Blood Justice: Courts, Conflict, and Compensation in Japan, France, and the United States

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In the mid-1980s, many blood transfusion recipients and close to half of Japanese, American, and French hemophiliacs realized that they had been infected with HIV-contaminated blood. In this article I argue that the legal conflicts over HIV-tainted blood in those three nations defy conventional comparative claims about courts, conflict, and compensation. I first describe the similar policy responses of France, Japan, and the United States as public health officials came to realize that HIV threatened the safety of the blood supply. I then focus on what happened when infected individuals began to demand redress. I argue that the mobilization around law by plaintiffs, the centrality of the courts in handling conflicts over HIV and blood, and bold, innovative responses by the judiciary were not distinctive characteristics of the American conflict. Instead, law and courts in all three nations were central players in the battles over blood. Most strikingly, in comparison to courts in the United States, those in France and Japan have been significantly more responsive to plaintiffs' claims. When one looks beyond the courts to legal and legislative action more broadly, the United States has been the least accepting of the plethora of demands for recompense.

I. Introduction

On October 23, 1992, in the Thirteenth Chamber of the Paris Court of Appeals, the same judge who sentenced Klaus Barbie announced his verdict in the celebrated case known as the *affaire du sang contaminé*, the tainted blood episode. The

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judge found the former Director of the National Blood Transfusion Center (CNTS), the former Scientific Director of CNTS, and the former Director General of Health guilty of criminal misconduct for their roles in distributing HIV-contaminated blood products that infected thousands of French hemophiliacs. His judgment drew attention to the existence of individual malfeasance (as opposed to institutional failure) in the tainted-blood affair and contradicted the premise of the government's financial compensation scheme—that the distribution of HIV-tainted blood and blood products could not have been prevented. Less than four years later, in April 1996, the Tokyo and Osaka District Courts issued an out-of-court settlement in litigation brought by HIV-infected hemophiliacs against five pharmaceutical companies and the Japanese Ministry of Health and Welfare (MHW). Defendants acknowledged their responsibility for causing the plaintiffs' infections, paid a cash settlement, and apologized. In May 1997, a year after the Japanese settlement, Judge John Grady of the U.S. District Court approved the settlement of a decertified class action lawsuit brought by American hemophiliacs with HIV infection. The settlement required pharmaceutical companies that distributed contaminated blood products in the early 1980s to financially compensate the plaintiffs.

In France, Japan, and the United States, nations with different legal traditions, social relations, and political cultures, hemophiliacs (sometimes in collaboration with those infected through whole blood transfusions) have successfully banded together and obtained redress through the legal and political process. Possessing a genetic condition affecting approximately one in 25,000 people, they have in varying degrees utilized novel legal procedures and pronouncements, mobilized, catalyzed (and exposed) political scandals, brought about the downfall and prosecution of elite government personnel and physicians, forced the reform of national blood policies, and won significant moral and financial victories.

Their actions, and the reactions of others, raise a number of important sociolegal questions. To what extent can conventional theories of comparative jurisprudence explain the legal processes and outcomes related to HIV-tainted blood in France, Japan, and the United States? Does sociolegal scholarship on the relative importance of law, courts, and litigation predict, or help to explain, the tenor and texture of conflict over AIDS and blood? Do the battles over blood in France, Japan, and the United States support claims about the non-litigious Japanese, the hierarchical French, and the ever-conflictual Americans? What, in short, can we learn comparatively about law and social conflict by examining the clashes over HIV-contaminated blood in these three nations?

In the first part of this article I focus on the extraordinary series of events leading up to the legal clash over HIV-tainted blood. I describe the unfolding of a common set of scientific and technical issues and recount the perhaps surprising degree of similarity in the policy responses of France, Japan, and the United States as public health officials came to realize that HIV threatened the safety of the blood supply. In the second part I concentrate on what happened once the tragic toll of HIV-contamination through blood became clear and infected individuals began to demand redress. Although the causes and consequences of HIV-tainted blood were almost the same in the three nations, it would be reasonable to expect claims for money, apology, and punishment to reflect the cultural and institutional contexts of the claimants; indeed, in some ways they did. Yet in many respects, conflicts over responsibility and redress have defied conventional expectations of sociolegal battles in these nations. In this article I argue that plaintiffs' mobilization around law, courts' centrality in handling conflicts over HIV and blood, and judges' bold and innovative responses were not distinctive characteristics of the U.S. conflict. Instead, lawyers and judges in all three nations were central players in the blood feuds (Feldman & Bayer 1999). Most strikingly, despite descriptions of adversarial legalism in the United States (Kagan 1995:88–118), courts in France and Japan have been significantly more responsive to plaintiffs' claims. When one looks beyond the courts to legal and legislative action more broadly, the United States has been the least accepting of the plethora of demands for recompense.

This study has both methodological and theoretical implications for legal and law and society scholarship. Methodologically, it illustrates a style of comparative analysis that is at odds with the tradition of using abstract or overly general data to compare entire nations and legal systems. The classic approach has its virtues, but in this article I focus on a much more circumscribed set of data—a particular event that unfolded simultaneously in different nations. The appearance of HIV, a new deadly disease-causing virus, in the industrialized world; its uneven repercussions for individuals and groups; the large financial stakes of private and public institutions in how HIV infection and AIDS is managed; the symbolic and social meanings of HIV and AIDS, and their transmission; the evolution of scientific consensus from a condition of deep scientific uncertainty; and the web of legal and regulatory controls that surround HIV and AIDS all make the HIV/blood nexus an ideal event for comparative study. It is difficult to know how far one can generalize from a single event; but event-based analysis is one promising route to a rich and accurate comparative understanding of different legal cultures and institutions.

The theoretical implications of this study speak to the long tradition of comparative legal scholarship, most specifically sociolegal writings on mobilization, litigiousness, and policy.[1] That literature is rife with disagreement about exactly how litigious we Americans *really* are. Yet even the most nuanced and careful work gets caught in an American exceptionalism, and assumes that litigation is a more important feature of the policy landscape in the United States than in any other jurisdiction. Christopher Busch et al. (1999:179), for example, claim that "a bookshelf's-worth of criticism has been leveled at the extent to which law has become the primary instrument for framing and resolving—indeed, for discussing—America's policy problems." Herbert Jacob (1996:1), introducing one of the few comparative sociolegal studies on law, courts, and politics, writes that although "many American political activists view litigation as another form of politics, their peers in other countries do not routinely consider going to court to achieve policy objectives." Although I address neither the empirical question of how to best measure the amount of litigiousness comparatively, nor the normative question of the desirability of litigiousness, I do take issue with the assumption that Americans are uniquely predisposed to turn to law as a way of resolving social conflict. In the HIV/blood affair, injured parties in Japan and France have been as keen as (if not more keen than) their U.S. counterparts to turn to law and courts in the struggle over HIV-tainted blood. Rather than an anomaly confined to this particular event, their reliance on law may be an indication of a more general tendency overlooked by sociolegal scholars.

In sum, the cross-national study of conflict over the distribution of HIV-contaminated blood provides an unusual opportunity to utilize a fresh comparative methodology and yields conclusions that appear to cut against well-established generalizations of comparative and sociolegal scholarship. Almost 30 years ago, in his magisterial work *The Gift Relationship*, British social scientist Richard Titmuss (1971) argued that only through comparative study was it possible to understand the link between the biology of blood and its social meaning. Likewise, the comparative examination of battles over HIV-tainted blood deepens our understanding of the relationship between courts, conflict, and compensation in Japan, France, and the United States.

[1] There is some danger in using the term "litigiousness" because it conveys an array of meanings. This article is not an empirical study of the relative likelihood that individuals in various nations will seek to resolve their disputes in the courts. Though I highlight the fact that people in France, Japan, and the United States are all quite willing to take their grievances to court, I am more concerned with a particular kind of litigation. In the cases this article examines, courts serve an expressive function through which disputes are aired and values are affirmed, judges are actors in policy conflicts, and the relationship between lawsuits, compensation, and justice is of central importance.

II. The "Iron Triangle" of Comparative Analysis

No available comparative theory explains (or even hints at) why Japan and France, rather than the United States, experienced volatile legal conflicts over HIV-contaminated blood. Instead, each corner of what I call the "iron triangle" of comparative legal study leads to conclusions that are directly refuted by the actual geography of the AIDS/blood events.[2] Nonetheless, the three dominant comparative perspectives that constitute the triangle—viewing legal processes and outcomes through the lens of (1) legal culture, (2) legal institutions, and (3) bureaucratic structure—present a formidable set of claims about conflict and litigation. Even though each of them falls intriguingly short of predicting the course of the French, Japanese, and U.S. blood conflicts, it is useful to review their fundamentals. These perspectives suggest a variety of ways to frame the national HIV/blood narratives that follow; more importantly, the way each fails to capture the essential features of those narratives is a critical part of the larger story this article recounts.

First, sociolegal studies of law, litigiousness, and culture describe and analyze the relative propensity of Japanese, French, and Americans to frame and resolve their grievances using the language and processes of law. In his classic work *The Legal Consciousness of the Japanese* (*Nihonjin no Hō Ishiki*), for example, Japanese legal sociologist Kawashima Takeyoshi (1967) noted a Japanese preference to settle disputes without resort to court. Kawashima explained this "fact" by invoking such Japanese cultural values as a desire for harmony and a distaste for the clear assignation of moral fault. Others who have followed in the wake of Kawashima's powerful argument, like legal philosopher Inoue Tatsuo (1999:57), note the contrast between "the confrontational mode of dispute resolution peculiar to Western litigious culture" and the Asian preference for "a consensual mode of dispute resolution."

Literature on French litigiousness and legal consciousness echoes these writings about Japan (Lasser 1995:1325–1410).[3] Laurent Cohen-Tanugi (1985:157), for example, in *Law Without the State (Le Droit sans l'Etat)*, writes: "Disputes are something that must be avoided or concealed, because they are unavoidably mixed with a vague notion of shame or incivility. Preferable to litigation are negotiations, dialogue or a friendly settlement. . . . The French legal tradition is thus fundamentally hostile to the

[2] The metaphor of an "iron triangle" of comparative approaches is not meant to imply that there is one comparative theory with three related dimensions. In fact, the "corners" of the triangle offer linked but sometimes competing explanations of legal behavior and institutions.

[3] Interestingly, as Mitchel de S.-O.-l'E. Lasser notes (1995:1329, n7), "American comparative analysis of the French civil legal system has been dormant for over 25 years."

development of litigation." Similarly, Dadomo and Farran (1993:11–12) assert that "the French do not see the law primarily as a means of settling disputes or restoring the peace," and Wilsford (1991:42, 49) argues that the French judiciary is weak and legal action generally ineffective.

These descriptions of the legal cultures of Japan and France portray two nations whose populaces share a notion of formal legal conflict akin to the Vatican's view of sexual relations. Although there may be certain times and places where it is unavoidable, one should not talk about it, must never enthusiastically embrace it, and would not be prudent to engage in it, except in the dark shadows of private life. Robert Kagan (1997:150), a sharp analyst of comparative legal scholarship, provides a delightful complement to these views. Reviewing 25 cross-national sociolegal studies, Kagan extracts one common theme. All of them identify an American legal style distinguished by "more complex and detailed bodies of rules; more frequent recourse to formal legal methods of implementing policy and resolving disputes; more adversarial and expensive forms of legal contestation; more punitive legal sanctions (including larger civil damage awards); more frequent judicial review, revision, and delay of administrative decisionmaking; and more malleability and unpredictability." In short, sociocultural analyses of litigation and legal culture in Japan, France, and the United States suggest that in most cases the Japanese and the French will try mightily to avoid the courts, whereas Americans will gravitate to them like flies unable to resist the sweet aroma of flypaper (Rosenberg 1991; Garapon 1995:493–506; Upham 1987).[4]

The second part of the iron triangle focuses more narrowly on legal institutions. For the past three decades, Japanese legal expert John Haley (1991:115) has been developing a strong challenge to Kawashima's claims about the power of Japanese legal consciousness to shape legal behavior. Haley argues that Kawashima overlooked a fundamental explanation for the Japanese avoidance of courts and thereby contributed to the "myth of Japanese aversion to litigation." Japanese rarely sue, according to Haley, for a variety of structural reasons. These reasons include the lack of a jury system, the existence of a career judiciary that seeks consistency of results (and thus makes litigation predictable), and the use of a system of registering property and family relationships (which limits litigation in cases of divorce, transfer of property, etc.). Additional factors, such as the absence of class action devices, the small number of licensed attorneys, and limited contingency fees also inhibit legal action in Japan.

[4] Gerald Rosenberg (1991) likens courts to flypaper and lawyers to flies who are unable to resist the spell of the courts. There is, of course, some excellent writing on litigation and courts in the United States, Japan, and France that complexifies the conventional wisdom summarized here. See, e.g., Garapon (1995) and Upham (1987).

A similar set of barriers to people taking legal action is easily identified in France. All judges are trained in Bordeaux, and their common education forges bonds that endure despite the likelihood of various transfers and different working environments. Impanelling juries is exceptional, done only in a small number of criminal cases brought before a specific court. Neither legal devices to encourage the grouping of plaintiffs in mass trials, nor a bar that works on a contingency arrangement, exist in France. Together, these institutional arrangements are configured in such a way as to keep potential plaintiffs away from the courts.

The situation is quite different in the United States. Access to courts is inexpensive; attorneys are abundant; and class actions allow large groups of individuals to join in a common legal action. Many judges are appointed for life and others are elected, so they need not worry about being disciplined by transfer. Juries are available in a wide range of cases. For better or worse, it would appear, there are few barriers to bringing a lawsuit in the United States, and one's prospects of success in the courts are considerably sunnier than in Japan or France.

Studies of bureaucracy, and political structure more generally, are the third corner of the iron triangle. In her comparative study of nuclear power, for example, Elizabeth Heger Boyle (1998:141–74, 156–57) argues that "[t]he political structure in France was crucial in limiting independent legal action. A powerful executive minimized the impact of civil society on policy." She goes on to highlight the importance of political centralization in France, which allows the state to ignore litigation. Leading scholars of France's public policy have developed a similar line of argument. They find little room in their work for an examination of litigation, and instead concentrate on studying the governing elite that dominates the public sector (Muller & Surel 1998; Fontaine 1996:481–98; Smith 1997).[5] Their work is similar to the many studies of Japan that focus on its highly autonomous, well-trained, and powerful bureaucracy and suggest that it successfully limits both the frequency with which citizens bring their grievances to the courts and the effectiveness of litigation. Frank Upham (1987:17), in his widely cited study of Japanese law and policy, argues that "[c]entral to the Japanese model of law generally and of litigation in particular is the elite's attempt to retain some measure of control over the processes of social conflict and change. The vehicle for that control is a skilled and dedicated

[5] Pierre Muller & Yves Surel (1998), e.g., spend characteristically little time on courts and litigation. Overviews of the study of public policy in France can be found in Joseph Fontaine (1996:481–98) and Andy Smith (1997).

bureaucracy . . . which has a long history of active intervention in Japanese society."[6]

Such descriptions of the political structure and bureaucracy in Japan and France stand in vivid contrast to American notions of checks and balances, and to the grip that pluralist thinking has long held on the study of politics and policy in the United States. Martin Shapiro (1995), describing a shift from a politics of interests to a politics of values and ideas, suggests that Americans readily embrace courts when they believe that bureaucrats and politicians have not adequately considered all policy options. "Our current faith in courts as policy makers," Shapiro writes, "stems in part from the closer approximation provided by two lawyers engaging in reasoned argument with one another in front of a third to the ordered exchange of views of the seminar room than is provided by the messy back-stairs struggles of legislatures and executive agencies" (11). In contrast to the descriptions of all-powerful French and Japanese officials, and citizens often imbued with faith in their competence, Shapiro portrays a U.S. system in which the judiciary plays a legitimate and powerful role in conflict over public policy.

III. Predicting the Contours of Conflict over HIV-Tainted Blood

Based upon observations from all three corners of the iron triangle, what might one have predicted about disputes over HIV and blood in Japan, the United States, and France? How would the nations be assembled on a spectrum, from most to least likely to involve group mobilization and protest, leading to persistent and complex litigation; most to least likely to have the courts become an important policy actor; most to least likely to quickly and generously provide some form of compensation; and most to least likely to treat the legal conflict as if it involved both questions of social justice and matters of conflicting legal principles? From the three perspectives that constitute the triangle, the United States would be at the "most" end of the spectrum, Japan would occupy the opposite pole, and France would be closer to Japan than to the United States in the majority of categories.

Clearly, these are broad generalizations to which careful scholars would add a host of caveats and qualifications. No single country, no less a set of three countries, neatly conforms to categorization, particularly in its treatment of a complex and multicausal event like blood contamination. Indeed, in the conclusion

[6] Another analyst of Japan, Karel van Wolferen (1989:210), in a book published the same year as hemophiliacs filed their claims in the Japanese courts, writes that "[o]n the whole, the Japanese still think of law as an instrument of constraint used by the government to impose its will. Japanese officials are free to pick and choose among laws, using them to further their own causes."

of this article I suggest a number of factors that help to explain the U.S., French, and Japanese legal conflicts over contaminated blood. Nevertheless, the inevitable quibbles provoked by general comparative claims aside, one would expect few comparative scholars to have inverted the above spectrum and arranged the three countries in the opposite way; yet that is precisely what one finds when concretely examining the conflicts over HIV and blood.

In the following pages, I present three narratives of national conflicts over HIV and blood—in Japan, France, and the United States—that highlight five comparative claims.

First, not only in the United States but also in Japan and France, the affected parties have banded together, framed their claims in the language of law, and gone to court. It is extremely difficult to divine a set of criteria by which to measure whether rights and interests were more or less frequently or forcefully asserted in one or another nation. But it is a far less complex matter to see that in all three places law was invoked early on in the struggles over HIV-tainted blood, to unify potential plaintiffs, attract attention to their case, and begin the process of resolving their claims.

Second, from the plaintiffs' perspectives, the actions of courts in France and Japan have been more generous, and more mindful of exploring issues of responsibility and fault than have courts in the United States.

Third, widening the legal lens to look beyond courts toward more general political and policy responses to the HIV/blood events, the United States remains the laggard. Our legislative and administrative responses to resolve the blood conflicts were slow, reluctant, and stingy.

Fourth, even though justice is a slippery concept that is not easily defined or measured, it does appear that some collective notion of justice, at least from the perspective of plaintiffs and public opinion, was most well served by courts in Japan. Justice was flirted with, but failed, in France, and was largely ignored in the United States. This conclusion is true to the extent that one treats some combination of financial payments, apology, criminal sanctions, and legal pronouncements as crucial components of justice in these cases.

Finally, it is a sad but inescapable conclusion that the legal systems of France, Japan, and the United States failed to function effectively in the tainted blood cases. In different but equally dysfunctional ways, a mixture of ignorance, nationalism, arrogance, industrial policy, greed, malfeasance, and confusion contributed to the national battles over blood and made them resistant to legal and political solutions.

IV. Contaminated Blood: Epidemiological Background and Policy Responses in the United States, France, and Japan

In the period between the identification of the first cases of blood-borne contamination and the implementation of measures to secure the blood supply, there were strong similarities in how the United States, France, and Japan confronted the problems raised by the distribution of HIV-tainted blood. This period, roughly covering the years 1981 to late 1985, was one of extraordinary scientific and epidemiological turbulence. It was during this short span of years that physicians discovered and reported the first cases of an ailment eventually called acquired immunodeficiency syndrome (AIDS); researchers discovered the virus (human immunodeficiency virus, or HIV) that causes AIDS; scientists developed a test to detect HIV in blood; and laboratories perfected a method to heat-treat blood plasma and inactivate HIV. Each of these events was subject to scientific and policy uncertainty in the United States, France, and Japan. In the years after 1985, individual patients, legal experts, and government officials carefully revisited the chronology of these accomplishments, seeking evidence of legitimate confusion, imprudence, and even criminal wrongdoing. Yet, looking back at the pre-1985 period, one discovers that French, Japanese, and American policy elites, despite different legal, political, and regulatory conditions, embraced a similar set of policy responses to the blood-borne transmission of HIV at almost the same time (Marmor 1999:349–66).

The first cases of a syndrome now known as AIDS were reported by the U.S. Centers for Disease Control and Prevention (CDC) in June 1981. A year later, in July 1982, the CDC identified three hemophiliacs with AIDS; and five months after that they announced that an infant appeared to have gotten AIDS from a blood transfusion. This cluster of facts, central to the legal conflict over HIV-tainted blood in every industrialized democracy, caused some experts to suspect that blood could transmit the still-unknown etiological agent responsible for AIDS. On the basis of these four cases, regulators and blood bankers had to decide what action, if any, was appropriate to assure the safety of the blood supply, and at what cost.

Reports issued by the CDC, the agency charged with monitoring the emergence and progression of diseases in the United States, reveal genuine uncertainty about the transmission of this new disease through blood. According to the CDC's July 16, 1982 "Morbidity and Mortality Weekly Report" (MMWR), "Although the cause of the severe immune dysfunction is unknown, the occurrence among the three hemophiliac cases suggests the possible transmission of an agent through blood products" (367). Al-

most one year later, on June 24, 1983, the MMWR reported that "[t]he cause of AIDS is unknown, but it seems most likely to be caused by an agent transmitted by intimate sexual contact, through contaminated needles, or, less commonly, by percutaneous [through the skin] inoculation of infectious blood or blood products" (311). The October 26, 1984, MMWR stated that the "possibility of blood or blood products being vehicles for AIDS transmission to hemophilia patients has been supported by the finding of risk of acquisition of AIDS for intravenous drug abusers and, subsequently, by reports of transfusion-associated AIDS cases" (590). On May 10, 1985, with 71 hemophiliacs and 149 transfusion recipients reported as having AIDS or AIDS-related infections, the MMWR declared that "persons exposed to the virus through transfusion [before 1985] may remain at risk of AIDS" (247).

The CDC's pronouncements, which were the most important source of information on AIDS for scientists and policymakers worldwide, left ample room for disagreement. By the end of 1985, scientists throughout the industrialized world agreed that AIDS was caused by the human immunodeficiency virus; a test had been developed that could detect the HIV-antibody in blood; and the heat treatment of factors VIII and IX (used by hemophiliacs because they lack a sufficient amount of their own blood-clotting factors) was demonstrated to inactivate HIV in blood and was approved in the United States, France, Japan, and elsewhere. Tragically, both HIV-contaminated whole blood and blood products (made from the pooled blood of thousands of donors) had been distributed since the 1970s. By the time government health officials, blood banks, and private physicians established a system for testing and treating blood, countless numbers of contaminated products had already been put into circulation.

A. Two Trails of Transmitting Tainted Blood

1. Whole Blood

The medical, political, and legal issues involving HIV-tainted blood can be separated into two distinct realms; one involving blood-transfusion recipients infected through whole blood, the other, hemophiliacs infected through blood products . Although these issues are interwoven, understanding the legal battles concerning contaminated blood requires that they be (at least initially) untangled.

Individuals may need a whole blood transfusion for a wide array of reasons: because of complications during childbirth or heart surgery, or because they are victims of auto accidents or violent crime, for example. In most cases, people who receive

blood transfusions do not donate and bank their own blood (what blood bankers call autologous transfusion), but receive blood that has been donated by one or a few individuals with a compatible blood type. If the unpaid blood donor was properly screened and healthy, then the transfused blood represents, in Richard Titmuss's account, an invaluable "gift." In part as a consequence of Titmuss's argument that blood freely given reaffirms the social bonds of community and is more likely to be free of viral contaminants than purchased blood, the whole blood supplies in the United States, France, and Japan (as well as in most other industrialized nations) are controlled by not-for-profit organizations such as the Red Cross and rely on non-remunerated giving by blood donors.

As the public health and blood banking communities came to realize that the vector for the transmission of the not-yet-known etiological agent that causes AIDS could be present in donated blood, they sought ways to secure the blood supply. The two most promising approaches were to screen blood donors and to test blood donations. Because a test to detect potentially contaminated blood was not yet available, it was donor screening—that is, the exclusion of those considered "high risk" from the donor population—that represented the first effort to limit the spread of the unknown agent through blood.

Whole blood collection initially became contentious when blood collection agencies began discussing the possibility of excluding gay men from the donor pool. An unusually high percentage of gay men were regular blood donors, yet the disproportionate number of AIDS cases being diagnosed in gay men made some blood professionals worry that the whole blood supply could become a source for the spread of the disease. As they began to formulate a strategy of protecting the blood supply that included the exclusion of gay donors, there was an outcry from what was rapidly becoming a well-organized and outspoken gay community, which viewed such action as unjustifiably stigmatizing. According to a spokesperson for the National Gay Task Force in the United States, for example, "[s]o-called fast lane gays are causing the problem, and they are just a minority of male homosexuals. You'll stigmatize, at the very time of a major civil rights movement, a whole group only a tiny faction of whom qualify as the problem we are here to address" (Bayer 1989: 78–79). Proposals to exclude gay men from the donor pool in France led the Comité d'Urgence Antirepression Homosexuelle to decry these recommendations as "anti-gay racism and the use of a biological phenomenon for moralizing purposes."[7] Gay men in Japan, in contrast, were not politically organized or outspo-

[7] According to Douglas Starr (1998:288), when donor questionnaires were first proposed in France in 1983, there was a backlash from gay groups and human rights activists.

ken, nor did the Japanese Red Cross implement a policy of donor exclusion until the late 1980s, so there was little public debate about blood collection. In the United States and France, however, the angry response of the gay community to policies aimed at blood safety but perceived as stigmatizing foreshadowed the later conflicts over blood in all three countries.

More technical efforts to secure the blood supply were aimed at developing a test that would indicate whether blood was potentially infectious. Such a test could be used both on blood donors and on collected whole blood to determine whether the blood should be made available for transfusion. The development of a test depended upon the knowledge of what caused AIDS. That knowledge was accompanied by a scientific and political disagreement between French and American researchers, both of whom claimed credit for discovering what is now called HIV (first called LAV by the French, HTLV-III by the Americans) in fall 1983 in France and in April 1984 in the United States.[8] By March 1985, the first test for HIV was approved in the United States.[9] The test was approved by the French government in June 1985, and by Japanese authorities in November 1986.[10]

By mid-1985, some combination of donor exclusion and blood testing in France and the United States had radically reduced the risk of transmitting HIV through whole blood. Japan, in contrast, had few worries about a contaminated whole blood supply. The number of infected units of donated blood has a direct relationship to the underlying epidemiological characteristics of the donor population—France and the United States had a much higher prevalence of HIV (seroprevalance) than did Japan, so more blood donors were HIV-infected in these countries and the risk to blood-transfusion recipients was thus higher. In all three countries, however, the likelihood of any particular donation being infected was low. Moreover, whole blood recipients have little in common. There are no special groups to which they belong; they are not a powerful lobby; they do not share a social or economic status. Indeed, they have no easy way of identifying each other, nor do they ordinarily have a reason to do so. These factors are crucial to understanding the difficulty HIV-infected

[8] An excellent discussion of the dispute over the discovery of HIV can be found in Steven Epstein (1996).

[9] The test indicates the presence of HIV-antibody in the blood, but does not detect HIV itself.

[10] There has been considerable controversy over the approval of the HIV-antibody test in France. Most contentious, and occupying a central place in French legal conflict over HIV and blood, is the failure of the National Health Laboratory to grant permission to Abbott to market its test when Abbott filed an application on 11 Feb. 1985. Abbott received a license on 25 July, more than a month after Diagnostics Pasteur's license was issued on 21 June 1985. The delay in granting a license to Abbott has fueled accusations that the state ignored the dangers to blood recipients in order to give Pasteur time to perfect its test and seize control of the lucrative French market.

whole blood transfusion recipients encountered in mobilizing, publicizing their demands, and securing compensation.

2. Blood Products

Hemophilia is a blood-clotting disorder that exists almost exclusively in men. For centuries, there was little that could be done to treat hemophiliacs. Their condition required them to avoid activities likely to cause bleeding. Even so, those with severe cases of hemophilia often experienced crippling bleeding in their hips, knees, and other major joints, and many died from blood loss at an early age. Whole blood transfusion, and, later, blood plasma exchange, provided the first opportunities to treat hemophiliacs, but the expense, discomfort, and limited efficacy of these treatments left most individuals affected by hemophilia hoping for technical advances that would enable them to lead less restricted lives.

Those hopes were answered in the mid-1960s. By freezing and centrifuging whole blood, scientists developed cryoprecipitate (cryo), a protein-rich product that aided the clotting process. Japanese, French, and U.S. medical regulatory bodies quickly approved the use of cryo as a hemophilia medication, and it became the primary treatment for most hemophiliacs. Although it did not completely alleviate the bleeding condition caused by hemophilia, it did enable those with relatively mild cases of hemophilia to "normalize" their lives.

Less than a decade later, scientists discovered a technique to isolate factors VIII and IX from blood plasma. Those concentrates, which could be injected either prophylactically or therapeutically, made it possible for people with hemophilia to engage in contact sports, go to regular schools and camps, and largely abandon the fear of fatal hemorrhaging. In a phrase regularly used in Japan, hemophiliacs were able to "come out," shed the shame of genetic difference, and begin to lead truly "normal" lives. As the French Hemophilia Association put it, "[E]very person to the Summit of Mont Blanc" (Steffen 1997).

Blood factor concentrates were a breakthrough technology, and hemophiliacs (or their families) pursued further autonomy by demanding the right to self-inject their medication. People in France, Japan, and the United States all declared that they or their offspring should not have to visit physicians' offices for a simple injection of blood product. Thus, by the early 1980s, when HIV was increasingly present in the blood supply, it was possible for hemophiliacs in France, the United States, and Japan to obtain a supply of clotting factor, leave it in a refrigerator, and use it when necessary. Not surprisingly, given the discretionary way in which such products can be used, consumption everywhere dramatically increased.

The lifestyle transformation that the use of these products engendered, and the enthusiasm with which they were consumed, came at a significant cost. Lurking just beyond the triumphant pronouncements of both doctors and patients, or rather imbedded within them, were two impending crises. First, the very process through which blood products were manufactured contained the seeds of possible disaster. In order for the process to be economically efficient, blood plasma from hundreds or thousands of different individuals was combined, or "pooled." Pooling meant that if even one blood or plasma donor was HIV-infected, all blood products made from that batch of plasma would be tainted with HIV. Consequently, the risk of HIV infection from the use of blood products is much higher than that from whole blood. Hemophiliacs using plasma concentrates were exposed to the blood of hundreds, thousands, perhaps tens of thousands, rather than the blood of only one or a few donors.

To make matters worse, unlike the norm of non-remuneration for whole blood donation, the American plasmapheresis (blood plasma collection) industry is a for-profit business that pays people to undergo the unpleasant task of providing plasma. The market incentives of the sellers, some have claimed, meant that even those who may have been at high risk for HIV infection continued to sell their plasma (Sapolsky 1989:145–63). This fact was relevant not only to American blood product consumers but also to consumers in Japan, for example, who used American products. There, the not-for-profit Japanese Red Cross controlled the collection and distribution of whole blood, while blood products, like other medications, were left to the control of pharmaceutical companies. Prohibited from paying donors for whole blood or blood plasma, those companies imported manufactured blood concentrates from the United States. This route of exchange underlies the conclusion that "dirty" American blood was to blame for the HIV infection of almost half of Japan's hemophiliacs (Feldman 1999:59–94).

The second crisis to come from the use of blood factors was that hemophiliacs, their physicians, and public health officials came to realize that the process of pooling plasma and manufacturing blood product concentrates exposed hemophiliacs to hepatitis B. Compared to the debilitation of hemophilia, they considered hepatitis B to be a relatively minor problem, an "acceptable risk," easily offset by the benefits of the enabling products (Resnick 1999:66). The calculation that the benefits of blood products outweighed their possible drawbacks in part clouded people's ability to balance accurately the salutary aspects of the new blood therapies with the possibility that those therapies might themselves be transmitters of infection and death.

In fact, scientists had long been trying to rid blood products of the hepatitis B virus. They pursued various methods, such as

washing the products with a detergent, but ultimately it was heat that appeared to work most effectively. Finding the ideal time and temperature at which to heat the products was a challenge; too much heat would not only inactivate the hepatitis virus but would also render the positive qualities of the product useless. And perhaps because the market for blood products was so strong, manufacturers did not have a powerful incentive to expedite a purification process that might increase the cost of an already expensive product and possibly introduce new, unanticipated risks.

As concern mounted about the connection between HIV and blood, however, and as the CDC reported an increasing number of cases of hemophiliacs with AIDS, heat treatment suddenly represented more than a way to prevent the spread of hepatitis. If heat purged the hepatitis virus, so too might it purge whatever was causing AIDS. By March 1983, the U.S. Food and Drug Administration (FDA) approved Baxter Healthcare's heat-treated blood product, and by February 1984 the FDA approved the sale of heated products by Miles Incorporated, Alpha Therapeutics, and Armour Pharmaceuticals (Institute of Medicine 1995:92). Heated products were available in France by September or October 1985 (Steffen 1999:95–126), and by July 1985 in Japan.

Thus, by early 1984, public health authorities internationally were aware of U.S. regulators' confidence that heat-treating blood products could effectively limit the spread of AIDS. Tragically, from the late 1970s, when HIV first appeared in the blood supplies of the industrialized world, until heat-treated products were routinely available (in mid to late 1985), government, industry, and individual physicians widely distributed HIV-tainted blood products. Hemophiliacs had entered an era they dramatically describe as a "hemophilia holocaust" (Starr 1998).

B. HIV in the Blood Supply: The Calm Before the Storm

Individuals infected through transfusions and hemophiliacs infected through blood products now see themselves as affected by quite different sorts of problems. Yet in late 1985, when both whole blood and blood concentrates were virtually "HIV-free" in the United States, France, and Japan, few people were thinking of themselves as "victims" of either individual or institutional wrongdoing. There was no overt political conflict over blood policy. Neither courts nor legislatures were called in to mediate disputes over HIV and blood. The media did not beat the drums of outrage as an increasing number of hemophiliacs and blood transfusion recipients discovered that they were HIV infected. And the public remained largely unaware that a bitter battle was brewing over why so many people had become infected and who was responsible for the "gift of life" becoming a vector of death.

Indeed, from the perspective of 1985, even people with acute foresight would not have predicted that a series of international blood feuds was soon to erupt. Instead (and despite conflict between French and American scientists over the discovery of HIV), throughout the early and mid-1980s attention was focused on how to limit the spread of HIV through whole blood and blood products. There was a rapid sharing of scientific and policy information between elites in Japan, the United States, and France and a resulting general convergence of blood policies. Basic information was now available, such as epidemiological data, blood bank policies of donor exclusion, and data about heated blood products. More importantly, government agencies, not-for-profit whole blood collection and distribution agencies, and private sector companies involved in plasma and blood concentrate manufacture, importation, and sales undertook similar regulatory measures. Ultimately, Japanese, American, and French regulations concerning the collection of whole blood, the implementation of a blood test for HIV-antibody, and the approval and distribution of heat-treated blood concentrates were enacted and implemented within months of each other,[11] despite complex domestic interests that needed to be reconciled.[12]

Moreover, the HIV-related policies of the three nations appear to have floundered in similar ways, and at similar times. In all three countries, whole blood was collected from potentially HIV-infected donors before the not-for-profit blood banks recognized the link between blood and AIDS. Contaminated whole blood and blood products continued to be distributed after the possible risk of HIV infection was known to many policymakers and blood experts. Hemophilia groups failed to sound a warning to their members about the emerging consensus that use of blood products could cause the transmission of AIDS. And physicians continued to treat their hemophiliac patients with blood concentrates without alerting them to the products' possible dangers. Combined, these elements help to explain the most tragic of similarities—that close to half of French, American, and Japanese hemophiliacs were infected with HIV, and that thousands of French and American (though few Japanese) people became infected through whole blood transfusions.

Despite these notable overlaps, it would be inaccurate to suggest that there were no meaningful national differences in the conditions leading to an HIV-contaminated blood supply. One such difference is the lapse of 20 months before Japan joined the

[11] While Baxter's heat-treated blood concentrates were approved in March 1983 by the FDA, which was almost two years earlier than such products were approved in Japan or France, heated products in all three countries did not become widely available until mid-1985.

[12] For example, the Japanese Ministry of Health and Welfare (MHW) was reluctant to accept U.S. data on the safety of heated products, and said that it needed to conduct its own tests before concluding that the products were safe.

United States in testing whole blood. One might reasonably expect such a delay to have caused considerable conflict in Japan. Yet, ironically, this single, most obvious difference among the U.S., French, and Japanese policy responses caused not a ripple of concern. It did not figure into the Japanese litigation over tainted blood, nor was it used to suggest that regulators or the Japanese Red Cross were incompetent. This situation can only be explained by the later-understood fact of the virtual absence of HIV-infected blood donors in Japan and the consequent lack of HIV infections caused by the delay in testing blood.

Other differences also existed. In France, for example, the government built a factory that was expected to make France a "European superpower" in blood products. The factory only processed whole blood collected in France and was built before it became clear that heat-treating would increase the safety of such products.[13] It could not be easily retooled. As a result, French blood products, manufactured exclusively from French blood, infected French hemophiliacs. In contrast, Japanese officials did not rely on domestic blood to manufacture blood products. Over 90% of Japan's factors VIII and IX were imported from the United States, and unheated products were distributed until mid-1985. Japanese hemophiliacs thus blame their infection on foreign blood products, in contrast to the French, who claim that such products may have been lifesaving.

Additionally, donating blood in France is thought of as an act of social integration, for example, so French officials collected whole blood in prisons, where there was a steady supply of willing donors. Unfortunately, HIV-infection rates in the prison population were high, which largely explains the 6,000 to 8,000 cases of transfusion-associated HIV in France. Another notable dissimilarity is that the United States led the world with respect to HIV-related policy and innovation, in part because of its high seroprevalence of HIV, its internationally respected public health regulatory system, and the disease surveillance capabilities of the CDC. Consequently, in almost every area of policy related to blood and HIV, the United States acted first. In Japan, where there were few AIDS cases (the first case of AIDS in Japan was reported in 1985),[14] even incompetence and inaction in securing the whole blood supply would have been inconsequential because almost no HIV-tainted whole blood was donated.

Nonetheless, in the years 1982–1985 there was only minor legal and political tension over HIV and blood in France, the United States, and Japan. Each of these countries appeared to be

[13] Blood products can also be made from whole blood, rather than blood plasma (as in the United States). This method has the advantage of utilizing donated whole blood, but has the disadvantage of requiring a large amount of whole blood to manufacture a small amount of product, and is thus less economically efficient.

[14] For an analysis of this case see Feldman & Yonemoto (1992).

experiencing a typical public health policy debate, carried on in closed quarters among elites who (despite certain disagreements) were able to compromise and enact policy without significant obstacles. The similarities among these countries in terms of the content and timing of their policies should not, of course, obscure the fact that even relatively small differences—a lag of one or two months by a country in implementing blood-screening methods, for example—may have resulted in additional HIV infections and deaths. But such differences do not explain the emergence and at least partial resolution of conflicts over HIV and blood in any of the three nations.

V. Legal Conflict over Blood in the United States, Japan, and France

By the late 1980s, the damage caused by the distribution of HIV-contaminated blood was clear. In Japan, approximately 2,000 of a total hemophiliac population of 5,000 were HIV infected; in the United States, at least 90% of those with severe hemophilia had become infected, and close to half of America's 20,000 hemophiliacs were HIV-positive; in France, with 3,000 cases of severe hemophilia, 1,200 were infected.[15] In addition, there were 4,000 to 6,000 blood transfusion–associated cases of HIV infection in France (Steffen 1999:109), almost 29,000 in the United States (Bayer 1999:33–34), and a handful in Japan, as well as spouses of hemophiliacs and newborns treated with blood products who tested positive for HIV.

In many instances, those caught in the crisis of HIV and blood saw themselves as different from others infected with HIV, such as gay men and intravenous drug users. Hemophiliacs in particular considered themselves the passive, "innocent" victims of a "drug-induced disaster" that was the fault of physicians, elected officials, government regulators, pharmaceutical companies, and blood banks, but not themselves. In all three countries, by 1990, groups and individuals who were HIV-infected through the blood supply had begun a search for someone or something that was responsible for their plight. They petitioned, sued, and lobbied, sometimes demanding apologies and money from, other times punishment of, those they believed were at fault. Everywhere, they sought to change the HIV/blood issue from a technical hunt for ways to improve blood safety to a prolonged legal and political controversy over justice, responsibility, and fault.

[15] There is no internationally consistent measure of the exact number of people affected by hemophilia. Because hemophilia can be mild or severe, there is a good deal of discretion whether to include particular individuals in public health statistics.

A. The United States

1. Legal and Regulatory Background of Blood in the United States

The most important and unusual aspect of the legal conflict over HIV and blood in the United States is the extent to which it has been affected by what are known as the blood shield laws. These laws were born from a controversy involving two local Kansas City commercial blood banks, the not-for-profit Community Blood Bank (CBB) of Kansas City, the local hospital association, and a group of pathologists. The commercial blood banks complained to the Federal Trade Commission (FTC) that the CBB and the large local hospitals were engaged in the restraint of trade. In 1966, in a case that ultimately involved 20,000 pages of documents and cost the government almost $500,000, the FTC ruled that the CBB and local hospitals were illegally limiting commerce in whole blood.[16]

The FTC ruling set off a panic in the blood world—suddenly, blood would be considered a product, like a computer or a book, and not a special, lifesaving community resource. As Tibor Greenwalt, the editor of *Transfusion* and a prominent blood expert stated, "If blood is to be treated like any other pharmaceutical product, all the efforts of those who have worked so hard to assure adequate supplies of blood from volunteer donors during the past 25 years have been wasted" (quoted in Starr 1998:196). Even before the FTC decision was announced, in 1964 a U.S. Senate subcommittee had debated legislation that would create an antitrust exemption for blood by defining it as a medical service rather than a product. The bill died in committee, and when it was reintroduced three years later, it again failed (Starr 1998:205). Nor did appeals of the FTC's ruling provide much relief for the not-for-profit medical community. In the first appeal, to an FTC panel, the decision was upheld. When a federal appeals court overturned the original finding, it did so only on jurisdictional grounds, holding that the FTC lacked authority over the not-for-profit blood banks (*Community Blood Bank of the Kansas City Area, Inc. v. FTC* [1969]).

The overturning of the FTC's ruling did not calm the concerns of the blood-banking community, which was determined to define itself as providing a service and thus beyond the reach of strict liability. Blood banks took their case to the states. By the late 1970s, each of the 50 states had exempted blood from product liability. Although some states sought to do this through case law, 48 enacted specific legislation, known as blood shield laws,

[16] In the matter of *Community Blood Bank of the Kansas City Area, Inc. vs. FTC*, 405 F2nd 1011 (1969), 1966. Richard Titmuss (1971:158-172) provides an interesting description and interpretation of this case in *The Gift Relationship: From Human Blood to Social Policy*.

that prohibited product liability lawsuits against blood banks. The reasoning of the states was straightforward. All U.S. citizens, as members of a common community equally prone to emergencies requiring transfusable blood, share an interest in having an available and affordable supply of blood. Because blood is an organic substance that inevitably carries some risks, however, even the most cautious blood suppliers may inadvertently provide a "gift of life" that poisons rather than cures. Were blood banks held to too high a standard of care, their legal costs would force them to sell blood at an extremely high price or go out of business. As a seminal New York case put it, if courts considered the provision of blood the sale of a product, "it would mean that the hospital, no matter how careful, no matter that the disease-producing potential in the blood could not possibly be discovered, would be held responsible, virtually as an insurer, if anything were to happen to the patient as a result of 'bad' blood" (*Perlmutter v. Beth David Hospital* [1954]). The decision that blood collectors and suppliers deserved special legal protection marked the beginning of the modern era of blood regulation.

For individuals who believe that they have been injured by receiving bad blood and want to seek recovery through the courts, state court decisions and the blood shield laws stand as a formidable barrier. Because blood is considered a service rather than a product, claims rooted in product liability and implied warranty are not allowable. As a result, the most common way for aggrieved individuals to seek recompense for blood-related injuries—whether caused by whole blood or blood products—is by alleging the tort of negligence.[17] Doing so requires plaintiffs to demonstrate that their injuries were caused by the failure of a blood provider to exercise reasonable care in collecting and distributing blood. Yet, in most cases, not-for-profit whole blood providers and corporate blood product manufacturers, united by their respective professional organizations, abide by common norms and practices.[18] When courts consider negligence claims and determine a provider's duty of care, they almost always look at industry-wide behavior as the most appropriate standard and will not rule that the entire industry has failed to act reasonably. Consequently, unless a particular provider is out of step with the industry as a whole, negligence claims will fail.

Two other aspects of U.S. blood policy merit mention. First, the United States is alone among industrialized nations in continuing to allow the widespread sale of blood. Even though the not-for-profit blood sector for several decades has been reliant

[17] Legal analyses of blood bank liability include Westfall (1989:1001), Glasgow Lotfi (1991:183), Russo (1992:87), and Eckert (1992:203).

[18] For the not-for-profit blood sector, the Association of American Blood Banks is the largest and most important organization. Its counterpart in the for-profit sector is the American Blood Resources Association.

upon non-remunerated blood donation, for-profit blood product manufacturers continue to pay people who provide blood plasma.[19] Payment is in part justified by the time and discomfort attendant to plasma donation. More importantly, it has allowed the U.S. pharmaceutical industry and multinationals with a presence in the United States to capture most of the world's plasma market. Legally protected by blood shield laws and presiding over a vast supply of blood plasma, these companies have remained relatively untouched by the American battles over HIV-tainted blood.

Second, until the mid-1990s regulatory authority over blood in the United States lacked any central or coherent focus. The CDC tracked the epidemiology of various blood-related pathogens, but lacked authority to implement, or even to design, regulations. The National Institutes of Health (NIH) and Department of Health and Human Services (DHHS) had no office dedicated to blood policy. The Food and Drug Administration's (FDA) Blood Products Advisory Committee (BPAC) was the closest governmental body to a central blood policy authority. Compromised by its lack of direct policymaking power and dominated by industry, however, it lacked both authority and credibility. As a result, the United States offered legal protection to the world's leading producers of blood products and the largest system of whole blood collection but lacked adequate bureaucratic or political oversight of the blood system.

2. U.S. Litigation over HIV and Blood

When hemophiliacs and blood transfusion recipients in the United States discovered that they were HIV infected, they voiced a shared sense of anger and betrayal.[20] They had followed the advice of the National Hemophilia Foundation (NHF) and/or their physicians, had used the drugs or whole blood provided by U.S. suppliers, and, in some cases, had been attentive to the announcements of public health officials, yet many were infected and dying. Clearly, they believed, someone or some company was responsible for their plight. As Elaine DePrince (1997:8), the mother of HIV-infected hemophiliacs, writes, "My sons were infected with HIV and died of AIDS because they used a blood product approved by the Food and Drug Administration. The FDA failed my children. The blood-banking industry failed them. Government agencies failed them. The law failed them."

As they began hiring lawyers to articulate their claims, the infected-blood recipients and their families discovered a legal regime that presented numerous barriers to successful legal action

[19] One verbal inconsistency of the blood world is to call those who sell their blood plasma "donors."

[20] Resnick (1999) provides an "insider" account of the reaction.

(see part V.). They had two choices: they could try to convince the courts that a particular blood product manufacturer or blood bank was a renegade, out of step with industry standards, and therefore negligent; or they could argue that the entire industry was negligent and should be held accountable for the distribution of HIV through blood. The first wave of individual claims filed over HIV and blood, ending in the late 1980s, asserted that defendants had failed to exercise a reasonable degree of care in collecting and distributing blood, which caused the plaintiffs to become infected with HIV. In almost all cases, courts relied upon an industry standard and found for the defendants. Only in a few cases, for example, those in which juries were instructed to use a general reasonableness standard or in which blood banks acted differently than the industry as a whole, did plaintiffs prevail (Eckert 1992:269–71, n253–58). Of the estimated 300 cases filed by 1993 (almost 1,000 cases were eventually brought), few courts upheld plaintiffs' claims.[21] In short, many infected individuals sought relief through the courts, but they rarely were successful.

Perhaps the most important case in the early years of litigation was filed in 1988 by a transfusion recipient, Suzie Quintana, who claimed that the entire blood industry was at fault for her infection (*Chris and Suzie Quintana v. United Blood Services*). The court rejected her claim, stating that the legal standard was whether the defendant, United Blood Services, abided by the industry standard of blood banks. She appealed, arguing that the lower court erred in rejecting her challenge to the industry standard. Quintana died on the same day that the appellate court awarded her $8.1 million. The final amount of the award was eventually settled out of court (Starr 1998:335). This and other judgments left hemophiliacs and blood transfusion recipients in a difficult situation. Individual litigation was costly and would most likely fail, but lumping it was psychologically and ethically unappealing. When several U.S. hemophiliacs began to mobilize their peers, they found a receptive audience.

By 1993, two groups of hemophiliacs had been formed. The Committee of Ten Thousand (COTT), named for the 10,000 American hemophiliacs reportedly suffering from HIV-related illnesses, adopted a strategy of lobbying for compensation. The Hemophilia/HIV Peer Association was more antagonistic. Michael Rosenberg, the leader of that group, called the former director of the National Hemophilia Foundation (NHF) "the Josef Mengele of the hemophilia holocaust" and accused both the blood industry and the NHF of ignoring the needs of hemophiliacs. Together, the two new organizations were remarkably successful in mobilizing their constituency. In 1993, they

[21] Though it is difficult to obtain data on all U.S. cases, several authors have attempted to do so. See, e.g., Kelley & Barber (1992) and Kern & Croy (1994:484–91). Starr (1998) asserts that almost 1,000 cases were filed, but provides no reference for that figure.

were able to file a class action against five blood fractionators and the NHF, a case that involved attorneys from ten firms and almost 9,000 patients but no transfusion recipients, who were left to fend for themselves (*Wadleigh v. Rhone-Poulenc Rorer, Inc.* [1994]). The long-standing links among American hemophiliacs —many of whom were members of hemophilia organizations, sought treatment from the same physicians, went to common camps and schools, and read the same specialized publications— served both to unify plaintiffs with hemophilia and to exclude blood-transfusion recipients (Kirp 1999:293–322).

Like many individual claims, the class action sought to prove that the defendants—Baxter Healthcare Corporation; Rhone-Poulenc Rorer, Inc.; Alpha Therapeutics Corporation; Miles, Inc.; Armour Pharmaceutical Company; and the NHF—were negligent in distributing HIV-infected blood products and assuring hemophiliacs about product safety in the 1980s. Yet leaders of the Hemophilia/HIV Peer Association and COTT were not content to rely on their attorneys to secure a legal victory. Long convinced that they were victims of professional arrogance, corporate greed, and government apathy, they sought attention from the general public. Describing themselves as "innocent" victims whose life-saving medicines had caused a life-ending illness, press releases, newsletters, speeches, and government testimony by spokespersons for hemophiliacs argued that the rights of hemophiliacs had been trampled and that they deserved justice. In the words of a hemophiliac who attended the 1993 NHF annual meeting, "I don't give a shit about the compensation. What are the chances of putting these criminals in jail? I'll give you everything I've got. I'll sell my house, I'll sell my business—just *get* those sonofabitches!" (Starr 1998:342).

Judge John Grady of the U.S. District Court certified the U.S. class action in August 1994, and hemophiliac agitation continued. Despite the Hemophilia/HIV Peer Association's and COTT's determination to generate a social movement to complement their litigation, U.S. hemophilia activists were unable to transform the HIV/blood issue into a scandal that captured public attention. As Theodore Marmor et al. have written, "Whether scandal emerges in any particular case depends in large part upon the degree to which those disclosing or investigating the wrongdoing are successful in capturing and maintaining public attention as the investigation and disclosures continue" (1999:353). COTT, the Hemophilia/HIV Peer Association, and others sympathetic to the hemophiliacs, the "disclosers" of scandal, tried mightily to frame their cause as a titanic struggle by a marginalized group to identify the outrageous conduct of callous organizations. Despite the terrible fact that many hemophiliacs were HIV-positive, however, advocates failed to attract much public attention. Unlike the incessant television, radio, and print cov-

erage of conflict over HIV-tainted blood in France and Japan, the issue in the United States did not capture the imaginations of a core of committed journalists, nor did it serve as a call to arms for others who might have joined the hemophiliacs' struggle. One can find dozens of popular books about HIV and blood in France and Japan; but even U.S. mega-stores like Barnes and Noble offer little about the U.S. HIV/blood controversy, for the simple reason that few books have been written on the topic for a general audience.[22]

Nor did the "investigators" of scandal, such as the authors of a 1995 Institute of Medicine (IOM) report on HIV and the blood supply, or the attorneys and judges involved in the HIV/blood cases, capture public attention. Mass torts, such as the Dow breast implant case, where claims of corporate negligence and campaigns to publicize the injuries of the defendants overcame tenuous assertions of causation, culminated in a series of judicial opinions and a huge cash settlement that were front-page and top-of-the-hour news stories (Angel 1996). Most court decisions in the HIV/blood cases, in contrast, lacked the bite needed to attract the spotlight, and the media largely buried those (such as *Quintana*) that did tell a gripping human story. The most visible litigation over HIV and blood featured legal clashes that neither captured nor maintained public attention. Judge John Grady's certification of the class action was big news to the parties in the case, but it barely caused a ripple beyond those immediately involved. Not even the class decertification by the Seventh Circuit Court of Appeals, in a decision written by Richard Posner, pushed the conflict into the open. Posner was concerned that the defendants could "easily be facing $25 billion in potential liability (conceivably more), and with it bankruptcy."[23] He worried that they would be "under intense pressure to settle" in a "blackmail settlement," although there was a "great likelihood that the plaintiffs' claims, despite their human appeal, lack legal merit."[24] Judge Posner's decision was reported by major U.S. newspapers, but without any sustained attention. And when the class action plaintiffs, who remained linked for settlement purposes, accepted a court-supervised conclusion to their claims, it garnered even less attention. Clearly, this is not the stuff of scandal.

Moreover, the HIV/blood plaintiffs in the United States were unsuccessful in negotiating for generous compensation. Settlement of the class action yielded approximately $100,000 per infected plaintiff, many of whom lacked adequate health insurance and had mounting legal bills, and all of whom were dying. Payments from the settlement were long delayed, and even central

[22] DePrince's (1997) is one of the few books of this type.

[23] *In the matter of Rhone-Poulenc Rorer Inc., et al.,* 51 F.3d 1293, 1298 (7th Cir. 1995).

[24] Ibid., 1299.

players in the negotiation, like COTT, rejected the settlement as "a profound betrayal" by their lawyers (Bayer 1999:52). The courts were surely at the center of conflicts over HIV-contaminated blood, but those conflicts never bubbled over into symbolic narratives of how a small and marginalized group of people with a genetically caused disease were dying "preventable" deaths. Unlike in the cases in Japan and France, the plaintiffs in the United States did not pursue criminal charges, and defendants were limited to corporations and associations, rather than to individuals and the state. Even the most overt politicization of the issue, in the form of proposed legislation and lobbying for a federal law to provide compensation to hemophiliacs, failed. Named after an HIV-positive hemophiliac boy in Florida, whose house was burned down by thugs who didn't want him to attend the local public school, the Ricky Ray Hemophilia Relief Fund Act floundered in Congress for several years before it was passed late in 1998. Coming as it did almost a decade after other industrialized nations had designed state compensation schemes, paying less than many of them, and excluding those who became HIV-infected though blood transfusions, the Act was the final scene in a not-very-dramatic public drama.[25] Rather than serving as an emotional climax, a financial and moral vindication for hemophiliacs, it was greeted as too little, too late by many involved parties.

In sum, the story of HIV and blood stands in sharp contrast to such well-publicized tort cases as the Dow breast implant litigation, the asbestos litigation, and others that have been at the center of debates about litigiousness, courts, and social policy in the United States. In all of the highly publicized cases, such legal matters as causation were notoriously difficult to prove. In all of them, plaintiffs demanded a mix of financial relief and moral vindication. The HIV cases, however, never entered the public's consciousness, never emerged as a symbolic clash between corporate greed and individual powerlessness, and never pitted the authority of the state against the submissiveness of patients. That perhaps makes them "normal" in the context of conflict in the United States. Most cases, even when advocates desperately want to bring their claims into public view, remain mundane affairs known only to those directly involved. Because U.S. courts did not emerge as crucial actors in debates over blood policy, compensation was paid reluctantly and stingily, and the legal conflict remained a relatively narrow technical affair rather than spilling over into a general debate over social justice, the HIV cases should be considered "typical" tort claims, resolved in a routine manner. It is therefore particularly interesting that in Japan and

[25] In September 2000, funds were finally appropriated to pay the compensation detailed in the Act.

France, what appeared to be private conflicts over HIV and blood, confronted by seemingly insurmountable doctrinal, political, and institutional hurdles, erupted into volatile political scandals.

B. Japan

1. Legal and Regulatory Background of Blood in Japan

Japan's war crimes in Manchuria, some involving human experimentation aimed at better understanding the properties of blood, remain one of the most reprehensible acts of the twentieth century (Harris 1994). Many of the victims were tortured and murdered by Japanese scientists, and some of the scientists used their newfound knowledge to start Japan's first blood bank; it was called the Nippon Blood Bank, and later renamed the Green Cross Corporation. From 1950 until the mid-1960s, the business of buying whole blood from needy individuals and selling it to hospitals thrived in Japan. But when the U.S. Ambassador to Japan, Edwin Reischauer, was attacked on the streets of Tokyo in 1964 and contracted hepatitis from the transfused blood he received in a Japanese hospital, blood policy underwent a substantial shift. Stung by international criticism that the commercial incentives of the for-profit blood industry were both immoral and antithetical to public health, the Japanese government quickly transformed the collection and distribution of whole blood into a not-for-profit enterprise.

Eliminating the profit-driven blood banks in Japan achieved what the post–World War II U.S. Occupation forces could not accomplish. General MacArthur's staff had persuaded the Ministry of Health and Welfare (MHW) to put the Japanese Red Cross Society (JRC), founded in 1868, in charge of blood collection. The JRC opened its first blood bank in 1952, based on non-remunerated donations, and had planned to make Japan self-sufficient with regard to its blood supply. By 1955, however, it was clear that the JRC could not successfully compete with the Green Cross, and it too began to purchase blood. When the tides changed and commercial blood banking became impossible, the JRC was once again in a position to take control of the not-for-profit blood sector.

The entrenched interests controlling Japan's commercial blood banks were not keen to abandon the blood business. Just as the JRC was consolidating its control over whole blood, the entrepreneur who had used his military past to develop Japan's blood banking industry, Naito Ryuichi, recast his business into a pharmaceutical company that could buy and sell products made from blood. His company, Green Cross, became Japan's most successful pharmaceutical venture, and by 1980 it was the coun-

try's largest importer and distributor of blood plasma derivatives, almost all of which came from the United States. Japan's dependence on imported blood concentrates, which lasted until calls for national self-sufficiency were heeded in the 1990s, contributed to the conclusion that the HIV-infection of Japanese through blood could have been avoided if domestic, donated blood was used to manufacture blood products. This intertwining of the symbolic and the economic supported a view that domestic blood was purer, cleaner, and safer than foreign blood. Like the conflict in France, described in the following section, all parties to the controversy in Japan agreed that the national interest, national blood, and blood safety were in some way inextricably intertwined.

The restructuring of Japan's blood system from its singular reliance on domestic, purchased blood to a two-tiered system—locally donated whole blood but blood products imported from the United States—had two important consequences. First, it brought into existence a number of uncoordinated, overlapping regulatory networks that continue, at least in part, to endure. The need for accountability between the JRC and the MHW, for example, was overshadowed by the symbolic connection between the JRC and the royal family, a member of whom has always been its honorary chair. The association with royalty has contributed to an aura of invincibility around the JRC, making it unusually autonomous and relatively free from the regulatory reach of the MHW. The MHW and the Green Cross, in contrast, developed an extremely close relationship. As regulators from the MHW reached retirement age and left the government, they almost always found a soft landing at the Green Cross, where they used their connections to smooth government-business relations. The difficulties experienced by foreign firms seeking to market certain types of blood products in Japan can be explained in part by the MHW's industrial policy of favoring such domestic corporations as the Green Cross over foreign enterprises.

The second consequence of Japan's restructuring is that, in giving its blessing to a blood system divided between whole blood and blood products, the MHW decided to treat blood products like other pharmaceuticals. Physicians in Japan have long both prescribed and provided medications, and sales of pharmaceuticals continue to constitute a non-trivial portion of doctors' incomes. The cost of most drugs is borne by the state rather than individual patients; what usually occurs is that doctors provide medications to patients and then apply to the government for reimbursement. The MHW sets a fee schedule that predetermines the exact amount of reimbursement, allowing physicians to profit from the difference between how much they pay for medicine and how much they will be reimbursed (Ikegami & Campbell 1995:1297). Even though the supply of domestic blood

products was limited and these products were significantly more expensive than imported products, the reimbursement level for blood products was determined based upon domestic supplies. Consequently, the MHW's reimbursement policy put Japanese physicians in the position of having a financial incentive to overprescribe imported blood products.[26]

All of these institutional and historical factors came into play as experts and the public learned that 2,000 Japanese hemophiliacs were HIV-infected.[27] Potentially benign industrial policy preferences were seen as masking corrupt government-business ties that protected market share over human life. Long-standing weaknesses in the state's regulatory power were recharacterized as recent failures that signaled the need for bureaucratic reform. Dependence on an international supplier of blood products, the United States, was depicted as immoral and as inevitably leading to an impure blood supply. And the standard practice of pharmaceutical reimbursement opened the door to charges that the medical system in Japan was structured to maximize blood product sales at the expense of individual health. In 1989, the HIV/blood conflict became the subject of a bitter but circumscribed conflict; by 1995, it was widely regarded as one of the biggest scandals of the postwar era.

2. Japanese Litigation over HIV and Blood

Hemophiliacs in Japan began lobbying the MHW in the mid to late 1980s as part of an effort to defeat legislation that they believed was discriminatory. As the only vocal opponents of the AIDS Prevention Act, hemophiliacs worried that public health regulations would not distinguish them from gay men, intravenous drug users, and others at high risk of HIV infection. In the eyes of hemophiliacs, and perhaps the public generally, hemophiliacs were different. They saw themselves as victims of a gross medical crisis caused by the actions of others, not their own behavioral choices. Determined to be publicly vindicated, they fought either to have the category "hemophiliac" eliminated from the proposed law or to defeat the law completely.

In addition, hemophiliacs in Japan sought an affirmative display of contrition from the MHW. They believed that the Ministry was responsible for their "drug-induced disaster," and they demanded an apology and financial compensation. In an attempt to limit hemophiliacs' opposition to AIDS legislation, MHW officials sought to satisfy their demands. In April 1988, the Ministry announced the establishment of a system of financial payments

[26] A more detailed description of the pharmaceutical industry can be found in Powell & Anesaki (1990:179–86).

[27] It now appears that the actual number of HIV-infected hemophiliacs in Japan is approximately 1,500.

to hemophiliacs (HIV Kansen Higai Kyusai Seido), a scheme that provided from $250 to $1,800 per month to HIV-infected hemophiliacs or their families. The Ministry, however, did not yield to hemophiliacs' insistence of an apology, calling the payments simply "relief" (*kyusai*) rather than "compensation" (*isharyo, hosho*), which would imply responsibility or fault. Unsatisfied with what they thought of as token payments, and intent on resolving the question of who was responsible for their tragedy, hemophiliacs brought their claims to the courts.

In 1989, two groups of hemophiliacs filed lawsuits in the Tokyo and Osaka District Courts. They accused the defendants—Green Cross Corporation, Cutter Japan, Baxter International, Bayer A.G., Nippon Zoki Pharmaceutical Corporation, and the MHW—of negligently distributing HIV-tainted blood and demanded an apology and almost one million dollars each. Even though Japanese law lacks the class action device so important to U.S. plaintiffs in mass tort cases, hemophiliacs were able to utilize other procedures to unite themselves under a common set of claims. Leading the litigation was Suzuki Toshihiro, a radical lawyer and activist who was a key player in the patients' rights movement. Closely allied with him was the left-wing hemophiliac attorney Yasuda Yukuo, and a group of younger lawyers, most associated with the Japan Civil Liberties Union, who were doing pro bono work. Hemophilia groups and their attorneys quickly began building litigation support organizations, such as the HIV Sosho o Sasaeru Kai (HIV Litigation Support Group). They demonstrated at the MHW, held rallies and sit-ins, and sought to capture the attention of the mass media. Despite their efforts, for the first several years after the lawsuits were filed, activists had little reason to feel optimistic about the prospects of victory and had ample room for despair.

The greatest reason for their pessimism was that civil suits in Japan are notoriously slow. Litigation over environmental pollution, for example, took the courts several decades to resolve. A complex case like the HIV/blood suit could take ten years or more, years during which many plaintiffs would die. Moreover, the claims were directed at powerful defendants. Neither the MHW nor the Green Cross was easily intimidated, and they had little to fear from the conservative courts. Finally, the negligence claims themselves involved a controversial set of assertions about foreseeability and causation, which were complicated by technical disagreements about heat treatment of blood, blood testing, and risk not easily resolved in court. The best hope for Japanese hemophiliacs was to succeed where American hemophiliacs had failed. They needed to transform their relatively narrow set of legal claims into an issue that would galvanize public support, captivate the media, and become a symbol of the struggle of a

small, disempowered group against the entrenched interests of business, the state, and the medical profession.

The window of opportunity for Japanese hemophiliacs in their struggle for compensation came as a consequence of general political instability. In July 1995, when oral arguments in the HIV/blood lawsuits ended, Japan had a socialist Prime Minister and a Health and Welfare Minister who were more sympathetic to the demands of hemophiliacs than was the previous Liberal Democratic Party (LDP) government. It is difficult to identify specific behind-the-scenes consultations between the executive branch, the Ministry of Health and Welfare, the Ministry of Justice, and a specific court. But the proximity of the Health Minister's announcement that the government would participate in an informal resolution of the blood litigation to the announcement by the Tokyo and Osaka District Courts that they would propose an out-of-court settlement suggests that there was close collaboration. Judges in both courts were sympathetic to hemophiliacs, but were perhaps reluctant to write opinions with profound political repercussions. The sitting government was more willing to settle than previous administrations because it could accept general responsibility but cast real blame on its predecessors. And hemophiliac plaintiffs, one-third of whom had died in the five years since the claim was filed, were eager to resolve the case. With the inevitability of appeal, a formal opinion guaranteed that the conflict over infected blood would remain in dispute for years to come.

The Courts' first settlement proposal, in October 1995, made little effort to mask their compassion for the plaintiffs; emotion rather than legal argument filled the settlement recommendation. The judges, characterizing hemophiliacs as victims of discrimination who lived in fear of public humiliation and aggression and were unable to obtain adequate medical care, declared that hemophiliacs were dying from a tragedy for which they bore no responsibility. According to the District Court judges, the Ministry and the companies should have provided information about the potential danger of unheated blood products; promoted alternative therapies (such as use of cryoprecipitate, imported heated products, or the emergency manufacture of domestic blood products); or stopped selling unheated products. Because the defendants knew the risks posed by contaminated blood but pursued none of these options, the Courts suggested that the five companies and the MHW accept responsibility, apologize, and pay to settle the case.

Negotiations between the parties and the Courts began quickly, and again the shifting political situation came into play. A new Prime Minister from the resuscitated LDP was elected as part of a coalition government, and the job of Minister of Health and Welfare was given to Kan Naoto, a reformist politician

known for his support of grassroots causes. As part of a coalition in which he belonged to the smallest and most progressive party, Kan lacked a strong incentive to protect the ruling LDP. Moreover, he was knowledgeable about the HIV/blood issue and had his own views about how he wanted to approach the settlement. During the three months between the time he took office and the announcement of a final settlement, Kan was at the middle of a stunning transformation. He forced reluctant bureaucrats to "find" and hand over internal files that they had refused to produce during litigation, such as minutes of MHW blood policy meetings from the early and mid-1980s. When the files were located, he released selected documents indicating that officials had discussed the possibility that AIDS could be transmitted through blood but had decided against a shift in policy. In February 1996, Kan apologized to "innocent patients" for the "belated recognition of the Ministry's responsibility for the case" (*Japan Times,* 17 Feb. 1996, p. 1).

In the aftermath of the proposed settlement, hemophiliacs in Japan continued to press their demands. The HIV Litigation Support Group, whose membership had swelled from just a few hundred in the early 1990s to more than 4,000 by 1996, organized a rally at Waseda University. Commemorating the December 1 World AIDS Day, 1,400 students assembled on campus to show their support for HIV-infected hemophiliacs. Two weeks later, demonstrations were held in eight cities across the nation, with 2,000 people gathering at the MHW. One Waseda University student said of his interest in the issue, "I believe it is a good opportunity to think of the relationship between people and the state. We should change the current system of government, which decides things behind closed doors" (*Japan Times,* 13 Dec. 1995, p. 2). Another described her involvement by expressing surprise "at what we have done during the past year to raise public awareness of the disaster caused by bureaucrats and medical experts. We are very happy to hear that many people say our activities have been effective in helping a wide segment of the public to understand the victims' plight, leading to pressure on the government to change its stance on the issue little by little" (*Japan Times,* 17 Feb. 1996, p. 3). Other groups collected hundreds of thousands of petition signatures and staged a sit-in at the MHW in frigid February weather (*Japan Times,* 14 Feb. 1996, p. 3). Together with the stance of Minister Kan, these actions mesmerized the media and the public. The battle over HIV-infected blood, once a clearly hopeless effort by a small group of sick and dying individuals, had become a major national scandal.

In March 1996, the Osaka and Tokyo District Courts announced a final settlement of the HIV/blood litigation. All plaintiffs were awarded 45 million yen/person (almost $400,000), and additional payments were made to those with AIDS. But money

was only one feature of the resolution. Presidents of the five defendant pharmaceutical companies and MHW officials were required to apologize formally to the plaintiffs, leaving no doubt as to their moral and legal culpability. Institutional reforms were undertaken; MHW advisory committee meetings were opened to the public, for example, and the Biologics and Antibiotics Division of MHW, which had controlled blood policy, was restructured and named the Blood Enterprise Countermeasures Office.

Additionally, criminal complaints against several prominent actors in the HIV/blood drama, complaints that only months earlier seemed certain to perish without a trace, were taken up by public prosecutors. The Tokyo police arrested the government's top blood policy advisor, Abe Takeshi, in August 1996. According to Japanese prosecutors, Abe had ignored scientific evidence of blood product contamination when designing the blood policy of Teikyo University Hospital, thereby causing hemophiliac patients to become infected with HIV. Criminal accusations were also filed against Matsushita Renzo, former director of the MHW's Pharmaceutical Affairs Bureau and later president of the Green Cross Company. He and two other former presidents of Green Cross were arrested and put on trial for allegedly selling unheated blood products after the risk of doing so had been made clear. They pleaded guilty to professional negligence in 1997, and in February 2000 they were sentenced to between 16 and 24 months in prison (*Japan Times*, 24 Feb. 2000, p. 1).[28]

The conflict over HIV and blood in Japan, once a legally problematic negligence complaint, ultimately unsettled significant public institutions. It highlighted the relationship between health regulators and pharmaceutical corporations, with their close and possibly corrupt connections. It brought attention to accusations that public and private elites downplay public health risks while seeking financial gains and/or bureaucratic power. And it contributed to a political debate on bureaucratic reform, particularly greater transparency, less hierarchy, and more public participation. In short, two lawsuits borne from hemophiliac dissatisfaction with the Hemophilia Relief Fund catalyzed a sensational public drama with national repercussions and became a meta-narrative about law, social justice, and social policy.

C. France

1. Legal and Regulatory Background of Blood in France

In comparison to that of either the United States or Japan, the blood supply in France long has been centrally coordinated and controlled. Until recently, the top of the regulatory pyramid affecting blood was occupied by the Ministry of Health; within

[28] The sentences were immediately appealed to the Osaka High Court.

the Ministry sat the General Department of Health (GDH, Direction Générale de la Santé); under the control of the GDH were the almost 200 local blood centers (Centre de Transfusion Sanguine); and assisting the GDH in coordinating the national and regional aspects of blood policy was the Fondation Nationale de la Transfusion Sanguine. Yet, according to Monika Steffen (1999:100), "Despite the existence of the Fondation, blood policy was fundamentally heterogeneous [and] the missions of the blood centers were 'confused and ill-defined,' constituting a conglomeration in which the only link was blood." Legal scholar Marie Angèle Hermitte (1996:132) echoes this view, describing a "republican feudalism" that allowed each blood center to monopolize the local collection, transformation, and sale of blood. Similarly, Aquilino Morelle (1996:211) describes the French state as a "giant" but the health sector as a "dwarf."[29] The appearance of a tight regulatory hierarchy thus masks a potent reality—that the French blood system was a collection of independent, sometimes incompatible, entities that were ideologically and structurally distinct.

Three additional aspects of France's blood policy are particularly important to the legal crisis that later raged over the distribution of tainted blood. First, like Japan, France manufactured few blood products in the early AIDS years. In part a reflection of their distaste for "foreign" blood, in part a sign of prudence in the face of a new technology, French physicians and professional organizations clung to the use of cryoprecipitate well after their counterparts in other nations had started to use more advanced products. In 1980, when public health officials began to actively develop a domestic supply of blood products, seven regional centers were created to turn domestic whole blood into factor VIII, the most common clotting factor used by hemophiliacs. Affirming the importance of national self-sufficiency in whole blood and blood products, in 1982 the government began pumping money into the National Blood Transfusion Center (CNTS, Centre National de la Transfusion Sanguine), its largest factory for blood product manufacture. At the helm of CNTS was Michel Garretta, whose goals were to make the CNTS the center of France's domestic blood industry and to eliminate dependence upon foreign blood products by relying on donated, domestic blood.[30] At about the same time, importation of foreign blood products was banned.

The timing of this foray into the blood business could not have been worse. Between 1982 and 1984, the CNTS's production of blood products in France rapidly increased, and the num-

[29] Morelle (1996) points out that before 1985 health issues were a sub-sector of the Ministry of Social Affairs. Compare this to David Wilsford (1991), who describes the strong French state and how it imposes policy on the health sector.

[30] National self-sufficiency of factor VIII in France was achieved in 1987.

ber of HIV-infected units of donated blood similarly rose. No way to test whole blood was yet available, and the ability to heat and thus purify blood plasma had been perfected only recently. Yet the CNTS facility, into which French money and pride were funneled, lacked the capacity to heat-treat and thus purify blood concentrates.[31] All of the concentrates produced by the CNTS—which constituted most of the products made and used in France—thus carried with them the potential to infect hemophiliacs with HIV. Reliance on imported (most likely American) products might not have lessened the impact of HIV-contaminated blood in France. Still, the existence of an industrial policy stressing blood self-sufficiency but lacking critical heat-treatment technology made it easy for infected hemophiliacs to accuse bureaucrats, politicians, and scientists of placing national industrial interests over individual needs.

The second consequence of France's blood policy is closely related to the domestic manufacture of blood products. Such products, as described previously, are generally made from whole blood pooled from many donors. It is not uncommon for thousands of lots of whole blood to be mixed together in the manufacturing process; making blood product requires a large supply of whole blood.[32] French authorities had an elegant idea about how to increase that supply. They identified an institution with a ready supply of potential blood donors, where the donation of blood was identified strongly with gift giving and social integration (Steffen 1999:105). That institution was prison.

Collection of whole blood in prisons started increasing in 1982 and peaked in 1984, when the Ministry of Justice (responding to blood centers in short supply of whole blood) increased the amount of blood that prisoners could donate (Starr 1998: 290). Blood collected in prison never amounted to a high proportion of blood collected nationally.[33] In 1985, only 0.37% of all donated blood came from prisoners. Because the prison population was far more likely than the general public to be at risk for HIV infection, however, experts have estimated that blood collected in prisons accounted for 25% of the HIV transmitted through the blood supply (Starr 1998:334).

Market share concerns are also an aspect of blood policy in France that affected the HIV/blood conflict. As described in section IV, an important step in eliminating HIV from the whole blood supply was to test blood for the HIV antibody. A test developed by Abbott Laboratories was licensed by the U.S. FDA in

[31] Production of heated concentrates started in February 1987 (Steffen 1997:27).

[32] This in part explains why the U.S. plasmapheresis industry depends upon a commercial plasma industry; it is extremely difficult to obtain a sufficient supply of whole blood or blood plasma through a wholly non-remunerated system.

[33] Most whole blood in France was obtained through 2,000 local donor associations, with 800,000 active members (Steffen 1997:17).

March 1985. Abbott was keen to capture the lucrative international market and on February 11, 1985, applied for a license to sell its test in France. But French authorities, still shaken by the controversy between the French scientist Luc Montagnier and the American Robert Gallo over the discovery of the virus that causes AIDS, were wary of the American test. They expressed concern about its accuracy, and worried about preserving market share for the test that Montagnier's company, Diagnostics Pasteur, was trying to develop. Pasteur's test was not ready to be manufactured and distributed until June 21, 1985, when it was approved by the National Health Laboratory (NHL). On July 25, 1985, the NHL licensed Abbott's test. The delay between Abbott's first license application and final approval, a delay of more than five months, was the third component of France's blood policy that had a particularly important impact on the legal crisis that would rage over HIV and blood.

2. French Litigation over HIV and Blood

Organized in 1955 by the director of CNTS, Jacques Soulier, the Association Française des Hémophiles (AFH) had long provided a network for hemophiliacs. Emphasizing "hemophiliacs' autonomy and their right to live normally" (Steffen 1997:20), the AFH had pressed medical authorities to increase hemophiliacs' access to factor VIII. Factor VIII had been available in limited quantities since it was first imported in 1975, but the AFH believed that a better supply would improve the lives of French hemophiliacs. At its 1980 meeting the AFH called for an aggressive campaign to produce factor VIII domestically. Domestic production started slowly, but increased dramatically in 1984.

As the tragic toll of tainted blood slowly came to light, individuals infected with HIV through whole blood and blood products in France began to mobilize. Hemophiliacs were stung by the fact that they were infected just when they thought that blood products would help them to become more autonomous. They were angered by what they considered the state's preference for national interests—*domestic* whole blood, a *French* blood test—and its apparent disregard for individual health. So they demanded both financial compensation and a hunt for those responsible for the distribution of HIV-tainted whole blood and blood products. The AHF, hoping to distance itself from other, less sympathetic AIDS-related groups, asked the media not to publish articles about hemophiliac contamination when it began negotiations with the state for a system of compensation (Steffen 1997:33).

France's parliament first discussed compensation in 1987, and in July 1989 it approved a compensation scheme, the eponymic Évin Agreement, after the Minister of Health. The government

presented it as an act of solidarity with victims rather than as compensation for injury. Those who accepted payments were barred from litigating their HIV/blood-related claims in the civil or administrative courts. Payments averaged $20,000 for HIV-infected hemophiliacs, and were also provided for individuals with AIDS or their families, up to a maximum of $125,000. Those with blood transfusion–related HIV infection were not covered by the scheme.

Although the Évin Agreement was an important first step, implementation was slow. By early 1990, the AFH began negotiating for a new compensation law. It was joined by transfusion recipients, who were organized (by a politician with an HIV-infected family member) into the Association de Défense des Transfusés (Steffen 1997:34). On December 31, 1991, parliament replaced the Évin Agreement. The new scheme was directed by a judge from the Cour de Cassation, who made compensation decisions based upon such factors as emotional distress due to HIV infection, health problems caused by HIV, loss of life-years, and economic loss to victims and heirs. Those already compensated under the Évin Agreement, which had paid an average of $23,000 to 1,037 HIV-positive hemophiliacs, could increase their funds with compensation from the new plan, which ranged from $3,000 to $500,000. In addition, transfusion recipients could now seek compensation. Though many hemophiliacs who accepted payments under the Évin Agreement and the new system forfeited their right to sue, others decided to bring their claims to court.

From 1987, when the AFH embarked on a strategy of negotiation, it had been unable to maintain hemophiliac solidarity. Some hemophiliacs disdained the impulse to negotiate, believing that direct confrontation was a more effective strategy for voicing and resolving hemophiliac concerns. Most prominent in this group was Jean Péron-Garvanoff, who in 1987 hired an attorney connected to the far-right National Front and filed a claim that sought damages as a consequence of becoming HIV infected through the blood supply.[34] Others quickly followed—in March 1988, claims were filed against the CNTS for merchandising fraud; in April, there were claims for manslaughter and non-assistance to persons in danger. In 1989 Garvanoff formed the Association des Polytranfusés (AP) as a radical alternative to the AFH and sued the CNTS and the AFH itself for fraud and non-assistance to persons in danger. No longer was the conflict over HIV-tainted blood in the shadows of France's legal life. Garvanoff, his

[34] The National Front, keen on embarrassing the ruling Socialists, was anxious to file damaging charges against the state. In addition, engaged in a campaign in which it asserted that the "national decline" of France was caused by immigration, delinquency, drug abuse, and AIDS, involvement in litigation over HIV and blood fit perfectly into the National Front's political program.

lawyer, and other members of the AP had explicitly undertaken a political attack on the state, mobilized the media, and brought the issue into full public view. Thereafter, as Doris Marie Provine (1996:228) writes, "pressure from French victims, particularly hemophiliacs and their families, [was] unrelenting at every level."

The cases filed in the years 1987–1989 started to galvanize the HIV/blood community; eventually, hemophiliacs and blood transfusion recipients brought almost 2,000 cases to courts in Paris and the provinces (Hermitte 1996:15). Yet litigants faced considerable legal hurdles. First, plaintiffs needed to decide whether to bring their claims through the administrative or the civil court system.[35] Because there are both public and private blood centers in France, plaintiffs had the option of selecting a venue. Some tried administrative courts, while others were attracted by the lower burden of proof and potentially more severe penalties in the regular civil courts.

Coupled with the choice of court was the selection of a cause of action. In the late 1940s, courts in France had evaluated the conduct of blood centers using product liability standards, but as a voluntary blood system took root the application of product liability became increasingly difficult (Hermitte 1996:43). Some plaintiffs favored manslaughter charges, which highlighted the "fault" of defendants but which were difficult to prove because of the need to show that a defendant's behavior had caused a plaintiff's infection. Merchandising fraud (concerning the quality of blood) was a possibility, but it had the disadvantage of being only a *délit* (offense, or misdemeanor) that was designed, according to the sarcastic assessment of a lawyer for the hemophiliacs, to prosecute the sale of "spoiled mustard." Charges of poisoning, a *crime* (felony), as well as charges of failure to assist a person in danger, were also possibilities. The implications of the choice were clear; fraud charges would be heard by a regular criminal court and carried a maximum sentence of four years; poisoning charges would be heard by a jury in the Cour de Assizes, and conviction could lead to a life sentence.

As an increasing number of HIV/blood cases were filed, the Conseil d'État ruled that all claims brought to administrative courts should be consolidated in the Administrative Court of Paris, and that all criminal cases filed in the civil court system should similarly be consolidated. Decisions in the administrative courts had been uneven. Lower courts were overruled by appel-

[35] It was clear from the outset of the legal proceedings that claims brought to the civil courts would be framed as criminal complaints. Under French law, crime victims can initiate criminal proceedings. With regard to HIV and blood, claims brought under tort law (negligence) or other possible civil claims would have been more burdensome to plaintiffs. According to one scholar, the HIV/blood cases have narrowed the gap between administrative and civil courts (Hermitte 1996:290).

late courts, which in turn were overruled by the Conseil d'État, creating an unpredictable situation to which consolidation offered no clear solution. The investigating judge in the civil cases, in contrast, consulted with the public prosecutor, victims' lawyers, and government actors. Together, they were able to streamline the prosecution of the cases by agreeing that the charges of fraud and failure to assist a person in danger, both *délits*, would be the central legal issues in a consolidated case.

The Administrative Court began investigating the consolidated case in 1990. In April 1991, an explosive article written by medical journalist Anne-Marie Casteret helped to change the legal conflict over HIV-tainted blood into a political scandal.[36] Casteret had obtained minutes from a May 1985 CNTS meeting at which officials discussed the distribution of HIV-contaminated factor VIII. The Director of the CNTS, Michel Garretta, was on record as favoring the continued use of contaminated supplies until safe, domestically manufactured products were available. Garretta resigned his post in June. Within months, the government's Lucas Report presented an official chronology of the events leading to contamination of the blood supply. It documented that licensing of the U.S. Abbott test was delayed to preserve market share for Diagnostics-Pasteur. As one commentator writes, "[F]or the press, the contaminated blood affair became a question of dirty money" (Steffen 1997:36). Four prominent health policy and blood experts were charged in the Paris Court of Appeals for their roles in the HIV/blood cases in October 1991; two months later, as described previously, a compensation package was assembled.

The Administrative Court of Paris announced its judgment in October 1992. Michel Garretta, now the former Director of CNTS, was sentenced to four years in prison for merchandising fraud and given a Fr 500,000 fine. Jean-Pierre Allain, former Scientific Director of CNTS, was also convicted of fraud; two of the four years of his sentence were suspended. Jacques Roux, former Director General of Health, was convicted of failure to assist a person in danger and was given a suspended sentence of four years. Robert Netter, former Director of the National Health Laboratory, was acquitted.

Determined to prove his innocence, Allain appealed, which provided plaintiffs with the opportunity to ask the appellate court to consider prosecuting defendants for poisoning. On July 17, 1993, the Court of Appeals rejected poisoning charges because the defendants' intent had not been established, but it af-

[36] According to Champagne & Marchetti (1994:40–62), the conflict over tainted blood transformed the role of the press in France by redefining the relationship between journalists and other professionals (such as politicians, physicians, and attorneys), opening the field of medical journalism to non-physicians, and encouraging investigative journalism.

firmed the convictions of Garretta, Allain, and Roux, and gave Netter a one-year suspended sentence.

Allain appealed again, this time to the court of last resort, the Cour de Cassation (Supreme Court). In June 1994, the reporting magistrate told the Criminal Chamber of the Court that Allain's appeal should be rejected and that Allain and Garretta deserved to be tried for poisoning rather than simply fraud. The following month the Court dismissed Allain's appeal, writing that "the evidence contains motives which can be qualified as the criminal act of poisoning and which are susceptible to separate charges" (Steffen 1997:52). The prosecutors' office in Paris began a new investigation into the HIV/blood case in 1995. By February 1996, 13 people were under legal investigation; 11 more were added by April 1997. As of September 1999, 31 people had been placed under investigation in a case that continues to galvanize public interest and bolster criticism of the government's handling of the blood system (Steffen 1997:52).[37]

The consolidated case in the criminal court was only one prong of the volatile legal and political battle over HIV and blood in France. Since the early days of the conflict, activists had called for politicians to be brought to justice. Garretta, Allain, Netter, and Roux, none of them members of the Socialist Party, had maintained that they were sacrificed to protect the Socialist ministers then in office. If prosecutions were to occur, three visible political figures—former Prime Minister Laurent Fabius, former Minister of Social Affairs Georgina Dufoix, and former Secretary of State for Health Edmond Hervé—would be the defendants. However, even if there was an agreement to try the politicians, there was no obvious mechanism through which to do so. The only available means for trying politicians was the Haute Cour de Justice, designed to hear charges of treason, and it had not been convened in 60 years. Some members of France's parliament actively pursued that route, but preliminary proceedings were stalled because of the statute of limitations. As part of the process of constitutional revision being undertaken by the Mitterrand government, parliament devised an innovative way of judging political conduct. It created a new court, the Cour de Justice de la République. Citizens with complaints against government actors could bring their grievances to a group of judges from the Cour de Cassation. One judge from that court was authorized to investigate and make recommendations to a mixed commission made up of professional magistrates and members of parliament, which would sit as a court.

In September 1996, the new court launched an investigation of Fabius, Dufoix, and Hervé on charges of poisoning and "com-

[37] In this case, those under investigation include Garretta, Allain, Roux, Netter, members and directors of ministerial cabinets, hemophilia specialists, scientists from CNTS, senior civil servants, former directors of Diagnostics-Pasteur, and others.

plicity in poisoning." A 400-page report was issued in March 1997, in which the chief prosecutor told parliament that there were no grounds for prosecution. In his view, the electorate could best resolve the issue, since he believed that the core concern was political, not criminal, responsibility. Nonetheless, the case continued, and in February 1999 the three politicians were tried for involuntary manslaughter *(homicide involontaire)* and involuntary bodily injury *(atteintes involontaires à l'intégrité physique)*. When the court announced its decision on March 9, 1999, Fabius and Dufoix were acquitted, and Hervé was convicted on a minor charge and not sentenced.

The French scandal over HIV and blood, likened by many to the Dreyfuss Affair, continues. Some bemoan the incursion of an "American model" of conflict where doctors and patients grapple in the courts (Engel 1993:5–31), while others celebrate the apparent willingness of courts to engage in urgent matters of social justice and public policy. Whatever one's evaluation, it is clear that the alleged reluctance of the French to press their claims in court, and the asserted marginal importance of courts in policymaking, do not explain the conflict over HIV-tainted blood. Indeed, in a series of legal battles beginning in the late 1980s and continuing today, one can observe how hemophiliacs and transfusion recipients effectively mobilized the media and public opinion in their quest for compensation and criminal prosecution. Judicial action not only affected discrete legal cases. It also had an impact on a wide range of issues relating to the public accountability of state actors, and it directly influenced the reform of French blood policy.[38] The conflict over HIV-tainted blood, in short, has been a transformative legal, political, and social event that presents a window onto law, courts, and policy in contemporary France.

VI. Conclusion

Tracking the story of HIV and blood in the United States, Japan, and France leads one to conclusions that rest uncomfortably with the "iron triangle" of conventional comparative claims about law, courts, and policy. Doris Marie Provine (1996:179) says that "[r]ights consciousness, which in the Anglo-American context implies a readiness to resort to courts, is not highly developed in France. The institutional limitations on judicial policymaking have undoubtedly discouraged activists from enlisting

[38] Litigation over HIV and blood led to reform of the entire blood system in France, much of it encapsulated in legislation passed on January 4, 1993. Previous structures were abolished—the National Blood Center, National Health Laboratory, Pharmaceutical Department of the Ministry of Health, and national expert commissions. New bodies were created—the French Agency for Blood, National Agency for Pharmaceuticals, Committee for Blood Transfusion Security, French Plasma Fractionating Laboratory, and others. Autologous blood transfusion became fully reimbursable.

courts in their efforts." With regard to Japan, Takayanagi Kenzō (1963:423) states that the Japanese preference for mediation results in part from "the Japanese national character, that the Japanese people are less assertive of their rights than Anglo-Saxons or Germans." Robert Kagan (1995:90) describes "the unique legal style that characterizes the American approach to public policy," inclining it to "more formal, adversarial procedures for resolving disputes" and "stronger, more punitive legal sanctions" than other jurisdictions. Yet, when they are viewed through the lens of conflicts over HIV and blood, these and many other comparative claims fall wide of the mark.

There are at least five ways in which one might try to shoehorn the case of HIV-tainted blood into the conventional comparative mold, or rather explain away its anomalous nature. First, perhaps blood defies conventional analysis. Just as Titmuss believed that blood could not and should not be treated as a mere market commodity, political scientist Monika Steffen claims that the French blood scandal is explained by "symbolic aspects of the blood system" (1997:5). In her view, this is why the powerful executive branch of government, and the hierarchical French state, were unable to contain the scandal. Indeed, the symbolic nature of blood is a near-universal phenomenon.[39] The Japanese sport a contemporary folkway of classifying personalities according to imagined blood types, and one of the most important "lessons" of their HIV-tainted blood conflict is the inherent danger of "foreign" blood. As recently as the 1940s in the United States, the identification of blood with racial stereotypes led to the maintenance of separate blood supplies for white and black soldiers (Dower 1986). The complex interplay of blood with notions of identity, purity, and power in all nations must be noted, but it does not fully explain any particular national battle, or the pattern of national conflicts, over HIV and blood.

Second, one might argue that local legal conditions explain the course of the conflicts. Blood shield laws in the United States, for example, doom most blood-related litigation against collectors and distributors of whole blood and blood products. Yet class action devices and contingency fees, at least to some extent, cut in the opposite direction, enabling large-scale negligence claims to come before the courts. In France, as in the United States, blood and blood products are legally classified as body parts rather than drugs, which removes them from normal market transactions and prevents legal claims based on product liability. In both France and Japan, linking parties in common cases and finding legal representation in the absence of a public interest bar or contingency fees inhibit exactly the sorts of claims brought in the blood cases. And in all three nations the causes of

[39] See, e.g., Piero Camporesi (1995) and Dorothy Nelkin (1999).

action considered by courts placed a significant burden of proof on the plaintiffs, for whom it was almost impossible to pinpoint a particular product that caused their infection, or a date on which infection occurred. It would be imprudent to dismiss the impact of local legal institutions on litigation over HIV and blood. But they do not provide a compelling comparative account of why the claims unfolded as they did.

Third, it is possible to highlight local political conditions, which undoubtedly were important to the way in which the "disputes" became "scandals" in France and Japan. Were it not for the declining influence of the Liberal Democratic Party in Japan, there would not have been a Socialist Prime Minister, and Kan Naoto would not have taken control of the Ministry of Health and Welfare. Were it not for political cohabitation (between Conservatives and Socialists) in France, it would have been far more difficult to put important political actors on trial. And were it not for the struggle for civil rights that since the 1960s had increased the visibility and power of gay groups in the United States, the politics of HIV and AIDS in America may not have been so consistently framed as a "gay" issue. Yet the Clinton administration, despite the shift from a Republican to a Democratic White House, did not identify the distribution of tainted blood as a fundamental failure of the Reagan years, and the almost complete absence of a politics of HIV and AIDS in Japan did not prevent the blood issue from exploding. While there is every reason to examine the local political climate when analyzing conflicts over AIDS and blood in different nations, there is no compelling reason to believe that such conditions can alone bear the weight of comparative understanding.

Fourth, the tainted-blood scandals may demand a more general explanation. Perhaps it is provided by generalizations about the nature of the state. France and Japan are well known for having a carefully selected and trained corps of civil servants who staff powerful and hierarchical agencies, in contrast to the less-elite nature of U.S. bureaucracy. According to Theodore Marmor (1999:258–59), "[B]oth French and Japanese bureaucrats have traditionally been expected to do their public jobs with confidence, competence, and little interference. . . . "[E]xpectations of protective security [related to blood safety] were high, and, once disappointed, [were] all the more angering." This may help to account for some of the vitriol directed at the government in both the French and Japanese stories and the criminal prosecution of individuals connected to important state bodies. But does it tell the whole story? What should one make of the fact that Japan and the United States both had two-tiered blood systems that divided policy between whole blood and blood products, while France had a unified system? How about the expectation in the United States that public health authori-

ties will balance individual and public interests when developing health policies, expectations that have lead to litigation aplenty? Why didn't a fundamental commonality of the three systems—the almost complete reliance of state policymakers on such advisory committees as the FDA's Blood Products Advisory Committee, Japan's AIDS Task Force, and France's Blood Transfusion Consultative Committee, consisting of blood experts with interests sometimes distinct from public concerns—lead to a common set of accusations? And why is it that anger in Japan and France, said to be impotent in the face of state power, pierced the thick shell protecting government actors? Understanding the nature of different states is an important task, but those differences do not render mute the incompatibility between conventional comparative sociolegal claims and the blood narratives.

The fifth and most obvious explanation for the trajectory of legal conflict over blood in the three countries is that they reflect real differences in the direct causes and consequences of contaminated blood. In contrast to the claims I presented in Part IV, which suggest that there was a surprising degree of uniformity in the pre-1986 blood policies and practices in Japan, France, and the United States, it is possible to identify some significant differences. The United States was indisputably first in testing whole blood and in heat-treating blood products, which makes it impossible to claim that U.S. policymakers were out of step with international practices. France had the highest proportion of transfusion-associated cases of HIV contamination, making it an easy target for claims that it failed to secure the whole blood supply. Japan had fallen radically short of its ambitions for blood product self-sufficiency, which nurtured public assertions that policy priorities were not calibrated to maximize public health. Both Japan and France delayed the licensing of a U.S. blood test and continued using unheated blood products months after they had been abandoned in the United States.

Such differences, however salient, do not explain why legal conflicts over tainted blood erupted so violently in Japan and France, but remained low-key in the United States. In all three countries, the majority of individuals were infected with HIV through blood before *any* preventative measures were taken.[40] That is why such a high percentage of hemophiliacs in every industrialized nation are HIV-positive.[41] Moreover, the French and

[40] It is extremely difficult to obtain good comparative data on the time of HIV infection, since many people do not know when they were infected and public health authorities collect and evaluate such data differently. But virtually all experts agree that, given the existence of HIV in the blood supply from the 1970s and the similarity in infection rates across nations, most people were infected before either the testing of whole blood or the heating of blood products was known to be effective.

[41] Because countries do not follow a shared system of maintaining statistics about hemophiliacs and hemophilia-related conditions, it is impossible to find data that are clearly comparable.

Japanese scandals emerged before many of the most-damning revelations about misconduct. In France, for example, the market-share motivations that in part led to delaying the Abbott test were unknown until after there was a French "scandal." The details of blood policy in the United States, France, and Japan, and the deeds of policy actors, were not always the same, but they fall far short of explaining why the United States remained relatively untouched by a scandal such as that experienced in France and Japan.

Additional similarities and differences may also illuminate the poor fit between comparative generalizations and the blood conflicts: a difference—bad luck (in their view) brought the U.S. hemophiliacs' class action to the desk of Judge Richard Posner; another judge may have made a different decision about class certification, and the case could have been enshrined in the pantheon of monster tort awards; a similarity—globalization, that omnipresent but indefinable turn-of-millennium force, can be credited with creating international networks of scientists, hemophiliacs, attorneys, and government actors who brought cross-border information to seemingly local conflicts.[42] Both of these factors are important. Yet neither of them, nor any of the five discussed previously, solves the comparative puzzle I have presented in this article—that victim mobilization and publicity, prolonged litigation, bold court pronouncements, and rapid legislative action related to HIV-tainted blood have been least apparent in the United States and most visible in Japan and France. Explaining why this is so requires more than simply explaining it away. It forces one to come to grips with the failure of these national battles over blood to conform to a conventional comparative mold.

Struggles over contaminated blood in all three countries suggest that it is time for sociolegal scholars to reconsider their dominant approach to comparative conflict, courts, and culture. At the very least, the three narratives offer a powerful counterexample to conventional comparative generalizations. Long-held views about civil law and common law systems; Japanese group-based and harmony-rooted values versus Western individualism and litigiousness; strong French bureaucrats and activist American judges; the importance of duty, obligation, and shame in Japan in contrast to the power of self-interest and guilt in the United States; all of these decisively fail to forecast the course of national conflicts over HIV-contaminated blood.

The case of HIV and blood, therefore, is a sonorous reminder that the United States is not the only land where rights have political salience, courts articulate and impart social values,

[42] Hermitte (1996), in contrast to most commentators, believes that blood experts in France were unaware of international debates over HIV and blood safety.

and citizens are able to invoke the language and authority of law to win a stunning legal and political victory. Jefferey Sellers (1995:411) makes a similar point in his study of administrative courts in the United States, France, and Germany, in which he challenges "the overly uniform typologies . . . that still plague much comparative political analysis." So too do some scholars of Japanese law and society. Robert Kidder and Setsuo Miyazawa (1993:624), for example, writing about environmental litigation, emphasize that litigation has "become part of a strategy for organizing and expressing opposition to the dominant political and economic tendencies of the postwar years." The case of HIV and blood clearly stands as a counterexample to notions of "adversarial legalism" that imply the marriage of adversarialism and legalism is a uniquely American union.[43]

Because I examine only one example of conflict in this article, it is too early to confidently proclaim the death of conventional comparative generalizations. Before one makes such a proclamation, further studies are needed to identify events that unfold simultaneously in different nations and to explore whether different legal systems react in counterintuitive ways (if one's intuitions are rooted in traditional legal and sociolegal scholarship). Based upon this analysis of blood battles in three nations, however, it is reasonable to predict that the interesting comparative sociolegal question is not *whether* the aggrieved can instrumentally assert their rights, go to court, and bring about legal and political change. That is clearly the case. Instead, the challenge is to identify *who* the actors are, *when* they will mobilize, *what* determines their impact on both the policy agenda and the policy outcomes, and *why* different courts in different countries will embrace certain issues and shrink from others.[44]

One additional comparative issue must be considered. In his book La Défaite de la Santé Publique (The Failure of Public Health), Aquilino Morelle (1996) stresses that court activism played a central role in the French blood scandal. He describes how judges worked with plaintiffs to narrow down the charges in the consolidated case and suggests that the blood litigation reveals a shift in the focus of French courts, from crimes to victims, and from imputation to compensation. This trenchant observation reveals a final irony in the sad fight over HIV and

[43] See, e.g., Robert Kagan (1995:88–118).

[44] None of the foregoing suggests that what we think we know about litigation rates in the United States, France, and Japan is wrong. Numerous studies indicate that there is less litigation per capita in Japan than in the United States. The mere counting of cases, however, reveals little about the willingness of courts to take an active role in certain disputes and bring about a resolution that is symbolically (and often materially) compelling. Indeed, the fact that more cases may be filed in U.S. courts than elsewhere is weak evidence of the importance of law and courts in U.S. policymaking. Reserving court action for a more limited number of conflicts may well make courts more, rather than less, politically important.

blood. The victims of blood contamination in all three countries went to court as part of a desire to achieve some semblance of justice. Convinced that they were dying unnecessary deaths, the infected identified who they considered were the responsible individuals and institutions and turned to law for help in their quest for a fair solution. The boundaries of their struggle were painfully evident; every one of them was dying, and not money, apology, or punishment could mitigate their fate.

Were courts and the legal system generally focused on victims and compensation, however, it might be possible to identify some sense in which a subjective feeling of justice was achieved. The Japanese courts came closest to providing victims with at least a fleeting impression of justice. The plaintiffs not only walked off with a massive cash settlement but also won guarantees of better access to medical care in the future. More important, they were offered formal apologies by the government and each defendant company. The image of the president of Japan's largest pharmaceutical company on his hands and knees, head bowed to the floor, remains the emotional and symbolic climax of the Japanese scandal. In the United States, in contrast, infected hemophiliacs continue to express bitterness at the failure of their class action lawsuit. The hemophiliac community appears irreparably divided. Government compensation is considered too little, too late. And the attempt to make the HIV/blood story into a public drama and politicize the plight of the actors has failed. At least, and this is not much, the case is over and the parties can get on with what is left of their lives.

In Morelle's homeland, however, the situation is even grimmer. There, one finds no closure, no symbolic end to the bitterness over blood. Douglas Starr (1998:337) writes that in Japan and France, "rightly or wrongly, concretely or symbolically, mistakes were acknowledged and perpetrators brought to task." Yet the cases that were consolidated in France almost a decade ago continue to bounce to and fro in the courts. There is no end in sight to the current criminal prosecution of more than 30 individuals, and the legal process has itself begun to create a new category of victims—those whose lives have been torn asunder as defendants in a case in which they have been neither convicted nor acquitted. The political prosecutions in the new Cour de Justice de la République ultimately were denounced by all parties, who derided them as incompetently managed and predictably benign. After the verdict was announced and no politicians were sentenced, victims and their families cried out in the courtroom, calling the defendants "murderers" and accusing the judges of having blood on their hands. In the French cases all parties consider themselves the losers. That is surely not what one would expect from a system focused on victims and compensation.

Perhaps, as some scholars have predicted, the advanced industrialized nations are converging toward a system in which litigation and courts play a similar role in the policy process (Tate & Vallinder 1995). Maybe the HIV/blood cases will turn out to be a harbinger of a more consistently activist judiciary in Japan and France, and an increasingly cautious bench in the United States. A more comprehensive attempt at comparative sociolegal theory-building depends upon a greater number of events touching on a variety of substantive issues. In the meantime, this exploration of conflict over tainted blood in three nations counsels a skeptical posture toward the conventional assumptions of the comparative sociolegal enterprise. Rather than serving as useful predictors, they are unreliable guides to how issues will be confronted and injuries compensated in Japan, France, and the United States.

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