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by

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There is a healthy debate raging within the medical community concerning the ethics of mandatory human immunodeficiency virus (HIV) testing of all pregnant women. In the early 1990s, prior to perinatal preventative treatments that are available today, an estimated 1,000 to 2,000 infants were born with HIV infection each year in the United States.[1] In 1994, clinical trials showed that HIV-infected women could reduce the risk of transmitting the virus to their babies by as much as two-thirds through administration of zidovudine (ZDV or AZT) during pregnancy, labor and delivery, and by giving the newborns AZT for the first six weeks after birth.[2] The results of these clinical trials fueled the debate for mandatory testing of all pregnant women. In 1994, the Public Health Service issued guidelines for using AZT during pregnancy, and in 1995, published guidelines for routinely counseling all pregnant women about HIV and offering them an HIV test. As health care professionals incorporated these guidelines into their clinical practice, the number of children with perinatally acquired AIDS dropped 43% by 1996.[3] Encouraged by these statistics, Congress mandated a study and review of the federal guidelines by a committee of the Institute of Medicine, an affiliate of the National Academy of Sciences, concerning HIV testing of all pregnant women. On October 14, 1998, the committee issued its report and recommended making HIV testing part of routine prenatal care. The committee believed that mandatory HIV testing of all pregnant women would save additional lives, especially among the minority communities, and more than pay for

itself by cutting the cost of caring for infected children, which can amount to tens of thousands of dollars annually for each child.[4] The committee was convinced that the benefits of mandatory testing, which are prevention of perinatal HIV transmission and better care for infected mothers and their children, greatly outweigh the burdens of possible violation of the mother's privacy and a possible decrease in the willingness to seek counseling about HIV and AIDS. The potential of saving lives and the cost-benefit analysis has only added fuel to this current ethical controversy.

The intended purpose of this article is three-fold: first, to examine the scientific evidence regarding the status of perinatal HIV prevention; second, to give an ethical analysis of the arguments for and against mandatory HIV testing of all pregnant women; and third, to determine if the federal guidelines should be revised to include mandatory HIV testing of all pregnant women and if this position is based on solid ethical principles.

Status of Perinatal HIV Prevention

In the United States, as of December 1997, 641,086 Americans had been reported with AIDS and 350,000 of them had died. The year after, the CDC estimated that as many as 650,000 to 900,000 Americans were living with HIV and at least 400,000 infections occur each year.[5] In 1996, according to the CDC, the estimated number of adults diagnosed with AIDS-defining opportunistic illnesses decreased for the first time, from 61,300 estimated cases in 1995 to 57,200 in 1996. Also in 1996, for the first time, the estimated deaths among persons with AIDS declined to 39,200 from 50,700 in 1995.[6] This decline in both the incidence of new cases and the mortality rate in adults can be attributed to the introduction of the three classes of antiretroviral drugs: nucleoside analogue antiretrovirals (AZT, ddI, ddC, 3TC, d4T),[7] the non-nucleoside reverse transcriptase inhibitors (nevirapine, delavirdine, efavirer),[8] and the protease inhibitors (crixivan, fortovase, norvir, viracept, and others).[9] Even more significant are the facts concerning the perinatal transmission of HIV. In the United States, if HIV-infected women are not treated with AZT in pregnancy, roughly 25 percent of their infants will be HIV infected when born. If they are treated with AZT, the figure falls to 8 percent or lower. Between 1992 and 1996, perinatally acquired AIDS cases declined 43% in the United States. In 1997, this trend continued with a 30% decline.[10] Currently in the United States, roughly 8 percent of all infants born to HIV-infected women - fewer than 500 a year - are born infected.[11] In the March 31, 1999 issue of *The New England Journal of Medicine*, data revealed that "a Caesarian alone reduces by half the risk of AIDS transmission during birth. An infected woman who has both a Caesarean and treatment with AZT has only a 2% chance of infecting her child."[12] The success of the AZT

regimen on pregnant women and now the new data on the effects of Caesarian birth has given new hope to those women infected with HIV and to their children.[13]

The HIV infection rate in children is closely linked with the HIV infection rate in women. According to the CDC, "HIV transmission from mothers to child during pregnancy, labor and delivery or by breast-feeding has accounted for 91 percent of all AIDS cases reported among United States children."[14] Statistics show that women of color and their children have always been and continue to be disproportionately affected by the HIV epidemic. In 1997, of the total 13,105 AIDS cases reported among U.S. women, 10,458 (80%) were among African-American and Hispanic women.[15] Of the 473 children reported with AIDS in 1998, 402 (85%) were African-American and Hispanic.[16] The reasons for the disproportionate infection rate among women of color is due not only to inadequate perinatal HIV prevention efforts, and inadequate access and utilization of prenatal care offered to women of color, but also to the sense of mistrust that both African-Americans and Hispanics have for the medical establishment.

This mistrust, especially by African-Americans, can be attributed to the events surrounding the Tuskegee Syphilis Study, which was sponsored by the United States Public Health Service from 1932 to 1972.[17] However, after careful research and analysis, it appears that this study is but a marker for a more serious problem regarding racist attitudes and stereotypes that has existed for centuries in the medical profession. Historian Alan Brandt argues that the medical professionals and researchers who directed and devised the Tuskegee Syphilis Study accepted the mainstream assumptions regarding blacks. "There can be little doubt that the Tuskegee researchers regarded their subjects as less than human. As a result, the ethical canons of experimenting on human subjects were completely disregarded."[18] The major impact of the Tuskegee story was that it authenticated a historically-based pattern of medical mistreatment that has been well-known to the African-American community through their own oral folkloric tradition. This pattern shows that African-Americans, and for that matter all minorities, were viewed as inherently inferior by the medical profession and public health agencies. This has led to the lingering suspicion that medical professionals are not out to help minorities, but to use them as guinea pigs.[19] The influence of racism in the medical profession and a general disregard toward those who are poor and vulnerable by the federal government has contributed to the "legacy of mistrust" in the minority communities and has had far-reaching consequences.[20] One major consequence has been that women of color are suspicious of any government-sponsored programs that advocate testing or experimental medications. The result has been that a 1995 study that analyzed data on

approximately one-sixth of all HIV-exposed children born in the United States found that only about half (53%) received the benefit of a full AZT treatment regimen (for the mother during pregnancy and delivery and for the infant for the first six weeks after birth). According the CDC, "the main reason for babies not having the advantage of therapy was that more than one-fourth of the mothers (26%) did not get prenatal care."[21] The majority of these mothers were women of color and a major reason for their lack of prenatal care is their suspicion of the medical establishment.

Mandatory HIV testing of all pregnant women would not only save countless lives but would also conserve a large percentage of medical resources. The CDC estimates that without intervention, a 25% mother-to-infant transmission rate would result in the birth of an estimated 1,750 HIV-infected infants annually in the United States, with a lifetime medical cost of $282 million. Researchers estimate that the annual cost of perinatal prevention is $67.6 million. This investment prevents 656 HIV infections and saves $105.6 million in medical care costs alone, for a net cost-savings of $38.1 million annually.[22] However, now with the new findings regarding the use of AZT and the effects of Caesarean birth, the number of lives saved and medical costs saved will increase.

Critics of mandatory HIV testing for all pregnant women focus on three distinct areas. First, there are those critics who believe the focus of testing and treatment should be on the high-risk population. The problem with this is that HIV knows no boundaries. Women not in the high-risk population may also have been exposed unbeknownst to them. To single out specific groups, such as women of color, within the population could lead to discrimination and may force those most in need of HIV counseling, testing, and treatment to take less advantage of prenatal care than they do at present. It would also further the suspicion women of color feel toward the medical establishment. Second, some critics argue that if HIV testing becomes mandatory for all pregnant women it will eliminate or at least decrease the counseling that is associated presently about HIV and AIDS. Mildred Williamson, president of the AIDS Policy Center for Children, Youth and Families, stated, "Women must fully understand what an HIV test is, and the implications of a positive or negative result. It is not enough to simply inform women that they are being tested for HIV, and put the burden on them to ask questons."[23] There is no reason to believe that there would be a decrease or an elimination of counseling on HIV and AIDS. Health care professionals have a professional and an ethical obligation to explain all tests and procedures to their patients as part of the principle of informed consent. To say that once mandatory testing becomes a federal guideline such counseling will cease to exist or the amount of counseling will decrease seems to question the professionalism and integrity of physicians. Third, some critics are concerned about protecting the privacy

of prospective mothers, especially regarding the documentation of HIV test results. The American Medical Association has adopted key principles regarding the patient's right to privacy and the confidentiality of medical records.

> 1) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged;
> 2) That patients' privacy should be honored unless waived by the patient in a meaningful way (i.e., informed, noncoercive) or in rare instances of strongly countervailing public interest and
> 3) That information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose.[24]

It is possible that the privacy of a pregnant woman might be violated. However, with various guidelines and safeguards in place, that medical records cannot be used without the informed consent of the patient, and with additional legislation being proposed to protect the privacy of HIV and AIDS patients, these concerns can be addressed in a way that would offer reasonable protection.

The practical concerns regarding mandatory testing of all pregnant women appear to be surmountable. From an ethical standpoint, however, this is a far more complex and controversial issue. Both sides in this debate appear to have legitimate concerns that they believe can be supported ethically. It must be determined which arguments are more convincing from an ethical point of view in the face of such a devastating crisis.

Ethical Analysis

The ethical controversy surrounding the debate over mandatory HIV testing of all pregnant women has taken on a sense of urgency because every day we delay in implementing this policy more children will be born infected with HIV and more women, unaware that they are HIV-infected, will not only go untreated but may also infect others through sexual contact or intravenous drug injection. Proponents of mandatory HIV testing, such as Dr. Marie McCormick, director of Maternal and Child Health at the Harvard School of Public Health, argue that "we have the tools to prevent HIV infection in newborns and we must make sure they are available to everyone."[25] The benefits of mandatory testing in preventing HIV infection to newborns and better care for infected mothers and their children can all be achieved at a cost to the country that is far below what

we spend today on treatment for infected individuals. This utilitarian argument is quite convincing, considering the devastating effect the AIDS epidemic has had on the allocation of medical resources both nationally and internationally. Time is of the essence for this public health issue and concern for the "common good" must be a priority. Opponents argue that mandatory testing will violate the basic human right of privacy. The term "right to privacy" encompasses "our right to live our personal lives as we see fit, to control what may be done to our own bodies, and to limit what information others may obtain about our personal affairs."[26] Opponents argue that a pregnant woman's privacy could also be violated because there are not adequate safeguards in place to keep the results of such testing confidential. Therefore, mandatory testing could violate their privacy twice – first by testing against their will, and then by giving others access to the results. Finally, opponents argue that this issue brings to light the reality of the slippery slope argument. If we allow for mandatory testing of all pregnant women today, why not for all people tomorrow? What about mandatory testing for drugs, alcohol, genetic disorders, etc? The ethical ramifications are far-reaching.

Society, in general, has always recognized that in our complex world there is the possibility that we may be faced with conflict situations that leave us with two options, both of which are nonmoral evils.[27] The time-honored ethical principle that has been applied to these situations is called the principle of the lesser of the two evils. "When one is faced with two options, both of which involve unavoidable (nonmoral) evil, one ought to choose the lesser evil."[28] According to bioethicist Richard McCormick, S.J.,

> The concomitant of either course of action is harm of some sort. Now in situations of this kind, the rule of Christian reason, if we are governed by the *ordo bonorum*, is to choose the lesser evil. This general statement is, it would seem, beyond debate; for the only alternative is that in conflict situations we should choose the greater evil, which is patently absurd. This means that all concrete rules and distinctions are subdsidiary to this and hence valid to the extent that they actually convey to us what is factually the lesser evil.... Now, if in a conflict situation one does what is, in balanced Christian judgment (and in this sense "objectively"), the lesser evil, his intentionality must be said to be integral. It is in this larger sense that I would attempt to read Thomas Aquinas's statement that moral acts "*recipiunt speciem secundum id quod intenditur*." Thus the basic category for conflict situations is the lesser evil, or avoidable/unavoidable evil, or proportionate reason.[29]

Therefore, in a conflict situation, an individual may directly choose to do a nonmoral evil (violating a person's autonomy, privacy, confidentiality) as a means to a truly proportionate good end (preservation and protection of human life).[30]

The principle of the lesser of two evils is applicable to the issue of mandatory HIV testing of all pregnant women because one is faced with two options, both of which involve unavoidable nonmoral evils. On the one hand, failure to allow for mandatory testing of all pregnant women would result in hundreds of innocent HIV-infected infants being born yearly, and hundreds of women remaining unaware of their HIV infection and thus unable to seek early treatment and to protect others from the possible transmission of this lethal disease. In addition, there is the loss of millions of dollars in medical care costs annually as scientific data has shown. On the other hand, allowing for mandatory testing would violate a pregnant woman's right to privacy by testing against her will, and also could possibly violate her privacy by giving others possible access to the results.

The direct intention of mandatory HIV testing of all pregnant women is to protect and preserve human life and to encourage social support, professional counseling and medical care. Studies have shown that the highest incidence of AIDS cases among women reported in the United States is among women of color. The direct intention of mandatory testing is to protect and preserve the lives of the most vulnerable, that is, the poor and the minorities, by stopping the spread of HIV transmission to innocent newborns and seeking immediate medical attention for infected mothers. However, in the process of protecting and preserving human life, which benefits the common good, the pregnant woman's autonomy is violated. One would hope that all pregnant women would voluntarily agree to HIV testing, but this is not always possible and has not been a reality. The linchpin for resolving which option is the lesser of two evils rests on whether or not there is a proportionate reason for allowing mandatory testing of all pregnant women.

Proportionate reason refers to a specific value and its relation to all elements (including nonmoral evils) in the action.[31] The specific value in allowing for mandatory testing is to protect and preserve human life by preventing the lethal transmission of HIV to innocent newborns and getting immediate medical treatment for the infected mothers. The nonmoral evil, which is the result of trying to achieve this value, is the violation of the pregnant woman's right to privacy. The ethical question is whether the value of protecting and preserving human life outweighs the nonmoral evil of violating a woman's right to privacy? To determine if a proper relationship exists between the specific value and the other

elements of the act, ethicist Richard McCormick, S.J. proposes three criteria for the establishment of proportionate reason:

1) The means used will not cause more harm than necessary to achieve the value.
2) No less harmful way exists to protect the value.
3) The means used to achieve the value will not undermine it.[32]

The application of McCormick's criteria to mandatory HIV testing of pregnant women supports the argument that there is a proportionate reason for allowing this testing. First, scientific data has proven that mandatory HIV testing of all pregnant women will save the lives of hundreds of innocent children and will prolong the lives of those determined to be infected if immediate medical treatment is begun. Voluntary HIV testing of pregnant women has helped lower the number of children with perinatally acquired AIDS by 43%. In addition, the CDC has estimated this would yield a net savings in medical costs and resources of $38.1 million annually.[33] With the present state of health care costs skyrocketing, this savings would certainly benefit the common good." It is apparent that the means used will cause more good than harm, and will cause less harm than necessary to protect and save lives.

Second, at present, there does not appear to be an alternative that is as effective as mandatory testing. It is true that other means exist, such as the federal guidelines that call for routine counseling of all pregnant women about HIV and offering them an HIV test. The result has been a 43 percent decrease in perinatal HIV transmission, which is an impressive decline. With additional education and more access to and utilization of prenatal care these statistics may even improve. However, the CDC statistics have shown that the highest rate of AIDS infections among women in the United States is among women of color. The barriers preventing women of color from seeking prenatal care and thus voluntarily agreeing to HIV testing are great. There is the "legacy of mistrust" which exists among the minority communities toward the medical establishment, the health care disparities which presently exist among the minority population, and the lack of adequate HIV education. Despite the success of the present federal guidelines, even the American Medical Association (AMA) supports the position that "there should be mandatory HIV testing of all pregnant women and newborns with counseling and recommendations for appropriate treatments."[34] Opponents to mandatory testing believe these barriers can be eliminated with education and increased access to prenatal care. However, as we wait for this to be accomplished, thousands of children will become

HIV infected, women who are HIV infected will be unaware of this fact and not seek appropriate treatment, and because they are unaware of their status, they have the potential to pass this disease onto many others. Voluntary HIV testing is less harmful, but it does not protect and preserve the value of human life.

Third, mandatory testing does not undermine the value of human life. One can argue convincingly that the intention of mandatory HIV testing of pregnant women is to save human lives. Mandatory testing will not only save the lives of countless newborns but will allow thousands of women who are unaware of their HIV status to begin treatments that may save their lives and the lives of others they could possibly infect in the future. In the process, there is the possibility that punitive effects could result from mandatory testing. If the federal guidelines are changed, will they require mandatory reporting of HIV test results?

The fear of discrimination is a real threat. There have been cases in the past when individuals have lost employment and medical insurance when employers and/or insurers have learned of an employee's HIV positive test results. However, proponents argue that mandatory testing results could be kept confidential with the proper procedures in place. The 1996 Health Insurance Portability and Accountability Act requires that the U.S. Department of Health and Human Services recommend to Congress a means for protecting individually identifiable information and establishing penalties for wrongful disclosure of such confidential data. The Department of Health and Human Services made such privacy recommendations to Congress for review on September 11, 1997.[35] *The New York Times* reported that as of January 1999, six bills relating to medical records were privately circulating in Congress.[36]

The purpose of mandatory testing is to save lives and it has been proven scientifically to be effective. This is a public health issue that must be addressed because innocent lives are being lost. It seems clear that there is a proportionate reason for the federal government to change its guidelines regarding mandatory HIV testing of all pregnant women. Such testing contributes to the well-being of the pregnant mothers, to the well-being of their newborns, to those who could be infected through contact with the undiagnosed, and by lowering medical costs to society as a whole over time. Therefore, it is ethically justified under the principle of proportionate reason for the federal government to change the guidelines regarding mandatory HIV testing for all pregnant women in the United States. Mandatory testing of all pregnant women is the lesser of two evils because the greater good is promoted in spite of the potential for evil consequences.

Finally, from an ethical perspective, opponents argue that allowing mandatory HIV testing of pregnant women will set a legal precedent which could have dire consequences in the future. The slippery slope argument

suggests that if particular precedents are accepted, then certain consequences will follow as a matter of due course. By setting federal guidelines that allow for mandatory testing in the case of all pregnant women, what would stop the federal government from establishing similar guidelines in the future for mandatory HIV testing for all people or for genetic diseases? Certainly the same ethical arguments could be used to justify both types of mandatory testing. Physical harm could be averted, treatments could be initiated sooner rather than later, and preventive care is certainly less costly than waiting for the disease to manifest itself. This is a valid argument, but it is an argument that could be used in any scenario. With every medical treatment there is always the potential for abuse. But because the potential is present does not mean it has to become a reality. Being aware of the possibility of abuse can be the impetus for safeguards which can be put in place to prevent similar abuses in the future. Because something can be abused does not mean it should be avoided. Instead, it should be an opportunity to address such weaknesses to avoid future negative ramifications.

Conclusion

I believe that mandatory HIV testing of all pregnant women in the United States is both a necessary and a vital part of a broader comprehensive strategy for preventing the spread of AIDS. After reviewing all the pertinent scientific data it is clear that mandatory HIV testing of all pregnant women would save thousands of human lives – mothers, newborns and others who could be infected as a result of these women not being aware of their HIV status. It is apparent that voluntary HIV testing has made some valuable inroads in decreasing perinatal HIV transmission, but the statistics showing the disproportionate rate of HIV infection among women of color are not very promising. Numerous barriers presently exist that cause women of color not to have access to or utilize prenatal care. To eliminate these barriers will take years, if elimination is possible at all. In the process, countless newborns will become HIV infected and infected mothers will fail to seek appropriate treatment and may even spread the disease to others, all because they are unaware of their HIV status. If we as a nation believe that the life of every person is sacred and should be treated with dignity and respect, especially the lives of the most vulnerable, then we must support what we believe is the greater good to protect and preserve human life. This does not mean that we should not continue to explore new ways to encourage voluntary HIV testing of all people. It does mean that if this is the best method available at the present time to protect the lives of innocent people, we must utilize it to its fullest capacity. It appears that the opponents to mandatory testing are saying the right to

privacy and autonomy is a greater good than the preservation of human life. The AIDS virus is a runaway epidemic and as Dr. Peter Piot, head of the United Nations AIDS Program has stated, the time is now for us to embrace not only a new realism but also a new sense of urgency if we are going to combat this dreaded killer.[37] We cannot allow fears of future ramifications and an absolute sense of privacy to stand in the way of fighting this lethal disease. Human lives hang in the balance. If the protection and preservation of human life is a priority in this country, then it is time to allow for mandatory HIV testing of all pregnant women, before it is too late for those who are the most vulnerable.

Postscript

On July 15, 1999, *The New York Times* reported that the drug nevirapine had cut the risk of mother-to-child transmission of HIV to 13% from 25% for the standard course of AZT in developing countries. Nevirapine, a drug used in combination "cocktail" treatments, has been marketed in the United States for treatment of HIV since 1996. The more practical therapy comes from substituting one marketed drug, nevirapine, for the standard drug, AZT. The treatment calls for both a mother and her infant to take nevirapine just one time – a mother takes the pill during labor, and her baby is fed the drug as a syrup once during the first three days of life. The cost of the two doses of nevirapine is $4, compared with $268 for the AZT regimen now used in developing countries. American and Ugandan researchers are planning another study to see if it would be more effective to give nevirapine to mother and infant for longer periods. Also, a continuing study in the United States and Europe aims to determine if adding nevirapine to standard regimens will further lower the transmission rate of HIV from mother to child.[38]

References

1. Centers for Disease Control and Prevention (CDC), "Status of Perinatal HIV Prevention," *Update* (June 1998):1.

2. CDC, "A Turning Point in the Epidemic," *Trends In The HIV And AIDS Epidemic*, (1998) 7.

3. Ibid.

4. Warren E. Leary, "Panel Urges H.I.V. Tests For All Pregnant Women," *New York Times*, 15 October 1998, A-22.

5. CDC, "A Turning Point In The Epidemic," 2.

6. . CDC, "HIV/AIDS," *Surveillance Report* 9 (June 1997): 3.

7. It should be noted that of the five currently approved nucleoside analogue antiretrovirals, only AZT and lamivudine (3TC) pharmacokinetics have been evaluated in clinical trials in human pregnancy to date. For more detailed information, see Department of Health and Human Services, *U.S. Public Health Service Recommendations for Use of Antiretroviral Drugs During Pregnancy for Maternal Health and Reduction of Perinatal Transmission of Human Immunodeficiency Virus Type I in the United States*, draft copy (Washington, D.C.: Office of Public Health and Science, 6 August 1997), 5.

8. A Phase I study in the U.S. evaluated the safety and pharmacokinetics of nevirapine in seven HIV-1-infected pregnant women and their infants. Nevirapine was administered as a single 200 mg. dose at the onset of labor, and a single dose of 2 mg. per kg body weight at two to three days of age to their neonates. The drug was well-tolerated by the women and no short-term adverse effects were observed in mothers or neonates. Ibid., p. 7. For a more detailed analysis, see M. Mirochnick et al., "Safety and Pharmacokinetics of Nevirapine in Neonates Born to HIV-1 Infected Women," (paper presented at the Fourth Conference on Retroviruses and Opportunistic Infections, Washington, D.C. 22-26 January 1997), abstract #723. Delavirdine has not been studied in pregnant women. Efavirer became available in the Fall of 1998.

9. Protease inhibitors are a new class of antiretroviral drug that have recently become available. These agents have been shown to reduce HIV viral load levels that are undetectable with currently available assays and to reduce the progression of the disease and mortality in many infected individuals. Although Phase I studies of several protease inhibitors (indinavir, ritonavir, and nelfinavir in combination with AZT and 3TC) in pregnant infected women and their infants will soon start in the U.S., there are currently no data available regarding drug dosage, safety, and tolerance of any of the protease inhibitors in pregnancy or neonates. Mirochnick et al., "Safety and Pharmacokinetics," see note 8 above. It should also be noted that a fourth class of antiretroviral drugs, called nucleotide analogue reverse transcriptase inhibitors (dipivoxil), is currently under investigation.

10. CDC, "Status of Perinatal HIV Prevention," 1.

11. S.G. Stolberg, "U.S. AIDS Research Abroad Sets Off Outcry Over Ethics," *New York Times*, 18 September 1997, A-33.

12. Editor, "Caesarean Plus Drug Is Proved To Reduce Transfer Of H.I.V.," *New York Times*, 29 January 1999, A-16.

13. On February 1, 1999, United Nations scientists reported that a new, simple and

relatively inexpensive drug treatment program of taking two pills a day that contain the two standard anti-HIV drugs: AZT and 3TC, can significantly reduce mother-to-infant transmission of the AIDS virus. This treatment worked as well whether the women started taking the pills about three weeks before delivery or at the onset of labor, which in most developing countries is the first time expectant mothers seek medical assistance. In either case the mother and the baby took the medication for only a week after birth. Dr. Joseph Sabo, the United Nations official who reported the findings believes the new strategy will be cost-effective but could not give figures. According to the United Nations, if the new regimen is widely accepted, it will save about 7 to 10 of every 100 babies who would otherwise have developed AIDS and presumably died from it. For a more detailed report on the United Nations studies, see Lawrence K. Altman, "Spare AIDS Regime is Found to Reduce Risk to Newborns," *New York Times* 2 February 1999, A-1 and A-15. It should also be noted that the day after this report was delivered, serious questions about its safety arose from a report of the deaths of two babies in a similar, separate French study. Both babies died from a rare neurological disease. Officials from the United States and the United Nations said they would immediately begin an investigation to determine whether there is a link between the drugs and the neurological disease and to assess the risk. Lawrence K. Altman, "Babies' Deaths Raise Fear Over AIDS Therapy," *New York Times* 3 February 1999, A-14.

14. CDC, "Status of Perinatal HIV Infections," 2.

15. In 1996, an estimated 6,750 African-American women were diagnosed with AIDS. Of these, 53% (3,620) were among women infected heterosexually and 43% (2,910) were attributed to injection drug use. Prior to the impact of treatment, AIDS incidence in African-American women infected heterosexually was increasing at a rate of between 15% and 30%. In 1996, incidence among Hispanic women infected through injection drug use dropped 8%, while incidence among Hispanic women infected heterosexually continued to increase, although at a slower rate than in recent years (dropping from annual increases of about 15% to an increase of less than 4% in 1996). By comparison, in 1996, an estimated 2,390 white women were diagnosed with AIDS. Of these, 51% (1,220) were among white women infected heterosexually and 43% (1,040) were among white women infected through injection drug use. In 1996, AIDS incidence among white women infected heterosexually leveled (0% change). See CDC, "Turning Point in the Epidemic," pp. 12-14.

16. CDC, "Status of Perinatal HIV Prevention," 2.

17. In 1932 the U.S. Public Health Service initiated a study on African-American men with syphilis in Macon County, Alabama, to determine the natural course of untreated, latent syphilis in black males. The study comprised 399 syphilitic men as well as 201 uninfected men who served as the control group. These men were led to believe they would receive free meals, "special free treatment" for what was called "bad blood," and burial insurance. In reality, they were enrolled in this study without their informed consent. These men were deceived in that the infected were

never told that they had syphilis, which was known to cause mental illness and death. In fact, the infected were never treated for the disease. To determine the natural course of syphilis, the researchers withheld the standard treatment of mercury and arsenic compounds from the subjects. In 1947 when penicillin was determined to be an effective treatment for syphilis, this, too, was withheld. The treatment these men actively received came in the form of placebos. The study was terminated in 1972. For a more detailed analysis of the Tuskegee Syphilis Study, see James H. Jones, *Bad Blood: The Tuskegee Syphilis Experiment – A Tragedy of Race and Medicine* (New York: The Free Press, 1981).

18. Allan Brandt, "Racism and Research: The Case of the Tuskegee Syphilis Study," *Hastings Center Report 8* (December 1978) 23, 27.

19. Angie Cannon, "Officials Hope Apology for Tuskegee Study is a Healing Step," *The Philadelphia Inquirer*, 16 May 1997, A-1.

20. Other examples of the general disregard of the federal government toward those who are poor and vulnerable have come to light recently. First, from 1963 to 1971, at Oregon State Prison and at Washington State Prison, prisoners' testicles were irradiated to learn what doses made them sterile. Second, from 1946 to 1956, mentally handicapped children at the Walter E. Fernald School in Waltham, MA were told they were joining the "science club" and were given radioactive material in their cereals. Third, from 1945 to 1947, 820 pregnant women were given small doses of radioactive iron at Vanderbilt University. Finally, during the 1960s and 1970s, subjects at the University of Cincinnati and three other universities were exposed to radiation over their entire bodies to measure the effects. For a more detailed analysis see, Matthew L. Wald, "Rules Adopted to Prohibit Secret Tests on Humans," *New York Times* 29 March 1997, A-1, 4; see also Ruth Faden, "The Advisory Committee on Human Radiation Experiments: Reflections on a Presidential Commission," *Hastings Center Report* 26 (September-October 1996): 5-10.

21. CDC, "Status of Perinatal HIV Prevention," 3. For a more detailed analysis of why African-Americans mistrust the medical profession, see Peter A. Clark, S.J., "A Legacy of Mistrust: African-Americans, The Medical Profession and AIDS," *Linacre Quarterly* 65 (February, 1998): 66-68.

22. CDC, "Status of Perinatal HIV Prevention," 2.

23. Leary, A-22.

24. D.J. Palmisano, "AMA Statement re: Medical Records Privacy and Confidentiality," to the Committee on Labor and Human Relations, U.S. Senate, October 28, 1997. See also, Thomas Reardon, "Patient Privacy and Confidentiality," *Report to the Board of Trustees – American Medical Association*, 9-A-98, p. 3.

25. Leary, A-22.

26. Gregory E. Pence, *Classic Cases in Medical Ethics* 2nd ed., (New York: McGraw-Hill, 1995), 430.

27. Nonmoral evil refers to the lack of perfection in anything whatsoever. As pertaining to human actions, it is that aspect which we experience as regrettable, harmful, or detrimental to the full actualization of the well-being of persons and of their social relationships. For a more detailed description see, Louis Janssens, "Ontic Evil and Moral Evil," in *Readings in Moral Theology, No. 1: Moral Norms and Catholic Tradition*, edited by Charles F. Curran and Richard A. McCormick, S.J. (Ramsey, NJ: Paulist Press, 1979), 60.

28. Richard A. McCormick, S.J., *How Brave a New World?: Dilemmas in Bioethics*, (Washington, D.C.: Georgetown University Press, 1981), 443.

29. Richard A. McCormick, S.J. and Paul Ramsey, *Doing Evil to Achieve Good: Moral Conflict Situations*, (Lanham, MD: University Press of American, 1985), 38. See also, Thomas Aquinas, *Summa Theologiae* II-II, q. 4, a. 7.

30. According to McCormick and Ramsey, "it can be argued that where a higher good is at stake and the only means to protect it is to choose to do a nonmoral evil, then the will remains properly disposed to the values constitutive of human good. The person's attitude or intentionality is good because he is making the best of a destructive and tragic situation. This is to say that the intentionality is good even when the person, reluctantly and regretfully to be sure, intends the nonmoral evil if a truly proportionate reason for such a choice is present." (Emphasis in the original) ibid., 39.

31. James J. Walter, "Proportionate Reason and its Three Levels of Inquiry: Structuring the Ongoing Debate," *Louvain Studies* 10 (Spring, 1984): 32.

32. McCormick's criteria for proportionate reason first appeared in Richard McCormick, *Ambiguity in Moral Choice* (Milwaukee, WI: Marquette University Press, 1973). He later reworked the criteria in response to criticism. His revised criteria can be found in *Doing Evil to Achieve Good*, eds. Richard McCormick and Paul Ramsey (Chicago, IL: Loyola University Press, 1978).

33. Ibid., 2. It should be noted that the Committee of the Institute of Medicine recommended that "employers and others who buy insurance coverage to insist on coverage for the tests, which would cost about three dollars each, if they were performed in conjunction with routine prenatal blood tests." See Leary, A-22.

34. American Medical Association-House of Delegates, "H-20.930 Counseling and Testing of Pregnant Women for HIV," Resolution 425, A-96, (1998).

35. Sylvia Fubini, "Electronic Medical Records: Efficiency vs. Privacy," *Inside Medical Technology* (September 1998): 3.

36. S.G. Stolberg, "Health Identifier for All Americans Runs Into Hurdles," *New York Times* 20 July 1998, A-1, A-11.

37. Sheryl Gay Stolberg, "Clinton Decides not to Finance Needle Programs," *New York Times* 21 April 1998, A-18.

38. For a more detailed analysis, see Lawrence K. Altman, "New Means Found for Reducing H.I.V. Passed to Child," *New York Times* 15 July 1999, A-1, A-17.