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NOTE

The Legal Liability of Blood Donor Services and Transfusion Providers in the Wake of the AIDS Crisis

I. INTRODUCTION

In December of 1982, the Centers for Disease Control (CDC) reported the first possible case of Acquired Immunodeficiency Syndrome (AIDS) transmitted exclusively through a blood transfusion.¹ Subsequent to this announcement, in January 1983, the American Red Cross, the American Association of Blood Banks, and the Council of Community Blood Centers released the *Joint Statement on AIDS Related to Transfusion*.² This statement recommended measures to limit and prevent the spread of AIDS through blood transfusions and blood products.³ In an effort to determine whether donors had been exposed to AIDS or suffered from any of the symptoms associated with AIDS and to protect the blood supply, the statement recommended a predonative screening of potential blood donors and also suggested that members of the high-risk groups for AIDS — homosexual men, intravenous drug users, Haitian immigrants and hemophiliacs — refrain from donating blood.⁴ In that same year, the Food and Drug Administration (FDA) approved these recommendations and released several additional predonative guidelines.⁵ By the summer of 1983, most blood centers were acting in accordance with the predonative screening measures issued in the joint statement and by

1. David Stevens, *Negligence Liability for Transfusion - Associated AIDS Transmission: An Update and Proposal*, 12 J. LEGAL MED. 221, 222 (1991). AIDS is a viral disease which attacks the human immune system leaving its host vulnerable to opportunistic infections. The CDC has published monthly AIDS statistics since the virus's discovery in 1981.

2. *Id.*

3. *Id.* The *Joint Statement on AIDS Related to Transfusion* recommended that hospitals make autologous transfusions more available to those persons who were to undergo elective surgeries. Moreover, the statement recommended that potential blood donors be more carefully screened for the symptoms of AIDS. However, these recommendations did not include any medical laboratory blood screening based on sexual orientation. See *infra* note 77 and *Kozup v. Georgetown Univ.* for these guidelines and other guidelines established by the statement.

4. Warren R. Janowitz, *Safety of the Blood Supply: Liability for Transfusion-Associated AIDS*, 9 J. LEGAL MED. 611, 612-13 (1988). These high-risk groups, excluding Haitians, were at high risk for the development of blood-borne illnesses and viruses. The occurrence of AIDS in these groups led to the belief that AIDS could be transmitted through whole-blood or whole-blood component transfusions and blood products from source plasma.

5. Stevens, *supra* note 1, at 222. For a detailed discussion of these guidelines see FDA, *Recommendations to Decrease the Risk of Transmitting Acquired Immune Deficiency Syndrome (AIDS) from Blood Donors* (Mar. 24, 1983).

the FDA, and in 1984, the medical community confirmed that AIDS could indeed be transmitted through blood and blood products.⁶ In 1984, the cause of AIDS, Human Immunodeficiency Virus (HIV), was isolated and documented.⁷ Subsequent to these determinations and guidelines, blood banks, healthcare facilities, and physicians were confronted with both the fight against AIDS and the question of how to best assist those persons afflicted with this disease, as well as the onset of litigation against those entities deemed responsible for the AIDS-related blood transfusion injuries.⁸

Most of the litigation surrounding transfusion-related liability has been brought by persons who contracted HIV from transfusions prior to March 1985.⁹ On March 2, 1985, the FDA licensed the first HIV antibody screening test, the enzyme-linked immunosorbent assay (ELISA) test.¹⁰ Since that time, blood banks, healthcare facilities, and physicians have screened potential donors' blood for the presence of HIV antibodies. The ELISA test detects 96-98% of all possible HIV-infected blood samples, but this test is problematic because its high degree of sensitivity sometimes results in false seropositive interpretations.¹¹ Another HIV antibody screening test currently in use is the Western Blot test which is even more sensitive and confirms or refutes the positive results of the ELISA test.¹² However, neither test can detect HIV antibodies during the six-week to eight-week window period when no antibodies are present.¹³ Consequently, because blood has a shelf-life of only thirty-five to forty-two days, the HIV-infected blood may be transfused to another person, resulting in the subsequent development of AIDS in the recipient before the donor's HIV status can even be determined.¹⁴ This window period of uncertainty, compounded by the fact that neither the ELISA test nor the Western Blot test is foolproof, raises concerns associated with the safety of the nation's blood supply.¹⁵

The CDC estimates that 29,000 persons received blood transfusions

6. Stevens, *supra* note 1, at 222.

7. *Id.* See *Perspectives on the Future of AIDS*, 253 JAMA 247 (1985).

8. Stevens, *supra* note 1, at 222-23.

9. *Id.* at 223.

10. *Id.*; Karen S. Lipton, *Blood Donor Services and Liability Issues Relating to Acquired Immune Deficiency Syndrome*, 7 J. LEGAL MED. 131 (1986). On March 2, 1985, Margaret M. Heckler, then the Secretary of Health and Human Services, announced that Abbott Laboratories of North Chicago had been given the first license to manufacture the HIV antibody screening tests.

11. Linda J. Anderson, *The AIDS Crisis and the Medical-Legal Implications of Transfusion Therapy*, 18 ANNA J. 291, 292 (1991).

12. *Id.* Although the Western Blot test is extremely sensitive, it too is unable to detect the presence of HIV antibodies during the window-phase of the virus. After the HIV antibodies are present in the blood, the ELISA test is 98% effective in the detection of AIDS, and when the ELISA test is used in conjunction with the Western Blot test the rate of effectiveness approaches 100%.

13. *Id.*

14. *Id.*

15. *Id.*

with units of HIV-infected blood between 1978 and 1984,¹⁶ before HIV antibody screening tests were readily available, yet currently there have been only 4,659 cases (2%) of AIDS attributed to this mode of transmission.¹⁷ The CDC further estimates that 12,000 of the 29,000 HIV-infected recipients were still alive in 1987.¹⁸ A 1987 *New England Journal of Medicine* article suggests that even with the ELISA and Western Blot screening tests, one in every 250,000 units of blood is infected with HIV despite a seronegative result.¹⁹ These estimates indicate the unlikelihood of the blood supply ever being completely safe from AIDS, and, as a result, unless a cure or vaccination for AIDS becomes available, litigation concerning transfusion-related AIDS will continue to ensue.

The purpose of this essay is to explore the status of law regarding blood transfusion liability and to examine public policy concerns for holding blood banks, healthcare facilities, and physicians liable for the transmission of HIV through blood transfusions. This essay only addresses the liability of blood banks, hospitals, and healthcare professionals who provide whole-blood and whole-blood component transfusions. The legal liability of pharmaceutical companies which manufacture blood products from source plasma may be different and is not discussed in this essay.

II. LEGAL BASES OF RECOVERY FOR TRANSFUSION-ASSOCIATED AIDS

The majority of litigation surrounding the liability of blood banks, healthcare facilities, and physicians, initiated by persons injured as a result of blood transfusions of whole-blood or whole-blood components, has been grounded in tort law.²⁰ Tort actions such as negligence and strict liability have been asserted by those persons injured through blood transfusions to recover for their injuries. Another claim of a contractual and commercial nature, a breach of an implied warranty, has also been asserted in this same vein. In this essay, the status of the law with respect to blood transfusion injuries and the ethical and public policy concerns surrounding each of the following causes of action will be discussed: implied warranty, strict liability, and negligence.

16. Stevens, *supra* note 1, at 223.

17. Centers for Disease Control, HIV/AIDS Surveillance Report, 9 (July 1992).

18. Stevens, *supra* note 1, at 223.

19. Janowitz, *supra* note 4, at 614. For the journal article containing this estimate and other related commentary on the accuracy of the ELISA and Western Blot tests, See Bove, *Transfusion Associated Hepatitis and AIDS*, 317 *NEW ENG. J. MED.* 242 (1987).

20. Lipton, *supra* note 10, at 132.

A. *Implied Warranty*

In order to determine what specific cause of action can be asserted by a plaintiff seeking to recover for a transfusion-related injury, one must first determine if a contractual relationship for the sale of a good existed between the plaintiff and the defendant.²¹ To establish a contractual relationship, the courts were forced to determine whether blood banks, healthcare facilities, and physicians were providing products for sale or services for their patients.²² If the court characterized the activity of a blood bank, healthcare facility, or physician as a sale of a product, then the normal contractual principles governed by the Uniform Commercial Code (U.C.C.) would apply. Thus, the seller of a product, according to U.C.C. section 2-315, impliedly warrants that the goods are of merchantable quality and are fit for the particular purpose for which they are used.²³ However, if the court determines that a blood transfusion is a service, rather than a product, then the plaintiff cannot recover under an implied warranty, but may be entitled to recovery based upon a tort claim.²⁴

The seminal case in the area of a breach of an implied warranty of fitness is *Perlmutter v. Beth David Hospital*.²⁵ In *Perlmutter*, the patient plaintiff was infected with hepatitis as a result of a blood transfusion.²⁶ The New York Court of Appeals denied recovery to the plaintiff asserting an implied warranty of fitness claim by determining that a blood transfusion was a service and not the sale of a product.²⁷ The court found that an implied warranty only applies to products; thus, an implied warranty cause of action could not be maintained in this case.²⁸ Furthermore, in reaching its decision, the New York Court of Appeals reasoned that to hold a blood bank, hospital, or physician liable would not be in the best interest of society because those organizations which supply medical aid cannot act as an insurer in every case in which there is a problem with a blood transfusion.²⁹ The *Perlmutter* court stated further public policy considerations when it found that

[I]f the transaction were to be deemed a sale, liability would attach

21. *Perlmutter v. Beth David Hosp.*, 123 N.E.2d 792 (N.Y. 1954).

22. *Id.* at 793.

23. *Id.* See U.C.C. § 2-315 (1988). The complete text of section 2-315 is as follows:
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 under the next section an implied warranty that the goods shall be fit for such purpose.

24. Lipton, *supra* note 10, at 133-35.

25. 123 N.E.2d 792 (N.Y. 1954).

26. *Id.* at 793.

27. *Id.* at 794.

28. *Id.* at 795.

29. *Id.*

irrespective of negligence or other fault. The art of healing frequently calls for a balancing of risk and dangers to a patient. Consequently, if injury results from the course adopted, where no negligence or fault is present, liability should not be imposed upon the institution or agency actually seeking to save or otherwise assist the patient.³⁰

The court in *Perlmutter* clearly based its decision on the equitable and societal concerns of holding those entities who are in the business of supplying a service or a good to the public necessary to save someone's life or expedite the human healing process liable for transfusion-associated injuries.³¹ Although the *Perlmutter* court was concerned with hepatitis contracted through a blood transfusion, the court in *Roberts v. Suburban Hospital Association* addressed the issue of the transmission of AIDS through a blood transfusion prior to the enactment of a blood shield statute and followed the public policy considerations of *Perlmutter*³² as did other courts.³³

In *Roberts* the court found, in addition to the fact that a blood transfusion is a service and not a product, that a hospital is not liable to a patient for a blood transfusion which exposes and directly causes a patient to subsequently contract the AIDS virus.³⁴ The court determined that if blood is contaminated with an infectious virus, then that blood is unfit or unmarketable; whether the virus is AIDS or hepatitis is irrelevant.³⁵ However, the court further stated that regardless of this finding, the legislature has determined, based upon public policy concerns, that hospitals and blood banks should be immune from liability with respect to blood transfusions, whether the claim is based upon strict liability or an implied warranty.³⁶ The immunity of which the *Roberts* court speaks stems from the promulgation of blood shield statutes.

B. Blood Shield Statutes

After the *Perlmutter* decision, some courts were reluctant to declare that a blood transfusion was a service rather than a product.³⁷ In *Cunningham v. MacNeal Memorial Hospital*, the court found that while the function of a blood bank is to obtain blood from donors for distribution

30. *Id.*

31. *Id.*

32. 532 A.2d 1081 (Md. App. 1987).

33. *See, e.g., Brody v. Overlook Hosp.*, 332 A.2d 596 (N.J. 1975) (rejecting the notion that a hospital could be held liable for transfusion-related injuries on a theory of strict liability).

34. 532 A.2d at 1089 (Md. App. 1987).

35. *Id.*

36. *Id.*

37. *See, e.g., Cunningham v. MacNeal Memorial Hosp.*, 266 N.E.2d 897 (Ill. 1970); *Community Blood Bank, Inc. v. Russell*, 196 So. 2d 115 (Fla. 1967) (finding that the appellate court had erred in failing to find that the measurement of damages in an action for the breach of warranties of merchantability was a question of fact).

and the function of a hospital is to transfuse blood as an ancillary function to medical treatment, "both entities are clearly within the distribution chain of the products involved."³⁸ Based upon this decision and others, a split of authority existed among jurisdictions concerning whether to allow recovery under implied warranty and strict liability theories.³⁹ Furthermore, a split also existed concerning from whom — the blood bank, hospital, or physician — recovery could be sought.⁴⁰ As a direct result of the public policy decisions of *Perlmutter* and the other cases which followed its ruling and the pressure imposed by the medical community and blood bank organizations, the majority of legislatures have promulgated blood shield statutes.⁴¹ Blood shield statutes act to bar a plaintiff's recovery under theories of implied warranty and strict liability from blood banks, hospitals, or physicians by stating that the supplying of blood for a transfusion is a service, rather than a product, or by limiting recovery for these causes of action.⁴² Forty-nine of the fifty

38. 266 N.E.2d at 901.

39. Janowitz, *supra* note 4, at 617.

40. *Id.*

41. Stevens, *supra* note 1, at 225. Blood shield statutes have been adopted in every state, except New Jersey, to insulate those entities which provide whole-blood or whole-blood component transfusions. These statutes were enacted to disallow recoveries by injured parties based on claims of product liability, implied warranties, and strict liability usually by stating that providing a blood transfusion is a service and not a product. Most of these statutes were promulgated prior to the AIDS epidemic to curtail the problem of hepatitis transfusion-related injuries; the remainder were enacted in response to the AIDS crisis. Moreover, the majority of states and the District of Columbia have disallowed recoveries in product liability, implied warranties, and strict liability claims. In Vermont, however, the supreme court has not entertained the question. For the complete text of each blood shield statute, see ALA. CODE § 7-2-314 (1984); ALASKA STAT. § 45.02.316(e) (1989); ARIZ. REV. STAT. ANN. §§ 32-1481, 36-1151 (1986); ARK. STAT. ANN. § 20-9-802 (1987); CAL. HEALTH & SAFETY CODE § 1606 (West 1990); COLO. REV. STAT. § 13-22-104 (1987); CONN. GEN. STAT. § 19a-280 (West 1986); DEL. CODE ANN. tit. 6, § 2-316(5) (1975); FLA. STAT. ANN. § 672.316(5) (West Supp. 1990); GA. CODE ANN. § 105-1105 (1984); HAW. REV. STAT. § 325-91 (1985); IDAHO CODE § 39-3702 (1985); ILL. REV. STAT. ch. 111½, ¶ 5102 (1990); IND. CODE ANN. § 16-8-7-2 (West 1984); IOWA CODE ANN. § 142A.8 (West 1989); KAN. STAT. ANN. § 65-3701 (1985); KY. REV. STAT. ANN. § 139.125 (Michie/Bobbs-Merrill 1992); LA. REV. STAT. ANN. § 9:2797 (West Supp. 1990); ME. REV. STAT. ANN. tit. 11, § 2-108 (West Supp. 1989); MD. HEALTH-GENERAL CODE ANN. § 18-402 (1990); MASS. GEN. LAWS ANN. ch. 106 § 2-316(5) (West 1990); MICH. COMP. LAWS ANN. § 333.9121(2) (West Supp. 1985); MINN. STAT. ANN. § 525.928 (West 1975); MISS. CODE ANN. § 41-41-1 (Supp. 1989); MO. ANN. STAT. § 431-069 (Vernon Supp. 1990); MONT. CODE ANN. § 50-33-102 to 104 (1989); NEB. REV. STAT. § 71-4001 (1986); NEV. REV. STAT. § 460.010 (1987); N.H. REV. STAT. ANN. § 507:8-b (1983); N.M. STAT. ANN. § 24-10-5 (1989); N.Y. PUB. HEALTH LAW § 580(4) (McKinney 1987); N.C. GEN. STAT. § 130A-410 (1989); N.D. CENT. CODE § 41-02-33(3)(d) (1983); OHIO REV. CODE ANN. 2108.11 (Baldwin 1990); OKLA. STAT. tit. 63, § 2151 (West 1984); OR. REV. STAT. § 97.300 (1989); PA. CONS. STAT. ANN. tit. 35, § 10021 (Purdon 1985); R.I. GEN. LAWS § 23-17-30 (1989); S.C. CODE ANN. § 44-43-10 (Law. Co-op. 1985); S.D. CODIFIED LAWS ANN. § 57A-2-315.1 (1988); TENN. CODE ANN. § 47-2-316(5) (1979); TEX. CIV. PRAC. & REM. CODE ANN. §§ 77.001-003 (Vernon 1986 & Supp. 1990); UTAH CODE ANN. § 26-31-1 (1989); VT. STAT. ANN. tit. 9A, § 2-108 (1990); VA. CODE ANN. § 32-1-297 (1985); WASH. REV. CODE ANN. § 70.54.120 (Supp. 1990); W. VA. CODE § 16-23-1 (1985); WIS. STAT. ANN. § 146.31(2) (West 1989); WYO. STAT. § 35-5-110 (1990).

42. *Id.*

states have adopted, in some form, a blood shield statute.⁴³ North Carolina's blood shield statute is representative of the majority of the blood shield statutes.⁴⁴ In North Carolina, blood donor services or the entities providing blood transfusions cannot be held liable under the theories of implied warranty of merchantability, implied warranty of fitness for a particular purpose, or strict liability, but these entities may be held liable in negligence if such can be established.⁴⁵ The other statutes found in a minority of jurisdictions allow recovery only in the tort actions of negligence and strict liability, but not under an implied warranty theory.⁴⁶ Even in New Jersey, the only state without a blood shield statute, the courts have discussed the liability of organizations and entities which provide blood transfusion services and have denied recovery to the injured plaintiffs in those cases based upon the public policy considerations as stated in the *Perlmutter* decision.⁴⁷ Although the wording of the blood shield statutes in each jurisdiction is different and each statute should be examined individually to determine its scope and applicability, the statutes have been quite effective in limiting plaintiffs' recovery.

C. *Strict Liability*

Strict liability in tort is another cause of action asserted by plaintiffs seeking to recover for injuries and damages sustained from blood transfusions. With strict liability, neither a contractual relationship nor any fault on the part of the blood bank, healthcare facility, or provider is a prerequisite for recovery.⁴⁸ However, in order for a plaintiff to succeed

43. *Id.*

44. N.C. GEN. STAT. § 130A-410 (1989). The complete text of section 130A-410 is as follows: The procurement, processing, distribution, or use of whole blood, plasma, blood products, blood derivatives and other human tissue such as corneas, bones or organs for the purpose of injecting, transfusing or transplanting any of them into the human body is declared to be, for all purposes, the rendition of a service by every participating person or institution. Whether or not any remuneration is paid, the service is declared not to be a sale of whole blood, plasma, blood products, blood derivatives or other human tissue, for any purpose. No person or institution shall be liable in warranty, express or implied, for the procurement, processing, distribution or use of these items but nothing in this section shall alter or restrict the liability of a person or institution in negligence or tort in consequence of these services.

45. Lipton, *supra* note 10, at 135.

46. *Id.* See, e.g., CONN. GEN. STAT. § 19a-280 (West 1986); LA. REV. STAT. ANN. § 9:2797 (West Supp. 1990); MICH. COMP. LAWS ANN. § 333.9121(2) (West Supp. 1985); MO. ANN. STAT. § 431-069 (Vernon Supp. 1990); OHIO REV. CODE ANN. § 2108.11 (Baldwin 1990); OKLA. STAT. tit. 63, § 2151 (West 1984); OR. REV. STAT. § 97.300 (1989); S.C. CODE ANN. § 44-43-10 (Law. Co-op. 1985); TENN. CODE ANN. § 47-2-316(5) (1979); VA. CODE ANN. § 32-1-297 (1985); and W. VA. CODE § 16-23-1 (1985).

47. See, e.g., *Magrine v. Kransnich*, 227 A.2d 539 (N.J. Super. 1967); *Johnson v. Mahlenberg Hosp.*, 232 A.2d 879 (N.J. Super. 1967).

48. *Howell v. Spokane and Inland Empire Blood Bank*, 785 P.2d 815 (Wash. 1990). The Washington Supreme Court made this statement concerning strict liability; however, the court still found that the transfusion of blood was a service and not a product, thus precluding liability based upon strict liability.

in an action for strict liability, the court must determine whether the jurisdiction allows such an action and, as with an implied warranty, whether a blood transfusion is a service or a product.⁴⁹ A strict liability claim is actionable only as to a defective and unreasonably dangerous product.⁵⁰ Thus, a plaintiff must meet this higher burden in order to recover damages.

The court in *Cunningham v. MacNeal Memorial Hospital*, one of the first cases that discussed strict liability in blood transfusion cases, found that a blood transfusion is a product and not a service and allowed a plaintiff who contracted hepatitis from a blood transfusion to recover her damages based upon a theory of strict liability.⁵¹ The court, in making its finding, cited the language of section 402A of the *Restatement of Torts*, which provides that an entity which sells a good or product in an unreasonably dangerous and defective condition is liable to the user or consumer for physical harm to his person or property even if fault on the part of the defendant entity cannot be proven.⁵² In *Cunningham*, the Illinois Supreme Court held that the hospital and the blood bank provided an unreasonably dangerous and defective product and that both organizations were a part of a "distribution chain" in which this product was involved.⁵³ After this ruling, the Illinois legislature and courts quickly and unequivocally overruled the *Cunningham* decision.⁵⁴

Prior to the enactment of the blood shield statutes, the majority of courts extended the *Perlmutter* decision concerning an implied warranty cause of action to those cases in which a strict liability cause of action was asserted.⁵⁵ Following the *Perlmutter* line of reasoning, a Washington Supreme Court in *Howell v. Spokane and Inland Empire Blood Bank*, refused to hold a blood bank and hospital liable when a plaintiff patient contracted AIDS from HIV-tainted blood during a transfusion.⁵⁶ Although Washington's blood shield statute bars actions based upon implied warranty and strict liability, the court found that the statute was not retroactive to the time period in which this patient's exposure took place, October 1984.⁵⁷ Here, the court denied recovery in strict liability based upon public policy concerns.⁵⁸ The court stated that the public needs an affordable, sufficient blood supply which warrants the distinction between those injured by a blood transfusion versus those injured by

49. Lipton, *supra* note 10, at 134.

50. RESTATEMENT (SECOND) OF TORTS § 402A (1965).

51. 266 N.E.2d 897 (Ill. 1970).

52. RESTATEMENT (SECOND) OF TORTS § 402A (1965).

53. 266 N.E.2d at 901.

54. See *Glass v. Ingalls Memorial Hosp.*, 336 N.E.2d 495 (Ill. App. Ct. 1975).

55. See, e.g., *Kolnig v. Milwaukee Blood Ctr., Inc.*, 127 N.W.2d 50 (Wis. 1964).

56. 785 P.2d 815 (Wash. 1990).

57. *Id.* at 822.

58. *Id.* See *supra* note 48 and accompanying text.

defective products.⁵⁹ Furthermore, at the time of this patient's exposure, no adequate method existed to screen the nation's blood supply for HIV antibodies; thus, strict liability could not be used as a deterrent for the prevention of future accidents of this nature.⁶⁰ The court also concluded that notwithstanding the fact that providers of blood and blood transfusions may be in the best position to absorb the cost of damages sustained by transfusions, these costs would be levied on the consumer, and this would not be in the public's best interest.⁶¹ Finally, although blood banks charge a fee for blood, they are typically non-profit organizations providing a necessary service to the public.⁶²

Similarly, in *Kozup v. Georgetown University* the District Court of the District of Columbia held that a plaintiff who contracted AIDS through a blood transfusion could not recover under strict liability.⁶³ The *Kozup* court, like the *Perlmutter* court, found that a blood transfusion is a service and not a product.⁶⁴ Furthermore, the court stated that the need for an affordable, adequate blood supply outweighed the need of this injured plaintiff to recover.⁶⁵ In dicta, the court mentioned that the comment k, "unavoidably unsafe product" exception, to section 402A of the *Restatement of Torts* would be inapplicable even if a blood transfusion could be found to be a product because of its impure nature, and that this exception applies only to products of a pure nature, such as drugs and vaccinations.⁶⁶ Presently, the ELISA and Western Blot tests have made the blood supply much safer than it was in March 1985, which further weakens the unavoidably unsafe product exception rationale in the case of blood. Thus, under the current status of the law, in most cases a plaintiff asserting a claim based upon strict liability would be unsuccessful.

D. Negligence

Because most courts have been reluctant to allow plaintiffs to recover under theories of implied warranty and strict liability, a plaintiff who contracts AIDS through a blood transfusion will most likely be successful when asserting a negligence claim against a blood bank, healthcare facility, or physician.⁶⁷ During the 1980's, plaintiffs generally asserted all three claims — implied warranty, strict liability, and negligence.⁶⁸

59. 785 P.2d at 822.

60. *Id.*

61. *Id.*

62. *Id.*

63. 663 F. Supp. 1048 (D.D.C. 1987), *aff'd in part, vacated in part on other grounds*, 851 F.2d 437 (D.C. Cir. 1988).

64. *Kozup*, 663 F. Supp. at 1059.

65. *Id.*

66. *Id.*

67. Janowitz, *supra* note 4, at 618.

68. Stevens, *supra* note 1, at 225.

While the courts dismissed the implied warranty and strict liability claims immediately, negligence claims usually survived summary judgment motions.⁶⁹ However, in the 1980's the vast majority of these cases were decided in favor of the defendant.⁷⁰ While there was no major award for negligence liability in the 1980's, when the 1990's began, the potential for such an award existed.⁷¹

A fundamental understanding of the elements of a negligence claim is essential in determining whether such a claim can be maintained. A defendant can be held liable under a theory of negligence by failing to act reasonably in light of all foreseeable risks and accepted standards of practice at the time the blood donation or transfusion occurs.⁷² The four essential elements required to assert a medical negligence claim are the following: a legally recognized duty requiring the defendant to conform to an accepted standard of conduct; a failure of the defendant to conform to that accepted standard of conduct; a reasonably close and foreseeable causal connection between the conduct of defendant and the actual injury which results; and the suffering of actual harm by the plaintiff.⁷³

In the past, the following three prominent negligence theories have been asserted against blood banks: a failure by a blood bank to use surrogate testing to eliminate AIDS-contaminated blood from the nation's blood supply before 1985 when HIV antibodies testing became readily available; a failure of a blood bank to use the HIV antibody screening tests once the test became available in March 1985; and a failure by a blood bank to warn the donor of the risk of donating blood on subsequent occasions after discovering the HIV antibodies in the donated blood units.⁷⁴ Although no plaintiff has recovered damages based upon the last theory of negligence, plaintiffs who have asserted either of the other two theories have been successful.⁷⁵ Additionally, the following three negligence theories have been asserted by plaintiffs against hospitals and physicians and have been occasionally successful: a claim based upon a physician's negligent determination that the plaintiff needed a blood transfusion; a claim based upon a physician's negligent medical treatment which created the need for the blood transfusion that caused the plaintiff's injury; and a claim based upon a physician's failure to inform the plaintiff of the risks associated with a blood transfusion, or a failure to advise the plaintiff about the possibility of a directed donation in which the blood is donated by a source chosen by the patient, or of an

69. *Id.*

70. *Id.*

71. *Id.* at 226.

72. *Id.*

73. Janowitz, *supra* note 4, at 619.

74. Stevens, *supra* note 1, at 226.

75. *Id.*

autologous blood donation in which blood is drawn from the patient prior to the surgery.⁷⁶

The seminal case concerning the negligent transfusion of blood epitomizing the 1980's trend not to hold blood banks, hospitals, and physicians liable for blood transfusions administered before March 1983, when the medical community was unaware that AIDS could be transmitted by blood, was *Kozup v. Georgetown University*.⁷⁷ In January 1983, at Georgetown University Hospital, a premature infant received a blood transfusion of AIDS-contaminated blood supplied by the American Red Cross.⁷⁸ After the infant contracted AIDS from the blood transfusion and died in 1986, the infant's parents brought a negligence claim against the hospital and the American Red Cross, stating that the hospital breached its duty of care by failing to take preventative measures to protect the infant from contracting AIDS, and alleging that the American Red Cross breached its duty of care to provide a sufficient and safe blood supply.⁷⁹ The court found that the care given to the infant was consistent with the prevailing professional standard of care, given the medical and scientific uncertainty at the time the blood was transfused.⁸⁰ In the 1980's the majority of courts held this view.⁸¹

However, in the 1990's, some federal courts began to allow plaintiffs to recover for these AIDS-related injuries sustained from blood transfusions.⁸² Furthermore, in some cases, especially those cases after March 1985, in which HIV antibody tests were available, but the blood units were not tested before the blood was transfused, the American Red Cross has settled prior to trial.⁸³ Two cases in which district courts have allowed substantial recoveries in negligent blood transfusion cases are

76. *Id.*

77. 663 F. Supp. 1048 (D.D.C. 1987), *aff'd in part, vacated in part on other grounds*, 851 F.2d 437 (D.C. Cir. 1988).

78. 663 F. Supp. at 1050.

79. *Id.* at 1055.

80. *Id.* at 1058.

81. *See, e.g., Hoemke v. New York Blood Ctr.*, 912 F.2d 550 (2nd Cir. 1990). The Court of Appeals for the Second Circuit found that the hospital did not breach a duty of care when the hospital personnel failed to advise a patient who contracted AIDS through a blood transfusion during a 1981 surgery of the option of an autologous or directed blood transfusion or by failing to inform or train hospital employees on how or when to avoid transfusions in some circumstances. Furthermore, the blood bank did not breach a duty of care when it failed to screen out gay male blood donors and failed to screen the blood with an alanine aminotransferase test, a test which detects hepatitis in the bloodstream. In *Kirkendall v. Harbor Ins. Co.*, 887 F.2d 857 (8th Cir. 1989), the court found that the blood bank's screening practices did not proximately cause the plaintiff to contract AIDS. The blood bank personnel were trained to use the ELISA tests after the blood had been transfused to the plaintiff.

82. Stevens, *supra* note 1, at 234.

83. *Id.* at 227.

*Gaffney v. United States*⁸⁴ and *Doe v. United States*.⁸⁵ Whether the appellate courts will uphold these awards is unclear, but the potential for recovery exists, especially in cases such as these two where gross medical malpractice is involved.

In *Gaffney*, a man who contracted AIDS from his deceased wife sued the United States on his own, as well as on his deceased wife and son's, behalf.⁸⁶ Gaffney's complaint alleged that as a result of a Massachusetts naval hospital physician's negligent management of his wife's pregnancy, his wife was required to undergo a blood transfusion with AIDS-contaminated blood.⁸⁷ The court found the physician's conduct to be gross medical malpractice and stated that even though the risk of contracting AIDS through a blood transfusion was unknown in September 1981, the risk of contracting transfusion-related illnesses such as hepatitis and syphilis was a foreseeable consequence of a blood transfusion.⁸⁸ The court stated that because the physician's negligent conduct was the proximate cause of the injuries to the Gaffney family, the fact that the physician neither foresaw nor should have foreseen the consequence of contracting AIDS through a blood transfusion would neither prevent his liability nor the liability of the hospital.⁸⁹

Similarly, in *Doe v. United States*, the Rhode Island District Court followed the holding of the *Gaffney* court by stating that the plaintiff must prove that his injury was a direct and foreseeable result of the defendant's negligence. The *Doe* court stated that when the plaintiff's son had a tonsillectomy in April 1983, there was clearly a foreseeable risk that a patient could contract AIDS through a blood transfusion; thus, the hospital should be held liable.⁹⁰

These results seem to indicate that courts are increasingly willing to hold hospitals, blood banks, and physicians liable for the damages they cause through AIDS-tainted blood transfusions. However, in reaching these decisions, these courts battled with the public policy concerns of two competing interests — the desire to protect the availability and integrity of the nation's blood supply versus the desire to compensate the innocent victim for his injuries. Furthermore, when asserting a negligence claim, the plaintiff faces many problems such as problems with causation, problems with establishing the proper professional standard of care, problems with establishing a negligent blood donor screening proce-

84. 1990 U.S. Dist. LEXIS 5184 (D. Mass. 1990).

85. 737 F. Supp 155 (D.R.I. 1990).

86. *Gaffney v. United States*, 1990 U.S. Dist. LEXIS 5184 (D. Mass. 1990) at *5 (asterisk indicates Lexis pagination).

87. *Id.*

88. *Id.* at *20.

89. *Id.*

90. 737 F. Supp. at 161-62.

ture case because the court will not allow discovery of the donor's identity, problems in determining when the statute of limitations begins to accrue, and problems in determining which court should hear the plaintiff's cause of action.

1. Standard of Care Problems

When a plaintiff asserts a negligence claim against a blood bank, healthcare facility, or physician for an injury associated with a blood transfusion, the plaintiff, in order to recover, must prove that the defendant failed to act reasonably in light of all foreseeable risks and accepted standards of practice at the time the blood donation or transfusion occurred.⁹¹ A blood bank, healthcare facility, and physician are often held to the professional standard of care which is the same degree of care that other blood banks and healthcare facilities and professionals would exercise in similar situations.⁹² In *Kozup*, the District of Columbia District Court held a hospital and a blood bank to the industry standard by which all other blood-donating services and transfusion providers could be measured in negligence cases.⁹³ However, to establish the industry standard of care for those entities providing blood transfusions, the plaintiff must deal with three different standards of care during three different time periods associated with the AIDS crisis.⁹⁴ These three time periods are of critical importance and are also a major source of conflict for the plaintiff trying to assert a negligence claim.

Before March 1983, conflicting information existed concerning whether AIDS could be transmitted through the nation's blood supply, and no blood donor screening guidelines or antibody screening tests were available to detect donors who carried the AIDS virus or those units of AIDS-tainted blood.⁹⁵ Therefore, a court is extremely unlikely to find that a blood bank, hospital, or physician could have known of the risk of AIDS, or should have known of the risk of AIDS and could have taken precautions against its transmission through a blood transfusion.⁹⁶

In regard to the second critical time period, from March 1983 to March 1985, the court, when hearing blood transfusion cases, will be concerned with various matters such as which of the FDA guidelines and recommended procedures and practices were implemented and the speed of their implementation.⁹⁷ In the majority of cases concerning negligent blood transfusions prior to March 1985, the court will determine if any

91. Stevens, *supra* note 1, at 227.

92. *Kozup v. Georgetown Univ.*, 663 F. Supp. 1048, 1057 (D.C. 1987).

93. *Id.*

94. Lipton, *supra* note 10, at 143.

95. *Id.* at 144.

96. *Id.*

97. *Id.* at 145.

negligent conduct existed in the performance of two common practices associated with blood transfusions — the use of FDA-recommended questionnaires and the use of surrogate tests to detect other viruses commonly found in AIDS patients' blood.⁹⁸ It is unlikely that a negligence claim could be proven in cases in which the screening of the donor occurred prior to the initiation of HIV antibody screening tests, because the courts, based on privacy and confidentiality rights, usually will not allow the plaintiff to discover the name of the donor who donated the AIDS-contaminated blood.⁹⁹ This inability to question a valuable witness compounded with the fact that donor questionnaires are highly dependent on the cooperation and honesty of blood donors, makes a case of negligent screening almost impossible for the plaintiff to prove.¹⁰⁰ Furthermore, a negligent failure by a blood bank, healthcare facility, or physician to use surrogate testing to detect AIDS in the blood would also be difficult to establish.¹⁰¹ Thus, this type of claim fails because even if a surrogate test determines that there is an infectious virus in a blood unit, the test will not confirm the presence of HIV antibodies, and none of the tests used during this time period were licensed by the FDA to screen for the presence of HIV antibodies.¹⁰² A defendant blood donor service or transfusion provider usually only needs to show that the defendant adhered to the FDA-recommended standards and the standards of the American Association of Blood Banks. This will establish that there was no breach of a duty of care to protect the nation's blood supply from the AIDS virus.¹⁰³

Finally, when considering the blood which was collected after the HIV antibody screening tests were routinely used, beginning in March 1985, a plaintiff, when asserting a breach of a standard of care argument, should base his negligence claim on the speed of the implementation of the screening tests and/or the varying sensitivities and specificities of one manufacturer's test versus that of another.¹⁰⁴ Although each of these types of negligence cases will be fact-specific, the CDC has stated that all blood banks, hospitals, and physicians quickly implemented the HIV antibody screening tests as soon as these tests became available.¹⁰⁵ Furthermore, the CDC indicated that once these tests were routinely used, then, barring any negligent failure to screen blood, these blood donor and transfusion services would operate with little risk of liability.¹⁰⁶

98. *Id.*

99. *Id.* at 146.

100. *Id.*

101. *Id.*

102. *Id.*

103. *Id.*

104. *Id.* at 151.

105. *Id.*

106. *Id.*

One of the earliest cases exemplifying the standard of care in the post-HIV antibodies test era and which may be indicative of subsequent rulings on this issue is *Smythe v. American Red Cross Blood Services Northeastern New York*.¹⁰⁷ In *Smythe*, the plaintiff was exposed to AIDS via a blood transfusion which contained no HIV antibodies.¹⁰⁸ The unit of blood used in the plaintiff's transfusion was donated on April 30, 1986, by a donor who recently had been exposed to the AIDS virus, but had not yet developed HIV antibodies.¹⁰⁹ The first unit of donated blood tested negative, but when the same donor returned to donate blood again almost two months later, his blood tested seropositive for the HIV antibody.¹¹⁰ The plaintiff brought a malpractice cause of action against the hospital and a negligence claim against the Red Cross stating that the hospital was negligent in its administration of blood and failed to adhere to accepted medical and surgical standards and that the blood bank was negligent in its collection and distribution of blood.¹¹¹ The plaintiff claimed that the negligence of both of these entities was the direct and proximate cause of her injuries.¹¹² However, the defendants subsequently moved for summary judgment pursuant to Rule 56 of the Federal Rules of Civil Procedure, and the court granted the defendants' motion.¹¹³

The *Smythe* case is noteworthy because it provides a detailed discussion of the facts surrounding the donation of blood and the appropriate standard of care to be used by hospitals and blood banks in the post-HIV antibodies test era in all cases. The general rule for the Red Cross and other entities which voluntarily gather and distribute blood is that these professionals and organizations are held to the prevailing standard of care of their profession or industry.¹¹⁴ However, if a profession or an organization is lax in its adoption and administration of its procedures, then the court can hold the defendant to a higher standard of care than adopted and administered by the profession or industry.¹¹⁵ The Red Cross was a forerunner in its implementation of predonative, disease-preventative measures and properly and promptly made every effort to comply with all guidelines to ensure the adequacy and safety of the nation's

107. *Smythe v. American Red Cross Blood Serv. Northeastern N.Y.*, 797 F. Supp. 147 (N.D.N.Y. 1992).

108. *Id.* at 150.

109. *Id.*

110. *Id.* at 150-51.

111. *Id.* at 149.

112. *Id.*

113. *Id.* at 153. Rule 56(b) of the Federal Rules of Civil Procedure states: "A party against whom a claim, counterclaim, or cross-claim is asserted or a declaratory judgment is sought may, at any time, move with or without supporting affidavits for a summary judgment in the party's favor as to all or any part thereof."

114. *Smythe*, 797 F. Supp. at 152.

115. *Id.*

blood supply.¹¹⁶ In this case, the court found that the evidence was overwhelming that the Red Cross followed all applicable FDA and American Association of Blood Banks guidelines and adhered to all prevailing and contemporary standards and practices of volunteer blood collecting services.¹¹⁷

In *Smythe*, the donor was given a pamphlet discussing the most current information concerning the donation of blood and the prevention of diseases, including AIDS, orally instructed by a Red Cross employee to read the pamphlet, and required to sign a statement verifying that he read it.¹¹⁸ Moreover, the donor was also required to answer twenty questions concerning his medical history and was given a physical by a Red Cross nurse which included a hemoglobin test and an examination for needle marks and skin lesions to determine if the donor may have been exposed to AIDS.¹¹⁹ Finally, the donated blood was tested for HIV antibodies and other blood-borne illnesses.¹²⁰ All these tests and implemented procedures led the Red Cross to find no reasons for the donor's blood to be rejected.¹²¹

As aforementioned, the ELISA and Western Blot test will detect most, but not all, blood that contains the AIDS virus; consequently, blood from a donor during the window-period of the virus will test seronegative for the HIV antibody.¹²² Since there is no blood test to detect AIDS before the HIV antibodies appear, the nation's blood supply will probably never be completely safe and reliable. Thus, as found in the *Smythe* case, when hospitals and the Red Cross adhere to the prevailing standard of care for their profession, summary judgment in favor of the defendants may be granted and these entities which provide these services will be protected from liability. The *Smythe* case may be indicative of how other courts will rule and could deter this type of plaintiff from seeking compensation for his or her transfusion-related injuries.

2. The Blood Donor's Right to Privacy and the Negligent Screening of Donors Problem

Traditionally, the plaintiff has faced many difficulties in trying to persuade a court to compel the discovery of a donor's identity. In order for a plaintiff to prove that the blood bank, healthcare facility, or physician used negligent screening practices, the donor's testimony is often crucial. However, once the donor's identity is discovered, his right to privacy is

116. *Id.*

117. *Id.*

118. *Id.* at 149-50.

119. *Id.*

120. *Id.*

121. *Id.*

122. *Id.* at 152-53. See *supra* note 12 and accompanying text.

lost, and his HIV-positive status is revealed. Generally, the legal justification for the donor's protection has been found within the protection afforded by the physician/patient privilege and the constitutional right to privacy.¹²³ Although a discussion of the physician/patient privilege and the constitutional right to privacy arguments are beyond the scope of this essay, the request for compelled discovery of a donor's medical records is becoming more frequent and is creating a major source of controversy between two public policy concerns — the right of an individual to recover his damages from an AIDS-contaminated blood transfusion and the donor's right to his anonymity. A split of authority exists on this issue with some courts finding that a donor's right to privacy and the need for an adequate blood supply are far superior to the rights of plaintiffs seeking discovery.¹²⁴ Other courts have allowed discovery of facts and information concerning the donor's predonative screening evaluation, but not his identity,¹²⁵ usually by using a veiled deposition decree.¹²⁶ At the other end of the spectrum, some courts have allowed the total disclosure of the donor's identity and last known address.¹²⁷ Thus, the question of whether the court will allow discovery of the donor's identity so that the plaintiff can more easily prove a negligent blood donor screening case varies among the jurisdictions, and an examination of each jurisdiction's case law is necessary.

3. Statute of Limitations Problems

As with most medical negligence cases, the time the statute of limita-

123. Lipton, *supra* note 10, at 161.

124. See *Rasmussen v. South Fla. Blood Serv.*, 500 So. 2d 533 (Fla. 1987). The plaintiff's motion to discover the names of fifty-one blood donors was deemed a fishing expedition by the court. This type of discovery was felt by the court not to further the plaintiff's interest in compensation for his injuries, but could, however, interfere in the personal lives of the donors and could hinder efforts to maintain an adequate blood supply. The plaintiff here was injured when he was struck by a car while sitting on a bench; he received fifty-one units of blood while hospitalized and died of AIDS two years later. In *Laburne v. East Jefferson General Hospital*, 555 So. 2d 1381 (La. 1990), the plaintiff contracted hepatitis via a blood transfusion. The Louisiana Supreme Court found that a donor's right to privacy and the need for an adequate blood supply outweighed the plaintiff's need for the discovery of the donor's name and address. The court stated that the discovery of the information on the donor's cards and follow-up questionnaires would suffice, and the discovery of the donor's name and address would be excessive.

125. See *Belle Bonfils Memorial Blood Ctr. v. District Court*, 763 P.2d 1003 (Colo. 1988) (allowing the discovery of masked donor cards, but not the donor's identity or address).

126. See *Doe v. American Red Cross Blood Serv.*, 125 F.R.D. 646 (D.S.C. 1989).

127. See *Sampson v. Am. Nat'l Red Cross*, 139 F.R.D. 95 (N.D. Tex. 1991) (finding that the right of privacy in transfusion-related injury cases is not absolute, but rather involves a weighing of interests). In *Watson v. Lowcountry Red Cross*, 974 F.2d 482 (4th Cir. 1992), the court found that the acceptance of the Red Cross's public policy arguments would lead to "blanket immunity from donation-related injuries," and the donor is the person who is in the best position to recall any negligence by the Red Cross in its screening process. Moreover, the court stated that the donor's testimony is very important in proving the plaintiff's negligence claim. Thus, the discovery of the donor's identity was allowed.

tions begins to accrue is a perennial problem, especially with diseases such as AIDS with long and varied incubation periods. A review of the medical malpractice case law in each jurisdiction will be necessary to determine whether the discovery rule is recognized in that jurisdiction and to determine when a negligence claim will be barred because of the running of the statute of limitations.

4. Procedural Problems

The issue of whether the American National Red Cross could sue or be sued in federal court was a question which generated much litigation. Currently, more than forty district courts have heard this question, but no consensus of authority exists.¹²⁸ The congressional charter of the American National Red Cross authorizes the Red Cross "to sue and be sued in courts of law and equity, State and Federal within the jurisdiction of the United States."¹²⁹ The Supreme Court decided, in the case of *American National Red Cross v. S.G.*, that the "sue and be sued" provision grants the federal courts original jurisdiction over all cases in which the Red Cross is a party to the action.¹³⁰ This provision, which specifically states that the federal court has original jurisdiction, was deemed by the court to be an express authorization granting federal jurisdiction.¹³¹ The *American National Red Cross* case is a landmark decision because in all subsequent cases in which the Red Cross is named as a defendant in a state-law action, the Red Cross is authorized to remove a case from a state court to a federal court pursuant to removal jurisdiction.¹³² The impact and repercussions of this decision are only speculative at this point, but some potential consequences include an increase in the federal district courts' docket and the selection of jurors from different localities which may affect the finding of culpability on the part of the Red Cross and the amount of damages awarded.

III. PUBLIC POLICY CONSIDERATIONS

In considering whether blood banks, hospitals, and physicians can be held liable to a plaintiff who contracted AIDS through an AIDS-tainted blood transfusion, the legislatures and courts have pursued a common goal — to protect the blood donor services and transfusion providers so that both an adequate blood supply and safe, cost-efficient blood transfusions will be available. Thus far, the trend appears to be that the courts are reluctant to find the defendant blood bank, hospital, or physician lia-

128. *American Nat'l Red Cross v. S.G.*, 112 S.Ct. 2465, 2468 n.1 (1992).

129. 36 U.S.C. § 2 (1988).

130. 112 S.Ct. at 2467.

131. *Id.* at 2472.

132. *Id.* at 2467; 28 U.S.C. 1441 (1988).

ble based upon theories of implied warranty, strict liability, and negligence. Even though the present risk of contracting AIDS through the blood supply is less likely with the advent of both accurate and sensitive HIV antibody screening tests, the legislatures, through the enactment of the blood shield statutes, have determined that a supplier of a good or service, such as blood, which greatly benefits the interest of society as a whole should not be faced with the burden of defending an infinite number of claims of damages and injuries resulting from blood transfusions. The cost of litigation is rapidly increasing, and this, in addition to the cost of potential awards against the defendant, would result in an increase in the price of blood and blood transfusions, and could possibly discourage blood banks and the medical industry from providing this risky and costly service which a patient may need to survive. Thus, by limiting the liability of blood banks, medical facilities, and physicians stemming from transfusion-associated injuries, these entities will continue to provide a valuable public service.

While the legislatures have limited recoveries under an implied warranty or a strict liability theory, the courts have made a negligence claim increasingly difficult for a plaintiff, without expending large amounts of money, time, and effort, to prove. The plaintiff must overcome many hurdles in proving a negligence claim, such as finding the applicable standard of care when the transfusion occurred. Furthermore, because the donor who donated the AIDS-tainted blood may be deceased, or the court refuses to compel the discovery of his identity, a valuable and necessary witness needed to prove a negligent donor screening case may be unavailable.¹³³ Also, as aforementioned, the fact that AIDS remains dormant and without any physical manifestations for an indefinite period of time gives rise to a statute of limitations problem. For these reasons, the plaintiff generally has been unable to recover under any theory, and the legislatures' and courts' goal of maintaining an adequate blood supply has been realized. Donors are more apt to donate blood if their identity and HIV status remain undisclosed. Additionally, if blood bank directors, hospital administrators, and physicians are confident that they will not be sued, then aggressive measures on their part to collect and transfuse blood will not be stifled.

However, these goals cannot be achieved without some costs. A chilling effect will result, causing fewer plaintiffs to initiate claims against blood collecting and transfusion-providing services if the plaintiff perceives his claim to be futile. If these organizations and persons providing these services are confident that they will be immune from any civil lia-

133. Jan M. Bennetts, *AIDS; Blood Bank Liability*, 27 WILLAMETTE L. REV. 355, 362-65 (1991). This thoughtful comment provides a more detailed discussion of strict liability as a viable option to provide compensation for those innocent victims of transfusion-related injuries.

bility resulting from an AIDS-tainted blood supply, what incentive, other than a moral one in protecting lives, would these entities have?¹³⁴ Would those providing these services become complacent in their present AIDS-preventive measures? How many people would have to die before the legislatures and courts would feel compelled to react? Even though blood transfusions are often necessary to save lives, how useful would transfusions be if they only cured the immediate crises, but later subjected a patient to the painful, deadly disease of AIDS? These public policy and ethical questions need answers which the legislatures and courts have failed to supply.

In considering these three main theories of recovery, would not a strict liability claim be a viable option for the plaintiff who in the future is exposed to the AIDS virus through a blood transfusion?¹³⁵ Here the plaintiff would not have to prove any negligence or fault on the part of the defendant, and a donor witness would not be necessary in order to prove a negligent donor screening case.¹³⁶ Furthermore, because of the HIV antibody screening tests, the blood supply is much safer, and the chance of contracting AIDS through a blood transfusion is much lower.¹³⁷ Thus, these blood banks, hospitals, and physicians who are in a much better position to absorb the cost of the injury, instead of the innocent plaintiff who is fighting a deadly disease and paying medical expenses, could bear the cost of an AIDS-tainted blood transfusion.¹³⁸ Furthermore, holding blood banks, hospitals, and physicians liable without fault would force them to operate a much safer organization or practice under the threat of civil litigation.¹³⁹ Blood banks would have to practice more stringent predonative measures, and a physician would be more likely to inform his patients of the dangers of blood transfusions and of the possibility of potentially safer alternatives such as directed or autologous donations. The blood from these alternative sources could be tested as well, and if that blood was not used during the surgery, then it could be used in the general blood supply. With all these advantages, an examination by the legislatures and courts of the possibility of allowing a strict liability cause of action in regard to AIDS-related blood transfusion injuries is warranted.

IV. CONCLUSION

As litigation surrounding AIDS-contaminated blood transfusions continues, the need for an adequate and safe blood supply and an innocent

134. *Id.*

135. *Id.* See *supra* note 134 and accompanying text.

136. *Id.*

137. *Id.*

138. *Id.*

139. *Id.*

victim's right to recover must be balanced in order to determine how the public's interest can be served best. Because of the existing laws, such as the blood shield statutes, and the obstacles involved in proving causation in a medical malpractice case, the trend has been to protect the blood supply in lieu of compensating those who have been injured and have suffered. Only by the thoughtful considerations of the legislatures, the courts, attorneys, and the public will the answers to these complicated questions and problems be found.

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