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RECENT DEVELOPMENTS

TORTS—STRICT LIABILITY—A Hospital Is Strictly Liable for Transfusions of Hepatitis-Infected Blood—Cunningham v. MacNeal Memorial Hospital*

While undergoing treatment at MacNeal Memorial Hospital in Chicago, Illinois, Mrs. Frances Cunningham was given several transfusions of whole blood. Apparently, some of the blood contained the virus of homologous serum hepatitis because Mrs. Cunningham was afflicted with that disease and forced to lengthen her stay in the hospital. She sued the hospital for 50,000 dollars on the allegation that the blood used in the transfusions “was defective and in an unreasonably dangerous condition.” The hospital defended on the ground that Mrs. Cunningham’s action was based on a theory of strict liability inapposite to blood transfusion cases. The trial court agreed and dismissed the complaint, but the appellate court reversed, holding that blood is a product subject to the doctrine of strict liability when sold. Significantly, however, the appellate court declined to determine whether the blood could have been made safe. Thus, the appellate court left open the issue whether the hospital might escape liability if it could show that the blood was incapable of being rendered safe.

* 47 Ill. 2d 443, 266 N.E.2d 897 (1970) [hereinafter principal case]. The appellate court decision, reversing a judgment on the pleadings for the defendant, is reported at 113 Ill. App. 2d 74, 251 N.E.2d 733 (1969).

1. Hepatitis is an inflammation of the liver. I ATTORNEY’S DICTIONARY OF MEDICINE 401 (1969). Homologous serum hepatitis is caused by a parenteral (through the blood stream) introduction of a filterable agent known as virus B. Its effects can vary from virtually none to severe illness and death. 2 R. Gray, ATTORNEY’S TEXTBOOK OF MEDICINE ¶ 38.30-37 (3d ed. 1970); J. Schmidt, ATTORNEY’S DICTIONARY OF MEDICINE AND WORD FINDER 357 (1965); C. Taber, TABER’S CYCLOPEDIC MEDICAL DICTIONARY, H-28 (9th ed. 1963). The condition is also known as serum hepatitis, homologous serum jaundice, serum jaundice, inoculation jaundice, transfusion jaundice, post-vaccinal hepatitis, post-vaccinal jaundice, and late arsphenamine jaundice. See J. Schmidt, supra at 357; M. Spellberg, DISEASES OF THE LIVER 256 (1954). Serum hepatitis is clinically and pathologically indistinguishable from infectious hepatitis, but the latter disease is contracted through the mouth and intestinal tract and has a shorter incubation period (10-40 days, as opposed to 45-160 days for serum hepatitis). M. Spellberg, supra at 257. Serum hepatitis can also be transmitted by blood on any instrument that pierces the skin. There are some recent indications that hepatitis may be spread by direct and indirect contact as well as through transfusions and contaminated needles. See N.Y. Times, Feb. 7, 1971, § 1, at 70, cols. 3-4.

2. 113 Ill. App. 2d at 75-76, 251 N.E.2d at 733-34. The substantive portions of the plaintiff’s complaint are reproduced in the appellate court opinion.

3. 113 Ill. App. 2d at 85, 251 N.E.2d at 738.

4. Since the case was before the appellate court on appeal from a judgment on the pleadings, the appellate court properly held that a decision on this question would have been premature, 113 Ill. App. 2d at 86, 251 N.E.2d at 739.

5. The appellate court was apparently implying that a possible defense could be
All such lingering doubts, however, were put to rest by the Illinois supreme court. In an unprecedented decision based primarily upon the Restatement (Second) of Torts section 402A, it agreed with the appellate court that blood is a product and that a transfusion is a sale within the meaning of the Restatement. But the supreme court went further and announced that the “unavoidably unsafe” exception of comment k to the Restatement could not provide the hospital with a valid defense. Comment k, according to the supreme court,” relates only to products which are not impure and which, even if properly prepared, inherently involve substantial risk of injury to the user.” Since hepatitis-infected blood is by definition impure, comment k could have no bearing on the case. By reading the comment so narrowly, the Illinois supreme court imposed strict liability on hospitals for transfusions of blood carrying the serum hepatitis virus. This Recent Development will briefly trace the development of hospital liability for transfusions of hepatitis-infected blood and will analyze both the impact of Cunningham on that area of the law and the correctness of the Cunningham decision.

6. Section 402A provides:
Special Liability of Seller of Product for Physical Harm to User or Consumer
1. One who sells any product in a defective condition unreasonably dangerous to the user or consumer or to his property is subject to liability for physical harm thereby caused to the ultimate user or consumer, or to his property, if
(a) the seller is engaged in the business of selling such a product, and
(b) it is expected to and does reach the user or consumer without substantial change in the condition in which it is sold.
2. The rule stated in Subsection (1) applies although
(a) the seller has exercised all possible care in the preparation and sale of his product, and
(b) the user or consumer has not bought the product from or entered into any contractual relation with the seller.
Restatement § 402A, at 347-48 (emphasis added).

7. Restatement § 402A, comment k at 353-54 provides in full:
Unavoidably unsafe products. There are some products which, in the present state of human knowledge, are quite incapable of being made safe for their intended and ordinary use. These are especially common in the field of drugs. An outstanding example is the vaccine for the Pasteur treatment of rabies, which not uncommonly leads to very serious and damaging consequences when it is injected. Since the disease itself invariably leads to a dreadful death, both the marketing and the use of the vaccine are fully justified, notwithstanding the unavoidable high degree of risk which they involve. Such a product, properly prepared, and accompanied by proper directions and warning, is not defective, nor is it unreasonably dangerous. The same is true of many other drugs, vaccines, and the like, many of which for this very reason cannot legally be sold except to physicians, or under the prescription of a physician. It is also true in particular of many new or experimental drugs as to which, because of lack of time and opportunity for sufficient medical experience, there can be no assurance of safety, or even perhaps of purity of ingredients, but such experience as there is justifies the marketing and use of the drug notwithstanding a medically recognizable risk. The seller of such products, again with the qualification that they are properly prepared and marketed, and proper warning is given, where the situation calls for it, is not to be held to strict liability for unfortunate consequences attending their use, merely because he has undertaken to supply the public with an apparently useful and desirable product, attended with a known but apparently reasonable risk.

8. 47 Ill. 2d at 455, 266 N.E.2d at 904.
The disease that allegedly caused Mrs. Cunningham her anguish has afflicted man for centuries, but not until the 1940's was it discovered that the causative virus could be introduced by the transfusion of blood. While hepatitis is not the only disease that can be transmitted by blood transfusion, it does represent one of the most serious risks associated with this treatment because of its frequency of occurrence, its undetectability, and the present lack of vaccines and other satisfactory methods of prevention.


10. See R. Gray, supra note 1, ¶ 38.35.

11. Other diseases that can be transmitted parenterally include malaria, syphilis, measles, and influenza. See Wiener, Medicolegal Aspects of Blood Transfusions, 151 J.A.M.A. 1495, 1498 (1955). These diseases, however, do not pose the serious threat that hepatitis does because they are readily detected when proper procedures are employed. See Van Wormer, Blood Transfusion Therapy, Pitfalls and Practice, Med. Trial Tech. Q., June, 1968, at 57-60.

12. Although there is agreement that the frequency of blood transfusions and the incidence of serum hepatitis resulting therefrom are such that the disease presents a very serious medical problem, the estimates demonstrate considerable divergence of opinion on what the contractual rate actually is. Thus one encounters contentions ranging from an infection rate of 3% in whole blood, R. Gray, supra note 1, ¶ 38.35, to one of 25%, Wiener, Prevention of Accidents in Blood Transfusions, 156 J.A.M.A. 1301, 1805 (1954). Others include .39%, 9 Traumatic Medicine & Surgery for the Attorney 110 (1959); 28% to 39%, VanMeveren, The Extension of Liability to Service Contracts—Emphasizing the Furnishing of Unfit Blood for Transfusion, 6 Am. Bus. L.J. 517, 518 (1968); and .1 to 1% “at most,” Butterich & Wilson, supra note 9, at 67. With the use of blood plasma the rate jumps to around 12%. VanMeveren, supra at 518.

The hepatitis-related fatality figures similarly show a difference of opinion, with some commentators asserting a rate of 5½% of those contacting the virus, Wiener, supra note 11, at 1037. Others estimate 6%, 9 Traumatic Medicine & Surgery for the Attorney, supra at 110; and 12%, Chalmers, Koff & Grady, A Note on Fatality in Serum Hepatitis, 49 Gastroenterology 23 (1965). The last cited article is the most complete study of the subject of those listed. In translating these percentages into numbers of patients affected one recent article summarized as follows:

Several studies on representative numbers of recipients of blood transfusions lead to estimates of 30,000 cases of serious overt illness and 1,200 to 3,000 deaths from transfusion-associated viral hepatitis [meaning in this instance serum hepatitis] each year in the United States. However, there is evidence that the reporting of the overt disease is incomplete and that the incidences of illness and mortality that it causes may be much higher. Also, it is estimated that the ratio of subclinical hepatitis cases associated with transfusion to cases of the overt disease may be as high as 5:1.

Panel of the Committee on Plasma and Plasma Substitutes of the Division of Medical Sciences, Statement on Laboratory Screening Tests for Identifying Carriers of Viral Hepatitis in Bloodbanking and Transfusion Services, 10 Transfusion 1-2 (1970) [hereinafter TRANSFUSION].

All of the above statistics are, of course, subject to the limitations of the studies that produced them, and this in part may explain the differences. Specifically, age of the recipient, source of the blood, number of transfusions given, and procedures employed by hospital and hospital can and do significantly affect the findings. See generally Chalmers, Koff & Grady, supra.

13. See note 16 infra.

14. Mosely & Galambos, Viral Hepatitis in Diseases of the Liver 410 (L. Schiff 3d ed. 1969) surmise at 468 that “[t]ransfusion-associated hepatitis, at least in relation to whole blood and some blood products, cannot be eliminated.” Furthermore, “[f]or the foreseeable future . . . no vaccine is likely to be available against . . . serum hepa-
Although there has been some literature heralding possible new effective discovery procedures, the majority of professional sentiment concedes that at this point in time there exists no foolproof analytical test or diagnosis that can identify the virus in a carrier. A carrier need never have contracted the disease, yet he can carry the virus indefinitely and pass it to numerous recipients should he habitually give blood. Moreover, despite some indications pointing to the possibility of controlling the virus, it is acknowledged that there is no certain means of rendering the virus harmless or expunging it from the blood, plasma, or serum that is to be transfused.

... For serum hepatitis, active immunization of the general population may not be feasible even if a vaccine is developed, because of numerous practical problems.


16. “Although many large efforts have been made to identify blood which has a high risk of transmitting hepatitis, there is still no proved method for identifying the hepatitis carriers.” Walsh, Purcell, Morrow, Chanock & Schmidt, Posttransfusion Hepatitis After Open-Heart Operations, 211 J.A.M.A. 261, 265 (1970). This is not to say that no carrier can be identified. Some demonstrate an overt illness that would call for immediate disqualification, while others have abnormalities discoverable by means of liver function tests. See Mosley & Galambos, supra note 14, at 420. Estimates of detection rates range from 25 to 75%. Butterich & Wilson, supra note 9, at 70. One study states that the only laboratory screening test, currently available or proposed, that offers any promise of useful application by blood-banking and transfusion services in identifying the long-incubation [serum] form of hepatitis carriers is a test for the presence of Australia antigen in blood.

Gocke & Kavey, Hepatitis Antigen, Correlation of Disease with Infectivity of Blood Donors, 1 THE LANCET 1055 (1969). The same study points out that at the current level of sensitivity, only about one-fourth of the cases can be detected by this means. All agree that there exists no certain method of identifying contaminated individuals. See, e.g., R. Gray, supra note 1, ¶ 38.35; Mosley & Galambos, supra note 14, at 420; Wiener, supra note 12, at 1305.

17. Mosley & Galambos, supra note 14, at 420; Wiener, supra note 12, at 1305.

18. Wiener, supra note 11, at 1438.

19. See, e.g., 279 NEW Eng. J. Med. 1290 (1968), where the director of a Red Cross Blood Program stated preliminary results from a Massachusetts survey indicated that by “packing” the red blood cells a much lower incidence of hepatitis was achieved. Other factors cited as possible mitigating influences are storage at room temperatures over a period of several months and plasma irradiation. See R. Gray, supra note 1, ¶ 38.35.

20. Butterich & Wilson, supra note 9, at 67 states: [Blood products have been used in large quantities only during the last 30 years ... and] there has been a striking rise in the number of cases of serum hepatitis reported yearly. Unlike diseases which are becoming more prevalent for unknown reasons, the increased incidence of serum hepatitis can be traced to epidemiologic factors which we simply have been unable thus far to control.

Mosley & Galambos, supra note 14, at 429-30, further explains: The repeated attempts to find processes for inactivating the viruses of hepatitis in pooled plasma have been unavailing. Initially ultraviolet irradiation appeared to be effective as judged by the results of human volunteer experiments. Subsequent
Thus, although a hospital may be careful in its selection of donors and meticulous in its methods of storage and administration, it is still quite possible that a patient may contract hepatitis and perhaps die if he has been injected with hepatitis-infected blood.

The lack of effective methods to discover and eliminate the virus makes it difficult for plaintiffs to prove a failure by hospitals to exercise reasonable diligence. Thus, attempts to hold hospitals liable for transfusions of hepatitis-contaminated blood based on a theory of negligence have been largely unsuccessful.21 The same want of preventive techniques renders a res ipsa loquitur assertion ineffective.22 A further obstacle encountered in some jurisdictions is the rule that the doctrine of respondeat superior cannot be used to hold a hospital liable for negligent harm inflicted by a physician or medical employee while rendering professional services.23 Finally, actions based on a theory of negligence per se24 or on the hospital’s experience . . . has demonstrated that plasma so treated, at least under conditions of commercial production, still has a higher than average risk. Similarly, initial work with storage for 6 months at “room” temperature, or under more carefully controlled conditions at 31.6° C (90° F), suggested that such material was safe, but a carefully controlled prospective investigation showed that this process was also ineffective. Irradiated pooled plasma treated with betapropiolactone is reportedly safe, but the study has not been confirmed and the material is commercially unavailable. No effective method for sterilizing fibrinogen or anti-hemophilic globulin preparations is available.

23. See Becker v. City of New York, 2 N.Y.2d 226, 232-33, 140 N.E.2d 262, 266, 159 N.Y.S.2d 174, 180 (1957), in which the court stated:
   . . . [A] hospital . . . [is] immune from liability predicated on the doctrine of respondeat superior, when a patient at the hospital is injured as the result of a medical act performed by an employee of the hospital in the course of treating the patient . . . The rationale for . . . [this] is that the hospital employee when performing a medical act is an independent contractor to the patient . . . The theory is that the hospital does not undertake to heal but merely to make healers available.
24. See, e.g., Merck & Co. v. Kidd, 242 F.2d 952 (6th Cir. 1957) (transfusion of hepatitis-contaminated blood not a sale of a "filthy substance" within the meaning of the Tennessee Food, Drug and Cosmetic Act); Hoder v. Sayet, 196 S.2d 205 (Fla. Ct. App. 1967) (not negligence per se for a hospital to purchase or obtain blood from commercial blood bank although such purchases may have increased the risk that the blood was contaminated).
failure to warn the patient of the dangers inherent in a transfusion have not been successful.

The lack of success in negligence suits prompted plaintiffs to base their actions on theories of implied warranty and strict liability. However, a sale-service dichotomy that developed within the implied warranty doctrine generally proved fatal to plaintiffs’ claims based on that theory. The sale-service dichotomy was first used to defeat a claim for damages resulting from a transfusion of hepatitis-infected blood in Perlmutter v. Beth David Hospital. In that case, the defendant hospital had furnished blood for use in a transfusion. Plaintiff contracted serum hepatitis and sued the hospital for breach of implied warranty. Recovery was denied. The New York Court of Appeals reasoned that the contract between the plaintiff and the defendant hospital was essentially one for services. Moreover, the contract was not divisible even though it provided that the hospital should supply certain “healing materials” such as medicines, drugs, and even blood. The court concluded, therefore, that there was no sale to which an implied warranty could attach.

Perlmutter has unquestionably been the most influential decision in this area of the law. Although often criticized and recently re-

26. For a discussion of the development of the implied warranty theory, see W. Prosser, supra note 22, § 97, at 678-81.
27. For a discussion of the theory of strict liability, see W. Prosser, supra note 22, §§ 74-79, at 672-73, § 87, at 672-85. It should be borne in mind that strict liability does not mean absolute liability. Under the latter theory, causation and harm alone furnish the basis for recovery. See Sweet v. State, 195 Misc. 494, 500-01, 89 N.Y.S.2d 506, 514 (Ct. Cl. 1949). Under strict liability, which is not founded upon negligence, there is still a dual requirement of (1) a defective product that is (2) unreasonably dangerous. See, e.g., Restatement § 402A; Wade, Strict Tort Liability of Manufacturers, 19 Sw. L.J. 1, 13 (1965).
28. The sale-service dichotomy is one of the contractual rules associated with implied warranty that is criticized by W. Prosser, supra note 22, § 95, at 655. Essentially, the sale-service rule states that implied warranties can only attach to a contract for the sale of products. Therefore, if the contract in any particular case is essentially one for services, there is no implied warranty. For examples of the application of this dichotomy in areas other than blood transfusion cases, see Consolidated Timber Co. v. Womack, 132 F.2d 101 (9th Cir. 1942); Child’s Dining Hall Co. v. Swingler, 173 Md. 490, 197 A. 105 (1938); Pappanastos v. State Tax Commn., 255 Ala. 50, 177 S. 158 (1937).
29. See cases cited in note 34 infra.
31. 308 N.Y. at 104, 123 N.E.2d at 794.
jected in a few cases, it has provided the foundation for decisions in the majority of jurisdictions that have adjudicated the issue. The Cunningham decision, however, may signify an end to that influence. The Illinois supreme court convincingly rejected the holding in Perlmutter that a transfusion of blood is a service rather than the sale of a product. Furthermore, since the Cunningham court deemed blood contaminated with hepatitis an unreasonably dangerous product, a patient contracting the disease by transfusion or other injection may be virtually assured of success in a strict liability action against the hospital.


33. See Hoffman v. Misericordia Hosp., 439 Pa. 501, 267 A.2d 867 (1970), in which the court held that even if a transfusion could not be characterized as a "sale" the plaintiff could still recover on the basis of breach of implied warranty. See also Jackson v. Muhlenberg Hosp., 96 N.J. Super. 314, 232 A.2d 870 (L. 1967), revd. on other grounds, 53 N.J. 138, 249 A.2d 65 (1969), in which the court held that a transfusion of human blood for consideration was a sale. A few courts, while denying claims based on a warranty running from the hospitals, have held that a warranty is properly assertable against commercial blood banks. See, e.g., Carter v. Inter-Faith Hosp., 60 Misc. 2d 733, 304 N.Y.S.2d 97 (Sup. Ct. 1969); Russell v. Community Blood Bank, Inc., 185 S.2d 749 (Fla. Ct. App. 1965).

34. The following jurisdictions have indicated adherence to the Perlmutter rationale: Arizona: Whitehurst v. American Natl. Red Cross, 1 Ariz. App. 326, 402 P.2d 584 (1965).
35. 47 Ill. 2d at 451-52, 266 N.E.2d at 900-02.
36. 47 Ill. 2d at 456, 266 N.E.2d at 904.
37. The RESTATEMENT § 402A would impose liability for the sale of an unreasonably dangerous product, and the court in Cunningham held that the transfusion of hepatitis-infected blood is such a sale. Assumption of risk remains a valid defense to an action.
The extent to which Cunningham will be accepted in other jurisdictions is difficult to determine. Although Perlmutter undoubtedly continues to have considerable influence, Cunningham seems to be in accord with the growing disenchantment of some courts with the Perlmutter rationale as well as with what some commentators have been advocating for several years. Moreover, several states still have no statute or judicial ruling dealing with the issue, and Cunningham may well be influential in those states that are disposed toward the view expressed in that case but are reluctant to effect the ground-breaking themselves.

On the other hand, several considerations tend to diminish the impact that Cunningham may have in other jurisdictions. Twenty-three states have enacted statutes that specifically preserve the "service" nature of blood transfusions. Since a sale is usually required brought under strict liability. See Restatement § 402A, comment n at 356. Comment n appears to limit the availability of the assumption of risk defense to cases in which the plaintiff "... discovers the defect and is aware of the danger, and nevertheless proceeds unreasonably to make use of the product." It is doubtful that a patient who is informed of both the need for a blood transfusion and the possibility of hepatitis virus in the blood to be used is acting unreasonably when he chooses to undergo the transfusion.

38. See cases cited in note 33 supra.
39. See authorities cited in note 32 supra.
40. For states with a judicial ruling on point, see notes 33 & 34 supra. For states that have a statute dealing with the issue, see note 41 infra.
41. See, e.g., CAL. HEALTH & SAFETY CODE § 1806 (West 1970), which provides:

Other states that have enacted similar legislation include:

Alaska: Alaska Stat. § 45.05.002 (1968).
to bring strict liability into play, the effect of these statutes will be to preclude any strict liability cause of action.

In addition, the doctrine of sovereign immunity may exempt publicly supported hospitals from the Cunningham approach in many states. There are a great many exceptions to the sovereign immunity rule, however, and it cannot be assumed that the existence of the doctrine in any given state necessarily precludes recovery under the Cunningham analysis. Moreover, the courts have imposed a variety of limitations upon the sovereign immunity doctrine. Furthermore, a court that is willing to accept the Cunningham analysis may also be willing to re-evaluate the doctrine of sovereign immunity and hold it inapplicable to blood transfusion cases. Yet conceding all this, the fact that the doctrine of sovereign immunity remains the law in over half of the states implies that the application of Cunningham will, in certain factual settings, thereby be impeded.

A similar concept is the doctrine of charitable immunity, and in those states where it is the law it too will hinder application of a strict-liability theory to blood transfusion cases. Although the trend is clearly in the direction of disapproval and limitation

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42. See note 6 supra.

43. But there will be no such elimination when there is no requirement of a sale. See Hoffman v. Misericordia Hosp., 439 Pa. 501, 267 A.2d 867 (1970), discussed in note 33 supra.

44. For a discussion of sovereign immunity as a defense to tort claims, see W. Prosser, supra note 22, § 125, at 1001-03, § 127, at 1019.

45. For example, military, veterans, and public-service hospitals are subject to suit under the Federal Tort Claims Act, 28 U.S.C. §§ 1291, 1346, 1402, 1504, 2110, 2401-02, 2401-12, 2671-80 (1964). The Act makes the United States liable for the wrongful acts or omissions of federal employees within the scope of their employment "in the same manner and to the same extent as a private individual under like circumstances" under the local law of the place where the tort occurs. 28 U.S.C. § 2674 (1964).

46. For example, the hospital may have to be engaged in a "governmental" function as opposed to a "proprietary" one in order to qualify for the immunity. See generally Health Law Center, Problems in Hospital Law 151-52 (1969) [hereinafter Health Law Center].

47. For an example of such a judicial re-evaluation that resulted in a holding that the doctrine does not protect public hospitals, see Muskopf v. Corning Hosp. Dist., 55 Cal. 2d 211, 359 P.2d 457, 11 Cal. Rptr. 89 (1961).

48. Health Law Center, supra note 45, at 152-54; W. Prosser, supra note 22, § 125, at 1004-10.

49. For an example of such a judicial re-evaluation that resulted in a holding that the doctrine does not protect public hospitals, see Muskopf v. Corning Hosp. Dist., 55 Cal. 2d 211, 359 P.2d 457, 11 Cal. Rptr. 89 (1961).


51. For a discussion of the defense of charitable immunity to tort claims, see W. Prosser, supra note 22, § 127, at 1019-24.

52. "Where the question of [charitable immunity] has arisen as of first impression
of charitable immunity, the doctrine continues to possess sufficient vitality in some jurisdictions\textsuperscript{52} to thwart the assertion of a strict-liability argument against charitable entities.\textsuperscript{53}

Perhaps the most significant of all the factors that will limit the influence of Cunningham is the analytical fragility of the court’s reasoning. For though the court took a laudable step forward in discarding the Perlmutter rationale, in doing so it brushed aside a powerful objection to the application of strict liability with very questionable commentary. The basic objection to holding hospitals strictly liable for transfusions of hepatitis-infected blood is based on comment \textit{k} to section 402A of the \textit{Restatement of Torts}. Comment \textit{k} excepts “unavoidably unsafe products” from the rule of strict liability. In order for a product to be unavoidably unsafe, three requirements must be met: (1) all reasonable efforts must be made to make the product safe; (2) proper warnings of possible danger must be given; (3) experience must justify the marketing of the product despite the risk involved.\textsuperscript{54} The court added a fourth requirement, however: the product must not be impure.\textsuperscript{55} Since hepatitis-infected blood is by definition impure, the court held that it did not fall within the comment \textit{k} exception.

It is extremely difficult to justify the court’s decision to read this additional requirement into comment \textit{k}. Indeed, the language of comment \textit{k} standing alone seems to refute thoroughly the court’s analysis:

\begin{quote}
\ldots [A] product properly prepared, and accompanied by proper directions and warning, is not defective, nor is it unreasonably dangerous \ldots [when], because of lack of time and opportunity for sufficient medical experience, there can be no assurance of safety, or even perhaps of purity of ingredients, but such experience as there is justifies the marketing and use of the \ldots [product] notwithstanding a medically recognizable risk.\textsuperscript{56}
\end{quote}

within recent years, it has been uniformly rejected; in no jurisdiction has the doctrine been adopted by overruling a prior judicial decision recognizing full liability.” \textit{Health Law Center}, \textit{supra} note 45, at 149. \textit{See also C. Kramer, Medical Malpractice} 21-27 (rev. ed. 1965). W. Prosser, \textit{supra} note 22, § 127, at 1024, states that the doctrine “is clearly in full retreat.”

51. Even where the doctrine still exists, its vitality is often circumscribed by limitations placed upon it. \textit{See generally Health Law Center}, \textit{supra} note 45, at 143-45.

52. For a jurisdiction-by-jurisdiction discussion of immunity rules and decisions, see Annot., 25 A.L.R.2d 29, 142-200 (1952).

53. The determination whether a hospital can be characterized as charitable is occasionally troublesome. No perfect definition can be framed. \textit{See Annot.}, 7 A.L.R.3d 1291, 1293 (1966).

54. \textit{Restatement} § 402A, comment \textit{k} at 354.

55. 47 Ill. 2d at 456, 256 N.E.2d at 904.

56. \textit{Restatement} § 402A, comment \textit{k} at 353-54 (former emphasis original, latter emphasis added).
Thus, comment $k$ specifically applies to the situation in which medical knowledge cannot assure purity of ingredients but the use of the product is justified nonetheless. Notably, the court omitted the portion relating to purity of ingredients from its quotation of comment $k$.57

Moreover, the comment cites the Pasteur vaccine as an example of a product to which strict liability should not attach. The court distinguished the Pasteur vaccine from hepatitis-infected blood on the ground that the latter is an impure substance while the former is a pure substance. This distinction is factually questionable. The Pasteur vaccine is cultured in the brains of small laboratory animals such as rats, mice, and rabbits. Small particles of brain material are left in the vaccine and it is this brain material that causes harm to recipients of the vaccine.58 Thus, the Pasteur vaccine is not a "pure" substance; it contains particles of foreign material that occasionally cause serious harm to the recipient just as does hepatitis-infected blood. This fact supports the conclusion that the court was engaged in a mere semantic exercise when it created the "pure-impure" distinction. And in so doing, the court distorted the thrust of comment $k$. Comment $k$ was intended to prevent the imposition of strict liability when the value of a medical product outweighs its potential for causing harm by such a substantial degree that the use of the product is justified.59 Therefore, in deciding whether the comment is applicable in any given situation, a court should determine only whether all reasonable efforts have been made to make the product safe and whether the necessity of administering the product outweighs an unavoidable element of risk to the patient. The fact that all medical efforts to remove the hepatitis virus from the blood have thus far been unsuccessful has already been documented.60 And the necessity of blood transfusions in modern medicine appears to be substantially on a par with that of the Pasteur vaccine.61 Therefore, it seems clear that the court erred in adding the

57. 47 Ill. 2d at 456, 266 N.E.2d at 903-04.
58. "All these vaccines [various rabies vaccines including the Pasteur vaccine] suffer from the presence of a large amount of foreign brain material which is capable of producing encephalitis and paralysis in a certain small proportion of individuals (1:4000 to 1:10,000)." MacCallum, Rabies, in VIRUS AND RICKETTSIAL DISEASES OF MAN 253, 261 (4th ed. 1967).
59. See Restatement § 402A, comment $k$ at 353-54, which justifies use of the Pasteur vaccine despite the great risk involved.
60. See notes 15-20 supra and accompanying text.
61. "The development of the modern blood transfusion in the past half-century is recognized by the medical profession as one of its finest achievements. Without today's blood transfusions many of the modern surgical practices would not be possible, and hemorrhage would be a far greater cause of death." Note, 42 Minn. L. Rev. 640, supra note 32. See also Trout, Blood Transfusions, 73 Dick. L. Rev. 201, 212 (1969).
requirement that a product must be pure in order for comment \( k \) to apply. 62

The application of strict liability in any given situation has always rested heavily upon public-policy considerations. Although the court in *Cunningham* erroneously distinguished comment \( k \), it was presumably free to reject the comment outright if it found sufficiently compelling reasons to do so. Therefore, an examination of the policy behind the application of strict liability to blood transfusion cases is required before any conclusions can be reached concerning the appropriateness of that doctrine for such cases.

Several commentators have argued that comment \( k \) should not except contaminated-blood cases from the scope of Restatement section 402A. 63 The proposition most often asserted is that the financial consequences of a transfusion that results in hepatitis should be borne by hospitals because they are in the best position to insure themselves against the loss. Insurance premium costs could then be absorbed into the general overhead costs of the health centers. In this manner, the cost of a transfusion would be spread to all those who avail themselves of the hospitals’ services in the form of higher hospital costs. 64 Additionally, it has been argued that the imposition

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64. Comment, 24 SW. L.J. 305, supra note 63, at 321-25; Comment, 23 ARK. L. REV. 236, supra note 63, at 245-49. This is the loss-spreading system imposed in effect by *Cunningham*. It should be added that a secondary loss-spreading will occur among those people who have medical insurance. The rise in hospital costs would be followed by a rise in premium rates for medical insurance. However, it is difficult to rely on private medical insurance as a loss-spreading device because many persons are simply not covered, often because of their financial status. J. BOWER, E. CONNORS, J. MOSHER & C. ROWLEY, *HOSPITAL INCOME FLOW—A STUDY OF THE EFFECTS OF SOURCE OF PAYMENT ON HOSPITAL INCOME* 48 (1970) [hereinafter *HOSPITAL INCOME*], demonstrate that payments from uninsured individuals account for approximately 15\% of the payments received by hospitals from patients. This estimate was supported in an interview with John Zurgich, Associate Director of University Hospital, The University of Michigan, in Ann Arbor, Michigan, March 19, 1971 [hereinafter Zurgich Interview].

Moreover, even for the majority of patients who do have some type of protection, the coverage is often far from adequate. See, e.g., S. GREENBURG, *THE TROUBLED CALLING* 132 (1965), in which the author states:

[Ins]urance pays 40 percent of the cost of surgery, 30 percent of the expenditures for the services of obstetricians, less than 10 percent of physicians’ out of hospital fees, and little or nothing for other services and supplies. This means that in the course of a year, patients have to pay out of pocket an additional $2.5 billion for hospitalization, $3.5 billion for doctors’ services, $3.9 billion for drugs and $4.5 billion for other health services, such as dental care, nursing-home care, and appliances. • • • While medical costs have been going up at the rate of 5 to 10 percent a year, the ratio of such costs met by insurance has shown an average annual increase of less than 2 percent. At the same time, insurance premium charges have
of strict liability would encourage a more rapid discovery of a cure for hepatitis or a means of detecting the virus in blood.\(^{65}\)

The role of tort law as a loss distributor has grown dramatically in recent years.\(^{66}\) In light of this development, it would seem anomalous to allow a single, unfortunate patient to bear the costs that result from a treatment—a blood transfusion—to which all persons might be subjected. However, before the legal system imposes risk allocation in blood transfusion cases, several questions should be considered. How is this allocation to be achieved? Who should be included within it? Is the tort law the most effective medium for reaching the desired result? The decision in Cunningham can be used as a tool of analysis in answering these questions.

As noted above, the result in Cunningham does effect some risk allocation.\(^{67}\) The court failed to point out, however, the severe drawbacks that this type of risk allocation entails. Of necessity, the hospitals' losses from some patients' contraction of post-transfusion hepatitis will be defrayed by increased assessments on all their patients.\(^{68}\) This is true because, unlike most manufacturers and sellers who bear this type of business expense, health centers are not able to modify the blood's characteristics or abstain from selling it altogether when the related financial responsibility becomes so onerous as to make its sale unprofitable.\(^{69}\) Similarly, the losses suffered by commercial blood banks will be passed on primarily to hospital patients and others in need of blood.\(^{70}\)

\(^{65}\) Comment, 24 Sw. L.J. 305, supra note 63, at 325; Comment, 23 Ark. L. Rev. 236, supra note 65, at 249.


\(^{67}\) See note 64 supra and accompanying text.

\(^{68}\) Predict Higher Patient Charges If Blood Is Treated as a Product, Modern Hosp., Nov. 1970, at 34.

\(^{69}\) Once a hospital undertakes the care of a patient, of course, it might often be under a duty to give the patient blood, and the failure to do so would clearly give rise to an action based on negligence. See Church v. Adler, 350 Ill. App. 471, 113 N.E.2d 327 (1953); Skeels v. Davidson, 18 Wash. 2d 358, 139 P.2d 301 (1943).

\(^{70}\) Interview with Dr. Harold A. Oberman, Professor of Pathology and Medical Director of the Blood Bank, University of Michigan Medical School, Ann Arbor, Michigan, April 15, 1971 [hereinafter Oberman Interview]. Most hospitals purchase the majority of their blood supply from various types of blood banks. See generally Committee on Public Health, Human Blood in New York City—A Study in Its Procurement, Distribution and Utilization (1958). Therefore, increased costs resulting from the imposition of strict liability on blood banks will be passed on to patients through the hospitals when the blood is resold.
The precise economic impact of this type of loss-spreading is not entirely clear. In some cases the cost of blood alone will be affected, but it seems probable that in many others the increased costs will be allocated among all medical services provided by the hospital.\textsuperscript{71} If this is the case, the resulting increase in already rapidly rising medical costs\textsuperscript{72} could be very substantial.\textsuperscript{73} Furthermore, if the Cunningham theory of strict liability in blood transfusion cases were to be applied to analogous situations such as organ transplants,\textsuperscript{74} the economic impact would be even more severe. And as medical costs rise, health care will be placed further beyond the reach of those persons in lower income brackets.

This economic burden on the poor is also a factor that distinguishes the strict liability imposed in Cunningham from that imposed by the courts in other product liability cases. An increase

\textsuperscript{71} Higher blood prices resulting from an imposition of liability on commercial blood banks will often be reflected only in the price of blood. At the University of Michigan Hospital, for example, it was estimated that the increased cost of blood derived from external sources would be reflected solely in the price charged for blood. On the other hand, if the hospital itself were held liable for hepatitis infection resulting from its own blood supply, those costs would be distributed among all products and services sold by the hospital. Moreover, some private insurers are considering the cancellation of hospital liability insurance entirely, apparently because of the unpredictable possibility of large recoveries. Should this happen, many hospitals and their patients might face an even more serious economic problem. Oberman Interview, supra note 70.

\textsuperscript{72} See \textit{Presidential Prescription for Health}, Time, March 1, 1971, at 11, in which it is stated that since 1960 the average daily cost of hospitalization has risen from $56 to $144. The nation's total health bill has reached $70 billion, more than double that of a decade ago. This now averages $324 per person per year. \textit{See also} Walsh, \textit{Medical Care: As Costs Soar, Support Grows for Major Reform}, 166 Science 1126 (1969); \textit{Crisis Ahead in Medical Care}, U.S. News & World Rep., Feb. 26, 1968, at 56; \textit{The $60-Billion Crisis over Medical Care}, Business Week, Jan. 17, 1970, at 50.

\textsuperscript{73} There can be no precise estimate of the increase in medical cost resulting from the imposition of liability for transfusing a vitiated serum. However, since "[s]ome 2.5 million hospital patients are transfused annually," F. Cook, supra note 64, at 157, and the incidence of infection may be around 3\%, with 30,000 serious cases and up to 3,000 deaths per year (see note 12 supra), the recoveries could well be enough to increase significantly the costs of hospitalization. This is particularly true in light of the fact that awards may well exceed the $50,000 asked for by Mrs. Cunningham in the principal case. With this in mind, it has been predicted that for a 400-bed hospital an average $14 per patient-per day increase would result from the holding in Cunningham. See Modern Hospy, supra note 68, at 35. Since hospital income is based primarily on the number of patient-days it has (Zurgich Interview, supra note 64) the smaller hospitals would experience even larger increases, and notably there is less patient insurance coverage in the rural health centers that have fewer beds than do other centers. See Hospital Income, supra note 64, at 25.

One concrete example of how Cunningham has affected blood-drawing institutions can be seen in the rise in insurance rates for a Chicago area blood bank, which experienced a twenty-fold increase in annual premiums ($1,500 to $30,000) following the decision. Letter from Nathan Smith, Executive Director of the Midwest Chapter of the National Hemophilia Foundation, to Richard French, of Howard & French, Chicago, Ill., Feb. 25, 1971. This increased insurance premium will almost certainly be reflected in an increased cost of blood coming from the Chicago area blood banks.

\textsuperscript{74} See notes 80-82 infra and accompanying text.
in the cost of automobiles, candy bars, or even canned meat that results from the imposition of strict liability on the manufacturer of these items does not have the effect of making a necessity of life less available to financially disadvantaged persons. It is submitted that the inability of hospitals to prevent the occurrence of hepatitis coupled with this potential economic impact on the poor renders application of strict liability in tort far less appropriate when hepatitis-infected blood is sold than when ordinary consumer goods are sold. The most desirable result would be to alleviate a recipient's financial burden without substantially increasing the costs of medical care in general. The most obvious way to achieve this result would be to distribute the expenses associated with transfusion-contracted hepatitis among the population as a whole. Since everyone is susceptible to disease and accident, and, correspondingly, the necessity of receiving blood, it is not a harsh result to expect all persons to bear a portion of the expense. The imposition of strict liability on hospitals will spread the costs primarily to the purchasers of hospitalization rather than to the public at large and therefore cannot achieve this result. 75

Another drawback to the Cunningham method of risk allocation is that recovery is predicated upon litigation, or at least the threat of litigation, against the hospital. This procedure inevitably suffers from the economic disadvantages that attorney and court fees diminish a plaintiff's recovery and insurance company profits increase the costs of providing the protection. 76 Moreover, since the poor are generally less aware of their rights and less able to litigate, 77 they are the least likely to be compensated for their losses. Additionally, as noted above, several states continue to hold some hospitals free from tort liability on the grounds of sovereign and charitable immunity. 78 In these states, some patients—again often the most needy—will be left without a remedy if the hospital provides its own blood supply. 79 Thus by raising medical costs and implementing a system

75. See notes 70-73 supra and accompanying text. It should be noted that some secondary loss-spreading among persons other than purchasers of hospitalization is inevitable. For example, medical insurance rates will probably increase as the cost of medical products rises; hence all policy holders will be affected whether or not they actually go to the hospital. Some insurance costs may, in turn, be passed on to the customers of those who purchase the insurance. This secondary loss-spreading, however, is extremely speculative and difficult to measure, and in any event will not be complete loss-spreading since the burden will not fall equally on all people.


77. See generally Note, Litigation Costs: The Hidden Barrier to the Indigent, 56 Geo. L.J. 516 (1968).

78. See notes 44-53 supra and accompanying text.

79. If the blood is supplied by a commercial blood bank, however, charitable and sovereign immunity would not bar an action against the blood bank. See note 53 supra.
of risk allocation that will be least accessible to the poor, Cunningham gives the least protection to those persons who need it most.

Furthermore, Cunningham may have ramifications in areas of medicine other than the transfusion of blood. For example, if a hospital were to have a patient badly in need of a kidney transplant and the kidney used in the transplant was undetectably diseased, the hospital might well be liable to the patient for any resulting harm. This would be so notwithstanding the fact that the hospital was providing the best possible treatment and the patient's life was extended several years as a result of the operation. Since in many instances the organs capable of being transplanted have grossly undetectable deficiencies, the extension of strict liability to such situations could have the dual effect of further raising hospital costs and reducing the available supply of transplant organs. Indeed, the Cunningham analysis could be applied to medicines, anesthetics, and practically any curative implement containing a hidden defect that can be classified as an impurity.

Finally, the hastening of medical triumphs is not a necessary or even probable consequence of the Cunningham result. Although product safety is without doubt a result toward which the imposition of strict liability is directed, the influence of such liability is questionable when the item sold is virtually unimprovable due to the lack of requisite information and techniques. It seems quite unlikely that the growth of medical knowledge will be quickened by making hospitals guarantors of the purity of substances not yet fully understood. Medical science seems to be making ample progress without the imposition of artificial economic stimuli. And there is evidence that the Cunningham result will promote the

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80. Other areas of transplants that could conceivably be affected include removable and built-in prostheses and artificial organs, as well as homotransplants (from either living humans or cadavers) and heterotransplants (from animal to man), Mouzas, The Present State of Organ Transplantation, 46 INT. SURGERY 570 (1966); and the thymus, Transplanting the Thymus, 2 THE LANCET 1226 (1968).

81. Oberman Interview, supra note 70.

82. It is quite likely that hospitals, wary of being held liable for hepatitis and related injurious elements or defects, would establish certain rules or guidelines that would tend to make blood and other materials less readily available. Zurgich Interview, supra note 64.


Public policy demands that responsibility be fixed wherever it will most effectively reduce the hazards to life and health inherent in defective products that reach the market. . . . It is to the public's interest to discourage the marketing of products having defects.

84. See, e.g., The Wall St. J., March 2, 1971, at 23, col. 1 (midwest ed.), which reports several of the efforts of individual researchers and such organizations as the National Research Council, the Division of Biologics Standards of the National Institutes of Health, the American Red Cross, and the American Association of Blood Banks.
spending of funds by medical groups to effect the legislative repeal of that case rather than to find a cure for hepatitis.\textsuperscript{85}

None of the above drawbacks were discussed or even mentioned by the court in Cunningham. The court seemed to assume that its decision to impose strict liability on hospitals would yield a socially desirable result.\textsuperscript{86} But as this Recent Development has attempted to demonstrate, the reverse may well be true. Admittedly, the Cunningham approach avoids the imposition of a staggering financial burden upon a single, unfortunate patient. However, this result has been achieved through a method of risk allocation that lacks efficiency, fails to provide protection for all persons who are in need of it, and leads to further increases in the cost of medical care.

Essentially, a greater diffusion of the costs attributable to the uncontrollable effects of proper medical care is needed; but, as pointed out above, the tort law cannot achieve this goal. It is submitted, therefore, that any decision concerning the allocation of risks for unavoidable medical accidents would more appropriately be made by a legislative body. Thorough committee investigations would enable a legislature to gain a more complete understanding of all the potential ramifications involved in spreading the costs of unavoidable medical accidents than the limited context of litigation will allow. Therefore, a legislature would be in a much better position to make practical and informed judgments about who should receive the needed protection, what products should be covered, and what the financial limits of the protection should be.

It should be recognized that a legislative approach at the state level would probably be impractical because, in order to achieve nationwide loss-spreading, all fifty states would have to enact virtually identical statutes. However, several major proposals for an extensive health care program have already been made at the federal level.\textsuperscript{87} There appears to be no reason why a provision for the type

\textsuperscript{85} In fact, the outgrowth of Cunningham in Illinois has been precisely such a lobbying effort. Noting that several states provide legislation to prohibit blood being termed a "sale" (see note 41 supra), the Illinois Medical Society and the Illinois Hospital Association both urged immediate enactment of statutes to counter the decision. \textit{American Medical News}, Oct. 12, 1970, at 3, col. 1. Several commentators have opined that this reaction would be typical in any state that adopts the Cunningham analysis. Zurgich Interview, supra note 64; \textit{American Medical News}, supra; \textit{The Wall St. J.}, March 2, 1971, at 23, col. 1 (midwest ed.).

\textsuperscript{86} \textit{See} 47 Ill. 2d at 457, 266 N.E.2d at 904, for the court's analysis of the economic arguments made against the imposition of strict liability.

\textsuperscript{87} Six major proposals have been formulated.

Senator Edward Kennedy's proposal would provide federally financed comprehensive health benefits, without cost sharing, for all United States citizens and residents, with the present exclusion of adult dental care and with limitations placed upon the purchase of drugs, treatment in nursing homes, and mental health care. There would be minimum cost to the lowest income earners, and up to $315 per year charged to those earning in excess of $15,000. S. 3, 92d Cong., 1st Sess. (1971). \textit{See} 117 CONG. REC. S. 109 (daily ed. Jan. 25, 1971).
Recent Developments

President Nixon's plan would expand and almost entirely replace the present medicaid program. Families on welfare and those in the lowest incomes would have their premiums paid by the Government, while other working poor would pay on a basis scaled upward as income rises. In addition, there would be possible coverage for all persons with "catastrophic" illnesses, i.e., situations involving extremely costly treatments or incapacitations for relatively long durations. S. 1623, 92d Cong., 1st Sess. (1971). See 117 CONG. REC. S. 1496, H. 774 (daily ed. Feb. 18, 1971).

The Aetna Life & Casualty proposal, one receiving wide backing from the insurance industry, would provide for the poor and uninsured to elect minimum benefits through private insurance, with the Government paying the premiums. This would include ambulatory and institutional care, with catastrophic medical expenses gradually being extended to all, starting with the poor. H.R. 4349, 92d Cong., 1st Sess. (1971). See 117 CONG. REC. S. 1958 (daily ed. Feb. 25, 1971).

The American Medical Association-backed Fulton-Broyhill bill would be based upon taxation credits and offered on a voluntary basis. Free coverage would be provided for those persons paying $300 or less income tax, while others would be allowed a graded scale of tax credits running from 98% ($301 income tax) to 10% (when taxes exceed $1,300). Minimum benefits would include medical services, hospitalization up to sixty days, and optional benefits including coverage for catastrophic illnesses. H.R. 4260-83, 92d Cong., 1st Sess. (1971). See 117 CONG. REC. S. 1957-58 (daily ed. Feb. 25, 1971).


Congresswoman Martha Griffiths' bill, supported by the AFL-CIO, calls for comprehensive health benefits to all persons residing in the United States for a year or more, with minimal cost to the lowest income earners and a maximum annual cost in any instance of $30 per individual and $100 per family. H.R. 22, 92d Cong., 1st Sess. (1971). See 117 CONG. REC. H. 197 (daily ed. Jan. 26, 1971).


The scope of this Recent Development does not include a comparison of the relative merits of these programs. However, it is urged that the proposal finally adopted should include provisions to insure adequate recompense for patients who contract hepatitis unavoidably or who suffer any other deleterious effects from the proper administration of modern medical therapy. Presently, because private insurance often furnishes only partial coverage (see note 64 supra), it appears that the Kennedy and Griffiths proposals would be the most amenable to this end.