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Acquired Immunodeficiency Syndrome: The Case for Anonymous Limited Discovery

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CURRENT ISSUES

ACQUIRED IMMUNODEFICIENCY SYNDROME: THE CASE FOR ANONYMOUS LIMITED DISCOVERY

First recognized by the Centers for Disease Control ("CDC") in June 1981,¹ Acquired Immunodeficiency Syndrome ("AIDS") is

¹ I. SLOAN, AIDS LAW: IMPLICATIONS FOR THE INDIVIDUAL & SOCIETY 1,1 (1988). According to Dr. James W. Curran, Director of HIV/AIDS of the Centers for Disease Control, the earliest known documented case of AIDS was later found to have occurred in 1959, in Zaire. J. Curran, Remarks at New Advances in AIDS: A Forum for Health Care Planners and Providers (October 17, 1990) (Albert Einstein College of Medicine, New York) [hereinafter "Forum"]. The CDC later recognized at least one American case of AIDS as early as 1979, and tests for the presence of the antibody to the AIDS virus on stored serum were found positive in a specimen from 1976. See Gibofsky & Laurence, *AIDS—Current Medical and Scientific Aspects*, in 9 J.L. MED. 497, 497 (1988).

In terms of epidemiology, the incidence of AIDS cases in the United States is concentrated in certain geographical areas, particularly New York, New Jersey, Florida, Texas and California. H. Jaffe, *The Medical Facts About AIDS*, in AIDS AND THE COURTS 7, 12 (C. Abt and K. Hardy eds. 1990). Currently, the highest concentration of cases is in the Dade County, Miami, Florida area. *Id.* AIDS is the leading cause of death in New York for males aged 25 to 44, and females aged 25 to 34. See S. Joseph, *HIV Testing and the Criminal Justice System in New York City*, in AIDS AND THE COURTS 53, 54 (C. Abt and K. Hardy eds. 1990). As of February 1989, approximately 19,000 cases of AIDS and over 10,000 AIDS-related deaths had been reported in New York City, and 60,000 AIDS cases and 48,000 AIDS-related deaths are projected for the New York area by 1993. *Id.*

The majority of AIDS cases have been diagnosed in men, with only nine percent of the total reported cases affecting women. See Jaffe, *supra*, at 12. Further, the disease has predominantly been found in the twenty to forty-five year old age category. *Id.* With regard to ethnicity, blacks have accounted for twenty-five percent of adult and fifty-six percent of pediatric cases; Hispanics account for thirteen percent of adult and twenty percent

an infectious disease which attacks the body's immune system, thereby significantly impairing its ability to fight invading bacteria and other infectious agents.² While the growth rate of new AIDS cases has decreased significantly,³ the number of infected persons continues to rise in absolute terms.⁴ The disease has raised many social, political, and legal issues.⁵ One particular legal issue con-

of pediatric cases through 1987. AMERICAN BAR ASSOCIATION, AIDS: THE LEGAL ISSUES, DISCUSSION DRAFT OF THE AMERICAN BAR ASSOCIATION AIDS COORDINATING COMMITTEE 9 (1988).

For further discussion of epidemiological issues raised, see generally Mueller, *The Epidemiology of the Human Immunodeficiency Virus Infection*, 14 LAW, MED. & HEALTH CARE 250, 258 (1987); AIDS: *Science and Epidemiology*, 14 LAW, MED. & HEALTH CARE 225 (1986); Weiss & Biggar, *The Epidemiology of Human Retrovirus-Associated Illnesses*, 53 MOUNT SINAI J. OF MED. 579 (1986).

² See UNITED STATES DEP'T OF HEALTH AND HUMAN SERVICES, SURGEON GENERAL'S REPORT ON ACQUIRED IMMUNO-DEFICIENCY SYNDROME 9 -10 (1986). The Human Immunodeficiency Virus ("HIV") causes AIDS by breaking down the body's immune system, making an infected person unusually susceptible to various viral, protozoal, fungal, and bacterial infections which a healthy person's immune system could resist. *Id.* See AIDS AND THE LAW 264 (W. Dornette ed. 1987) (CDC definition of AIDS); 36 MORBIDITY & MORTALITY WEEKLY REP. (Supp. 1S, Aug. 14, 1987) (CDC's revised definition of AIDS).

³ Gibofsky & Laurence, *supra* note 1, at 497 (citing J. LAURENCE, THE AIDS READER (1987)).

⁴ See H. Jaffe, *The Medical Facts About Aids*, in AIDS AND THE COURTS 7, 12 (C. Abt and K. Hardy eds. 1990) (83,000 domestic cases at beginning of 1989); New York State Dep't of Health, AIDS: 100 Questions and Answers (April 1989) (pamphlet distributed by AIDS Advisory Council) (90,000 cases as of March 1989). As of September 1990, 152,126 domestic cases of AIDS have been reported to the CDC, a portentous increase in the last year alone. Telephone interview with member of Technical Information Activity Staff of CDC (Nov. 1, 1990).

The CDC has estimated that by the end of 1992 there will be more than a third of a million AIDS cases in this country, with more than a quarter of a million deaths. Jaffe, *supra*, at 14. For 1992 alone it has been estimated that "80,000 new cases would be reported, and 66,000 Americans would die of AIDS." *Id.* Furthermore, the CDC has estimated that an additional 1.5 million Americans have been infected with HIV, and twenty to fifty percent of those infected are expected to ultimately develop AIDS. See INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES, CONFRONTING AIDS: DIRECTIONS FOR PUBLIC HEALTH, HEALTH CARE AND RESEARCH 5 (1986).

If these projections prove correct, by 1992 AIDS will be the second leading cause of premature death in the United States, and will nearly equal unintentional injury—largely automobile accidents—as the leading cause of premature death in men. Jaffe, *supra*, at 15.

⁵ See, e.g., Thompson, *A Losing Battle with AIDS*, TIME, July 2, 1990, at 42-43 (medical developments and Sixth International Conference on AIDS in San Francisco); Gostin, *The AIDS Litigation Project. A National Review of Court and Human Rights Commission Decisions, Part I: The Social Impact of AIDS*, 263 J. A.M.A. 1961-70 (1990) (consequences of AIDS in society); Spece, *AIDS: Due Process, Equal Protection, and the Right to Treatment*, 4 ISSUES L. MED. 283-344 (1988) (AIDS patients' right to medical treatment); Albert, *A Right to Treatment for AIDS Patients?*, 92 DICK. L. REV 743 (1988) (same); Levhars, et al., *AIDS and Medicaid: The Role of Medicaid in Treating those with AIDS*, 44 PUBLIC WELFARE 20 (government programs to finance care of AIDS patients).

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cerns the liability of blood banks and hospitals for, respectively, supplying and transfusing individuals with AIDS-infected blood.⁶

Despite the development of screening tests for AIDS,⁷ a significant risk of infection by transfusion of blood remains,⁸ given the nature of the disease⁹ and the fact that current screening tests

For a discussion of the consequences of AIDS in the work-force, see generally *Shuttleworth v. Broward County Office of Budget and Management Policy*, 639 F. Supp. 654 (S.D. Fla. 1986) (rights of employee fired for having AIDS); Gostin, *The AIDS Litigation Project. A National Review of Court and Human Rights Commission Decisions, Part II: Discrimination*, 263 J. A.M.A. 2086-93 (1990) (discrimination against persons with AIDS); Brown, *AIDS in the Workplace; A Legal Dilemma*, 43 Sw. L.J. 837 (1988) (AIDS-related problems of discrimination and privacy in workplace, including employee and applicant testing); M. Cecire, *AIDS Presents Many Legal Issues for Workplace*, *Legal Times*, Dec. 2, 1985, at 13-14 (same).

For examples of AIDS and education concerns, see generally *Thomas v. Atascadero Unified School Dist.*, 622 F. Supp. 376 (C.D. Cal. 1987) (child with AIDS entitled to protection from discrimination in school); Jones, *The Education for All Handicapped Children Act: Coverage of Children with Acquired Immune Deficiency Syndrome (AIDS)*, 15 J.L. & EDUC. 195 (1986) (social issues involved in education of children with AIDS); Sotto, *Undoing a Lesson of Fear in the Classroom: The Legal Recourse of AIDS-Linked Children*, 135 U. PA. L. REV. 193 (1986) (same).

⁶ See Rabkin, *Individual and Institutional Liability for Transfusion-Acquired Diseases*, 256 J. A.M.A. 2242-43 (1986) (unless and until legislatures or judiciary revoke classification of blood as service, liability can only be grounded in negligence); Miller, *Potential Liability for Transfusion-Associated AIDS*, 253 J. A.M.A. 3419-23 (1985) (discussing hospital, blood bank, and physician liability) Hermann, *Liability Related to Diagnosis and Transmission of Aids*, 15 LAW, MED. & HEALTH CARE 36-45 (Summer 1987) (liability related to medical malpractice and transfusions via blood, needle sharing, childbirth, and sexual intercourse). See also notes 16 through 58 and accompanying text (discussing blood bank and hospital liability).

⁷ See Ward, Grindon, Feorino et al., *Laboratory and Epidemiologic Evaluation of an Enzyme Immunoassay for Antibodies to HTLV-III*, 256 J. A.M.A. 357, 361 (1986); Weiss, Goedert, Sarnagadharan et al., *Screening Test for HTLV-III (AIDS-agent) Antibodies: Specificity, Sensitivity, and Applications*, 253 J. A.M.A. 221, 225 (1985).

⁸ See Cohen, Munoz, Reitz, et al., *Transmission of Retrovirus by Transfusion of Screened Blood in Patients Undergoing Cardiac Surgery*, 320 NEW ENG. J. MED. 1172-76 (1989) (1 in 36,282); Kleinman & Secord, *Risk of Human Immunodeficiency Virus (HIV) Transmission by Anti-HIV Negative Blood: Estimates Using the Lookback Methodology*, 28 TRANSFUSION 499-501 (1988) (1 in 68,000); Peterman, Lui, Lawrence, Allen, *Estimating the Risks of Transfusion-Associated Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus Infection*, 27 TRANSFUSION 371-74 (1987) (predicting 29,000 infections transmitted between 1978 and 1984).

The CDC has estimated that the overall risk of becoming infected with HIV following a transfusion is currently 1 in 40,000. Jaffe, *supra* note 4, at 24.

⁹ See Forum, *supra* note 1 (statement of Dr. Ruy Soeiro). According to Dr. Soeiro, there is an initial latent phase of the disease, during which there is an apparent immunity to HIV. Accord Gibofsky & Laurence, *AIDS—Current Medical and Scientific Aspects*, in 9 J.L. MED. 497, 499 (1988) ("Antibodies to HIV-1 . . . occur earliest in the course of viral infection; however, the levels of antibodies may fall and become undetectable . . ."). In Dr. Soeiro's opinion, it is the acute stage, featuring a loss of CD-4 cells — a sub-population of T-cell lymphocytes (white blood cells) — which are vital to the immune system, that is the best marker of the condition of the patient. See Forum, *supra* note 1.

The latent characteristic of the disease is particularly consequential in the transfusion setting, given the uncertainty of the interval for "seroconversion" (testing positive for

provide ambiguous results.¹⁰ One study projected that there would be at least 10,600 transfusion-related AIDS cases stemming from pre-1985 infection.¹¹ Moreover, several researchers point out that the attainment of a blood supply with a zero-risk of transmitting infectious disease may not be possible.¹²

To further complicate the ordeal of the person transfused with AIDS-infected blood, courts have denied the aggrieved victims

HIV-antibody) following infection. Gibofsky & Laurence, *supra*, at 499-500. That is, studies have indicated that seroconversion may not occur in some individuals for nine to twelve months. *Id.* As potential donors, these asymptomatic individuals—while seronegative for the antibody—may be harboring the active virus in infected cells, and represent an obvious dilemma for blood transfusion facilities and blood suppliers. *Id.*

¹⁰ AIDS LEGAL GUIDE 4-3, 4-4 (A. Rubenfeld ed. 1987) (current HIV-antibody tests are apt to provide false positive results); Osborn, *HIV Antibody Testing Uses and Limitations*, in AIDS AND THE COURTS 45 (C. Abt. and K. Hardy eds. 1987) ("ELISA test . . . is prone to errors of timing, technical mishap, or biologic ambiguity"); Howard, *HIV Screening — Scientific, and Legal Issues*, 9 J.L. MED. 601, 603-04 (1988) ("positive predictive value can vary greatly depending on . . . prevalence of HIV infection in a particular group screened"); Ward et al., *Transmission of Human Immunodeficiency Virus (HIV) by Blood Transfusions As Negative for HIV Antibody*, 318 NEW ENG. J. MED. 473, 473 (1988) (present tests may not identify antibody) (footnotes omitted); Barnes, *AIDS Test is, Unfortunately, Still Ambiguous*, N.Y. Times, May 5, 1987, at A34, col.3 (ambiguous characteristics of AIDS test results).

Several studies estimate that four to five of every 1 million donors screened as negative for HIV may be infected. Ward, *supra*, at 476 (citing Bove, *Transfusion-Associated Hepatitis and AIDS: What is the Risk?*, 317 NEW ENG. J. MED. 242-45 (1987) (emphasis added)). Consequently, according to these figures, seventy-two to ninety persons may be infected each year under these circumstances. Ward, *supra*, at 476. More importantly, if the likelihood of donation before the development of detectable antibody is taken into account, i.e., during the latent stage, it has been predicted that as many as 460 recipients of screened blood may become infected annually. *Id.* Cf. Peterman & Ward, *What's Happening to the Epidemic of Transfusion-Associated AIDS?*, 29 TRANSFUSION 659, 659 (1989) (793 cases of transfusion-associated AIDS reported from July 1988 to June 1989).

Recommending that the Food and Drug Administration should make new antigen tests available to blood banks immediately, Dr. Allan Salzburg, a physician at the Veteran's Administration Medical Center, pointed out that despite the use of the ELISA (enzyme-linked immunosorbent assay) test, HIV cannot be detected in about seven percent of the carriers tested. A. Salzburg, *Letter to the Editor*, 319 NEW ENG. J. MED. 515, 515 (1988). Further, the author stated that in areas such as New York and San Francisco, where the presence of HIV is ten to fifteen times above the national average, "two to four units per 19,000 could be contaminated and go undetected." *Id.*

¹¹ Kalbfleisch & Lawless, *Estimating the Incubation Time Distribution and Expected Number of Cases of Transfusion-Associated Acquired Immune Deficiency Syndrome*, 29 TRANSFUSION 672, 674-75 (1989). The authors note that "these numbers of observed recent infections would suggest a large number of future cases and therefore a substantial infection rate after 1985." *Id.* at 675. Moreover, if long-term projections are adjusted for the change in the surveillance definition of AIDS in 1987 — 22 percent of all transfusion-related AIDS cases reported in 1988 were diagnosed by the new classification — these estimates would be conspicuously higher. Peterman & Ward, *supra* note 10, at 660.

¹² Peterman & Ward, *supra* note 10, at 659-60 (citing Greetings, *A Final Look Back With Comments About A Policy of Zero-Risk Blood Supply*, 27 TRANSFUSION 447, 447-48 (1987)).

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discovery of information regarding donor identity¹³ on constitutional and policy grounds.¹⁴ Since donor identity is essential in establishing blood bank or hospital liability, this denial is often detrimental to the victim's case.¹⁵ This Note will examine the issue of anonymous limited discovery in AIDS cases, in light of the divergence of trial court opinions in this area. Part One of this Note will discuss a plaintiff's possible causes of action, and the need for discovery of the donor's identity. Part Two will review the Federal Rules of Civil Procedure regarding discovery, defining the scope and limitations of its application. Part Three will address the donor's informational right to privacy. Part Four will discuss the public policy issues raised, particularly the potential impact on voluntary blood supplies. Part Five will examine the balancing test used to weigh the parties' respective interests, in light of recent case law. Finally, Part Six will propose the application of anonymous limited discovery by courts as one practical approach to such cases.

I. THEORIES OF RECOVERY

An individual who has contracted AIDS via a transfusion of contaminated blood will often seek to recover damages from a hospital,¹⁶ blood bank,¹⁷ or blood product manufacturer,¹⁸ de-

¹³ See *infra* notes 133-148 and accompanying text (cases denying discovery).

¹⁴ *Id.*

¹⁵ See *infra* notes 35-58 and accompanying text (reviewing causes of action).

¹⁶ See, e.g., *Cutler v. Graduate Hosp.*, 717 F. Supp. 338 (E.D. Pa. 1989) (patient brought personal injury action against hospital for transfusing AIDS-infected blood during operation); *Mason v. Regional Medical Center of Hopkins County*, 121 F.R.D. 300 (W.D. Ky. 1988) (patient who received AIDS-infected transfusions during child birth brought suit against hospital for supplying unreasonably dangerous product); *Robert v. Suburban Hosp. Ass'n*, 73 Md. App. 1, 532 A.2d 1081 (Md. Ct. Spec. App. 1987) (hemophiliac brought suit against hospital seeking damages resulting from contraction of AIDS through transfusion of contaminated blood); *Stenger v. Lehigh Valley Hosp. Center*, 386 Pa. Super. 574, 563 A.2d 531 (1989) (patient brought negligence action against hospital in connection with transfused blood from donor who tested positive for AIDS virus); *Longoria v. McAllen Methodist Hosp.*, 771 S.W.2d 663 (Tex. Ct. App. 1989) (parents of four year-old child who died of AIDS brought tort action against hospital which supplied blood). For further discussion of hospital liability in transfusion-related AIDS cases, see Comment, *Hospital and Blood Bank Liability to Patients Who Contract AIDS Through Blood Transfusions*, 23 SAN DIEGO L. REV. 875 (1986) (negligence is only viable theory of recovery against hospital for AIDS-infected transfusion) [hereinafter "Comment, *Hospital and Blood Bank Liability*"].

Although a plaintiff in a transfusion-related AIDS case will almost certainly sue the hospital which administered the transfusion, plaintiffs will generally name a blood bank as a

pending on the circumstances of the underlying transfusion procedure. In such cases, a plaintiff will usually pursue a remedy based

co-defendant if the hospital has purchased the contaminated blood from that independent supplier. *See, e.g., Cutler*, 717 F. Supp. at 338 (American National Red Cross named co-defendant); *Kozup v. Georgetown Univ.*, 663 F. Supp. 1048 (D.D.C. 1987), *modified*, 851 F.2d 437 (D.C. Cir. 1988) (American Red Cross named co-defendant); *Longoria*, 771 S.W.2d at 663 (United Blood Services named co-defendant).

¹⁷ *See, e.g., Bradway v. American Nat'l Red Cross*, 132 F.R.D. 78 (N.D.Ga. 1990) (recipient of AIDS-contaminated blood brought action against blood supplier); *Hoemke v. New York Blood Center*, No. 88 Civ. 9029 (S.D.N.Y. Nov. 28, 1989) (1989 WESTLAW 14767, Allfed library) (patient who contracted AIDS from 1981 blood transfusion brought suit against blood center), *aff'd*, 912 F.2d 550 (2d Cir. 1990); *Boutte v. Blood Sys., Inc.*, 127 F.R.D. 122 (W.D. La. 1989) (donee who received blood transfusion brought action against blood bank after testing positive for HIV antibody); *Doe v. American Red Cross Blood Serv.*, 125 F.R.D. 646 (D.S.C. 1989) (plaintiff who contracted AIDS virus as result of blood transfusion brought action against blood bank); *Howell v. Spokane & Inland Empire Blood Bank*, 114 Wash. 2d 42, 785 P.2d 815 (1990) (en banc) (AIDS victim filed strict liability and implied warranty action against blood bank that supplied hospital with infected blood). For further discussion of blood bank liability, see generally Comment, *Hospital and Blood Bank Liability*, *supra* note 16; Comment, *Transfusion-Associated Acquired Immunodeficiency Syndrome (AIDS): Blood Bank Liability?*, 16 U. BALT. L. REV. 81 (1986) (under present law, victims of transfusion-associated AIDS will find it almost impossible to recover against blood banks) [hereinafter "Comment, *Transfusion-Associated AIDS*"].

¹⁸ *See, e.g., Miles Laboratories, Inc., Cutter Laboratories Div. v. Doe*, 315 Md. 2d 704, 708, 556 A.2d 1107, 1109 (1989). A blood product manufacturer is, *inter alia*, a commercial preparer and supplier of a blood clotting factor concentrate. *Id. See McKee v. Miles Laboratories, Inc.*, 675 F. Supp. 1060, 1061 (E.D. Ky. 1987). Since hemophiliacs lack the protein Factor VIII necessary for normal coagulation of blood, these companies have developed a method by which this absent protein can be produced and distributed to hemophiliacs. *Id.* First, blood plasma is purchased from blood donors. *Id.* All the purchased plasma is then combined (or pooled) with plasma donated from thousands of other individuals. *Id.* The Factor VIII is then precipitated out of those combined plasma and is freeze-dried and packaged in powdered form. *See Rodgers v. Miles Laboratories, Inc.*, 802 P.2d 1346, 1347, (Wash. 1991) (en banc). Finally, this blood clotting factor concentrate is sold to hospitals and physicians where it is administered intravenously by mixing the powdered concentrate with sterile water prior to use. *Id. See generally* 21 C.F.R. § 640 (1990) (regulations governing human blood and blood products).

Since the medical community has determined that the HIV virus can be transmitted through blood plasma, hemophiliacs who have developed AIDS from using this factor concentrate have begun to sue the manufacturers of this product. *See, e.g., Coffee v. Cutter Biological*, 809 F.2d 191 (2d Cir. 1987) (plaintiffs brought product liability suit against commercial producers of blood component products); *Ray v. Cutter Laboratories*, 744 F. Supp. 1124 (M.D. Fla. 1990) (mother of three hemophilic children infected with AIDS virus brought suit against various plasma product manufacturers); *Doe v. Travenol Laboratories*, 698 F. Supp. 780 (D. Minn. 1988) (patient infected with AIDS virus while using anti-hemophilic factor filed suit against product's manufacturer); *McKee v. Miles Laboratories, Inc.*, 675 F. Supp. 1060 (E.D. Ky. 1987) (widow of hemophilic brought suit against supplier of blood coagulant); *Miles Laboratories, Inc., Cutter Laboratories Div. v. Doe*, 315 Md. 704, 556 A.2d 1107 (1989) (action brought against supplier of blood products on behalf of hospital patients who contracted AIDS virus); *Rodgers v. Miles Laboratories, Inc.*, 116 Wash. 2d 195, 802 P.2d 1346 (1991) (guardian of child infected with AIDS filed product liability action against manufacturer of blood products).

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on several legal theories:¹⁹ strict liability,²⁰ implied warranty,²¹ and negligence.²²

A. *Strict Liability in Tort*

In transfusion-related AIDS cases, a plaintiff may attempt to recover damages under the theory of strict liability in tort, which has its basis in the Restatement (Second) of Torts.²³ Under this

¹⁹ See, I. SLOAN, AIDS LAW: IMPLICATIONS FOR THE INDIVIDUAL & SOCIETY (1988) (tort liability for transmission of AIDS through blood supply).

Although the most common theories to sue under are strict liability in tort, implied warranty, and negligence, it should be recognized that many additional theories of recovery exist under which a plaintiff may pursue compensation in a transfusion-associated setting. See *Hoemke v. New York Blood Center*, No. 88 Civ. 9029 (S.D.N.Y. Nov. 28, 1989) (1989 WESTLAW 147642, Allfed library) (fraud and breach of fiduciary duty), *aff'd*, 912 F.2d 550, 551 (2d Cir. 1990); *Kozup v. Georgetown Univ.*, 663 F. Supp. 1048, 1051 (D.D.C. 1987) (battery and informed consent), *modified*, 851 F.2d 437 (D.C. Cir. 1988); *Savino v. Nassau Hosp.*, 127 App. Div. 2d 579, 580, 511 N.Y.S.2d 379, 380 (2d Dep't 1987) (wrongful death); *Howell v. Spokane & Inland Empire Blood Bank*, 785 P.2d 815, 817 (Wash. 1990) (en banc) (violation of consumer protection act).

Although liability may be imposed upon a blood supplier, it would be virtually impossible for a transfusion-related AIDS victim to recover damages from the donor of the contaminated blood. See Williams, *Blood Transfusions and AIDS: A Legal Perspective*, 32 MED. TRIAL TECH. Q. 267, 271 (1986) [hereinafter "Williams"]. In order to prove that the donor was negligent, the transfusion-associated AIDS victim would have to demonstrate that the donor knew or should have known that he was infected with or was a carrier of AIDS, and that the disease could endanger a transfusion recipient. *Id.* Further, even assuming the plaintiff could demonstrate that the donor was negligent in donating the blood, the transfusion recipient would probably be unable to recover damages since the usual donor would not have the insurance or the resources to satisfy the claim. *Id.* For a discussion of the potential criminal ramifications of intentionally or negligently donating contaminated blood, see I. SLOAN, *supra*, at 17-21.

²⁰ See *infra* notes 23-27 and accompanying text (discussing strict liability).

²¹ See *infra* notes 28-34 and accompanying text (discussing implied warranty).

²² See *infra* notes 35-58 and accompanying text (discussing negligence).

²³ RESTATEMENT (SECOND) OF TORTS §402(a) (1965). The Restatement provides:

- (1) One who sells any product in a defective condition unreasonably dangerous to the user or consumer or to his property is subject to liability for physical harm caused to the ultimate user or consumer, or to his property, if
 - (a) the seller is engaged in the business of selling a product; and
 - (b) it is expected to and does reach the user or consumer without substantial change in the condition in which it was sold;
- (2) The rule stated in subsection (1) applies although
 - (a) the seller has exercised all possible care in the preparation and sale of his product; and
 - (b) the user or consumer has not brought the product from or entered into any contractual relationship with the seller.

Id. Section 402(a) has been adopted, in some form or another, by almost every state. See W.P. KEETON, D. DOBBS, R. KEETON & D. OWEN, PROSSER AND KEETON ON THE LAW OF TORTS § 98, at 694 (5th ed. Supp. 1988) [hereinafter "PROSSER AND KEETON"]. As of 1988, the

theory, liability will be imposed upon a manufacturer or retailer when a dangerously defective product causes physical injury or property damage, irrespective of whether a particular defendant was negligent.³⁴ Section 402(a) of the Restatement, however, expressly limits the application of this theory to cases involving the sale of a product.³⁵ The primary obstacle to recovering under this theory has been the implementation of state "blood shield statutes," which characterize the transfusion of blood or blood products as a service rather than as a sale of a product.³⁶ As a conse-

only jurisdictions which had failed to expressly adopt the theory of strict tort liability for defective products were Delaware, Massachusetts, Michigan, North Carolina, Virginia, and the District of Columbia. *Id.*

Moreover, it is commonly stated that there are three reasons for holding manufacturers and dealers strictly liable for personal or property injury caused by defective products. *Id.* at 692. First, innocent victims should not be forced to bear the costs of accidents. *Id.* at 693. Second, strict liability promotes accident prevention because manufacturers are in a better position to ascertain and control the risks associated with their products. *Id.* Third, manufacturers are in a better position than individuals to bear the costs because they can distribute the losses by charging higher prices for the costs of products. *Id.*

³⁴ RESTATEMENT (SECOND) OF TORTS § 402 (a) (1965).

³⁵ *Id.*

³⁶ See, e.g., ALA. CODE §7-2-314(4) (1984); ARIZ. REV. STAT. ANN. §36-1151 (1986); CAL. HEALTH & SAFETY CODE §1606 (West 1979); KY. REV. STAT. ANN. §139.125 (Michie/Bobbs-Merrill 1982); ME. REV. STAT. ANN. tit. 11, §2-108 (Supp. 1989); MINN. STAT. ANN. §525.928 (West 1975); MISS. CODE ANN. §41-41-1 (Supp. 1990); N.Y. PUB HEALTH LAW §580(4) (McKinney Supp. 1989); OR. REV. STAT. §97.300 (1984); UTAH CODE ANN. §26-31-1 (1989). Several states have enacted statutes which only preclude recovery under strict liability. See, e.g., IOWA CODE ANN. §142A.8 (West 1989); LA. REV. STAT. ANN. §9:2797 (West Supp. 1990). Other state statutes specifically preclude recovery under implied warranties of fitness and merchantability. See, e.g., ALASKA STAT. §45.02.316(e) (1986); ARK. STAT. ANN. §20-9-802 (1987); CONN. GEN. STAT. ANN. §19a-280 (West 1986); DEL. CODE ANN. tit. 6, §2-316(5) (1975); IDAHO CODE §39-3702 (Supp. 1989); MO. ANN. STAT. §431.069 (Vernon Supp. 1989); N.D. CENT. CODE §41-02-33 (3)(d) (1983); TENN. CODE ANN. §47-2-316(5) (1979). Some statutes specifically preclude recovery under strict liability, implied warranty of fitness, and implied warranty of merchantability. See, e.g., GA. CODE ANN. §105-1105 (Harrison 1990); ILL. ANN. STAT. ch. 111 ½, para. 5102 (Smith-Hurd 1988); IND. CODE §16-8-7-2(a) (Burns Supp. 1989); KAN. STAT. ANN. §65-3701 (1985); MD. HEALTH GEN. CODE ANN. §18-402 (1987); W. VA. CODE §16-23-1 (1985).

Although New Jersey and the District of Columbia do not have a blood shield statute, these jurisdictions apply the same restrictions through common law. See, e.g., *Kozup v. Georgetown Univ.*, 663 F. Supp. 1048 (D.D.C. 1987) (under District of Columbia common law, blood transfusion is considered to be medical service), *modified*, 851 F.2d 437 (D.C. Cir. 1988); *Brody v. Overlook Hosp.*, 127 N.J. Super. 331, 317 A.2d 392 (N.J. Sup. Ct. 1974) (blood transfusion deemed to be a service), *aff'd*, 66 N.J. 448, 332 A.2d 596 (1975). Only the state of Vermont lacks a blood shield policy.

The progenitor of the sales/service dichotomy vis-a-vis blood transfusions was the case of *Perlmutter v. Beth David Hosp.*, 308 N.Y. 100, 123 N.E.2d 792 (1954). In *Perlmutter*, a plaintiff sought to recover damages for breach of implied warranty from a hospital claiming that she had contracted hepatitis through a transfusion of contaminated blood. *Id.* at

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quence of the sale/service characterization, the plaintiff will not likely succeed in an action based solely on strict liability.²⁷

103, 123 N.E.2d at 793. In rejecting the plaintiff's claim, the court held that liability could not attach because a blood transfusion did not constitute a sale under the provisions of New York's Sales Act. *Id.* at 108, 123 N.E.2d at 795. The court reasoned that a blood transfusion was merely an "incidental and very secondary adjunct" feature of a service provided by a hospital. *Id.* at 106, 123 N.E.2d at 795. To label a transfusion as a sale, the court noted, would make the hospital liable "no matter how careful, no matter that the disease producing potential in the blood could not possibly be discovered . . ." *Id.*

Although the *Perlmutter* Rule led to the enactment of the modern blood shield statutes, a number of courts, as well as commentators, have nevertheless, criticized the *Perlmutter* sale/service dichotomy. *See, e.g.,* Russell v. Community Blood Bank, Inc., 185 So.2d 749, 752 (Fla. Dist. Ct. App. 1966) (distortion for *Perlmutter* court to twist sale into shape of service), *rev'd on other grounds*, 196 So.2d 115 (Fla. 1967); Cunningham v. MacNeal Memorial Hosp., 47 Ill. 2d 443, 444, 266 N.E.2d 897, 901 (1970) (*Perlmutter* view was unrealistic); Boland, *Strict Liability in Tort for Transfusing Contaminated Blood*, 23 ARK. L. REV. 236, 247 (1969) (*Perlmutter* court justified its policy decision by resorting to "kind of nonunderstanding nonsense, in awkwardly averring that a sale is not a sale"); Williams, *supra* note 19, at 274-275 (*Perlmutter* Rule deficient because transfer of blood is sale despite fact that it occurred in course of what may be labelled service transaction); Comment, *Liability Without Fault and the AIDS Plague Compel a New Approach to Cases of Transfusion-Transmitted Disease*, 61 U. COLO. L. REV. 81, 112 (1990) ("*Perlmutter's* sale/service distinction ignores development in the law which incorporated principles of no-fault liability and the traditional principle of warranty from contract law to create a new kind of warranty.") [hereinafter "Comment, *Liability Without Fault*"]. The general criticism levied against the *Perlmutter* conclusion is that the court rendered a pure policy decision disguised under the veil of a sale/service distinction. *See* Comment, *Transfusion-Associated AIDS*, *supra* note 17, at 89. More specifically, commentators have suggested that the *Perlmutter* court characterized a transfusion as a service in order to provide a legal basis of protection for the blood industry against claims premised on implied warranty or strict liability. *Id.* at 90.

²⁷ *See supra* notes 23-26 and accompanying text (discussing strict liability cause of action).

It should also be noted that courts have held that strict liability does not apply in transfusion-related AIDS cases because blood and blood products fall within the "unavoidable unsafe product" exception to strict liability which is delineated in RESTATEMENT (SECOND) OF TORTS § 402(a) comment k. *See, e.g.,* Rodgers v. Miles Laboratories, Inc., 802 P.2d 1346, 1353 (Wash. 1991) (en banc). Under § 402(a) comment k, strict product liability is not applicable to those "products which in the present state of human knowledge, are quite incapable of being made safe for their intended and ordinary use . . . [S]uch a product, properly prepared, and accompanied by proper directions and warning, is not defective, nor is it *unreasonably* dangerous." *Id.* Consequently, in *Rodgers*, the court held that a plaintiff who contracted AIDS through the use of factor concentrate did not have a cause of action based upon strict liability because the relative value to society of this product outweighed the possible risks involved to the user. *Id.* at 1351. *Contra* Comment, *Liability Without Fault*, *supra* note 26, at 112-114 (liability without fault should always be applied in transfusion-related AIDS cases since it is "soundest and the most conscionable approach" to this problem). Moreover, the court in *Rodgers* also noted that, pursuant to comment k, although a manufacturer of an unavoidably unsafe product would not be liable under strict liability, if the manufacturer failed to warn of a defect of which it either knew or should have known about, it would be liable under the theory of negligence. *See Rodgers*, 802 P.2d at 1353.

B. Implied Warranty

Alternatively, a plaintiff may rely on the theory of implied warranty. Under section 2-314 of the Uniform Commercial Code, a seller of goods is liable for breach of implied warranty where the goods sold are not of merchantable quality.²⁸ Similarly, Section 2-315 imposes liability for breach of implied warranty when the goods sold are not fit for the particular purpose for which they were bought.²⁹ In an attempt to establish liability, a transfusion-related AIDS victim may argue that a blood supplier is bound by an implied warranty that the blood or blood product sold was fit for transfusion.³⁰ Recovery under this theory, however, is limited by several doctrines.³¹ One limitation is that the transaction must involve a "sale" of goods.³² Since almost every jurisdiction now characterizes a blood transfusion as a service and not a sale,³³ implied warranty, like strict liability, has also been of limited utility to a plaintiff.³⁴

²⁸ U.C.C. § 2-314 (1989).

²⁹ U.C.C. § 2-315 (1989).

³⁰ See, e.g., *Cutler v. Graduate Hosp.*, 717 F. Supp. 338 (E.D. Pa. 1989) (plaintiff argued blood supplier liable on theory of implied warranty for providing unfit product); *Roberts v. Suburban Hosp. Ass'n*, 73 Md. App. 1, 532 A.2d 1081 (Md. Ct. Spec. App. 1987) (same); *Howell v. Spokane & Inland Empire Blood Bank*, 785 P.2d 815 Wash. (1990) (en banc) (same).

³¹ See, e.g., U.C.C. § 2-314, 2-315 (1989) (there must be sale to create implied warranty); U.C.C. § 2-316 (1989) (implied warranty may be excluded or modified through use of disclaimers); U.C.C. § 2-607 (1989) (in order for buyer to preserve his remedies, buyer must notify seller within reasonable time of discovery of breach or be barred from recovery).

³² U.C.C. § 2-314 (1989). § 2-314 (1) states that "unless excluded or modified (Section 2-316), a warranty that goods shall be merchantable is implied in a contract for their sale if the seller is a merchant with respect to goods of that kind." *Id.* Similarly, U.C.C. § 2-315 presupposes that the transaction involves a sale of goods. § 2-315 states that:

Where the seller at the time of contracting has reason to know any particular purpose for which the goods are required and that the buyer is relying on the seller's skill or judgment to select or furnish suitable goods, there is unless excluded or modified . . . an implied warranty that the goods shall be fit for such purpose.

Id.

³³ See *supra* note 26 and accompanying text (discussing state "blood shield statutes" which characterize transactions as service).

³⁴ See, e.g., *Coffee v. Cutter Biological*, 809 F.2d 191, 193 (2d Cir. 1987) (Connecticut's blood shield statute precludes assertion of implied warranty against commercial producers of blood products); *Doe v. Travenol Laboratories, Inc.*, 698 F. Supp. 780, 783 (D. Minn. 1988) (Minnesota's blood shield statute protects processors of blood from being liable for breach of implied warranty); *Cutler v. Graduate Hosp.*, 717 F. Supp. 338, 339 (E.D. Penn. 1984) (Pennsylvania's blood shield statute requires dismissal of breach of implied warranty claim); *Miles Laboratories, Inc., Cutter Laboratories Div. v. Doe*, 315 Md. 704, 710, 556

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C. Negligence

A plaintiff will commonly pursue compensation based on a negligence theory given that strict liability and implied warranty claims will likely be dismissed.⁸⁶ To recover on this basis, plaintiff must prove that the defendant owed him a duty of care, that the defendant breached that duty, and that the breach was the proximate cause of the plaintiff's injury.⁸⁶

When an individual receives a blood transfusion, the duty owed to the recipient by the hospital, blood bank, or blood product manufacturer is determined by the standard of due care applicable to the industry at the time of the transfusion.⁸⁷ With regard to blood testing, "this standard is based upon the ability of the medical community to discover the disease, as well as the ability to de-

A.2d 1107, 1110 (1989) (Maryland's blood shield statute abrogates implied warranty claims against blood product suppliers); *Howell v. Spokane & Inland Empire Blood Bank*, 785 P.2d 815, 818 (Wash. 1990) (en banc) (Washington's blood shield statute precludes recovery on implied warranty claim).

⁸⁶ See *Ray v. Cutter Laboratories*, 744 F. Supp. 1124, 1127 (M.D. Fla. 1990) (contending that defendant was negligent for failing to utilize process which could detect and remove defect from blood); *Kozup v. Georgetown Univ.*, 663 F. Supp. 1048, 1055-56 (D.D.C. 1987) (asserting that defendants negligent by failing to screen blood and implement laboratory tests to eliminate contaminated blood), *modified*, 851 F.2d 437 (D.C. Cir. 1988). It therefore necessarily follows that negligence is the only viable cause of action for a transfusion-associated AIDS plaintiff. See Comment, *Hospital and Blood Bank Liability*, *supra* note 16, at 896; Comment, *Liability Without Fault*, *supra* note 26, at 112.

⁸⁷ See PROSSER & KEETON, *supra* note 23, at 164-65.

⁸⁷ See *Vuono v. New York Blood Center, Inc.*, 696 F. Supp. 743, 746-47 (D. Mass. 1988) ("negligent standard often requires that the actor's conduct could be tested against a background of ordinary usage and custom"); Comment, *Hospital and Blood Bank Liability*, *supra* note 16, at 889-90. Conformity with industry customs and standards, however, does not conclusively establish the absence of negligence, especially where such customs are clearly dangerous and careless. See *Vuono*, 696 F. Supp. at 747; RESTATEMENT (SECOND) OF TORTS § 295 comment c (1965) ("no group of individuals and no industry or trade can be permitted, by adopting careless and slipshod methods to save time, effort, or money, to set its own uncontrolled standard at the expense of the rest of the community"). The basis for the view that an industry standard or custom is not dispositive on the issue of negligence is the case of *The T.J. Hooper*, 60 F.2d 737 (2d Cir.), *cert. denied*, 287 U.S. 662 (1932). In *T.J. Hooper*, Judge Learned Hand opined:

There are, no doubt, cases where courts seem to make the general practice of the calling the standard of proper diligence; we have indeed given some currency to the notion ourselves Indeed in most cases reasonable prudence is in fact common prudence; but strictly it is never its measure; a whole calling may have unduly lagged in the adoption of new and available devices. It never may set its own tests, however persuasive be its usages. Courts must in the end say what is required; there are precautions so imperative that even their universal disregard will not excuse their omission.

Id. at 740.

velop an accurate, reliable, and generally accepted method for testing blood for such disease."³⁸

One obstacle facing a transfusion-related AIDS victim seeking to recover on the theory of negligence has been the inability to prove that a particular defendant failed to exercise reasonable care in the testing of AIDS-contaminated blood.³⁹ This difficulty stems from the fact that prior to the implementation of the enzyme-linked immunosorbent assay ("ELISA") test in 1985, there existed no recognized medical standard for determining whether donated blood was infected with the Human Immunodeficiency Virus ("HIV"), the virus which causes AIDS.⁴⁰ Consequently, virtually all pre-1985 transfusion recipients have been unable to prove that they contracted AIDS through negligent blood testing.⁴¹ Moreover, despite the adoption of the ELISA test as an industry standard, recovery for a post-1985 transfusion recipient remains difficult.⁴² A plaintiff must prove that a defendant either

³⁸ Comment, *Hospital and Blood Bank Liability*, *supra* note 16, at 889 (citing *Hutchins v. Blood Servs.*, 161 Mont. 359, 362-67, 506 P.2d 449, 451-53 (1973)).

³⁹ See Comment, *Hospital and Blood Bank Liability*, *supra* note 16, at 890 (discussing negligence cause of action).

⁴⁰ See C. Dale, N. Jones, J. Shampansky, *Blood Testing for Antibodies to the AIDS Virus: The Legal Issues 1*, in AIDS LEGAL, LEGISLATIVE, AND POLICY ISSUES 101 (N. Quist ed. 1990) (definition of HIV). Symptoms of HIV infection include:

unexplained weight loss; night sweats; blue or purple spots typical of Kaposi's sarcoma, or on mucous membranes; swollen lymph nodes lasting more than one month; persistent white spots or unusual blemishes in the mouth; fever greater than 99 [degrees] F for more than 10 days; persistent cough and shortness of breath; persistent diarrhea.

AIDS AND THE LAW, *supra* note 2, app. at 346. See also Comment, *Hospital and Blood Bank Liability*, *supra* note 16, at 879 n.23 ("[o]n March 2, 1985, the ELISA test for screening HTLV-III/LAV antibodies was licensed by the Food and Drug Administration (FDA). 50 Fed. Reg. 9909 (1985)"). For further discussion of the ELISA test, see *supra* notes 7-10.

⁴¹ See Comment, *Hospital and Blood Bank Liability*, *supra* note 16, at 890. See, e.g., *McKee v. Miles Laboratories, Inc.*, 675 F. Supp. 1060 (E.D. Ky. 1987). In *Miles*, decedent's widow brought suit against a supplier of blood coagulant, claiming that her husband's death from AIDS was caused by the use of the defendant's product. *Id.* at 1061. The decedent, however, was diagnosed as having AIDS over eighteen months before the ELISA test was even implemented. *Id.* Granting summary judgment to the defendant on the issue of negligence, the court held that the lack of any test to purify or screen blood or a blood by-product for the AIDS virus demonstrated that the blood supplier did not violate an industry standard of care. *Id.* at 1064.

⁴² See Comment, *Hospital and Blood Bank Liability*, *supra* note 16, at 891. See generally R. SHILTS, AND THE BAND PLAYED ON 539 (1987) (immediate distribution of ELISA test to over 2,300 blood banks and plasma centers following test's licensing suggests establishment of industry standard of care).

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failed to perform the ELISA test, improperly administered the test, or failed to discard blood it knew to be contaminated.⁴³ Such information, however, is entirely within the purview of the defendant,⁴⁴ highlighting the necessity for plaintiffs in transfusion-related AIDS cases to pursue discovery in order to depose the technicians and/or health-care providers who administered the testing procedure.

Further, despite assertions that a properly administered ELISA test is 100 percent sensitive,⁴⁵ the nub of the matter is that a negative test result will not preclude negligence on behalf of the defendant.⁴⁶ Specifically, given that HIV antibodies may be undetectable for nine to twelve months, a test performed during this latency period may not reveal the presence of the HIV virus.⁴⁷ It is therefore submitted that hospitals, blood banks, or blood product manufacturers have a duty to either re-test the blood before it is transfused, or delay acceptance of the donated blood for a nine to twelve month period. The need for blood suppliers to re-test or to delay acceptance becomes more pronounced when one considers that a plaintiff will often have to respond to a defendant's affirmative defense that the plaintiff was infected with AIDS by some other means than a blood transfusion.⁴⁸ In such a case, the mere fact that the donated blood tested HIV-negative will proba-

⁴³ See Comment, *Hospital and Blood Bank Liability*, *supra* note 16, at 891 (discussing negligence cause of action).

⁴⁴ *Id.* Unless a transfusion-related AIDS victim is able to gain access to information on testing procedures, the plaintiff will be unable to make out a prima facie case, and a court will then grant summary judgment to the defendant. See, e.g., *Stenger v. Lehigh Valley Hosp. Center*, 386 Pa. Super. 574, 588, 563 A.2d 531, 538 (1989).

⁴⁵ See Comment, *Transfusion-Associated AIDS*, *supra* note 17, at 100. This commentator noted that when the ELISA test is used in combination with the Western Blot analysis, the effective rate of detection for the AIDS antibodies is 100 percent. *Id.* See also *Kozup v. Georgetown Univ.*, 663 F. Supp. 1048, 1053 (D.D.C. 1987), *modified*, 851 F.2d 437 (D.C. Cir. 1988); *Mckee v. Miles Laboratories, Inc.*, 675 F. Supp. 1060, 1064 (E.D. Ky. 1987). Such a conclusion, however, is incorrect because the medical community has conclusively determined that the current AIDS tests are not 100 percent dispositive. See Weiss, et al., *Screening Test for HTLV-III (AIDS Agent) Antibodies*, 253 J. A.M.A. 221, 223-24 (1985) (ELISA test 98.6 percent specific and 97.3 percent sensitive for antibodies to HTLV-III/LAV). See generally, *supra* notes 7-10 (discussing merits of screening tests).

⁴⁶ See *supra* notes 7-10 and accompanying text (discussing ambiguity of test results).

⁴⁷ See *supra* notes 7-10 and accompanying text (discussing ambiguity of test results).

⁴⁸ See, e.g., *Stenger v. Lehigh Valley Hosp. Center*, 386 Pa. Super. 574, 578, 563 A.2d 531, 533 (1989) (in answer to complaint, defendant denied that plaintiff contracted AIDS from blood transfusion).

bly serve as a bar to recovery, unless the plaintiff is permitted to depose the donor to determine whether the blood supplier was negligent in the screening process.⁴⁹

Moreover, liability may be established if a plaintiff is able to prove that the defendant failed to implement, or negligently implemented the prevailing screening guidelines.⁵⁰ Although the first AIDS case was diagnosed in 1981,⁵¹ it was not until July of 1982 that the medical community became aware of the risk of transmission by blood transfusion, and suggested the implementation of certain preventive measures.⁵² In 1983, the United States

⁴⁹ See Comment, *Liability Without Fault*, *supra* note 26, at 91. Comment, *Hospital and Blood Bank Liability*, *supra* note 16, at 891-92.

⁵⁰ See, e.g., *Boutte v. Blood Sys., Inc.*, 127 F.R.D. 122, 125 (W.D. La. 1989) (plaintiff's claim requires proof that blood bank failed to adequately screen donor and test blood); *Kirkendall v. Harbor Ins. Co.*, 698 F. Supp. 768, 775 (W.D. Ark. 1988) (plaintiff must prove liability based on failure to perform proper testing), *aff'd* 887 F.2d 857 (8th Cir. 1989); *Mason v. Regional Medical Center of Hopkins County*, 121 F.R.D. 300, 301 (W.D. Ky. 1988) (discovery may lead to evidence of negligence in course of accepting, testing, using blood); *Kozup v. Georgetown Univ.*, 663 F. Supp. 1048, 1057 (D.D.C. 1987) (to prevail on negligence theory plaintiff must prove defendant violated an established standard of screening), *modified*, 851 F.2d 437 (D.C. Cir. 1988); *Belle Bonfils Memorial Blood Center v. District Court*, 763 P.2d 1003, 1007 (Colo. 1988) (plaintiff must prove negligence in screening and testing donors); *Doe v. New York Univ. Medical Center*, 561 N.Y.S.2d 326 (Sup.Ct. N.Y. County 1990) (plaintiff's claim requires proof that hospital failed to properly screen or implement adequate safeguards); *Tarrant County Hosp. Dist. v. Hughes*, 734 S.W.2d 675, 679 (Tex. Ct. App. 1987) (donor information needed to sue for failure to conform to standard of testing). For further discussion of blood suppliers' liability for negligent screening practices, see Williams, *supra* note 19, at 270-73; Comment, *Hospital and Blood Bank Liability*, *supra* note 16, at 891-94; Comment, *Liability Without Fault*, *supra* note 26, at 85-94.

⁵¹ See *supra* note 1 and accompanying text (discussing earliest known cases of AIDS).

⁵² See *Kozup v. Georgetown Univ.*, 663 F. Supp. 1048, 1051, 1052 (D.D.C. 1987), *modified*, 851 F.2d 437 (D.C. Cir. 1988). On July 27, 1982, representatives from the blood industry, hemophiliac groups, gay community organizations, CDC, FDA, and the National Institute of Health attended a conference in Washington, D.C., entitled an "Open Meeting of the Public Health Service on Opportunistic Infections in Patients with Hemophilia." *Id.* at 1051. At this meeting, evidence was presented that blood and blood by-products could be a possible mode of transmission of the AIDS virus. *Id.* The CDC was of the opinion that certain preventive measures should be adopted in order to curtail the potential spread of the AIDS virus. See SHILTS, *supra* note 42, at 170. These measures included donor deferral guidelines, and requested individuals who fit into the certain high-risk groups, such as homosexuals, Haitians, and drug users, not to donate blood. *Id.* Despite the new evidence of blood transmission, this conference issued no formal recommendation on donor screening. See *Kozup*, 663 F.Supp. at 1051.

On January 4, 1983, an ad hoc advisory committee for the United States Public Health Services (USPHS) consisting of representatives of many of the same organizations that had attended the July, 1982 conference on hemophilia and AIDS, met to discuss screening guidelines. *Id.* at 1051. One of the primary issues raised at this meeting was the use of the hepatitis antibodies test as a surrogate test for the AIDS virus. See SHILTS, *supra* note 42, at

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Public Health Service ("USPHS") formally issued screening guidelines for the blood industry.⁵³ These guidelines essentially amounted to a "voluntary self-deferral program" for potential donors in the high risk category.⁵⁴ Since the USPHS's recommendations were adopted by the blood industry as the standard of care, in order to recover a plaintiff would have to demonstrate that the blood supplier failed to properly implement these screening procedures, and as a consequence, plaintiff developed AIDS.⁵⁵ Again, information surrounding the circumstances of the donation can be obtained only from the donor himself or the screening interviewer.⁵⁶ However, only the impartial donor can supply the neces-

220-21. The purpose of a surrogate test is to search "for common elements between the disease for which the test was developed and that disease which does not yet have a test." Comment, *Liability Without Fault*, *supra* note 26, at 87. At this conference, a CDC virologist presented evidence that at least 80 percent of the AIDS-contaminated blood would test positive for hepatitis core antibodies. See SHILTS, *supra* note 42, at 221. The CDC therefore argued that the blood industry should implement surrogate testing since it would reduce drastically the threat of transmitting AIDS via a transfusion. *Id.* at 222. The conference, however, adjourned without issuing a recommendation for surrogate testing of donated blood due largely to the blood industry's belief that it would be financially prohibitive to implement this testing procedure. *Id.* at 223. It is interesting to note, however, that two blood banks in California implemented surrogate testing several months after the conference ended, and by June 1, 1984, such testing was routinely done by most non-profit blood banks through northern California. See *Synder v. Mekhjian*, 244 N.J. Super. 281, 289, 582 A.2d 307, 311 (N.J. Super. Ct. App. Div. 1990).

⁵³ See SHILTS, *supra* note 42, at 242-43.

⁵⁴ *Id.* According to these measures, members of the high-risk group were asked to refrain from donating blood or plasma. *Id.* The high-risk group, however, did not include all homosexuals, but "merely those who were sexually active, had overt symptoms of immune deficiency, or had engaged in sexual relations with people who did." *Id.* These guidelines also did not require the screening interviewers to identify and exclude members of the high-risk group through examinations of lymph glands and evaluating the donor's weight. See, Comment, *Liability Without Fault*, *supra* note 26, at 88. In addition, these guidelines did not suggest the use of surrogate testing, but rather called for studies to evaluate screening procedures. See SHILTS, *supra* note 42, at 242.

⁵⁵ See *Synder v. Mekhjian*, 244 N.J. Super. 281, 293, 582 A.2d 307, 313-14 (N.J. Super. Ct. App. Div. 1990) (allowing limited discovery to provide plaintiff access to information regarding screening procedures); Hermann, *AIDS: Malpractice and Transmission Liability*, 58 U. COLO. L. REV. 63, 81 (1986-87) (need for information regarding screening procedures).

⁵⁶ See *Quintana v. United Blood Servs.*, No. 86-CV-11750 (Denver Dist. Ct. June 3, 1988), *rev'd*, slip op. Colo. Ct. App. (Jan. 17, 1991) (1991 WESTLAW 3771, Allstates library); *Hospital and Blood Bank Liability*, *supra* note 16, at 891-94; Comment, *Liability Without Fault*, *supra* note 26, at 85-91. A transfusion-related AIDS victim could also recover damages under the theory of negligence if he could demonstrate the industry standard of care adopted by the blood supplier was itself negligent. See *Quintana v. United Blood Servs.*, No. 86-CV-11750 (Denver Dist. Ct. June 3, 1988), *rev'd*, slip op. Colo. Ct. App. (Jan. 17, 1991) (1991 WESTLAW 3771, Allstates library) (plaintiff can present evidence which demonstrates that screening and testing customs and practices in defendant's industry might

sary information regarding the interviewer's screening process, specifically, whether the interviewer failed to inquire if the donor had certain diseases or symptoms, especially those opportunistic infections which accompany AIDS.⁵⁷ This underscores the need to pursue discovery in order to ascertain whether proper screening procedures were utilized. Otherwise, absent discovery, plaintiff will be unable to establish two elements of his prima facie case: a lack of reasonable care and causation.⁵⁸

not have been reasonable and prudent); Comment, *Liability Without Fault*, *supra* note 26, at 88-94. See generally The T.J. Hooper, 60 F.2d 737 (2d Cir.), *cert. denied*, 287 U.S. 662 (1932) (conformity with industry standard is not dispositive on issue of negligence).

One commentator has suggested that the amount of AIDS-contaminated blood in the blood supply could have been significantly reduced had the blood industry adopted surrogate testing and mandatory exclusion of all persons in the high risk group, as the CDC had suggested, rather than a policy of voluntary self deferral. See Comment, *Liability Without Fault*, *supra* note 26, at 89; Cf. Hermann & Gorman, *Hospital Liability and AIDS Treatment: The Need for a National Standard of Care*, 20 U.C. DAVIS L. REV. 441, 464 (1987) (adopting CDC guidelines for standard of care in AIDS-related litigation would provide "efficient, clear, and authoritative basis for determining liability" since court would have definite and manageable reference point for determining whether hospital breached its duty at particular time).

⁵⁷ See, e.g., Synder v. Mekhjian 244 N.J. Super. 281, 295, 582 A.2d 307, 315 (N.J. Super. Ct App. Div. 1990); Belle Bonfils Memorial Blood Center v. District Court of Denver, No. 88SA45, 763 P.2d 1003, 1013 (1988) (masked donor information cards provide insufficient information relating to defendant's screening and testing procedures). See Comment, *Liability Without Fault*, *supra* note 26, at 91-92 (donor is only impartial source of information regarding screening procedures).

In situations where it is difficult for a plaintiff to gain knowledge of, or access to facts surrounding the defendant's conduct, courts have permitted plaintiffs to utilize the doctrine of *res ipsa loquitur*, which creates an inference that a defendant was negligent. See RESTATEMENT (SECOND) OF TORTS § 328D; PROSSER & KEETON, *supra* note 23, at 242-62. Plaintiffs in transfusion-related AIDS cases have attempted to argue that *res ipsa loquitur* should be employed to create an inference that a hospital, blood bank, or blood product manufacturer was negligent in screening potential blood donors. See, e.g., Howell v. Spokane & Inland Empire Blood Bank, 785 P.2d 815, 824 (Wash. 1990) (*res ipsa loquitur* not available where plaintiff has not shown hospital had exclusive control over transfused blood) (en banc). The doctrine of *res ipsa loquitur* requires that a defendant have exclusive control over the agency or instrumentality producing the injury, which in the case of transfusion-related AIDS, is the infected blood. See PROSSER & KEETON, *supra* note 23, at 249. Courts have determined, however, that the exclusive control requirement cannot be met in a transfusion case because no one defendant — whether a hospital, blood bank, or blood product manufacturer — can be said to have exclusive control over the donated blood. See Howell, 785 P.2d at 824. Consequently, AIDS-related plaintiffs are precluded from using *res ipsa loquitur* to establish that a blood supplier was negligent in screening potential blood donors. *Id.* See also Comment, *Transfusion-Associated AIDS*, *supra* note 17, at 97-98 (*res ipsa loquitur* inapplicable in transfusion-related AIDS cases since AIDS virus cannot conclusively be determined by scientifically validated test, negligence cannot be drawn solely from fact that individual received transfusion and later contracted AIDS).

⁵⁸ See, e.g., Boutte v. Blood Sys., Inc., 127 F.R.D. 122, 125-26 (W.D. La. 1989) (to prose-

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II. SCOPE OF DISCOVERY

Under Federal Rule of Civil Procedure 26, “[p]arties may obtain discovery regarding any matter, *not privileged*, which is relevant to the subject matter involved in the pending action.”⁵⁹ One issue raised is whether the records of a blood bank or hospital, which include the identity of the donor, as well as other donor medical information, are “privileged” within a patient-physician context, and therefore exempt from discovery under the Rule 26 exception.⁶⁰

A general ethical principle of medicine, which has been codified by various state legislatures, provides that a physician has a duty to maintain the confidentiality of communications made with a patient during the course of an examination.⁶¹ An unauthorized dis-

cutte claim plaintiff needs access to donor); *Belle Bonfils Memorial Blood Center*, 763 P.2d at 1013 (masked donor cards provide insufficient information to permit plaintiff to prosecute their claim); *Gulf Coast Regional Blood Center v. Houston*, 745 S.W.2d 557, 560 (Tex. Ct. App. 1988) (unless plaintiff is able to gain knowledge of relevant facts known by donor, plaintiff will have difficulty prosecuting claim); *Tarrant County Hosp. Dist. v. Hughes*, 734 S.W.2d 675, 679 (Tex. Ct. App. 1987) (without access to donor identity it is unlikely plaintiff can prosecute). See also Comment, *Liability Without Fault*, *supra* note 26, at 91-93. But see *Doe v. American Red Cross Blood Serv.*, 125 F.R.D. 646, 657 (D.S.C. 1989) (“society’s interest in maintaining an adequate and safe supply of volunteer blood, coupled with the donor’s interest in privacy, outweighs plaintiff’s interest in questioning the donor”); *Krygier v. Airweld, Inc.*, 137 Misc. 2d 306, 309, 520 N.Y.S.2d 475, 477 (Sup.Ct. Dutchess County 1987) (“Exposing donors to public scrutiny in order to determine what they may have told [blood bank] has only marginal utility in advancing the plaintiff’s theory of liability.”).

⁵⁹ FED. R. CIV. P. 26(b) (emphasis added).

⁶⁰ See *Doe v. American Red Cross Blood Serv.*, 125 F.R.D. 646, 651 (D.S.C. 1989) (South Carolina statutes aimed at preventing Department of Health from disclosing donor names does not render identity of donor absolutely privileged); *Belle Bonfils Memorial Blood Center*, 763 P.2d at 1007 (“one issue is whether the information sought is privileged”); McDonald, *Ethical Problems for Physicians Raised by AIDS and HIV Infection: Conflicting Legal Obligations of Confidentiality and Disclosure*, 22 U.C. DAVIS L. REV. 557, 573 n.104 (1988) (Federal Rules of Civil Procedure do not address issue of whether attorney of patient can seek information regarding patient from physician) [hereinafter *Ethical Problems*].

⁶¹ See SMITH, STATE AND FEDERAL STATUTORY PROTECTION OF CONFIDENTIALITY IN EPIDEMIOLOGIC AND HEALTH CARE SETTINGS 104 (1985). See, e.g., N.Y. CIV. PRAC. L. & R. § 4504 (McKinney Supp. 1990). The New York statute provides:

(a) Confidential information privileged. Unless the patient waives the privilege, a person authorized to practice medicine, registered professional nursing or dentistry . . . shall not be allowed to disclose any information which he acquired in attending a patient in a professional capacity, and which was necessary to enable him to act in that capacity.

Id. See also N.Y. PUB. HEALTH LAW Art. 31 (McKinney 1990). Article 31 of the New York State Public Health Law regulates human blood and transfusion services. The regulations concerning blood banks are codified at 10 NYCRR 58-2 *et. seq.* Section 58-2.10 addresses

closure by a physician of medical information concerning a patient could give rise to an action in tort for invasion of privacy.⁶² It should be emphasized that this privilege operates in court-related proceedings only.⁶³ Furthermore, as the privilege is statutory in nature,⁶⁴ many states have limited the scope of the privilege, largely curtailing its continued significance.⁶⁵ In addition, the

confidentiality:

the donor's name, address, telephone number, social security number and any other information which would directly or indirectly identify the blood donor of any specific unit shall not be disclosed by the blood bank to any person or entity except upon the written consent of the donor or except to the [New York State Department of Health].

Id.

⁶² See, e.g., *Horne v. Patton*, 291 Ala. 701, 704, 287 So. 2d 824, 825 (1973) (physician disclosed patient information to patient's employer); *Doe v. Roe*, 93 Misc.2d 201, 204, 400 N.Y.S.2d 668, 671 (Sup.Ct. N.Y. County 1977) (verbatim publication by psychiatrist of former patient's feelings, emotions, and fantasies along with diagnoses of the illness suffered); *Schaffer v. Spicer*, 88 S.D. 36, 38, 215 N.W.2d 134, 136 (1974) (psychiatrist's affidavit concerning mother's mental health given to father's attorney to be used in custody proceeding). Cf. *Anderson v. Strong Memorial Hosp.*, 140 Misc.2d 770, 775-76, 531 N.Y.S.2d 735, 740 (Sup.Ct. Monroe County 1988) (use of photograph), *aff'd* 151 App.Div.2d 1033, 542 N.Y.S.2d 96 (4th Dep't 1989). See generally M. GUNDERSON, D. MAYO & F. RHAME, *AIDS: TESTING AND PRIVACY—ETHICS IN A CHANGING WORLD* 75-93 (1989) (constitutional, common law, and statutory bases of privacy actions).

⁶³ See Weiss, *AIDS: Balancing the Physician's Duty to Warn and Confidentiality Concerns*, 38 EMORY L.J. 279, 286-87 (1989) (historical development of confidentiality).

⁶⁴ J. WIGMORE, *EVIDENCE IN TRIALS AT COMMON LAW* § 2380 (McNaughton rev. ed. 1970). At common law no privilege between physicians and patient was recognized. See *Chase v. Schmakadeka* (In re Goan), 83 Idaho 568, 575, 366 P.2d 831, 835 (1961) (physician-patient privilege is purely statutory creation, in derogation of common-law rule that physician could be compelled to disclose information acquired in treatment of patient); *Camperlengo v. Blum*, 56 N.Y.2d 251, 254, 436 N.E.2d 1299, 1300, 451 N.Y.S.2d 697, 698 (1982) (same) (citations omitted). In the absence of a statute to the contrary, no physician-patient privilege is recognized. See, e.g., *Peagler v. Atlantic Coast Line R.R. Co.*, 101 S.E.2d 821, 825-26 (S.C. 1958) (absent statute in South Carolina, common law rule prevails). See generally *Ethical Problems*, *supra* note 60, at 572 (whether various states recognize physician-patient privilege).

⁶⁵ C. McCORMICK, *EVIDENCE* § 98, 101-104 (2d ed. 1972) (some states do not recognize privilege at all, and in states where it exists by legislative enactment, it is subject to many exceptions and waivers for numerous reasons). Accord J. WIGMORE, § 2380, nn. 3, 5, and 6. See, e.g., *Holliday v. Harrows*, 91 App.Div.2d 1062, 1063, 458 N.Y.S.2d 669, 670 (2d Dep't 1983) (non-medical information not related to diagnoses or treatment is not privileged); *Williams v. Roosevelt Hosp.*, 66 N.Y.2d 391, 394, 488 N.E.2d 94, 97, 497 N.Y.S.2d 348, 351 (1985) ("privilege seeks to protect . . . confidential communications, not the mere facts and incidents of a person's medical history"); *Commonwealth ex. rel Platt v. Platt*, 266 Pa. Super. 276, 283-84, 404 A.2d 410, 414-15 (1979) (privilege not applicable to observations as opposed to communications). A considerable number of states limit the privilege to communications to the physician so far as "necessary to enable him to prescribe or act for the patient." See, e.g., *In re Zuniga*, 714 F.2d 632, 640 (6th Cir.) (as general rule, privilege does not cover patient identity), *cert. denied*, 464 U.S. 983 (1983); CAL.; *EVID. CODE* § 992 (Deer-

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privilege is limited in federal criminal cases and not recognized in non-diversity cases.⁶⁶

Applying this principle to the case of a transfusion-related AIDS victim attempting to prove the elements of a cause of action, it is important to distinguish medical technicians from physicians or professional nurses.⁶⁷ Courts addressing this issue have generally not extended the privilege to cover revelations made by patients to blood banks or hospitals because transfusions and blood tests in these facilities are often performed by non-physicians, and the information is often communicated to data-storage personnel.⁶⁸ Further, the argument for privilege becomes increasingly tenuous when a physician conveys patient information to hospital record administrators or independent data systems, given the apparent ease and likelihood of dissemination to other third parties.⁶⁹

ing 1990); N.Y. CIV. PRAC. L. & R. § 4504 (McKinney Supp. 1990).

⁶⁶ Gellman, *Prescribing Privacy: the Uncertain Role of the Physician in the Protection of Patient Privacy*, 62 N.C.L. REV. 255, 272 (1984) (regarding patient-physician privilege). See *Doe v. United States (In re Doe)*, 711 F.2d 1187, 1193 (2d Cir. 1983) ("since no doctor-patient privilege existed at common law . . . none exists in federal law"); *United States v. Meagher*, 531 F.2d 752, 753 (5th Cir.) (physician-patient privilege is limited in federal criminal trials), *cert. denied*, 429 U.S. 583 (1976). See also *United States v. Kansas City Lutheran Home and Hosp. Ass'n*, 297 F. Supp. 239, 244 (W.D. Mo. 1969) (court will not recognize physician-patient privilege unless Congress so mandates).

⁶⁷ See, e.g., *Belle Bonfils Memorial Blood Center v. District Court*, 763 P.2d 1003, 1009 (Colo. 1988) (person who interviewed donor was not a medically trained physician, surgeon, or professional nurse, nor were any present); *Tarrant County Hosp. Dist. v. Hughes*, 734 S.W.2d 675, 677 (Tex. Ct. App. 1987) ("[n]othing in the record reflects that the blood donors were seen by a physician or received medical care when they donated blood").

⁶⁸ See, e.g., *Doe v. American Red Cross Blood Servs.*, 125 F.R.D. 641, 651 n.7 (D.S.C. 1989) (holding that state statute does not prevent health history nurse from revealing the donor's identity); *Belle Bonfils Memorial Blood Center*, 763 P.2d at 1009 (finding that privilege does not include communications with medical technicians) (citing *Block v. People*, 125 Colo. 36, 240 P.2d 512 (1951), *cert. denied*, 343 U.S. 978 (1952)); *Stenger v. Lehigh Valley Hosp.*, 386 Pa.Super 574, 587, 563 A.2d 531, 537 (1989) (holding that patient-physician privilege is inapplicable where procedure was not performed by physician); *Tarrant County Hosp. Dist.*, 734 S.W.2d at 677 ("Nothing in the record reflects that blood donors were seen by physician or received medical care when they donated blood"); *But see United Blood Servs. v. Nevada Dist. Court*, No. 20375 (Nev. 1990) (patient-physician privilege exists between health care provider and blood donor privilege is not absolute) (unpublished).

⁶⁹ Boyer, *Computerized Medical Records and the Right to Privacy—The Emerging Federal Response*, 25 BUFFALO L. REV. 37, 49-51, 77 (1975). Some courts have concluded that patient records kept by certain institutions are not protected by the physician-patient privilege, either because of the public nature of the institutions involved or because records were kept pursuant to a public requirement. See, e.g., *Commonwealth v. Korbin*, 395 Mass. 284, 292-93, 479 N.E.2d 674, 681 (1985) (information kept for Medicaid purposes not privileged). Other courts have made no distinction between private and public institutions. See,

A second issue raised is whether a blood bank or hospital can obtain a protective order limiting the scope of discovery.⁷⁰ Federal Rule of Civil Procedure 26(c) specifically provides that courts "may make any order which justice requires to protect a party from annoyance, embarrassment, oppression, or undue burden or expense"⁷¹

Given the breadth of the protective provision of Rule 26(c), a court has ample power to protect claims of privacy.⁷² Blood banks and hospitals argue that public disclosure of the blood donor's possible affliction with AIDS would subject that individual to such public harassment and discrimination as to warrant a protective order prohibiting discovery.⁷³ The threat of such harassment was a key factor motivating several courts to deny discovery of the donor's identity.⁷⁴ It must be emphasized, however, that these courts premised their decisions on the likelihood of revelation of donor identity resulting from discovery.⁷⁵ This assumption is inaccurate

e.g., *Matter of Handicapped Child*, 118 Misc.2d 137, 139, 460 N.Y.S.2d 256, 258 (Sup.Ct. Erie County 1983) (records kept at public psychiatric facility privileged).

⁷⁰ See AIDS LEGAL GUIDE 4-8 to 4-9 (A.R. Rubinfeld 2d ed. 1987). "Discovery orders do constitute state action and therefore must respect all applicable constitutional limits, including rights of privacy, informational privacy, and due process." *Id.* at 4-8.

⁷¹ FED. R. CIV. P. 26. (emphasis added).

⁷² See WRIGHT & MILLER, FEDERAL PRACTICE AND PROCEDURE: CIVIL § 2036, at 267 (West 1970) ("Rule 26(c) was adopted as a safeguard for the protection of parties and witnesses in view of the almost unlimited right of discovery given by Rule 26(b)"); *Marrrese v. American Academy of Orthopaedic Surgeons*, 726 F.2d 1150, 1159 (7th Cir. 1984) (en banc) (regarding court discretion in this area), *rev'd on other grounds*, 470 U.S. 373 (1985). The court stated that "a motion under Rule 26(c) to limit discovery requires the district judge to compare hardship to the party against whom discovery is sought, if discovery is allowed, with the hardship to the party seeking discovery, if discovery is denied." *Id.* See also *Collins & Aikman Corp. v. J.P. Stevens & Co.*, 51 F.R.D. 219, 221 (D.S.C. 1971) (need for limited discovery in circumstances where harassment to third parties would likely result).

⁷³ See generally L. TRIBE, AMERICAN CONSTITUTIONAL LAW 1394-95 (2d ed 1988) (association with AIDS amounts to "grievous stigma and the source of much discrimination and harassment"). *Accord* Brandt, *Aids: From Social History to Social Policy*, 14 L. MED. & HEALTH CARE 231, 234 (1986). See also Comment, *AIDS: A Legal Epidemic?*, 17 AKRON L. REV. 717, 735 (1984) (man in California—who was rumored to, but did not have AIDS—was fired from his job, received abusive phone calls, and had his house set on fire).

⁷⁴ See, *e.g.*, *Coleman v. American Red Cross*, 130 F.R.D. 360, 362 (E.D. Mich. 1990) (denying discovery in light of record of discrimination against persons identified with AIDS in jobs, housing and health care services); *Doe v. American Red Cross Blood Servs.*, 125 F.R.D. 646, 652 (D.S.C. 1989) (citations omitted); *Rasmussen v. Southern Florida Blood Serv.*, 500 So.2d 533, 537 (Fla. 1987) ("[d]isclosure of donor identities in any context involving AIDS could be extremely disruptive and even devastating to the individual donor").

⁷⁵ See *Rasmussen*, 500 So.2d at 537; *Coleman*, 130 F.R.D. at 362; *Doe*, 125 F.R.D. at 652.

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for two reasons. First, it underestimates the ability of the court to order limited anonymous discovery to contain such public revelation.⁷⁶ Second, it ignores the possibility that the donor may be deceased, in which case privacy issues would be of less import.⁷⁷

III. DONOR'S INFORMATIONAL RIGHT TO PRIVACY

The right of privacy is a relatively new development in the common law.⁷⁸ In 1890, Samuel Warren and Louis Brandeis, noting that "political, social, and economic changes entail the recognition of new rights,"⁷⁹ explored this concept and asserted that "the individual is entitled to decide whether that which is his shall be given to the public."⁸⁰ It was upon this foundation that the tort right of invasion of privacy evolved.⁸¹ Despite all the scholarship on this subject, it was the effort of William Prosser who, "without

⁷⁶ See *infra* notes 149-167 and accompanying text (cases allowing discovery).

⁷⁷ See RESTATEMENT (SECOND) OF TORTS § 652I. Section 652I provides: except for the appropriation of one's name or likeness, an action for invasion of privacy can be maintained only by a living individual whose privacy is invaded. *Id.* See *Lugosi v. Universal Pictures*, 25 Cal. 3d 813, 824, 160 Cal. Rptr. 323, 329, 603 P.2d 425, 431 (1979) (action for invasion of privacy did not survive death and could not be asserted by anyone other than person whose privacy has been invaded). See generally PROSSER AND KEETON, *supra* note 23, § 117, at 849.

⁷⁸ See T. COOLEY, TORTS at 91 (2d. ed. 1888) (first to recognize "right to be let alone"). While not expressly provided for in the Constitution, several state constitutions have explicitly recognized the individual's right to privacy, including Alaska, California, Florida, Hawaii, Illinois, and Montana. See AIDS LEGAL GUIDE 4-3 (A. Rubinfeld ed. 1987). Several other states have acknowledged a limited right to privacy, including New York, Massachusetts, and Pennsylvania. *Id.* (citing *Sexual Orientations and the Law* § 11.06(1)(d)(viii) (R. Achtenberg ed. 1985)). See generally Note, *Toward a Right of Privacy as a Matter of State Constitutional Law*, 5 FLA. ST. U.L. REV. 631, 690-729 (1977) (right to privacy under state constitutions); Feigler, *The Use of the State Constitutional Right to Privacy to Defeat State Sodomy Laws*, 14 N.Y.U. REV. L. & SOC. CHANGE 973, 980-83 (1986) (same).

⁷⁹ Warren & Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193, 193 (1890).

⁸⁰ *Id.* at 199. In considering the limitations of this right, and what remedies may be invoked for its enforcement, the authors posited:

[t]he design of the law must be to protect those persons with whose affairs the community has no legitimate concern, from being dragged into undesirable publicity and to protect all persons, whatsoever; their position or station, from having matters which they may properly prefer to keep private, made public against their will.

Id. at 214-15. Cf. Bloustein, *Privacy, Tort Law and the Constitution: Is Warren and Brandeis' Tort Petty and Unconstitutional as Well?*, 46 TEX. L. REV. 611 (1978) (criticism of tort of privacy); Kalven, Jr., *Privacy in Tort Law — Were Warren and Brandeis Wrong?*, 31 LAW & CONTEMPORARY PROBLEMS 326, 328 (1966) (suggests right to privacy is petty tort).

⁸¹ See Prosser, *Privacy*, 48 CALIF. L. REV. 383, 386 (1960). See also W. PROSSER, HANDBOOK OF THE LAW OF TORTS § 117 (4th ed. 1971) (discusses acceptance of views of Brandeis and Warren).

any attempt to exact definition,"⁸³ organized the case law into the four categories which have come to be recognized as the current torts of privacy.⁸³

The United States Supreme Court initially examined the right to privacy in the seminal case of *Olmstead v. United States*,⁸⁴ which focused upon whether the fourth amendment protected against non-trespassory government intrusions by means of a wiretap.⁸⁵ Chief Justice Taft's majority opinion adopted a strict construction of the amendment, and denied recognition of a privacy right under the circumstances.⁸⁶ Justice Brandeis, on the other hand, emphasized a liberal construction of the amendment, which would "protect . . . [against] every unjustifiable intrusion by the government upon the privacy of the individual, whatever the means employed."⁸⁷

While the Supreme Court has never fully accepted Justice Brandeis' dissenting opinion,⁸⁸ his expansive view of the right to privacy proved to be the cornerstone of subsequent rulings in this

⁸³ Prosser, *Privacy*, *supra* note 81, at 389.

⁸⁴ See RESTATEMENT (SECOND) OF TORTS § 652 A-E 1977 (adopting Prosser's categories). The four interests and torts Prosser proffered included: (1) intrusions upon plaintiff's seclusion or solitude, or into his private affairs; (2) public disclosure of embarrassing private facts about plaintiff; (3) publicity that places the plaintiff in a false light; and (4) appropriation for the defendant's advantage of the plaintiff's name or likeness. *Id.* For one commentator's criticism of Prosser's classification scheme, see generally Bloustein, *Privacy as an Aspect of Human Dignity: An Answer to Dean Prosser*, 39 N.Y.U. L. REV. 962, 1003 (1964) ("injury is to our individuality, to our dignity as individuals, and the legal remedy represents a social vindication of the human spirit thus threatened rather than a recompense for the loss suffered").

⁸⁵ 277 U.S. 438 (1928).

⁸⁶ *Id.* at 456-57.

⁸⁷ *Id.* at 465. One commentator explained the decision, stating:

In effect, the majority looked upon the Fourth Amendment as a guaranty against a particular method of invading privacy or personal security—as a ban on physical intrusion of the house and seizure of material objects—rather than a protection of the right of privacy itself. . . ."

William Beany, *The Constitutional Right of Privacy*, 1962 SUP. CT. REV. 212, 219.

⁸⁸ *Olmstead*, 277 U.S. at 478. Justice Brandeis endeavored to extend the traditional search and seizure concepts of the fourth amendment to intangible property such as information. *Id.*

⁸⁹ See, e.g., *United States v. Payner* 447 U.S. 727 (1980) (tax returns); *Dalia v. United States*, 441 U.S. 238 (1979) (warranted electronic surveillance); *Whalen v. Roe*, 429 U.S. 589 (1977) (prescription drug records); *California Bankers Ass'n v. Schultz*, 416 U.S. 21 (1974) (bank records). See generally D. O'BRIEN, *PRIVACY, LAW, AND PUBLIC POLICY* 53 (1979) (Supreme Court never accepted Brandeis' liberal construction of fourth amendment).

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area.⁸⁰ The Supreme Court later came to recognize a “zone of privacy” in two areas: first, in the disclosure of personal matters,⁸⁰ and second, in the independence of various types of decision-making.⁸¹

The breadth of the constitutional protection of an individual’s informational right to privacy in matters concerning public disclosure of personal information remains unclear, largely because the Supreme Court has yet to expound on the specific expanse of the privacy right and lower courts have differed in their treatment of the issue.⁸²

⁸⁰ See, e.g., *Cruzan v. Director, Missouri Dep’t of Health*, 110 S. Ct. 2841 (1990) (right to refuse medical treatment); *Roe v. Wade*, 410 U.S. 113 (1973) (right to abortion); *Stanley v. Georgia*, 394 U.S. 557 (1969) (right to receive medical information). *But see*, e.g., *Skinner v. Railway Labor Executive Ass’n*, 489 U.S. 602 (1989) (employee drug testing); *Bowers v. Hardwick*, 478 U.S. 186 (1986) (sodomy laws). See generally Posner, *The Uncertain Protection of Privacy by the Supreme Court*, 1979 SUP. CT. REV. 173, 181. The Supreme Court overruled the *Olmstead* decision in 1967. See *Katz v. United States*, 389 U.S. 347, 353 (1967).

⁸¹ See, e.g., *Detroit Edison Co. v. NLRB*, 440 U.S. 301, 318-19 (1978) (recognizing privacy interest as to certain employment examination results); *Nixon v. Administrator of Gen. Servs.*, 433 U.S. 425, 465 (1977) (regarding President’s privacy right relating to certain documents); *Whalen v. Roe*, 429 U.S. 589, 598-600 (1977) (recognizing “individual interest in avoiding disclosure of personal matters”).

While commentators have advanced differing definitions of privacy, one theme common to many of the definitions offered has been the individual’s right of control over personal information. See A. MILLER, *ASSAULT ON PRIVACY* 25 (1971) (privacy is “the individual’s ability to control the circulation of information relating to him”); Fried, *Privacy*, 77 *YALE L.J.* 475, 482-83 (1965) (“privacy is not simply an absence of information about us in the minds of others; rather it is the control we have over information about ourselves The person who enjoys privacy is able to grant or deny access to others”); Gerety, *Redefining Privacy*, 12 *HARV. C.R.-C.L. L. REV.* 233, 236 (1977) (“privacy [is] . . . autonomy or control over the intimacies of personal identity”); Gross, *The Concept of Privacy*, 47 *N.Y.U. L. REV.* 34, 53 (1967) (“privacy is the condition of human life in which acquaintance with a person or with affairs of his life which are personal to him is limited”); Parker, *A Definition of Privacy*, 27 *RUTGERS L. REV.* 275, 280-81 (1974) (“privacy is control over whom and by whom the various parts of us can be sensed by others It is control over the sort of information found in dossiers and data banks”).

⁸² See, e.g., *Roe v. Wade*, 410 U.S. 113, 152-53 (1973) (right to privacy encompasses woman’s right to terminate pregnancy); *Stanley v. Georgia*, 394 U.S. 557, 568 (1969) (“zone of privacy” extends to reading and viewing materials in one’s home); *Griswold v. Connecticut*, 381 U.S. 479, 485-86 (1965) (marital right to privacy extends to contraceptive use).

⁸³ See *Whalen*, 429 U.S. at 602-06; *Nixon*, 433 U.S. at 457-58. While the Supreme Court has previously focused on the privacy interest of disclosing information to the government, the Court did not delineate the scope of constitutional protection relating to public dissemination of information to the public. *Id.* See also *Kimberlain v. United States Dep’t of Justice*, 788 F.2d 434, 438 (7th Cir. 1986) (extent of right of informational privacy has yet to be fully defined); *Barry v. City of New York*, 712 F.2d 1554, 1558 (2d Cir.), *cert. denied*, 464 U.S. 1017 (1983).

For examples of lower court decisions discussing the individual’s informational right to

In the context of transfusion-related AIDS cases, a court must be particularly sensitive to the donor's right to privacy—to keep his identity and medical history confidential—because the possession of such information by unauthorized persons raises the possibility of discrimination against the AIDS carrier, particularly in the insurance and employment areas.⁹³ Insurers, wary of covering the high costs associated with medical treatment of AIDS patients, have sought to screen for high risk groups to avoid providing coverage to potential AIDS victims.⁹⁴ Similarly, some employers have

privacy, see, *J.P. v. DeSanti*, 653 F.2d 1080, 1090 (6th Cir. 1981) (allowing compilation of juvenile information); *St. Michael's Convalescent Hosp. v. California*, 643 F.2d 1369, 1371-72 (9th Cir. 1981) (statute which mandated disclosure of information related to medical program's costs did not violate informational right of privacy); *United States v. Westinghouse*, 638 F.2d 570, 580 (3d Cir. 1980) (government's interest in medical records outweighed employees' privacy interest); *McElrath v. Califano*, 615 F.2d 434, 441 (7th Cir. 1980) (rejecting claim disputing regulations requiring disclosure of social security number as condition to welfare); *Plante v. Gonzales*, 575 F.2d 1119, 1137 (5th Cir. 1978) (using balancing test, court held that state's interest in disclosure outweighed Senator's privacy interest), *cert. denied*, 439 U.S. 1129 (1979); *Williams v. Thomas Jefferson Univ.*, 343 F. Supp. 1131, 1132 (E.D. Pa. 1972) (denying discovery of names of women who had abortions at defendant hospital's facilities); *Head v. Colloton*, 331 N.W.2d 870, 876 (Iowa 1983) (denying discovery of identity of potential bone marrow donor).

⁹³ See *Wash. Post Nat'l Weekly Ed.*, Dec. 23, 1985, at 37, col. 1 (quarantine of AIDS patients). In a nation where more than one in four Americans favors putting people with AIDS into quarantine to keep them away from the general public, the likelihood of discrimination against and the consequent need to protect the privacy of AIDS carriers and victims is apparent. *Id.* See also Schatz, *The AIDS Insurance Crisis: Underwriting or Overreaching?*, 100 HARV. L. REV. 1782, 1784 (1897) (examples of discrimination).

In 1988, the Presidential Commission on the Human Immuno-deficiency Virus, established by the executive order of President Reagan in June 1987, issued a report detailing the Commission's findings and recommendations on how to prevent discrimination against HIV-infected persons. Banks, *AIDS and Government: A Plan of Action?*, 87 MICH. L. REV. 1321, 1326 (1989). The report stated:

HIV-related discrimination is impairing this nation's ability to limit the spread of the epidemic Public health officials will not be able to gain the confidence and cooperation of infected individuals or those at high risk for infection if such individuals fear that they will be unable to retain their jobs and their housing, and that they will be unable to obtain the medical and support services they need because of discrimination based on a positive HIV antibody test.

Id. (citing REPORT OF THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC 119 (1988)) [hereinafter "COMMISSION REPORT"].

The Commission, however, rejected the idea of proposing anti-discrimination protection specifically tailored for HIV-carriers, but added that in "the long term, federal legislation which clearly provides comprehensive anti-discrimination protection for all persons with disabilities, including those with HIV-infection, is needed." *Id.* at 1326 n.26 (citing COMMISSION REPORT, at 121). The Commission also recommended that the President issue an executive order barring discrimination against persons with AIDS by establishing HIV-infection as a handicapping condition. *Id.* (citing COMMISSION REPORT, at 121).

⁹⁴ See Schatz, *supra* note 93, at 1786 (weighing public policy with financial concerns of

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fired AIDS victims in order to avoid paying higher insurance premiums and to protect against the perceived threat of transmission to other employees.⁹⁵ Moreover, unauthorized disclosure of AIDS-identifying information may have a devastating impact on the victim's personal relationships since many persons,⁹⁶ being misinformed about methods of transmission, view AIDS as a "modern day leprosy."⁹⁷

One issue raised is whether the donor's constitutional right to privacy would serve to bar a transfusion recipient infected with AIDS from discovering the donor's name and/or AIDS-identifying medical records, necessary to pursue a cause of action.⁹⁸ The majority of courts which have addressed the constitutional issue of a blood donor's informational right to privacy have allowed discovery.⁹⁹

insurance industry); Note, *AIDS Antibody Testing and Health Insurance Underwriting: A Paradigmatic Inquiry*, 49 OHIO ST. L.J. 1059 (1989) (insurance and discrimination). Insurers have made efforts to avoid the cost of AIDS by testing for HIV and by identifying and rejecting high risk applicants. Schatz, at 1805. The insurance industry has used underwriting methods to reject an unprofitable burden and shift it onto the government. *Id.* It is preferable to place responsibility on the insurance industry because it is better able to evenly distribute the costs of AIDS. *Id.* at 1804.

⁹⁵ See Leonard, *Employment Discrimination Against Persons with AIDS*, 10 U. DAYTON L. REV. 683, 687-89 (1985) (effect of AIDS on workplace).

⁹⁶ See Gray & Melton, *The Law and Ethics of Psychosocial Research on AIDS*, 64 NEB. L. REV. 637, 655-60 (1985). Disclosure of this information "often concerns the most intimate and embarrassing details of a patient's life, and [its] public exposure may well strip him of much of his own sense of human dignity." *Id.* at 655. Persons with AIDS are often shunned due to fear of catching AIDS and its stigma. *Id.* at 656. See also Note, *AIDS: A Crisis in Confidentiality*, 62 S. CAL. L. REV. 1701, 1708-09 (1989). Being diagnosed as having AIDS is exactly the kind of personal information that leads to discrimination and ostracism. *Id.* Much of this behavior results from the fact that AIDS is often acquired through conduct which is not acceptable to much of our society. *Id.*

⁹⁷ See Rasmussen v. Southern Fla. Blood Servs., 500 So. 2d 533, 537 (Fla. 1987).

⁹⁸ See *supra* notes 35-58 and accompanying text (discussing need for discovery).

⁹⁹ See Stenger v. Lehigh Valley Hosp., 386 Pa. Super. 574, 587-88, 563 A.2d 531, 534-35 (Pa. Super. Ct. 1989) (limited discovery from donor whose identity was protected would not constitute an impermissible violation of donor's right to privacy); Mason v. Regional Medical Center of Hopkins County, 121 F.R.D. 300, 303 (W.D. Ky. 1988) (no constitutional protective right of privacy preventing disclosure of blood donor information, however, donor's identity would be kept confidential and revealed only to limited number of persons); Gulf Coast Regional Blood Center v. Houston, 745 S.W.2d 557, 560-61 (Tex. Ct. App. 1988) (plaintiff's right to discover donor's identity outweighs donor's right to privacy); Tarrant County Hosp. Dist. v. Hughes, 734 S.W.2d 675, 679 (Tex. Ct. App. 1987) (court order compelling hospital to identify blood donors not impermissible violation of donors' right to privacy); In Re Complex Blood Litig., No 908843, (Cal Super. Ct. San Francisco County 1990) (limited discovery under protective order allows access to information concerning facts and circumstances surrounding donation, but prohibiting disclosure

To date, one case, *Rasmussen v. Southern Florida Blood Services*,¹⁰⁰ has held that the right of privacy as expressed in a state constitution encompasses the disclosure of donor identity, and therefore denied discovery.¹⁰¹ *Rasmussen*, however, is distinguishable from the majority of cases on point, given that Florida's constitution Revision Commission specifically amended the state's constitution with the right of informational privacy in mind.¹⁰² The court pointed out that "a principal aim of the constitutional provision is to afford individuals some protection against the increasing collection, retention, and use of information relating to all facets of an individual's life."¹⁰³

Furthermore, the facts of *Rasmussen* are distinguishable from other cases since the subpoena sought by petitioner would supply unrestricted access to the names and addresses of the blood donors with no limitations on potential revelation to the public.¹⁰⁴ Consequently, the court reasoned that the potential for discrimination or harassment against the donor stemming from such unrestricted discovery mandated the denial of plaintiff's discovery request.¹⁰⁵

A second related issue is whether a health care provider has a duty to disclose AIDS-related information to third parties—whether or not a constitutional protection of informational privacy exists—to initially alert the transfusion recipient of the potential transmission of HIV from a previous transfusion.¹⁰⁶

of donor identity, not violative of constitutional privacy grounds); *Contra Taylor v. West Pa. Hosp.*, No. GD87-00206, (Pa. D & C. 3d 1987) (unpublished) (denying discovery on constitutional privacy grounds).

¹⁰⁰ 500 So. 2d 533 (Fla. 1987).

¹⁰¹ *Id.* at 535-36.

¹⁰² *Id.* at 535.

¹⁰³ *Id.*; see FLA. CONST. Art. V, § 23. The Florida Constitutional amendment provides: Right of Privacy—Every natural person has the right to be let alone and free from governmental intrusion into his private life except as otherwise provided herein. This section shall not be construed to limit the public's right of access to public records and meetings as provided by law.

Id.

¹⁰⁴ *Rasmussen*, 500 So. 2d at 537.

¹⁰⁵ *Id.*

¹⁰⁶ See PROSSER AND KEETON, *supra* note 23, § 53, at 357. In determining whether a physician's failure to warn a third party in such circumstances is actionable, the general common law provided that "no action could be founded upon the breach of a duty owed only to some person other than plaintiff. He must bring himself within the scope of a definite

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Since *Tarasoff v. Regents of the University of California*¹⁰⁷ was decided in 1976, courts have held that in a health care context physicians have a duty to protect third parties from potential injury through disclosure of information regarding a patient, including a duty to warn the identified non-patient.¹⁰⁸ In the area of disease transmission, it is well established that a physician may be liable in tort for failure to warn third parties at risk that the patient has a contagious disease.¹⁰⁹ Generally, this duty is limited to informing

legal obligation . . . 'Negligence in the air, so to speak, will not do.' " *Id.* However, an exception to the rule applies in cases where defendant has a protective or custodial relationship with a person whose conduct requires control. RESTATEMENT (SECOND) OF TORTS § 315. The Restatement provides that a duty of care may arise where:

(a) a special relation . . . between the actor and the third person . . . imposes a duty upon the actor to conduct, or (b) a special relation [exists] between the actor and the other which gives rise to the other a right of protection.

Id. See also Harper & Kime, *The Duty to Control the Conduct of Another*, 43 YALE L.J. 886, 887 (1934) ("there is ordinarily no duty to act for the protection of others").

¹⁰⁷ 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14. (1976).

¹⁰⁸ See *Tarasoff*, 17 Cal.3d at 435, 131 Cal.Rptr. at 23, 551 P.2d at 335 (psychiatrist has duty to warn potential third parties of potential dangerous patient). The *Tarasoff* court balanced a number of considerations, including:

the foreseeability of harm to the plaintiff, the degree of certainty that the plaintiff suffered injury, the closeness of the connection between the defendant's conduct and the injury suffered, the moral blame attached to the defendant's conduct, the policy of preventing future harm, the extent of the burden to the defendant and the consequences to the community of imposing a duty to exercise care with resulting liability for breach, and the availability, cost, and prevalence of insurance for the risk involved.

Id. at 434, 151 P.2d at 342, 131 Cal. Rptr. at 22.

For further case law following the *Tarasoff* holding, see Jablonski: *ex rel. Pahls v. United States*, 712 F.2d 391, 398 (9th Cir. 1983) (psychiatrists' failure to warn girlfriend that mental patient's violence was likely to be directed at her was proximate cause of victim's death); Lipari v. Sears, Roebuck & Co., 497 F. Supp. 185, 190 (D. Neb. 1980) (therapist must initiate whatever precautions are reasonably necessary to protect potential victims of patient when therapist knows or should know patient presents unreasonable risk of harm to others); Bradley Center, Inc. v. Wessner, 296 S.E.2d 693, 696 (Ga. 1982) (private mental health hospital liable in wrongful death action for issuing unrestricted weekend pass to patient despite patient's previously manifested intent to kill victim); Irwin v. Town of Ware, 392 Mass. 745, 761, 467 N.E.2d 1292, 1303-04 (1984) (town liable for negligence when police officers failed to take into protective custody motorist who subsequently struck and injured plaintiffs).

For various commentators' discussion of the implications of the *Tarasoff* decision, see Note, *The Duty to Warn Third Parties: A Retrospective on Tarasoff*, 18 RUTGERS L.J. 145, 165 (1986) (*Tarasoff* doctrine should be refined to reflect societal and professional realities); Note, *Standard of Care, Duty, and Causation in Failure to Warn Actions against Mental Health Professionals*, 11 VT. L. REV. 343, 344 (1986) (disagreeing with Vermont's extension of *Tarasoff* doctrine); Note, *Extending a Psychotherapist's Duty to Warn Beyond Protecting Life: Who Should Lock the Barn Door?*, 11 VT. L. REV. 353, 360 (1986) (same).

¹⁰⁹ See, e.g., Davis v. Rodman, 227 S.W. 612, 614 (Ark. 1921) (physician has duty to

known parties at risk.¹¹⁰

It is submitted that the *Tarasoff* and contagious disease cases are analogous to the situation presented in known HIV-positive blood transfusion cases.¹¹¹ That is, as HIV is known to be transmissible by blood contact,¹¹² physicians have a duty to warn recipients of blood from donors, later identified as HIV-positive, of the potential risk¹¹³ of developing AIDS.¹¹⁴

instruct family members, nurses, and medical staff of patient's typhoid fever); *Skillings v. Allen*, 143 Minn. 323, 325, 173 N.W. 663, 663 (1919) (duty to warn family member of patient's scarlet fever infection); *Simonsen v. Swenson*, 104 Neb. 224, 226, 177 N.W. 831, 832 (1920) (physician's warning to third party not breach of confidentiality); *Wojcik v. Aluminum Co. of Am.*, 18 Misc. 2d 740, 746-47, 183 N.Y.S.2d 351, 358 (Sup. Ct. Erie County 1959) (duty to warn family).

¹¹⁰ *Id.* at 746, 183 N.Y.S.2d at 357-58.

¹¹¹ See Note, *The Conflict Between a Doctor's Duty to Warn a Patient's Sexual Partner that the Patient has AIDS and A Doctor's Duty to Maintain Patient Confidentiality*, 45 WASH. & LEE L. REV. 355, 374 (1988) (*Tarasoff* and related cases discuss doctors' dilemma in balancing patients' confidentiality and privacy rights with duty to inform others).

¹¹² See 34 MORBIDITY & MORTALITY WEEKLY REP. 561 (1985) (relating contraction of AIDS virus to blood transfusion, sexual contact and needle injuries to hospital employees); 34 MORBIDITY & MORTALITY WEEKLY REP. 575 (1985) (contraction of AIDS "in intravenous drug users, blood transfusion recipients and persons with hemophilia . . . occurs via infectious blood or blood products"); 33 MORBIDITY & MORTALITY WEEKLY REP. 181, 181-82 (1984) (health-care workers at risk of contracting AIDS only when exposed to blood of AIDS patients and not through casual contact, airborne spread or occupational tasks); Seligan and Gosnell, *AIDS: Myths and Reality*, NEWSWEEK, Sept. 23, 1985, at 20-21. The proven methods of transmission include sexual or blood-stream contact with an infected person; there is, as yet, no evidence that the virus can be transmitted through casual contact, saliva, tears, or air. *Id.*

¹¹³ See Ward, Letter to the Editor, 322 NEW ENG. J. OF MED. 755 (1990) (citing J. Mosley, et al. *The Transfusion Safety Study*, in Department of Health and Human Services, *Abstracts of the International Conference on AIDS* 160 (1987) (not all HIV-positive blood recipients become HIV-positive themselves)). In Ward's study, of the 38 recipients of blood from an HIV-positive donor, 36 became infected with HIV. *Id.* It is not known what factors caused these two blood recipients not to become HIV-positive. *Id.*

¹¹⁴ See Curran, Clark, & Gostin, *AIDS: Legal and Policy Implications of the Application of Traditional Disease Control Measures*, 15 LAW, MED. & HEALTH CARE 27, 29 (1987). The need for such notification is analogous to the justification for state law or public health regulations providing for "contact-tracing" of sexual partners of persons diagnosed with AIDS. *Id.* at 30-31. Contact-tracing is a means used by public health agencies to identify and locate susceptible contacts of an individual known to be infected with a communicable disease. *Id.* See also Gostin & Ziegler, *A Review of AIDS-Related Legislative and Regulatory Policy in the United States*, 15 LAW, MED. & HEALTH CARE 5, 10 (1987) (arguments for and against public policy options). The authors point out that as the foundation of contact-tracing is a statutory requirement to report the disease, the program's effectiveness has been limited as only a minority of states require HIV-positive reporting. *Id.*; See CDC, *Additional Recommendations to Reduce Sexual and Drug Abuse-Related Transmission of HTLV-III/LAV*, 35 MORBIDITY & MORTALITY WEEKLY REP. 152 (1986). The CDC has recommended implementing contact-tracing programs since March 1986. *Id.*

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More specifically, Congress should enact legislation mandating the establishment of "look-back" programs by all blood-service establishments which would require physicians and/or the facilities to effectively screen out HIV-positive blood donors and identify, locate, and warn the transfusion recipient of the risk of infection.¹¹⁵ Institution of "look-back" programs would effectively interrupt the spread of the disease to the recipient's family members and sexual partners by informing the recipient of proper health care techniques.¹¹⁶ Further, access to information assembled via a "look-back" program would assist a donee in the discovery stage to determine whether a viable cause of action for damages exists.¹¹⁷

The efficacy of such a program would depend on the accuracy of the tests used to screen for the HIV antibody. As previously noted, the ability of the ELISA and Western Blot Tests¹¹⁸ to identify infected blood may not be possible during the latent stage of disease.¹¹⁹ The Food and Drug Administration, therefore, should license new tests, including the HIV antigen¹²⁰ and polymerase

¹¹⁵ See AIDS AND THE LAW 235 (W. Dornette ed. 1987). The author described the "look-back" program initiated by the American Red Cross, American Association of Blood Banks, and the Council of Community Blood Centers in 1986. *Id.* One significant drawback of the 1986 plan is its reactive nature which depends on the initial identification of HIV-positive transfusion recipients. *Id.* Such a down-stream approach will inevitably preclude identification of many infected persons. *Id.* See also J.K. and Susie L. Wadley Research Inst. v. Morris, 776 S.W.2d 271, 279 (Tex. Ct. App. 1989) (only case where transfusion recipient and his wife, who were both diagnosed as having AIDS, sued blood bank which administered procedure, asserting liability for harm due to failure of facility to implement "look-back" program).

¹¹⁶ See AIDS LEGAL GUIDE 4-6 (A. Rubinfeld ed.) (1987) (citing Centers for Disease Control, RECOMMENDED ADDITIONAL GUIDELINES FOR HIV ANTIBODY COUNSELING IN THE PREVENTION OF HIV INFECTION AND AIDS, app.IV (1988)).

¹¹⁷ See *supra* notes 59-60 and accompanying text (problematic issues in discovery which "look-back" programs can solve).

¹¹⁸ See 1988 AMERICAN BAR ASSOCIATION, AIDS: THE LEGAL ISSUES 85 (positive ELISA tests are confirmed by Western Blot tests).

¹¹⁹ See *supra* notes 7 through 10 and accompanying text (discussing difficulty in testing for AIDS).

¹²⁰ See Allain, Laurian, Paul, Seen, *Serological Markers in Early Stages of Human Immunodeficiency Virus Infection in Haemophiliacs*, 2 LANCET 1233, 1233-36 (1986) (long-term study comparing sensitivity of western blot detection and polymerase chain reaction tests); Leslie, Reesink, Bakker, Huisman, & Ten Veen, *Clinical Importance of HIV Antigens and Anti-HIV Core Markers in Persons Infected With HIV*, 318 NEW ENG. J. MED. 1204 (1988) (study concluding that HIV-antigen test is "valuable" serum marker in predicting infection); Ward et al., *supra* note 10, at 476 ("Assays for HIV antigens or other tests that detect antibodies to recombinant HIV antigens may help to identify persons earlier in the

chain reaction¹²¹ tests, which would likely be better overall predictors of infection, and it should issue guidelines standardizing and modifying the method of performing the Western Blot test.¹²²

IV. PUBLIC POLICY INTERESTS

In the United States, blood supplies originate from voluntary and compensated donations.¹²³ There has been evidence that blood donated by volunteers is less likely to contain impurities than that of compensated donors.¹²⁴ Consequently, the federal government encourages the expansion of the nation's voluntary blood donation program.¹²⁵ One significant argument raised by blood banks and hospitals in opposition to plaintiffs' discovery is that permitting revelation of donor identity will have an adverse impact on the quantity and quality of the voluntary blood supply.¹²⁶

course of HIV infection than the enzyme immuno assays currently licensed.") (citing Goudsmit, deWolf, Paul, et al., *Expression of Human Immunodeficiency Virus Antigen (HIV-Ag) in Serum and Cerebrospinal Fluid during Acute and Chronic Infection*, 2 LANCET 177, 177-80 (1986)).

¹²¹ Peterman & Ward, *supra* note 10, at 659-60 (recommending additional tests, including polymerase chain reaction, to determine if donors have latent infections).

¹²² See D. Burke et al., *Letter to the Editor*, 320 NEW ENG. J. MED. 462, 462-63 (1989) (discussing modifications in Western Blot testing procedures); R. Vogt, M.D., *Letter to the Editor*, 320 NEW ENG. J. MED. 462, 462 (1989) (there is no standardized method for performing Western Blot analysis — currently at least four different "standard" criteria are used by various laboratories) (citing Consortium for Retrovirus Standardization, *Serological Diagnosis of Human Immunodeficiency Virus Infection by Western Blot Testing*, 260 J. A.M.A. 674, 674-79 (1988)).

¹²³ See 21 CFR § 606.121 (c)(5)(ii), (iii) (1990) (volunteer donor is person who does not receive monetary payment for blood furnished); 21 CFR § 606.121 (c)(5)(i) (1990) (compensated donor is one who receives monetary payment for blood provided). The Food and Drug Administration requires that blood packaging contain specific labelling regarding donor classification. 21 CFR § 606.120 (b)(2) (1985).

¹²⁴ See Williams, *supra* note 19, at 269-70 ("blood from paid donors and commercial blood banks is more likely to be contaminated than volunteer blood"). The author, explaining the higher incidence of contaminated blood from compensated donors' supplies, stated, "commercial blood banks tend to be located in central cities and congested urban areas. This may lead donors who are members of groups with a high incidence of disease like hepatitis, or who are exposed to those groups with a high incidence of disease." *Id.* at 270 (citing Franklin, *Tort Liability for Hepatitis: An Analysis and a Proposal*, 24 STAN. L. REV. 439, 445 (1972)).

¹²⁵ See National Blood Policy, 39 Fed. Reg. 32,702 (1974) (identifying four major problems with national blood supply system and proposing solutions).

¹²⁶ See *Coleman v. American Red Cross*, 130 F.R.D. 360, 362-63 (E.D. Mich. 1990) (us-

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Defendant blood banks and hospitals aver that the volume of voluntarily donated blood will decrease as a consequence of discovery principally because the mere hint of litigation and the possibility of public scrutiny of one's personal life will discourage volunteers from donating blood.¹²⁷ Further, they assert that the quality of the nation's blood supply will be negatively affected because the donors will be less willing to provide the accurate, and concomitantly personal, information on which the system relies.¹²⁸

It is submitted that the prediction of a negative impact on the voluntary blood supply is purely speculative. Conceivably, allowing anonymous limited discovery in transfusion-related AIDS cases will have a positive impact on the nation's blood supply because infected donors, knowing of the possibility of being involved in future litigation, will refrain from donating blood. Furthermore, if courts utilize anonymous limited discovery to protect the confidentiality of the donor's identity, potential donors will not have to fear public disclosure of private and often detailed medical information, and therefore will not be discouraged from making voluntary donations.

Blood banks and hospitals have a significant interest in asserting

ing balancing test, court determined that possible harm to volunteer blood supply outweighed plaintiff's discovery needs); *Doe v. American Red Cross Blood Servs.*, 125 F.R.D. 646, 652-53 (D.S.C. 1989) (finding donors' confidentiality of paramount importance in uncontaminated blood supply); *Mason v. Regional Medical Center of Hopkins County*, 121 F.R.D. 300, 303 (W.D. Ky. 1988) (donor's identity revealed only to few because of ensuing stigma and possible decline in overall donations); *Krygier v. Airweld, Inc.*, 137 Misc.2d 306, 309, 520 N.Y.S.2d 475, 477 (Sup.Ct. Kings County 1987) (blood bank and "society's interest in maintaining the free flow of volunteer blood far outweigh the plaintiff's right to disclosure . . ."); *Doe v. University of Cincinnati*, 42 Ohio App. 3d 227, 538 N.E.2d 419 (1988) (donee denied access to donor's identity because confidentiality considered major factor in donations). *Contra Belle Bonfils Memorial Blood Center v. District Court*, 763 P.2d 1003, 1012-13 (Colo. 1988) (patient's need to know donor's identity more important than donor's right to privacy); *Gulf Coast Regional Blood Center v. Houston*, 745 S.W.2d 557, 559-60 (Tex. Ct. App. 1988) (donee's health interests are paramount to potential adverse effects on blood supply); *Tarrant County Hosp. Dist. v. Hughes*, 734 S.W.2d 675, 677-80 (Tex. Ct. App. 1987) (donor's representatives failed to show societal interest in blood donor program which would outweigh donee's interest in discovering donor's identity). *But cf. Stenger v. Lehigh Valley Hosp. Center*, 563 A.2d 531, 537 (Pa. Super. 1989) (limited discovery allowed to protect donee because minimal risk of adversely affecting amount of volunteer blood donations).

¹²⁷ *Id.*

¹²⁸ *Id.* See also *American Red Cross Blood Servs.*, 125 F.R.D. at 652 (regarding House subcommittee hearing on confidentiality issues related to blood donation held on July 29, 1985).

both the donor and society's interests in preventing discovery. That is, as previously explained, without deposing the donor it will be virtually impossible for the plaintiff-victim to pursue his cause of action.¹²⁹

V. BALANCING OF INTERESTS

In reaching their decisions as to the outcome of these issues, courts apply a balancing test and weigh the interests served by allowing plaintiff to proceed with discovery against the donor's right to privacy.¹³⁰ The factors to be weighed in balancing the parties' interests were articulated by the court in *United States v. Westinghouse Electric Corp.*¹³¹ These include "the potential harm in . . . disclosure, the injury from disclosure to the relationship in which the record was generated, the adequacy of safeguards to protect unauthorized disclosure, the degree of need for access, and whether there is an express statutory mandate, articulated public policy, or other recognizable public interest militating toward access."¹³²

In the area of disclosure of blood donor identity, courts have differed in their conclusions as to the precedence of these competing interests. Several courts, in weighing the factors enumerated above, have held that the blood donor's privacy interest and society's dependence on a voluntary blood supply are more important than the victim's interest in uncovering the donor's identity.¹³³

In 1989, a South Carolina district court in *Doe v. American Red Cross Blood Services*,¹³⁴ held that plaintiff was not entitled to discover the identity of a transfusion donor.¹³⁵ Plaintiff received the

¹²⁹ See *supra* notes 35-60 and accompanying text (discussing necessity of identifying donor to bring successful claim against defendant hospital or blood bank).

¹³⁰ See *Seattle Times Co. v. Rhinehart*, 467 U.S. 20, 32 (1984) (court order which compels or restricts pre-trial discovery constitutes state action which is subject to constitutional limitations).

¹³¹ 638 F.2d 570 (3d Cir. 1980). See also *Nixon v. Administrator of Gen. Servs.*, 433 U.S. 425, 459 (1977) (utilization of balancing test to weigh litigants' interests).

¹³² *Westinghouse Elec. Corp.*, 638 F.2d at 578 (3d Cir. 1980).

¹³³ See *infra* notes 134-148 and accompanying text (discussing cases which have denied discovery).

¹³⁴ 125 F.R.D. 646 (D.S.C. 1989).

¹³⁵ *American Red Cross Blood Servs.*, 125 F.R.D. at 657.

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contaminated blood during a gall bladder operation.¹³⁶ The court gave priority to the donor and blood bank's interests, reasoning that plaintiff's interest had been adequately accommodated by the information already provided to him.¹³⁷

The Florida Supreme Court in *Rasmussen v. Southern Florida Blood Services*¹³⁸ likewise denied a blood transfusion recipient's request for discovery.¹³⁹ In *Rasmussen*, plaintiff was sitting on a park bench when he was subsequently hit by an automobile.¹⁴⁰ During treatment for his injuries, decedent was transfused with fifty-one units of blood.¹⁴¹ He was diagnosed as having AIDS fourteen months later.¹⁴² The court reasoned that the "potential of significant harm to most, if not all, of the . . . donors in permitting such a fishing expedition is great and far outweighs the plaintiff's needs under these circumstances."¹⁴³

Similarly, the New York Supreme Court in *Krygier v. Airweld, Inc.*,¹⁴⁴ held that the donor's interest in confidentiality and society's interest in maintaining a voluntary blood supply outweighed plaintiff's interest in obtaining discovery.¹⁴⁵ In *Krygier*, plaintiff was critically burned by the explosion of an acetylene torch.¹⁴⁶ During surgery he received twenty-one units of blood, which plaintiff alleged were contaminated with AIDS.¹⁴⁷ The court emphasized that "[e]xposing donors to public scrutiny in order to determine what they may have told [the blood bank] has only marginal utility in advancing the plaintiff's theory of liability."¹⁴⁸

¹³⁶ *Id.* at 647.

¹³⁷ *Id.* at 654.

¹³⁸ 500 So. 2d 533 (Fla. 1987).

¹³⁹ *Rasmussen*, 500 So. 2d at 535-36.

¹⁴⁰ *Id.* at 534.

¹⁴¹ *Id.*

¹⁴² *Id.*

¹⁴³ *Id.* at 538.

¹⁴⁴ 520 N.Y.S.2d 475 (Sup. Ct. Kings County 1987).

¹⁴⁵ *Krygier*, 137 Misc.2d at 309, 520 N.Y.S.2d at 477. See also *Coleman v. American Red Cross*, 130 F.R.D. 360, 362 (E.D. Mich. 1990) (potential danger to voluntary blood supply from compelled disclosure alone outweighed plaintiff's discovery needs). The *Coleman* court, however, noted that "plaintiffs have failed to demonstrate either a compelling need for this information or any special circumstances militating in favor of disclosure of the donor's identity." *Id.* at 363.

¹⁴⁶ *Krygier*, 137 Misc.2d at 308, 520 N.Y.S.2d at 476.

¹⁴⁷ *Id.*

¹⁴⁸ *Krygier*, 137 Misc.2d at 309, 520 N.Y.S.2d at 477.

Nonetheless, several courts have reached the opposite conclusion, i.e., that the donor and society's interests are *not* superior to plaintiff's right to discovery.¹⁴⁹

The New Jersey Superior Court in *Synder v. Mekhjian*,¹⁵⁰ held that plaintiff could pursue a limited or "veiled" discovery to provide him with needed information regarding screening procedures.¹⁵¹ In *Synder*, plaintiff underwent elective coronary bypass surgery in August 1984.¹⁵² In 1986, a blood-bank "look-back" program determined that plaintiff was transfused with AIDS-infected blood.¹⁵³ Weighing the interests implicated, the court granted limited discovery, stressing that "litigant's discovery need cannot otherwise be met and it is possible to accommodate that need with limited and controlled intrusion."¹⁵⁴

In *Stenger v. Lehigh Valley Hospital Center*,¹⁵⁵ the Pennsylvania Superior Court allowed plaintiffs' request for discovery to learn of the screening procedures used by defendant hospital.¹⁵⁶ In 1984, plaintiff sustained acute personal injuries as a result of a car accident, for which she received multiple blood transfusions.¹⁵⁷ In 1986, she, her husband, and their six month old son were diagnosed as being infected with AIDS.¹⁵⁸ The court concluded that "a limited and protective discovery order can be formulated . . . which will insure that the Stengers learn the information necessary to establish their claim while at the same time protecting confidentiality."¹⁵⁹ The court added that there is no correlation between discovery and a reduced number of blood donations.¹⁶⁰

Similarly, in *Gulf Coast Regional Blood Center v. Houston*,¹⁶¹ the Texas Court of Appeals authorized limited discovery into the lo-

¹⁴⁹ See *infra* notes 150-167 and accompanying text (reviewing cases allowing discovery).

¹⁵⁰ 244 N.J. Super. 281, 582 A.2d 307 (N.J. Super Ct. App. Div. 1990).

¹⁵¹ *Synder*, 244 N.J. Super. at 297, 582 A.2d at 315.

¹⁵² *Id.* at 284-85, 582 A.2d at 309.

¹⁵³ *Id.*

¹⁵⁴ *Id.* at 296, 582 A.2d at 314-15.

¹⁵⁵ 563 A.2d 531, 537 (Pa. Super. 1989)

¹⁵⁶ *Stenger*, 563 A.2d at 539.

¹⁵⁷ *Id.* at 532-33.

¹⁵⁸ *Id.* at 533.

¹⁵⁹ *Id.* at 537.

¹⁶⁰ *Id.*

¹⁶¹ 745 S.W.2d 557, 559-60 (Tex. Ct. App. 1988).

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cation and identity of blood donors.¹⁶³ In this case, plaintiff brought a wrongful death action against a blood bank for alleged negligence in testing and failing to warn decedent, who died of AIDS.¹⁶³ The court reasoned that the trial court effectively balanced the interests of both parties by permitting a limited discovery which "afforded the donors protection from undue publicity and intrusion into their private lives."¹⁶⁴

In *Tarrant County Hospital District v. Hughes*,¹⁶⁵ the Texas Court of Appeals also allowed discovery of donor identity,¹⁶⁶ finding the injury to society no less speculative than a determination that society would benefit by discouraging donations by those infected with AIDS.¹⁶⁷

VI. ANONYMOUS LIMITED DISCOVERY

It is submitted that one practical approach to the problem of balancing the respective interests of the parties would be for courts to allow plaintiffs to pursue a anonymous limited discovery of information from the donor. Federal Rule of Civil Procedure 26 (c) permits a court to "make any order which justice requires . . . including . . . that the discovery be had only by a method of discovery other than that selected by the parties seeking discovery."¹⁶⁸ Given the considerable extent of discretion which a judge possesses relating to discovery,¹⁶⁹ the court may fashion a special

¹⁶³ *Gulf Coast Regional Blood Center*, 745 S.W.2d at 563.

¹⁶³ *Id.* at 559.

¹⁶⁴ *Id.* at 560.

¹⁶⁵ 734 S.W.2d 675, 677-80 (Tex. Ct. App. 1987).

¹⁶⁶ *Tarrant County Hosp. Dist.*, 734 S.W.2d at 680.

¹⁶⁷ *Id.* at 677-80.

¹⁶⁸ FED. R. CIV. P. 26(c).

There are nine principal purposes of depositions: 1) to discover evidence; 2) to discover what the witness knows or thinks; 3) to discover how a witness will testify at trial and to commit the witness to that testimony; 4) to perpetuate helpful testimony that may be unavailable at trial; 5) to obtain testimony to support or oppose a motion; 6) to discover an expert witness's assumptions, . . . opinions, . . . and the limits of his studies, tests, and examinations; 7) to assess the persuasiveness and credibility of witnesses; 8) to establish foundation testimony needed for trial; and 9) to impress one's opponent with the strength of one's case in order to induce a favorable settlement.

W. SCHWARZER & L. PASAHOW, CIVIL DISCOVERY: A GUIDE TO EFFICIENT PRACTICE 85 (1989).

¹⁶⁹ See J. FRIEDENTHAL, M. KANE, & A. MILLER, CIVIL PROCEDURE 415 (1985) [hereinafter FRIEDENTHAL, KANE & MILLER]. With regard to the extent of a judge's authority during the

limited protective order allowing for an anonymous or "veiled" discovery of donor information in transfusion-related AIDS cases, applying discovery devices including oral depositions,¹⁷⁰ written depositions,¹⁷¹ and written interrogatories.¹⁷² The majority of courts to date which have employed anonymous limited discovery

discovery period, these commentators remarked:

The court also has the power to control the time, place, and atmosphere of the discovery situation. It may make orders with respect to the way in which the discovery is to be recorded, and it may be creative in its attempts to ascertain the extent to which discovery is appropriate in a given situation. In all these ways the court may structure or limit discovery to provide for the open exchange of information desired by the rules, at the same time assuring that the discovery process is used only for legitimate and non-abusive purposes.

Id.

¹⁷⁰ See FED. R. CIV. P. 30(c). An oral deposition permits a lawyer to confront and question any party, including a witness, regarding the subject matter of the case. *Id.* That person, called the deponent, is placed under oath by an officer, usually the court reporter, who is in charge of that deposition. See FED. R. CIV. P. 28. The function of the reporter is to record the questions, answers, and any objections made by the parties or the witnesses. See FED. R. CIV. P. 30(c). After the deposition has been concluded, the reporter will prepare a transcript, which the deponent is then called upon to sign. See FED. R. CIV. P. 30(e).

An oral deposition has both advantages and disadvantages. FRIEDENTHAL, KANE, & MILLER, *supra* note 169, at 395. The greatest benefit of an oral deposition is that it allows an attorney to examine a possible witness and ascertain how that witness will appear at trial if he is called to testify. *Id.* On the other hand, the primary difficulty with oral depositions is their expense. *Id.* at 396. Each litigant must pay not only for the effort his attorney makes in deposing a witness but also for the cost of the deposition transcripts and probably for witness time and travel costs. *Id.*

¹⁷¹ See FRIEDENTHAL, KANE & MILLER, *supra* note 169, at 398. A written deposition, also known as a deposition by written questions, is like an oral deposition except that the litigants' attorneys do not ask the questions. *Id.* Instead, both parties' attorneys will deliver their written questions to the officer who then reads these questions to the witness whose oral answers are then recorded. *Id.*; FED. R. CIV. P. 31. While written depositions can be an appropriate alternative to avoid the expense of an oral deposition, written depositions tend to be an ineffective means to assess a deponent's strengths and weaknesses because the lawyers do not observe the witnesses. FRIEDENTHAL, KANE & MILLER, *supra* note 169, at 399. Therefore, written depositions are most often used to acquire objective information about matters for which no follow-up questions are likely to be required. *Id.*

¹⁷² See FED. R. CIV. P. 31. Written interrogatories permit one party to send another a series of questions to be answered under oath within a specific time. *Id.* A court order is not required, and the entire exchange can be accomplished by mail. *Id.* Unlike a deposition, however, written interrogatories may only be sent to the parties involved and not to any person who may possess relevant information regarding the subject matter of the case. See FED. R. CIV. P. 33(a).

One advantage of written interrogatories is that they are a relatively inexpensive means to obtain access to a "greater range of information" since the responding party will usually have to investigate and conduct research prior to answering. *Id.* The disadvantage of written interrogatories is that since the responding party's attorney will draft the answers, they can sometimes tend to be ambiguous. *Id.*

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have ordered that written,¹⁷³ rather than oral,¹⁷⁴ depositions be taken, perhaps reflecting the courts' concern for the preservation of confidentiality.¹⁷⁵

A court which employs anonymous limited discovery can amply safeguard the donor's constitutional right to informational privacy as the intrusion into the donor's personal affairs will be minimal. Because the intrusion would be slight, it would not outweigh the plaintiff-victim's right to conduct discovery which may expedite his efforts to prove causation. Examples of some restrictions placed on discovery include: (1) providing for deposition, at a confidential date and time, to be supervised or executed by a court-appointed referee;¹⁷⁶ (2) allowing the donor to refrain from providing identifying information, and to disguise or conceal his physical appearance from the reporter at deposition;¹⁷⁷ (3) limiting the number of persons who will have access to the information, including counsel for both parties;¹⁷⁸ (4) prohibiting counsel of parties from disclosing the information, either directly or indirectly, to third parties without a specific court order;¹⁷⁹ (5)

¹⁷³ See, e.g., *Boutte v. Blood Sys. Inc.*, 127 F.R.D. 122, 126 (W.D. La. 1989) (written depositions ordered); *Mason v. Regional Medical Center of Hopkins County*, 121 F.R.D. 303, 304 (W.D. Ky. 1988) (same); *In re Complex Blood Bank Litig.*, No. 908-843, 6-7 (1989) (same); *Belle Bonfils Memorial Blood Center v. District Court*, 763 P.2d 1003, 1013-14 (Colo. 1988) (same).

It must be recognized that a large number of courts have allowed for limited anonymous discovery and provided safeguards, but did not delineate a particular method to be utilized by plaintiff's counsel. See, e.g., *Doe v. New York Univ. Medical Center*, N.Y.L. J., Aug. 14, 1990, at 18, col.1-2 (Sup.Ct. N.Y.County 1990) (ordering limited discovery but failing to delineate guidelines for carrying out order); *Stenger v. Lehigh Valley Hosp.*, 563 A.2d 531, 539 (Pa. 1989); *Gulf Coast Regional Blood Center V. Houston*, 745 S.W.2d 557, 560 (Tex. Ct. App. 1988) (same); *Tarrant County Hosp. Dist. v. Hughes*, 734 S.W.2d 679, 680 (Tex. Ct. App. 1987) (same).

¹⁷⁴ See *United Blood Servs.*, No. 20375 at 2 (allowing for telephonic deposition upon locating donor).

¹⁷⁵ See *Belle Bonfils Memorial Blood Center*, 763 P.2d at 1013 ("oral deposition pursuant to C.R.C.P. 30 is not appropriate, as the identity of the donor must be preserved").

¹⁷⁶ See, e.g., *Boutte*, 127 F.R.D. at 126; *Belle Bonfils Memorial Blood Center*, 763 P.2d at 1014; *Gulf Coast Regional Blood Center*, 745 S.W.2d at 560.

¹⁷⁷ *Id.*

¹⁷⁸ See, e.g., *Belle Bonfils Memorial Blood Center*, 763 P.2d at 1014 (court clerk mailed written questions to donor and then delivered answers to attorneys after concealing any clues to donor's name and address); *Regional Medical Center of Hopkins County*, 121 F.R.D. 300, 304 (W.D. Ky. 1988) (court ordered that only one attorney from each side depose donor); *Gulf Coast Regional Blood Center*, 745 S.W.2d at 560 (only parties' attorneys were allowed access to names and addresses of donors).

¹⁷⁹ *But cf. Belle Bonfils Memorial Blood Center*, 763 P.2d at 1014 (even court order not

preventing the identifying information of the donor from being revealed to any party whatsoever, including counsel;¹⁸⁰ (6) forbidding the parties and their counsel from contacting the donor, either directly or indirectly, or pursuing further discovery;¹⁸¹ (7) sealing with the court the information acquired from the donor;¹⁸² and (8) destroying the materials obtained at the close of the case.¹⁸³

It is submitted that implementation of anonymous limited discovery by a court will adequately protect the right of privacy of the donor from the initial stages of discovery through the trial stage. As noted above, courts may apply various techniques to safeguard the donor's identity throughout trial proceedings.¹⁸⁴ It should be noted, however, that despite veiled discovery the donor may become further involved in the litigation. Several courts have intimated that it may be necessary to involve the donor in the trial.¹⁸⁵ In addition, defendants may assert that there is a constitutional right to confront, cross-examine, and impeach an adverse witness in a civil case, pursuant to the seventh amendment.¹⁸⁶

permissible to reveal donor's identity); *Regional Medical Center of Hopkins County*, 121 F.R.D. at 304 (court order needed to reveal donor's identity to third parties); *Gulf Coast Regional Blood Center*, 745 S.W.2d at 560 (same).

¹⁸⁰ See *United Blood Servs., v. Nevada Dist. Court*, No. 20375, 7 (Nev. 1990).

¹⁸¹ See *Belle Bonfils Memorial Blood Center*, 763 P.2d at 1014 (court clerk was only person allowed to have contact with donor); *Gulf Coast Regional Blood Center*, 745 S.W.2d at 560 (court order required to contact donor).

¹⁸² See, e.g., *Belle Bonfils Memorial Blood Center*, 763 P.2d at 1014 (donor's written answers, name and address sealed); *Gulf Coast Regional Blood Center*, 745 S.W.2d at 560 (same).

¹⁸³ See *Gulf Coast Regional Blood Center*, 745 S.W.2d at 560 (documents to be destroyed after judgment delivered).

¹⁸⁴ See *supra* notes 150-157 and accompanying text (sealing and destroying documents, use of court clerk and denial access to donor to conceal donor identity).

¹⁸⁵ See, e.g., *Synder v. Mekhjian*, 244 N.J. Super. 281, 294, 582 A.2d 307, 315 (N.J. Super. Ct. App. Div. 1990) (donor may have no objection to openly providing information).

¹⁸⁶ *Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 176 (1970) (Black, J., concurring) ("right to confront, cross examine and impeach adverse witnesses is one of the most fundamental rights sought to be preserved by the Seventh Amendment"); *Edward J. Sweeney & Sons, Inc. v. Texaco*, 637 F.2d 105, 128 (3d Cir. 1980) (deeming right to confront witnesses fundamental especially in cases of conspiracy); *Fisher v. Shamburg*, 624 F.2d 156, 162 (10th Cir. 1980) (same); *Singer v. Wadman*, 595 F. Supp. 188, 272 (D. Utah 1982) (same); *Professional Investors Life Ins. Co. v. Roussel*, 528 F. Supp. 391, 395 (D. Kan. 1981) (same); *Paton v. LaPrade*, 471 F. Supp. 166, 171 (D.N.J. 1979) (same). *Contra Fisher Bros., Inc. v. Mueller Brass Co.*, 630 F. Supp. 493, 497 n.7 (E.D. Pa. 1985) ("[t]here is no constitutional right to confront witnesses in a civil case").

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Should it become necessary to further involve the donor in a trial, it is suggested that a court implement procedural measures designed to protect the donor's identity similar to the devices used in trade secrets cases.¹⁸⁷

CONCLUSION

Alfred North Whitehead wrote that "those who are imaginative have but slight experience and those who are experienced have feeble imaginations"¹⁸⁸ It will take the resourcefulness and imagination of Congress, the Executive, and the Judiciary to resolve the legal issues surrounding the AIDS epidemic. The utilization by courts of anonymous limited discovery is an equitable method of enabling victims of transfusion-related AIDS to pursue a remedy, while at the same time, maintaining the infected donor's right to privacy. This equity is especially welcome considering the possibility that unlimited discovery will adversely impact the nation's voluntary blood supply and the fact that discovery of a donor's identity is crucial to the plaintiff, who will likely pursue negligence as a cause of action.

Mark G. Pedretti & Vincent L. Gallo, Jr.

¹⁸⁷ See, e.g., *In re Iowa Freedom of Information*, 724 F.2d 655, 658 (8th Cir. 1983) (to determine if there is trade secret, trade secret itself must be revealed, so do so *in camera* to protect secret); *Space Aero Prods. Co. v. R.E. Darling Co.*, 238 Md. 93, 122, 208 A.2d 74, 89 (Md. 1968) (secrecy is primary protection, so exclude all witnesses except expert witnesses); *Air Prods. and Chems., Inc. v. Johnson*, 442 A.2d 1114, 1128 (Pa. Super. Ct. 1982) ("public disclosure of a trade secret, by a party seeking to protect its interests results in an abandonment of that trade secret"). It has long been recognized that where litigation involves trade secrets a trial court has the discretionary authority to implement various procedural safeguards designed to prevent public disclosure of confidential information in the course of trial. *Id.* See also Note, *Publicker Industries v. Cohen: Public Access to Civil Proceedings and a Corporation's Right to Privacy*, 80 Nw. U.L. REV. 1319, 1342-50 (1987) (balancing risks, constitutionality, and effectiveness of closing trade secret trials to public observation); Comment, *The First Amendment Right of Access to Civil Trials After Globe Newspaper Co. v. Superior Ct.*, 51 U. CHI. L. REV. 286, 302-06 (1984) (recent cases in which trade secrets were not legitimate and closed trial was not needed).

For a discussion of the various techniques which could be utilized by a court in attempting to shield an AIDS-infected donor's identity, see *F.T.C. v. Lonning*, 539 F.2d 202 (D.C. Cir. 1976) (limiting disclosure of information to counsel of record); *United States v. International Business Machs. Corp.*, 67 F.R.D. 40, 43 (S.D.N.Y. 1975) (*in camera* proceedings); *Sun Dial Corp. v. Rideout*, 29 N.J. Super. 361, 102 A.2d 90 (N.J. Super. Ct.) (deleting details from record), *aff'd*, 16 N.J. 252, 108 A.2d 442 (1954).

¹⁸⁸ A.N. WHITEHEAD, *SCIENCE AND THE MODERN WORLD* 24 (1925).

