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The Liability of Blood Banks and Manufacturers of Clotting Products to Recipients of HIV-Infected Blood: A Comparison of the Law and Reaction in the United States, Canada, Great Britain, Ireland, and Australia, 27 J. Marshall L. Rev. 465 (1994)

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THE LIABILITY OF BLOOD BANKS AND MANUFACTURERS OF CLOTTING PRODUCTS TO RECIPIENTS OF HIV- INFECTED BLOOD: A COMPARISON OF THE LAW AND REACTION IN THE UNITED STATES, CANADA, GREAT BRITAIN, IRELAND, AND AUSTRALIA

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It is uncontroverted that, within the United States, the first HIV transfusion lawsuits were filed in 1985. Presently, there are between three hundred and five hundred pending lawsuits,¹ almost all of which involve persons infected with HIV. The suits generally arose from patient exposures to infected blood plasma or to blood transfusions administered before the Food and Drug Administration (FDA) approved the test for HIV antibodies in March 1985.² In most cases, defendants have been successful, especially on motions for summary judgment. In fact, a 1990 survey by the American Association of Blood Banks (AABB), shows that less than a dozen

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The author discussed some of the issues in this Article at a meeting of the International Bar Association, Medicine and the Law Committee, in October 1993.

1. Cynthia Kelly & John P. Barber, *Legal Issues in Transfusion Medicine: Is Blood Banking a Medical Profession?*, 12 CLINICS IN LAB. MED. 819, 819-20 (1992). Some estimate that at least one-half of American hemophiliacs are HIV-infected and some, regrettably, have infected their spouses. Reginald Rhein, Jr., et al., *Freeing Hemophiliacs From the Risk of AIDS*, BUS. WK., Mar. 13, 1987, at 38.

2. Notwithstanding the present HIV/AIDS test, there is no 100% guaranty of transfusion safety because of the estimated three-month "window period" between the time of infection and the time of the production of antibodies. The FDA suggests the present risk of transmission is between 1 in 38,000 and 1 in 153,000. 58 Fed. Reg. 34,962 (1993) (to be codified at 21 C.F.R. §§ 606, 610) (proposed June 30, 1993).

cases resulted in awards for the plaintiffs.³ Unlike the United States, other countries have reduced litigation drastically by providing government payments to HIV transfusion victims. This Article compares litigation in the United States with litigation and other alternatives in Canada, Great Britain, Ireland, and Australia.

This Article compares the law and trends in HIV-infected blood product litigation within the United States, Canada, Great Britain, Ireland, and Australia. Part I discusses the heavy burdens which face the HIV-infected plaintiff in American courts. Part I further provides a chronological summary of the discovery of HIV/AIDS and its relation to HIV-infected blood product litigation. Part II describes the recent developments in Canadian tainted blood litigation. Part III addresses the response of Great Britain and Ireland to HIV-infected blood product litigation. Finally, Part IV analyzes the history of the problem in Australian courts, as well as the Australian government's initiatives.

I. UNITED STATES

Unlike the perhaps irrational blame attached to gays and drug addicts who become HIV positive through unsafe sex or needle sharing, everyone considers the victim infected with HIV by transfusion or by plasma to be "innocent."⁴ It is no accident that California named the Paul Gann Blood Safety Act after a man who died from HIV/AIDS complications after receiving an HIV-infected transfusion.⁵ Nevertheless, the plaintiff in these blood products cases must surmount heavy burdens in order to succeed in American courts.

The widespread sympathy for these HIV victims has not generally resulted in remuneration through successful litigation. The time consuming nature of litigation often exacerbates the plaintiff's problem because HIV transfusion litigation can be very time consuming. The length of a lawsuit is especially important when a plaintiff has a terminal illness. Litigation generally occurs in federal court either because this is mandatory when the American Red Cross is a defendant,⁶ or because a blood bank or blood products

3. Kelly & Barber, *supra* note 1, at 820.

4. "Clearly a plaintiff's case arouses sympathy for the 'innocent' manner in which he became ill." Snyder v. Mekhjian, 593 A.2d 318, 333 (N.J. 1991) (Garibaldi, J., dissenting).

5. CAL. HEALTH & SAFETY CODE § 1645 (West 1994). The Gann Act requires the medical professional to talk with patients about blood donor options such as using one's own blood or asking acquaintances to donate. *Id.*

6. Plaintiffs must sue the American Red Cross in a federal court which will apply state law. American Nat'l Red Cross v. S.G., 112 S. Ct. 2465, 2472 (1992). The Supreme Court concluded that the American National Red Cross' Charter, 36 U.S.C. § 2 (1988) provides original federal jurisdiction for all cases in which the Red Cross is a party. *Id.* The American Red Cross collects about

defendant will remove the case to a federal court based on diversity.⁷ This may necessitate a time-consuming procedure when a federal judge has to determine whether a state medical protection statute protects a blood bank or blood products defendant. Such statutes may, among other provisions, have a shorter statute of limitations or repose, or somehow restrain the scope of plaintiff's discovery.⁸

A significant minority of jurisdictions have concluded that these medical protection statutes may protect blood banks when they bar a plaintiff's cause of action before he or she was even aware of the HIV-infection.⁹ In *Estate of Doe v. Vanderbilt University, Inc.*, the plaintiff contracted HIV/AIDS through a 1984 transfusion, but was unaware of her infection until 1989.¹⁰ The federal judge, applying state law, dismissed her claim of negligent provision of blood because of Tennessee's three-year statute of repose.¹¹ The judge did certify that issue to the United States Court of Appeals for the Sixth Circuit and suggested it certify the question to the Tennessee Supreme Court.¹² Needless to say, this time-consuming procedure is of minimum value to the HIV positive plaintiff.¹³

one-half of all donated blood in the United States. *United Blood Servs. v. Quintana*, 827 P.2d 509, 513 (Colo. 1992) (en banc).

7. *S.G.*, 112 S. Ct. at 2472.

8. *E.g.*, FLA. STAT. ANN. § 95.11 (West 1982); MO. REV. STAT. § 516.105 (Vernon 1993); TENN. CODE ANN. § 29-26-116 (1980).

9. *Estate of Doe v. Vanderbilt Univ., Inc.*, 824 F. Supp. 746, 747 (M.D. Tenn. 1993); *see also Doe v. Shands Teaching Hosp. and Clinics, Inc.*, 614 So. 2d 1170 (Fla. Dist. Ct. App. 1993) (upholding the constitutionality of Florida's Medical Malpractice Statute of Repose); *Smith v. Paslode Corp.*, 799 F. Supp. 960, 963 (E.D. Mo. 1992) (upholding the Missouri Blood Shield statute in the face of a constitutional challenge), *modified*, 7 F.3d 116 (8th Cir. 1993). In *Smith*, the Eighth Circuit remanded the case to determine whether the Red Cross was negligent in performing its look-back procedures. 7 F.3d at 119.

The American Red Cross is a health care professional and thus within the medical statute of limitations. *Smith*, 799 F. Supp. at 966. A shorter Statute of Limitations clearly protects the Red Cross. Other courts hold that the Statute of Limitations does not include blood banks and that the sale of blood is not the practice of medicine. *Silva v. Southwest Blood Bank, Inc.*, 601 So. 2d 1184, 1188-89 (Fla. 1992); *see also J.K. & Susie L. Wadley Research Inst. v. Beeson*, 835 S.W.2d 689, 696 (Tex. Ct. App. 1992) (holding that the Texas' Medical Liability and Insurance Improvement Act does not allow a shorter Statute of Limitations for blood banks).

10. *Estate of Doe*, 824 F. Supp. at 747.

11. *Id.* at 751.

12. *Id.*

13. *See Bradway v. American Nat'l Red Cross*, 965 F.2d 991, 993 (11th Cir. 1992) (certifying the question of limitations to the Georgia Supreme Court). The Georgia Supreme Court eventually held that its limitations period applied in 1993 to effectively bar the plaintiff's suit. *Bradway v. American Nat'l Red Cross*, 426 S.E.2d 849, 852 (Ga. 1993).

In *Kaiser v. Memorial Blood Ctr. of Minneapolis, Inc.*, 938 F.2d 90, 93-94 (8th cir. 1991), the federal court certified a similar issue to the Minnesota Supreme Court. However, the state court found the statute inapplicable. Kai-

Even if a plaintiff is not time barred or otherwise precluded from litigation, he or she has a limited choice of which cause of action to bring. In the United States, unlike Canada and perhaps Australia, an HIV-infected plaintiff may not sue successfully under any product liability or implied warranty theory. The plaintiff's sole remedy—negligence—requires him or her to prove the blood bank had a duty, that the bank breached that duty, and that the breach was a proximate cause of his or her infection.¹⁴

Duty and Breach of Duty

In order to prove a breach of duty, the plaintiff generally must proceed on either of two theories. First, the plaintiff may claim the defendant blood bank was negligent in predonation procedures by failing to screen the potential donors adequately. Second, the plaintiff may claim the defendant failed to utilize surrogate blood testing.¹⁵ The plaintiff's burden increases significantly when the jurisdiction follows the standard of professional care rather than that of the ordinary, reasonable person.

The HIV/AIDS plaintiff should attempt to establish that the defendant blood bank followed inadequate predonation screening procedures. Some of the crucial issues for litigation arising from transfusions between 1981 and March 1985 are: the defendants' knowledge about HIV/AIDS; when the defendants became aware of the risk of HIV/AIDS transmission through blood transfusions; and what the industry could have done to minimize HIV/AIDS transmission.¹⁶ While generalizations are often difficult to make, it is

ser v. Memorial Blood Ctr. of Minneapolis, Inc., 486 N.W.2d 762, 766 (Minn. 1992); see also Doe v. American Nat'l Red Cross, 976 F.2d 372, 376 (7th Cir. 1992) (certifying a similar question to the Wisconsin Supreme Court). Upon certification, the Wisconsin Supreme Court held that a blood bank was not a health care provider. Doe v. American Nat'l Red Cross, 500 N.W.2d 264, 264-65 (Wis. 1993).

Smith v. Cutter Biological, Inc., 823 P.2d 717 (Haw. 1991), took this theory of non-applicability one step further. The Hawaii Supreme Court, looking to a market share theory, held the statute permitted suits against blood banks even though the plaintiff could not prove the identity of the actual blood bank tortfeasor. *Id.* at 727-29.

The state supreme court may decline to answer a certified question. Coleman v. American Nat'l Red Cross, 483 N.W.2d 621 (Mich. 1992).

14. Jaime v. St. Joseph Hosp. Found., 853 S.W.2d 604, 607 (Tex. Ct. App. 1993).

15. Surrogate blood testing "is used when there is no direct test available to defect the presence of a disease or the antibody generated by the disease." United Blood Servs. v. Quintana, 827 P.2d 509, 515 (Colo. 1992) (en banc). "Surrogate testing is thus utilized to determine the presence of factors believed to be statistically linked to the presence of a disease." *Id.* For further discussion of surrogate testing, see *infra* notes 31-34 and accompanying text.

16. An excellent chronological summary of the discovery of HIV/AIDS and the threat of HIV transmission through blood appears in Doe v. Cutter Biological, Inc., 971 F.2d 375, 381 (9th Cir. 1992), and in the somewhat outdated analysis in Kozup v. Georgetown University, 663 F. Supp. 1048, 1050-53 (D.D.C.

more likely that a court will find a defendant's breach of duty if the transfusion date is closer to 1985. In *Hoemke v. New York Blood Center*,¹⁷ for example, the court stated: "Vital to our conclusion are the particular facts of this case, specifically the year [1981] in which the transfusion occurred. Had the transfusion occurred even a short time later, the reasoning and conclusions might well have been different, given the emerging knowledge of AIDS in the 1980s."¹⁸ As HIV/AIDS awareness increased toward the mid-

1987), *aff'd in relevant part*, 851 F.2d 437 (D.C. Cir. 1988). For an informative television broadcast, see *Frontline: AIDS Blood and Politics* (Corp. for Public Broadcasting television broadcast, Nov. 30, 1993).

17. 912 F.2d 550 (2d Cir. 1990).

18. *Id.* at 553-54. The key issue in these case is clearly when the research and warnings about HIV transmission in blood were available to the defendants. *Id.* at 552. No one believed in the *possibility* that the HIV/AIDS was blood borne until eight months after plaintiff's 1981 operation. *Id.* In a case involving a 1982 operation and necessary transfusions, the hospital won on a summary judgment based on the hospital expert's affidavit that the defendant met the standards of care at a time when no one used surrogate testing. *Jaime*, 853 S.W.2d at 614-15. In a later case, a court said the hospital did more than any other blood bank in order to avoid negligence and that the defendant was a pioneer in the area of donor's questioning. *Osborne v. Irwin Hosp.*, 7 Cal. Rptr. 2d 101, 129 (Cal. Ct. App. 1992). No other blood bank in the nation used surrogate tests at that time. *Id.* at 123; *see also Wilson v. Irwin Memorial Blood Bank*, 18 Cal. Rptr. 2d 517, 518-524 (Cal. Ct. App. 1993) (discussing the medical profession's recognition of the need for surrogate testing in the mid-1980s). In a case involving a transfusion in September 1983, the plaintiff received a single vial of koyné and became HIV positive. *Doe v. Miles Lab., Inc.*, 927 F.2d 187, 189-90 (4th Cir. 1991). Yet there was still no consensus that HIV/AIDS was transmissible through blood transfusions until early 1984. *Id.* No blood bank utilized donor screening or testing procedures in September 1983. *Id.* at 191; *see Reyes v. United States*, 770 F. Supp. 58 (D.P.R. 1991) (finding that the plaintiff failed to show any violation of standard of care regarding a 1983 transfusion), *aff'd*, 971 F.2d 744 (1st Cir. 1992); *Smythe v. American Red Cross Blood Servs.*, 797 F. Supp. 147, 153 (N.D.N.Y. 1992) (granting motion for summary judgment because the defendant complied with professional standard of care by following FDA regulations and blood bank standards). In *Jones v. Miles Lab., Inc.*, 887 F.2d 1576, 1577 (11th Cir. 1989), an individual donated plasma on January 31, 1983, and February 3, 1983. At the time, it was not the industry-wide practice to ask donors about high risk behavior. *Id.* at 1579. FDA recommendations concerning high risk began March 24, 1983. *Id.* at 1580. Defendant wrote an internal memo on February 8, 1983, regarding the need to ask about high risk donors. *Id.* The court held that the question of negligence centered around those few days of February 1983. *Id.* at 1581. The judge granted a motion for judgment N.O.V. and set aside the jury award of \$1.6 million. *Id.* at 1582. In *Kirkendall v. Harbor Ins. Co.*, 698 F. Supp. 768, 773 (W.D. Ark. 1988), *aff'd*, 887 F.2d 857 (8th Cir. 1989), the blood at issue was inventoried only days before the test kits became available. The court, applying the professional standard of care, rejected the argument that the bank should have asked their donors sexually specific question or should have used surrogate testing. *Id.* at 773-78.

Thus, most of the cases dealing with tainted transfusions in the early 1980s resulted in findings for the blood banks because plaintiffs could not establish violations of the professional standard of care. In *McKee v. Miles Lab., Inc.*, 675 F. Supp. 1060, 1064 (E.D. Ky. 1987), *aff'd sub nom. McKee v. Cutter Lab., Inc.*, 886 F.2d 219 (6th Cir. 1989), the defendant pharmaceutical company did not use alternative testing to identify the HIV virus. However, the court held that

1980s, blood banks had to take more steps to fulfill their increased duties with regard to blood product recipients.¹⁹

Discovery is the key factor in determining whether the defendant blood bank either failed to adequately screen prospective donors who were HIV positive or that the defendant blood bank failed to utilize surrogate testing which would test for blood abnormalities often found among high-risk groups. Once informed of their status, HIV positive transfusion victims sought information from the HIV-infected donor through the blood bank. Plaintiffs' attorneys insisted this was necessary in order to determine whether the blood bank followed its own screening procedures in accepting donor blood and whether the screening procedures were adequate.²⁰ Blood bank representatives responded: "Where a donor's name has been revealed, the plaintiffs have jumped at the chance to bring a lawsuit against that individual."²¹

Courts diverge on whether, and to what extent, blood banks must reveal the donor's information for discovery purposes. Generally, "there is an increased sensitivity to discrimination against HIV-positive individuals. It is a fair summary that most recent cases more frequently allow disclosure, and do so under increasingly detailed confidentiality restrictions."²² Courts which have denied discovery, often cite one of three essential propositions: that the plaintiff's lawyer either was on a "fishing expedition"²³; that public policy necessitated that a donor's fear of publicity must not jeopardize the "free flow of volunteer blood"²⁴; and that the donor

the defendant did not violate the standard of care within the profession because the industry did not know that HIV could be transmitted through blood until 1984, and therefore, the industry did not screen or conduct alternative testing prior to that time. *Id.* at 1063-64. In *Shelby v. St. Luke's Episcopal Hosp.*, No. CIV.A.H-86-3780, 1988 WL 28996, at *3 (S.D. Tex. Mar. 17, 1988), the court rejected the plaintiff's argument that the industry's standard of care was careless because "no test for the HIV virus was available at the time the blood in question was transfused."

19. For a good discussion of the chronology and discovery of HIV/AIDS routes of transmission and testing, see *United Blood Servs. v. Quintana*, 827 P.2d 509, 513-16 (Colo. 1992) (en banc).

20. John M. Willis, Esq., Donor Identity and Discovery Directed to Donors: Obtaining Access to Donors of HIV-Infected Blood, Speech at Am. Trial Lawyers Ass'n Convention (Aug. 1, 1992).

21. *In the Field . . .*, AIDS POL'Y AND LAW, Oct. 16, 1992, at 6 (remarks of Cynthia Kelly, AABB General Counsel).

22. *Roth v. New York Blood Ctr., Inc.*, 596 N.Y.S.2d 639, 642-43 (N.Y. Sup. Ct. 1993).

23. *Rasmussen v. South Florida Blood Serv., Inc.*, 500 So. 2d 533, 538 (Fla. 1987). Whether *Rasmussen* bars all discovery is a question now certified before the Florida Supreme Court. *Whigham v. Shands Teaching Hosp. and Clinics, Inc.*, 613 So. 2d 110 (Fla. Dist. Ct. App. 1993).

24. *Krygier v. Airweld, Inc.*, 520 N.Y.S.2d 475, 477 (N.Y. Sup. Ct. 1987). The *Krygier* court denied discovery citing the need for a "free flow" of donations and the "marginal utility [served by the disclosure] in advancing plaintiff's theory of liability." *Id.* The court also noted that the physician/patient privilege

has either a state or federal constitutional right to privacy.²⁵

Most recent decisions allow limited discovery of a donor with the understanding that none of the parties will sue the donor or reveal his or her identity. In *Roth v. New York Blood Center*,²⁶ the court temporarily denied discovery for failure to guarantee complete donor confidentiality, but rejected the public policy defense of a chilling effect on the nation's blood supply:

As to the request for an unlimited disclosure of the donor's name, in the event the donor is alive, with the avowed purpose of deposing the donor about a broad range of topics, that request is denied. Plaintiff has not (1) established the relevance of the proposed inquiry sufficient to show a compelling need for the discovery desired; (2) confined the scope of the disclosure request, (3) professed a willingness to limit access to the information, or (4) offered an argument in relation to the impact of any disclosure order on the donor and the policy of encouraging HIV and AIDS testing and treatment. Accordingly, the request is denied with leave to renew upon proper papers.²⁷

In another case alleging negligent screening by the Red Cross, a court put stringent requirements on discovery which included ordering the plaintiff to pay donor's court-appointed attorney fees while also maintaining the lawyer's confidentiality.²⁸

Other courts turn the public policy argument on its head. In *Doe v. Puget Sound Blood Center*,²⁹ the Court upheld a \$1.8 million verdict against the blood bank and dismissed the public policy argument as bordering on "speculation."³⁰ The court noted: "[T]rue public interest is [in] an uninfected blood supply . . . [which] should

applies to blood banks. *Id.* at 476-77. Courts have also discussed the fear of jeopardizing blood supplies by frightening donors. *E.g.*, *Bradway v. American Nat'l Red Cross*, 132 F.R.D. 78, 80 (N.D. Ga. 1990); *Doe v. American Red Cross Blood Servs.*, 125 F.R.D. 646, 650 (D.S.C. 1989); *Rasmussen*, 500 So. 2d at 537-38. In *Ellison v. American National Red Cross*, 151 F.R.D. 8 (D.N.H. 1993), the court concluded the need to preserve the nation's blood supply outweighed the decedent's private interest in obtaining the donor's identity. *Id.* at 11. The court rejected plaintiff's argument that "without the ability to contact the donor, it will be virtually impossible for Mr. Ellison to sustain his case." *Id.*

25. *Doe v. University of Cincinnati*, 538 N.E.2d 419, 424 (Ohio Ct. App. 1988). The court also noted the donor had a right to privacy plus based on written assurances of confidentiality. *Id.* at 425. This plaintiff's interest in discovery did not outweigh the donor's interest in privacy arising from the federal and state constitutions and the written assurances. *Id.* This court also rejected defendant's contention that it should deny discovery because of physician/patient privilege. *Id.* at 423. Some courts also cite a donor's statutory right to privacy. See *Krygier*, 520 N.Y.S.2d at 477 (citing N.Y. Civ. Prac. L. & R. 3103 (McKinney 1994)).

26. 596 N.Y.S.2d 636 (N.Y. Sup. Ct. 1993).

27. *Id.* at 646.

28. *Diabo v. Baystate Medical Ctr.*, No. CIV.A91-10648-F, 1993 WL 379563, at *1 (D. Mass. Sep. 22, 1993).

29. 819 P.2d 370 (Wash. 1991).

30. *Id.* at 379.

discourage donors who are in the high risk groups."³¹ Other courts grant discovery requests upon concluding that donors have no constitutional or other privacy rights while "affording the donors protection from undue publicity and intrusion into their private lives."³²

Besides using stringent donor questionnaires and excluding high-risk groups, blood banks could minimize HIV-infection by utilizing surrogate testing. These tests would detect Hepatitis B and other diseases common to those in high-risk categories. As explained in *United Blood Services v. Quintana*,³³ the test procedure correctly identifies between sixty-six and eighty-eight percent of all HIV-infected donors.³⁴ The court wrote: "The tests, however, had a two to five percent false-positive rate, which would result in a rejection of uninfected blood and would thereby diminish the nation's blood supply."³⁵ In *Quintana*, after the plaintiff claimed that the failure to utilize surrogate testing constituted negligence, the defendants necessarily insisted that the above procedure was too unreliable, overbroad, and not cost-effective.³⁶

Even if plaintiff obtains discovery of an HIV-infected donor or proves the defendant failed to utilize surrogate testing, he or she may still face an uphill struggle in order to prove a breach of duty. Most jurisdictions utilize a professional or industry-wide standard

31. *Id.* (emphasis in original); see *Watson v. Lowcountry Red Cross*, 974 F.2d 482, 489 (4th Cir. 1992) (finding no evidence to substantiate speculative claim that limited discovery will jeopardize the nation's blood supply). The court found that the donor's privacy rights were not violated. *Id.* at 488. Even if they were, the plaintiff's rights outweighed the donor's rights. *Id.* The court wrote: "At most, the invasion of the donor's privacy is minimal and this interest is greatly outweighed by the plaintiff's need for the information and the related public interest in seeking that injuries are compensated." *Id.* Another court also rejected the public policy argument that to allow disclosure would hinder voluntary blood donations. See JOHN PAUL BARBER, AMERICAN ASS'N OF BLOOD BANKS, DIGEST OF TRANSFUSION-ASSOCIATED HIV/AIDS LITIGATION 22 (Oct. 28, 1992) (citing *John Jones v. American Nat'l Red Cross*, Civil Action No. 88-4510 (GEB), (D.N.J. Mar. 1, 1989)). A balancing test favors limited discovery even though it might result in potential donors being less likely to give blood or "conceal important information during the screening process." *Borzillieri v. Am. Nat'l Red Cross*, 139 F.R.D. 284, 291 (W.D.N.Y. 1991). Defendants succeeded in obtaining an order to stay discovery from the United States Court of Appeals for the Second Circuit. Deborah Pines, *Discovery Stayed in AIDS-Tainted Blood Suit*, N.Y. L.J., Jan. 15, 1992, at 1. The case settled on February 13, 1992. Telephone Interview with Gregory P. Krull, attorney for the plaintiff (Oct. 8, 1993).

32. *Gulf Coast Regional Blood Ctr. v. Houston*, 745 S.W.2d 557, 560 (Tex. Ct. App. 1988). Of course, some courts have come to the opposite conclusion on the issue of the donor's privacy. See *Mason v. Regional Medical Ctr. of Hopkins County*, 121 F.R.D. 300, 303 (W.D. Ky. 1988) (holding that a blood donor's identity must be revealed to a limited group of persons).

33. 827 P.2d 509 at 515 (Colo. 1992) (en banc).

34. *Id.* at 515.

35. *Id.*

36. *Cf. id.* at 525.

of care rather than the standard of the ordinary, reasonable person.³⁷ In *Wilson v. Irwin Memorial Blood Bank*, the court applied a professional standard of care and noted that the majority of courts followed this rule of law.³⁸

When the courts utilize the professional standard, expert testimony is necessary in order to prove a departure from the professional standard. Courts may require a plaintiff to find an expert witness certified not merely in internal medicine, but "rather . . . [one] in blood banking."³⁹ Thus, the plaintiff failed to comply with "the general rule in medical malpractice cases . . . that expert medical testimony is required to establish proper medical procedure."⁴⁰ A plaintiff who became HIV positive from a 1988 transfusion, therefore, had no case against Red Cross because he could not show that Red Cross actions "were not in accordance with those of similarly situated blood collectors at the time of the challenged actions."⁴¹ Thus, until 1985, defendants could successfully assert that it was not a generally accepted blood bank practice either to screen very carefully prospective donors or to utilize surrogate testing.⁴²

The vast majority of cases result in decisions for the defendants, often after a determination that the defendants met the standard of care at the time of the transfusion. In one such case, *Gibson v. Methodist Hospital*,⁴³ the Texas Supreme Court at first concluded that defendant might have violated the applicable standard of care based on the proffered testimony of plaintiff's expert who held "a Ph.D. in environmental health" from a correspondence school.⁴⁴ On December 16, 1992, the Texas Supreme Court withdrew its opinion and denied plaintiff's writ which resulted in dis-

37. Clark C. Havighurst, *Altering the Applicable Standard of Care*, 49 *Law and Contemp. Probs.* 265, 266-67 (1986). "[A]dherence to prevalent professional standards creates an almost irrebuttable presumption of due care." *Id.* at 267.

38. 18 Cal. Rptr. 2d 517, 524 (Cal. Ct. App. 1993) (citing Theodore Silver, *One Hundred Years of Harmful Error: The Historical Jurisprudence of Medical Malpractice*, 1992 *Wis. L. Rev.* 1193, 1216-19); see, e.g., *Smith v. Paslode Corp.*, 799 F. Supp. 960, 972 (E.D. Mo. 1992) (granting the Red Cross' motion for summary judgment based on the professional standard of care because evidence showed that the "blood banking profession almost uniformly did not use surrogate testing as a marker for HIV or AIDS"), *modified*, 7 F.3d 116 (8th Cir. 1993).

39. *Barton v. American Red Cross*, 829 F. Supp. 1290, 1300 (M.D. Ala. 1993).

40. *Id.* at 1302.

41. *Id.* at 1297.

42. Kelly & Barber, *supra* note 1, at 819.

43. No. D-2057, 1992 WL 140842 (Tex. June 24, 1992), *withdrawn on reh'g* (Dec. 16, 1992).

44. *Texas Reverses Position on Hospital Liability for Blood Bank Actions*, *Blood Bank Wk.*, Jan. 15, 1993, at 5; Respondents' Motion for Rehearing on Application for Writ of Error at 13, *Gibson*, No. D-2057, 1992 WL 140842.

missal of plaintiff's lawsuit.⁴⁵

There have, of course, been some cases where plaintiffs were successful. Generally, this is because a defendant neither utilized surrogate testing,⁴⁶ nor aggressively questioned prospective donors.⁴⁷ These defendants generally failed to follow AABB recommendations.⁴⁸ The court may have also adopted the reasonable person standard.⁴⁹

Often, however, a jury award becomes at best a pyrrhic victory. Consider the following three cases. In *Brown v. United Blood Services*,⁵⁰ the estate of an HIV positive plaintiff received a jury award of \$970,000.⁵¹ Prior to that determination, the case went to the Nevada Supreme Court which had placed stringent limits concerning the discovery procedure regarding the HIV positive donor. In post-trial motions, the trial judge reduced the award to \$135,400.⁵² On subsequent appeal, the Nevada Supreme Court joined "the clear and growing consensus of jurisdictions" by concluding that the defendant had satisfied the professional standard of care which left the estate without any recovery.⁵³

In *United Blood Services v. Quintana*,⁵⁴ the plaintiff tested HIV positive in November 1985 as a result of a May 1983 transfusion. In 1989, after a four-week jury trial, the trial judge instructed the jury that the defendant would not be negligent if it followed the professional standard of care.⁵⁵ The appellate and supreme courts

45. *Texas Reverses Position on Hospital Liability for Blood Bank Actions*, *supra* note 44, at 5.

46. *United Blood Servs. v. Quintana*, 827 P.2d 509, 512 (Colo. 1992). In *Quintana*, defendant's screening procedures "did not include the aggressive questioning and physical examination of blood donors as recommended by the National Hemophilia Foundation." *Id.* at 517.

47. *Crandall v. Southwest Florida Blood Bank, Inc.*, 581 So. 2d 593, 595 (Fla. Dist. Ct. App. 1991). The court reversed the lower court's grant of summary judgment for the defendant because they were negligent in screening blood donors. *Id.* Plaintiff's expert witness believed the defendant should have required the donors to disclose whether they had a recent medical history of "fever, skin eruption, aching joints and muscles, weakness, lymph gland enlargement, sore throat, gastrointestinal symptoms, headache, or sensitivity to light." *Id.* at 595.

48. In *J.K. & Susie L. Wadley Research Inst. v. Beeson*, 835 S.W.2d 689 (Tex. Ct. App. 1992), the surviving spouse and son of a recipient who contracted HIV/AIDS after an April 1983 transfusion received \$800,000 from a jury. *Id.* at 692. The defendant did not follow AABB and Centers for Disease Control recommendations. *Id.* at 699-700. In addition, the court held that blood banks do not provide health care and, thus, could not assert the shorter health care Statute of Limitations. *Id.* at 696.

49. *Snyder v. Mekhjian*, 582 A.2d 307, 313 (N.J. Super. Ct. App. Div. 1990), *aff'd*, 593 A.2d 318 (N.J. 1991).

50. 858 P.2d 391, 396 (Nev. 1993).

51. *Id.* at 393.

52. *Id.* at 393.

53. *Id.* at 396.

54. 827 P.2d 509 (Colo. 1992).

55. *Id.* at 511-13.

disagreed and stated that adhesion to professional standards was only a rebuttable presumption of due care.⁵⁶ This necessitated a new trial, and in November 1992, the jury awarded the plaintiff \$8.15 million (approximately \$16 million with interest).⁵⁷ Unfortunately, the plaintiff died prior to the verdict.⁵⁸ Understandably, the defendant appealed and the case eventually settled for an undisclosed amount in late 1993.⁵⁹

In *Walls v. Armour Pharmaceutical Corp.*,⁶⁰ the plaintiff child contracted HIV from a blood clotting manufacturer sometime between 1983 and 1985.⁶¹ In 1989 he sued Armour, but died in 1992.⁶² On January 22, 1993, a jury awarded his subsequently divorced parents \$2 million.⁶³ On July 19, 1993, the federal court denied defendant's motion for judgment as a matter of law.⁶⁴ On September 1, 1993, the court denied the defendant's motion for a new trial.⁶⁵ It was devastating for the parties that his case was not final ten years after the date he may have been infected.

Perhaps the delay and cost of litigation will be minimized by following the result of class action hemophiliac suits against the major blood plasma corporations and by a judicial willingness to accept market share or alternative theories of liability. Although the plaintiff cannot prove which defendant caused the injury, a federal judge has permitted the plaintiff to proceed with his case based on an alternative theory of liability.⁶⁶ Under the alternative liabil-

56. *Id.* at 521.

57. *Transfusions: Award of 8.15 Million Upheld in Colorado Tainted Blood Suit*, AIDS Pol'y and L., Nov. 13, 1992, at 2.

58. *Id.* The *Quintana* court received expert testimony from Don Francis, M.D., whom Randy Shilts claims was the first to identify the HIV danger to the blood supply in his book. *AND THE BAND PLAYED ON*. Alexander Peters, *Good Enough for HBO, but not for the Witness Box*, THE RECORDER, Jan. 20, 1993, at 2. Interestingly, a California court would not allow Dr. Francis to testify as an expert witness against Irwin Memorial Hospital because his expertise was in hepatitis and not blood banking. *Id.*

59. Telephone Interview with Kay Johnson, paralegal at Lewis and Roca, Phoenix, Arizona, attorneys for United Blood Services (Mar. 10, 1994). The court vacated the award on October 28, 1993. *Id.*

60. 832 F. Supp. 1467 (M.D. Fla. 1993).

61. *Id.* at 1469.

62. *Id.*

63. *Id.*

64. *Id.* at 1504.

65. *Walls v. Armour Pharmaceutical Corp.*, 832 F. Supp. 1505 (M.D. Fla. 1993).

66. *Poole v. Alpha Therapeutic Corp.*, 696 F. Supp. 351, 355 (N.D. Ill. 1988). The United States District Court stated:

[W]e adopt the market-share alternate theory of liability as formulated by the Washington Supreme Court. However, as a prerequisite to its use, a plaintiff must make a showing that she has made a genuine attempt to locate and to identify the manufacturer responsible for her injury. We further restrict this vehicle of recovery to those actions sounding in negligence; it may not be used in conjunction with allegations of fraud, breach of warranty or strict liability.

ity theory, if a plaintiff proves that several defendants acted negligently, but cannot prove which defendant in fact caused his injury, the burden of proof shifts to the defendants to prove that they did not cause the injury.⁶⁷ This allows relief even though plaintiffs cannot prove which manufacturer of clotting products made the contaminated Factor VIII clotting product that caused the injury.⁶⁸

Plaintiffs may also base their claims on market share liability. This is possible when the plaintiffs can establish an inherent inability to determine which manufacturer was responsible for their injuries.⁶⁹ The plaintiff must show the court that they made a "genuine attempt to locate and to identify the manufacturer."⁷⁰ The percentage of market share held by each defendant determines the extent to which they are liable for the plaintiff's recovery.⁷¹ The market share theory applies only in negligence; it is inapplicable in cases involving fraud, breach of warranty, or strict liability.⁷²

In *Doe v. Cutter Biological, Inc.*, the court concluded: "[A] hemophiliac plaintiff does not necessarily have to prove which of the four major manufacturers made the so-called Factor VIII clotting product."⁷³ Although one plaintiff could not specify which company manufactured the contaminated product, the court allowed the case to proceed based on the allegation that the four manufacturers knew of potential viruses in the clotting product and should have purified it.⁷⁴

Waldleigh v. Rhone-Poulenc Rorer, Inc., a class action suit presently awaiting certification filed against four blood product makers and the National Hemophilia Foundation, illustrates the alternative liability theory applied in HIV transfusion cases.⁷⁵ The plain-

Id.

67. *Ray v. Cutter Laboratories*, a federal district court in Florida explicitly allowed the plaintiffs to proceed on their theory of market share liability, provided they could establish an inherent inability to determine which manufacturer was responsible for their injury. *Id.* at 196.

68. *Id.* Practitioners should also note *Poole* is one of the few cases where the court sanctioned plaintiff attorneys for including one frivolous cause of action in their multi-count complaint. *Poole v. Alpha Therapeutic Corp.*, 698 F. Supp. 1367, 1374 (N.D. Ill. 1988).

69. *Ray v. Cutter Labs., Inc.*, 754 F. Supp. 193, 196 (M.D. Fla. 1991).

70. *Id.*

71. *Doe v. Cutter Biological, Inc.*, 971 F.2d 375, 379 (9th Cir. 1992).

72. *Ray*, 754 F. Supp. at 196.

73. *See Doe v. Cutter Biological, Inc.*, 971 F.2d at 378 (applying Hawaiian law). Adherence to industry practices was not dispositive on the issue of negligence. *Id.* at 382-83. The court proceeded under the theory of market share liability. *Id.* at 380.

74. 971 F.2d 375, 379 (9th Cir. 1992) (explaining the difference between the alternative liability, enterprise liability and market share liability theories).

75. *Id.*

76. Complaint, No. 93 C 5969, (N.D. Ill. Sept. 30, 1993); PROD. SAFETY & LIAB. REP., Oct. 8, 1993, at 1013; see Laura Duncan, "Alternative Liability" Theory Opens Court Doors to HIV-Hemophiliacs, CHI. DAILY L. BULL., Dec. 21,

tiffs alleged that by 1982 the companies had become aware of the risks of HIV and blood contamination, but failed either to warn hemophiliacs of the risk or to withdraw the products from the market.⁷⁶ The complaint also alleged that the hemophiliac foundation breached its fiduciary duty to provide medical information to its plaintiff members, and had circulated incorrect information that the risk of using Factor VIII was minimal.⁷⁷

It is also possible that up to 8,000 lawsuits by HIV positive hemophiliacs will form a class action.⁷⁸ In *In re Factor VIII or IX Concentrate Blood Products, Products Liability Litigation*, plaintiffs allege that the defendants' failure to warn, negligent manufacturing of medication between 1980 and 1985, negligent failure to recall products, and fraudulent misrepresentation resulted in plaintiffs contracting HIV.⁷⁹ In their brief, the plaintiffs succinctly argue:

[S]everal former government employees and scientists are now willing to testify regarding the facts surrounding [factor concentrates] and AIDS but they have specifically stated they do not wish to testify more than a couple of times.⁸⁰

In addition, some plaintiffs have accumulated 'tens of thousands' of pages of documents, many of them technical and complex, that need to be analyzed, computerized, and centralized.⁸¹

Notwithstanding class action litigation by hemophiliacs, plaintiffs who contracted HIV/AIDS from blood or blood products have no choice but to engage in costly and time consuming litigation. Unlike similarly-situated complainants in Canada, Great Britain and some Australian states, there is no choice between litigation and the acceptance of governmental compensation.

II. CANADA

On September 15, 1993, the Canadian provincial governments diverged from the United States view when they offered HIV/AIDS blood/blood product victims a compensation scheme.⁸² Claimants

1993, at 1 (discussing the alternative liability theory in contaminated blood cases).

76. *Id.*

77. *Id.* A federal judge in the Northern District of Illinois has also been assigned to preside over multi-district litigation throughout the country for purposes of discovery. *Id.*

78. *AIDS: Blood Factor Cases Should Be Consolidated in Florida Federal Court, MDL Petition Says*, 21 PROD. SAFETY & LIABILITY REP. 776, 776 (1993) [hereinafter *Blood Factor Cases*].

79. *Id.*

80. *Id.*

81. *Id.*

82. See Tanya Willmer, *Canada Offers More Cash for Some HIV-Infected People*, REUTER LIB. REP., Dec. 1, 1993 (reporting on recent action by most of Canada's provincial governments to provide compensation for individuals who contracted HIV from infected blood products).

had until March 15, 1994, to accept the offer. By March 19, 1994, 826 of the 910 eligible victims filed for government compensation.

Canada, unlike the United States, neither permits the sale of blood nor shields the identity of blood donors. Moreover, provincial governments have created a compensatory scheme for HIV/AIDS transfusion victims.⁸³ Presently, there are about 120 lawsuits against provincial governments and the Canadian Red Cross. The compensation offer is the conclusion of a major effort by the provincial governments, the Canadian Red Cross and insurance companies. From the total fund of \$151 million (Canadian), the approximately 1,000 infected individuals would receive an immediate payment of \$22,000 and an annual lifetime payment of \$30,000. Spouses and children of spouses would receive lesser payments for a period of five years.⁸⁴

Almost all litigation came to a standstill while plaintiffs considered whether to accept the offer.⁸⁵ Plaintiffs would have preferred to wait until they receive the results of a judicial inquiry begun in November 1993 into the Canadian blood system.⁸⁶ The inquiry will not be complete until—at the earliest—the end of 1994.⁸⁷ Should a victim accept the compensation, he must sign a waiver which would preclude any future litigation against either the government, the Red Cross, pharmaceutical companies or hospitals.

Two cases will apparently be unaffected by the provincial offers. In December 1993, a group of plaintiffs filed a class action suit against the Ontario Provincial Government and the Canadian Red Cross, which the court rejected because the claims “are highly individual in nature.”⁸⁸ The plaintiffs’ attorney insists that “for a large number of those affected, the compensation is both unfair and seriously inadequate, while the government’s requirement that all af-

83. *Id.*

84. *Id.*

85. See Andre Picard, *Terms of Deal Over Blood Draw Protests*, *GLOBE & MAIL*, Dec. 7, 1993, at A5 (discussing the public’s disapproval of the government’s compensation offer which requires HIV/AIDS victims to waive their right to bring legal action before the disclosure of judicial inquiry results). Nova Scotia only requires the release of the government from liability. The Law Society of Upper Canada has strongly suggested extreme caution in advising settlement. Press Release from The Law Society of Upper Canada, Feb. 28, 1994.

86. *Id.*

87. *Id.* Justice Horace Krever, head of the Commission of Inquiry on the Blood System in Canada, believes it will take almost two years to report the Commission’s findings. Tanya Willmer, *Canada Starts Inquiry Into Tainted Blood Scandal*, *REUTER LIB. REP.*, Feb. 14, 1994. A good summary of the Krever inquiry in Toronto last March appears in Warren Gerard, *Ending the Silence of Tainted Blood*, *Toronto Star*, Mar. 19, 1994, at B1.

88. Barry Brown, *Ontario Judge Disallows Joint Lawsuit by 732 Who Got HIV Via Tainted Blood*, *TORONTO STAR*, Feb. 21, 1994, at A5. Plaintiffs filed a notice of appeal on February 24, 1994.

fected people accept the package and sign a release—before all relevant information is available—is unconscionable.”⁸⁹ In the other case, *Estate of Pittman v. Bain*, the decedent contracted HIV in 1984 from a blood transfusion.⁹⁰ Although the physician learned the blood donor’s HIV status in 1989, he may not have informed Pittman “because it might further upset his health and because he didn’t think the couple were having sexual relations.”⁹¹ Unfortunately, Pittman, who Bain thought was impotent, continued to have sexual relations with his wife who also became HIV positive.⁹² In March 1994, the trial judge awarded the plaintiffs at least \$515,000—subject to calculation of Mrs. Bain’s lost income and future medical expenses.⁹³

In Canada, unlike the United States, it is common practice to sue the Canadian Red Cross and other defendants for breach of its warranty of fitness implied by the common law or by a provincial Sale of Goods Act.⁹⁴ Litigants may also sue in negligence, alleging the doctrine of *res ipsa loquitur* and that the defendant failed to screen, warn, or test. The plaintiffs may even claim the defendant was negligent in using blood from the United States since it “was less reliable and [less] protected from contamination than that of Canada in that the blood was bought from individuals creating a higher risk that blood would be obtained from persons with a higher than normal likelihood of HIV infection.”⁹⁵

The seminal Canadian case establishing a plaintiff’s liberal access to discovery concerning the blood donor is *Sharpe Estate v. Northwestern General Hospital*.⁹⁶ The plaintiff sued, *inter alia*, the Canadian Red Cross as a third-party defendant. In *Sharpe*, the plaintiff sought to compel the Red Cross to answer a series of questions which would require the Red Cross to produce a detailed list of blood and blood products supplied to the defendant hospital and

89. *HIV Class Action Launched to Serve People Affected by Tainted Blood Supply*, CANADA NEWSWIRE, Dec. 8, 1993.

90. For a discussion of *Pittman*, see D’Arcy Jenish & Diane Brady, *Lethal Blood; A Formal Search Begins for AIDS Virus Carriers*, MACLEAN’S, May 3, 1993, at 40. See also Brad Evenson, *Bad Blood’s Deadly Legacy*, OTTAWA CITIZEN, Sept. 11, 1993, at B1 (discussing the poor judgment of Pittman’s physician in failing to tell his patient of his possible HIV diagnosis).

91. Evenson, *supra* note 90, at B1; see also Wendy Darroch, *HIV Trial Hears Final Arguments*, TORONTO STAR, Feb. 3, 1994, at A24 (discussing *Pittman*).

92. *Id.* Pittman died from AIDS related pneumonia in 1990.

93. *Pittman v. Bain*, No. 21488/91U, slip op. at 311 (Ontario Ct. of Justice, Gen. Div., Mar. 14, 1994). Madam Justice Susan E. Lang found the doctor was responsible for forty percent of the plaintiff’s injury. *Id.* The blood bank and the hospital were each liable for twenty percent. *Id.*

94. *E.g.*, Sales of Goods Act, R.S.O., ch. 462 (1980) (Ont.).

95. Plaintiff’s Complaint at 10, *Gardner v. Canadian Red Cross*, No. 1636-93 (Ont. filed July 13, 1992).

96. 74 D.L.R. (4th) 43 (1990).

to produce a list identifying the donors from whom the blood or blood products could have come. The parties stipulated that there were about 1,250 donors from whom the blood and blood products originated. The Red Cross objected on two primary grounds: public policy arising from the need to protect the confidentiality of the donor and the claim of documentary privilege⁹⁷; and the high degree of inconvenience and expense to the Red Cross if the court ordered it to answer the questions.⁹⁸ Each side relied primarily on United States donor discovery cases.⁹⁹ On appeal, the Canadian High Court affirmed the master's requirement that plaintiff have his discovery and ignored United States cases, relying instead upon the Canadian Supreme Court case of *Slavutych v. Baker*.¹⁰⁰ In *Slavutych*,¹⁰¹ the Court placed a heavy burden on the party claiming privilege by requiring that it show "[t]he injury that would inure to the relation by the disclosure of the communications [is] greater than the benefit thereby gained for the correct disposal of litigation."¹⁰²

As a result of the *Sharpe* decision which essentially opened the door for disclosure of donor information, plaintiffs' attorneys and the Red Cross have agreed that the Red Cross and other defendants will pay the donor's attorneys fees. The donor's attorney will also accept service of process. The donor, if physically able, will testify at trial or at a video deposition. Often, a designated judge who has expertise in the matter will preside. The identity of the donor is confidential and the neither the parties nor the media may disclose his or her name.¹⁰³

*Gardner v. Canadian Red Cross*¹⁰⁴ presents a typical case,

97. *Id.* at 47.

98. The Red Cross estimated it would take one employee six months to complete the task. *Id.* at 58.

99. For example, the Canadian Red Cross relied on *Rasmussen v. South Florida Blood Servs., Inc.*, 500 So. 2d 533 (Fla. 1987), which held that disclosure of donor information would be contrary to the public interest of encouraging people to donate blood. *Sharpe*, 74 D.L.R. (4th) at 48. The plaintiff pointed to *Gulf Coast Regional Blood Ctr. v. Houston*, 745 S.W.2d 557 (Tex. Ct. App. 1988), where a court ordered the defendant to disclose to the plaintiff's attorney certain information regarding the donor of the HIV tainted blood. *Sharpe*, 76 D.L.R. (4th) at 54.

100. *Sharpe v. Northwestern Gen. Hosp.*, 76 D.L.R. (4th) 535 (1991) (affirming the lower court).

101. 55 D.L.R.(3d) 224 (1975).

102. *Id.* (citing 8 WIGMORE ON EVIDENCE ¶ 2285 (1961)) (emphasis in original).

The case settled out of court with all parties agreeing to say only that *Sharpe* is no longer before the courts.

103. See *supra* note 90, and accompanying text (discussing the *Pittman* court's efforts to protect the ill donor's privacy and accommodate his circumstances). In *Pittman*, the judge actually went to the hospital of the terminally-ill donor and conducted an evidentiary hearing.

104. No. 1636-93 (Ont. filed July 13, 1992).

brought by minor HIV positive plaintiffs through their guardians. The complaint names ten defendants and claims general and non-pecuniary damages of \$3 million and pecuniary damages of \$2 million arising from their contraction of HIV/AIDS through blood transfusions.¹⁰⁵ The parents, in their own names, claim \$250,000 in damages pursuant to the Family Law Act. The ten defendants include the Red Cross, drug-blood product manufacturers and distributors, as well as the physicians and hospitals involved. The plaintiffs allege that since 1982, the defendants knew, or should have known, of the risk of HIV via blood transmission and should have used testing to identify high-risk donors and isolate the infected blood. The defendants also allegedly failed to warn plaintiffs of the risks of HIV contamination and to afford plaintiffs an informed choice as to alternative methods of treatment. The plaintiffs' complaint alleges that the defendants took inadequate steps:

- a. to warn . . . of the risks they faced of HIV and AIDS from contaminated Factor VIII;

- c. to screen . . . potential donors and donated blood for those who had a high risk of carrying the HIV;
- d. to test . . . blood supplies "in stock" and blood collected . . . from donors for the presence of indicators of a high risk of HIV in the blood;
- e. to treat . . . blood supplies "in stock" and blood collected . . . from donors to destroy the HIV;

- h. to institute . . . heat treatment of blood products early enough to prevent . . . infection;

- k. to avoid the importation of blood, blood products or concentrated Factor VIII from the United States.¹⁰⁶

Undoubtedly, the verdict in *Pittman* may have had an impact on whether a claimant accepted the government's offer by March 15, 1994. At the very least, however, the HIV infected claimants had a choice as to whether to accept the alternative to time consuming litigation.

III. GREAT BRITAIN

While the Act of Union of 1707 created Great Britain, there are still significant differences between the English and the Scottish legal systems. For example, while the Secretary of State may play a major role in Scottish litigation, he has no similar counterpart in

105. Plaintiff's Complaint para. 1, 16, Gardner v. Canadian Red Cross, No. 1636-93.

106. Plaintiff's Complaint para. 16, 17, Gardner v. Canadian Red Cross, No. 1636-93.

English law. In England, government offers made to hemophiliacs (and reluctantly to those contracting HIV from transfusions) have led to acceptance by virtually all claimants. This has resulted in the near cessation of litigation. In the Republic of Ireland, the government has compensated HIV/AIDS transfusion victims, but left the door open to further litigation against blood product manufacturers who supplied government health authorities with infected blood products.

Within Great Britain, the most significant case has been *Re HIV Haemophiliac Litigation*.¹⁰⁷ This case involves over 900 plaintiffs, the majority of whom are hemophiliacs who contracted HIV through American Factor VIII blood products from commercial sources. Many of the plaintiffs are wives and children of the victims, some of whom are already deceased. In total, this case has involved 70 solicitors and 220 defendants. The crucial issues were whether the court would permit the disclosure of approximately 600 documents over claims of public immunity and whether the Department of Health and other defendants breached a duty owed plaintiffs. The complaint stated that the defendants went beyond mere negligence when they relied upon the United States blood supply. Specifically, plaintiffs alleged that defendants: (1) breached a duty by not achieving self-sufficiency in blood and therefore relying on the United States for HIV infected Factor VIII, especially since the United States allowed paid donors to contribute blood; (2) breached a duty by failing to exclude or screen donors, and (3) breached a duty by failing to use adequate heat treatment.¹⁰⁸ The Court of Appeal concluded the plaintiffs had "a good arguable" common law negligence claim.

Lord Justice Gibson wrote: "The task of the court is properly to balance the public interest in preserving the immunity on the one hand, and the public interest in the fair trial of the proceedings on the other. It has been said that the test is intended to be fairly strict."¹⁰⁹ Among the documents which Judge Gibson ordered disclosed were reports of Government ministers and officials concerning:

- 1(a)(i) Whether to adopt a policy of self sufficiency in blood products;
.....
- 1(b)(ii) What warnings to issue to blood donors in order to discourage those at risk from giving blood . . . ;
.....
- 1(b)(iii) How best to implement a procedure for the screening of blood donations;

107. *Re Haemophiliac Litigation*, Court of Appeal (Civil Division), Sept. 20, 1990, reprinted in THE INDEPENDENT, Oct. 2, 1990, at 8.

108. *Id.*

109. *Id.*

- 1(b)(iv) Whether, when and how to introduce the use of heat treated blood products;
- 1(b)(v) What steps to take to minimise the risk of hepatitis infection to haemophiliacs and others.¹¹⁰

Once the court granted most of the plaintiffs' discovery requests, there developed a tremendous pressure to settle. On remand, Mr. Justice Ognall, in pressing settlement, suggested the case had an ethical component which made it distinguishable and "increasingly notorious"¹¹¹ and necessitated the raising of "political considerations rather than purely legal ones."¹¹² He wrote: "It is rare that I take an initiative of this kind in civil litigation before me, but the circumstances of these actions are such that I have no hesitation in doing so, and in much more specific terms than might normally be expected or considered appropriate."¹¹³

By November, the government agreed to pay millions of pounds in compensation to claimants with individual figures ranging from £21,500 for an infected child to £60,500 for a married hemophiliac with at least one dependent child.¹¹⁴ The government also agreed to make small payments to HIV infected sexual partners of hemophiliacs and to surviving spouses.¹¹⁵ Later, the government awarded over £12 million to non-hemophiliacs who became HIV positive through transfusions or tissue transfers.¹¹⁶ Given the government's decision thirty days earlier to extend compensation only to HIV infected hemophiliacs, many viewed this abrupt change of position as a "U-turn" for political purposes.¹¹⁷

This new government compensation drastically reduced, but did not entirely eliminate litigation. In 1992, for example, a twelve-year-old hemophiliac sued the Birmingham Central District Health Authority, alleging: "The sellers of blood in the U.S. included a substantial proportion of drug abusers and homosexuals—the sort of people who were more prone to hepatitis B, a known risk in the 1970s, and to Aids [*sic*] when the epidemic struck at the end of the

110. *Id.*

111. Thomas Prentice, *Judge's Pressure Over HIV Victims*, THE TIMES (London), Oct. 1, 1990, at 1D.

112. *Id.*

113. *Id.*

114. See Francis Gibb, *Haemophiliac AIDS Children to Share £1.5m*, THE TIMES (London), May 10, 1991, at 6A (discussing the government's compensation offer). This amount was in addition to the £20,000 paid one year earlier to each infected hemophiliac. *Id.*

115. *Id.*

116. Robin Oakley, *Pounds for HIV Blood Victims*, THE TIMES (London), Feb. 17, 1992, at 16H.

117. See Clare Dyer, *Change of Heart on HIV Blood Victims; Non-Haemophiliacs With AIDS Virus to Get Compensation*, GUARDIAN, Feb. 17, 1992, at 3. As Margaret Jay, Director of the National AIDS Trust explained: "One has to be skeptical about the timing. Nothing has changed in the situation except the need to clear the decks before the next election." *Id.*

seventies. These simple truths ought to have been known to the health authority."¹¹⁸ After three days, the trial, which many expected to last several weeks, ended when the High Court approved a £75,000 settlement.¹¹⁹

In late 1993, a widow obtained legal aid in order to sue both the South Birmingham Health Authority which prescribed the drug AZT to her husband, a hemophiliac who contracted HIV/AIDS from infected blood products.¹²⁰ Susan Threakall claims that her deceased husband displayed no symptoms prior to taking the AZT in its prescribed doses.¹²¹ She alleges that her husband's condition deteriorated rapidly as a result of the medication.¹²² Although Threakall initially received legal aid to sue the South Birmingham Health Authority, she recently obtained public funding to bring suit against the AZT manufacturer, Wellcome, as well.¹²³

Three other plaintiffs who contracted HIV through blood transfusions are also seeking damages based on negligence. These plaintiffs named as defendants the Health Authority and the donor of the infected blood. Plaintiffs have sought to obtain the name of the donor and other confidential medical information from the Health Authority.¹²⁴

118. *Boy of 12 Sues Over HIV Contamination*, THE TIMES (London), Oct. 22, 1992.

119. *See HIV Boy Settles for £75,000*, PRESS ASS'N NEWSFILE, Oct. 24, 1992 (discussing the twelve-year-old's settlement with the Birmingham Central District Health Authority).

120. Peter Pallot, *Widow Wins Cash for AIDS Drug Fight*, DAILY TELEGRAPH, Aug. 31, 1993, at 5.

121. *Id.*

122. *Id.*

123. *See* Press Release from J. Keith Park & Co., Liverpool, Eng., Jan. 11, 1994 (announcing the decision of the Legal Aid Board of England to assist Mrs. Threakall in her suit against Wellcome). Threakall has also named as a defendant the National Institute of Allergic and Infectious Diseases, the United States agency that tested and promoted the drug. Neville Hodgkinson, *Court Battles Launched Over Anti-AIDS Drug*, THE TIMES (London), Jan. 30, 1994.

124. The Independent, Feb. 14, 1993 at 4. *Re HIV Haemophiliac Litigation* did not discuss the issue of donor discovery. That topic is discussed in Andrew Grubb & David Pearl, *Discovering the Identity of a Blood Donor*, NEW L.J., June 28, 1991, at 897 and July 5, 1991, at 938. The authors strongly argue:

There is a strong (perhaps, literally, a vital) public interest in maintaining an adequate blood supply. This underlying public interest, in itself, justifies maintaining the confidentiality of blood donors' records and identity.

We are persuaded by this argument and it has been accepted in principle in a number of American cases to justify total non-disclosure.

Id. at 899. The authors further conclude that those United States cases that allow limited donor discovery have "elaborate discovery orders and even if an English court were to adopt them, which we doubt, ultimately the interests that compete with the plaintiff's need for discovery are not given proper weight. Only acceptance of public interest immunity will achieve this." *Id.* at 938.

IV. SCOTLAND

In *AB v. Glasgow and West of Scotland Blood Transfusion Service*,¹²⁵ the plaintiff alleged that, in 1986, he received a tainted blood transfusion administered by the defendant. As a result, he contracted HIV/AIDS. He sought a court order requiring the transfusion service to disclose the name and address of the donor. The plaintiff sought this court order only:

[T]o enable him to raise an action of damages against the donor, on the ground that he negligently failed to disclose to the [blood bank] his high risk of HIV infection, negligently failed to complete accurately a health questionnaire which donors are asked to complete, and negligently donated blood for transfusion knowing that there was a high risk of it being infected.¹²⁶

The plaintiff also sued the blood bank for its allegedly inadequate screening procedures.¹²⁷

Not only did the defendant blood transfusion service oppose the plaintiff's request, but the Secretary of State for Scotland vigorously intervened "as [a representative of] the public interest by virtue of his responsibility under the National Health Service (Scotland) Act [of] 1978 to maintain and promote that service."¹²⁸ The Secretary insisted that disclosure should be prohibited "on the ground of public policy in order to ensure that there is and continues to be a sufficient supply of donor blood to the health service nationally."¹²⁹ According to the Secretary, the nation required the supply for "necessary and often emergency medical procedures in the treatment of illness . . ."¹³⁰ Furthermore, he argued disclosure would discourage prospective donors. Donors would stop giving blood out of fear that they might be open to a lawsuit "on the basis of some adverse effect resulting from the use of the blood for transfusion purposes."¹³¹ Lord Justice Morison questioned:

Why [would] such persons . . . be deterred from pursuing these motives by an apprehension that they might be unjustifiably sued[?] *If on the other hand there are any persons who give blood without due regard to their responsibilities, the public interest would plainly be served if they were discouraged from doing so.* But as was conceded on behalf of the petitioner that I was not entitled to investigate the validity of the conclusion expressed by the Secretary of State unless it appeared that the conclusion was patently unreasonable or had been expressed on an erroneous basis, and this obviously cannot be said in the present case.¹³²

125. SCOTS L. TIMES, Jan. 15, 1993, at 36.

126. *Id.* at 37.

127. *Id.*

128. *Id.*

129. *Id.*

130. SCOTS L. TIMES, *supra* note 125, at 37.

131. *Id.*

132. *Id.* (emphasis added).

Lord Justice Morison reiterated Scottish law which precludes a Scottish court from using its inherent power to override the objection of a government minister "upon the basis of an assessment of the merits of the objection."¹³³ Thus the court concluded that infringement of donor anonymity would place the Scottish blood supply at risk. A plaintiff's right to seek damages should be subordinate to "a material risk to the sufficiency of the national supply of blood for purposes of transfusion."¹³⁴ Lord Justice Morison clearly had reservations about his decision when he wrote:

[I]t is offensive to any notion of justice that persons should be deprived of the ability to claim damages from those by whose negligence they have been injured. If public policy requires this, it seems to me that it would be reasonable for public policy to provide also some alternative means of compensation.¹³⁵

But for the Secretary of State's intervention, he would have required disclosure:

The court's approach to [the blood transfusion service's] objection would be different from that which applies to a ministerial objection based on the public interest. In particular, it would in my opinion be legitimate for the court to consider and assess the merits of the respondents' objection in light of the nature of the work which they perform, so as to determine whether or not the petitioner's interest should prevail over that objection. This would involve consideration of the quality of the evidence upon which the respondents rely, and it might also involve a determination whether their own procedures are adequate to support the immunity which they say ought to be accorded to donors.¹³⁶

Technically, the above case is still before the courts, but it has been stayed to enable the plaintiff to obtain further expert medical advice. In fact, the plaintiff has applied for compensation under the government scheme and many believe that once the plaintiff receives compensation, the above action will be formally terminated.¹³⁷

V. IRELAND

Approximately half of the hemophiliacs in Ireland, who are HIV positive, have sued the Irish government which was responsible for the distribution of Factor VIII.¹³⁸ The government awarded each claimant approximately 80,000-100,000 L.I.R. which was sig-

133. *Id.*

134. *Id.*

135. SCOTS L. TIMES, *supra* note 125, at 37.

136. *Id.* at 38.

137. Interview with Lord Abernethy, Judge of Court of Sessions, Scotland (formerly Alistair Cameron, Q.C., attorney for the blood bank in *AB v. Glasgow and West of Scotland Blood Transfusion Serv.*), in New Orleans, LA (Oct. 11, 1993).

138. *Doe v. Hyland Therapeutics Div.*, 807 F. Supp. 1117 (S.D.N.Y. 1992).

nificantly higher than the British settlement. Approximately eighty plaintiffs also decided to sue the three American companies that produced the HIV tainted Factor VIII blood clotting products.¹³⁹ The defendant corporations removed the cases to federal court. The judge in *Doe v. Hyland Therapeutics Div.* decided that New York was not the most convenient forum.¹⁴⁰ The court applied the principles of *forum non conveniens* and concluded that plaintiffs should litigate in Ireland, and if for any reason they were unable to sue in Ireland, the federal court would again consider accepting jurisdiction.¹⁴¹ Contrary to the wishes of the plaintiffs, the High Court in the Republic of Ireland accepted jurisdiction and concluded that fifty-four plaintiffs could obtain justice in Ireland.¹⁴² The plaintiffs previously hoped either that Ireland would decline jurisdiction or that Ireland would exercise jurisdiction and apply American law. The Supreme Court of Ireland affirmed the High Court on March 9, 1994.¹⁴³ One problem for litigants in the Republic of Ireland is that Ireland does not accept alternate share or market share liability. Additionally, there are significant discovery problems because Ireland does not allow the taking of depositions.¹⁴⁴ Furthermore, Ireland does not recognize a cause of action for pain and suffering on behalf of the decedent's estate.

VI. AUSTRALIA

Unlike the United States, all Australian states, except New South Wales, have settled claims for those infected with HIV tainted blood. Similar to decisions in Great Britain and perhaps Canada, the overwhelming majority of Australian cases have been settled. This is a clear preference for the lower cost of settlement over the high cost of legal services. Whether new Australian legislation will permit strict liability claims is uncertain. This may result in costly, time consuming, and unpredictable lawsuits.

In a major case on blood bank liability, *E v. Australian Red*

139. *Id.*

140. *Id.* at 1125.

141. See *Group Seeks US Hearings for HIV Actions*, IRISH TIMES, July 30, 1993, at 2; *Drug Firms Fight Transfer of Case*, IRISH TIMES, Aug. 5, 1993, at 2; *Court Told HIV Cases Should Be Tried Here*, IRISH TIMES, Aug. 6, 1993, at 2; *Haemophiliacs Fail to Have Case Against Firms Heard in U.S.*, IRISH TIMES, Aug. 28, 1993, at 2 [hereinafter *Haemophiliacs Fail*].

According to the federal decision in the United States, the defendants, with the approval of the Irish court, had to waive the Statute of Limitations, accept service of process, and allow discovery within the bounds of the Federal Rules of Civil Procedure. *Doe*, 807 F. Supp. at 1133.

142. *Haemophiliacs Fail*, *supra* note 141.

143. *Irish Court to Deal with Haemophiliacs' Claims*, IRISH TIMES, Mar. 9, 1994, at 4.

144. *Doe*, 807 F. Supp. at 1123.

Cross Society,¹⁴⁵ the court rejected the expedited claim of "E" against the above three defendants.¹⁴⁶ "E" had an operation in October 1984, eleven days after the tainted blood donation. In essence, the plaintiff argued that the blood bank's screening of the donor was inadequate and that the blood bank should have utilized surrogate testing. Both sides presented expert witnesses from the United States and cited American publications as authority.¹⁴⁷ The plaintiff also argued that the Trade Practices Act¹⁴⁸ enabled him to sue for breach of implied warranties of merchantability and fitness for a particular purpose.

Both the trial court and the full federal court examined the detailed questionnaire requesting that donors who were at risk not give blood and concluded that, whatever inadequacies this form might have had, the use of the form would not constitute negligence.¹⁴⁹ Both courts also concluded that under all the circumstances it was not mandatory for the Red Cross to introduce surrogate testing. The Federal Court of Australia held:

There was no reported Australian blood transfusion AIDS case until . . . July 1984. In contrast to the United States, where haemophilic AIDS cases emerged at the very beginning of the epidemic, there was no reported Australian haemophilic AIDS case until the end of 1984. I do not think that these differences sufficiently explain the failure of the Australian authorities even to investigate the possibility of surrogate testing. But, in determining what decision about anti-HBc testing ought to have been made, if the issue had been discussed, it is relevant to remember that there was then a mood of optimism about the extent of the problem in this country. As late as December 1984, a publication of the AIDS Task Force quoted the risk of contracting AIDS through blood transfusion at about one in 100,000.¹⁵⁰

The court also dismissed the implied warranty allegations. It noted that blood banks "do not actually conduct trade in blood" and held that the supplying of blood or blood products is not an act in commerce.¹⁵¹ In addition, the court noted the absence of a contract between the plaintiffs and the blood banks.¹⁵² The full federal court basically reiterated the holding of the trial court and Judge Lockhart favorably cited a seminal decision in the New York Court of Appeals which established that the transfusion of blood to a pa-

145. 99 A.L.R. 601 (1991), *appeal denied*, 105 A.L.R. 53 (1991).

146. *Id.* at 612.

147. For example, the plaintiff utilized the testimony of Dr. Ed Engleman, Director of Stanford Medical School Blood Center. *Id.* at 612. Dr. Engleman was one of early advocates of the necessity of blood bank testing.

148. Trade Practices Act, AUSTRAL. ACTS P. §§ 71, 74 (1974).

149. *E v. Australian Red Cross*, 99 A.L.R. 601, 655, *aff'd*, *E v. Australian Red Cross*, 105 A.L.R. 53, 59 (1991).

150. *E v. Australian Red Cross*, 99 A.L.R. at 663.

151. *Id.* at 641.

152. *Id.* at 643.

tient is part of service and not a sale of goods.¹⁵³

Other Australian cases have also denied plaintiffs relief. In *Dwan v. Farquhar*,¹⁵⁴ an HIV positive plaintiff became infected as the result of a May 31, 1983, operation, but was not diagnosed HIV positive until December 23, 1986. On February 6, 1987, he sued the surgeon, the hospital and the Australian Red Cross Society. According to the court, the plaintiff could have overcome the restrictions of the Statute of Limitations if, and only if, "it appear[ed] to the Court that there [was] evidence to establish the right of action."¹⁵⁵ In affirming the Chamber Judge's dismissal of plaintiff's claim, the court concluded that on "31 May 1983 there was no test available through which it could be established whether or not a particular person was an AIDS carrier or whether or not a particular blood product was contaminated by AIDS."¹⁵⁶ Thus the blood bank could not have taken any action to eliminate high-risk donors. The court wrote:

It is purely guesswork whether the donor of the blood containing the virus was a high-risk or low-risk person, whether his condition could have been known to him let alone to the authorities, or whether the discouragement of high-risk donors would have prevented this unfortunate occurrence. In the absence of any identification of the relevant AIDS agent or of any screening test it is impossible to suggest any action which the Blood Bank should have taken at that time which would probably have prevented the chain of circumstances which led to the appellant's condition.¹⁵⁷

The court also rejected the plaintiff's *res ipsa loquitur* argument when the plaintiff failed to establish negligence.¹⁵⁸

In *H v. Royal Princess Alexandra Hospital for Children*, the court concluded the defendant utilized proper blood collecting procedures and, thus, denied relief to a sixteen-year-old hemophiliac who had become HIV positive from infected Factor VIII.¹⁵⁹ In "*PQ*" *v. Australian Red Cross Society*, a jury concluded that the Red Cross was not negligent because the blood bank acted in accordance with current blood bank standards.¹⁶⁰

153. *E v. Australian Red Cross*, 105 A.L.R. at 59 (citing *Perlmutter v. Beth David Hosp.*, 123 N.E.2d 792 (N.Y. 1954)).

154. 1 Q.R. 234 (1988).

155. *Id.* at 239 (Thomas, J.).

156. *Id.* at 238 (Mathews, J.).

157. *Id.* at 244 (Thomas, J.).

158. *Id.* at 241.

159. *Roger S. Magnusson, Public Interest Immunity and the Confidentiality of Blood Donor Identity in AIDS Litigation*, 8 AUSTL. B. REV. 226, 228 n.9 (1991-92) (citing AUST. TORTS REP. 81-000).

160. *PQ v. Australian Red Cross Soc'y*, 1 V.R. 19, 33 (1992). The Supreme Court of Victoria examined the particular duty which the Red Cross owed to the plaintiff and concluded that there had been no breach. The court stressed:

[W]hether [the Red Cross] fell short of the required standard of care is to be tested, not by reference to a reasonable person with the defendant's actual resources of staff, facilities and finance, but by reference a reasonable per-

The only major reported case providing a remedy to a plaintiff was *BC v. Australian Red Cross Society*.¹⁶¹ In *BC*, the plaintiff sued the Red Cross for negligently failing to screen the October 1984 blood donation for high-risk donors. The plaintiff succeeded in obtaining a court order mandating that the Red Cross disclose the name, address, sex, age, and occupation of the HIV-infected blood donor. In finding for the plaintiff, the court balanced competing interests involving the Red Cross' claim of public interest immunity¹⁶² and "the harm to the administration of justice which would be caused by non-disclosure."¹⁶³ In mandating disclosure, the court doubted that donors "would be so upset by limited, judicially-supervised disclosure that the blood supply would be jeopardised,"¹⁶⁴ while "the disclosure of material evidence was of 'considerable public importance.'"¹⁶⁵ The case settled, but left open the issue as to whether a plaintiff could sue an HIV positive donor personally if he provided "false or misleading information" to the Australian Red Cross.¹⁶⁶ However, it is uncertain whether defendant blood banks will continue to succeed. In many recent cases, plaintiffs allege violations of consumer protection regulations such as the Trade Practices Act, which classifies blood as a regular good in commerce.¹⁶⁷

Perhaps more significant than recent legislative enactments is the increasing willingness of Australian states to compensate HIV transfusion victims. By early 1991, the State of Victoria paid the equivalent of \$16.7 million to 109 blood product/plasma victims.¹⁶⁸

son with adequate resources available to conduct the enterprise in which the Red Cross was engaged.

Id. Thus, the court refused to hold the Red Cross to the elevated standard of care which the plaintiff argued was appropriate. *Id.*

161. *BC v. Australian Red Cross Soc'y*, Supreme Court of Victoria, 25 February 1991, *appeal dismissed*, *Australian Red Cross Soc'y v. BC*, Supreme Court of Victoria, 7 March 1991. For judicial comment on the "reasonable and proper" settlement, see *Australian AIDS Victims Receive Landmark Out-of-Court Payment*, REUTERS, May 22, 1991 [hereinafter *Australian AIDS Victims*]. The judge further said: "There are many tragic cases which come before this court, but few as tragic as this."

162. See Magnusson, *supra* note 159, at 233 (pointing out that, pursuant to the court's holding in *BC*, "HIV-infected donors are protected from liability for injury caused by their donated blood unless they have provided false or misleading information").

163. *Id.* at 233. The Red Cross' main contention was that the disclosure of the donor's identity "was a breach of anonymity which would cause apprehension amongst donors, who, fearing public embarrassment, investigation and possible litigation, would thereafter be reluctant to donate blood." *Id.*

164. *Id.* at 232. The plaintiff argued she could not enforce her legal rights without access to the donor's identity. *Id.*

165. *Id.* at 236.

166. *Id.* at .

167. See Magnusson, *supra* note 159, at 227 (discussing the role of consumer statutes in AIDS litigation); see also *E. v. Australian Red Cross*, 99 A.L.R. at 61 (discussing the plaintiff's allegations of breach of warranty and negligent misrepresentation under the Trade Practices Act).

168. 1992 WORLD INSURANCE REPORT, January 31, 1992.

The average payment amounted to \$153,000.¹⁶⁹ In May 1991, Western Australia agreed to award \$4.2 million (United States) to twenty-two HIV positive transfusion victims for an average payout of approximately \$200,000.¹⁷⁰ At the end of 1992, Queensland paid thirty-four HIV positive victims \$5.04 million by for contaminated blood infection; the average payment was \$148,000 and the highest payment was \$315,000.¹⁷¹ A combination of humanitarianism and a desire to save millions of dollars in legal costs led the various governments to set up these compensation procedures.

VII. CONCLUSION

Various countries have shown that litigation is not the most viable way to resolve HIV transfusion cases. One alternative that works well is arbitration conciliation. In Massachusetts, the family of an employee who became HIV positive as a result of a blood transfusion sued several defendants.¹⁷² A lawyer/conciliator managed to get all parties to settle for \$1.15 million with the burden shared by several defendants.¹⁷³ Another viable alternative to litigation involves the creation of a compensatory system similar to the National Vaccine Injury Compensation Program.¹⁷⁴ This would provide swift, certain compensation to HIV transfusion victims while they are still alive. There has also been discussion of no-fault compensation based on the British model as well as the National Vaccine Injury Compensation Program.¹⁷⁵ Although the best approach to the HIV transfusion litigation may not be certain, it is becoming increasingly clear that there is an urgent need for an effective solution to the complicated litigation problems in the American cases.

169. *Id.*

170. See *Australian AIDS Victims*, *supra* note 161.

171. *HIV Victims Paid Millions of Dollars*, XINHUA GEN. OVERSEAS NEWS SERV., Dec. 23, 1992.

172. See Barbara Rabinovitz, *Case Illustrates Benefits of System*, MASS. LAW. WKLY., Dec. 7, 1992, at 3.

173. *Id.*

174. See Keith M. Garza, *Administrative No-Fault Recovery for Transfusion-Related HIV Infection*, 60 DEF. COUNSEL J. 384 (1993) (discussing the compensation of HIV transfusion victims without a showing of the provider's fault). In his study of alternatives to litigation in cases involving HIV-infected persons, Garza refers to the National Vaccine Injury Compensation Program, 40 U.S.C. §§ 300aa et seq. (1986), which permits children to recover on a no-fault basis for injuries incurred during vaccinations. Garza, *supra*, at 385.

175. *Recent Report Analyzes the Safety of Our Blood Supply*, MICH. LAW. WKLY., Nov. 9, 1992, at 21.

