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Supreme Court of Delaware.
Robert BRZOSKA and Mary Ann Brzoska, his wife, et al., Plaintiffs Below, Appellants,
v.
Edward P. OLSON, Administrator of the Estate of Raymond P. Owens, Defendant Below, Appellee.

Submitted: May 25, 1995.Decided: Sept. 8, 1995.

WALSH, Justice, for the majority:

In this appeal from the Superior Court, we confront the question of whether a patient may recover damages for treatment by a health care provider afflicted with Acquired Immunodeficiency Syndrome ("AIDS") absent a showing of a resultant physical injury or exposure to disease. The appellants, plaintiffs below, are 38 former patients of Dr. Raymond P. Owens, a Wilmington dentist who died of AIDS on March 1, 1991. In an action brought against Edward P. Olson, the administrator of Dr. Owens' estate, the plaintiffs sought recovery under theories of negligence, battery, and misrepresentation. After limited discovery, the Superior Court granted summary judgment in favor of Dr. Owens' estate, ruling that, in the absence of a showing of physical harm, plaintiffs were not entitled to recover under any theory advanced. Plaintiffs have appealed only the rulings disallowing recovery on the claims of battery and misrepresentation.

We conclude that the Superior Court correctly ruled that, under the circumstances of Dr. Owens' treatment, there can be no recovery for fear of contracting a disease in the absence of a showing that any of the plaintiffs had suffered physical harm. Specifically, plaintiffs cannot recover under battery *as a matter of law* because they could not show that their alleged offense was reasonable in the absence of being actually exposed to a disease-causing agent.

Prior to his death, Dr. Owens had been engaged in the general practice of dentistry in the Wilmington area for almost 30 years. Although plaintiffs have alleged that Dr. Owens was aware that he had AIDS for at least ten years, it is clear from the record that it was in March, 1989, that Dr. Owens was advised by his physician that he was HIV-positive. Dr. Owens continued to practice, but his condition had deteriorated by the summer of 1990. Toward the end of 1990, he exhibited open lesions, weakness, and memory loss. In February, 1991, his physician recommended that Dr. Owens discontinue his practice because of deteriorating health. Shortly thereafter, on February 23, Dr. Owens was hospitalized. He remained hospitalized until his death on March 1, 1991.

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Shortly after Dr. Owens' death, the Delaware Division of Public Health (the "Division") undertook an evaluation of Dr. Owens' practice and records, in part to determine if his patients had been placed at risk through exposure to HIV. The Division determined that Dr. Owens' equipment, sterilization procedures and precautionary methods were better than average and that he had ceased doing surgery since being diagnosed as HIV-positive in 1989. Although the Division determined that the risk of patient exposure was "very small," it notified all patients treated by Dr. Owens from the time of his 1989 diagnosis until his death that their dentist had died from AIDS and that there was a possibility that they were exposed to HIV. The Division also advised the former patients that they could participate in a free program of HIV testing and counseling. Some patients availed themselves of the Division's testing while others secured independent testing. Of the 630 former patients of Dr. Owens who have been tested, none have tested positive for HIV.

After brief discovery, the Owens defendants ("Owens") moved for summary judgment on the ground that all plaintiffs' claims, under whatever theory articulated, did not state a cognizable claim for damages in the absence of a showing of physical injury. The Superior Court ruled that plaintiffs had no basis for recovery for "fear of AIDS" in the absence of an underlying physical injury.

Under the Restatement (Second) of Torts, "[a]n actor is subject to liability to another for battery if (a) he acts intending to cause a harmful or offensive contact with the person ... and (b) a harmful contact with the person of the other directly or indirectly results." *Restatement (Second) of Torts* § 18 (1965); *see also* W. Page Keeton, *et. al., Prosser and Keeton on Torts,* § 9 at 39 (5th ed. 1984) (hereafter "Prosser and Keeton") ("A harmful or offensive contact with a person, resulting from an act intended to cause the plaintiff or third person to suffer such a contact, or apprehension that such contact is imminent, is a battery."). This Court has recognized that, under appropriate factual circumstances, a patient may have a cause of action against a medical practitioner for the tort of battery for acts arising from the practitioner's professional conduct. *See Newmark v. Williams,* Del.Supr., 588 A.2d 1108, 1115 (1991) (citing *Prosser and Keeton,* § 18 at 114).

In essence, the tort of battery is the intentional, unpermitted contact upon the person of another which is harmful or offensive. The intent necessary for battery is the intent to make contact with the person, not the intent to cause harm. *Id.,* § 8 at 36. In addition, the contact need not be harmful, it is sufficient if the contact offends the person's integrity. *Id.,* § 9 at 40. "Proof of the technical invasion of the integrity of the plaintiff's person by even an entirely harmless, yet offensive, contact entitles the plaintiff to vindication of the legal right by the award of nominal damages." *Id.* The fact that a person does not discover the offensive nature of the contact until after the event does not, *ipso facto,*preclude recovery. *See Restatement (Second) of Torts* § 18 cmt. d (1965).

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Although a battery may consist of any unauthorized touching of the person which causes offense or alarm, the test for whether a contact is "offensive" is not wholly subjective. The law does not permit recovery for the extremely sensitive who become offended at the slightest contact. Rather, for a bodily contact to be offensive, it must offend a *reasonable* sense of personal dignity. *Restatement (Second) of Torts* § 19 (1965).

In order for a contact be offensive to a reasonable sense of personal dignity, it must be one which would offend the ordinary person and as such one not unduly sensitive as to his personal dignity. It must, therefore, be a contact which is unwarranted by the social usages prevalent at the time and place at which it is inflicted. *Restatement (Second) of Torts* § 19 cmt. a (1965); *Prosser and Keeton,* § 9, at 42. The propriety of the contact is therefore assessed by an objective "reasonableness" standard. Plaintiffs contend that the "touching" implicit in the dental procedures performed by Dr. Owens was offensive because he was HIV-positive. We must therefore determine whether the performance of dental procedures by an HIV-infected dentist, standing alone, may constitute offensive bodily contact for purposes of battery, i.e., would such touching offend a *reasonable* sense of personal dignity?

As noted, HIV is transmitted primarily through direct blood-to-blood contact or by the exchange of bodily fluids with an infected individual. In a dental setting, the most probable means of transmission is through the exchange of bodily fluids between the dentist and patient by percutaneous (through the skin) contact, by way of an open wound, non-intact skin or mucous membrane, with infected blood or blood-contaminated bodily fluids. During invasive dental procedures,[5] such as teeth extraction, root canal and periodontal treatments, there is a risk that the dentist may suffer a percutaneous injury to the hands, such as a puncture wound caused by a sharp instrument or object during treatment, and expose the dentist and patient to an exchange of blood or other fluids. Robert S. Klein, *et al., Low Occupational Risk of Human Immunodeficiency Virus Infection Among Dental Professionals,* 318 NEW ENG.J.MED. 86 (1988). Although the use of gloves as a protective barrier during invasive dental procedures reduces the risk of exposure of HIV, their use cannot prevent piercing injuries to the hands caused by needles, sharp instruments or patient biting. *Transmission of Human Immunodeficiency Virus in a Dental Practice,* 116ANNALS IN MED. 798, 803 (1992). The risk of HIV transmission from a health care worker to a patient during an invasive medical procedure is very remote. In fact, even a person who is *exposed* to HIV holds a slim chance of infection. The CDC has estimated that the theoretical risk of HIV transmission from an HIV-infected health care worker to patient following actual percutaneous exposure to HIV-infected blood is, by any measure, less than one percent.

As earlier noted, the offensive character of a contact in a battery case is assessed by a "reasonableness" standard. In a "fear of AIDS" case in which battery is alleged, therefore, we examine the overall reasonableness of the plaintiffs' fear in contracting the disease to determine whether the contact or touching was offensive. Since HIV causes AIDS, any assessment of the

fear of contracting AIDS must, *ipso facto,* relate to the exposure to HIV. Moreover, because HIV is transmitted only through fluid-to-fluid contact or exposure, the reasonableness of a plaintiff's fear of AIDS should be measured by whether or not there was a channel of infection or actual exposure of the plaintiff to the virus.

It is unreasonable for a person to fear infection when that person has not been exposed to a disease. In the case of AIDS, actual exposure to HIV may escalate the threat of infection from a theoretical, remote risk to a real and grave possibility if the person exposed is motivated by speculation unrelated to the objective setting. Such fear is based on uninformed apprehension, not reality. In such circumstances, the fear of contracting AIDS is *per se* unreasonable without proof of actual exposure to HIV. In our view, the mere fear of contracting AIDS, in the absence of actual exposure to HIV, is not sufficient to impose liability on a health care provider. AIDS phobia, standing alone, cannot form the basis for recovery of damages, even under a battery theory because the underlying causation/harm nexus is not medically supportable.

AIDS is a disease that spawns widespread public misperception based upon the dearth of knowledge concerning HIV transmission. Indeed, plaintiffs rely upon the degree of public misconception about AIDS to support their claim that their fear was reasonable. To accept this argument is to contribute to the phobia. Were we to recognize a claim for the fear of contracting AIDS based upon a mere allegation that one *may* have been exposed to HIV, totally unsupported by any medical evidence or factual proof, we would open a Pandora's Box of "AIDS-phobia" claims by individuals whose ignorance, unreasonable suspicion or general paranoia cause them apprehension over the slightest of contact with HIV-infected individuals or objects. Such plaintiffs would recover for their fear of AIDS, no matter how irrational. *See* James C. Maroulis, *Can HIV–Negative Plaintiffs Recover Emotional Distress Damages for Their Fear of AIDS?,* 62 FORDHAM L.REV. 225, 261 (1993) ("Allowing juries to decide whether the plaintiff's fear is reasonable even where there is no evidence of exposure invites jury speculation and may allow recovery based on ignorance or unreasonable fear of the disease."). We believe the better approach is to assess the reasonableness of a plaintiff's fear of AIDS according to the plaintiff's *actual*—not *potential*—exposure to HIV.

In sum, we find that, without actual exposure to HIV, the risk of its transmission is so minute that any fear of contracting AIDS is *per se* unreasonable. We therefore hold, *as a matter of law,* that the incidental touching of a patient by an HIV-infected dentist while performing ordinary, consented-to dental procedures is insufficient to sustain a battery claim in the absence of a channel for HIV infection. In other words, such contact is "offensive" only if it results in actual exposure to the HIV virus. We therefore adopt an "actual exposure" test, which requires a plaintiff to show "actual exposure" to a disease-causing agent as a prerequisite to prevail on a claim based upon fear of contracting disease. Attenuated and speculative allegations of exposure to HIV do not give rise to a legally cognizable claim in Delaware.

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In this action, plaintiffs have never alleged, either individually or collectively, *actual exposure* to HIV. Nonetheless, we must consider whether, from this record, there is any evidence of actual exposure to HIV from Dr. Owens as to any patient which would entitle plaintiffs' battery claims to survive a motion for summary judgment.

In this case, the material facts are not in dispute. Even viewing the facts from plaintiffs' vantage point, the record fails to establish actual exposure to HIV. Plaintiffs argue to the contrary, noting that Dr. Owens exhibited lesions on his arms, legs, and elbow, and that he was known to have cut himself on at least one occasion while working on a patient. They have not, however, averred that the wound or lesions of Dr. Owens ever came into contact with the person of any of the plaintiffs, nor have they identified which patient was present during Dr. Owens' injury or even whether that patient was a plaintiff in this action. In fact, nothing in this record suggests any bleeding from Dr. Owens or that any wound or lesions ever came into contact with a break in the skin or mucous membrane of any of the plaintiffs. Plaintiffs have failed to demonstrate any evidence of actual exposure to potential HIV transmission beyond mere unsupported supposition.

Plaintiffs also claim that Dr. Owens maintained a casual attitude toward infection control measures and did not adhere to universal precautions, thus posing a risk of infection to his patients. They note that Dr. Owens did not always wash his hands between patients and that he relied largely upon his assistants for infection control measures. In support of their claim, plaintiffs refer to an affidavit of Dr. William Shaffner, M.D., Professor of Medicine, Division of Infectious Diseases, Vanderbilt University School of Medicine. In that affidavit, Dr. Shaffner states that there is a potential for AIDS transmission if a dentist bleeds into a patient's mouth while performing invasive procedures, that the potential risk of AIDS transmission is higher if infection control procedures are casual, that a person can spread HIV through open herpes lesions, that a physician or dentist should not practice with lesions, especially on the hands, and that Dr. Owens created a greater risk of HIV transmission to his patients than to those of Dr. Acer (Florida dentist who transmitted HIV to five patients).

In our view, the affidavit of Dr. Shaffner was insufficient to create an issue of material fact. The record reflects a finding that Dr. Owens' use of gloves during dental procedures was "consistent." It was also found that Dr. Owens was "better than average" in his employment of procedures for disinfection and sterilization. Even if it be assumed that the affidavit, taken at face value, suggests that Dr. Owens failed to comply with universal precautions, a factual inference of actual exposure is not warranted. Dr. Shaffner's affidavit does not recite that any plaintiff was "actually exposed" to HIV. Because actual exposure is necessary to support a claim based on a fear of contracting disease, the affidavit is insufficient to overcome summary judgment in this case.

Although Dr. Owens presumably came into contact with the bodily fluids of some of the plaintiffs who bled during their dental procedures, there is no indication that the plaintiffs were

actually exposed to a disease-causing agent. Again, HIV transmission requires fluid-to-fluid contact. In this case, plaintiffs have not been exposed to HIV, but rather, they have been exposed only to an HIV-infected dentist. Plaintiffs merely hypothesize as to how a possible exposure to HIV could have occurred without offering any substantiating evidence to that effect. Plaintiffs have shown nothing except that their risk of HIV infection was theoretical and remote. As such, plaintiffs' claims do not rise above mere speculation.

Because plaintiffs have failed to show, individually or collectively, any exposure to the virus, the reasonableness of the plaintiffs' fear is not a material issue of fact. If any of the plaintiffs had contracted AIDS, or at least been exposed to HIV, their battery claim might prove successful, assuming that their consent to the procedures was vitiated. Absent such contraction or exposure, however, their claim of battery, like their claim of negligence, must fail.

In conclusion, the tort of battery requires a harmful or offensive contact, and “offensive” conduct is tested by a reasonableness standard. We hold that the fear of contracting a disease without exposure to a disease-causing agent is *per se* unreasonable. Thus, absent actual exposure to HIV, plaintiffs cannot recover for fear of contracting AIDS.
The judgment of the Superior Court is AFFIRMED IN PART, REVERSED IN PART, and REMANDED for proceedings consistent with this opinion.