they provide a guarantee that resulting emotional distress claims are genuine.

A number of reasons explain why courts acknowledge that the circumstances surrounding the two groups of cases guarantee genuine claims for emotional distress. First, in both groups of cases exceptions are warranted.

308 W. F. Buckley Jr., Crucial steps in combating the AIDS Epidemic: Identify All the Carriers, N.Y. TIMES, Mar. 18, 1986, at A27.
309 Foltz, supra note 96, at 12.
310 Id.; see AIDS Test Nets, supra note 74, at 8.
311 Fullilove, M.D., supra note 226, at 7.
312 See Martin & Dean, supra note 31, at 95.
because the emotional distress stems from death-related circumstances: the death or corpse of a loved one.\textsuperscript{314} Second, the courts agree that defendants in both situations accept responsibility to perform duties upon which the plaintiff relies.\textsuperscript{315} Finally, the courts believe that such defendants have a duty to refrain from "emotional risk conduct",\textsuperscript{316} as it is quite foreseeable that their negligence will trigger emotional distress in others.\textsuperscript{317}

Negligent HIV testing which harvests false-positive results creates predicaments analogous to the two groups of cases excepted from the historical emotional distress standards. Therefore, cases involving false-positive HIV test results are worthy of recognition as a third exception. Applying the courts' rationale from these two categories of cases to false-positive claims, it is apparent that the same indicia of reliability are present to guarantee genuine emotional distress claims.

Without a doubt, false-positive plaintiff's emotional distress is death-related. Being infected by the AIDS virus is essentially a death sentence because HIV infection is nearly a conclusive indication that one will develop AIDS and subsequently die.\textsuperscript{318} In addition, a special relationship exists between the parties because the victims of false-positive HIV test results rely on their testing counselors or doctors to diagnose them correctly and counsel them accurately regarding test reliability.\textsuperscript{319} Furthermore, it is naturally foreseeable that a false-positive HIV test result will prompt severe emotional distress.\textsuperscript{320} The recipient of such erroneous news is faced with eminent suffering and death. In coping, those individuals are likely to contemplate, and often attempt, suicide, and make irrevocable life choices. They will certainly be subjected to discrimination and to the emotional impact of developing a fatal disease shrouded by a heavy social stigma.\textsuperscript{321} Finally, both those performing the test


\textsuperscript{315}Id.

\textsuperscript{316}For the purposes of this Note emotional risk is defined as "conduct that is foreseeable to a reasonable person to result in emotional distress." Mega, supra note 288, at 396 n.76; see also, Jacqueline M. Mega, Comment, Negligent Infliction of Emotional Distress: Confusion in New York and a Proposed Standard: Lynch v. Bay Ridge Obstetrical and Gynecological Associates P.C., 56 Brook. L. Rev. 379, 396 n.76 (1996): "The court, by recognizing causes of action in these types of situations, has put individuals dealing with the transmission of messages and the handling of corpses on notice that negligent performance of their job may result in liability for emotional distress." Id.

\textsuperscript{317}Id.

\textsuperscript{318}See supra text accompanying notes 211-244.

\textsuperscript{319}See supra Part II.A-B.

\textsuperscript{320}Baker & Arthur, supra note 50, at 4.

\textsuperscript{321}See supra Part IV.A-B. and accompanying notes 211-313.
and those counseling the recipient accepted the responsibility of accurately diagnosing a test recipient, and, thus, have a duty to refrain from emotional risk conduct.\textsuperscript{322} Therefore, when negligent testing procedures result in an erroneous HIV-positive diagnosis, this duty is breached;\textsuperscript{323} needless mental anguish is a direct and certain result.

VI. CONCLUSION

An individual’s knowledge of his HIV status is a significant aspect of thwarting the AIDS epidemic. Accurate HIV testing and diagnosis are an essential means to this end. However, a growing number of cases suggest that HIV testing is not serving its purpose. Instead, many individuals are negligently diagnosed as carrying the virus and are forced to confront needless psychological hardships associated with HIV and AIDS. To bring them some measure of recompense, the victims of false-positive results seek relief under the theory of negligent infliction of emotional distress. In deciding these cases, some courts look to the true heart of the matter—mental suffering on behalf of the plaintiff—and allow recovery. Unfortunately, other courts arbitrarily enforce historical tort doctrines and permit negligent testing to go unaddressed at the plaintiff’s expense. These inconsistent results are illogical and unfair.

As severe emotional distress and anxiety are inherent in a HIV-positive test result, such line drawing cannot be justified. The courts barring recovery must reconsider the application of these traditional doctrines to false-positive cases so that the true purpose of the tort, to compensate for needless mental anguish, can be effectuated.

KENNETH C. ROBLING\textsuperscript{324}

EDITOR’S NOTE:

At our press time after this Note was written in February 1995, a negligent infliction of emotional distress claim for false-positive HIV diagnosis went before the Alaska Supreme Court. The Supreme Court of Alaska, unanimously, followed the precise reasoning set forth by the author of this Note to justify setting aside

\textsuperscript{322}See McKee, supra note 3, at 6. The article suggests that the testing recipient is the patient, and thus the "victim" of false positive results. Id. "Making the patient ... solely responsible for the coordination of her health care is not a workable solution. It should not be the patient's responsibility." Id.

\textsuperscript{323}See Heiner v. Moretuzzo, No. 16312, 1994 WL 78687, at *1 (Ohio App. 9 Dist. Mar. 16, 1994), in which the dissent stated the testing facility owed the plaintiff a duty to correctly analyze her blood, which was breached as a result of false positive diagnosis. Id. at *4 (Quillen, J. dissenting).

\textsuperscript{324}I wish to thank Professor Patricia A. Falk for her guidance and insightful comments. My gratitude also extends to Professors Phyllis L. Crocker and Dena S. Davis for their helpful suggestions. Finally, a special thanks goes to my colleagues Janice Aitken and Melody L. Harness for their tireless editorial efforts.
Alaska's physical injury doctrine as a prerequisite to emotional distress damages. Chizmar v. Mackie, 896 P.2d 196 (1995). In Chizmar, the Court traced the historical development and abandonment of the emotional distress recovery limitations, and discussed the widely recognized exceptions to the traditional recovery barriers (negligent mishandling of a corpse and negligent transmission of a telegram). The Court analogized the seriousness of such emotional distress claims to cases in the negligent HIV testing context and found the magnitude of a false-positive HIV diagnosis of equal nature. Despite the plaintiff's lack of physical injuries as a result of the misdiagnoses, the Court concluded that the physician owed the patient a duty to refrain from activity which presented a foreseeable and unreasonable risk of emotional harm. Id. at 205. Because a jury could reasonably conclude that the mental anguish stemming from a false HIV diagnosis is both foreseeable and severe, the Court abandoned the physical injury doctrine and remanded the case for further proceedings. Id. at 213.

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