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BLOOD, SWEAT, AND TEARS: TOWARD A NEW
PARADIGM FOR PROTECTING DONOR PRIVACY

Kevin Hopkins*

Privacy and property ownership are among the most fundamental rights that we have as citizens of this country. Governmental intrusion on either right runs counter to our tradition of protecting those rights . . . [and] should be prohibited except under the most compelling circumstances.

Arthur Miller¹

The quality of one's life changes irrevocably when something like this [HIV infection] becomes public. Reason and rational thought are too often waived out of fear, caution, or just plain ignorance.

Arthur Ashe²

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¹ Arthur R. Miller, Confidentiality, Protective Orders, and Public Access to the Courts, 105 Harv. L. Rev. 427, 475 (1991).

² Arthur Ashe & Arnold Rampersad, Days of Grace 17 (1993). In 1983, tennis legend Arthur Ashe received HIV-infected blood during open-heart surgery. See id. at 15-16. In 1992, he was forced to reveal his HIV positive status after *USA Today* threatened to publish a lead it had received concerning his health. See id. at 6-11. Ashe notes that the pa-

INTRODUCTION

During the early 1980s, the United States faced its first major health crisis since the emergence of small pox, polio, malaria and tuberculosis. In 1981, the Center for Disease Control ("CDC") reported the first few cases of persons infected with Human Immunodeficiency Virus ("HIV"),³ a virus that would later be identified as the cause of Acquired Immune Deficiency Syndrome ("AIDS") and which would reach epidemic proportions worldwide.⁴ By June 1999 in the U.S., a cumulative total of 711,344 men, women and children with AIDS were reported to the Center for Disease Control.⁵ Of the total number of AIDS cases reported, 420,201 individuals have died.⁶ Estimates and reports of HIV infections are equally startling. In 1992, between 650,000 and 900,000 persons in the U.S. were infected with HIV.⁷ By 1996, approximately 700,000 individuals in the U.S. were infected, with 41,000 new HIV infections reported annually.⁸ Finally, the Joint United Na-

per had placed him in the "unenviable position of having to lie if [he] wanted to protect [his] privacy." See *id.* at 7. Mr. Ashe died of AIDS on February 6, 1993. See Robin Finn, Arthur Ashe, Tennis Champion, Dies of AIDS, *N.Y. Times*, Feb. 7, 1993, at A1.

³ See *Pneumocystis Pneumonia—Los Angeles*, 30 *Morbidity & Mortality Wkly. Rep.* 250, 250-52 (1981). HIV manifests itself in several physiological states: "an asymptomatic carrier state, a mildly symptomatic state with transient immunologic abnormalities . . . and other malignant conditions." *Perspectives on the Future of AIDS*, 253 *JAMA* 247, 247 (1985). Although there is a clinical distinction between HIV and AIDS, the distinction is irrelevant in controversies involving the discovery of donor identities and HIV-related medical information. Therefore, HIV and AIDS may be used interchangeably throughout this Article.

⁴ See Joint United Nations Programme on HIV/AIDS, *AIDS Epidemic Update: December 1999*, at 3-5, available at <<http://www.unaids.org/hivaidsinfo/documents.html#wad>> [hereinafter *AIDS Epidemic Update*]. Congress has defined AIDS as: "[a] severe collapse of the body's natural abilities to fight off infection. AIDS . . . is part of a spectrum of progressively more serious illnesses now believed to result from HIV. Generally, people do not die of HIV infection or the immune deficiency itself, but rather of the so-called opportunistic infections and conditions that arise as the immune system is destroyed by HIV infection." H.R. Rep. No. 511, 101st Cong., 2d Sess., at 23 (1990). The most common opportunistic infections are *Pneumocystis Carinii* (pneumonia) and Kaposi's Sarcoma (a specific skin cancer). See *id.*

⁵ See U.S. Dep't of Health and Human Servs., Pub. Health Serv., CDC, *HIV/AIDS Surveillance Report 6 tbl. 2* (June 1999) [hereinafter *HIV/AIDS Surveillance Report*]. This figure includes reported cases from U.S. states, dependencies, possessions and associated nations.

⁶ See *id.* at 28 tbl. 19.

⁷ See John M. Karon et al., *Prevalence of HIV Infection in the United States, 1984 to 1992*, 276 *JAMA* 126, 128 (1996).

⁸ See Scott D. Holmberg, *The Estimated Prevalence and Incidence of HIV in 96 Large*

tions Programme on HIV/AIDS and the World Health Organization have estimated that approximately 32.4 million adults and 1.2 million children worldwide were infected with HIV by the end of 1999.⁹

Nearly two decades after the first reported case of AIDS, only one percent of all reported AIDS-related cases were the result of blood transfusions.¹⁰ Despite the relatively small number of reported AIDS-related deaths resulting from blood transfusions, however, HIV transmission through blood transfusions continues to remain a legitimate concern.¹¹ First, CDC reports indicate that the HIV epidemic will remain a national and international health and public policy concern for years to come.¹² Second, blood transfusions are critical in saving lives.¹³ Third, a latency period exists where an individual infected with HIV is capable of transmitting the virus but may have no physical symptoms for several

US Metropolitan Areas, 86 *Am. J. Pub. Health* 642, 650 (1996). Currently, the CDC has reported a cumulative total of 113,959 HIV-infected adults and children living in the United States and American territories. See HIV/AIDS Surveillance Report, *supra* note 5, at 8 tbl. 3.

⁹ See AIDS Epidemic Update, *supra* note 4.

¹⁰ See HIV/AIDS Surveillance Report, *supra* note 5, at 12 tbl. 5. As of June 1999, the CDC reported a cumulative total of 8,430 (1 percent) of all AIDS cases were the result of blood transfusions. See *id.* This total includes thirty-eight adults/adolescents and two children who developed AIDS after receiving blood transfusions that screened negative for the HIV antibody. See *id.* An additional thirteen adults developed AIDS after receiving HIV-infected tissue and organs or through artificial insemination. See *id.* Cf. Mortality Attributable to HIV Infection/AIDS-United States, 1981-1990, 40 *Morbidity & Mortality Wkly. Rep.* 41, 43 (1991) (where CDC estimates indicated that between 1981 and 1990, 2943 transfusion-related AIDS deaths occurred accounting for 2.9 percent of the total AIDS-related deaths in the United States). A decrease in the percentage of deaths resulting from blood transfusions can be attributed to mandatory surrogate testing of blood and increases in the rates for other exposure categories.

¹¹ Although the risk of HIV transmission of screened blood is minimal, almost all cases of transfusion-associated HIV infections are the result of blood donated during the "window period" (i.e., when recently infected donors are infectious but have not developed sufficient levels of antibodies necessary for detection). See U.S. Dep't of Health and Human Servs., Public Health Serv., CDC, U.S. Public Health Service Guidelines for Testing and Counseling Blood and Plasma Donors for Human Immunodeficiency Virus Type 1 Antigen, 45 *Morbidity & Mortality Wkly. Rep.* 1, 1 (1996).

¹² According to the CDC, AIDS will continue to be a public health challenge worldwide in the 21st century. See The HIV/AIDS Epidemic: The First 10 Years, 40 *Morbidity & Mortality Wkly. Rep.* 357, 357 (1991).

¹³ See *infra* text accompanying notes 67-71 (discussing the role of blood transfusions in the national health care system).

months or years after being infected.¹⁴ Fourth, there is no cure for AIDS and no screening device to detect the presence of HIV in the blood stream.¹⁵ As long as transmission of HIV or any other disease through blood transfusion remains a possibility, there must be legal measures in place to deal with it.

Due to the incurable nature of HIV and its high mortality rate, blood banks have faced intense pressure and scrutiny from the courts and state legislatures when attempting to protect the privacy of donors in tort litigation by individuals who have received HIV-infected blood.¹⁶ Both institutions continue to struggle with the issue of when disclosure of a blood donor's identity, HIV positive status and other confidential medical information is permissible in lawsuits against blood banks for negligently providing HIV-infected blood donations. In the typical tort case, the plaintiff seeks disclosure of the identity of the blood donor and other blood bank records in order to establish a negligence claim against the blood bank or the donor.¹⁷ The blood bank, which is usually the

¹⁴ Persons infected with HIV range from those who are "asymptomatic" (i.e., having no signs or symptoms of the disease) to those having severe opportunistic infections and malignancies. See Alan R. Lifson et al., *Progression and Clinical Outcome of Infection Due to Human Immunodeficiency Virus*, 14 *Clinical Infectious Diseases* 966, 966 (1992). The estimated latency period between exposure to HIV and the onset of symptoms can vary from six months to more than ten years. See Jake Taylor, Comment, *Sex, Lies and Lawsuits: A New Mexico Physician's Duty to Warn Third Parties Who Unknowingly May Be at Risk of Contracting HIV from a Patient*, 26 *N.M. L. Rev.* 481, 484 n. 28 (citing Ron Brookmeyer & Mitchell H. Gail, *AIDS Epidemiology: A Quantitative Approach* 11 (1994)).

¹⁵ See *infra* notes 48-51 and accompanying text for a discussion of the ELISA and Western Blot tests. Each test only screens blood for the presence of the antibody to HIV and does not detect the virus itself.

¹⁶ See *infra* notes 63-65 and accompanying text.

¹⁷ Recipients of HIV infected blood transfusions commonly seek recovery against blood banks under one of the following theories: (1) breach of warranty; (2) strict liability; and (3) negligence. See Daniel L. Russo, Jr., Comment, *Blood Bank Liability to Recipients of HIV Contaminated Blood*, 18 *U. Dayton L. Rev.* 87, 89 (1992). See also Karen Shoos Lipton, *Blood Donor Services and Liability Issues Relating to Acquired Immune Deficiency Syndrome*, 7 *J. Legal Med.* 131, 132-50 (1986) (discussing general theories of recovery in AIDS-related litigation); Robert C. Greif, Comment, *Hospital and Blood Bank Liability to Patients Who Contract AIDS Through Blood Transfusions*, 23 *San Diego L. Rev.* 875, 880-81 n.27 (1986) (reviewing cases brought under each of these theories when plaintiffs had contracted serum hepatitis through blood transfusions). Currently, judicial decisions and legislative enactments have prevented recovery against blood banks based on all theories except negligence. See Russo, *supra*, at 89-98. Forty-eight out of fifty states have enacted "blood shield statutes" which protect blood suppli-

target of these battles, is faced with few alternatives. First, it can provide the requested information and risk breaching its own policies of privacy and confidentiality towards its donors, ultimately subjecting it to litigation by the donor. Second, the blood bank can refuse to provide the information and risk civil action by the plaintiff through a court order to access this information. Even when ordered by a court to disclose the requested information, however, blood banks are confronted with the additional issue of limiting disclosure to the information necessary for the plaintiff to establish the causal link to the HIV-infected donation while preventing access to other non-HIV-related information.

By default, the blood bank becomes the donor's advocate. In defending the privacy of its clients, the blood bank may file a motion for a protective order with the court to prevent disclosure of any information concerning the donor's identity or HIV positive status in order to protect against "annoyance, embarrassment, oppression, or undue burden or expense."¹⁸ A trial court then balances the competing interests to be served by granting or denying discovery.¹⁹

ers from liability against claims for both breach of warranty and strict liability. See *id.* at 93 n.62 (listing the various state blood shield statutes).

There are two theories of recovery in negligence: donor screening and blood testing. See, e.g., *Hoemke v. N.Y. Blood Ctr.*, 912 F.2d 550, 552-54 (2d Cir. 1990) (discussing plaintiff's theory of blood bank negligence for failure to employ sufficiently vigorous methods for screening out high-risk donors); *Osborn v. Irwin Mem'l Blood Bank*, 7 Cal. Rptr. 2d 101, 111-29 (Ct. App. 1992) (discussing plaintiff's theory of blood bank negligence for failing to conduct surrogate testing). However, as a result of the FDA's licensing of the ELISA test in March 1985 and current requirements that all blood be tested for HIV, chances of a finding of liability for negligent blood testing post-ELISA are remote and must rest on a claim of incompetence in performing the ELISA test. See Robert K. Jenner, *Transfusion-Associated AIDS Cases*, 26 *Trial* 30, 31-32 (May 1990). Because of this, the strongest theory for negligence against blood banks lies in donor screening. See *id.* at 32.

¹⁸ Fed. R. Civ. P. 26(c). Because of the stigma attached to AIDS, persons with HIV often experience intense discrimination and ostracism. See Michael L. Closten, *Introduction: HIV-AIDS in the 1990s*, 27 *J. Marshall L. Rev.* 239 (1994).

¹⁹ In applying a Rule 26(c) analysis, the courts have considered and weighed the following interests: (1) the plaintiff's interest in compensation for injury; (2) the donor's interest in privacy; and (3) society's interest in a safe and adequate blood supply. See *Rasmussen v. South Fla. Blood Serv.*, 500 So. 2d 533, 535-38 (Fla. 1987). See also *W. Page Keeton et al., Prosser and Keeton on the Law of Torts* §1, 5-6 (5th ed. 1984) (noting that the purpose of tort law is to compensate plaintiffs for injuries resulting from the conduct of another); *National Blood Policy*, 39 *Fed. Reg.* 32702, 32702 (1974) (noting

During the early stages of blood bank litigation, there were grave concerns about the modes of HIV transmission.²⁰ The courts, when weighing the competing interests of the parties, consistently favored disclosure because of concerns for protecting the national blood supply.²¹ This made both legal and practical sense when there was no adequate testing mechanism for HIV in donors.²² Even in those instances where the courts held for the donors, judicial remedies sometimes failed to provide sufficient protection for donor privacy and enforcement against improper uses of personal and private information.²³ However, in light of the current mandatory surrogate testing of blood,²⁴ and aggressive Food and Drug Administration ("FDA") monitoring of blood services,²⁵ there is no longer a reason to consistently undervalue donor privacy. Furthermore, it is inevitable that new diseases will appear and jeopardize the safety of the national blood supply in the future.

the safety and adequacy of the blood supply as principal goals in the provision of blood services); *infra* Part IV, Section A (discussing the donor's interest in privacy).

²⁰ See *infra* Part I, Section A (discussing the AIDS crises).

²¹ See *infra* note 64.

²² See *infra* Part I, Section B (discussing the development of surrogate testing).

²³ See *infra* note 171 (discussing a federal district court's response to an abuse of a discovery order requiring confidentiality).

Tainted blood litigation, however, is symptomatic of a much larger problem: technology and its impact on invasions of privacy. Today, one's blood, urine, breath, fingerprints, credit history, DNA and even consumer preferences are becoming increasingly accessible in an age of scientific and technological advancements that seem both driven and determined to place such matters in the public domain. See Michael J. Pelczar, Jr. et al., *Microbiology: Concepts and Applications* 350-400 (1993) for a discussion of deoxyribonucleic acid (DNA), where one's unique genetic material is stored. Unfortunately, the potential for even greater violations of donor privacy is inevitable as technology increases. The privacy concerns of donors today are no longer limited to only blood donations but now encompass other bodily transfers such as sperm, egg, bone marrow, and organ donations. As a result of recent advancements in medical technologies and procedures, infectious blood-borne diseases can be transferred indirectly through tissue and organ transplants. Consequently, claims in negligence arising from these procedures will also implicate judicial consideration of the donor's right to privacy. Because organ and tissue transfers have only been possible through recent medical technologies, case law in this area is still developing. Current blood bank-donor litigation may set precedent for how these cases will be resolved in the future.

²⁴ See *infra* Part I, Section B. Surrogate testing "is used when there is no direct test available for detecting the presence of a disease or the antibody generated by the disease." *United Blood Servs. v. Quintana*, 827 P.2d 509, 515 (Colo. 1992). It is designed to detect the presence of factors believed to be statistically linked to the presence of the disease. See *id.*

²⁵ See *infra* text accompanying notes 80-85.

To safeguard donor privacy in future blood bank litigation, policy makers must take the lead in enacting legislation that will provide the donor with the maximum protection for privacy but allow the plaintiff access to relevant information necessary to establish her legal claims.²⁶ In response to these concerns, this Article advocates that state legislatures adopt an absolute privilege for blood donors to ensure the adequacy and continuity of the blood donation process. In suits against blood banks, the Article proposes the adoption of a qualified blood bank-donor privilege to protect confidential information provided during the course of the screening process.

I. HIV AND BLOOD TRANSFUSIONS

A. *The AIDS Crisis*

On June 5, 1981, the CDC and California health care workers reported the first U.S. cases of the disease that later came to be known as AIDS.²⁷ At that time, however, physicians and researchers knew very little concerning the cause and mode of transmission of HIV or the full extent of the effect of HIV on the immune system. Nor were there any specific tests in existence to determine evidence of HIV infection in the blood, therefore, making it impossible to detect the presence of the virus within blood donations.²⁸

Between 1982 and 1983, the medical community concluded that AIDS could be transmitted through the blood stream after no-

²⁶ In most cases, the plaintiffs have sued the specific blood bank or hospital that provided the infected blood and not the donor (most likely because the donors have died). See generally *Long v. American Red Cross*, 145 F.R.D. 658, 662 (S.D. Ohio 1993); *Doe v. Puget Sound Blood Ctr.*, 819 P.2d 370, 376-77 (Wash. 1991) (noting that the deceased donor was not a named party in the suit). But see *Coleman v. American Red Cross*, 130 F.R.D. 360, 362 (E.D. Mich. 1990) (noting the plaintiffs had decided not to sue the donor individually).

²⁷ The first reported cases of AIDS in the United States were found in homosexual men and involved two diseases: pneumocystis carinii (pneumonia) and Kaposi's sarcoma (a rare skin cancer). See *Pneumocystis Pneumonia—Los Angeles*, 30 *Morbidity & Mortality Wkly. Rep.* 250, 250-52 (1981); *Kaposi's Sarcoma and Pneumocystis Pneumonia Among Homosexual Men—New York and California*, 30 *Morbidity & Mortality Wkly. Rep.* 305 (1981). See also *The HIV/AIDS Epidemic: The First 10 Years*, 40 *Morbidity & Mortality Wkly. Rep.* 357 (1991).

²⁸ See *supra* note 15 and accompanying text.

ting that patients who had received blood transfusions were contracting AIDS.²⁹ In 1982, after discovering three cases of opportunistic infections in hemophiliacs who had received clotting factors produced from blood products, and a case of AIDS-like symptoms presented by an infant who had received multiple blood transfusions at birth, researchers began to consider the possibility that HIV could be transmitted through blood.³⁰ During this period, the CDC identified four groups at highest risk for developing AIDS: homosexual males, intravenous drug users, Haitian immigrants, and hemophiliacs.³¹

As a result of these findings, the CDC sponsored a meeting to discuss the status of the nation's blood supply on January 4, 1983.³² The meeting was attended by representatives from the

²⁹ See *Pneumocystis Carinii Pneumonia Among Persons with Hemophilia A*, 31 *Morbidity & Mortality Wkly. Rep.* 365 (1982) (describing three cases of persons with hemophilia who had developed AIDS). See also *Possible Transfusion-Associated Acquired Immune Deficiency Syndrome (AIDS)—California*, 31 *Morbidity & Mortality Wkly. Rep.* 652, 653 (1982) (where the editorial commentary to the CDC report stated, “[t]he etiology of AIDS remains unknown, but its reported occurrence among homosexual men, intravenous drug abusers, and persons with hemophilia A suggests it may be caused by an infectious agent transmitted sexually or through exposure to blood or blood products”).

³⁰ See *Pneumocystis Carinii Pneumonia Among Persons with Hemophilia A*, supra note 29; *Possible Transfusion-Associated Acquired Immune Deficiency Syndrome (AIDS)—California*, supra note 29 (reporting that a 20-month old infant had developed an “unexplained cellular immunodeficiency and opportunistic infection” after receiving a transfusion of platelet derived from the blood of a male subsequently diagnosed with AIDS).

³¹ See *Current Trends Update: Acquired Immunodeficiency Syndrome (AIDS)—United States*, 32 *Morbidity & Mortality Wkly. Rep.* 688, 689 (1984). See also James W. Curran et al., *Acquired Immunodeficiency Syndrome (AIDS) Associated with Transfusions*, 310 *New Eng. J. Med.* 69, 70 (1984). Currently, the CDC has identified the following at-risk groups for adults and adolescents: men who have sex with men (57 percent); those who inject drugs (26 percent); men who have sex with men and inject drugs (8 percent); those with hemophilia/coagulation disorder (1 percent); those who have heterosexual contact with persons who are members of at-risk groups (10 percent); those who receive blood transfusions, blood components, or tissue (1 percent); and other risks not reported or identified (9 percent). See U.S. Dep’t of Health and Human Servs., *Pub. Health Serv., CDC, HIV/AIDS Surveillance Report 14* tbl. 5 (June 1999). Finally, the CDC has identified the following at-risk groups for children at age thirteen or below: those with hemophilia/coagulation disorder (3 percent); mothers with HIV or who are at risk for HIV infection (91 percent); those who receive blood transfusions, blood components, or tissues (4 percent); and other risks not reported or identified (2 percent). See *id.* (percentages are cumulative and current up to June 1999).

³² See *HIV and the Blood Supply: An Analysis of Crisis Decisionmaking 70-71* (Lau-

FDA, the American Red Cross, the American Association of Blood Banks, the Council of Community Blood Banks, the National Hemophilia Foundation, the National Gay Task Force, and the Pharmaceutical Manufacturer's Association.³³ On January 13, 1983, the American Red Cross, the American Association of Blood Banks and the Council of Community Blood Banks issued a Joint Statement that recommended the increased usage of "autologous blood transfusions" and a more thorough screening of all potential blood donors.³⁴ Specifically, the Joint Statement made several recommendations that were designed to limit the possible spread of AIDS through blood products.³⁵ It did not, however, recommend a routine implementation of laboratory blood testing or the screening of donors on the basis of sexual preference.³⁶ Recommendations concerning the discouraging of at-risk group participation in the donation process occurred two months later.³⁷

During March 1983, the U.S. Public Health Service Committee and the FDA's Bureau of Biologics issued memoranda to blood banks and manufacturers of plasma derivatives recommending the use of "self-screening" measures designed to decrease the collections of blood from individuals known to be at-risk for

ren B. Leveton et al. eds., 1995) (discussing the CDC's public meeting) [hereinafter HIV and the Blood Supply]. See also *United Blood Servs. v. Quintana*, 827 P.2d 509, 514-15 (Colo. 1992) (discussing the January 4, 1983 meeting and participants).

³³ See *Quintana*, 827 P.2d at 515.

³⁴ Joint Statement on the Acquired Immune Deficiency Syndrome (AIDS) Related to Transfusion, 23 *Transfusion* 87, 87 (1983) [hereinafter Joint Statement on AIDS]. An autologous transfusion is one in which the patient provides his or her own blood to be used in an upcoming surgery. See *Jones v. Philadelphia College of Osteopathic Med.*, 813 F. Supp. 1125, 1127 (E.D. Pa. 1993) (noting that autologous transfusion is "banking one's own blood").

³⁵ See Joint Statement on AIDS, *supra* note 34, at 87-88. For example, the Statement recommended a more thorough screening of blood and plasma donors through increased questioning designed to detect possible exposure to AIDS. See *id.* See also *Quintana*, 827 P.2d at 514-15.

³⁶ See *Kozup v. Georgetown Univ.*, 663 F. Supp. 1048, 1052 (D.D.C. 1987) (noting the Joint Statement did not recommend laboratory screening tests or donor screening on the basis of sexual preference); *Quintana*, 827 P.2d at 515 (noting that the Joint Statement suggested that donor screening should include only questions designed to detect possible exposure to AIDS).

³⁷ See Kathryn Glasgow Lotfi, Suppliers of AIDS-Contaminated Blood Now Face Liability, 34 *Howard L.J.* 183, 188 n.49 (1991) (citing Andrea Rock, Inside the Billion-Dollar Business of Blood, Money, March 1986, at 152, 153); HIV and the Blood Supply, *supra* note 32, at 72-73.

transmitting HIV.³⁸ The FDA's memorandum recommended that blood banks institute additional measures to decrease blood collection from groups at-risk for transmitting AIDS and to create educational programs to discourage at-risk donors from giving blood.³⁹ Additionally, the FDA recommended that blood banks train personnel responsible for donor screening on how to recognize the early signs and symptoms of AIDS,⁴⁰ and that blood banks begin to distribute pamphlets to donors belonging to high-risk groups.⁴¹ At that time, however, neither the FDA nor the Public Health Organization had recommended surrogate blood testing.⁴² Finally, by April 1984, scientists discovered that HIV was the probable cause of AIDS.⁴³

B. Development of Surrogate Testing

Prior to 1986, blood banks were left alone with the task of screening potential donors for disease. Donors were excluded only on the bases of medical histories of exposure to hepatitis, syphilis, blood disease, tuberculosis, malaria, cancer, heart problems, epilepsy, unexplained weight loss, or the taking of certain medications.⁴⁴ Although, blood banks provided potential donors with an AIDS information sheet describing the risks involved in donating HIV-infected blood and requiring donors to provide answers to a list of questions designed to obtain the donor's medical history,⁴⁵ blood donations were only screened for hepatitis B, syphilis, and

³⁸ See *Quintana*, 827 P.2d at 515-16. On March 4, 1983, the Public Health Service issued recommendations for donor screening that paralleled those issued on March 24, 1983 by the FDA. See *Kozup*, 663 F. Supp. at 1052. Specifically, these memorandums recommended that donor screening include information and questions designed to detect possible AIDS symptoms and exposure to patients with AIDS. See *Quintana*, 827 P.2d at 515-16.

³⁹ See *Quintana*, 827 P.2d at 515-16.

⁴⁰ See *id.* at 516.

⁴¹ See *Kozup*, 663 F. Supp. at 1052.

⁴² See *Quintana*, 827 P.2d at 515.

⁴³ See *Kozup*, 663 F. Supp. at 1052 (citing Peter J. Fischinger, *Acquired Immune Deficiency Syndrome: The Causative Agent and the Evolving Perspective*, *Current Probs. Cancer*, Jan. 1985, at 1, 4; *Perspectives on the Future of AIDS*, 253 *JAMA* 247 (1985)).

⁴⁴ See *Belle Bonfils Mem'l Blood Ctr. v. District Ct.*, 763 P.2d 1003, 1005 (Colo. 1988). See also *Quintana*, 811 P.2d at 427 (describing blood bank screening procedures).

⁴⁵ See *Belle Bonfils Mem'l Blood Ctr.*, 763 P.2d at 1006.

other antibodies.⁴⁶

In 1988, the FDA implemented mandatory testing of all donated blood.⁴⁷ By that time, several surrogate screening tests had been developed to detect the presence of HIV antibodies in the blood stream. On March 2, 1985, the FDA approved the licensing of an enzyme-linked immunosorbent assay test ("ELISA").⁴⁸ On April 30, 1987, Biotech Research Laboratories received a product license from the FDA for manufacture of the Western Blot test kit.⁴⁹ Although more costly and less sensitive than ELISA, the Western Blot test is used to confirm or refute the positive results of the ELISA.⁵⁰ When used together, the ELISA and the Western Blot tests are considered to be 99 percent effective in detecting HIV antibodies.⁵¹ Neither test, however, can detect the presence of HIV during the six to eight-week window period occurring between the time of the initial HIV infection and the formation of antibodies in the donor's blood.⁵² Recently, however, the FDA has

⁴⁶ See *id.*

⁴⁷ See Human Immunodeficiency Virus (HIV) Requirements, 21 C.F.R. § 610.45 (1999) (the regulation was published as a final rule on January 5, 1988 in 53 Fed. Reg. 116).

⁴⁸ See 50 Fed. Reg. 9909 (1985). See also 50 Fed. Reg. 28477 (1985). The ELISA was specifically created for screening large amounts of blood donations. See Michael J. Barry et al., *Screening for HIV Infection: Risks, Benefits, and the Burden of Proof*, 14 L. Med. & Health Care 259, 260 (1986). It was designed to create a high number of false positives to provide additional protection of the blood supply. See Taunya Lovell Banks & Roger R. McFadden, *Rush to Judgment: HIV Test Reliability and Screening*, 23 Tulsa L.J. 1, 16 (1987). Although the ELISA test has proven 98.6 percent specific and 97.3 percent sensitive for the detection of antibodies for HIV, it does not ensure against "false positives." See Stanley H. Weiss et al., *Screening Test for HTLV-III (AIDS AGENT) Antibodies*, 253 JAMA 221, 223-24 (1985). It is 100 percent effective when used in conjunction with a second test, the Western Blot Analysis. See Barry, *supra*, at 260 (noting that screening tests for HIV are designed to detect serum antibodies produced by the immune system in response to protein components of the virus and do not directly detect HIV).

⁴⁹ See Michael Abramowitz, *Rockville Firm's Test Kit for AIDS is Approved*, Wash. Post, May 1, 1987, at F1.

⁵⁰ See *HIV and the Blood Supply*, *supra* note 32, at 78. The Western Blot test is the most commonly used confirmatory test for HIV infection and has a 99 percent accuracy rate. See Barry, *supra* note 48, at 260; Robert Steinbrook, *Cheap, Speedy Test for AIDS Virus Found*, L.A. Times, Feb. 14, 1987, at 1 (noting that the Western Blot has a 99 percent accuracy rate).

⁵¹ See Defense Research Institute, *Misdiagnosed AIDS Provides New Liability for Medical Field*, AIDS Litig. Rep. 16096, 16096 (Sept. 13, 1996).

⁵² See *HIV and the Blood Supply*, *supra* note 32, at 78. Because neither ELISA nor the Western Blot detects the presence of HIV itself, there is a "window period" between the

encouraged all blood banks and hospitals to use exclusively, blood screened by nucleic acid testing ("NAT") in order to help eradicate viral infections in the blood supply.⁵³ NAT can detect tiny amounts of a virus like hepatitis C or HIV even before the donor's body has recognized the infection.⁵⁴ Although the test is expected to be capable of eliminating the few HIV cases that result each year from blood transfusions, it is still in the experimental stages.⁵⁵

II. CIVIL DISCOVERY AND BLOOD BANKS

Rule 26(b)(1) of the Federal Rules of Civil Procedure allows litigants to conduct broad discovery, including information that may be inadmissible evidence if it appears "reasonably calculated to lead to the discovery of admissible evidence."⁵⁶ The purpose of the liberal discovery policy is to assist parties in trial preparation or settlement of legal disputes and provide trial courts with wide discretion to manage the process.⁵⁷ The scope of discovery, how-

time an individual becomes infected with HIV and the body's production of sufficient antibodies to be detectable with surrogate testing. See *id.* This period can range between as short as six to twelve weeks, or as long as six months. See Occupational Exposure to Bloodborne Pathogens: Final Rule, 56 Fed. Reg. 64004, 64014 (1991) (discussing serological testing for antibodies formed in response to HIV infection). The average incubation period from the time of infection to the AIDS stage of the disease, however, is between eight and ten years. See Dennis Osmond, HIV Disease Progression from Infection to CDC-Defined AIDS Incubation Period, Cofactors, and Laboratory Markers, in *The AIDS Knowledge Base* § 1.7, at 1.7-1-1.7-13 (P.T. Cohen et al. eds., 2d ed. 1994).

⁵³ See *Blood Banks Will Begin Gene Testing to Help Increase Safety*, N.Y. Times, Mar. 7, 1999, at A24.

⁵⁴ See *id.*

⁵⁵ See *id.*

⁵⁶ Fed. R. Civ. P. 26(b)(1). The Rule provides that

Parties may obtain discovery regarding any matter, not privileged, which is relevant to the subject matter involved in the pending action, whether it relates to the claim or defense of the party seeking discovery or to the claim or defense of any other party, including . . . the identity and location of persons having knowledge of any discoverable matter . . . if the information sought appears reasonably calculated to lead to the discovery of admissible evidence.

Id. See also Advisory Note to Fed. R. Civ. P. 26(b) (1946 Amendment) (indicating that "[t]he purpose of discovery is to allow a broad search for facts, the names of witnesses, or any other matters which may aid a party in the preparation or presentation of his case.").

⁵⁷ See *Seattle Times Co. v. Rhinehart*, 467 U.S. 20, 34 (1984); 6 James Wm. Moore et al., *Moore's Federal Practice* § 26.02 (3d ed. 1997) (noting that "[d]iscovery serves to narrow and clarify the issues and ascertain the facts that are actually in dispute and require trial."). See also *United States v. Procter & Gamble Co.*, 356 U.S. 677, 682 (1958)

ever, has some limitations. First, as indicated in Rule 26, irrelevant and privileged information is not subject to discovery.⁵⁸ Second, upon a showing of good cause, a court has broad discretion in limiting or prohibiting discovery of relevant and non-privileged information in order to prevent “annoyance, embarrassment, oppression or undue burden or expense”⁵⁹ In determining whether good cause exists to prohibit discovery of relevant and non-privileged information, the trial court must weigh the competing interests that would be served by granting or denying discovery.⁶⁰ Federal courts have adopted a strict interpretation of the good cause requirement and force the party seeking confidentiality to demonstrate the particular harm that would result if a court declined to grant a protective order.⁶¹ Although Rule 26 was designed to provide trial courts with the means to minimize the impact of discovery on competing privacy interests, it presumes that even private information is discoverable unless a movant can demonstrate a particular harm or injury that would result from disclosure of the requested information.

Trial courts have identified three competing interests when granting or denying a plaintiff’s request for confidential information about the donor in AIDS litigation: (1) plaintiff’s interest in compensation for her injuries; (2) donor’s privacy interest in the nondisclosure of personal information; and (3) society’s interest in

(citing *Hickman v. Taylor*, 329 U.S. 495, 501 (1947)) (noting that the Federal Rules of Civil Procedure make a civil trial “less a game of blindman’s buff [sic] and more a fair contest with the basic issues and facts disclosed to the fullest practicable extent.”).

⁵⁸ See supra note 56.

⁵⁹ Rule 26(c) of the Federal Rules of Civil Procedure provides: “Upon motion by a party or by the person from whom discovery is sought . . . and for good cause shown, the court in which the action is pending . . . may make any order which justice requires to protect a party or person from annoyance, embarrassment, oppression, or undue burden or expense” Fed. R. Civ. P. 26(c).

⁶⁰ See Richard P. Campbell, *The Protective Order in Products Liability Litigation: Safeguard or Misnomer?*, 31 B.C. L. Rev. 771, 775-85 (1990) (providing a survey of federal case law implementing the balancing process). Specifically, the court must balance the plaintiff’s interest in obtaining the information and the defendant’s or society’s interest in keeping the information confidential. See *Estate of Hoyle v. American Red Cross*, 149 F.R.D. 215, 216 (D. Utah 1993).

⁶¹ See, e.g., *Smith v. Bic Corp.*, 869 F.2d 194, 201 (3d Cir. 1989); *Cipollone v. Liggett Group, Inc.*, 822 F.2d 335, 343 (3d Cir. 1987); *Nestle Foods Corp. v. Aetna Cas. & Sur. Co.*, 129 F.R.D. 483, 484 (D.N.J. 1990).

maintaining an adequate and safe national blood supply.⁶² The balancing of these interests, however, has not been easy. Federal and state courts are divided on the scope of discovery in AIDS cases. On the one hand, several courts have denied the plaintiff access to the donor on the basis of a right to privacy under both federal and state constitutions, society's interest in a safe and adequate blood supply, or a combination of the two interests.⁶³ On the other hand, many courts have permitted discovery of donors in furtherance of the tort law policy of compensating injured victims and the societal interest in maintaining a safe national blood supply.⁶⁴ Finally, several states have enacted statutes designed to pro-

⁶² See *Rasmussen v. South Fla. Blood Serv., Inc.*, 500 So. 2d 533, 534-38 (Fla. 1987). *Rasmussen* is the landmark case on the issue of discovery of donor identities and confidential information and has set the stage for all subsequent litigation on the issue. In *Rasmussen*, the plaintiff was struck by a car while sitting on a park bench. See *id.* at 534. During his hospitalization, plaintiff received fifty-one units of blood through transfusions. See *id.* Approximately one year later, plaintiff was diagnosed as having AIDS and later died. See *id.* To demonstrate that the cause of his injury was the medical treatment he received because of the accident, plaintiff served the defendant blood service with a subpoena duces tecum requesting "any and all records, documents and other material indicating the names and addresses of the [51] blood donors." *Id.* The blood service then filed a motion with the trial court to either quash the subpoena or to issue a protective order barring disclosure of the identities of the donors. See *id.* The trial court denied the motion and required the blood service to furnish the requested information. See *id.*

On review, the District Court of Appeal applied a balancing test under the Florida discovery rules that considered the plaintiff's interest in discovery of the names of the donors in order to prove the aggravation of his injuries and to allow for compensation, the donors' privacy interests under both the federal and Florida State Constitution, and the societal interest in ensuring the safety and adequacy of the nation's blood supply. See *South Fla. Blood Serv., Inc. v. Rasmussen*, 467 So. 2d 798, 801-04 (Fla. Dist. Ct. App. 1985), *aff'd*, 500 So. 2d 533 (Fla. 1987). It concluded that the free flow of donated blood was of sufficient public importance and when combined with the donors' privacy interests, it "outweigh[ed] *Rasmussen's* interest in discovering the [donors'] names and addresses." *Id.* at 804. The Florida Supreme Court later affirmed the District Court of Appeal's use of the balancing test and its reasoning. See *Rasmussen*, 500 So. 2d at 538.

⁶³ See *Ellison v. American Nat'l Red Cross*, 151 F.R.D. 8, 10-11 (D.N.H. 1993); *Estate of Hoyle v. American Red Cross*, 149 F.R.D. 215, 217 (D. Utah 1993); *Bradway v. American Nat'l Red Cross*, 132 F.R.D. 78, 80 (N.D. Ga. 1990); *Doe v. American Red Cross Blood Servs., S.C. Region*, 125 F.R.D. 646, 657 (D.S.C. 1989); *Rasmussen*, 500 So. 2d at 537-38; *Laburre v. East Jefferson Gen. Hosp.*, 555 So. 2d 1381, 1384-85 (La. 1990); *Krygier v. Airweld, Inc.*, 520 N.Y.S.2d 475, 477 (Sup. Ct. 1987); *Doe v. University of Cincinnati*, 538 N.E.2d 419, 425 (Ohio Ct. App. 1988); *Taylor v. West Penn Hosp.*, 48 Pa. D. & C.3d 178, 180 (Ct. C.P. Allegheny County 1987). But see *Coleman v. American Red Cross*, 130 F.R.D. 360, 362-63 (E.D. Mich. 1990), *aff'd in relevant part*, 979 F.2d 1135 (6th Cir. 1992) (holding that the societal interest in the blood supply, alone, outweighed the plaintiff's discovery needs).

⁶⁴ See *Coleman v. American Red Cross*, 23 F.3d 1091, 1096 (6th Cir. 1994); *Diabo v.*

tect the confidentiality of donor identities and HIV-related information but allow access to the information by plaintiffs upon a showing of compelling need or good cause.⁶⁵

III. THE PROBLEMS IN APPLYING RULE 26(C) IN BLOOD LITIGATION

There are several problems in applying Rule 26(c) and its state equivalents in blood bank cases. First, the judicial concern in maintaining a national blood supply that is safe and adequate is no longer justified as the overriding factor in balancing the competing interests under Rule 26(c) when current testing technologies already provide the maximum protection possible for blood safety. Second, because the Rule fosters a policy of liberal discovery, it inherently favors the plaintiff and fails to provide consistent and adequate recognition of the donor's privacy interest. Finally, an

Baystate Med. Ctr., 147 F.R.D. 6, 10-11 (D. Mass. 1993); Long v. American Red Cross, 145 F.R.D. 658, 672 (S.D. Ohio 1993); Borzillieri v. American Nat'l Red Cross, 139 F.R.D. 284, 289 (W.D.N.Y. 1991); Sampson v. American Nat'l Red Cross, 139 F.R.D. 95, 99-100 (N.D. Tex. 1991); Boutte v. Blood Sys., Inc., 127 F.R.D. 122, 126 (W.D. La. 1989); Mason v. Regional Med. Ctr. of Hopkins County, 121 F.R.D. 300, 303-04 (W.D. Ky. 1988); Belle Bonfils Mem'l Blood Ctr. v. District Ct., 763 P.2d 1003, 1012-13 (Colo. 1988); Most v. Tulane Med. Ctr., 576 So. 2d 1387, 1388 (La. 1991); Snyder v. Mekhjian, 593 A.2d 318, 323-25 (N.J. 1991); Arnold v. American Nat'l Red Cross, 639 N.E.2d 484, 494-97 (Ohio Ct. App. 1994); Stenger v. Lehigh Valley Hosp. Ctr., 609 A.2d 796, 800-02 (Pa. 1992); Gulf Coast Reg'l Blood Ctr. v. Houston, 745 S.W.2d 557, 559-60 (Tex. Ct. App. 1988); Tarrant County Hosp. Dist. v. Hughes, 734 S.W.2d 675, 679 (Tex. Ct. App. 1987); Doe v. Puget Sound Blood Ctr., 819 P.2d 370, 374-79 (Wash. 1991). See also National Blood Policy, 39 Fed. Reg. 32702, 32702 (1974).

⁶⁵ See Fla. Stat. Ann. § 381.004(3)(e)(9)(a) (West Supp. 2000) (allowing the plaintiff access to HIV-test results and related information under a court order, upon a showing by the plaintiff of compelling need for the information that cannot be obtained through other means). See also Ariz. Rev. Stat. Ann. § 36-665(A),(B)(1) (West 1993); Conn. Gen. Stat. Ann. § 19a-583 (a)(10)(A) (West 1997); Del. Code Ann. tit. 16, § 1203(a)(10)(a) (1995); Ga. Code Ann. §§ 24-9-47(t)(1)(B), (t)(2) (1995); Haw. Rev. Stat. Ann. § 325-101(a)(11) (Michie Supp. 1999); Iowa Code Ann. § 141.23(1)(g)(1) (West Supp. 1999); Ky. Rev. Stat. Ann. § 214.181(5)(c)(9)(a) (Michie 1999); La. Rev. Stat. Ann. § 40:1300.15(B)(1) (West 1992); Me. Rev. State. Ann. tit. 5, § 19203-D(2)(E) (West Supp. 1999); Mich. Comp. Laws Ann. § 333.5131(1), (3)(a) (West Supp. 1999); Ohio Rev. Code Ann. § 3701.24.3(C)(1)(b) (Anderson 1999); Pa. Stat. Ann. tit. 35, § 7608(a)(1) (West 1993); N.J. Stat. Ann. § 26:5C-9(a) (West 1996) (court order requiring showing of good cause); N.Y. Pub. Health Law § 2785(2)(a) (McKinney 1993); Vt. Stat. Ann. tit. 12, § 1705(a) (Supp. 1995); Va. Code Ann. § 32.1-36.1(A)(7) (Michie 1997); Wash. Rev. Code Ann. § 70.24.105(2)(f) (West Supp. 2000); W. Va. Code § 16-3C-3(a)(9)(i) (Supp. 1999). But see N.C. Gen. Stat. § 130A-143(6) (1999); Okla. Stat. Ann. tit. 63, § 1-502.2(A)(1) (West 1997) (allowing access through court order but failing to provide a specific standard for granting access).

application of Rule 26(c) in federal diversity actions has resulted in inconsistent outcomes in both federal and state courts, thus implicating the *Erie Doctrine*.⁶⁶

A. Blood Safety is No Longer an Overriding Factor Under Rule 26(c)

An important goal of the national blood policy is to ensure “a supply of blood and blood products adequate to meet all of the treatment and diagnostic needs of the population of this country.”⁶⁷ Within the past fifty years, blood transfusions have saved millions of lives and have become an “indispensable requirement for patient care” in the United States.⁶⁸ Each year, approximately 12 million blood transfusions are performed in the United States⁶⁹ and 70 million units of blood and blood components are transfused worldwide.⁷⁰ Blood transfusions remain critical for saving lives and there is no viable long-term substitute for blood.⁷¹

During the beginning of the AIDS crisis, trial courts, when determining whether to grant a protective order to blood banks under Rule 26(c), accorded significant weight to the effect of the disclosure of donor identity and HIV-related information on the nation’s

⁶⁶ See *infra* Part III, Section C (discussing the *Erie Doctrine*).

⁶⁷ National Blood Policy, 39 Fed. Reg. 32702, 32702 (1974).

⁶⁸ S.M. Lewis, How Safe is a Blood Transfusion?, 48 World Health 20, 20 (1995). Blood transfusions are performed to prevent serious medical complications such as “shock, cardiac or respiratory arrest, necrosis or tissue damage, and hemorrhage.” See Kathryn W. Pieplow, Comment, AIDS, Blood Banks, and the Courts: The Legal Response to Transfusion-Acquired Disease, 38 S.D. L. Rev. 609, 613 n.17 (1993) (citing the author’s interview with Henry Travers, M.D., Medical Director, McKennan Hospital Blood Bank, in Sioux Falls, S.D. (Dec. 23, 1992)). Currently, there are only two short-term substitutes for blood: artificial hemoglobin and fluorocarbon. See *id.* at 613, n.17.

⁶⁹ See Sally Squires, Blood Banks Adopt Stricter AIDS Test, Wash. Post, Apr. 2, 1996, at Z6; Protecting the Nation’s Blood Supply from Infectious Agents: New Standards to Meet New Threats: Hearings Before the Subcomm. on Human Resources and Intergovernmental Relations of the House Government Reform and Oversight Comm., 104th Cong. 87 (1995) (prepared statement of Kathryn C. Zoon, Director, Center for Biologic Evaluation and Research, Food and Drug Administration) [hereinafter Prepared Statement of Kathryn C. Zoon]. Much of the blood donated is processed into products such as derivatives, immune globulin (used to prevent infections) and clotting factors used to treat hemophilia. See *id.*

⁷⁰ See HemaSure Plans Product Launch, Membrane & Separation Tech. News, Jan. 1995 (newsletter).

⁷¹ See Pieplow, *supra* note 68, at 613 n.17.

blood supply.⁷² The final outcomes in these cases turned on the courts' conclusions as to which of the remaining interests would further the national blood policy.⁷³

The significance of the use of blood and blood products in medical treatment is unquestionable. Society continues to have a compelling interest not only in maintaining a safe blood supply and in maintaining adequate levels of blood at all times. Therefore, in order to remain viable, Rule 26(c) must continue to promote both of these interests. Neither goal is furthered, however, when applying the Rule in blood bank litigation.

Plaintiffs have argued that discovery of donor identities and HIV-related information about the donor will result in a safer blood supply.⁷⁴ The rationale behind this argument is that if donors are aware that their identities could be disclosed in future litigation, then at-risk donors will self-select and opt out of the blood donation process, therefore making the national blood supply safer.⁷⁵ Under this argument, the potential for litigation would serve as an additional screening device to deter at-risk donors from giving blood in the future.

Although the safety of the blood supply was a major concern during the early stages of the AIDS crisis, its significance today has been greatly diminished.⁷⁶ Today, the national blood supply is the safest that it has ever been at any time during the history of the United States.⁷⁷ Blood donations are now tested for seven different diseases—an increase from only two during 1981.⁷⁸

⁷² See *supra* text accompanying notes 62-64.

⁷³ See *Boutte v. Blood Sys., Inc.*, 127 F.R.D. 122, 126 (W.D. La. 1989) (holding that discovery of information from the donor concerning the blood bank's screening procedures would ensure blood safety); *Doe v. American Red Cross Blood Servs., S.C. Region*, 125 F.R.D. 637, 653 (D.S.C. 1989) (recognizing that confidentiality is essential in maintaining a volunteer blood donation system that can meet society's demands). See also *National Blood Policy*, 39 Fed. Reg. 32702, 32702 (1974).

⁷⁴ See *Bradway v. American Nat'l Red Cross*, 132 F.R.D. 78, 80 (N.D. Ga. 1990).

⁷⁵ See *Coleman v. American Red Cross*, 130 F.R.D. 360, 362-63 (E.D. Mich. 1990).

⁷⁶ It is important to remember that most of the blood bank litigation concerning HIV infected blood occurred during the heart of the AIDS crisis when its mode of transmission was uncertain, technologies were still developing, and aggressive FDA monitoring of the blood supply had just begun.

⁷⁷ See *Prepared Statement of Kathryn C. Zoon*, *supra* note 69.

⁷⁸ See *id.* at 93.

Since 1986, the FDA has significantly increased its oversight of the blood industry.⁷⁹ The FDA has continued to ensure the safety of blood by its efforts to improve the operation of the existing blood collection process through education, regulatory controls, quality assurance initiatives, and new products.⁸⁰ Currently, the FDA's blood safety system consists of five layers that begin at the blood collection center and extend throughout the manufacture and distribution of the blood products.⁸¹ The FDA performs routine inspections of blood banks in order to monitor their operation and to verify their adherence to regulations and standard procedures.⁸² During these inspections, investigators monitor the screening of donors, blood testing, labeling, storage and handling, record keeping and other practices.⁸³ When violations occur, the FDA has the power to issue warning letters or suspend or revoke a blood bank's license to operate.⁸⁴ It may also take legal action against the violator and issue civil or criminal penalties, including the seizure or recall of the products.⁸⁵

Both aggressive FDA monitoring of the national blood supply and recent advances in blood testing technologies have made the U.S. blood supply one of the safest in the world.⁸⁶ Therefore, most additional benefits from screening that may be derived from the threat of litigation will be realized and accounted for by the more recent blood testing technologies.⁸⁷

⁷⁹ See *id.*

⁸⁰ See *id.* at 95.

⁸¹ First, blood banks are required to perform donor screening by asking donors questions about their health and other risk factors. See *id.* at 91. Trained personnel screen potential donors and request all donors who may pose health threats, to remove themselves from the donation process. See *id.* Second, once the blood is donated, it is tested for blood-borne agents such as HIV and hepatitis. See *id.* Third, blood collection establishments are required to keep a list of "deferred donors" to prevent the use of blood given by these donors. See *id.* at 92. Fourth, all blood products are quarantined until they have been properly tested and the donation records have been verified. See *id.* Finally, blood collection establishments are required to investigate any breaches of these safeguards and to correct any deficiencies that are detected. See *id.*

⁸² See *id.*

⁸³ See *id.*

⁸⁴ See *id.* at 92-93.

⁸⁵ See *id.* at 93.

⁸⁶ See *id.* at 90.

⁸⁷ See *id.* at 93. Cf. *infra* text accompanying note 226 (recognizing that screening may provide critical protection in cases where HIV-infected blood is donated during the win-

In addition, blood banks have argued that allowing discovery of donor identities and HIV-related information could result in severe shortages of blood.⁸⁸ They contend that the possible threat of future litigation against donors for providing disease-infected blood would result in a disincentive to give blood, not only for at-risk donors, but also for the public at large.⁸⁹ They argue that application of the Rule could result in a serious disincentive to donate blood, running contrary to the societal interest in maintaining an adequate blood supply. Under this rationale, only a refusal to grant discovery under Rule 26(c) would promote the societal interest of maintaining an adequate blood supply.

Despite the fact that there is very little anecdotal evidence to support this argument, it may have some merit.⁹⁰ Current levels of blood donations in the United States are at an all-time low and experts have predicted that serious nationwide shortages will occur in the year 2000.⁹¹ Although fear of subsequent litigation may have contributed to these shortages, many blood banks have attributed the current shortages to a lack of enthusiasm by younger generations of Americans as compared to the enthusiasm of post-

dow period).

⁸⁸ See e.g., *Coleman v. American Red Cross*, 130 F.R.D. 360, 363 (E.D. Mich. 1990); *Boutte v. Blood Sys., Inc.*, 127 F.R.D. 122, 126 (W.D. La. 1989); *Rasmussen v. South Fla. Blood Serv., Inc.*, 500 So. 2d 533, 538 (Fla. 1987).

⁸⁹ See *Boutte*, 127 F.R.D. at 126. Blood banks have argued that the threat to all volunteer donors of being brought into litigation and subjected to questioning into intimate areas of their personal lives could seriously affect the supply of blood donations. See *LaBurre v. East Jefferson Gen. Hosp.*, 555 So. 2d 1381, 1384 (La. 1990). See also *Doe v. American Red Cross Blood Servs., S.C. Region*, 125 F.R.D. 646, 653 (D.S.C. 1989) (citing *South Fla. Blood Serv., Inc. v. Rasmussen*, 467 So. 2d 798, 804 (Fla. Dist. Ct. App. 1985)).

⁹⁰ See *Sampson v. American Nat'l Red Cross*, 139 F.R.D. 95, 97-98 (N.D. Tex. 1991) (recognizing the validity of the public policy interest in maintaining an adequate blood supply but finding no anecdotal or statistical evidence to indicate that voluntary blood donations had declined as a result of judicial orders and opinions). See also *Long v. American Red Cross*, 145 F.R.D. 658, 667-72 (S.D. Ohio 1993); *Snyder v. Mekhjian*, 593 A.2d 318, 324 (N.J. 1991); *Stenger v. Lehigh Valley Hosp. Ctr.*, 563 A.2d 531, 537 (Pa. Super. Ct. 1989).

⁹¹ See *Donors Needed to Help Avert Blood Shortages*, NY Times, June 28, 1999, at A12 (noting that approximately 60 percent of Americans are eligible donors yet only 5 percent actually donate). The National Blood Data Resource Center has predicted that in the year 2000, Americans will donate approximately 11.7 million units of blood, yet hospitals will need 11.9 million units. See *id.*

World War II donors.⁹² In light of the current shortages of the nation's blood supply, however, any application of Rule 26(c) that could even remotely result in an additional disincentive to give blood might seriously undercut the legitimate public interest in maintaining an adequate blood supply. Assuming that this could be the case, a denial of discovery under Rule 26(c) is the only application of the Rule that would promote this interest.

Neither a safe blood supply nor the maintenance of an adequate level of blood is sufficient justification for allowing discovery of donor identities and HIV-related information under Rule 26(c). Therefore, the societal interest in maintaining the integrity of the blood supply should no longer be used as the decisive and overriding factor to tip the balance in favor of either the plaintiff or donor's interests. Consequently, the plaintiff and donor's interests are now at par with each other and should be evaluated accordingly.

B. Rule 26(c) is Pro-Plaintiff

The Federal Rules of Civil Procedure allow litigants broad discovery of all information relevant to the subject matter in a case.⁹³ For discovery purposes, the relevance standard is broadly and liberally construed, and will vary with the subject matter at issue.⁹⁴ Information will be relevant as long as it is "reasonably calculated to lead to the discovery of admissible evidence."⁹⁵ Thus, inherent in Rule 26 is the presumption that either party is entitled to dis-

⁹² See *id.* at A12.

⁹³ See Fed. R. Civ. P. 26(b)(1). There are limits on discovery, however. Parties are not entitled to seek discovery of information that is privileged, irrelevant, or unlikely to lead to discoverable evidence. See *id.* See also *Food Lion, Inc. v. United Food & Commercial Workers Int'l Union*, 103 F.3d 1007,1012 (D.C. Cir. 1997) (holding that the district court erred in requiring a third-party to produce documents that were irrelevant to the suit).

⁹⁴ See *Herbert v. Lando*, 441 U.S. 153, 177 (1979) (holding that the discovery rules are to be given a broad and liberal treatment). The scope of relevance in discovery is broader than the standard of admissibility of evidence during trial and will include information that may be inadmissible at trial. See *United States v. City of Torrance*, 164 F.R.D. 493, 495 (C.D. Cal. 1995) (holding that discoverable information does not have to be admissible at trial); *Nestle Foods Corp. v. Aetna Cas. & Sur. Co.*, 135 F.R.D. 101, 104 (D.N.J. 1990) (holding that admissibility at trial is not the standard for measuring relevancy for discovery purposes).

⁹⁵ Fed. R. Civ. P. 26(b)(1).

cover and access all relevant matters in a case during the discovery phase.⁹⁶

In blood bank litigation involving claims of negligence in donor screening, plaintiffs often argue that discovery of a donor's identity is essential to demonstrate a blood bank's negligence and that its actions were the proximate cause of their injuries.⁹⁷ Plaintiffs in these cases have argued that discovery of the donor is necessary in order to determine the blood bank's screening procedures at the time of the donation of HIV-infected blood and whether those procedures were actually followed.⁹⁸ The rationale behind this contention is that donors are persons with knowledge of the relevant facts and without such information, plaintiffs will experience difficulty in prosecuting their claims.⁹⁹

Clearly, information surrounding the circumstances resulting in a blood bank's collection and supplying of disease-infected blood is relevant in any claim against it for negligence in donor screening.¹⁰⁰ Two viable sources for this information are the blood bank employee or technician who conducts the donor interview and the donor.¹⁰¹ Because of the relevance of this information, plaintiffs enjoy an implicit presumption of access to the donor under Rule 26.

A presumption of discovery, however, raises questions of fundamental fairness when a blood bank moves for a protective order under Rule 26(c). In balancing the competing interests under this

⁹⁶ See *Long v. American Red Cross*, 145 F.R.D. 658, 660 (S.D. Ohio 1993) (recognizing a presumption that a party may obtain discovery of any information that has some identifiable relationship with a claim or defense raised by the party); *Digital Equip. Corp. v. Micro Tech., Inc.*, 142 F.R.D. 488, 490 (D. Colo. 1992) (holding a presumption exists that all matters relevant to a pending case are discoverable).

⁹⁷ See *Long*, 145 F.R.D. at 661; *Coleman v. American Red Cross*, 130 F.R.D. 360, 361 (E.D. Mich. 1990).

⁹⁸ See *Sampson v. American Nat'l Red Cross*, 139 F.R.D. 95, 97 (N.D. Tex. 1991); *Boutte v. Blood Sys., Inc.*, 127 F.R.D. 122, 124 (W.D. La. 1989); *Most v. Tulane Med. Ctr.*, 576 So. 2d 1387, 1388 (La. 1991).

⁹⁹ See *Gulf Coast Reg'l Blood Ctr. v. Houston*, 745 S.W.2d 557, 560 (Tex. Ct. App. 1988).

¹⁰⁰ See *Boutte*, 127 F.R.D. at 124 (citing *Belle Bonfils Mem'l Blood Ctr. v. District Ct.*, 763 P.2d 1003 (Colo. 1988)).

¹⁰¹ See *id.* See also *Diabo v. Baystate Med. Ctr.*, 147 F.R.D. 6, 8 (D. Mass. 1993); *Ellison v. American Nat'l Red Cross*, 151 F.R.D. 8, 11 (D.N.H. 1993); *Doe v. Puget Sound Blood Ctr.*, 819 P.2d 370, 376 (Wash. 1991).

Rule, the plaintiff's interest in compensation for her injuries can be coupled with the presumption of access to all information relevant to her pending claim. This could automatically result in providing a court with a sufficient basis for assigning an even greater value to the plaintiff's position when weighing it against the donor's privacy interests. Thus, a court could always justify a ruling in favor of the plaintiff.

As a result of the broad scope of discovery under Rule 26, blood banks are left with the onus of having to file motions for protective orders under Rule 26(c). Under the Federal Rules of Civil Procedure, a party may not seek to discover information that is privileged or irrelevant.¹⁰² As previously discussed, the circumstances surrounding a blood bank's collection and distribution of disease-infected blood is relevant to a claim for negligence in donor screening.¹⁰³ Therefore, the only bases for a blood bank's refusal to comply with a plaintiff's discovery request for the donor's identity or HIV-related information would be that the blood bank has either asserted a claim of privilege or has already moved for a protective order and is awaiting the results.

These arguments do not succeed. First, most courts that have considered issues of privilege in blood litigation have focused primarily on the blood bank's claim that information conveyed and obtained through the donation process should be protected under the physician-patient privilege. These courts have held the physician-patient privilege inapplicable in this context, however, mainly because blood banks do not provide medical treatment.¹⁰⁴ No jurisdiction to date has recognized a separate blood bank-donor privilege to protect against disclosure of confidential information provided by donors during the screening process. Thus, blood banks have no other recourse but to file for protection under Rule 26(c). By doing this, they are forced to assume the burden of

¹⁰² See Fed. R. Civ. P. 26.

¹⁰³ See *supra* notes 97-98 and accompanying text.

¹⁰⁴ See *Doe v. American Nat'l Red Cross*, 798 F. Supp. 301, 305 (E.D.N.C. 1992); *Belle Bonfils Mem'l Blood Ctr.*, 763 P.2d at 1009; *LaBurre v. East Jefferson Gen. Hosp.*, 555 So. 2d 1381, 1383-84 (La. 1990); *Snyder v. Mekhjian*, 593 A.2d 318, 323 (N.J. 1991); *Doe v. University of Cincinnati*, 538 N.E.2d 419, 423 (Ohio Ct. App. 1988); *Tarrant County Hosp. Dist. v. Hughes*, 734 S.W.2d 675, 677 (Tex. Ct. App. 1987); *Doe v. Puget Sound Blood Ctr.*, 819 P.2d at 374.

showing “good cause” to prevail—an almost impossible task in light of liberal discovery rules that favor the plaintiff.¹⁰⁵

No court has held that a right to privacy recognized under either federal or state law is sufficient grounds, alone, to deny discovery of a donor’s identity or HIV-related information.¹⁰⁶ A few courts, however, have recognized that donors may enjoy an expressed or inherent right to privacy under either the federal or state constitutions,¹⁰⁷ or on the basis of the physician-patient privilege.¹⁰⁸ Although most courts recognize the donor’s privacy interest, they often fail to assign any significant weight to it when balancing the competing interests under Rule 26(c).¹⁰⁹ At least two

¹⁰⁵ See *supra* notes 59-61 and accompanying text (discussing “good cause”).

¹⁰⁶ Cf. *Rasmussen v. South Fla. Blood Serv., Inc.*, 500 So. 2d 533, 535-38 (Fla. 1987) (recognizing a donor’s privacy interest under both the state and federal constitutions but also concluding that disclosure would circumvent the public interest to discourage any disincentives to volunteer blood donations).

¹⁰⁷ See *id.* at 536. See also *Estate of Hoyle v. American Red Cross*, 149 F.R.D. 215, 217 (D. Utah 1993) (citing *Doe v. American Red Cross*, 125 F.R.D. at 652) (recognizing the donor had a strong interest in privacy under federal common law); *Doe v. American Red Cross Blood Servs., S.C. Region*, 125 F.R.D. 646, 650 (D.S.C. 1989) (recognizing donor privacy under the state and federal constitutions, but holding that the right is not absolute); *LaBurre*, 555 So. 2d at 1382 (recognizing the donor enjoyed a right to privacy under federal and state law); *Arnold v. American Nat’l Red Cross*, 639 N.E.2d 484, 497 (Ohio Ct. App. 1994) (recognizing the donor enjoyed an inherent right to privacy that prevented discovery of the donor’s identity under both the federal and Ohio constitutions); *Doe v. University of Cincinnati*, 538 N.E.2d at 424-25 (recognizing that the donor enjoyed an inherent right to privacy under the federal Constitution and under Ohio common law); *Stenger v. Lehigh Valley Hosp. Ctr.*, 609 A.2d 796, 800-02 (Pa. 1992) (recognizing that the donor’s identity may be protected under both the federal and Pennsylvania constitutions but holding the right is not absolute).

¹⁰⁸ See *Head v. Colloton*, 331 N.W.2d 870, 876 (Iowa 1983) (holding that although a bone marrow donor was not an actual patient of the hospital’s transplant unit, she enjoyed the rights of a patient); *Krygier v. Airweld, Inc.*, 520 N.Y.S.2d 475, 476-77 (Sup. Ct. 1987) (finding the physician-patient privilege applicable to the relationship between a blood bank and donor); *Stenger*, 609 A.2d at 803 (noting that donor identity could “potentially be subjected to the privilege”).

¹⁰⁹ See *Belle Bonfils Mem’l Blood Ctr.*, 763 P.2d at 1012-13 (recognizing the donor’s interest in privacy but affording it no significant weight or discussion). See generally *Borzillieri v. American Nat’l Red Cross*, 139 F.R.D. 284, 287-88 (W.D.N.Y. 1991) (recognizing that the donor has a federal constitutional right to privacy but holding that a properly framed protective order would not violate her constitutional right); *Bradway v. American Nat’l Red Cross*, 132 F.R.D. 78, 80 (N.D. Ga. 1990) (recognizing the donor’s privacy interest but failing to provide it a significant weight or discussion, or to consider a federal right of privacy); *Boutte v. Blood Sys., Inc.*, 127 F.R.D. 122, 125 (W.D. La. 1989) (recognizing the donor’s interest in privacy but finding that the interests of the parties could be adequately protected under the Federal Rules of Civil Procedure); *Most v.*

jurisdictions have refused to recognize a basic right of privacy for blood donors even under federal law.¹¹⁰

Because federal and state courts have consistently failed in recognizing and providing significant weight to the donor's privacy interest, favorable results for the donor under Rule 26(c) have been extremely tenuous and for the most part, heavily dependent upon the specific forum with jurisdiction over the case.

C. Rule 26(c) Raises Erie Concerns

In addition, the inconsistent treatment by courts of the donor's interest in privacy has the potential to implicate and violate the twin aims of the *Erie* Doctrine: "discouragement of forum shopping and avoidance of inequitable administration of the laws."¹¹¹ In *Erie Railroad Co. v. Tompkins*, the Supreme Court, in interpreting Section 34 of the Federal Judiciary Act of 1789, held its purpose was to ensure that "in all matters except those in which some federal law is controlling, the federal courts exercising jurisdiction in diversity of citizenship cases would apply . . . the law of the State . . ."¹¹² In short, *Erie* holds that federal courts must apply state substantive law and federal procedural law.¹¹³ The following scenarios illustrate the possible *Erie* implications in blood donor

Tulane Med. Ctr., 576 So. 2d 1387, 1388 (La. 1991) (recognizing the donor's privacy concerns but failing to afford any significant weight or discussion); *Snyder v. Mekhjian*, 582 A.2d 307, 313-15 (N.J. Super. Ct. App. Div. 1990), *aff'd*, 593 A.2d 318 (N.J. 1991) (finding that the donor's privacy interest had been adequately protected by the state's confidentiality of records of AIDS patients thereby avoiding a consideration of a federal right to privacy).

¹¹⁰ See *Sampson v. American Nat'l Red Cross*, 139 F.R.D. 95, 99 (N.D. Tex. 1991) (avoiding consideration of the defendant's federal right of privacy claim and questioning whether a right to privacy even arises in the context of discovery between non-governmental parties); *Mason v. Regional Med. Ctr. of Hopkins County*, 121 F.R.D. 300, 303 (W.D. Ky. 1988) (failing to recognize any claim of a donor's right to privacy even under federal law).

¹¹¹ *Hanna v. Plumer*, 380 U.S. 460, 468 (1965) (discussing the twin aims of *Erie R.R. Co. v. Tompkins*, 304 U.S. 64, 78 (1938) (holding that "[e]xcept in matters governed by the Federal Constitution or by Acts of Congress, the law to be applied in any case is the law of the State.")). See also *Gasperini v. Center for Humanities, Inc.*, 518 U.S. 415, 430 (1996) (applying *Erie* and holding that ignoring an application of the New York standard to damage awards on claims governed by New York law would result in "'substantial' variations between state and federal [money judgments]" (internal citations omitted)).

¹¹² *Erie R.R. Co.*, 304 U.S. at 72-73.

¹¹³ See *Hanna*, 380 U.S. at 471.

litigation.

First, a few federal courts, when conducting a balancing of the competing interests under Rule 26(c), have concluded that the Federal Rules of Civil Procedure alone are sufficient to protect the donor's privacy interest and have relied solely upon these Rules in reaching their decisions.¹¹⁴ Consequently, these courts have avoided any consideration of an inherent or expressed right of privacy under either federal or state law.¹¹⁵ Following this approach, however, would allow a federal court to conclude that the right of privacy should be treated as procedural in nature and not substantive, and would present a conflict in situations where a state has recognized a substantive right of privacy either under state or federal law.¹¹⁶

Second, current judicial treatments of blood donation cases also implicate *Erie* in situations where federal courts have recognized a substantive right to privacy under federal law, but state courts have failed to recognize the existence of a right of privacy under either state or federal law.¹¹⁷ Under this scenario, a federal

¹¹⁴ See *Boutte*, 127 F.R.D. at 125; *Doe v. American Red Cross Blood Servs.*, 125 F.R.D. 637, 650 (D.S.C. 1989). See also *Seattle Times Co. v. Rhinehart*, 467 U.S. 20, 35 n.21 (noting that the protection of privacy is "implicit in the broad purpose and language of [Rule 26(c)]"). For a further discussion of this point, see Arthur R. Miller, *Confidentiality, Protective Orders, and Public Access to the Courts*, 105 Harv. L. Rev. 427, 465 n.199 (1991).

¹¹⁵ See *Boutte*, 127 F.R.D. at 125; *Doe v. American Red Cross Blood Servs.*, 125 F.R.D. at 650.

¹¹⁶ For example, in *Rasmussen*, the Florida Supreme Court held that donors enjoy a right to privacy under both the Florida Constitution and the U.S. Constitution. See *Rasmussen v. South Fla. Blood Serv., Inc.*, 500 So. 2d 533, 536 (Fla. 1987). Following this approach, a federal district court in Florida could arguably bypass a consideration of the constitutional question of a right of privacy and could rule that the Federal Rules of Civil Procedure, alone, are sufficient to protect the donor's privacy concerns. See *South Fla. Blood Serv., Inc. v. Rasmussen*, 467 So. 2d 798, 803 (Fla. Dist. Ct. App. 1985), *aff'd*, 500 So. 2d 533 (Fla. 1987) (where the District Court of Appeals noted that Florida Rule of Civil Procedure 1.280(c), the state equivalent of Fed. R. Civ. P. 26(c), adequately protected the donor's privacy interest).

¹¹⁷ For example, in *Yeager v. Local Union 20*, a case involving a false-light privacy claim, the Ohio Supreme Court ruled that Ohio does not recognize a false-light cause of action. See *Yeager v. Local Union 20*, 453 N.E.2d 666, 670 (Ohio 1983). However, in *Cantrell v. Forest City Publishing Co.*, the United States Supreme Court recognized an Ohio appellant's false-light privacy claim and found for the appellant. See *Cantrell v. Forest City Publishing Co.*, 419 U.S. 245, 252-53 (1974). In a footnote, the Court stated that "[a]lthough this [was] a diversity action based on state tort law, there [was] re-

court cannot afford the privacy protection permitted under federal laws because under *Erie*, it must rule in a manner consistent with state law that would typically govern the substantive nature of a claim.¹¹⁸

Finally, *Erie* implications are potentially raised when the state court has recognized a substantive right of privacy that is based on federal law, but the federal district in the same state has failed to recognize a federal right of privacy.¹¹⁹ This scenario places the federal district court in the position of having to either conform to *Erie*'s application of state substantive law (in this case a right that is bootstrapped to the federal right of privacy),¹²⁰ or violate the principle of *stare decisis*.¹²¹

At the very least, a Rule 26(c) balancing of the competing interests in blood litigation implicates concerns of federalism and the *Erie* doctrine. Therefore, federal and state legislative reevaluation of the continued use of this rule in blood litigation is warranted solely on this basis.

markably little discussion of the relevant Ohio or West Virginia law by the District Court. . . . It [was] clear, however, that both Ohio and West Virginia recognize[d] a legally protected interest in privacy." *Id.* at 248 n.2. Arguably, under this scenario, a federal district court in Ohio would be bound by the Supreme Court's recognition and discussion of false-light privacy, but under *Erie* would be placed in the position of having to follow state substantive law on the privacy claim.

¹¹⁸ See *Erie R.R. Co. v. Tompkins*, 304 U.S. 65, 78 (1938).

¹¹⁹ For example, this situation could occur in the State of Texas. In *Tarrant County Hospital District*, a case involving the discovery of the donor's identity in blood litigation, the Court of Appeals noted that "[n]either the Federal Constitution nor [the Texas] State Constitution expressly mentions any right of privacy," but acknowledged, however, the existence of a right of privacy under federal case law. *Tarrant County Hosp. Dist. v. Hughes*, 734 S.W.2d 675, 678-79 (Tex. Ct. App. 1987). The Texas Court of Appeals then disagreed with the *Rasmussen* court's finding of a donor's right to privacy under both state and federal law. See *id.* at 679. The U.S. District Court for the Northern District of Texas in *Sampson*, however, in considering the same issue, briefly questioned whether federal constitutional privacy rights even arise in the context of discovery between private parties and avoided a consideration of the defendant's federal right of privacy claim altogether. See *Sampson v. American Nat'l Red Cross*, 139 F.R.D. 95, 99 (N.D. Tex. 1991).

¹²⁰ See *Erie R.R. Co.*, 304 U.S. at 78.

¹²¹ *Stare decisis* is the policy of courts "to stand by precedent and not to disturb settled point[s]." *Blacks Law Dictionary* 1406 (6th ed. 1990). See also *State Oil Co. v. Khan*, 522 U.S. 3, 20 (1997) (citing *Payne v. Tennessee*, 501 U.S. 808, 827 (1991) and noting that *stare decisis* "promotes the evenhanded, predictable, and consistent development of legal principles, fosters reliance on judicial decisions, and contributes to the actual and perceived integrity of the judicial process.").

IV. PROTECTION OF DONOR PRIVACY: THE CASE FOR A LEGISLATIVE PRIVILEGE

A critical review of Rule 26(c) and its application in blood bank cases indicates the inherent fallacies in relying on the judiciary to provide sufficient protection of donor privacy when balancing the competing interests. Thus, the real issue in determining whether to grant protective relief for blood banks that oppose disclosing donor identities and HIV-related information should not be handled through a procedural balancing of the respective interests. The better approach is one that recognizes the legitimate substantive claims of both plaintiffs and donors, but is mindful of and sensitive to the societal concerns in furthering the national blood policy. It should provide the maximum protection possible for policing donor privacy, yet allow the plaintiff access to essential information necessary to establish her legal claim against the blood bank or donor.

This Part of the Article will analyze the donor's substantive claim to a right to privacy and the legal basis for its protection. It will provide an overview of the adoption and use of common law privileges to protect specific types of relationships where society, for public policy reasons, has recognized the necessity of confidentiality in maintaining the integrity of those relationships. The Article will argue that maintenance of the blood bank-donor relationship is critical for the success of the American health care system and that confidentiality is essential for the stability and continuity of the national blood supply. Finally, it will explain why the blood bank-donor relationship should be accorded protection under privilege law.

A. The Constitutional Right to Privacy

1. Judicial Recognition of a Substantive Right

When requesting protection for the donor under Rule 26(c), blood banks typically contend that the donor's interest in anonymity implicates a right to privacy under federal or state law.¹²² They

¹²² See *Rasmussen v. South Fla. Blood Serv., Inc.*, 500 So. 2d 533, 535-36 (Fla. 1987) (evaluating the blood bank's assertion that the donors rights to privacy were protected by the state and federal constitutions).

have argued that disclosure of donor identities in any context involving HIV could be both disruptive and devastating to the individual donor, and lead to discrimination in employment, housing and medical treatment.¹²³ Therefore, in balancing the competing interests involved, the court must determine not only whether a substantive right to privacy exists, but also the appropriate weight to afford it.¹²⁴

The right to privacy is “the most comprehensive of rights and the right most valued by civilized man.”¹²⁵ It is a substantive right—one that is fundamental and “implicit in the concept of ordered liberty,”¹²⁶ and one that can only be protected through measures designed to insure confidentiality.¹²⁷ The right to privacy, however, is a relatively recent development of the common law and was first considered in a landmark law review article written by Samuel D. Warren and Louis D. Brandeis in 1890.¹²⁸ In that article, Warren and Brandeis argued that “[p]olitical, social, and economic changes entail the recognition of new rights,”¹²⁹ and asserted that “the individual is entitled to decide whether that which is his shall be given to the public.”¹³⁰ Specifically, the two scholars argued that instantaneous photographs and newspaper publications had “invaded the sacred precincts of private and domestic life,”¹³¹ and believed the law should provide protection against such intrusions.¹³² The current tort of invasion of privacy emanated from the Warren and Brandeis article and was later defined

¹²³ See *id.* at 537 (citing the district court’s characterization of AIDS as the “modern day equivalent of leprosy”).

¹²⁴ See *supra* notes 107, 109-10.

¹²⁵ *Stanley v. Georgia*, 394 U.S. 557, 564 (1969) (citing *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting)).

¹²⁶ The Supreme Court has alluded to the right to privacy as one of those fundamental rights that is “implicit in the concept of ordered liberty” such that “neither liberty nor justice would exist if [they] were sacrificed.” *Palko v. Connecticut*, 302 U.S. 319, 325-26 (1937).

¹²⁷ See Arthur R. Miller, *Confidentiality, Protective Orders, and Public Access to the Courts*, 105 *Harv. L. Rev.* 427, 464 (1991).

¹²⁸ Samuel D. Warren & Louis D. Brandeis, *The Right to Privacy*, 4 *Harv. L. Rev.* 193 (1890).

¹²⁹ *Id.* at 193.

¹³⁰ *Id.* at 199.

¹³¹ *Id.* at 195.

¹³² See *id.* at 211.

and organized into four distinct categories by William Prosser.¹³³

The federal Constitution does not expressly mention a right to privacy.¹³⁴ In 1928, the Supreme Court examined the first claim for privacy in *Olmstead v. United States*, a case based upon a Fourth Amendment claim against the government for wiretapping.¹³⁵ In *Olmstead*, federal law enforcement officers had tapped the telephones of several persons suspected of conspiring to violate the National Prohibition Act.¹³⁶ The defendants objected to the government's admission of the evidence obtained by the wiretapping on the basis that the government's actions constituted an unreasonable search and seizure in violation of the Fourth Amendment.¹³⁷ The defendants also argued that they enjoyed a right to the exclusive enjoyment of a telephone conversation free from interference, and that this was a right to privacy.¹³⁸ The Court, however, adopted a strict construction of the Fourth Amendment and refused to recognize a right to privacy under the circumstances.¹³⁹

In *Griswold v. Connecticut*, the Supreme Court recognized an inherent right to privacy emanating from several constitutional amendments contained in the Bill of Rights.¹⁴⁰ In explaining its

¹³³ See William L. Prosser, *Privacy*, 48 Calif. L. Rev. 383, 386 (1960). See also W. Page Keeton et al., *Prosser and Keeton on the Law of Torts* 849-50 (5th ed. 1984). The categories include: (1) the intrusions upon an individual's seclusion or solitude, or into one's private affairs; (2) the public disclosure of embarrassing private facts about a person; (3) publicity that places an individual in a false light; and (4) the appropriation of a person's name or likeness for the commercial gain of another. See *Restatement (Second) of Torts* § 652 (1977) (adopting Prosser's categories).

¹³⁴ Although the federal Constitution does not expressly provide for a right to privacy, many states, however, have amended their constitutions to include this right. For example, the Florida Constitution provides: "Every natural person has the right to be let alone and free from governmental intrusion into his private life except as otherwise provided herein . . ." Fla. Const. art. I, § 23. See also Alaska Const. art I, § 22; Ariz. Const. art II, § 8; Cal. Const. art. I, § 1; Haw. Const. art. I, § 6; Ill. Const. art. I, § 6; La. Const. art. I, § 5; Mont. Const. art. II, § 10; S.C. Const. art. I, § 10. Idaho and New Mexico have recognized a right to privacy for crime victims during the criminal justice process only. See Idaho Const. art. I, § 22(1); N.M. Const. art. II, § 24(A)(1).

¹³⁵ See *Olmstead v. United States*, 277 U.S. 438 (1928) (holding that wiretapping was not a search within the meaning of the 4th Amendment).

¹³⁶ See *id.* at 455.

¹³⁷ See *id.*

¹³⁸ See *id.* at 440.

¹³⁹ See *id.* at 465.

¹⁴⁰ See *Griswold v. Connecticut*, 381 U.S. 479, 485-86 (1965) (recognizing an implied right to privacy of married persons to use contraceptives).

decision, the *Griswold* Court noted that the right to privacy in marital decisions involving contraceptives emanated from the “penumbras” surrounding the specific guarantees in the Bill of Rights,¹⁴¹ and held the marital relationship fell within the zone of privacy created by several fundamental rights under the Constitution.¹⁴²

In subsequent rulings, the Supreme Court has further explained that the right to privacy is also founded in the Fourteenth Amendment’s concept of personal liberty,¹⁴³ and implicates two distinct interests.¹⁴⁴ First, the right to privacy encompasses an individual’s interest in avoiding disclosure of personal matters.¹⁴⁵ Second, the right encompasses an individual’s interest in independence in making certain kinds of personal, but important decisions.¹⁴⁶ The former interest is at issue in civil discovery matters.¹⁴⁷

2. Public Disclosure of Personal Information

In *Whalen v. Roe*, the Supreme Court considered the privacy interest in avoiding disclosure of personal matters in the context of medical records and examined the potential conflict between a public agency’s statutory right to access the medical records of patients and their constitutional privacy interests.¹⁴⁸ In *Whalen*, a group of patients with prescriptions for Schedule II drugs challenged the constitutionality of a New York statute requiring that

¹⁴¹ See *id.* at 484-85.

¹⁴² See *id.* at 485.

¹⁴³ See *Roe v. Wade*, 410 U.S. 113, 152-53 (1973) (finding a right of privacy based upon the Fourteenth Amendment’s concept of personal liberty).

¹⁴⁴ See generally *Whalen v. Roe*, 429 U.S. 589, 599-600 (1977).

¹⁴⁵ See *id.* See also *Nixon v. Administrator of Gen. Servs.*, 433 U.S. 425, 457 (1977) (reaffirming the existence of a right to privacy in personal information).

¹⁴⁶ See *Whalen*, 429 U.S. at 599-600. The court has characterized these decisions as ones that deal with “matters relating to marriage, procreation, contraception, family relationships, and child rearing and education.” *Paul v. Davis*, 424 U.S. 693, 713 (1976). See also *Roe v. Wade*, 410 U.S. at 153 (holding the right of privacy is broad enough to encompass a woman’s decision to have an abortion); *Stanley v. Georgia*, 394 U.S. 557, 568 (1969) (holding that the zone of privacy extends to reading and viewing materials in one’s home); *Loving v. Virginia*, 388 U.S. 1, 12 (1967) (holding that the choice to marry a person of another race lies with the individual and can not be infringed upon by the state); *Griswold v. Connecticut*, 381 U.S. 479, 485-86 (1965) (holding the marital right to privacy extends to contraceptive use).

¹⁴⁷ See *Miller*, *supra* note 127, at 464.

¹⁴⁸ *Whalen*, 429 U.S. at 598-604.

records be kept of all prescriptions for individuals receiving those drugs and filed with the State Department of Health.¹⁴⁹ The records included the name, address and age of each patient.¹⁵⁰ In challenging the propriety of the statute, the patients argued that the statute invaded the constitutionally protected “zone of privacy.”¹⁵¹ Specifically, they argued that the statute infringed upon both their interest in non-disclosure of personal matters and their autonomy in making personal decisions.¹⁵²

The Court, in reaching its decision, recognized that the constitutionally protected zone of privacy involved both the “individual interest in avoiding disclosure of personal matters, and . . . the interest in independence in making certain kinds of important decisions.”¹⁵³ The Court noted that disclosure of private medical information to doctors, hospital personnel, insurance companies and to public health agencies was an essential part of modern health care, even when the disclosure could reflect negatively on the patient.¹⁵⁴ It further stated that requiring disclosure to those agents of the State responsible for the health of the community did not “automatically amount to an impermissible invasion of privacy.”¹⁵⁵ The Court held that because the statute included a provision that prohibited the public disclosure of the patient’s identity and specified security guidelines for its proper administration,¹⁵⁶ it did not present a threat to either of the privacy interests raised that would establish a constitutional violation.¹⁵⁷ Although the Court in *Whalen* found sufficient statutory safeguards already in place to protect against the public disclosure of the patients’ personal information, the court reserved judgment on privacy issues involv-

149 See *id.* at 591-93.

150 See *id.* at 593.

151 *Id.* at 598.

152 See *id.* at 600. The patients argued that recording and storing information concerning an individual’s drug use “create[d] a genuine concern that the information [would] become publicly known and that it [would] adversely affect their reputations.” *Id.* This would in turn create hesitation for physicians in prescribing medications and for patients in pursuing medical treatments. See *id.*

153 *Id.* at 599-600.

154 See *id.* at 602.

155 *Id.*

156 See *id.* at 594-95.

157 See *id.* at 600.

ing the unauthorized exposure of collections of private data.¹⁵⁸

Unlike the Court's clear pronouncements in cases dealing with the right of privacy in personal decision-making,¹⁵⁹ the *Whalen* holding cannot be construed to pronounce a clear rule regarding the right to privacy in preventing disclosure of personal information.¹⁶⁰ However, several federal Courts of Appeals in interpreting *Whalen* have held that the disclosure of personal information is constitutionally protected,¹⁶¹ and have recognized a qualified constitutional right to the confidentiality of medical records and medical communications.¹⁶² In *United States v. Westinghouse Electric*

¹⁵⁸ The Court reserved judgment on administrative schemes that may contain less comprehensive security measures against disclosure than under the New York Statute. See *id.* at 605-06. See also *Anderson v. Romero*, 72 F.3d 518, 522 (7th Cir. 1995) (noting that the Court in *Whalen* implied that the disclosure of a person's medical records by or under compulsion of the government might "presumably" invade the substantive due process right of privacy).

¹⁵⁹ See *supra* note 146.

¹⁶⁰ See *Adams v. Drew*, 906 F. Supp. 1050, 1054-56 (E.D. Va. 1995) (noting that the Court's holding in *Whalen* was not definitive on the issue of a right to privacy in preventing disclosure of personal information).

¹⁶¹ See *e.g.*, *Powell v. Schriver*, 175 F.3d 107, 111 (2d Cir. 1999) (holding that a transsexual prison inmate has a privacy right of confidentiality in his medical records); *Doe v. City of New York*, 15 F.3d 264, 267 (2d Cir. 1994) (holding that a person infected with HIV has a constitutional right to privacy based on *Whalen*); *United States v. Westinghouse Elec. Corp.*, 638 F.2d 570, 577 (3d Cir. 1980); *Plante v. Gonzalez*, 575 F.2d 1119, 1132 (5th Cir. 1978) (finding a privacy "right to confidentiality" based on *Whalen*).

¹⁶² See *Norman-Bloodsaw v. Lawrence Berkeley Lab.*, 135 F.3d 1260, 1269 (9th Cir. 1998) (holding that "[t]he constitutionally protected privacy interest in avoiding disclosure of personal matters clearly encompasses medical information and its confidentiality"); *F.E.R. v. Valdez*, 58 F.3d 1530, 1535 (10th Cir. 1995) (holding that the plaintiffs had a legitimate expectation of privacy in medical records); *Schall by Kross v. Tippecanoe County Sch. Corp.*, 864 F.2d 1309, 1322 n.19 (7th Cir. 1988); *Doe v. SEPTA*, 72 F.3d 1133, 1137 (3d Cir. 1995) (holding that medical records are protected under a right to privacy); *Westinghouse Elec. Corp.*, 638 F.2d at 577; *Doe v. City of New York*, 15 F.3d 264, 267 (2d Cir. 1994). But see *Borucki v. Ryan*, 827 F.2d 836, 848 (1st Cir. 1987) (describing the existence of the right as an open question); *Doe v. Wigginton*, 21 F.3d 733, 740 (6th Cir. 1994) (rejecting the right). Even Congress has recognized that medical records and information stand on a different level than that for other relevant information. For example, the Federal Rules of Civil Procedure impose a higher burden for discovery of reports concerning a party's physical or mental condition. Compare Fed. R. Civ. P. 35 with Fed. R. Civ. P. 26(b). See also 8A Charles Allen Wright & Arthur R. Miller, *Federal Practice and Procedure: Civil 2d* § 2234.1 (3d ed. 1994) (noting that a Rule 35 motion for an order for a physical or mental examination when the plaintiff has placed her health in controversy is discretionary upon a showing of good cause). Finally, medical files are specifically exempted from disclosure under The Freedom of Informa-

Corp., the Third Circuit held that “[i]nformation about one’s body and state of health is matter which the individual is ordinarily entitled to retain within the ‘private enclave where he may lead a private life.’”¹⁶³

Finally, the Second Circuit has construed a right of confidentiality in personal medical information to include information regarding the state of one’s health.¹⁶⁴ In *Doe v. City of New York*, the court reasoned that there are only a few matters that are as personal as the status of one’s health and only a few over which one would prefer to maintain greater control.¹⁶⁵ The *Doe* court held that the privacy interest in this type of information is at its zenith in the context of an individual’s HIV status.¹⁶⁶

In summary, both federal and state courts have recognized that the disclosure of the donor’s identity in conjunction with her HIV status implicates the privacy interest in avoiding public disclosure of personal matters.¹⁶⁷ For the most part, these courts have based their conclusions on the confidential and private nature of medical records and communications as alluded to in *Whalen*.¹⁶⁸ The des-

tion Act, 5 U.S.C. § 552(b)(6) (1989).

¹⁶³ *Westinghouse Elec. Corp.*, 638 F.2d at 577 (quoting *United States v. Grunewald*, 223 F.2d 556, 581-82 (2d Cir. 1956) (Frank, J., dissenting)). See also *Doe v. City of New York*, 15 F.3d at 267 (agreeing that “the right to confidentiality includes the right to protection regarding information about the state of one’s health.”).

¹⁶⁴ See *Doe v. City of New York*, 15 F.3d at 267. In *Doe*, the Second Circuit noted that the privacy interest in medical information will vary with an individual’s condition and stated:

Clearly, an individual’s choice to inform others that she has contracted what is at this point invariably and sadly a fatal, incurable disease is one that she should normally be allowed to make for herself. This would be true for any serious medical condition, but is especially true with regard to those infected with HIV or living with AIDS, considering the unfortunately unfeeling attitude among many in this society toward those coping with the disease.

Id. See also *Doe v. Borough of Barrington*, 729 F. Supp. 376, 384-85 (D.N.J. 1990) (recognizing that the hysteria that surrounds AIDS extends to the family members of the person suffering with AIDS and holding that disclosure of AIDS is also a violation of their privacy).

¹⁶⁵ See *Doe v. City of New York*, 15 F.3d at 267.

¹⁶⁶ See id.

¹⁶⁷ See supra notes 106-07, 109.

¹⁶⁸ See *Whalen v. Roe*, 429 U.S. 589, 602 (1977) (holding that disclosure of private medical information to doctors, hospital personnel and insurance companies “does not automatically amount to an impermissible invasion of privacy”). See supra notes 161-63.

ignation of HIV status clearly refers to the state of one's health and can only be confirmed through specific medical testing.¹⁶⁹ Therefore, it would fall within the subsequent judicial interpretations of the individual's interest in avoiding disclosure of personal matters as contemplated in *Whalen*.

B. Privileges and the Blood Bank-Donor Relationship

The confidential nature of an individual's HIV status seems to implicate a right to privacy under the federal Constitution. Because disclosure of HIV status continues to provoke hostility, discrimination and intolerance from others, the donor's privacy interest remains compelling,¹⁷⁰ and judicially imposed safeguards to police this interest often fail in preventing the disclosure of this personal information and in providing sanctions for its violation.¹⁷¹ Under the federal discovery rules, if blood banks could claim a privilege on behalf of donors, then confidential medical information such as an individual's HIV status would be shielded from discovery.¹⁷² Thus, the best approach for protecting donor privacy in the donation process is to create specific legislative privileges that are designed to promote candor and confidentiality during the donor screening process and to shield the altruistic donor¹⁷³ from subsequent litigation.

1. The Nature and Origin of Privileges

In general, privileges are rules that operate to prevent the revelation of confidential matter within a judicial proceeding.¹⁷⁴ Privileges arise when certain classes of relationships or communica-

¹⁶⁹ See *supra* text accompanying notes 47-55.

¹⁷⁰ See *Doe v. City of New York*, 15 F.3d at 267 (noting that an individual who reveals her HIV status is exposed to discrimination and intolerance). See also Michael L. Closen, Introduction: HIV-AIDS in the 1990s, 27 J. Marshall L. Rev. 239 (1994).

¹⁷¹ See *Coleman v. American Red Cross*, 23 F.3d 1091, 1096 (6th Cir. 1994). In *Coleman*, the Sixth Circuit held that the district court's dismissal of the plaintiffs' case against the donor was unwarranted even after the plaintiffs' attorney, in a previous suit against the blood bank, had disclosed the donor's identity in violation of a protective order requiring that the donor's identity remain confidential.

¹⁷² See *supra* note 56 (discussing Fed. R. Civ. P. 26(b)(1)).

¹⁷³ For purposes of this discussion, "altruistic donor" will include the voluntary donor who unknowingly provides disease-infected blood.

¹⁷⁴ See John William Strong, McCormick on Evidence § 72.1 (5th ed. 1992) [hereinafter McCormick on Evidence].

tions are deemed to be of sufficient social importance to society that they must be protected.¹⁷⁵ They are evidentiary in nature and result in making the ascertainment of the truth either more difficult or impossible in some instances.¹⁷⁶ Privileges operate as impediments to the important truth-seeking function of the legal system by promoting other but less immediate goals.¹⁷⁷ According to Dean John Wigmore, four fundamental conditions must be met in order to establish a privilege:

- (1) The communications must originate in a *confidence* that they will not be disclosed.
- (2) This element of *confidentiality must be essential* to the full and satisfactory maintenance of the relation between the parties.
- (3) The *relation* must be one which in the opinion of the community ought to be sedulously *fostered*.
- (4) The injury that would inure to the relation by the disclosure of the communications must be *greater than the benefit* thereby gained for the correct disposal of litigation.¹⁷⁸

Evidentiary privileges originated with the imposition of compulsory process in Elizabethan England.¹⁷⁹ The concept arose when reliance on witnesses led to the establishment of a universal duty to testify.¹⁸⁰ In 1577, the first evidentiary privilege to be recognized under English common law was one that protected the at-

¹⁷⁵ See *id.* at § 72. See also Note, Parent-Child Loyalty and Testimonial Privilege, 100 *Harv. L. Rev.* 910, 911 (1987).

¹⁷⁶ See McCormick on Evidence, *supra* note 174, at § 72. See also Developments in the Law—Privileged Communications, 98 *Harv. L. Rev.* 1450, 1454 (1985) [hereinafter Privileged Communications] (noting that “privileges expressly subordinate the goal of truth seeking to other societal interests”).

¹⁷⁷ See generally Privileged Communications, *supra* note 176, at 1454-63 (discussing an overview of the historical evolution of American privilege law).

¹⁷⁸ See 8 John Henry Wigmore, *Evidence in Trials at Common Law* § 2285, at 527 (John T. McNaughton rev. ed. 1961) (emphasis in original).

¹⁷⁹ See Privileged Communications, *supra* note 176, at 1455

¹⁸⁰ See *id.* (citing Act for Punishment of Such as Shall Procure or Commit Any Wilful Perjury, 1562, 5 *Eliz. I.*, ch. 9, § 12) (imposing a penalty on persons refusing to attend after service of process and tender of expense).

torney-client relationship.¹⁸¹ By the 1600s, a spousal privilege was recognized at common law and was available in both civil and criminal cases.¹⁸² These privileges, however, were not absolute and exceptions to both arose during the seventeenth and eighteenth centuries.¹⁸³

In 1810, Judge Zephaniah Swift published *A Digest of the Law of Evidence*, the first American authoritative source of evidence law.¹⁸⁴ Swift's treatise reiterated the attorney-client and the spousal privileges of common law England.¹⁸⁵ During this time, however, many states had begun to enact privilege statutes to replace the English common law of privileges.¹⁸⁶ The first legislative privilege appeared as early as 1828, when New York created a statutory physician-patient privilege.¹⁸⁷ By mid-nineteenth century, the common law rules of evidence had begun to dissipate as states conducted statutory revisions of their privilege law.¹⁸⁸

The Federal Rules of Evidence recognize two types of privileges: relational privileges and activity privileges.¹⁸⁹ The most prominent privileges that emanated from the common law are the relational privileges—those designed to “protect the integrity of certain relationships from the scrutiny of judicial process.”¹⁹⁰ A relationship will be privileged when it is “sufficiently important that society is willing to sacrifice the production of probative evi-

181 See *Berd v. Lovelace*, 21 Eng. Rep. 33 (1577). See also *Dennis v. Codrington*, 21 Eng. Rep. 53 (1580).

182 See Wigmore, *supra* note 178, § 2227, at 213 & n.12.

183 See Henry Bathurst, *The Theory of Evidence* 95-96 (London 1761).

184 See Zephaniah Swift, *A Digest of the Law of Evidence* (1810).

185 *Id.* at 91-96. Although Smith noted the physician and clergy claims for privileges, he dismissed them as being unsupported. See *id.* at 95.

186 *Privileged Communications*, *supra* note 176, at 1458. This was done primarily in response to changing attitudes towards England immediately following the Revolutionary war and a popular dissatisfaction with the common law. See *id.*

187 See Wigmore, *supra* note 178, § 2380, at 819.

188 See *Privileged Communications*, *supra* note 176, at 1460.

189 See Fed. R. Evid. 501 (recognizing privileges under both federal common law and state law). See also Note, *Making Sense of Rules of Privilege Under the Structural (II)logic of the Federal Rules of Evidence*, 105 Harv. L. Rev. 1339, 1341-43 (1992) [hereinafter *Making Sense of Rules of Privilege*] (differentiating relational and activity privilege rules). Activity privileges exclude from admission facts concerning certain extrinsic actions taken by the parties. See *id.* at 1342.

190 *Making Sense of Rules of Privilege*, *supra* note 189, at 1345.

dence to preserve confidentiality within the relationship,"¹⁹¹ the relationship is dependent upon confidentiality for its vitality, and the fundamental nature of the relationship will change if confidentiality is not assured.¹⁹² Both federal and state courts have acknowledged several relational privileges: attorney-client; physician-patient; psychotherapist-patient; clergy-communicant; and marital privileges.¹⁹³ The next Subsection will evaluate the application and viability of privilege rules in the context of the blood bank-donor relationship.

2. Blood Banks and Privilege Law

In addition to asserting a claim of privacy for protection of donor identity in blood litigation, blood banks have also contended that the blood bank-donor relationship is one that is protected under privilege law. Specifically, they have argued that confidential information and communications concerning the donor should be protected under the physician-patient privilege.¹⁹⁴ Currently, only a few courts have held that an extension of the physician-patient privilege would be appropriate in the blood bank-donor context.¹⁹⁵ These courts have extended the physician-patient privilege to blood banks on the basis that the privilege is designed to protect the privacy of information communicated to the physician by the patient and to prevent against exposing the patient to embarrassment.¹⁹⁶ They have reasoned that this policy rationale is applicable

¹⁹¹ *Id.* at 1343.

¹⁹² *See id.* at 1343-44.

¹⁹³ *See* Wigmore, *supra* note 178, § 2285, at 528; *Privileged Communications*, *supra* note 176, at 1501-75 (examining the history, scope and theories of these privileges).

¹⁹⁴ *See supra* text accompanying note 108. Forty-five states and the District of Columbia have enacted statutes that recognize a physician-patient privilege to protect communications relevant for a patient's treatment. *See* Stephen Aaron Silver, Note, *Beyond Jaffee v. Redmond: Should the Federal Courts Recognize a Right to Physician-Patient Confidentiality?*, 58 *Ohio St. L.J.* 1809, 1810-11 n.7 (1998) (listing specific state statutes).

¹⁹⁵ *See supra* note 108.

¹⁹⁶ *See* *Krygier v. Airweld, Inc.*, 520 N.Y.S.2d 475, 476-77 (Sup. Ct. 1987). In *Krygier*, however, the court based its denial of discovery on the state equivalent of Rule 26(c). *See id.* at 476. To date, no other court has held the physician-patient privilege applicable when addressing the discovery issue in blood donation litigation. *See, e.g.,* *Stenger v. Lehigh Valley Hosp. Ctr.*, 609 A.2d 796, 803 (Pa. 1992) (noting that the Pennsylvania physician-patient privilege statute is limited to "information communicated to a physician by a patient" and holding that the donor's identity would "potentially be subjected to the privilege").

to the blood bank-donor relationship because the altruistic donor is subjected to embarrassment and innuendo once a plaintiff has acquired HIV from a pool of donations and the donor's identity has been implicated.¹⁹⁷

The prevailing view, however, is that the blood bank-donor relationship lacks a critical element contemplated by state legislatures when drafting and adopting the physician-patient privilege: the facilitation of medical treatment.¹⁹⁸ These courts have held the privilege inapplicable to the blood bank-donor relationship because an extension of the privilege would fail to further the primary goal of treatment of the donor.¹⁹⁹ There are several reasons for this conclusion. First, the donor's blood is not drawn by a physician.²⁰⁰ Second, a blood donor is not considered a patient within the language of the physician-patient privilege statutes.²⁰¹ Finally, the information provided to the blood bank by the donor does not assist in any manner in providing medical treatment to the donor.²⁰² In short, these courts have failed to extend the physician-patient privilege to the blood bank-donor relationship solely because blood banks do not meet the statutory definition of "physician" and do not provide medical treatment as required by the statute.²⁰³ However, they have continued to find that the donor enjoys a right to privacy against disclosure of personal information,²⁰⁴ and recognize that openness and candor by blood donors in answering questions about their medical and personal histories should be encouraged.²⁰⁵

¹⁹⁷ See *Krygier*, 520 N.Y.S.2d at 476-77; *Stenger*, 609 A.2d at 803.

¹⁹⁸ See *Belle Bonfils Mem'l Blood Ctr. v. District Ct.*, 763 P.2d 1003, 1009 (Colo. 1988); *Laburre v. East Jefferson Gen. Hosp.*, 555 So. 2d 1381, 1384 (La. 1990); *Doe v. University of Cincinnati*, 538 N.E.2d 419, 423 (Ohio Ct. App. 1988).

¹⁹⁹ See *Laburre*, 555 So. 2d at 1383 (noting that a principal purpose of the physician-patient privilege is to "encourage full disclosure by the patient of his symptoms and condition . . . in order to ensure proper diagnosis and treatment").

²⁰⁰ See *Doe v. University of Cincinnati*, 538 N.E.2d at 422.

²⁰¹ See *Belle Bonfils Mem'l Blood Ctr.*, 763 P.2d at 1009; *Laburre*, 555 So. 2d at 1384; *Doe v. University of Cincinnati*, 538 N.E.2d at 422-23.

²⁰² See *Laburre*, 555 So. 2d at 1384; *Doe v. University of Cincinnati*, 538 N.E.2d at 423.

²⁰³ See *Belle Bonfils Mem'l Blood Ctr.*, 763 P.2d at 1009; *Laburre*, 555 So. 2d at 1384; *Doe v. University of Cincinnati*, 538 N.E.2d at 422-23.

²⁰⁴ See *Doe v. University of Cincinnati*, 538 N.E.2d at 424.

²⁰⁵ See *Laburre*, 555 So. 2d at 1384.

Currently, no jurisdiction has recognized a separate blood bank-donor privilege. However, for the following reasons, the blood bank-donor relationship satisfies all of the requisite conditions for the establishment of a privilege and donors should be granted protection against all subsequent disclosures of communications made to blood bank personnel during donor consultation.

a. The Blood Bank-Donor Relationship Is Critical for Saving Lives

Under Wigmore's definition, an essential requirement for the establishment of a privilege is that the relationship is one "which in the opinion of the community ought to be sedulously fostered," and where the benefit derived from the relationship outweighs any detrimental effect on the truth seeking process.²⁰⁶ The blood banking industry is the largest collector of blood in the country.²⁰⁷ Today, licensed blood establishments include "more than 1,000 donor centers that collect, process and distribute blood and blood products in interstate commerce"²⁰⁸ Each year, several million units of blood are drawn from volunteer donors to be used to save the lives of millions of Americans.²⁰⁹

As a result of the critical role that blood plays in the nation's health care system, the blood bank-donor relationship warrants that state legislatures grant to donors an absolute privilege to ensure that adequate levels of blood will be available at all times and

²⁰⁶ Wigmore, *supra* note 178, § 2285, at 527. See also *Privileged Communications*, *supra* note 176, at 1472 (discussing Wigmore's definition of privilege).

²⁰⁷ See Jeffrey McCullough, *The Nation's Changing Blood Supply System*, 269 *JAMA* 2239, 2239 (1993). See also *Protecting the Nation's Blood Supply from Infectious Agents: New Standards to Meet New Threats: Hearings Before the Subcomm. on Human Resources and Intergovernmental Relations of the House Government Reform and Oversight Comm.*, 104th Cong. 91 (1995) (prepared statement of Kathryn C. Zoon, Director, Center for Biologic Evaluation and Research, Food and Drug Administration) [hereinafter *Prepared Statement of Kathryn C. Zoon*]. The blood banking industry has evolved from a "loosely organized medical service into a major manufacturing industry" *Id.* Currently, it is comprised of three types of blood establishments: blood banks, transfusion services, and plasmapheresis centers. See *id.* Blood banks may operate as free-standing entities or be associated with hospitals. See *id.*

²⁰⁸ Monica Revele, *Progress in Blood Supply Safety*, 29 *FDA Consumer* 21, 22 (1995).

²⁰⁹ See *id.* at 21. Approximately 40,000 units (pints) of blood are used every day in the United States. See *U.S. Blood Shortages Expected Next Year, Gov't Says*, *Med. Indus. Today*, June 29, 1999.

a qualified privilege to prevent blood banks from disclosing confidential information such as donor identities and HIV status during civil proceedings.²¹⁰ Clearly, a compelling concern of federal and state courts when balancing the competing interests under Rule 26(c) or its state equivalents has been the effect on the national blood supply of granting discovery of personal information such as donor identities when associated with the donor's HIV positive status.²¹¹ More importantly, however, the uniqueness and significance of blood in saving lives has made it a priceless and indispensable commodity both to individuals and society.²¹² Thus, in order to prevent against the potential for future shortages and inadequate supply levels of blood, a sacrifice of the production of probative evidence to preserve confidentiality within the blood bank-donor relationship is certainly warranted in light of the utilitarian benefits to society in eliminating all potential inhibitions to donating blood.²¹³

b. Confidentiality Is Vital in Maintaining an Effective Blood Bank-Donor Relationship

In addition, a relationship will be privileged when communications made within the relationship have originated under an expectation of confidentiality that is essential for its continued maintenance and the relationship would suffer injury if the communications were disclosed.²¹⁴ For example, both the attorney-client privilege and the physician-patient privilege operate under the presumption that full disclosure of the facts is critical for maintaining the attorney's ability to effectively represent the client²¹⁵ and the physician's ability to effectively render diagnosis

²¹⁰ See *supra* notes 67-71 and accompanying text. See also *infra* Part V, Sections A, B (discussing proposals for an absolute and a qualified privilege).

²¹¹ See *supra* text accompanying notes 62-63.

²¹² See *supra* text accompanying notes 67-71.

²¹³ See *supra* notes 89-91 (discussing the potential for a disincentive to give blood under Rule 26(c)).

²¹⁴ See Wigmore, *supra* note 178, § 2285, at 527 (noting that confidentiality must be essential to the satisfactory maintenance of the relationship and that injury to the relationship must occur upon disclosure of communications that have originated in the confidential nature surrounding the relationship).

²¹⁵ See *United States v. Hodge & Zweig*, 548 F.2d 1347, 1355 (9th Cir. 1977). In *Hodge*, the Ninth Circuit stated that "[i]n our legal system the client should make full disclosure to the attorney so that the advice given is sound, so that the attorney can give all appropriate protection to the client's interest, and so that proper defenses are raised if

and medical treatment to the patient.²¹⁶ To achieve the disclosure of facts necessary in rendering effective service within these relationships, communications made during the course of these relationships have been deemed confidential.²¹⁷ Thus, society has concluded that the attorney-client, and physician-patient relationships would suffer significantly in the absence of a privilege and clients and patients would be discouraged from confiding in their lawyers or doctors.

Similar to attorney-client or physician-patient relationships, confidentiality is an essential consideration in blood donation.²¹⁸ Communications made to blood banks by donors during the donation process originate under an expectation of confidentiality by both donors and blood banks. Even prior to 1985, blood banks throughout the United States consistently operated under a longstanding practice of maintaining the privacy of information concerning blood donors.²¹⁹ In 1985, the U.S. House of Representatives Subcommittee on Health and the Environment held hearings on the issue of blood donor confidentiality.²²⁰ All witnesses who

litigation results." *Id.* See also *Privileged Communications*, supra note 176, at 1503 (noting that a later justification for the attorney-client privilege was to "assure the client of the effective legal assistance of a well-informed trial attorney").

²¹⁶ See *Laburre v. East Jefferson Gen. Hosp.*, 555 So. 2d 1381, 1383 (La. 1990) (noting that "[a] principal purpose of the physician-patient privilege is to encourage full disclosure by the patient of his symptoms and condition to the physician in order to ensure proper diagnosis and treatment.").

²¹⁷ See *Wigmore*, supra note 178, § 2306, at 588 (noting that under the attorney-client privilege, "communications" will include both words uttered by the client and acts that are voluntarily disclosed and made known to the attorney.) See also *id.* § 2383, at 842; *Privileged Communications*, supra note 176, at 1534 (noting that under the physician-patient privilege, confidential communications will include all information obtained by the physician in the course of treatment, whether verbally from the patient or directly through observation).

²¹⁸ See *Doe v. University of Cincinnati*, 538 N.E.2d 419, 425 (Ohio Ct. App. 1988).

²¹⁹ See *Taylor v. West Penn Hosp.*, 48 Pa. D. & C.3d 178, 187-88 (Ct. C.P. Allegheny County 1987) (referring to the 1985 hearings on blood donor confidentiality conducted by the U.S. House of Representatives Subcommittee on Health and Environment).

²²⁰ See *id.* at 187 (citing Subcommittee on Health and Environment of the Committee on Energy and Commerce of the United States House of Representatives (99th Cong., 1st Sess., Serial No. 99-45, pp. 111-202)). Witnesses appearing before the Subcommittee included: "Dr. Frank E. Young, Commissioner of Food and Drugs of the Department of Health and Human Services; Dr. Edward N. Brandt, Jr., former Assistant Secretary of Health; [and] Dr. Joseph R. Bove, Professor of Laboratory Medicine at Yale University School of Medicine and Chairman of the Committee on Transfusion Transmitted Diseases of the American Association of Blood Banks . . ." *Id.* at 187-88.

appeared before the subcommittee uniformly testified that maintaining the confidentiality of blood donors had been a long-standing practice of blood collection entities throughout the United States.²²¹

During the blood donation process, a donor often receives written assurances from blood bank personnel that any information she furnishes will remain confidential.²²² Blood banks typically advise donors that their blood will be tested for diseases, that donors will be notified in the event that the test results indicate the detection of a disease, and the information will not be disclosed to any other person outside of the donation process.²²³ Even without these assurances, however, the average donor expects that any information the blood bank obtains concerning her will be treated as confidential.²²⁴

Also similar to the attorney-client and physician-patient relationships, the donor and blood bank's expectations of confidentiality are critical for maintaining the blood bank-donor relationship. Unfortunately, the donor who altruistically donates her blood is exposed to embarrassment and innuendo once a recipient has acquired an infectious disease such as HIV and the donor has been identified.²²⁵ As a result, the donor may be discouraged from providing open and candid answers to questions concerning her medical and personal history. An honest and open dialogue between blood bank technicians and donors could provide a critical level of protection in cases where donated blood is HIV-infected but escapes detection by either ELISA or the Western Blot Analysis because the donation occurred during the window period.²²⁶

Just as a patient and client receive the primary benefits of effective medical treatment by a physician or representation by an attorney, donors also receive several primary benefits during the

²²¹ See *id.* at 188. See also *Ellison v. American Nat'l Red Cross*, 151 F.R.D. 8, 10 (D.N.H. 1993) (discussing former FDA Commissioner Frank E. Young's testimony concerning the blood products community's policies and procedures for confidentiality in the treatment of donor information).

²²² See *West Penn. Hosp.*, 48 Pa. D. & C.3d at 187.

²²³ See *id.*

²²⁴ See *id.*

²²⁵ See *Krygier v. Airweld, Inc.*, 520 N.Y.S.2d 475, 476-77 (Sup. Ct. 1987).

²²⁶ See *supra* note 11.

course of the blood bank-donor relationship. Blood banks provide donors with the important health benefit of being informed of their HIV status through test results and initial HIV counseling.²²⁷ They receive thousands of test results that are positive for HIV and other diseases each day.²²⁸ Although many of the test results are false positives, blood banks provide counseling and advice to the donor and develop records such as donor deferral registries designed to prevent any subsequent donations by the donor.²²⁹ It is unquestionable that early detection and treatment of HIV can result in a longer and better quality of life for the donor and when combined with specific medical treatments, the possible elimination of HIV altogether.²³⁰

Finally, the nature of the blood bank-donor relationship would change drastically if current presumptions and expectations of confidentiality of blood banks and donors were removed from the donation process. A primary goal of the blood bank-donor relationship is to ensure an adequate and safe supply of blood and blood components from volunteer donors.²³¹ Confidentiality assists blood banks in achieving these goals in two ways. First, the safety of a unit of blood for transfusion is determined by serological testing of blood and donor health history screening.²³² Ensuring confidentiality promotes the safety of the blood supply by creating an atmosphere in which donors will feel free to be completely honest and accurate in discussing their health histories

²²⁷ See Gordon Slovut, *Blood Given by Family and Friends is Not Safer*, 'U' Expert Says, *Minn. Star Trib.*, May 5, 1993, at A21.

²²⁸ See *id.*

²²⁹ See *id.* See also McCullough, *supra* note 207, at 2241 (describing the donor deferral registry process).

²³⁰ Recent research has demonstrated that AIDS may not be invincible. See Philip Elmer-Dewitt, *Turning the Tide*, *Time*, Dec. 30, 1996, at 54. During 1997, Dr. David Ho and his research team made a major breakthrough in the study of HIV. Dr. Ho reported on an experiment he had conducted which indicated that by administering protease-inhibitor cocktails to HIV patients in the earliest stages of infection, the patients experienced remarkable recoveries. See *id.* at 54. During a press conference to report on his findings, Dr. Ho explained that under the right conditions, his experiment might eliminate HIV from a small group of men treated within three months of infection. See Christine Gorman, *The Disease Detective*, *Time*, Dec. 30, 1996, at 58.

²³¹ See National Blood Policy, 39 Fed. Reg. 32702, 32702 (1974). See also Karen Shoos Lipton, *Blood Donor Services and Liability Issues Relating to Acquired Immune Deficiency Syndrome*, 7 *J. Legal Med.* 131, 161 (1986).

²³² See *supra* text accompanying notes 47-55.

without the fear that personal information might be later disclosed to persons outside of the donation process.²³³ Second, confidentiality promotes the adequacy of the blood supply by ensuring that donors will not be deterred from donating blood on the basis that information which may adversely affect their “employment, insurability, reputation in the community, and personal relationships will be publicly disclosed.”²³⁴

Although policy makers have designated the donation of blood as a “service,” it is not a requirement.²³⁵ Not only would many donors, including those who are disease-free, be less likely to provide candid answers to personal questions if their communications could be revealed and disclosed in subsequent lawsuits against them, many would likely refrain from giving blood altogether. Despite the lack of anecdotal evidence to support this point, both would be reasonable responses in a society where blood donation is not mandatory.²³⁶ Under a simple cost-benefit analysis, the benefits attributed to providing a service to individuals in need of blood transfusions would be easily outweighed by the cost and expense to the donor of disclosure of the donor’s identity and HIV status in litigation, should the donor’s blood be disease-infected.²³⁷ These potential responses by donors would certainly result in cir-

²³³ See Lipton, *supra* note 231, at 161.

²³⁴ *Id.*

²³⁵ For purposes of strict liability and breach of warranty claims, most state legislatures have enacted “blood shield” statutes, which characterize the transfusion of blood as a medical service rather than a product. See Kathryn W. Pieplow, Comment, AIDS, Blood Banks, and the Courts: The Legal Response to Transfusion-Acquired Disease, 38 S.D. L. Rev. 609, 622-24 (1993) (discussing and listing the various blood shield statutes). In the absence of the sale of a product, neither strict liability in tort nor breach of warranty claims are applicable. See *id.* at 622-23.

²³⁶ See National Blood Policy, 39 Fed. Reg. 32702, 32702 (1974) (seeking to accelerate the development of an all-voluntary supply of blood); Prepared Statement of Kathryn C. Zoon, *supra* note 207, at 87 (indicating that each year approximately 12 million units of blood are drawn from volunteer donors).

²³⁷ The effect of disclosure of this information has had a devastating effect on the lives of donors. Not only does the stigma attached to a disclosure of HIV positive status affect the employment and insurability of the donor, the donor is often subjected to extreme ostracism by family members, friends and society. See *Rasmussen v. South Fla. Blood Serv.*, 500 So. 2d 533, 537 (Fla. 1987) (referring to HIV as the “modern day equivalent of leprosy” and concluding that HIV infection or a suspicion of HIV can lead to “discrimination in employment, education, housing and even medical treatment”). See also McCullough, *supra* note 207, at 2242 (noting that an HIV positive screening test result may have a negative effect on an individual’s employment and insurability).

cumventing the primary goals of the blood bank-donor relationship and would result in devastation for those individuals in desperate need of blood transfusions.

In summary, the same policy rationales for holding communications made within the attorney-client and physician-patient relationships confidential are appropriate for communications made within the blood bank-donor relationship. The promotion of candor and openness by donors in answering questions regarding their medical and personal histories benefits all of society.²³⁸ Creating an environment in which donors will provide blood banks with sufficient personal information regarding their medical histories and backgrounds is necessary to further ensure the safety of the current and future blood supply, and to provide donors with the earliest possible detection of HIV for treatment purposes.

V. DEFINING THE SCOPE OF A DONOR PRIVILEGE: TWO PROPOSALS FOR PROTECTING PRIVACY

To ensure the maximum protection for donor privacy and to promote the National Blood Policy, state legislatures should adopt an absolute donor privilege to protect donors during the donation process and a qualified blood bank-donor privilege to protect against disclosure of donor identity and confidential medical information in subsequent litigation. In this Part, the Article presents two specific proposals and explains how each will provide sufficient safeguards for privacy while promoting a liberal discovery. Finally, the Article explains how the proposals will assist in eliminating many of the current problems in applying Rule 26(c).

A. Blood Donor Privilege—Blood Donation and Collection

Proposal I. The voluntary furnishing and donating of whole blood, blood products and organs is declared to be, for the purpose of injecting or transfusing into the human body for any objective whatsoever, the rendition of a service. No person participating in rendering such services shall be liable for civil damages at any time.

²³⁸ See *Laburre v. East Jefferson Gen. Hosp.*, 555 So. 2d 1381, 1384 (La. 1990).

Proposal I provides the voluntary blood donor with the same protection that blood banks currently enjoy in the blood collection process.²³⁹ It is modeled after state blood shield statutes²⁴⁰ and is designed to prohibit the subsequent civil prosecution in tort against all donors by any recipient of disease-infected blood or blood products.²⁴¹ For purposes of breach of warranty and strict liability in tort claims, almost all state legislatures have determined that blood banks enjoy an absolute privilege when collecting blood to be supplied for use by hospitals in medical treatment.²⁴² To implement this policy, state legislators have enacted blood shield statutes that expressly provide that the collection and supplying of blood by blood banks is a service and not a product, thus acknowledging the critical importance and role that blood plays in the nation's health care system.²⁴³

Because blood transfusions remain critical for saving lives and there are no viable long-term substitutes for blood in medical treatments,²⁴⁴ the blood donation process must also be given similar protection to ensure against any impediments to maintaining adequate levels of blood at all times. This protection is especially important in light of current predictions that the United States will experience significant shortages in the national blood supply as

²³⁹ Because payment for blood creates a greater incentive for persons to knowingly and willfully donate disease-infected blood, protection under Proposal I is limited only to the voluntary donor.

²⁴⁰ See *supra* note 235 (discussing blood shield statutes). For example, the language of the Florida Exclusion or Modification of Warranties statute provides:

The procurement, processing, storage, distribution, or use of whole blood, plasma, blood products, and blood derivatives for the purpose of injecting or transfusing the same, or any of them, into the human body for any purpose whatsoever is declared to be the rendering of a service by any person participating therein and does not constitute a sale . . . and the implied warranties of merchantability and fitness for a particular purpose are not applicable

Fla. Stat. Ann. § 672.316(5) (West 1993). See also Idaho Code § 39-3702 (1998); Kan. Stat. Ann. § 65-3701 (1992).

²⁴¹ For this discussion, the term "recipient" will include not only the plaintiff who receives disease-infected blood or blood products during her medical treatment, but also blood banks, hospitals, or state governmental entities (e.g., state operated blood banks or hospitals) that collect and transfuse blood.

²⁴² See *supra* note 235.

²⁴³ See *id.*

²⁴⁴ See Pieplow, *supra* note 235, at 613 n.17.

early as this year.²⁴⁵ Therefore, the creation of an absolute privilege to protect activities involving blood would simply entail extending the current privilege given in the blood collection process to the blood donation process.

Adopting an absolute privilege to protect donors in the donation process will have several major benefits. First, it would ensure the maximum protection for donor privacy because personal and confidential information provided by the donor during the donation process could never be used against the donor in subsequent civil actions. Second, an absolute donor privilege would further promote the National Blood Policy's goal of providing an adequate supply of blood.²⁴⁶ Specifically, the privilege would create an atmosphere conducive for candor and accuracy during the donor screening process. Donors would no longer have to fear that personal information provided during the blood bank screening process could ultimately be disclosed and used against them in later lawsuits, thus alleviating any potential inhibitions that donors might have towards donating blood. Third, the absolute donor privilege would extend not only to those voluntary donors who unknowingly provide HIV-infected blood, but to any altruistic donor who may be infected with a bloodborne disease. Consequently, the privilege would provide the necessary flexibility for protecting voluntary donors from liability for new diseases that may occur in the future.

An absolute donor privilege would prevent any subsequent tort actions against the voluntary donor who donates disease-infected blood and would eliminate any potential inhibitions for giving blood that currently exist when applying Rule 26(c) of the Federal Rules of Civil Procedure.²⁴⁷ However, it would not prevent the

²⁴⁵ See *supra* text accompanying notes 91-92.

²⁴⁶ See National Blood Policy, 39 Fed. Reg. 32702, 32702 (1974).

²⁴⁷ Currently, the plaintiff can elect to sue both the blood bank and the donor for negligence, or the HIV-infected donor for fraud, battery and intentional infliction of emotional distress. See *supra* note 17 (discussing negligence claims). See also *Doe v. Johnson*, 817 F. Supp. 1382, 1387-1400 (W.D. Mich. 1993) (discussing the plaintiff's claims for fraud, battery and intentional infliction of emotional distress for receiving HIV during sexual relations with the defendant). My proposal would eliminate all tort actions against the donor, but would not affect the plaintiff's ability to sue the blood bank under tort law. Because blood banks are the collectors and distributors of blood donations, they are in the best position to screen individual donors through questions and observations,

State, on behalf of its citizens, from filing criminal actions against the donor who knowingly and willfully provides disease-infected blood.²⁴⁸ Therefore, the State would retain an appropriate legal remedy against the non-altruistic donor.²⁴⁹

B. Blood Bank-Donor Privilege

Proposal II. Unless the donor waives the privilege, or in civil suits where the plaintiff has demonstrated adequate necessity and justification for the information, a blood bank or its authorized personnel shall not be allowed to disclose any communication made, or information acquired, during consultation with the donor in a professional capacity, and which was necessary to enable the blood bank to act in that capacity.

Proposal II provides a qualified protection of confidential information communicated to the blood bank by the donor when the information is provided in the course of the donor screening process. It is modeled after state physician-patient privilege statutes²⁵⁰ and is no more than a codification of the existing protocol and expectations of confidentiality that currently operate during the

and surrogate testing of blood prior to distribution.

²⁴⁸ Several states have enacted criminal statutes penalizing the exposure of others to HIV. For example, the Illinois Criminal Transmission of HIV statute, Ill. Comp. Stat. Ann. 5/12-16.2 (West 1999) provides: "(a) A person commits criminal transmission of HIV when he or she, knowing that he or she is infected with HIV . . . (2) transfers, donates, or provides his or her blood, tissue, semen, organs, or other potentially infectious body fluids for transfusion, transplantation, insemination, or other administration to another . . ." See also Ark. Code Ann. § 5-14-123(b) (Michie 1999); Ga. Code Ann. § 16-5-60(c)(5) (1999); La. Rev. Stat. Ann. § 43.5(B) (West 1997); Md. Code Ann., Health-General § 18-601.1(a) (1999); Mich. Stat. Ann. § 333.5210(1) (West 1999); Mo. Ann. Stat. § 191.677.1 (West Supp. 1999); Mont. Code Ann. § 50-18-112 (1999); S.C. Code Ann. § 44-29-145(3) (Law. Co-op. Supp. 1998); Tenn. Code Ann. § 39-13-109(a)(2) (1997).

²⁴⁹ See supra note 173 (defining "altruistic donor").

²⁵⁰ For example, the New York physician-patient privilege statute provides: Confidential information privileged. Unless the patient waives the privilege, a person authorized to practice medicine, registered professional nursing, licensed practical nursing, dentistry, podiatry or chiropractic shall not be allowed to disclose any information which he acquired in attending a patient in a professional capacity, and which was necessary to enable him to act in that capacity.

N.Y. C.P.L.R. 4504 (McKinney Supp. 2000). See also Ohio Rev. Code Ann. § 2317.02(B)(1) (Anderson Supp. 1998); Pa. Stat. Ann. tit. 42, § 5929 (West 1982).

blood donation process.²⁵¹

Similar to other relational privileges, the blood bank-donor privilege may be waived by the beneficiary of the privilege (in this case the blood donor). A plaintiff also may obtain discovery of the donor's medical or personal information upon a showing of necessity and justification.²⁵² The heightened proof requirement contained in the blood bank-donor privilege is consistent with current legislative policies that allow access to a person's HIV test results through a court order when the plaintiff has shown a compelling need for the information.²⁵³ Finally, necessity and justification would be satisfied by a demonstration of a substantial need for the materials and that the plaintiff is unable without undue hardship to obtain the substantial equivalent of the information by other means.²⁵⁴ For example, in negligence suits against a blood bank, the substantial need requirement would require more than merely a naked claim that the plaintiff needs access to the donor's identity and personal history in order to determine the blood bank's screen-

²⁵¹ See *supra* text accompanying notes 219-224.

²⁵² The use of the heightened proof requirement is taken from the Supreme Court's discussion of the attorney work-product privilege in *Hickman v. Taylor*, 329 U.S. 495, 510 (1947). In *Hickman*, the Supreme Court dealt with the issue of whether notes taken by the defendant's attorney during interviews with witnesses to a tug boat accident that were made in preparation for litigation, were discoverable under the Federal Rules of Civil Procedure. See *id.* at 498-500. The Court held that the privacy of an attorney's work product was critical for the proper preparation of a client's case and that a party seeking to invade this privacy during the discovery process had the burden of demonstrating necessity and justification for the information. See *id.* at 511-12. The *Hickman* Court noted that in the work-product context, this standard can be met by demonstrating that the relevant facts are essential to the preparation of the plaintiff's case or that witnesses are no longer available or can be reached only with difficulty. See *id.* at 511.

²⁵³ See *supra* note 65 (listing state HIV confidentiality statutes). Although state HIV confidentiality statutes place the burden of proof on the plaintiff, they generally require that the court balance the competing interests at stake before granting access to a person's HIV test results. See, e.g., Fla. Stat. Ann. § 381.004(3)(e)(9)(a) (West 1999). Ironically, the interests to be balanced are virtually identical to those considered under the Rule 26(c) analysis.

²⁵⁴ In defining "necessity and justification," I borrow from the language of Rule 26(b)(3) of the Federal Rules of Civil Procedure. See Fed. R. Civ. P. 26(b)(3). Rule 26(b)(3) codifies the principles discussed in *Hickman v. Taylor* and provides that the attorney's work product is discoverable only upon the plaintiff's demonstration of a substantial need for the materials or that the materials or their equivalents cannot be obtained without undue hardship. See *id.* advisory committee's note (discussing the 1970 Amendments to Rule 26).

ing process used at the time of the blood donation.²⁵⁵ The plaintiff would be required to make a prima facie showing that information contained in the donor medical and personal histories was relevant and necessary for establishing an important element in the plaintiff's case.²⁵⁶

In satisfying the undue hardship requirement, the plaintiff would be required to demonstrate that she cannot acquire the requested information in some other way.²⁵⁷ For example, the plaintiff could access information concerning the blood bank's screening procedures by requesting a copy of all questions or information posed or disseminated by the blood bank to the donor during the screening process.²⁵⁸ The plaintiff may also be able to access this information by questioning the blood bank lab technician or employee who withdrew the donation or the donor.²⁵⁹ Therefore, this element would require a showing that the donor or blood bank technician is either deceased or can no longer be

²⁵⁵ See *Most v. Tulane Med. Ctr.*, 576 So. 2d 1387, 1388 (La. 1991) (holding that this claim was sufficient alone to allow the plaintiff access to the donor's identity).

²⁵⁶ See Ugo Colella, *HIV-Related Information and the Tension Between Confidentiality and Liberal Discovery: The Need for a Uniform Approach*, 16 J. Legal Med. 33, 45 (1995) (indicating that "[t]he threshold question in any discovery dispute involving HIV-related information should be whether the information is critical to the requesting party's case."). Without seeing the file, however, the plaintiff would only be able to speculate as to its contents. Therefore, to overcome the substantial need requirement, she would only have to demonstrate the possibility, and not the certainty, that the claimed documents would contain evidence of the blood bank's negligence. See *Logan v. Commercial Union Ins. Co.*, 96 F.3d 971, 977 (7th Cir. 1996) (holding that in a bad faith action against an insurance carrier where documents requested by the plaintiff were protected by the work-product privilege, the plaintiff had to demonstrate some likelihood or probability that the documents could contain evidence of bad faith).

²⁵⁷ See *Director, Office of Thrift Supervision v. Vinson & Elkins, LLP*, 124 F.3d 1304, 1308 (D.C. Cir. 1997) (holding that "[u]ndue hardship asks whether the moving party can acquire the information any other way.").

²⁵⁸ See *Boutte v. Blood Sys., Inc.*, 127 F.R.D. 122, 123 (W.D. La. 1989) (noting that the blood bank provided the plaintiff with copies of the donor's interview questionnaire and the results of tests performed on the unit of blood donated).

²⁵⁹ See *supra* text accompanying notes 100-01. To protect the privacy of the donor, the court could require that the donor be questioned through interrogatories or an anonymous deposition. See *Watson v. Medical Univ. of S.C.*, 974 F.2d 482, 484 (4th Cir. 1992) (allowing the plaintiff to submit written questions to a court appointed attorney for the donor); *Boutte*, 127 F.R.D. at 126 (allowing the plaintiff to question the donor through an anonymous deposition). Finally, the court could require that the donor's answers to interrogatories or deposition be filed under seal with the court. See *Watson*, 974 F.2d at 490.

reached.²⁶⁰ Finally, once the plaintiff has established the requisite showing of proof, the court could conduct an *in camera* examination of the donor's records in order to preserve their confidentiality and to determine if they contain any evidence of negligence by the blood bank.²⁶¹ After being satisfied that the documents contain evidence of negligence, the court could order that all references to the donor in the documents be redacted.²⁶² It could also require the substitution of a pseudonym for the name of the donor in all discovery and trial pleadings.²⁶³

Similar to Proposal I, adopting a qualified blood bank-donor privilege is also beneficial to both the donor and society. First, the blood bank-donor privilege would eliminate the need for the current judicial balancing of the respective interests under Rule 26(c) because blood banks could legitimately assert a privilege that would exempt donor communications from general discovery altogether.²⁶⁴ Rule 501 of the Federal Rules of Evidence requires that federal courts recognize and apply state privilege law when exercising diversity jurisdiction.²⁶⁵ Therefore, the recognition of a legislative privilege by federal district courts would create uniformity in the handling of the donor's privacy interest, thus eliminating the judicial inconsistencies and possible *Erie* concerns that arise when applying Rule 26(c).

Second, unlike the federal discovery rules where plaintiffs enjoy the presumption of a liberal and broad discovery,²⁶⁶ the adoption of a blood bank-donor privilege would create the presumption that information obtained and disclosed during the relationship is confidential and non-discoverable. The heightened proof requirement contained in the privilege provides an additional layer of protection for the donor's privacy while allowing for the discovery of the requested information only upon the requisite showing by the

²⁶⁰ See *Hickman v. Taylor*, 329 U.S. 495, 511 (1947).

²⁶¹ See *Logan*, 96 F.3d at 977.

²⁶² See *Watson*, 974 F.2d at 484 (noting that the blood bank provided the plaintiff with a redacted copy of the donor's screening questionnaire).

²⁶³ See Fla. Stat. Ann. § 381.004(3)(e)(9)(b) (West Supp. 2000) (requiring the substitution of a pseudonym for the name of the subject of an HIV test when a court has ordered disclosure of the test results).

²⁶⁴ See supra notes 56, 59 (discussing Federal Rules of Civil Procedure 26(b)(1), (c)).

²⁶⁵ See Fed. R. Evid. 501.

²⁶⁶ See supra text accompanying notes 93-96 (discussing discovery).

plaintiff. Unlike under Rule 26(c) where the burden to defend confidentiality was placed on the blood bank, the plaintiff would have to demonstrate both requirements before a court could grant access to the donor's medical and background histories. Consequently, shifting the burden of proof to the plaintiff would ensure that donors always receive a basic level of protection for privacy throughout the screening process and promote the goals of a broad and liberal discovery as envisioned by the drafters of the Federal Rules of Civil Procedure.

Third, the blood bank-donor privilege would also foster an atmosphere conducive for openness and candor by donors in responding to questions concerning their medical histories and other personal information. Candid responses by donors would ultimately work towards promoting the National Blood Policy's goals of creating both a safe and adequate blood supply by providing the assurance that information provided during the relationship is confidential.²⁶⁷ Finally, once a plaintiff has demonstrated necessity and justification under the blood bank-donor privilege, the absolute donor privilege under Proposal I would shield the altruistic donor from all subsequent civil liability where the donor's identity has been either inadvertently or purposefully disclosed in violation of a confidentiality order.²⁶⁸

CONCLUSION

As we enter the third decade of the AIDS epidemic, HIV infection through blood transfusions continues to raise legitimate health and legal concerns. However, neither the privacy of blood donors nor the discovery of information necessary to establish a plaintiff's negligence claim against a blood bank has to be jeopardized. In relationships where society has concluded that communications made between the parties are essential for furthering those relationships, the judiciary and the legislature have recognized privileges against disclosure of such communications in private litigation. The critical role that blood plays in the nation's health care

²⁶⁷ See National Blood Policy, 39 Fed. Reg. 32702, 32702 (1974).

²⁶⁸ See *supra* note 171 (illustrating the need for a sufficient judicial remedy for breaches of confidentiality orders designed to prevent disclosure of the identity of the HIV-infected donor).

industry warrants the adoption of an absolute privilege to protect individuals who donate blood and a qualified blood bank-donor privilege to protect against the disclosure of confidential information disseminated during the donor screening process.

The giving of blood continues to be the “gift of life” for those who desperately need it. Yet, in hindsight, the judiciary’s treatment of the discovery of donor identities and health-related information in blood bank litigation has too often neglected the legitimate privacy concerns of blood donors. Today, even the altruistic donor is subject to legal actions by a recipient of a transfusion should any disease infect her blood. In light of the epidemic proportions of individuals infected by HIV each year, the stigmatization that continues to plague the victims of the disease and their families, and the decreased concerns for blood safety, state legislatures have the responsibility to institute even greater protection for the privacy of their citizens. This can be done while continuing to effectively safeguard a plaintiff’s right to access relevant information critical for litigation and society’s interest in a safe and adequate blood supply.

