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QUINTANA v. UNITED BLOOD SERVICES: EXAMINING INDUSTRY PRACTICE IN TRANSFUSION-RELATED AIDS CASES

AIDS throws new light on traditional questions of value, compels a fresh look at the performance of the institutions we depend on and brings society to a crossroads for collective action that may, with the passage of years, mark a key measure of our time.

— Harvey V. Fineberg, Dean of the
Harvard School of Public Health¹

INTRODUCTION

Acquired Immune Deficiency Syndrome (AIDS) presents one of the most serious and controversial public health problems of our time.² Since the first cases of AIDS were diagnosed in the United States in 1981, the number of people infected with the Human Immunodeficiency Virus (HIV), which causes AIDS and AIDS-related conditions, has increased exponentially.³ The Centers for Disease Control (CDC) estimates that as many as 1.5 million people are infected with the virus in the U.S. alone.⁴ Fueled in part by such numbers, the widespread fear generated by HIV is unprecedented in modern society.⁵

¹ Harvey V. Fineberg, *The Social Dimension of AIDS*, SCI. AM., Oct. 1988, at 128.

² Dianne Feinstein, *Foreword to AIDS: PRINCIPLES, PRACTICES & POLITICS* xv, xv (Inge B. Corless & Mary Pittman-Lindeman eds., 1988).

³ Susan Y. Chu, *Epidemiology of HIV in the United States*, in AIDS: ETIOLOGY, DIAGNOSIS, TREATMENT AND PREVENTION 99, 99 (Vincent D. DeVita, Jr. et al. eds., 3d ed. 1992). From 1981 through February 1991, over 160,000 AIDS cases in the United States were reported to the Centers for Disease Control (CDC). Presently AIDS is the second leading cause of death in men in the U.S. between the ages of 25 and 44 years, and the eighth leading killer among women aged 25 to 44. Paul A. Volberding, *Clinical Spectrum of HIV Disease*, in AIDS: ETIOLOGY, DIAGNOSIS, TREATMENT AND PREVENTION, *supra*, at 123, 123.

⁴ William L. Heyward & James W. Curran, *The Epidemiology of AIDS in the U.S.*, SCI. AM., Oct. 1988, at 72. While infection with HIV may lead to full-blown AIDS, infected persons can be asymptomatic carriers. *Id.* An estimated five to ten million people worldwide are infected with the AIDS virus. Jonathan M. Mann et al., *The International Epidemiology of AIDS*, SCI. AM., Oct. 1988, at 82.

⁵ D. Anthony Forrester, *AIDS: The Responsibility to Care*, 34 VILL. L.

What began primarily as a medical problem, today raises a number of troublesome political, social, and ethical questions, which pose profound challenges to the legal system. Presently courts must confront the issue of liability of blood suppliers for transfusion-associated AIDS. With approximately three million Americans each year, and ninety-five percent of the U.S. population by the time they reach age seventy-two, requiring transfusions of blood or blood products,⁶ the quality of the nation's blood supply, particularly in light of the AIDS epidemic, affects much of our society.⁷

As of February 1991, over five thousand people were infected with HIV-contaminated blood or blood products and developing AIDS.⁸ Moreover, the CDC estimates that up to 15,000 people are currently infected with transfusion-related HIV.⁹ The majority of these cases involve blood or blood products received before a screening test for the HIV antibody became available in 1985.¹⁰ Since the average incubation period¹¹ of the disease is 7.8 years with a maximum period of approximately ten years,¹² individuals infected with HIV prior to 1985 may have developed symptoms of AIDS and many subsequently have died.¹³ Fortunately, the victims of HIV-contaminated transfusions can turn to the legal system to seek compensation from the suppliers of the tainted blood for their injuries.

REV. 799, 799 (1989).

⁶ See Ross D. Eckert, *Blood, Money, and Monopoly*, in SECURING A SAFER BLOOD SUPPLY 3, 49 (Ross D. Eckert & Edward L. Wallace eds., 1985), for a discussion of blood, plasma, their various components, and the products that can be derived from each.

⁷ *Id.*

⁸ Chu, *supra* note 3, at 106.

⁹ *Update: Acquired Immunodeficiency Syndrome — United States, 1989*, 39 MORBIDITY & MORTALITY WKLY. REP. 81 (1990).

¹⁰ Chu, *supra* note 3, at 106.

¹¹ The incubation or latency period is the delay between the time of HIV which causes AIDS and AIDS-related conditions, infection and the manifestation of clinical AIDS symptoms. Susan Aoki & Paul Holland, *The Safety of Blood and Blood Products*, in AIDS: ETIOLOGY, DIAGNOSIS, TREATMENT AND PREVENTION, *supra* note 3, at 463, 464.

¹² *Study Predicts 99 Percent of Infected Men to Get AIDS*, 3 AIDS POL'Y & L. (BNA) No. 11, at 2 (June 15, 1988).

¹³ Aoki & Holland, *supra* note 11, at 464.

The protection courts once afforded blood banks from such AIDS litigation is diminishing.¹⁴ Until recently, blood suppliers were not held negligent for contaminated transfusions because the common perception was that during the early 1980's, transfusion-transmitted HIV did not pose a foreseeable risk.¹⁵ However, in *Quintana v. United Blood Services*,¹⁶ a Colorado state court jury abrogated this view, ordering a blood supplier to pay over six million dollars in damages to a woman who contracted AIDS from a 1983 transfusion.¹⁷ The jury rejected the blood bank's claim that in light of limited medical knowledge available at the time of the transfusion, the blood bank took reasonable and prudent precautions to safeguard the blood supply.¹⁸ Rather, the jury concluded not only that the defendant blood bank was negligent under the prevailing standard of care, but that the 1983 industry standard as a whole was deficient.¹⁹

The *Quintana* litigation marked the first time in the United States that a judge allowed a jury to scrutinize blood industry standards at the time of an HIV-tainted transfusion.²⁰ Subsequently, *Quintana* opens the door to recovery under a negligence theory for other transfusion victims.²¹ This Article examines

¹⁴ Kathryn G. Lotfi, *Suppliers of AIDS-Contaminated Blood Now Face Liability*, 34 HOW. L.J. 183, 183 (1992); David Stevens, *Negligence Liability for Transfusion-Associated AIDS Transmission*, 12 J. LEGAL MED. 221, 240 (1991).

¹⁵ See *Kozup v. Georgetown Univ.*, 663 F. Supp. 1048, 1057-58 (D.D.C. 1987) (refusing to hold blood bank liable for failure to employ surrogate testing where no governmental or medical organizations advocated its use for AIDS screening), *aff'd in part, vacated in part on other grounds*, 851 F.2d 437 (D.C. Cir. 1988); *Doe v. Miles Lab., Inc.*, 927 F.2d 187, 195 (4th Cir. 1991); *Osborn v. Irwin Memorial Blood Bank*, 7 Cal. Rptr. 2d 101, 128-29 (Cal. Ct. App. 1992).

¹⁶ No. 86 Civ. 11750 (Dist. Ct., Denver County, Colo. Aug. 1, 1991) (special verdict form), *aff'd*, 811 P.2d 424 (Colo. App. 1991), *aff'd and remanded*, 827 P.2d 509 (Colo. 1992).

¹⁷ *Id.*

¹⁸ See *id.*

¹⁹ *Id.*

²⁰ Howard Pankratz, *\$8 Million Awarded in AIDS Trial*, DENVER POST, August 2, 1992, at 1A, 15A.

²¹ The date of the contaminated transfusion is a key factor in determining the imposition of liability where the knowledge concerning AIDS changed rapidly. Prior to 1982 the possibility of AIDS being transmissible by blood transfusions had not been publicized. Thus, the case for imposing liability becomes stronger as the date of the transfusion gets later.

the liability of blood suppliers for transfusion-associated AIDS and argues that imposing liability on blood banks for failing to reduce the threat of transfusion-transmitted AIDS in 1983 achieves a socially desirable result. Part I briefly outlines the medical knowledge regarding transfusion-associated AIDS and the evolution of the blood banking community's position concerning the epidemic. Part II establishes an analytical framework for the *Quintana* case by reviewing the theories of liability typically advanced by victims of HIV-tainted transfusions and the obstacles impeding each theory. Part III examines *Quintana*, focusing particularly on the implications of the decision for future transfusion cases. Part IV discusses the public policy issues involved and concludes that the public interest is best served by imposing liability on the blood industry for failing to take readily available precautions to reduce the risk of HIV-contaminated transfusions between mid-1983 and 1985.

I. AIDS: A BRIEF BACKGROUND OF THE DISEASE

Acquired Immunodeficiency Syndrome (AIDS) is a fatal viral disease caused by a human retrovirus referred to as the Human Immunodeficiency Virus (HIV).²² The virus is transmitted by exposure to infected blood, sexual contact with an infected person, and perinatally, from an infected mother to her child.²³ Infected persons are susceptible to a number of opportunistic infections and diseases which would not normally affect healthy individuals.²⁴ While individuals infected with HIV may remain healthy and asymptomatic,²⁵ the fatality rate of the infection is extraordinarily high:²⁶ almost 100% mortality among patients with opportunistic infections and cancers.²⁷

²² Ruth I. Connor & David D. Ho, *Etiology of AIDS: Biology of Human Retroviruses*, in AIDS: ETIOLOGY, DIAGNOSIS, TREATMENT AND PREVENTION, *supra* note 3, at 13, 13.

²³ Alan R. Lifson, *Transmission of the Human Immunodeficiency Virus*, in AIDS: ETIOLOGY, DIAGNOSIS, TREATMENT AND PREVENTION, *supra* note 3, at 111, 111-16. Although HIV may be present in nearly any body fluid, the virus is transmissible only by blood, semen, and vaginal and cervical secretions. *Id.*

²⁴ Volberding, *supra* note 3, at 123.

²⁵ *Id.* at 128. Such individuals are often unaware that they are infected with HIV, yet are carriers of the virus, capable of transmitting it to others. *Id.*

²⁶ *Id.* at 123.

²⁷ Paul A. Volberding, *AIDS Overview*, in AIDS: PRINCIPLES, PRACTICES,

Ultimately, AIDS destroys the body's natural immune system and affects the central nervous system, leading to mental deterioration.²⁸ Presently, researchers have found no vaccine or cure for the disease.²⁹

AIDS was first recognized in mid-1981 in major urban areas of the United States and primarily among homosexual men.³⁰ Although medical knowledge regarding the disease was limited, the general public knew by 1982 that certain groups — including homosexual and bisexual men, intravenous drug users, and recently arrived Haitians — were at high risk for contracting AIDS.³¹ At that time, no test was available to detect either the presence of the HIV virus or exposure to the virus in blood or blood products.³²

The Centers for Disease Control (CDC)³³ received the first report of a hemophilia patient with AIDS in January 1982.³⁴ Six months later, the CDC published an article describing three cases of AIDS in heterosexual hemophiliacs who were neither intravenous drug users nor Haitian immigrants, suggesting for the first time the transmissibility of AIDS by blood.³⁵ Follow-

& POLITICS, *supra* note 2, at 97, 99.

²⁸ *Id.*

²⁹ *Id.* at 97.

³⁰ Myron Essex, *Origin of AIDS, in AIDS: ETIOLOGY, DIAGNOSIS, TREATMENT AND PREVENTION, supra* note 3, at 3, 3.

³¹ See *Quintana v. United Blood Serv.*, 827 P.2d 509, 514 (Colo. 1992); see also Matt Clark, *AIDS: A Lethal Mystery Story*, NEWSWEEK, Dec. 27, 1982, at 63.

³² See *Kozup v. Georgetown Univ.*, 663 F. Supp. 1048, 1057 (D.D.C. 1987), *aff'd in part, vacated in part on other grounds*, 851 F.2d 437 (D.C. Cir. 1988). A test for exposure to the virus would detect HIV antibodies, generated in response to the virus.

³³ See OFFICE OF THE FED. REGISTER, NAT'L ARCHIVES AND RECORDS ADMIN., UNITED STATES GOVERNMENT MANUAL, 1989/90, at 307 (1989). The CDC is an agency in the Public Health Service charged with preventing and controlling infectious and chronic diseases and reducing health risks through education and information.

³⁴ Terence L. Chorba & Bruce L. Evatt, *Transfusion-associated AIDS, in BLOOD, BLOOD PRODUCTS, AND AIDS* 17, 23 (R. Madhok et al. eds., 1987). Hemophilia is a hereditary blood defect almost exclusively of males characterized by delayed clotting of the blood and consequent difficulty in controlling bleeding even after minor injuries. WEBSTER'S NINTH NEW COLLEGIATE DICTIONARY 564 (1984).

³⁵ *Pneumocystosis Carinii Pneumonia among Persons with Hemophilia A*, 31 MORBIDITY & MORTALITY WKLY. REP. 365, 365-67 (1982); see *Osborn v.*

ing this publication, the Public Health Service held an open meeting of its Committee on Opportunistic Infections in Patients with Hemophilia, alerting attendees to the possible transmission of AIDS by blood.³⁶ In December 1982, the CDC published another article about an infant diagnosed with AIDS one year after receiving multiple blood transfusions.³⁷ An investigation revealed that one of the nineteen blood donors had also developed AIDS.³⁸ In the same article the CDC also disclosed that two adults who fell into no high-risk group for AIDS, but who had also received blood transfusions, suffered from AIDS symptoms.³⁹ The article closed by stating: "This report and continuing reports of AIDS among persons with hemophilia A raise serious questions about the possible transmission of AIDS through blood and blood products."⁴⁰

The reaction of blood suppliers to the CDC's reports was mixed. The majority refused, at least publicly, to accept the potential threat of transfusion-related AIDS and worried about the negative impact of the articles on the blood supply.⁴¹ Dr. Joseph Bove, head of the Food and Drug Administration's (FDA) Blood Advisory Committee⁴² and an officer of the American Association of Blood Banks, displayed the prevalent attitude: In response to the announcement that AIDS might be in the blood supply, he publicly denied any evidence that transfusions spread

Irwin Memorial Blood Bank, 7 Cal. Rptr. 2d 101, 112 (Cal. Ct. App. 1992). These patients had received numerous injections of the blood product Factor VIII used by hemophiliacs.

³⁶ See *Kozup*, 663 F. Supp. at 1051. Among those in attendance were representatives of the American Red Cross (ARC), the CDC, the National Institutes of Health (NIH), the Food and Drug Administration (FDA), the American Association of Blood Bankers, and the National Gay Task Force.

³⁷ *Possible Transfusion-Associated Acquired Immune Deficiency Syndrome (AIDS) — California*, 31 MORBIDITY & MORTALITY WKLY. REP. 652, 652-54 (1982).

³⁸ *Id.* at 653.

³⁹ *Id.* at 654.

⁴⁰ *Id.*

⁴¹ RANDY SHILTS, *AND THE BAND PLAYED ON 207* (1988).

⁴² This committee is made up of a small group of industry and medical experts who meet quarterly with FDA officials to offer advice on regulatory matters. Andrea Rock, *Inside the Billion Dollar Business of Blood*, MONEY, March 1986, at 152.

AIDS.⁴³ Nonetheless others became convinced that AIDS was bloodborne.⁴⁴

On January 4, 1983, the CDC sponsored a meeting to discuss several reported cases of AIDS and possible methods of protecting the nation's blood supply.⁴⁵ At that time, five reported cases of AIDS among hemophiliacs existed, along with one possible transfusion-related case, and five other AIDS cases related to blood products.⁴⁶ While the participants discussed various measures for donor screening guidelines, no consensus was reached about implementing such safety measures.⁴⁷

On January 13, 1983, the American Red Cross, the American Association of Blood Banks, and the Council of Community Blood Banks⁴⁸ released a joint statement that while the possibility that AIDS was transmissible by blood did exist, the evidence was "inconclusive."⁴⁹ Nevertheless they recommended making autologous transfusions⁵⁰ more readily available and

⁴³ SHILTS, *supra* note 41, at 207.

⁴⁴ See Rock, *supra* note 42, at 152. Following a December 1982 meeting arranged by the FDA in which a CDC doctor presented the data regarding HIV-contaminated blood transfusions, Dr. William V. Miller, a member of the FDA's blood advisory committee recalled believing that at least some AIDS cases were being caused by tainted blood. *Id.*

⁴⁵ See *Kozup v. Georgetown Univ.*, 663 F. Supp. 1048, 1051-52 (D.D.C. 1987), *aff'd in part, vacated in part on other grounds*, 851 F.2d 437 (D.C. Cir. 1988). Representatives from several organizations were present at the meeting, including the following: the ARC, the NIH, the American Association of Blood Banks, the National Hemophilia Foundation, the Pharmaceutical Manufacturers Association, the National Gay Task Force. *Id.* Officials from the CDC were also present, as well as representatives from the Food and Drug Administration, the one federal agency with regulatory power over the blood banks.

⁴⁶ *Id.* at 1051.

⁴⁷ *Id.* The organizations agreed that members of high risk groups should be precluded from donating blood although they did not reach agreement on a means of doing this. They discussed the possibility of screening out individuals on the basis of sexual orientation. They, however, declined to adopt such a practice, questioning whether it would be either appropriate or effective.

⁴⁸ The American Red Cross processes 50% of the nation's blood supply while members of the American Association of Blood Banks provides much of the remainder. *Osborn v. Irwin Memorial Blood Bank*, 7 Cal. Rptr. 2d 101, 114 n.6 (Cal. Ct. App. 1992).

⁴⁹ *Kozup*, 663 F. Supp. at 1052.

⁵⁰ For patients undergoing elective surgery, one alternative to receiving transfusions from anonymous donors is to store their own blood in advance in

initiating more thorough donor screening by allowing potential donors to self-defer if they fell into a high-risk group.⁵¹ The statement did not go so far as to endorse surrogate testing,⁵² nor did it advocate direct or indirect questioning about a donor's sexual preference.⁵³ Notably, while the joint statement downplayed the risk of transfusion-transmitted AIDS, the chairman of the joint statement committee acknowledged in a private memo dated January 24, 1983, that future transfusion-related cases would likely occur and that the most that could be done in the situation would be to "buy time."⁵⁴ He warned that he did not want society or lawyers to interpret the committee's actions as "agreeing with the concept . . . that AIDS can be spread by blood."⁵⁵

Notwithstanding the January 13 joint statement, the National Hemophilia Foundation⁵⁶ in a memorandum of January 14, 1983 encouraged added safety measures and recommended that source plasma centers manufacturing blood prod-

anticipation of the surgery. Chorba & Evatt, *supra* note 34, at 177-78.

⁵¹ Eckert, *supra* note 6, at 62. This involved educating potential donors through posters and brochures which listed specific groups at high risk for AIDS and urged those who fell within these categories to refrain from donating.

⁵² Where no direct test is available to detect the presence of a disease or the antibody generated by the disease, surrogate tests may be employed to determine if factors believed to be statistically linked to the disease are present. The Hepatitis-B Core Antibody Test is an example of a surrogate test which screens for the antibodies to hepatitis, a disease often present in people who have AIDS. One problem associated with these tests is that they have a two to five percent false positive rate, thus causing uninfected blood to be improperly rejected. *Quintana v. United Blood Serv.*, 827 P.2d 509, 515 n.3 (Colo. 1992).

⁵³ These measures would probably have imposed additional costs on suppliers, but would have increased the safety of transfusions at the time.

⁵⁴ See BLOOD SUPPLY SAFETY: HEARING BEFORE THE SUBCOMM. ON OVERSIGHT AND INVESTIGATIONS OF THE HOUSE COMM. ON ENERGY AND COMMERCE, 101st Cong., 2d Sess. 73-74, 91-92 (1990) [hereinafter BLOOD SUPPLY SAFETY] (Internal report written by Dr. Bove, Exhibit C, and testimony concerning that report).

⁵⁵ *Id.*

⁵⁶ The National Hemophilia Foundation is a voluntary health organization consisting of hemophiliacs, their families, health care professionals and other interested persons. The organization supports research, disseminates literature and helps in blood recruitment drives. ENCYCLOPEDIA OF ASSOCIATIONS 12735 (26th ed. 1992).

ucts "implement direct questioning of blood donors and evaluate and implement surrogate testing of donated blood in order to reduce the risk of AIDS."⁵⁷ In March 1983, the FDA and the United States Public Health Service advised the blood banking industry to institute safety measures, including self-screening and improved educational programs for blood bank personnel, aimed at decreasing blood collection from high-risk groups.⁵⁸ Neither agency, however, recommended that blood banks adopt surrogate tests.⁵⁹

Six months later, the Stanford University Blood Bank departed from industry custom by using a surrogate test on donated blood designed to reduce transfusion transmission of AIDS.⁶⁰ In a unique display of insight, officials at the Stanford Blood Bank reasoned that the unusually long latent phase of AIDS and the extraordinarily high fatality rate of the disease warranted extra precautions.⁶¹ Dr. Edgar G. Engleman, medical Director of the Stanford Blood Bank acknowledged that the test was not perfect, yet stated "the benefits of preventing at least some AIDS-contaminated blood from entering the blood supply outweighed the fact that a small amount of normal blood was unavoidably discarded and that each unit of blood cost six dollars more."⁶²

Staff members of at least one other blood bank recognized the safety advantages of surrogate tests and recommended their use; however, the blood banking industry's opposition prevented their adoption.⁶³ Dr. David De Jongh, the former director of the Blood Bank at Charity Hospital in New Orleans, and proponent of surrogate testing, explained in an affidavit that the blood industry's opposition was due in part to "their fear that the institution of the core test by some blood banks would create

⁵⁷ Quintana v. United Blood Serv., 827 P.2d 509, 515 (Colo. 1992).

⁵⁸ Kozup v. Georgetown Univ., 663 F. Supp. 1048, 1052 (D.D.C. 1987), *aff'd in part, vacated in part on other grounds*, 851 F.2d 437 (D.C. Cir. 1988).

⁵⁹ *Id.*

⁶⁰ BLOOD SUPPLY SAFETY, *supra* note 54, at 34 (testimony of Dr. Edgar G. Engleman, Medical Director, Stanford University Blood Center). The Stanford Blood Bank was the first in the U.S. to screen donated blood with a surrogate test, referred to as the T cell ratio test, which added six dollars to the cost of each unit of blood. *Id.*

⁶¹ *Id.*

⁶² *Id.*

⁶³ *Id.* at 94 (Affidavit of Dr. De Jongh, Exhibit E).

a standard of care by which their blood banks would be required to abide."⁶⁴ Exhibiting this fear, other blood banks rejected the conclusion that the benefits of testing justified the costs and declined to initiate similar measures.⁶⁵ They criticized Stanford's testing program as a publicity stunt creating unnecessary panic and anxiety and ignored later evidence demonstrating the efficacy of surrogate testing.⁶⁶

In 1984 the medical community finally reached a consensus that AIDS was in fact transmissible by blood.⁶⁷ In April, scientists in the United States and France independently isolated and identified the virus that most experts regard as the probable cause of AIDS.⁶⁸ One year later a screening test for the HIV antibody, the enzyme-linked immunosorbent assay (ELISA) test, became available and the CDC implemented guidelines for its use.⁶⁹ The ELISA test has proven 98.6% effective in detecting exposure to AIDS, and when paired with a second test, the Western Blot Analysis, the detection rate increases to 100%.⁷⁰ Consequently, the risk of contracting AIDS from blood products

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ *Id.* at 96. Follow-up interviews in 1983 revealed several donors whose blood had been rejected based on the screening test, yet who had donated at other blood banks despite falling into categories at high risk for AIDS. Moreover, the introduction of the HIV antibody test enabled the Stanford Blood Bank to retrospectively test frozen blood that had been excluded which showed that the test had screened out approximately two-thirds of the HIV infected individuals who had donated blood. *Id.*

⁶⁷ James W. Curran et al., *Acquired Immunodeficiency Syndrome (AIDS) Associated With Transfusion*, 310 N. ENG. J. MED. 69, 69-75 (1984).

⁶⁸ Volberding, *supra* note 27, at 97-98. Dr. Robert C. Gallo of the U.S. National Cancer Institute referred to the retrovirus as HTLV-III, while Dr. Luc Montagnier at the Pasteur Institute in Paris called it LAV and Jay Levy of the University of California, San Francisco called it ARV. In 1986, an international committee on nomenclature renamed the retrovirus now known as HIV. *Id.*

⁶⁹ *Kozup v. Georgetown Univ.*, 663 F. Supp. 1048, 1052-53 (D.D.C. 1987) (citations omitted), *aff'd in part, vacated in part on other grounds*, 851 F.2d 437 (D.C. Cir. 1988).

⁷⁰ *Id.*; see also Philip P. Mortimer, *Serological Tests, in BLOOD, BLOOD PRODUCTS AND AIDS*, *supra* note 34, at 125, 135. The procedure employed is to first use and ELISA. If the result is positive, a second ELISA is used. If the result is still positive, the blood is then subject to the Western Blot, which is both a more complex and more expensive procedure. *Id.*

has declined considerably.⁷¹ Nonetheless, an estimated 15,000 people were infected with HIV through blood and blood products prior to 1985,⁷² most of whom are expected to eventually develop AIDS.⁷³

Transfusion recipients who have subsequently developed AIDS symptoms can turn to the legal system to seek compensation from doctors, hospitals, and blood banks under theories of tort and contract. Until recently, courts have consistently sided with blood suppliers on the grounds that the suppliers' knowledge of transfusion-associated AIDS in the early 1980's was limited and that the measures taken to reduce risk conformed to the general custom and practice among blood banks.⁷⁴ However, as the court in *Quintana* ultimately concluded, evidence suggests that the blood industry could have responded to the HIV-threat more diligently.⁷⁵ By 1983, AIDS had become a "major blood banking issue"⁷⁶ and the general public was aware that the blood supply could be contaminated by HIV.⁷⁷ In addition, the industry knew that certain high-risk groups for AIDS should be excluded from donating blood.⁷⁸ Yet confronted with the opportunity to respond to this threat in early 1983, the blood banking industry first rejected reports that AIDS could be spread by blood and, when it could no longer deny the risk of transfusion transmission, downplayed it.⁷⁹ In the face

⁷¹ The possibility still exists that a person infected with HIV may falsely test negative where the infection has not yet progressed to the stage in which antibodies develop.

⁷² Aoki & Holland, *supra* note 11, at 464.

⁷³ Peter L. Page, *AIDS Damage Liabilities: Tort Risks and Remedies for AIDS Transmission*, in *AIDS AND THE COURTS* 307, 307 (Clark C. Abt & Kathleen M. Hardy eds., 1990).

⁷⁴ *Kozup*, 663 F. Supp. at 1056-57; *Quintana v. United Blood Servs.*, 811 P.2d 424, 427 (Colo. App. 1991), *aff'd*, 827 P.2d 509 (Colo. 1992); *see also* Roger Parloff, *Tainted Tort*, *AM. LAW.*, Sept. 1992, at 76.

⁷⁵ PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC, REPORT OF THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC 78 (1988) [hereinafter PRESIDENTIAL COMMISSION REPORT].

⁷⁶ *Wadley Research Inst. v. Beeson*, 835 S.W.2d 689, 699 (Tex. Ct. App. 1992).

⁷⁷ Clark, *supra* note 31, at 63.

⁷⁸ *See Quintana v. United Blood Serv.*, 827 P.2d 509, 515 (Colo. 1992); *see also* SHILTS, *supra* note 41, at 224.

⁷⁹ BLOOD SUPPLY SAFETY, *supra* note 54, at 12-13 (testimony of Dr. Marcus

of the AIDS threat, most blood banks failed to adopt available measures which would have reduced the amount of HIV tainted blood entering the blood supply.⁸⁰ They avoided promoting effective screening procedures, implementing surrogate tests, educating the public about the risk of transfusion transmitted AIDS, or encouraging alternative methods of collecting blood.⁸¹ In short, the blood industry subjected transfusion recipients to an unreasonable risk of contracting AIDS through blood during the early years of the AIDS epidemic.

II. THEORIES OF LIABILITY

Victims of contaminated transfusions can turn to the legal system for relief. Typically, three theories of liability are available against blood banks: strict products liability, breach of implied warranties, and negligence. In pursuing each theory, plaintiffs face substantial obstacles which tend to insulate blood suppliers from liability. The following section discusses the three theories in the context of transfusion-related AIDS and examines the difficulties associated with each.

A. STRICT LIABILITY

Plaintiffs generally attempt to impose liability on blood banks under the doctrine of strict liability for the sale of an unreasonably dangerous product.⁸² Section 402A of the Second Restatement of Torts provides that one who sells a product which is in a defective condition and is unreasonably dangerous to the user is strictly liable for harm.⁸³ Specifically, strict

A. Conant, Professor, University of California Medical Center at San Francisco); Rock, *supra* note 42, at 152.

⁸⁰ See generally BLOOD SUPPLY SAFETY, *supra* note 54.

⁸¹ *Id.* at 12-13 (testimony of Dr. Marcus Conant).

⁸² See generally *Kozup v. Georgetown Univ.*, 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); *McKee v. Miles Labs.*, 675 F. Supp. 1060 (E.D. Ky. 1987); *Kirkendall v. Harbor Ins. Co.* 698 F. Supp. 768 (W.D. Ark. 1988).

⁸³ Section 402A states:

(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 thereby caused to the ultimate user or consumer, or to his property, if

(a) the seller is engaged in the business of selling such a product, and

liability applies only where the sale of a product has occurred, rather than the provision of a service.⁸⁴ Because of this distinction, transfusion victims have argued that a blood transfusion is a sale of a product, thereby subjecting blood banks to strict liability, while blood banks have countered that they are providing a service, and consequently insulated from strict liability.⁸⁵ Thus, in determining the applicability of the strict liability doctrine, the threshold issue is whether the acquisition of blood or blood products constitutes a sale of a product or a service.

1. *Common Law*

Traditionally, courts have safeguarded hospital blood suppliers, holding that when a hospital furnishes blood or blood products to a paying patient "as an incident to hospital treatment," the provision is a service, therefore exempting the hospital from strict liability.⁸⁶ Some jurisdictions have distinguished between hospitals and blood banks and have permitted sales-based liability claims against the latter on the grounds that they are sellers of blood rather than providers of medical care.⁸⁷ The more widely accepted view, however, recognizes no distinction between a transfusion as part of a more general

(b) it is expected to and does reach the consumer without substantial change in the condition in which it is 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 bought the product from or entered into any contractual relation with the seller.

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

⁸⁴ *Id.*

⁸⁵ See *Perlmutter v. Beth David Hosp.*, 123 N.E.2d 792, 793 (N.Y. 1954); *Kozup*, 663 F. Supp. at 1058-60.

⁸⁶ See *Perlmutter*, 123 N.E.2d at 796. But see *Cunningham v. MacNeal Memorial Hosp.*, 266 N.E.2d 897, 901 (Ill. 1970). Notably, while *Cunningham* rejected the service analysis, the Illinois legislature subsequently overturned *Cunningham*.

⁸⁷ See generally *Hansen v. Mercy Hospital*, 570 P.2d 1309 (Colo. Ct. App. 1977); *Russell v. Community Blood Bank*, 185 So. 2d 749 (Fla. 1966); *Hoder v. Sayet*, 196 So. 2d 205 (Fla. Dist. Ct. App. 1967); *Weber v. Charity Hosp.*, 487 So. 2d 148 (La. 1986). In the three jurisdictions which distinguish between hospitals and blood banks, legislatures have overruled these decisions by statute.

medical treatment from the transfusion alone.⁸⁸ This is illustrated in *Roberts v. Suburban Hospital Association*,⁸⁹ where the plaintiff, a hemophiliac who received transfusions from the defendant hospital, later became infected with HIV.⁹⁰ Although the plaintiff did not receive the transfusion as part of a more general treatment, the court dismissed his strict liability and breach of warranties claims on the grounds that they arose from the provision of a service.⁹¹ The court reasoned, "A transfusion is not just a sale of blood The transfusion . . . is what [the patient] really needs and pays for and that involves the application of medical skill. It would be artificial at best, and probably inaccurate, to conclude as a matter of law that the product predominates over the service."⁹²

2. Blood Shield Statutes

This common law distinction between a sale and a service, and the resulting judicial protection of blood suppliers has been codified in forty-eight states with the passage of so-called blood shield statutes.⁹³ These statutes provide immunity to blood banks and blood products manufacturers in one of two ways. Either the statutes specifically characterize the distribution of blood as a service, not a sale, or the statutes expressly safeguard suppliers of blood and blood products from strict liability.⁹⁴ Additionally, courts have consistently construed blood shield statutes in favor of blood suppliers, effectively barring plaintiffs' strict liability claims.⁹⁵

⁸⁸ See *Howell v. Spokane & Inland Empire Blood Bank*, 785 P.2d 815, 821 (Wash. 1990); *Roberts v. Suburban Hosp. Assoc.*, 532 A.2d 1081, 1088 (Md. Ct. Spec. App. 1987).

⁸⁹ 532 A.2d 1081 (Md. Ct. Spec. App. 1987).

⁹⁰ *Id.* at 1082.

⁹¹ *Id.*

⁹² *Id.* at 1088.

⁹³ For a list of blood shield statutes, see *id.* at 1086 n.3. Every state has enacted blood shield statutes except New Jersey and Vermont.

⁹⁴ See Dana J. Finberg, Note, *Blood Bank and Blood Products Manufacturer Liability in Transfusion-Related AIDS Cases*, 26 U. RICH. L. REV. 519, 524 nn.32-33 (1992).

⁹⁵ See generally *McKee v. Miles Labs.*, 675 F. Supp. 1060 (E.D. Ky. 1987). See Finberg, *supra* note 94, at 531, for a brief discussion on how plaintiffs may argue around blood shield statutes. For example some statutes were specifi-

The Connecticut blood shield statute, at issue in *Coffee v. Cutter Biological and Miles Laboratories*,⁹⁶ barred claims arising from breach of implied warranties, but remained silent as to strict liability.⁹⁷ Nevertheless, the court interpreted it to preclude plaintiff's strict liability claim.⁹⁸ In reaching this conclusion, the court relied on the "plain and unambiguous" words of the statute, which characterized transactions involving blood and blood components as services rather than sales.⁹⁹

3. Comment k

Some courts have circumvented the strict liability analysis by categorizing blood as an unavoidably unsafe product as defined in comment *k* to section 402A of the Second Restatement of Torts.¹⁰⁰ Comment *k* provides that a product which is "incapable of being made safe for [its] intended use" will not give rise to strict liability. An example of this type of product cited in the Restatement is the rabies vaccine.¹⁰¹ While the injection of the vaccine may produce "serious and damaging consequences," its use is justified where the "disease itself invariably leads to a dreadful death."¹⁰² In the case of con-

cally addressed to hepatitis and not amended until after the transfusion. See, e.g., *Miles Labs. v. Doe*, 556 A.2d 1107, 1111 (Md. 1989). Nevertheless in such cases, courts have found blood banks immune from liability under the common law.

⁹⁶ 809 F.2d 191 (2d Cir. 1987).

⁹⁷ The statute provides:

The implied warranties of merchantability and fitness shall not be applicable to a contract for the sale of human blood, blood plasma, or other human tissue or organs from a blood bank or reservoir of such other tissues or organs. Such blood, blood plasma, and the components, derivatives or fractions thereof, or tissue or organs shall not be considered as medical services.

CONN. GEN. STAT. ANN. § 19a-280 (West 1986).

⁹⁸ *Coffee*, 809 F.2d at 191.

⁹⁹ *Id.* at 193. The court rejected the plaintiff's claims that the statute did not bar strict liability claims and did not apply to commercial manufacturers of blood products. *Id.*

¹⁰⁰ See *Snyder v. Mekhjian*, 582 A.2d 307, 312 (N.J. 1990); *Miles Labs.*, 556 A.2d at 1107; *Brody v. Overlook Hosp.*, 317 A.2d 392, 397 (N.J. 1974); *Hines v. St. Joseph's Hosp.*, 527 P.2d 1075, 1076 (N.M. 1974).

¹⁰¹ RESTATEMENT (SECOND) OF TORTS § 402A cmt. k (1966).

¹⁰² *Id.*

taminated blood, the absence of a direct test to determine whether a particular unit of blood was infected with the AIDS virus prior to 1985 has influenced a few courts to classify blood acquired during this period as an unavoidably unsafe product, thereby precluding claims of strict liability.¹⁰³

In *Miles Laboratories v. Doe*,¹⁰⁴ the court found the Maryland blood shield statute inapplicable;¹⁰⁵ however, it categorized both blood and blood products as "unavoidably unsafe" and thus exempt from strict liability under comment *k* of the Restatement.¹⁰⁶ The court reasoned, "the singular medical utility of blood and blood products, together with the compelling necessity for their use when medically indicated, ordinarily outweighs the known risk in all blood transfusions that the products may contain some impurities."¹⁰⁷

4. *Summation*

Blood suppliers have three weapons to avoid claims of strict liability and effectively bar recipients of tainted transfusions from recovery under this theory. First, blood banks may insulate themselves by turning to exculpatory blood shield statutes, generally construed in favor of suppliers.¹⁰⁸ An alternative is the common law characterization of a blood transfusion for a fee as a service.¹⁰⁹ Finally, blood banks may rely on the willingness of some courts to classify blood as an "unavoidably unsafe product" under comment *k*.¹¹⁰ Consequently, the blood bank-

¹⁰³ See cases cited *supra* note 100.

¹⁰⁴ 556 A.2d 1107 (Md. 1989).

¹⁰⁵ At the time of the transfusion and filing of the suit, the statute had limited immunity from transfusion-associated disease to infection with the hepatitis virus. A later amendment extended protection for AIDS also, but the court interpreted the amendment to apply prospectively. *Id.*

¹⁰⁶ *Id.* at 1125. The court discussed the common law and its embracing of § 402, including comment *k*.

¹⁰⁷ *Id.* at 1121.

¹⁰⁸ *McKee v. Miles Labs.*, 675 F. Supp. 1060, 1062 (E.D. Ky. 1987); *Coffee v. Cutter Biological & Miles Labs.*, 809 F.2d 191, 194 (2d Cir. 1987).

¹⁰⁹ *Perlmutter v. Beth David Hosp.*, 123 N.E.2d 792, 796 (N.Y. 1954); *Roberts v. Suburban Hosp. Assoc.*, 532 A.2d 1081, 1088 (Md. Ct. Spec. App. 1987).

¹¹⁰ *Snyder v. Mekhjian*, 582 A.2d 307, 312 (N.J. 1990).

ing industry is virtually immune from the imposition of strict liability.

B. BREACH OF IMPLIED WARRANTIES

A second theory of liability advanced by victims of HIV-tainted transfusions is the breach of implied warranties of merchantability and fitness for a particular purpose under the Uniform Commercial Code (U.C.C.).¹¹¹ Section 2-314 of the U.C.C. subjects a seller to liability for the sale of goods which fail to meet a certain minimum standard if the seller is "a merchant with respect to goods of that kind."¹¹² In addition, under section 2-315, a seller is liable if the good is unfit for the particular purpose for which it is intended.¹¹³ The applicability of breach of warranty in transfusion-associated AIDS cases turns on whether blood and blood products are considered goods for which a "seller" may be liable within the meaning of article two of the U.C.C..¹¹⁴ While plaintiffs argue that the provision of blood is the equivalent of a sale, subjecting sellers to implied warranties, blood banks rely on the position that plaintiffs acquired a service rather than a good.¹¹⁵

¹¹¹ *Kozup v. Georgetown Univ.*, 663 F. Supp. 1048, 1051 (D.D.C. 1987), *aff'd in part, vacated in part on other grounds*, 851 F.2d 437 (D.C. Cir. 1988); *Roberts*, 532 A.2d at 1082.

¹¹² Section 2-314 provides: "(1) Unless excluded or modified (Section 2-316), a warranty that the goods shall be merchantable is implied in a contract for their sale if the seller is a merchant with respect to goods for that kind." U.C.C. § 2-314 (1972).

¹¹³ Section 2-315 provides:
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.
U.C.C. § 2-315 (1972).

¹¹⁴ This is similar to the threshold issue in determining the susceptibility of a blood supplier to a strict liability claim. *See supra* notes 86-92 and accompanying text.

¹¹⁵ *Perlmutter v. Beth David Hosp.*, 123 N.E.2d 792, 793-95 (N.Y. 1954); *Kozup*, 663 F. Supp. at 1058-59; *Doe v. Cutter Lab.*, 703 F. Supp. 573 (N.D. Tex. 1988).

1. *Common Law*

Generally, courts have been reluctant to impose liability on blood suppliers and blood products manufacturers for breach of implied warranties.¹¹⁶ As with strict liability, courts have turned to the sale/service distinction to insulate blood banks from liability.¹¹⁷ The seminal case in this area is *Perlmutter v. Beth David Hospital*.¹¹⁸ In *Perlmutter*, a patient sued the treating hospital for damages resulting from transfusion-associated serum hepatitis.¹¹⁹ The plaintiff sought recovery on the theory that a sale had occurred, thus subjecting the provider of the blood to implied warranties.¹²⁰ The Court of Appeals of New York rejected this view, characterizing the transfusion as a service, and barring all claims based on implied warranties.¹²¹ In arriving at this result, the court looked to the primary object of the transaction between the plaintiff and defendant, in this case the medical treatment, and concluded that the transfer of blood for a fee was not a sale, but merely incidental to the hospital's provision of services.¹²²

2. *Blood Shield Statutes*

The *Perlmutter* immunity has been extended to blood banks through previously discussed blood shield statutes, further insulating blood suppliers from claims based upon implied warranties.¹²³ The statutes either characterize the distribution of blood as a service, or expressly state that implied warranties of merchantability and fitness are not applicable. Thus,

¹¹⁶ *Kozup*, 663 F. Supp. at 1058-59; *Miles Labs. v. Doe*, 556 A.2d 1107, 1123 (Md. 1989); *Perlmutter*, 123 N.E.2d at 795-96; *Kirkendall v. Harbor Ins. Co.* 698 F. Supp. 768, 770 (W.D. Ark. 1988).

¹¹⁷ See generally *Perlmutter v. Beth David Hosp.*, 123 N.E.2d 792 (N.Y. 1954).

¹¹⁸ *Id.*

¹¹⁹ *Id.* at 793.

¹²⁰ *Id.* at 793-96. In her complaint, plaintiff alleged that defendant, upon whom she relied, knew the purpose for which the blood was to be used and impliedly warranted that the blood was "fit" for its intended purpose, and of "merchantable quality." *Id.* at 793.

¹²¹ *Id.* at 796.

¹²² *Id.*

¹²³ See *supra* notes 93-99 and accompanying text.

neither strict products liability nor breach of implied warranties present viable remedies to plaintiffs seeking recovery for contaminated transfusions.

C. NEGLIGENCE

As a result of the virtual immunity afforded blood suppliers from sales-based liability, negligence has become the most likely means of recovery for victims of AIDS-contaminated transfusions.¹²⁴ To establish negligence, a plaintiff must prove defendant owed plaintiff a duty, defendant breached that duty, and the breach was the proximate cause of the plaintiff's injury.¹²⁵ Plaintiffs who have contracted AIDS through transfusions frequently predicate their negligence claims against blood banks on deficient donor screening and failure to implement surrogate testing.¹²⁶

While negligence remains perhaps the sole viable remedy for victims of AIDS-tainted transfusions, plaintiffs still face obstacles in establishing the liability of blood banks under this theory. To recover, plaintiffs must prove that a blood bank's standard of care was below the industry standard, or that the industry standard was so low that it was negligent.¹²⁷ Unfortunately for plaintiffs, the industry standard of care at the time of the transfusion is difficult to determine. Some courts have excluded qualified experts not directly practicing in the blood banking industry from testifying about the standard of care.¹²⁸ Also the Federal government's limitation on testimony and production of documents from its employees at the Department of Health and Human Services deprives plaintiffs of valuable information concerning the CDC's evolving position on the standard of care.¹²⁹ Finally, some courts deny plaintiffs access

¹²⁴ Donald H. Hermann, *AIDS: Malpractice and Transmission Liability*, 58 U. COLO. L. REV. 81, 106 (1989).

¹²⁵ W. PAGE KEETON ET AL., *PROSSER AND KEETON ON THE LAW OF TORTS* § 30, at 165 (5th ed. 1984).

¹²⁶ See *Wilson v. Irwin Memorial Blood Bank*, No. A054946, 1993 Cal. App. LEXIS 375, at *1 (Cal. Ct. App. Apr. 9, 1993); *Quintana v. United Blood Serv.*, 827 P.2d 509, 515 (Colo. 1992).

¹²⁷ *Quintana*, 827 P.2d at 519-21.

¹²⁸ *Id.* at 513; *Wilson*, 1993 Cal. App. LEXIS 375, at *21.

¹²⁹ See generally *Moore v. Armour Pharmaceutical*, 927 F.2d 1194 (11th Cir. 1991) (quashing subpoena of CDC physician).

to donor identities even though donors could best determine if blood banks were adhering to customary practices.¹³⁰

1. *The Standard of Care*

The primary obstacle confronting victims of tainted transfusions is establishing the standard of care at the time of transfusion.¹³¹ Courts have held that blood banks should be judged by a professional standard, established by the testimony of qualified experts familiar with the norms of the industry.¹³² Such a standard would allow a blood bank to escape liability provided it adhered to industry custom. In other words, if a blood bank exercised the "reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by others" in the same industry under similar circumstances, then that supplier met the applicable standard of care.¹³³ One commentator explains this deference to industry custom as a function of the "healthy respect which the courts have had for the learning of a fellow profession and their reluctance to overburden it with liability based on uneducated judgment."¹³⁴ In effect, the professional standard requires a court to find a blood bank free from negligence if it followed the safety measures adopted by other blood banks at the time of transfusion, regardless of whether the customary practices were sufficient.

In applying a professional standard to blood banks in transfusion-related AIDS cases, courts have precluded plaintiffs from establishing the inadequacy of the national blood banking community's standard of care.¹³⁵ In *Osborn v. Irwin Memorial Blood Bank*,¹³⁶ the plaintiff alleged that the blood bank negligently failed to implement surrogate testing and aggressive

¹³⁰ See *Rasmussen v. South Florida Blood Servs.*, 500 So. 2d 533, 537-38 (Fla. 1987) (holding that donor identities should not be discovered).

¹³¹ Mike McKee, *Blood Bank Cases: A Fair Fight?*, RECORDER, May 1992, at 4.

¹³² *Quintana v. United Blood Servs.*, 827 P.2d 509, 524 (Colo. 1992); *Osborn v. Irwin Memorial Blood Bank*, 7 Cal. Rptr. 2d 101, 124 (Cal. Ct. App. 1992); *Doe v. American Red Cross*, 377 S.E.2d 323, 326 (S.C. 1989).

¹³³ *Osborn*, 7 Cal. Rptr. 2d at 121 (citations omitted).

¹³⁴ KEETON ET AL., *supra* note 125, § 32, at 189.

¹³⁵ See *Osborn*, 7 Cal. Rptr. 2d at 120-21.

¹³⁶ *Id.*

donor screening.¹³⁷ Rejecting the plaintiff's argument, the court held that defendant's procedures conformed to the practices followed by the industry and thus it was not liable.¹³⁸ In addressing the surrogate testing issue, the court relied on the evidence that no blood bank was performing surrogate tests in early 1983 and concluded that an entire profession simply could not be negligent.¹³⁹ The court acknowledged that custom and practice would not control in cases of ordinary negligence, citing the landmark case *The T.J. Hooper* for this rule.¹⁴⁰ However, it distinguished *Osborn* as a professional negligence case, thus governed by the customary practice standard.¹⁴¹ This view reflected the prevailing opinion in blood bank cases up to *Quintana*.¹⁴² In sum, what suppliers "should" have been doing at the time of transfusion played a minimal role in transfusion-related AIDS cases based on negligence.

2. Expert Qualifications

A second obstacle impeding plaintiffs from establishing negligence has been the reluctance of certain courts to allow expert testimony challenging the standard of care.¹⁴³ A few courts have permitted only those with blood bank expertise to

¹³⁷ *Id.* at 115. In February 1983, plaintiffs' child had contracted AIDS through a blood transfusion supplied by Irwin Memorial. *Id.* at 103.

¹³⁸ *Id.* at 128.

¹³⁹ *Id.* at 123-24.

¹⁴⁰ 60 F.2d 737 (2d Cir. 1932). Judge Learned Hand wrote: "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 may never set its own tests, however persuasive may 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.

¹⁴¹ *Osborn*, 7 Cal. Rptr. 2d at 125. The court also discussed *Helling v. Carey*, 519 P.2d 981 (1974), in which the Washington Supreme Court found an ophthalmologist negligent for failing to administer a glaucoma test to a patient under the age of 40, although expert testimony established that custom did not require such testing. However, the *Osborn* court discounted *Helling* as the minority rule. *Osborn*, 7 Cal. Rptr. 2d at 126.

¹⁴² See *Doe v. American Red Cross*, 377 S.E.2d 323, 325 (S.C. 1989); *Hines v. St. Joseph's Hosp.*, 527 P.2d 1075, 1078 (N.M. 1974).

¹⁴³ See *Quintana v. United Blood Serv.*, 827 P.2d 509, 517 (Colo. 1992); *Wilson v. Irwin Memorial Blood Bank*, No. A054946, 1993 Cal. App. LEXIS 375, at *21 (Cal. Ct. App. Apr. 9, 1993).

testify about the adequacy of the standard of care in the industry at the time of transfusion. In doing so, courts have excluded testimony by individuals highly prominent in the field of AIDS. For example, Dr. Marcus Conant, a San Francisco physician and professor who had been involved in AIDS clinical research since its inception and treated thousands of AIDS patients since the Spring of 1981,¹⁴⁴ has been excluded as an expert witness because he was not directly practicing in the blood industry.¹⁴⁵

3. *Limitations on Department of Health and Human Services Employees*

A third difficulty plaintiffs have encountered is the Federal government's general prohibition of its scientists and Department of Health and Human Services (HHS) employees from testifying as experts or producing documents on blood transfusion liability issues.¹⁴⁶ This ban includes researchers from the Centers for Disease Control who warned blood bank officials in January 1983 about the possible transmissibility of AIDS through blood and the need for greater precautionary measures.¹⁴⁷ By 1989, the government had avoided at least fifty

¹⁴⁴ BLOOD SUPPLY SAFETY, *supra* note 54, at 11-12 (testimony of Dr. Marcus Conant, Professor, University of California Medical Center at San Francisco). Dr. Conant started the first multi-disciplinary AIDS clinic in the U.S. in the summer of 1981 and also started the organization that later became the San Francisco AIDS Foundation in May of 1982. He established the AIDS Clinical Research Center at the University of California Medical Center, San Francisco. Further, Dr. Conant chaired the California Task Force on AIDS until 1988 when he was appointed Co-Chair of the California AIDS Leadership Committee.

¹⁴⁵ *Quintana*, 827 P.2d at 513; *Wilson*, 1993 LEXIS 375, at *21.

¹⁴⁶ See *Moore v. Armour Pharmaceutical*, 927 F.2d 1194 (11th Cir. 1991). The HHS promulgated regulations restricting employee testimony in private litigation. The regulations read in part:

No Department of Health and Human Services employee may provide testimony or produce documents in any proceeding to which this part applies concerning information acquired in the course of performing official duties or because of the employee's official relationship with the Department of Health and Human Services unless authorized by the agency head, after consultation with the Office of the General Counsel, that compliance with the request would promote the objectives of the Department of Health and Human Services.

45 C.F.R. § 2.3(a) (1992).

¹⁴⁷ See *supra* text accompanying notes 45-47.

requests or subpoenas from plaintiffs' attorneys seeking testimony of certain CDC physicians.¹⁴⁸

According to one department official, the government blocked such testimony to "minimize interference with the performance of official duties and preserve the impartiality of the department."¹⁴⁹ The government has also argued that allowing such testimony would violate its practice of remaining "strictly neutral" in private litigation.¹⁵⁰ Yet, CDC officials and other government employees who fall under the prohibition have testified on behalf of defendant blood banks.¹⁵¹ The effect of this policy has been to further disadvantage plaintiffs, preventing valuable testimony on behalf of transfusion-AIDS victims.¹⁵²

In *Moore v. Armour Pharmaceutical*,¹⁵³ plaintiffs sought to subpoena CDC physician, Dr. Bruce Evatt.¹⁵⁴ The HHS had prohibited plaintiffs from deposing Dr. Evatt, and the Eleventh Circuit upheld the district court's quashing of the subpoena. In ruling against the plaintiffs, the court found the government's interest in "maximizing the use of its limited resources in dealing with a national health crisis" outweighed the plaintiff's interest in deposing Dr. Evatt.¹⁵⁵

¹⁴⁸ Parloff, *supra* note 74, at 79.

¹⁴⁹ See *Moore*, 927 F.2d at 1196-97.

¹⁵⁰ *Id.*

¹⁵¹ Parloff, *supra* note 74, at 79 (discussing a CDC official designated to testify for the Red Cross in a case which ultimately ended in summary judgment, and an official from the National Institutes of Health, a part of Health and Human Services, who did testify).

¹⁵² See generally SHILTS, *supra* note 41, at 220-21.

¹⁵³ 927 F.2d 1194, 1195-96 (11th Cir. 1991). The plaintiffs sued blood industry members who allegedly supplied contaminated blood to their children. The children were hemophiliacs who became infected with HIV. *Id.*

¹⁵⁴ *Id.* at 1196. Plaintiffs sought testimony regarding the CDC's position with respect to the evolution of AIDS and the screening techniques available at specific times. See BLOOD SUPPLY SAFETY, *supra* note 54, at 78. Dr. Evatt, one of the CDC's leading AIDS researchers, had presented data in 1982 and again in 1983 showing AIDS carriers could be identified by surrogate tests. *Id.*

¹⁵⁵ *Moore*, 927 F.2d at 1197. The court also found the plaintiff's subpoena too broad since the information sought could have led to months of testimony by Dr. Evatt. *Id.* at 1198.

4. *Discovery of Donor Identity*

A fourth obstacle for plaintiffs alleging negligence has been the reluctance of courts to permit disclosure of a donor's identity.¹⁵⁶ To protect the privacy and preserve the confidentiality of blood donors, courts have denied access to donor identities. This has precluded plaintiffs from a useful means of exposing possible deficient donor screening procedures, since donors are frequently in a good position to know whether blood banks adhered to customary practices. For example, a donor would best know whether a blood bank provided accurate information on high-risk groups. Yet, courts have resisted divulging their identities. Some courts, however, have adopted approaches that preserve anonymity, while allowing plaintiffs to obtain necessary information. In *Belle Bonfils Memorial Blood Center. v. District Court*,¹⁵⁷ the blood donor furnished the court clerk with his name and address, enabling the clerk to provide him with a written questionnaire.¹⁵⁸ Upon receipt of the answers, the court instructed the clerk to delete all reference to donor identity, protecting the confidentiality of the information.¹⁵⁹ This procedure effectively circumvented the statute forbidding access to identities of individuals who tested positive for AIDS while still preserving donors' privacy.¹⁶⁰

¹⁵⁶ See *Rasmussen v. South Florida Blood Serv.*, 500 So. 2d 533, 537-38 (Fla. 1987). Where access might deter future donation, the court found society's interest in maintaining the blood supply greater than the plaintiff's need for discovery.

¹⁵⁷ See *Belle Bonfils Memorial Blood Ctr. v. District Court*, 763 P.2d 1003 (Colo. 1988).

¹⁵⁸ *Id.* at 1007.

¹⁵⁹ *Id.*

¹⁶⁰ See Gregory N. Woods & Ann V. Thornton, *Deadly Blood: Litigation of Transfusion-Associated AIDS Cases in Texas*, 21 TEX. TECH L. REV. 667, 713 (1990). Examples of questions that a plaintiff may seek to ask a donor include the following: whether the blood bank screener provided information on high-risk groups, whether the high-risk information was adequate to alert the donor that he or she might fall into such a group, or whether the blood bank gave the donor a confidential opportunity to defer giving blood. *Id.*

III. *QUINTANA v. UNITED BLOOD SERVICES*¹⁶¹

While the outcome of each transfusion-AIDS victim's case depends on its particular facts and circumstances, the *Quintana* litigation demonstrates the arguments plaintiffs typically advance and the difficulties they encounter in seeking compensation for their injuries. The plaintiffs in *Quintana* were able to overcome these obstacles with greater success than other AIDS transfusion plaintiffs. The Colorado Supreme Court's holding that blood banks acting in conformity with industry practices could still be second-guessed in court, and the subsequent jury verdict finding the entire blood industry negligent may open the door to recovery for plaintiffs in similar transfusion cases.

A. ORIGINS OF *QUINTANA*

The *Quintana* case arose from the transfusion of several units of blood and plasma received by plaintiff Susie Quintana on May 27, 1983, during emergency surgery for an accidental gunshot wound.¹⁶² United Blood Services (UBS), a division of the nation's second-largest blood-gathering organization, supplied the contaminated blood to the Cortez, Colorado hospital which treated Quintana.¹⁶³ Two years later, in December 1985, doctors diagnosed Quintana with AIDS.¹⁶⁴ Upon notification that one of the units of blood or plasma she received may have been infected, UBS conducted tests which revealed that one of the donors was in fact infected with HIV at the time of the transfusion.¹⁶⁵

B. THE FIRST TRIAL

Susie Quintana and her husband filed suit against UBS, alleging negligence for failure to adequately screen high-risk donors through questioning and physical examination, and failure to employ available tests that would have indicated the

¹⁶¹ 811 P.2d 424 (Colo. Ct. App. 1991), *aff'd*, 827 P.2d 509 (Colo. 1992).

¹⁶² *Quintana*, 827 P.2d at 512.

¹⁶³ *Id.* UBS is a non-profit blood banking division of Blood Systems, Inc. *Id.*

¹⁶⁴ *Quintana*, 811 P.2d at 426.

¹⁶⁵ *Id.* UBS also learned from the donor's physician that the donor "pursued 'a gay lifestyle.'" *Quintana*, 827 P.2d at 512.

presence of HIV in the donated blood.¹⁶⁶ In response, UBS admitted that it furnished the units of blood transfused into Quintana and that the donor of one of those units later tested positive for the AIDS infection.¹⁶⁷ Nevertheless, UBS denied that it acted negligently, maintaining that its donor screening and blood testing procedures at the time of Quintana's transfusion "conformed with industry custom and practice," thus meeting the applicable standard of care and shielding the blood bank from liability.¹⁶⁸

During the trial, the court ruled that the defendant's conduct should be measured against the professional negligence standard — what others in the industry were doing at the time.¹⁶⁹ The trial court limited the scope of admissible evidence by excluding three of plaintiffs' experts who would have challenged the reasonableness of 1983 industry practices.¹⁷⁰ Moreover, the court instructed the jury that "a blood bank's compliance with custom and practice established, as a matter of law, the absence of negligence."¹⁷¹ Subsequently, the jury returned a general verdict in favor of the defendant, finding that UBS was not liable because its screening practices had complied with industry standards.¹⁷²

C. PLAINTIFFS CHALLENGE RULING

On appeal, the plaintiffs challenged the trial court's incorporation of a professional negligence standard of care, which could only be established by experts familiar with the industry's customary practices.¹⁷³ The Quintanas argued, "the reasonableness of the defendant's conduct, rather than compliance with accepted and customary practices of blood banks, should govern the determination of their negligence claims."¹⁷⁴ The Colorado Court of Appeals agreed, holding that "ordinary princi-

¹⁶⁶ *Id.*

¹⁶⁷ *Id.*

¹⁶⁸ *Id.* at 427.

¹⁶⁹ *Quintana*, 827 P.2d at 513.

¹⁷⁰ *Id.* at 517.

¹⁷¹ *Quintana*, 811 P.2d at 428.

¹⁷² *Id.*

¹⁷³ *Quintana*, 827 P.2d at 518.

¹⁷⁴ *Quintana*, 811 P.2d at 427.

ples of negligence" should control.¹⁷⁵ The appellate court concluded that the trial court erred in excluding plaintiffs' evidence which challenged the reasonableness of the blood industry's customs and practices.¹⁷⁶ Furthermore, the court found error in the trial judge's jury instructions equating compliance with industry custom with the absence of negligence.¹⁷⁷ In light of the foregoing, the appellate court reversed the jury verdict and ordered a new trial.¹⁷⁸

D. COLORADO SUPREME COURT

The Colorado Supreme Court granted certiorari to review the decision of the court of appeals.¹⁷⁹ While the supreme court found that the court of appeals should have imposed a professional standard of care rather than a general standard, the Colorado high court stated that compliance with that standard was "not conclusive proof that additional precautions were not required."¹⁸⁰ Furthermore, the supreme court sanctioned the admissibility of the Quintanas' proffered expert evidence;¹⁸¹ such evidence was necessary to establish that the blood banking community's screening and testing procedures were unreasonably deficient in protecting the blood supply from the AIDS threat.¹⁸² According to the Court, the trial court's exclusion of this evidence was "tantamount to permitting the blood banking community to establish its own standard of legal liability despite evidence tending to show that the blood banking

¹⁷⁵ *Id.* at 431. The court found that defendant's conduct should be measured against what a reasonable and prudent blood bank would or should have done under the same or similar circumstances. *Id.*

¹⁷⁶ *Id.*

¹⁷⁷ *Quintana*, 827 P.2d at 517-18. The court defined negligence as the failure to meet the standard of the professional community to which UBS belonged, and instructed the jury that as long as UBS' procedures were consistent with the standard of care of the community, that it would not be negligent.

¹⁷⁸ *Quintana*, 811 P.2d at 432.

¹⁷⁹ *Quintana*, 827 P.2d at 511.

¹⁸⁰ *Id.* at 525.

¹⁸¹ *Id.* at 517. Plaintiffs had formerly been excluded from introducing the testimony of Dr. Marcus A. Conant, Dr. Thomas Asher and Dr. Edgar Engleman. See *supra* note 60 and accompanying text.

¹⁸² *Quintana*, 827 P.2d at 525.

community had adopted unreasonably deficient practices and procedures."¹⁸³ Finally, the supreme court affirmed the appellate court's finding of error in the jury instructions equating compliance with the blood banking industry's customs and practices with the absence of negligence.¹⁸⁴ The supreme court did not express an opinion on whether the blood banking industry's standard of care fell below a reasonable level, or whether UBS itself was negligent; however, the court granted the Quintanas a new trial, leaving this determination to be made by a jury.

E. THE SECOND TRIAL

Four months after the supreme court decision, a Denver trial court jury ordered UBS to pay \$6.6 million to Susie Quintana and \$1.65 million to her husband following a three-week trial.¹⁸⁵ After five and one half hours of deliberation, the jury concluded that in light of the standard of care in the blood banking industry in April 1983, UBS had negligently supplied AIDS-contaminated blood to Quintana.¹⁸⁶ Moreover, the jury found that the standard of care set by the blood banking profession as a whole was "unreasonably deficient," because the industry had failed to use "proven scientific safeguards" to protect the blood supply.¹⁸⁷

F. ANALYSIS

The *Quintana* case signifies a departure from the protection traditionally afforded blood suppliers from transfusion-associated litigation and a willingness of courts to give greater weight to the interests of transfusion victims. In *Quintana*, the plaintiffs were able to overcome the traditional obstacles facing similarly situated plaintiffs. First, the Colorado appeals and supreme court decisions conceded that the national blood bank-

¹⁸³ *Id.*

¹⁸⁴ *Id.*

¹⁸⁵ See *Quintana v. United Blood Services*, No. 86 Civ. 11750 (Dist. Ct., Denver County, Colo. Aug. 1, 1991) (Special Verdict Forms A, B, C), *aff'd*, 811 P.2d 424 (Colo. App. 1991), *aff'd and remanded*, 827 P.2d 509 (Colo. 1992). The jury awarded Susie Quintana \$6.5 million for negligence, and Chris \$1.65 million for negligent infliction of emotional distress and loss of consortium.

¹⁸⁶ Pankratz, *supra* note 20, at 1A, 15A.

¹⁸⁷ *Id.*

ing industry's standard of care may have been lagging at the time of Quintana's transfusion, and so, conformity with such standards did not establish due care. In allowing a jury to scrutinize the blood banking industry's standards, rather than rely solely on adherence to custom as evidence of due care, the supreme court effectively required only a general standard of care, while ostensibly ruling that a professional standard of care applied in these negligence cases. Thus, under *Quintana*, if a blood bank acted in accordance with other members of the blood banking community, such compliance with custom no longer provides an absolute defense to liability.

Second, the plaintiffs in *Quintana* benefitted from the admission of expert testimony by individuals with national reputations in the field of AIDS, but who lacked so-called "blood bank expertise." Overcoming the trial court's pretrial ruling excluding plaintiff's proffered expert testimony, the Quintanas presented the testimony of Dr. Marcus Conant, Dr. Thomas Asher and Dr. Edgar Engleman.¹⁸⁸ These experts sharply criticized the response of the blood industry to the AIDS crisis.¹⁸⁹

Third, in *Quintana*, the expert testimony of Dr. Donald Francis, a former CDC researcher, was allowed.¹⁹⁰ Dr. Francis had been previously prohibited by the government from testifying; however, in 1992 he retired from the CDC and left its control.¹⁹¹ His testimony was instrumental in establishing a deficient standard of care in the national blood banking community because in early 1983, Dr. Francis had forcefully warned blood bank officials to adopt safety measures to protect the blood supply.¹⁹² His criticism of the blood industry was partic-

¹⁸⁸ *Quintana*, 827 P.2d at 517.

¹⁸⁹ Howard Pankratz, *AIDS Expert: Blood Bank Negligent in '83*, DENVER POST, July 16, 1992, at 1A, 12A; see Pankratz, *supra* note 20, at 15A. This testimony convinced juror that the blood banks were "dragging their feet."

¹⁹⁰ See Parloff, *supra* note 74, at 79.

¹⁹¹ *Id.*

¹⁹² SHILTS, *supra* note 41, at 221. During the previously mentioned January 4, 1983 CDC meeting, Shilts described Dr. Francis as pounding his fist on the table and shouting, "How many people have to die? How many deaths do you need? Give us the threshold of death that you need in order to believe that this is happening and we'll meet at that time and we can start doing something."

ularly helpful since it was based on what he and other CDC researchers knew in 1983, rather than on hindsight.¹⁹³

Finally, the court in *Quintana* allowed plaintiffs to correspond in writing with the donor of the tainted blood, while preserving his anonymity.¹⁹⁴ The donor was served with a written interrogatory under oath, posing a number of questions designed to ascertain whether the donor was at high risk for AIDS.¹⁹⁵ The interrogatory concluded by asking the donor if the preceding questions had been read to him, whether any of his replies would have been yes.¹⁹⁶ The donor answered affirmatively, thereby indicating that he fell into a high-risk group.¹⁹⁷ In response to *Quintana's* litigation, he wrote, "My understanding of AIDS, at the time I donated blood, was that it was most likely to occur, and had occurred, among Haitians, intravenous drug users and homosexual men with a history of promiscuity — over 1,000 different sexual partners."¹⁹⁸

IV. PUBLIC POLICY ISSUES

In assessing tort liability, a court should consider the potential impact of a decision on the general public. Due in part to the conflicting interests of individuals, determining where the public interest lies is a complex task; however, a just and practical result for the present and future requires courts to undertake this process.¹⁹⁹ An examination of the public policy

¹⁹³ See Mike McKee, *A Long Awaited Witness From the CDC*, RECORDER, Sept. 21, 1992, at 1. The availability of Dr. Francis as an expert witness should also benefit future plaintiffs. Since Dr. Francis retired he has been deposed for at least six other trials. *Id.*

¹⁹⁴ *Quintana*, 827 P.2d at 517.

¹⁹⁵ The written interrogatory provided donor with the following questions: 1) Have you ever had sexual contact with someone who had received a blood transfusion?; 2) Have you ever had sexual contact with someone who is in a group at high risk of AIDS or exposure to AIDS?; 3) Have you ever visited Haiti?; 4) Have you ever injected drugs into your vein(s)?; 5) Have you ever had sex with a man since 1978?; 6) Are you a hemophiliac?. *Id.*

¹⁹⁶ The interrogatory did not require that he indicate to which questions, if any, he would answer yes.

¹⁹⁷ *Id.*; see generally Howard Pankratz, *Gay Thought Only Promiscuous Got AIDS*, DENVER POST, July 22, 1992.

¹⁹⁸ *Id.* Such correspondence helped the *Quintanas* establish the blood bank's negligence and should likewise benefit future plaintiffs.

¹⁹⁹ KEETON ET AL., *supra* note 125, § 3, at 15-16.

issues surrounding transfusion-related AIDS litigation illustrates the difficulty of weighing the competing societal interests and the necessity of this inquiry both in achieving a fair result for the parties involved and ensuring a safer blood supply.

If other courts follow the second trial court in *Quintana* in holding the entire blood industry negligent for its actions after mid-1983, the impact on blood suppliers will be considerable, as a proliferation of lawsuits and potentially large judgment awards are likely.²⁰⁰ With the increased litigation, the ramifications on blood banks in terms of costs should be significant. The increased potential for liability will probably lead to substantially higher insurance premiums for blood banks.²⁰¹ Moreover, industry officials speculate that some blood banks may have to file for bankruptcy protection.²⁰² Ultimately, imposing such liability on blood suppliers will affect all of society as hospitals, insurers and consumers will have to share the increased costs in the form of higher prices for blood. In addition to the economic costs, these lawsuits may negatively impact the morale of people in the blood industry,²⁰³ and cause a loss of the public trust necessary to recruit donors.²⁰⁴

On the other hand, the multi-million dollar verdict in *Quintana* may raise the hopes and expectations of similarly situated victims of contaminated transfusions. From the perspective of these individuals, and society at large, imposing liability will have positive effects. Not only will victims be compensated for losses suffered, but under the threat of liability, blood banks will have stronger incentives to prevent future contamination, thereby enhancing the overall safety of the blood supply.

²⁰⁰ See Stevens, *supra* note 14, at 232 (discussing recent liability awards). See generally Carol McGraw, *Some AIDS Victims Win Blood Cases*, L.A. TIMES, Sept. 16, 1990, at 1.

²⁰¹ Joshua Hammer, *AIDS, Blood and Money*, NEWSWEEK, Jan. 23, 1989, at 43. In 1988, the Greater Ins. Co. of Cincinnati raised blood bank premiums by 500%. *Id.*

²⁰² See Sandra Blakeslee, *Blood Banks Facing Hundreds of AIDS Suits*, NEW YORK TIMES, April 27, 1989, at 18; McGraw, *supra* note 200, at 1.

²⁰³ Blakeslee, *supra* note 202, at 18. Mr. Gilbert Clark, executive director of the American Association of Blood Banks explained, "[a] major problem caused by these lawsuits is an emotional one This is a lifesaving profession and people in it have a public service attitude toward life. All of a sudden they're being accused of being baby killers." *Id.*

²⁰⁴ Parloff, *supra* note 74, at 78.

Whether holding the blood industry liable for negligence achieves a desirable social result thus poses a serious and controversial question to the legal system. The following section addresses this question and the surrounding issues, and concludes that imposing liability on blood banks will best serve the interests of society.

A. THE NATIONAL BLOOD POLICY

Prior to the early 1970's, one-quarter of the U.S. blood supply came from paid donors.²⁰⁵ At that time the incidence of patients contracting hepatitis via transfusion was not uncommon.²⁰⁶ An influential study conducted in the late 1960's concluded that cash blood caused higher rates of post-transfusion hepatitis.²⁰⁷ This view gained support in the U.S. among government officials, physicians and nonprofit blood collectors.²⁰⁸ Subsequently, in 1973, the Department of Health, Education, and Welfare (HEW) announced the National Blood Policy, aimed at improving the quality of blood by encouraging its donation and discouraging its sale.²⁰⁹ The National Blood Policy called for a safe and adequate blood supply for everyone in need.²¹⁰ A decade later, the onset of the AIDS epidemic tested the efficacy of this policy. During the early years of the disease, the

²⁰⁵ Eckert, *supra* note 6, at 6.

²⁰⁶ *Id.* Hepatitis is an inflammation of the liver capable of producing malaise, anorexia, fever, nausea, and jaundice. Ultimately, it can lead to chronic liver dysfunction and death. One aspect of the disease that distinguishes it from AIDS is that it can be successfully treated.

²⁰⁷ *Id.* at 7. That study and others indicated that hepatitis carriers were more likely to be found among lower socioeconomic groups in inner cities with poor health and sanitation facilities. Commercial blood banks were generally located in these skid row areas, which were close to hospitals and sources of supply. Thus, poor and destitute people, many of whom may not have known they were infected with hepatitis or may have been willing to give false health histories, often sold their blood to commercial blood banks for a cash payment. *Id.* at 11.

²⁰⁸ *Id.* at 7, 14.

²⁰⁹ *Id.* It was thought that abandoning the practice of paying blood donors and requiring an altruistic motive would reduce the incentive to donate for those in skid row areas who were infected or at risk, and thereby raise the quality of the blood supply. As a result of this federal policy, commercial blood banks largely disappeared by the late 1970's. *Id.*

²¹⁰ Nancy R. Holland, *Blood Policy Dynamics: An Overview*, in AIDS: PUBLIC POLICY DIMENSIONS 101, 101 (John Griggs ed., 1987).

blood industry fulfilled half of its responsibility — to maintain an adequate blood supply — but failed at the other — to ensure the safety of that supply.

B. BLOOD INDUSTRY'S FAILURE TO ENSURE THE SAFETY OF THE BLOOD SUPPLY

Courts maintain that in 1983 the limited medical knowledge concerning AIDS did not warrant greater precautionary measures than the ones taken.²¹¹ They claim that despite warnings, the evidence that AIDS was transmissible by blood was too inconclusive to justify any action that could threaten the adequacy of the blood supply.²¹² Furthermore, courts permit blood suppliers to rely on custom, contending that since the industry had not initiated new screening and testing procedures, they were in compliance with the applicable standard of care.²¹³ By the middle of 1983, however, blood banking officials should have known that the linkage of AIDS to the blood supply had alarmed the public and had reduced the number of donors.²¹⁴ The blood banks probably perceived that this could threaten the quantity of the blood supply as well as their own financial viability.²¹⁵ Moreover, blood banking leaders appeared to understand that an early response to the crisis could subject them to unwanted liability.²¹⁶ As a result, the indus-

²¹¹ See *Osborn v. Irwin Memorial Blood Bank*, 7 Cal. Rptr. 2d 101, 128-29 (Cal. Ct. App. 1992); *Wilson v. Irwin Memorial Blood Bank*, No. A054946, 1993 Cal. App. LEXIS 375, at *1 (Cal. Ct. App. Apr. 9, 1993); *Kozup v. Georgetown Univ.*, 663 F. Supp. 1048, 1053 (D.D.C. 1987); *Valdiviez v. U.S.*, 884 F.2d 196, 197 (5th Cir. 1989).

²¹² See cases cited *supra* note 211, 214.

²¹³ *Id.*; see also *Kirkendall v. Harbor Ins. Co.*, 698 F. Supp. 768, 778-79 (W.D. Ark. 1988).

²¹⁴ See James Mann, *AIDS Scare Hits Nation's Blood Supply*, U.S. NEWS & WORLD REPORT, July 25, 1983, at 71. BLOOD SUPPLY SAFETY, *supra* note 54, at 12-13, 116 (statement of Dr. Marcus Conant, Exhibit G).

²¹⁵ BLOOD SUPPLY SAFETY, *supra* note 54, at 12-13, 116 (statement of Dr. Marcus Conant, Exhibit G).

²¹⁶ *Id.* at 73 (Exhibit C). An internal report written by Dr. Joseph Bove stated, "[b]lood banks that wish to sell plasma . . . need to do something. Perhaps our Committee should prepare guidelines We are reluctant to do this since we do not want anything we do now to be interpreted by society (or legal authorities) as agreeing with the concept . . . that AIDS can be spread by blood." *Id.*

try responded with extreme caution.²¹⁷ Their approach was first to reject the possibility that AIDS was transmissible by blood, then to downplay the risks of transfusion-associated AIDS and reassure the public and the medical profession that the blood supply was safe.²¹⁸

For example, on January 13, 1983, the three voluntary blood service organizations²¹⁹ issued a joint statement indicating that the risk of contracting AIDS through transfusion was "one-in-a million."²²⁰ Again on June 22, 1983 the three organizations issued a joint news release repeating the one case per million statistic.²²¹ A later test, however, revealed that in nine regional Red Cross centers, 38 per 100,000 donors were HIV-infected, or 380 persons per million.²²² As one commentator points out, blood bank officials probably should not have made the "one-in-a-million" statement before they could have known the real risk of transfusion-associated AIDS.²²³ No one expected the blood banks to anticipate, protect and warn against all possible blood-related risks during the early years of the AIDS epidemic; yet neither did anyone suspect that they would engage in falsely reassuring the public and minimizing the risks of transfusion-associated AIDS before fully understanding the problem.²²⁴

²¹⁷ See generally BLOOD SUPPLY SAFETY, *supra* note 54, at 12-13 (statement of Dr. Marcus Conant, Professor, University of California Medical Center at San Francisco).

²¹⁸ *Id.*

²¹⁹ The three organizations were the American Red Cross, the American Association of Blood Banks, and the Council of Community Blood Centers.

²²⁰ BLOOD SUPPLY SAFETY, *supra* note 54, at 28 (statement of Ross D. Eckert, Professor, Claremont McKenna College).

²²¹ *Id.* at 116 (Exhibit G); see Ross D. Eckert, *AIDS and the Blood Bankers*, REGULATION, Sept./Oct. 1986, at 15. Also, in June 1983, the president of the American Association of Blood Banks said, "there is little or no danger to the general public." Furthermore, former HHS secretary Margaret Heckler announced that "there should be no fear among the public that they may develop AIDS through . . . blood transfusions." *Id.*

²²² Schorr et al., *Prevalence of HTLV-III Antibody in Blood Donors*, 313 NEW ENG. J. MED. 384 (1985).

²²³ BLOOD SUPPLY SAFETY, *supra* note 54, at 29 (statement of Ross Eckert, Professor, Claremont McKenna College). The statement may have caused some patients to undergo elective surgeries that they might have postponed if they suspected the risks were greater, or unknown. *Id.*

²²⁴ See Harvey M. Sapolsky, *Is Honesty the Best Policy?*, in AIDS: PUBLIC

In addition to downplaying the risk that HIV could be transmitted by transfusion, the blood industry erred in failing to adopt readily available safety measures²²⁵ which would have reduced the amount of AIDS-contaminated blood that entered the blood supply prior to 1985.²²⁶ For example, at the January 4, 1983 meeting held by the CDC, participants had discussed donor questioning and listened to CDC researchers present evidence that surrogate tests could screen out approximately ninety percent of individuals who had developed AIDS.²²⁷ Yet, blood banks failed to adopt surrogate testing or implement subsequent recommendations for greater precautions.²²⁸ While it had not been scientifically established that AIDS was transmissible through blood in the middle of 1983, it had become a major blood banking issue and a well-recognized possibility among the general public by the middle of 1983.²²⁹

Given the growing fear of AIDS, the increasingly apparent seriousness of the disease, the probability of transmission by blood and the availability of mechanisms to reduce the risks of

POLICY DIMENSIONS, *supra* note 210, at 111 (arguing that shading the truth, or "minimization," is a form of dishonesty that may not be a wise choice for blood banks where the safety of the blood supply and the public health are at stake).

²²⁵ Namely, surrogate testing and aggressive donor screening as to lifestyles and behaviors, as well as medical histories, would have enhanced the safety of the blood supply. Other measures include conducting physical examinations to detect swollen lymph glands — an early symptom of AIDS — or providing a confidential room for donor questioning.

²²⁶ See BLOOD SUPPLY SAFETY, *supra* note 54, at 33-37 (testimony of Dr. Edgar Engleman).

²²⁷ *Id.* at 12-13, 107-09 (statement of Marcus A. Conant, Professor, University of California Medical Center at San Francisco, Exhibit A, Summary Report from January 4, 1983 meeting). The summary report stated that "laboratory tests . . . may be most effective in preventing potential transmitters of AIDS." *Id.*

²²⁸ *Id.* at 13, 34-37 (statement of Dr. Marcus A. Conant, Professor, University of California Medical Center at San Francisco, and statement of Dr. Edgar Engleman, Medical Director, Stanford University Blood Center); see *supra* note 60 and accompanying text. At least one blood bank acted on the information by adopting surrogate testing and later attempted, to no avail, to demonstrate its effectiveness.

²²⁹ James Mann, *AIDS Scare Hits Nation's Blood Supply*, U.S. NEWS & WORLD REPORT, July 25, 1983, at 71; see also *The Toll: Who the Victims Are*, NEWSWEEK, April 18, 1983, at 75. This article observed, "AIDS poses a serious threat to the nation's 20,000 hemophiliacs, some of who require 30 to 40 transfusion of blood-clotting concentrates each year." *Id.*

contamination, the prudent course of action would have been to diligently protect the blood supply.²³⁰ Instead, the blood banks responded passively, first denying the existence of a problem, then later downplaying the risks.²³¹ The report of the Presidential Commission on the HIV Epidemic²³² reflects this view, concluding that "the initial response of the nation's blood banking industry to the possibility of contamination of the nation's blood by a new infectious agent was unnecessarily slow."²³³

In sum, evidence shows that the blood industry maintained an adequate blood supply during the early years of the AIDS epidemic, but failed to respond to threats to the safety of that supply as quickly or as diligently as reasonably possible. The blood industry could have screened donors more aggressively, adopted surrogate testing, educated the public about AIDS, and recommended alternative methods of obtaining blood for elective surgeries. In fact blood banks were encouraged, or perhaps warned, to take such measures,²³⁴ however, they declined to "accept imperfect solutions to urgent problems."²³⁵ Meanwhile, thousands of people were infected with HIV through contaminated blood and blood products.

C. WHY DID THE BLOOD INDUSTRY FAIL?

Numerous commentators and critics offer explanations of why the blood banking industry acted as it did between 1983 and 1985.²³⁶ One explanation for the blood industry's inappropriate response to the AIDS crisis is the overriding concern with

²³⁰ Notably, the factors listed which should have led to greater precautionary measures are not observations made in hindsight but rather were apparent in 1983 and 1984.

²³¹ See generally BLOOD SUPPLY SAFETY, *supra* note 54.

²³² The advisory commission was created by executive order of Ronald Reagan in 1987 to investigate the spread of HIV and to advise the President on the public health dangers, including the medical, legal, ethical, social, and economic impact, of the epidemic.

²³³ PRESIDENTIAL COMMISSION REPORT, *supra* note 75, at 78.

²³⁴ See BLOOD SUPPLY SAFETY, *supra* note 54, at 12-13, 33-37 (statement of Dr. Marcus Conant and statement of Dr. Edgar Engleman).

²³⁵ *Id.* at 34-35.

²³⁶ See discussion *infra* parts IV.C.1-3.

maintaining the adequacy of the blood supply.²³⁷ Alternative explanations, further discussed below, focus on the weak incentives for blood banks to act diligently²³⁸ and the preoccupation with costs and profits displayed by blood suppliers.²³⁹

1. *Maintaining an Adequate Blood Supply*

One explanation for the blood banks' failure to respond more quickly and aggressively to the threat of possible HIV-contamination of the blood supply in mid-1983 involves their concern with maintaining the adequacy of the blood supply.²⁴⁰ During the earlier years of the AIDS epidemic, fears of blood shortages and loss of donors seem to have influenced blood banking officials to wait for more conclusive evidence that HIV was indeed transmissible by blood rather than to take greater precautions.

While a concern with maintaining the blood supply was both important and legitimate, it serves as a tenuous justification for failure to acknowledge and address the possible transfusion transmission of AIDS in 1983 and 1984. In addition to preserving an adequate blood supply, blood banks were also responsible for ensuring its safety and educating the public as to its risks. Moreover, alternative measures existed which could have alleviated some of the alleged threat of shortage. For example, blood banks could have recommended autologous donations for patients prior to elective surgical procedures whereby the patients own blood could be donated during the month prior to surgery.²⁴¹ Blood banks could also have pro-

²³⁷ See, e.g., *Snyder v. Mekhjian*, 582 A.2d 307, 318 (N.J. 1990); BLOOD SUPPLY SAFETY, *supra* note 54, at 13, 91 (statement of Dr. Marcus Conant).

²³⁸ BLOOD SUPPLY SAFETY, *supra* note 54, at 18-23 (statement of Ross D. Eckert, Professor, Claremont McKenna College); Eckert, *supra* note 6, at 40-52; Eckert, *supra* note 221, at 16-18.

²³⁹ See generally Rock, *supra* note 42; Hammer, *supra* note 201; Parloff, *supra* note 74, at 81.

²⁴⁰ See, e.g., *Snyder*, 593 A.2d at 318; BLOOD SUPPLY SAFETY, *supra* note 54, at 13, 91 (statement of Dr. Marcus Conant, Professor, University of California Medical Center at San Francisco).

²⁴¹ BLOOD SUPPLY SAFETY, *supra* note 54, at 36 (statement of Dr. Edgar Engleman). Autologous blood is unquestionably the safest blood because it does not expose patients to any infections to which they are not already exposed. While most blood banks did not refuse to take autologous blood, they may have discouraged its use by limiting the locations and hours available for

vided directed donations, which patients were requesting,²⁴² or returned to the practice of compensating aggressively screened donors. Another possibility was the implementation of donor registries.²⁴³ Finally, the blood industry could have developed innovative methods for maintaining an adequate blood supply, such as requiring patients who received medical services to donate blood as part of their payment.²⁴⁴ While such alternatives would probably have increased the costs for blood banks, they could have shifted the costs to hospitals, insurers and consumers. Thus, notwithstanding concerns about the quantity of the blood supply, the more appropriate course of action would have been to depart from familiar routines and attempt to reduce the risk of HIV-tainted transfusion during the early years of the AIDS epidemic.

2. *Weak Incentives to Change Industry Custom*

Another explanation for the blood industry's excessively cautious approach centers on the lack of incentives for blood banks to act diligently to ensure the safety of the blood supply in 1983. The structure of the blood industry, its influence over regulation, and its general immunity from liability minimized the incentives for blood banks to respond quickly and aggressively to the AIDS threat.

First, the reorganization of the blood services industry in the 1970's, pursuant to the national blood policy, contributed to the creation of weak incentives to actively safeguard the blood supply in the early 1980's. Among the goals of the 1973 national blood policy was to discourage the sale of blood, and reduce competition for donors among nonprofit blood banks through regionalization.²⁴⁵ Subsequently, commercial blood suppliers virtually disappeared and local nonprofit monopolies or cartels

donations. *Id.*

²⁴² A directed donation is the collection and use of a designated donor's blood for a specific patient. Thus, patients undergoing surgery could request that their family donate any necessary blood.

²⁴³ See Eckert, *supra* note 221, at 20. Successful donor registries would require more frequent donations from a smaller pool of low-risk, demonstrably healthy donors, probably for cash payment. *Id.*

²⁴⁴ Alinka F. Baker, Comment, *Liability Without Fault and the AIDS Plague Compel a New Approach to Cases of Transfusion-Transmitted Disease*, 61 U. COLO. L. REV. 81, 85 (1990).

²⁴⁵ Eckert, *supra* note 6, at 6.

replaced them.²⁴⁶ Regional associations of local blood banks and hospitals formed, and hospitals and patients had little choice but to purchase the blood supplied by their regional blood bank.²⁴⁷ Thus, consumer demand for safe blood had little effect. As a result of this lack of competition, the blood industry's incentives to take necessary precautions in the face of the AIDS crisis were weak.

Second, the influence of the blood industry over its own regulation also functioned to limit its incentives to act diligently in 1983.²⁴⁸ While the FDA set the minimum standards for screening donors and testing blood, the FDA had relied heavily on blood bank officials for guidance, thereby creating the opportunity for self-interested advice.²⁴⁹ One critic reflected this view, describing published FDA recommendations as "nothing more than watered-down recommendations from the blood banking industry itself."²⁵⁰ Moreover, the FDA Blood Products Advisory Committee had received far more information from blood banks than consumers, and thus favored the blood banks.²⁵¹ In addition to lopsided information, suppliers have had an advantage over consumers because three of the eleven voting committee members are blood bankers, compared to one nonvoting consumer representative.²⁵² The committee's recommendations to the FDA probably reflected this unequal representation. Consequently, the resulting regulations provid-

²⁴⁶ Eckert, *supra* note 221, at 16-17. In 1978, the FDA required separate labeling of cash and noncash blood, subjecting medical services providers to increased liability for using cash blood. *Id.*

²⁴⁷ *Id.* at 17.

²⁴⁸ BLOOD SUPPLY SAFETY, *supra* note 54, at 22 (statement of Ross Eckert, Professor, Claremont McKenna College).

²⁴⁹ *Id.*

²⁵⁰ *Id.* at 14 (statement of Dr. Marcus Conant, Professor, University of California Medical Center at San Francisco).

²⁵¹ *Id.* at 29-31 (statement of Ross Eckert, Professor, University of California Medical Center at San Francisco). The Blood Products Advisory Committee is responsible for making recommendations to the FDA regarding transfusion-related issues. Representatives of consumers who frequently use blood products do not appear before the committee often and representatives of healthy consumers appear rarely. This is due in part to the fact that healthy consumers are unlikely to require a transfusion, and possess little information about blood safety and regulation. *Id.*

²⁵² *Id.* at 29.

ed weak incentives for blood banks to actively safeguard the blood supply during the early years of the AIDS epidemic.²⁵³

The final factor that minimized the blood industry's incentives to diligently reduce the risks of HIV contamination of the blood supply was the customary protection afforded blood banks from transfusion-associated liability.²⁵⁴ Blood shield statutes immunized suppliers from sales-based liability in forty-eight states,²⁵⁵ and industry custom provided an absolute defense to negligence.²⁵⁶ Thus, blood banks knew that following the customs and practices of the industry would insulate them from liability, and leave consumers with little opportunity to subject them to discipline. This knowledge, combined with the noncompetitive nature of blood banks and the excessive influence exerted by them on blood banking regulations produced weak incentives for the industry to respond quickly and diligently to the threat of AIDS.

3. *Preoccupation with Costs*

A final explanation for the foot-dragging of the blood industry in response to the AIDS threat involves the profit-based motives influencing blood banks.²⁵⁷ Blood banking was a \$2.5 billion business in 1989,²⁵⁸ and the risk of HIV-contaminated transfusions threatened revenues.²⁵⁹ Where safety measures to minimize the risk of HIV infection would have increased costs without immediately recognizable benefits,²⁶⁰ non-profit blood

²⁵³ *Id.* at 30.

²⁵⁴ *Id.*

²⁵⁵ See *supra* notes 93-99 and accompanying text.

²⁵⁶ See *supra* notes 131-142 and accompanying text.

²⁵⁷ See Rock, *supra* note 42, at 152; Hammer, *supra* note 201, at 43; Parloff, *supra* note 74, at 81.

²⁵⁸ Hammer, *supra* note 201, at 43.

²⁵⁹ *Id.* Despite reassurances, the risk of transfusion transmitted AIDS had reduced the number of people willing to donate for fear that they could somehow contract the disease by donating. Also, blood banking officials suspected any type of testing or screening would result in a loss of donors and blood — a situation they sought to avoid where their revenues relied on an ever-increasing supply of blood.

²⁶⁰ See Eckert, *supra* note 221, at 18; BLOOD SUPPLY SAFETY, *supra* note 54, at 118-19 (Exhibit I, Red Cross cost benefit analysis of surrogate testing). See generally Rock, *supra* note 42.

banks declined to implement such measures.²⁶¹ Provided other industry members adhered to this low standard, suppliers could claim custom as a defense and avoid liability, thus causing great pressure for conformity.²⁶² In short, where the costs of reducing the risk of transfusion transmitted AIDS were high and the chances of incurring liability for inaction in 1983 were low, blood suppliers focused primarily on the financial impact of their decision rather than their responsibility to safeguard the blood supply.

D. THE BLOOD BANKING INDUSTRY SHOULD BE HELD ACCOUNTABLE IN LIGHT OF SOCIETAL INTERESTS

Thousands of people in the U.S. are infected with HIV as a result of contaminated transfusions received between 1983 and 1985.²⁶³ For the individuals who have developed AIDS, the economic and social costs are overwhelming.²⁶⁴ In the past, the policy of protecting an adequate blood supply which shielded blood suppliers from liability seems to have outweighed the rights of individual victims of transfusion-associated AIDS to recover damages. But this calculation overlooks the comparatively important policies of ensuring the safety of the blood supply.

Three factors in evaluating the conflicting interests of suppliers against that of victims and society are the moral aspect of the defendant's conduct, the capacity of the parties to bear the loss, and the prevention of future harm.²⁶⁵ The following discussion will apply the three factors to transfusion AIDS litigation and conclude that holding the blood industry negligent achieves a socially desirable result by punishing the

²⁶¹ Taking such precautions would also raise the standard of care, subjecting blood banks to greater liability — another situation blood banking officials sought to avoid.

²⁶² See, e.g., BLOOD SUPPLY SAFETY, *supra* note 54, at 93-95 (Exhibit E, affidavit of Dr. David De Jongh).

²⁶³ See, *supra* note 9.

²⁶⁴ See *Monthly Review*, AIDS L. & Litig. Rep. (Univ. Pub. Group), Jan. 1992, at 5. The estimated cost of annual treatment is \$32,000 per patient and range much higher. This estimate assumes averages of 1.6 hospital stays per year at 15 days per stay, and \$1,000 a day for time in the hospital. It also assumes that outpatient costs comprise 25% of the total calculated cost of care for an AIDS patient. *Id.*

²⁶⁵ KEETON ET AL., *supra* note 125, § 4, at 21-25.

blood industry for past culpable conduct, allocating the loss to the party most capable of absorbing it, and giving blood suppliers future incentive to more diligently maintain the safety of the blood supply.

1. *Moral Aspect of Defendant's Conduct*

In balancing the conflicting interests of blood suppliers and victims of contaminated transfusions, one factor which weighs in favor of victims is the moral aspect of the defendants conduct.²⁶⁶ As Prosser explained, moral blame or fault has come to mean "no more than a departure from the conduct required of man by society for the protection of others, and it is the public and social interest which determines what is required."²⁶⁷ In reference to transfusion cases, evidence suggests that blood suppliers imposed an unreasonable risk of harm on transfusion recipients from 1983 to 1985. They responded unnecessarily slowly to initial threats of contamination of the blood supply,²⁶⁸ declined to implement surrogate testing and aggressive donor screening,²⁶⁹ and downplayed the risk of infection with HIV through blood.²⁷⁰ For this failure to live up to an "ideal standard of conduct"²⁷¹ as viewed by society, the blood industry should be held negligent as a matter of public policy.

Blood suppliers' fears of shrinking revenues and loss of donors²⁷² hardly seem to justify inaction, especially when alternative methods of collecting blood were available and the costs could have been shifted to consumers and insurers. The growing awareness of the seriousness of AIDS and the devastating impact of the potential injury on its victims should have prompted blood suppliers to act. Most patients, if faced with the choice between a risk of contracting AIDS through transfusion or an opportunity to protect themselves at a greater expense, would undoubtedly have accepted the added costs.²⁷³

²⁶⁶ *Id.*

²⁶⁷ *Id.* at 18.

²⁶⁸ See *supra* notes 211, 214-217 and accompanying text.

²⁶⁹ See *supra* notes 225-229 and accompanying text.

²⁷⁰ See *supra* notes 218-224 and accompanying text.

²⁷¹ KEETON ET AL., *supra* note 125, § 4, at 22.

²⁷² Hammer, *supra* note 201, at 43.

²⁷³ BLOOD SUPPLY SAFETY, *supra* note 54, at 77 (testimony of Dr. Conant,

However, as previously discussed, transfusion recipients exercised little control over the blood they acquired.²⁷⁴ At the least, blood banks could have given transfusion recipients the option of incurring costs to reduce the risk of injury.

In sum, the blood industry had a duty to the public to safeguard the blood supply. Yet, it appears that during the early years of the AIDS epidemic, blood suppliers focused excessively on their costs, rather than attending to the safety of the blood and the impact of AIDS on its victims. For failing to reduce the risk of HIV infection through blood by readily available measures, the interests of society favor that blood banks be held negligent.

2. *Capacity to Bear the Loss*

Imposing liability on blood service organizations also furthers societal interests by allocating the loss to the party more able to absorb and avoid it. One objective of tort law is to compensate victims for unreasonable harm, and courts have often attempted to place the financial burden on the party who is best suited to bear it.²⁷⁵ In the context of transfusion-related AIDS litigation the party best able to shoulder the burden appears to be the blood supplier.

Blood suppliers have the capacity to bear loss due to their substantial annual revenues and liability insurance policies.²⁷⁶ In procuring these policies, blood banks can anticipate the potential of tort suits arising from the transfusion of contaminated blood. Furthermore, blood suppliers may spread the loss among hospitals, consumers and their insurers in the form of higher prices for blood. In doing so, they can effectively maximize the number of people bearing the loss and minimize its effect on each person.

Individual AIDS victims on the other hand often do not have the capacity to cover the costs associated with the disease.²⁷⁷ The expenses for treatment and care are enormous,

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²⁷⁴ See *supra* notes 248-254 and accompanying text.

²⁷⁵ KEETON ET AL., *supra* note 125, § 4, at 22. This is a function of the capacity of both parties to absorb the loss or avoid it.

²⁷⁶ See Hammer, *supra* note 201, at 44.

²⁷⁷ See generally Gordon Bock, *A Burden Too Heavy to Bear: Insurance Companies Face the Staggering Cost of AIDS*, TIME, Aug. 31, 1987, at 39.

and regardless of who shoulders the economic burden, the victims must bear the social costs of the disease.²⁷⁸ Moreover, one in five AIDS patients has no insurance, and those with private insurance often do not receive coverage for the services most needed.²⁷⁹ In light of the foregoing considerations, the blood industry appears best able to bear the cost, thus bolstering the public policy argument in favor of holding the industry liable for its action between mid-1983 and 1985.

3. *Prevention of Future Harm*

A final policy factor favoring imposing liability on the blood service industry is the prevention of future harm.²⁸⁰ As discussed earlier, the blood industry had limited incentives to actively safeguard the blood supply during the early years of the AIDS epidemic.²⁸¹ Blood banks were virtually immune from liability as long as they complied with custom. Yet, where the blood banks themselves heavily influenced industry standards, compliance with custom may have provided insufficient protection. A more socially desirable policy would allow courts to scrutinize custom, as the supreme court permitted in *Quintana*, and subject the blood industry to liability where the evidence establishes that their actions and omissions were inappropriate. This policy would provide suppliers with increased financial incentive to adopt available precautionary measures to prevent future harm. Such prevention would be preferable to a policy of reaction where it might result in a decrease in transfusion-related litigation and, ultimately, the saving of lives.

CONCLUSION

Blood banks may no longer be immune from liability in transfusion-related AIDS litigation. The Colorado Supreme

²⁷⁸ See generally Mary C. Dunlap, *AIDS and Discrimination in the United States: Reflections on the Nature of Prejudice*, 34 VILL. L. REV. 909 (1989); see also Fineberg, *supra* note 1, at 128. People known to be infected with HIV have lost jobs, homes and friends while children with AIDS have been denied access to public schools. *Id.*

²⁷⁹ Fineberg, *supra* note 1, at 134. For example, private health insurance covers only 15 percent of the cost of drugs prescribed outside the hospital. *Id.*

²⁸⁰ See generally KEETON ET AL., *supra* note 125, § 4, at 23.

²⁸¹ See *supra* notes 248-257 and accompanying text.

Court's decision in *Quintana v. United Blood Services* demonstrates one court's willingness to depart from the traditional protection afforded the nation's blood banks and to give greater weight to the interests of transfusion victims. In allowing a jury to scrutinize blood-industry standards at the time of transfusion, the court opened the door to imposing liability on the supplier of contaminated blood and led to a finding that the entire blood industry was negligent. Subsequently, *Quintana* could have significant implications for blood suppliers, tainted-transfusion recipients and their respective insurers.

Imposing liability on blood banks for contaminated blood distributed in mid-1983 and thereafter achieves a socially desirable result where the evidence established that blood banks knew by early 1983 of the risk of transfusion-transmitted AIDS, yet declined to respond to the threat until 1985. By holding blood banks negligent for failing to adequately avoid the risk of tainted transfusions, the legal system punishes the blood industry for past culpable conduct, allocates the loss to the party best able to bear it and promotes prevention in American health care. Where the immunity once afforded blood suppliers from liability may have inhibited incentives to act, imposing liability in cases like *Quintana* should compel the blood industry to more diligently maintain the safety of the blood supply should a similar situation arise.

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