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# IS IT CONSTITUTIONAL AND WILL IT BE EFFECTIVE? AN ANALYSIS OF MANDATORY HIV TESTING OF PREGNANT WOMEN

*Dorian L. Eden*<sup>†</sup>

**NOTHING EVOKES MORE SYMPATHY** than the image of an innocent baby afflicted with a terrible disease. However, each year thousands of babies are born with diseases that could have been prevented. One such disease is HIV. This paper will analyze the current debate over the constitutionality of mandatory HIV testing of pregnant women. My argument is that while the Supreme Court would find mandatory HIV testing of pregnant women constitutional, mandatory testing is not the most effective way to reduce perinatal transmission.<sup>1</sup> The first section is a brief overview of the history behind HIV. The second section examines the maternal-fetal conflict and discusses its impact on mandatory HIV testing. The third section examines the constitutional arguments in favor of and against mandatory HIV testing. The fourth section discusses the endorsements of and legislation requiring HIV testing of pregnant women. The fifth section discusses mandatory treatment of pregnant women as analogous to mandatory treatment of HIV-positive pregnant women. Finally, the sixth section discusses the policy implications of mandatory testing.

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I would like to thank my husband and parents for listening to my endless talk on this subject and my sister for answering my medical questions. I would also like to thank Professor Sharona Hoffman for her help and guidance and the Health Matrix staff for all their hard work.

<sup>1</sup> Perinatal transmission occurs when a pregnant woman transmits a disease to her fetus, either during pregnancy or immediately after birth. See *STEDMAN'S MEDICAL DICTIONARY* 1349 (27th ed. 2000).

## I. HISTORY OF HIV

The discovery of HIV in 1981 marked the beginning of a better understanding of how this disease is spread.<sup>2</sup> Then, in 1985, tests were developed to identify those who were infected with HIV. As a result, the public began crying out for mandatory testing of the groups that initially seemed to be affected by the disease, homosexuals and intravenous drug users.<sup>3</sup> Debate over mandatory testing was based on four underlying factual assumptions that persisted until November 1994:<sup>4</sup>

1. HIV infection is incurable and fatal, and the only thing the health care system can offer those infected with the virus is counseling and medicine to slow the inevitable, deteriorative process;
2. HIV is a virus transmitted by a limited number of well-established, private, intimate and/or illegal behaviors;
3. The diagnostic test for HIV is good, but not perfect, at identifying those who are infected and at excluding those who are not infected;
4. HIV is a stigmatizing condition, and those who test positive may experience negative consequences not only in terms of health status, but also in terms of personal and professional well-being.<sup>5</sup>

Today, it is known that the disease is not limited to any group and can attack a person regardless of sexual orientation, age, race, or gender. Although still without a cure, the likelihood of transmission can be reduced and the longevity of life

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<sup>2</sup> See Elizabeth B. Cooper, *Why Mandatory HIV Testing of Pregnant Women and Newborns Must Fail: A Legal, Historical, and Public Policy Analysis*, 3 CARDOZO WOMEN'S L.J. 13, 13 (1996) (indicating that gay men were the first population in which HIV was recognized in the early 1980s).

<sup>3</sup> See Michelle Oberman, *Test Wars: Mandatory HIV Testing, Women, and Their Children*, 3 U. CHI. L. SCH. ROUNDTABLE 615, 616 (1996).

<sup>4</sup> In November 1994, the AIDS Clinical Trial Group Protocol 076 was stopped and the data was collected. The study demonstrated that AZT administered during pregnancy reduced the perinatal transmission rate. See *id.* at 624.

<sup>5</sup> *Id.* at 616 (citation omitted).

can be increased with treatment. This knowledge, as well as the fatality of the disease, has led to a resurgence of the call for mandatory testing among various groups. The most recent group to be targeted is pregnant women.

It is estimated that "four million women give birth each year in the United States."<sup>6</sup> Of those infants born, 7,600 are to HIV-infected women<sup>7</sup> and approximately 26%, or 2,000 of those born, acquire the virus from their mothers.<sup>8</sup> Studies have shown that the majority of the mothers become infected through heterosexual contact or drug use.<sup>9</sup> Although clinical tests of pregnant women began late, the AIDS Clinical Trials Group ("ACTG") Protocol 076 ("076 Study") showed that a regimen of AZT during pregnancy, labor, and then administered to the newly born infant, successfully reduced the risk of perinatal HIV transmission.<sup>10</sup> The 076 Study demonstrated a greater than 75 percent reduction in pediatric AIDS cases diagnosed in 1998 as compared to the peak incidence of pediatric AIDS cases diagnosed in 1992.<sup>11</sup> New tests have demonstrated the perinatal transmission rate with AZT treatment to be as low as three percent.<sup>12</sup> These tests have led to considerable debate over whether

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<sup>6</sup> Evans McMillion, Note, *The Case Against Mandatory HIV Testing of Pregnant Women: The Legal and Public Policy Implications*, 5 DUKE J. GENDER L. & POL'Y 227, 227 (1998) (citing BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES 74 tbl. 89 (117th ed. 1997)).

<sup>7</sup> See Ann M. Buchanan, *The Ethics of Mandatory Versus Voluntary HIV Testing of Pregnant Women*, 57 CURRENT SURGERY 166, 166 (2000).

<sup>8</sup> See *id.*

<sup>9</sup> See Committee on Pediatric AIDS, American Academy of Pediatrics, *Identification and Care of HIV-Exposed and HIV-Infected Infants, Children, and Adolescents in Foster Care*, 106 PEDIATRICS 149, 149 (2000) (reporting HIV/AIDS epidemiology of women). There are cases of children remaining asymptomatic after HIV-infection, or having mild symptoms (such as anemia or developmental delay) until about age four. There have been remarkable cases of children living to age fifteen, despite perinatal transmission. See *id.* at 150.

<sup>10</sup> See Centers for Disease Control & Prevention, Revised U.S. Public Health Service Recommendations for Human Immunodeficiency Virus Screening of Pregnant Woman, Oct. 20, 2000, at 1 (*available at* <<http://www.cdc.gov/hiv/frn/perinatal.pdf>>); see also McMillion, *supra* note 6, at 228 (citing Elizabeth B. Cooper, *Why Mandatory HIV Testing of Pregnant Women and Newborns Must Fail: A Legal, Historical, and Public Policy Analysis*, 3 CARDOZO WOMEN'S L.J. 13, 19 n.32 (1996)).

<sup>11</sup> See Centers for Disease Control & Prevention, *supra* note 10.

<sup>12</sup> See Health Care Financing Admin., *Pregnancy and HIV: What Women and Doctors Need to Know* (visited Mar. 4, 2001) <<http://www.hcfa.gov/hiv/default.htm>>. Prenatal and postnatal care includes a regimen of AZT during pregnancy and a cesarean section instead of vaginal delivery. In addition, a shorter AZT

HIV testing should be a mandatory part of a pregnant woman's prenatal care.

## II. THE MATERNAL-FETAL CONFLICT AND ITS IMPACT ON MANDATORY HIV TESTING

The states have asserted an interest in protecting a viable fetus. For example, the South Carolina Supreme Court upheld the state's conviction of a pregnant woman who used illegal drugs during her pregnancy based on its criminal child neglect state statute.<sup>13</sup> The court determined that South Carolina law "recognized that viable fetuses are persons holding certain legal rights and privileges."<sup>14</sup> Similarly, the Fourth Circuit upheld mandatory cocaine testing of pregnant women if certain factors indicating drug use were present and possible prosecution if the woman did not obtain treatment.<sup>15</sup> The problems arise when considering the mother's rights weighed against the fetus' "rights," if a fetus has rights, or against the state's interest in protecting a viable fetus. In addition, as medical technology advances, fetuses will be considered viable at an earlier stage, thus allowing the state to assert an interest in protecting the fetus at an earlier stage in pregnancy.

"Maternal-fetal conflict is a term used to identify those situations in which there is a discordance between the interests of a pregnant woman and the fetus she is carrying."<sup>16</sup> The conflict is created by: the independent interests of the mother and the fetus, the obligations (if any) that are attached to pregnancy, and the state's desire to intervene if the woman's actions do or may create a risk to the fetus.<sup>17</sup>

There are many examples of situations that create a maternal-fetal conflict. For example, if a woman decides to have an abortion, she is determining that she owes no duty to her fetus, and that her interests outweigh those of potential life. Medical

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regimen during pregnancy is now thought to be as effective in reducing perinatal HIV transmission as the longer treatment.

<sup>13</sup> See *Whitner v. State*, 492 S.E.2d 777 (S.C. 1997).

<sup>14</sup> *Id.* at 779.

<sup>15</sup> See *Ferguson v. City of Charleston*, 186 F.3d 469 (4th Cir. 1999), *rev'd and remanded*, 121 S. Ct. 1281 (2001) (holding state's mandatory urine testing for cocaine in pregnant women did not violate the 4th Amendment); see also *infra* notes 39-41 and accompanying text.

<sup>16</sup> Linda Farber Post, *Bioethical Considerations of Maternal-Fetal Issues*, 24 *FORDHAM URB. L.J.* 757, 758 (1997).

<sup>17</sup> See *id.*

treatment is another example of the maternal-fetal conflict. An adult, if competent, can refuse medical treatment. However, some courts have overridden a woman's refusal of treatment and ordered it for the benefit of her fetus;<sup>18</sup> framing the controversy "in terms of two issues: '(1) what constitutes a risk of harm to the fetus that is sufficiently grave to justify limitation of the woman's liberty, and (2) what constitutes a legitimate reason for the woman not to take appropriate steps to prevent harm.'"<sup>19</sup> The conflict between whose rights are greater, the fetus' (or the state's interest in protecting a viable fetus) or the woman's, have created the question of what is a compelling state interest in promoting fetal rights over a woman's rights?<sup>20</sup>

The maternal-fetal conflict has a direct impact on mandatory HIV testing. The fetal rights advocates would argue for mandatory HIV testing to reduce the likelihood of perinatal transmission. However, the woman's rights clash with the fetus' "right" to not contract HIV, or at least the state's interest in having healthy children born. The woman has a privacy right and a right to refuse medical treatment (here AZT treatment). In addition, she has a Fourth Amendment right to bodily integrity and to not be subjected to an unreasonable search and seizure. Finally, she has a right to equal protection, to not be singled out and tested merely because she is pregnant and a woman.<sup>21</sup>

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<sup>18</sup> See, e.g., *Jefferson v. Griffin Spalding County Hosp. Auth.*, 274 S.E.2d 457 (Ga. 1981) (allowing forced cesarean section to save life of fetus despite mother's refusal); *Raleigh Fitkin-Paul Morgan Mem'l Hosp. v. Anderson*, 201 A.2d 537 (N.J. 1964) (finding blood transfusion necessary to save life of fetus, despite mother's refusal to consent based on her beliefs as a Jehovah's witness); *In re Jamaica Hosp.*, 491 N.Y.S.2d 898 (Sup. Ct. 1985) (allowing forced blood transfusion to save a not yet viable fetus, despite mother's refusal).

<sup>19</sup> Post, *supra* note 16, at 765 (quoting TOM L. BEAUCHAMP & LEROY WALTERS, *CONTEMPORARY ISSUES IN BIOETHICS* 276 (4th ed. 1994)).

<sup>20</sup> See *id.*

<sup>21</sup> Each of these rights will be examined at length in the next section.

### III. THE CONSTITUTIONAL ARGUMENTS FOR AND AGAINST MANDATORY HIV TESTING OF PREGNANT WOMEN

#### A. Privacy Rights and How Mandatory HIV Testing Can Pass the Test

The right to privacy, or as Justice Brandeis termed it, the “right to be let alone”<sup>22</sup> is not explicitly found in the Constitution. Rather, it stems from the “penumbra” of rights in the First, Third, Fourth, Fifth, and Ninth Amendments, and is recognized as the right to make personal decisions.<sup>23</sup> The Supreme Court has extended these rights “to include marriage, procreation, contraception, relationships, child rearing, and education...”<sup>24</sup> When a state attempts to intrude into one of these areas, the courts examine the intrusion using the strict scrutiny test, meaning the state must show it has a compelling interest and is using narrowly tailored (or the least restrictive) means to achieve that interest.<sup>25</sup> In *Roe v. Wade*,<sup>26</sup> the Court found that the state did not have a compelling interest in protecting a fetus prior to viability, but restricted a woman’s right to have an abortion at the time of viability of the fetus.<sup>27</sup> The Court found that once a fetus could live on its own outside of its mother’s womb, the state could then assert a compelling interest in protecting it.<sup>28</sup> *Roe* seemed to be a benchmark in recognizing a woman’s rights over her unborn fetus. However, any restrictions of the woman’s right might lead the Court to find mandatory HIV testing to be permissible.

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<sup>22</sup> See *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting) (calling this right “the most comprehensive of rights and the right most valued by civilized men”).

<sup>23</sup> See Jennifer Brown, *A Troublesome Maternal-Fetal Conflict: Legal, Ethical, and Social Issues Surrounding Mandatory AZT Treatment of HIV Positive Pregnant Women*, 18 BUFF. PUB. INTEREST L.J. 67, 80 (2000) (quoting *Griswold v. Connecticut*, 381 U.S. 479 (1965) (recognizing marital privacy right from the penumbra of rights)).

<sup>24</sup> *Id.* at 181.

<sup>25</sup> See, e.g., *Roe v. Wade*, 410 U.S. 113, 155 (1973) (finding a woman’s right to have abortion from Due Process Clause of the Fourteenth Amendment). I am intentionally limiting my discussion of the constitutional aspects to cases involving pregnant women because these are most similar and most applicable to this discussion.

<sup>26</sup> 410 U.S. 113 (1973).

<sup>27</sup> See *Roe*, 410 U.S. at 163.

<sup>28</sup> See *id.* (defining viability as the pivotal point in the abortion debate).

In *Planned Parenthood v. Casey*<sup>29</sup> the Supreme Court further restricted a woman's right to abort her fetus. Finding that a state cannot restrict a woman's right to abort prior to viability, the Supreme Court rejected the use of the strict scrutiny test, instead analyzing the state's restrictions using the undue burden test.<sup>30</sup> The Court stated:

We reject the trimester framework, which we do not consider to be part of the essential holding of *Roe*...The trimester framework suffers from these basic flaws: in its formulation it misconceives the nature of the pregnant woman's interest; and in practice it undervalues the State's interest in potential life, as recognized in *Roe*.<sup>31</sup>

The Supreme Court explained the undue burden test to be:

the appropriate means of reconciling the State's interest with the woman's constitutionally protected liberty...[That] [t]o promote the State's profound interest in potential life, throughout pregnancy the State may take measures to ensure that the woman's choice is informed, and measures designed to advance this interest will not be invalidated as long as their purpose is to persuade the woman to choose childbirth over abortion. These measures must not be an undue burden on the right.<sup>32</sup>

The undue burden test allowed the Court to uphold such regulations as: a 24-hour waiting period before an abortion could be performed, parental consent requirements for a minor, requiring that a woman be told of the development of her fetus, and reporting and recording requirements for statistical purposes.<sup>33</sup>

If the Supreme Court had used the strict scrutiny test, the state would have had to prove that the law in *Casey* was necessary to accomplish the end goal, and the government's purpose in achieving that end would have to have been compelling. In addition, the law must have used the least restrictive means to

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<sup>29</sup> 505 U.S. 833 (1992).

<sup>30</sup> See *Planned Parenthood*, 505 U.S. at 876-78.

<sup>31</sup> *Id.* at 837.

<sup>32</sup> *Id.* at 876-78.

<sup>33</sup> See *id.* at 881-901.



achieve the goal.<sup>34</sup> The burden of proof rests on the state, while the undue burden test places the burden of proof on the plaintiff. Although it is not exactly clear what the undue burden test is,<sup>35</sup> by employing this less stringent test, the Court seemed “to be saying that an undue burden exists only if there is a showing that the regulation will keep someone from getting an abortion”<sup>36</sup> before viability. The Court acknowledged the State’s “profound interest in potential life”<sup>37</sup> and allowed the State to ensure a woman’s choice is informed, even if the purpose of the information is to persuade her to choose childbirth over abortion.<sup>38</sup>

Although the Court has not allowed a state to completely prohibit a woman’s right to have an abortion, it has permitted states to restrict a woman’s right. For example, the 24-hour waiting period upheld in *Casey* assumes that a woman will not have adequately considered her decision to have an abortion before seeking one. The state assumed, in a paternalistic way, that a woman was not capable of deciding what was best for her without some outside help.

When a state or court determines at what point during a pregnancy a woman is no longer able to obtain an abortion, it is restricting a woman’s right to choose. As states increase their interest in protecting a viable fetus, the woman’s ability to make decisions for herself and her fetus decrease. An amplified state interest increases the likelihood that the Supreme Court would uphold mandatory HIV testing of pregnant women.

Although the Supreme Court reversed the Fourth Circuit’s decision in *Ferguson v. City of Charleston*,<sup>39</sup> on the grounds that law enforcement involvement negates a warrantless search without consent,<sup>40</sup> the court did not determine that hospitals or doctors could not test pregnant women for drug use. Rather, the

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<sup>34</sup> See ERWIN CHERMERINSKY, CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES § 6.5, at 416 (1997).

<sup>35</sup> See Erin Daly, *Reconsidering Abortion Law: Liberty, Equality, and the New Rhetoric of Planned Parenthood v. Casey*, 45 AM. U.L. REV. 77, 144-45 (1995) (examining abortion law and the impact of *Casey* on a woman’s right to seek an abortion).

<sup>36</sup> CHERMERINSKY, *supra* note 34, § 10.3.3.1, at 673.

<sup>37</sup> *Id.* at 672.

<sup>38</sup> See *id.*

<sup>39</sup> 121 S. Ct. 1281 (2001), *rev’d*, *Ferguson v. City of Charleston*, 186 F.3d 469 (4th Cir. 1999).

<sup>40</sup> See *Ferguson*, 121 S. Ct. at 1289-93.

Court determined that “[t]he reasonable expectation of privacy enjoyed by the typical patient undergoing diagnostic tests in a hospital is that the results of those tests will not be shared with nonmedical personnel without her consent.”<sup>41</sup> As long as law enforcement is not involved with drug testing, then presumably the hospitals can continue to test pregnant women.<sup>42</sup> Both HIV and illegal drug use, especially during pregnancy, can negatively affect a fetus. But once the state has an interest in protecting the fetus from its mother’s drug use, then the state can argue it has an interest in protecting a fetus from all sorts of diseases. Part of what is at issue is at what point the state can assert such a profound interest in protecting human life.

The Supreme Court has already recognized a state interest after viability by disallowing abortions in most instances. If the state has an interest in not only ensuring that the child is born alive, but also healthy, then the state, through its doctors, will be able to test for illegal drug use, HIV, and other, less stigmatizing diseases and conditions.<sup>43</sup> Since the Court has consistently allowed a state to assert an interest in the fetus, it is likely to uphold drug testing (without the involvement of law enforcement), and in turn, HIV testing.

Those who argue that mandatory HIV testing is unconstitutional might claim there is a difference between HIV testing and drug testing of a pregnant woman. However, this is a distinction without a difference. The argument can be made that a woman who uses drugs will not learn anything new by having a drug test during prenatal testing. However, a woman who discovers she is HIV positive during pregnancy will learn new information that could be very traumatic. While this argument is correct, a woman will not remain ignorant about her HIV status forever. Once she or her child begins to show symptoms and requires medical care, the woman will be forced to face her disease. If, however, she is notified during her pregnancy she increases her fetus’ chance to be born healthy. Counseling could help decrease the trauma and teach the pregnant woman how to

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<sup>41</sup> *Id.* at 1288.

<sup>42</sup> If, however, a hospital “undertake[s] to obtain such evidence from their patients for the specific purpose of incriminating those patients, [it has] a special obligation to make sure that the patients are fully informed about their constitutional rights, as standards of knowing waiver require.” *Id.* at 1292.

<sup>43</sup> States are already permitted to test both pregnant women and the newborn for various diseases. See *infra* notes 54-59 and accompanying text.

live with HIV as well as inform her of the advances in medical technology that may one day find a cure for HIV. While HIV is different from drug abuse or addiction, there are many other potentially traumatic diseases a woman could find out she has by submitting to a prenatal test. HIV should not be any different simply because a woman is frightened to find out the results.

### B. An Examination of HIV Testing Under the Fourth Amendment Right to Bodily Integrity

The Fourth Amendment guarantees that “[t]he right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated....”<sup>44</sup> The Supreme Court has held that a blood test is a search under the Fourth Amendment<sup>45</sup> and thus it must be determined if the test is reasonable. Since HIV testing is administered by testing blood, it clearly falls under the Fourth Amendment search. In determining if a warrantless or suspicionless search is reasonable, courts have applied a special needs balancing test.<sup>46</sup> The balancing test “balanc[es] the need to search against the invasion which the search entails.”<sup>47</sup> As long as a special governmental need is advanced and the intrusion on privacy is minimal, then a court may uphold a special needs search.<sup>48</sup>

In *Skinner v. Railway Labor Executives' Association*,<sup>49</sup> the courts determined that the government had a legitimate interest in conducting drug testing of railroad employees in order to protect public safety. In *Fosman v. State*,<sup>50</sup> the court found that the government also had a legitimate interest in requiring HIV testing of a man accused of sexual assault. These interests were determined to outweigh the privacy rights of the railroad em-

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<sup>44</sup> U.S. CONST. amend. IV.

<sup>45</sup> See *Schmerber v. California*, 384 U.S. 757, 767 (1966) (holding blood testing is considered a Fourth Amendment search).

<sup>46</sup> See *Chandler v. Miller*, 520 U.S. 305 (1997) (finding state drug testing for political candidates violated Fourth Amendment due to suspicionless searches); see also *Skinner v. Railway Labor Executives' Ass'n*, 489 U.S. 602 (1989) (upholding drug testing of railroad employees under special needs test).

<sup>47</sup> *Fosman v. State*, 664 So. 2d 1163, 1165 (Fla. Dist. Ct. App. 1995) (citing *New Jersey v. T.L.O.*, 469 U.S. 325, 337 (1985) (upholding forced HIV testing of defendant charged with sexual battery when victim requested such testing).

<sup>48</sup> See *Chandler*, 520 U.S. at 314.

<sup>49</sup> 489 U.S. 602 (1989).

<sup>50</sup> 664 So. 2d 1163 (Fla. Dist. Ct. App. 1995).

ployees and the *charged* (but not convicted) defendant. Courts have also upheld mandatory HIV testing of firefighters and paramedics under the special needs test, claiming that the state's interest in preserving the safety of its citizens outweighs the privacy rights of the public employees.<sup>51</sup>

The Supreme Court would likely find that a state has a legitimate interest in protecting its citizens from HIV infection, especially its newest citizens. The state has an interest in protecting a viable fetus from death regardless of when the impending death would occur, for example, before birth, or within a few years from HIV. While the pregnant mother has a privacy right in choosing to be tested, her privacy is not absolute. Once a woman seeks prenatal care, she submits to a variety of tests, such as mandatory syphilis testing<sup>52</sup> and now possibly drug testing, as long as the threat of prosecution is not tied to treatment.<sup>53</sup> Mandatory syphilis testing began in pregnant women in 1916 after a fatal outbreak of syphilis in the early 1900s and discovery of perinatal transmission. Currently, 45 states still mandate syphilis testing as part of prenatal testing.<sup>54</sup> Ohio also mandates gonorrhea testing of pregnant women.<sup>55</sup> Despite mandated gonorrhea and syphilis testing, "research has not uncovered a single reported case, in any state or federal jurisdiction, where the authority of the state to require these tests has even been questioned."<sup>56</sup> Other states require a hepatitis B test,<sup>57</sup> rubella, measles, tetanus, and chlamydia, as well as mandatory newborn tests such as: PKU (metabolic disease that can cause retardation), galactosemia (enzyme deficiency), homocystinuria

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<sup>51</sup> See Kellie E. Lagitch, Note, *Mandatory HIV Testing: An Orwellian Proposition*, 72 ST. JOHN'S L. REV. 103, 123 (1998) (citing Anonymous Fireman v. City of Willoughby, 779 F. Supp. 402, 408, 418 (N.D. Ohio 1991) (holding that firefighters and paramedics are required to take an annual HIV test because of the high-risk nature of their work)).

<sup>52</sup> See Samantha Catherine Halem, Note, *At What Cost?: An Argument Against Mandatory AZT Treatment of HIV-Positive Pregnant Women*, 32 HARV. C.R.-C.L. L. REV. 491, 496-97 (1997).

<sup>53</sup> See *Ferguson v. City of Charleston*, 121 S. Ct. 1281 (2001).

<sup>54</sup> See R. Curtis McNeil, Note, *Prenatal Testing Under Ohio Revised Code Section 3701.242: The Doctors' Dilemma and the State's Shame*, 22 DAYTON L. REV. 301, 310 (1997) (arguing that HIV testing should be added to prenatal care).

<sup>55</sup> See *id.*

<sup>56</sup> *Id.*

<sup>57</sup> See *Doe v. Lai-Yet Lam*, 268 A.D.2d 206, 206 (N.Y. App. Div. 2000) (finding that hospital's failure to notify mother of positive hepatitis B test was a breach of duty to the fetus and the mother).

(metabolic deficiency), hypothyroidism (thyroid deficiency), and hemoglobinopathies (disease that can cause sickle-cell).<sup>58</sup> These are prenatal tests that a woman cannot opt out of, despite their possible stigmatizing effects.

When a woman seeks prenatal treatment, she is consenting to be tested for what is mandated by the state in which she is seeking treatment. She submits to testing and treatment. "With such broad and unquestioned approval of testing of pregnant women for sexually transmitted diseases,"<sup>59</sup> it is likely that the Supreme Court would treat HIV testing as any other STD in this instance. In addition, since the state has an interest in not only protecting a viable fetus, but also in preventing the spread of sexually transmitted diseases, the Court would uphold testing as fulfilling a special need of the state.<sup>60</sup> The Supreme Court is likely to uphold mandatory HIV testing of pregnant women on a Fourth Amendment challenge.

### C. Can Mandatory HIV Testing Survive an Equal Protection Challenge?

The Fourteenth Amendment prohibits states from implementing laws that deny citizens equal protection.<sup>61</sup> While some might argue that mandatory HIV testing of pregnant women violates the equal protection clause since *only* pregnant women would be force-tested, and not the father of the fetus, this argument is also likely to fail a Supreme Court analysis.

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<sup>58</sup> See McNeil, *supra* note 54, at 309 & n.53.

<sup>59</sup> *Id.* at 310.

<sup>60</sup> The Supreme Court's holding in *Ferguson v. City of Charleston* may guide how the Court responds to mandatory HIV testing. The Court, in *Ferguson*, objected to the involvement of the police in the drug testing and treatment of pregnant women. 121 S. Ct. 1281 (2001). However, since an HIV test result cannot be turned over to police, nor used in the prosecution of a woman, the Court would revert to the special needs test. As the Court pointed out in *Ferguson*:

While the ultimate goal of the program may well have been to get the women in question into substance abuse treatment and off of drugs, the immediate objective of the searches was to generate evidence *for law enforcement purposes* in order to reach that goal. The threat of law enforcement may ultimately have been intended as a means to an end, but the direct and primary purpose of [the hospital's] policy was to ensure the use of those means. In our opinion, this distinction is critical.

*Id.* at 1291 (citations omitted).

<sup>61</sup> U.S. CONST. amend. XIV, §1.

Congress determined that employment discrimination against pregnant women must be stopped and thus enacted the Pregnancy Discrimination Act<sup>62</sup> ("PDA") in 1978, which states:

The terms "because of sex" or "on the basis of sex" include, but are not limited to, because of or on the basis of pregnancy, childbirth, or related medical conditions; and women affected by pregnancy, childbirth, or related medical conditions shall be treated the same for all employment-related purposes, including receipt of benefits under fringe benefit programs, as other persons not so affected but similar in their ability or inability to work, and nothing in section 2000e-2(h) of this title shall be interpreted to permit otherwise. This subsection shall not require an employer to pay for health insurance benefits for abortion, except where the life of the mother would be endangered if the fetus were carried to term, or except where medical complications have arisen from an abortion: *Provided*, That nothing herein shall preclude an employer from providing abortion benefits or otherwise affect bargaining agreements in regard to abortion.

The Supreme Court interpreted this to prohibit discrimination against a pregnant woman solely because of her pregnancy.<sup>63</sup> However, the Court has only recognized pregnancy discrimination in employment cases and not in a forced medical treatment case.<sup>64</sup>

There are two levels of scrutiny for evaluating gender classifications. To withstand an intermediate scrutiny test, "[a] classification 'must be reasonable, not arbitrary, and must rest upon some ground of difference having a fair and substantial relation to that object of the legislation, so that all persons similarly situated shall be treated alike.'"<sup>65</sup> In *Craig v. Boren*,<sup>66</sup> the Su-

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<sup>62</sup> 42 U.S.C. § 2000e(k) (1994).

<sup>63</sup> See *Newport News Shipbuilding & Dry Dock Co. v. EEOC*, 462 U.S. 669 (1983) (finding employee health insurance that provided a female worker's pregnancy with more benefits than a male worker's wife's pregnancy prohibited by the PDA).

<sup>64</sup> See *Halem*, *supra* note 52, at 523-24.

<sup>65</sup> *Reed v. Reed*, 404 U.S. 71, 76 (1971) (quoting *Royster Guano Co. v. Virginia*, 253 U.S. 412, 415 (1920)).

preme Court held that gender classifications must serve an important governmental interest and the law must be substantially related to that end.<sup>67</sup> A challenge under this scrutiny forced a woman “to prove that the state’s objective could be better achieved through less intrusive means, and that the program of mandatory treatment offered by the state is not sufficiently tailored to fulfill the state’s goals.”<sup>68</sup>

However, since the 1970s, the Supreme Court has re-examined gender classifications. In *United States v. Virginia*,<sup>69</sup> the Court indicated that a law must pass an “exceedingly persuasive”<sup>70</sup> test, a higher level of scrutiny. In addition, the “State must show at least that the [challenged] classification serves important governmental objectives and that the discriminatory means employed are substantially related to the achievement of those objectives”<sup>71</sup> for the law to be upheld. This is the test that would be applied to an equal protection analysis of mandatory HIV testing of pregnant women.

The important governmental objective that is involved with mandatory HIV testing is protecting the viable fetus from death. The state has a compelling interest in protecting the viable fetus from an immediate death in abortion cases. This interest would be extended to protect a viable fetus even when death was not immediate, as in an abortion, but rather almost certain to occur within a couple of years. The state would also argue that the means (of testing only pregnant women) are substantially related to the achievement of those objectives. Since only the mother and not the father can directly transmit the disease to the fetus, the state’s interest is in testing the mother. In addition, since only the mother can reduce the transmission rate to the fetus (by taking AZT), the state’s interest in protecting the fetus lies only in the mother. If the father could directly transmit or reduce the rate of transmission to the fetus, then the state’s interest in testing him would increase.

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<sup>66</sup> 429 U.S. 190 (1976) (holding that the gender-based Oklahoma law denied 18-20 year-old males equal protection under the Fourteenth Amendment).

<sup>67</sup> *See id.* at 197.

<sup>68</sup> *Halem, supra* note 52, at 524.

<sup>69</sup> 518 U.S. 515 (1996) (holding the Virginia Military Institute policy of excluding women from enrolling violated the Equal Protection Clause).

<sup>70</sup> *Id.* at 533.

<sup>71</sup> *Id.* (citing *Mississippi Univ. for Women v. Hogan*, 458 U.S. 718, 724 (1982) (quoting *Wengler v. Druggists Mut. Ins. Co.*, 446 U.S. 142, 150 (1980)) (internal quotation marks omitted)).

There are two ways to prove gender classifications. First is that the law is facially discriminatory; second is that the law is facially neutral but has a discriminatory intent.<sup>72</sup> The Virginia law was facially discriminatory in that the Virginia Military Institute excluded women from enrollment. In *Nashville Gas Company v. Satty*,<sup>73</sup> the Court determined that an employer's policy of denying women their seniority upon return from maternity leave fit the second category of having a discriminatory intent. In addition, the Court held that this policy violated Title VII.<sup>74</sup>

Mandatory HIV testing of pregnant women, if discriminatory, is facially neutral but has a potentially discriminatory intent. Testing serves an important governmental interest in preventing perinatal transmission and protecting fetuses. The only way to ensure that a pregnant woman does not transmit HIV to her fetus is to: (1) determine the woman's serostatus;<sup>75</sup> and (2) administer AZT during the pregnancy, labor and for the baby's first three days of life (or six weeks depending on which treatment plan is used). In addition, the mother should not breast feed. AZT is not a drug without side effects and if a woman who is not HIV-positive takes the medication, it might cause more harm than good to both her and the fetus. Unlike *Satty*, mandatory testing would not punish a woman for becoming pregnant or for being a woman; rather the state's interest lies in protecting the fetus.

Although this argument is the one most likely to fail a constitutional analysis, in recent years the Supreme Court has demonstrated that it is willing to uphold a greater interest in protecting potential life.<sup>76</sup> Therefore, the Court is likely to uphold

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<sup>72</sup> See CHEMERINSKY, *supra* note 34, § 9.4.2, at 607.

<sup>73</sup> 434 U.S. 136 (1977).

<sup>74</sup> See *id.* at 142 (stating that the employer's policy was facially neutral but had discriminatory intent).

<sup>75</sup> Serostatus is a person's HIV status, and refers to seroconversion or "the development of detectable specific antibodies" in the blood as a result of HIV infection. STEDMAN'S MEDICAL DICTIONARY, *supra* note 1, at 1623.

<sup>76</sup> See, e.g., *Planned Parenthood v. Casey*, 505 U.S. 833 (1992). Other federal courts have followed and upheld abortion regulations. See, e.g., *Greenville Women's Clinic v. Bryant*, 222 F.3d 157 (4th Cir. 2000) (upholding state regulation of abortions because it did not create undue burden on the right to obtain an abortion); *Planned Parenthood v. Farmer*, 220 F.3d 127 (3d Cir. 2000) (striking down state law which prohibited partial birth abortions because the statute was unconstitutionally vague, creating an undue burden on the right to get an abortion).



HIV testing of pregnant women despite an equal protection argument.

#### IV. STATE PLANS IMPLEMENTING HIV TESTING AS PART OF PRENATAL CARE

Doctors and medical associations recognize the medical importance of a pregnant woman knowing her HIV status. Over the last few years, various medical associations have endorsed prenatal HIV testing and all states have included HIV testing in their prenatal care. The most recent and controversial endorsement came from the American Medical Association ("AMA") who "supports the position that there should be mandatory HIV testing of all pregnant women and newborns with counseling and recommendations for appropriate treatment."<sup>77</sup> The AMA also endorsed draft legislation, which would mandate HIV testing of pregnant women.<sup>78</sup> In addition, "the Centers for Disease Control and Prevention (CDC) of the United States Public Health Service and The American College of Obstetricians and Gynecologists (ACOG), together with the American Academy of Pediatrics (AAP), have issued statements that recommend the offering of HIV testing at the first pregnancy visit."<sup>79</sup> Finally, the Institute of Medicine has recommended "a nationwide policy of HIV testing during pregnancy (with right of refusal)."<sup>80</sup>

Only two states have followed the recommendations of the AMA. Connecticut<sup>81</sup> has implemented mandatory HIV testing of

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<sup>77</sup> American Med. Ass'n, *H-20.930 Counseling and Testing of Pregnant Women for HIV*, (visited Mar. 5, 2001) <[http://www.ama-assn.org/apps/pf\\_online/pf\\_online?f\\_n=browse&doc=poli.../H-20.925.htm](http://www.ama-assn.org/apps/pf_online/pf_online?f_n=browse&doc=poli.../H-20.925.htm)>.

<sup>78</sup> See Public Health Initiatives: HIV Prevention Act of 1999, Letter to Rep. Tom Coburn, MD on his draft HIV legislation—September 9, 1999 (*available at* <http://www.ama-assn.org/ama/pub/article/4117-4304.html>) (writing on behalf of the AMA to Rep. Coburn noting their intent to make a formal endorsement of the HIV Prevention Act of 1997); see also Comprehensive HIV Prevention Act of 1997, H.R. 1219, 106th Cong. §§ 201-03 (1997) (proposed by Rep. Nancy Pelosi).

<sup>79</sup> Richard M. Grimes et al., *Legal Considerations in Screening Pregnant Women for Human Immunodeficiency Virus*, 180 AM. J. OBSTETRICS & GYNECOLOGY 259, 259 (1999) (citations omitted).

<sup>80</sup> Committee on Pediatric AIDS, *supra* note 9, at 149.

<sup>81</sup> See 1999 Conn. Pub. Acts 99-2 (Spec. Sess.) (requiring HIV testing to be completed during prenatal testing and requiring, that if mother does not seek prenatal care, HIV test must be performed on infant within 28 days of birth with the results distributed to the mother within 48 hours of test administration).

pregnant women, and New York<sup>82</sup> has implemented mandatory HIV testing of all newborns. Research has indicated that these states have not faced any challenges to their policies. Most states have implemented programs where HIV testing is included in prenatal testing; however, the woman can opt-out of the testing. She must sign a waiver that she does not wish to have an HIV test, and this is kept in her medical record.<sup>83</sup> Some others require that an examining doctor suggest that a pregnant woman has an HIV test, but if she declines there is no requirement of a signed waiver.<sup>84</sup> Other states have implemented a mandatory counseling session on HIV risks to a fetus and testing (where a woman can opt out).<sup>85</sup> The testing and counseling appears to be successful, with most pregnant women tested during prenatal care.<sup>86</sup>

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<sup>82</sup> See N.Y. PUB. HEALTH LAW § 2500-f (McKinney Supp. 2001). This law mandates all newborns be tested and the results given to the mother. Unfortunately there are two problems with this law. First, there is an approximately 30 day lag between test administration and result distribution, during which that time the mother is free to engage in any sort of behavior. See Post, *supra* note 16, at 772-73. Second, although the law mandates testing for the newborn, this test is in essence a determination of the mother's serostatus. If a woman is HIV-positive and gives birth, her newborn will be born with her HIV antibodies, and, as a result, the newborn will test positive for HIV antibodies. Within 15-18 months of birth, 75% of these newborns will develop their own antibodies, and no longer test HIV-positive since they did not contract the virus from their mother. See *id.*

<sup>83</sup> See, e.g., DEL. CODE ANN. tit. 16, § 708 (2000) (requiring all pregnant women seeking prenatal care to be tested for STDs; however, the women can opt-out of testing by signing a waiver); FLA. STAT. ANN. § 384.31 (West 2000) (requiring pregnant women to sign a waiver if they refuse an HIV test); TENN. CODE ANN. § 68-5-703(c) (Supp. 2000).

<sup>84</sup> See, e.g., IOWA CODE ANN. § 141A.4 (West Supp. 2000) (requiring the distribution of HIV prevention literature to pregnant women); N.J. STAT. ANN. §26:5C-16 (West 2000) (providing information on benefits, notification, and guidelines for HIV testing).

<sup>85</sup> See *Prenatal Discussion of HIV Testing and Maternal HIV Testing—14 States, 1996-1997*, 48 MORBIDITY & MORTALITY WKLY. REP. 401 (1999) (analyzing data collected from 14 states participating in the Pregnancy Risk Assessment Monitoring System for HIV testing and counseling of pregnant women); see also *KMA Urges Routine Testing of All Pregnant Women*, ASSOCIATED PRESS NEWSWIRE, Sept. 21, 2000, at 1 (describing the benefits behind the Kentucky Medical Association's resolution for HIV testing of all pregnant women); Halem, *supra* note 52, at 495-96.

<sup>86</sup> See *Prenatal Discussion of HIV Testing and Maternal HIV Testing—14 States, 1996-1997*, *supra* note 85; see also Buchanan, *supra* note 7, at 166 (reporting that studies have demonstrated that most women voluntarily consent to prenatal testing if given the choice in addition to counseling and information); McMillion, *supra* note 6, at 243.

The Federal Government appears to have taken a stance in favor of mandatory testing by enacting the Ryan White CARE Act Amendments of 1996.<sup>87</sup> This bill requires that by the year 2000,

[i]f the Health and Human Services (HHS) Secretary determines that mandatory testing has not become routine practice, each state will have eighteen months in which to demonstrate one of the following or *lose* its Ryan White CARE Act funds: (1) a fifty percent reduction in the rate of new AIDS cases resulting from perinatal transmission (comparing most recent data to 1993 data); (2) HIV testing of at least ninety-five percent of the women who have received at least two prenatal visits prior to thirty-four weeks gestation; (3) a program of mandatory testing of all newborns whose mothers have not undergone prenatal HIV testing.<sup>88</sup>

This act virtually ensures that prenatal HIV testing will continue to be routine, if not mandatory by mid-2002.

#### V. ANALOGOUS ARGUMENTS TO MANDATORY TREATMENT FOR HIV-POSITIVE PREGNANT WOMEN THAT STEM FROM THE STATE'S POLICE AND PARENS PATRIAE POWER.<sup>89</sup>

Part of the problem with advocating mandatory HIV testing of pregnant women is if it is mandated, then what? Would there be mandatory treatment of pregnant women? If treatment is mandated, who will pay for it, and will treatment continue for the mother after the fetus is born? These questions must be answered before mandatory testing is implemented nationwide.

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<sup>87</sup> Ryan White CARE Act Amendments of 1996, Pub. L. No. 104-146, sec. 7(b), § 2625(c)(1)(E), 110 Stat. 1346, 1369 (1996), *amended by* Ryan White CARE Act Amendments of 2000, Pub. L. No. 106-345, sec. 212, § 2625(c), 114 Stat. 1319, 1340 (2000).

<sup>88</sup> Theresa M. McGovern, *Mandatory HIV Testing and Treating of Child-Bearing Women: An Unnatural, Illegal, and Unsound Approach*, 28 COLUM. HUM. RTS. L. REV. 469, 470 (1997) (citing to 42 U.S.C.A. § 300ff-34); *see also* Jim Williams, *AIDS Policy and the Fight Against AIDS Discrimination*, 15 N.Y.L. SCH. J. HUM. RTS. 483, 501-02 (1999) (suggesting that the only way states can meet such a high bar imposed by the government is to have mandatory newborn HIV testing).

<sup>89</sup> *Parens patriae* power is the state acting in its capacity on behalf of a citizen unable to care for himself; usually the state asserts this power to protect children. *See* BLACK'S LAW DICTIONARY 1137 (7th ed. 1999).

Although uncommon, courts have not shied away from mandating treatment for pregnant women. When mandatory treatment has been allowed for pregnant women, the courts often cite the Tenth Amendment "police powers," and the "parents patriae" doctrine.<sup>90</sup>

"The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."<sup>91</sup> This amendment gives the states the power to protect the public health and welfare. The state's police powers have been invoked to justify mandatory vaccinations, medical examinations, and even quarantines.<sup>92</sup> The Supreme Court in *Jacobson v. Massachusetts*<sup>93</sup> upheld a statute that mandated smallpox vaccinations for the public health. The Court allowed a state to act to preserve public health by "enact[ing] quarantine laws and 'health laws of every description.'"<sup>94</sup> The Court did limit state intervention to that which has a "real or substantial relation" to a public health objective, the method of enforcement cannot be "a plain, palpable invasion of rights," nor can the state go "far beyond what is reasonably required for the safety of the public...."<sup>95</sup>

The Supreme Court in *Prince v. Massachusetts*<sup>96</sup> acknowledged a state's right to override a parent's decision to refuse medical treatment for his or her child even though the treatment conflicted with their religious beliefs. Recognizing that although parents have a right to freedom of religion, the Court determined that they do not have the "liberty to expose...the child...to ill health."<sup>97</sup> Although courts have relied on this to override a parent's refusal of medical treatment, they are divided on whether this is constitutionally permissible when the child's life is not in imminent danger, or if the treatment is not likely to cure the condition.<sup>98</sup>

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<sup>90</sup> See Lagitch, *supra* note 51, at 129 (discussing justification for the states' authority to implement mandatory HIV testing of pregnant women).

<sup>91</sup> U.S. CONST. amend. X.

<sup>92</sup> See Halem, *supra* note 52, at 509.

<sup>93</sup> 197 U.S. 11 (1905).

<sup>94</sup> *Id.* at 25.

<sup>95</sup> *Id.* at 31, 28.

<sup>96</sup> 321 U.S. 158 (1944) (upholding a state's power to control the conduct of children as opposed to adults).

<sup>97</sup> *Id.* at 166-67 (quoting *People v. Pierson*, 68 N.E. 243 (1903)).

<sup>98</sup> See Halem, *supra* note 52, at 513-14 (citing Suzanne Sangree, *Control of Childbearing by HIV Positive Women: Some Responses to Emerging Legal Policies*,

Relying on these powers, forty states still have laws that allow for mandatory treatment of persons with tuberculosis<sup>99</sup> to protect the greater public from becoming infected. There are also cases of states mandating medical treatment for the protection of the fetus. In *Jefferson v. Griffin Spalding County Hospital Authority*,<sup>100</sup> the Supreme Court of Georgia authorized a doctor or hospital to force a pregnant woman to undergo a forced cesarean section for the benefit of her viable fetus. The hospital argued that there was a 99% certainty that the fetus would not survive a vaginal birth and a 50% chance the woman would not survive either. A cesarean section, the hospital argued, was almost certain to protect the lives of the fetus and the mother.<sup>101</sup> The court concluded that the fetus was "a viable human being and entitled to the protection of the Juvenile Court Code of Georgia."<sup>102</sup>

The Supreme Court of New Jersey in *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson*<sup>103</sup> allowed a viable fetus to receive a blood transfusion against the wishes and consent of the pregnant mother. The court determined that absent the transfusion, both the mother and fetus would likely die during the pregnancy.<sup>104</sup> Holding that the fetus is entitled to state protection, the court found the state's interests in protecting the fetus outweighed the mother's religious freedom to refuse such treatment.<sup>105</sup>

Similarly, the Supreme Court of New York, in *In re Jamaica Hospital*,<sup>106</sup> allowed a non-viable fetus to receive a blood transfusion despite its mother's refusal. The court determined that "the state has a highly significant interest in protecting the

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41 BUFF. L. REV. 309, 376-77 (1993)); see also Brown, *supra* note 23, at 90 (discussing the difficulty of predicting whether *parens patriae* would be sufficient for a state to override a mother's consent in the case of HIV).

<sup>99</sup> See Brown, *supra* note 23, at 88 (citing Lawrence O. Gostin, *Controlling the Resurgent Tuberculosis Epidemic: A 50-State Survey of Tuberculosis Statutes and Proposals for Reform*, 269 JAMA 255 (1993)).

<sup>100</sup> 274 S.E.2d 457 (Ga. 1981).

<sup>101</sup> See *id.* at 458.

<sup>102</sup> *Id.* at 459.

<sup>103</sup> 201 A.2d 537 (N.J. 1964).

<sup>104</sup> See *id.* at 538.

<sup>105</sup> See *id.*

<sup>106</sup> 491 N.Y.S.2d 898 (Sup. Ct. 1985).

life of a mid-term fetus, which outweighs the patient's right to refuse a blood transfusion on religious grounds."<sup>107</sup>

In addition, in *Ferguson v. City of Charleston*,<sup>108</sup> the Fourth Circuit upheld a state law that tested pregnant women displaying signs of drug use and then mandated treatment or jail time. The Supreme Court reversed because of the involvement of law enforcement. However, Justice Kennedy pointed out, "[t]he beginning point ought to be to acknowledge the legitimacy of the State's interest in fetal life and of the grave risk to the life and health of the fetus, and later the child, caused by cocaine ingestion."<sup>109</sup> While *Roe v. Wade*<sup>110</sup> and *Casey v. Planned Parenthood*<sup>111</sup> initially recognized a state's interest in protecting a viable fetus, by allowing South Carolina to conduct drug tests of pregnant women, absent any police involvement, the State's interest in protecting a fetus is furthered, not only prohibiting abortions after viability, but also ensuring that a fetus is born healthy and drug-free.

Once a woman is determined to be HIV-positive, the state must then decide if treatment is the best course to prevent perinatal transmission. While the ACTG 076 Study found that AZT administered during the pregnancy, labor and then for six weeks after birth limited the rate of transmission, further testing has shown still lower transmission rates, and has demonstrated that a shorter AZT regimen is as effective.<sup>112</sup> The standard treatment starts at week 28 of pregnancy and continues during the newborn's first six weeks of life.<sup>113</sup> New research, demonstrated in developing countries, and reported by the National Institutes of Health, has found that treatment beginning at 35 weeks of pregnancy and then continuing for three days after birth was as effective as the standard regimen.<sup>114</sup> In addition to being as effec-

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<sup>107</sup> *Id.* at 900.

<sup>108</sup> 186 F.3d 469 (1999), *rev'd and remanded*, 121 S. Ct. 1281 (2001).

<sup>109</sup> *Ferguson v. City of Charleston*, 121 S. Ct. 1281, 1294 (2001) (Kennedy, J., concurring).

<sup>110</sup> 410 U.S. 113 (1973).

<sup>111</sup> 505 U.S. 833 (1992).

<sup>112</sup> See *supra* notes 10-11 and accompanying text.

<sup>113</sup> See National Institute of Health, News Release, *Shorter AZT Treatment Reduces Mother to Child HIV Transmission as Well as Longer Treatment But for Less Cost*, (last modified Oct. 4, 2000) <<http://www.nih.gov/news/pr/oct2000/nichd-04.htm>> (discussing AZT treatment study in approximately 1,500 pregnant women in Thailand).

<sup>114</sup> See *id.*

tive, it costs eight hundred dollars less than the longer treatment. The longer treatment costs about \$1000 U.S. dollars, while the shorter regimen costs \$200 U.S. dollars.<sup>115</sup> Perinatal transmission can also be further reduced by cesarean section and by not breast-feeding.<sup>116</sup>

The Centers for Disease Control and Prevention estimates that approximately \$240 million is spent each year to care for children inflicted with HIV.<sup>117</sup> By curbing the transmission rate, this cost would be reduced to \$1,520,000 per year. This money would decrease the money spent on treatment because it would be used to stop perinatal transmission.

The Ryan White CARE Act was reauthorized on October 20, 2000, and it guaranteed "uninterrupted federal support for medical services for low-income, uninsured and underinsured people living with HIV disease."<sup>118</sup> Many people living with AIDS and HIV face discrimination in obtaining and keeping life insurance and health insurance.<sup>119</sup> Congress is attempting to deal with these problems by such measures as the Ryan White CARE Act and the Kennedy-Kassebaum Health Coverage Act. If a woman has insurance, then her insurance, under these two new laws, should pay for prenatal testing for HIV<sup>120</sup> and treatment, if necessary.

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<sup>115</sup> *See id.*

<sup>116</sup> *See* National Institute of Health, News Release, *C-Sections Before Labor and Rupture of Membranes Reduce the Risk of Maternal-Infant HIV Transmission by Half*, (last modified Jan. 28, 1999) <<http://www.nih.gov/news/pr/jan99/nichd-28.htm>>.

<sup>117</sup> *See* Lagitch, *supra* note 51, at 106 (explaining that the high public cost of treating infants with HIV has prompted government officials to support mandatory HIV testing of newborns).

<sup>118</sup> San Francisco AIDS Foundation, *An Overview of Key Changes to the Ryan White CARE Act* (last modified Nov. 2, 2000) <[http://www.sfaf.org/policy/key\\_changes\\_rw.html](http://www.sfaf.org/policy/key_changes_rw.html)>.

<sup>119</sup> *See* Catherine Hanssens, *One (Very) Small Step for Health Care Reform: What Does the Kennedy-Kassebaum Health Coverage Act Mean for You?* (last modified Spring/Summer 1997) <<http://www.thebody.com/hanssens/reform.html>> (stating that with the availability of treatment comes the problems of access to insurance and health care which are aggravated by discrimination). This act places limits "on pre-existing conditions, and it expands both the availability and portability ... of health insurance." *Id.* Many insurance companies pay for T-cell counts or other tests and treatments. However, courts are increasingly on the side of the HIV-infected person in insurance discrimination cases. *See id.*

<sup>120</sup> Anonymous testing for HIV is usually free. *See generally* San Francisco AIDS Foundation, *supra* note 118 (discussing modifications to the Ryan White CARE Act).

In addition, for women without insurance or lower-income women, Medicaid may pay for prenatal care, including HIV treatment to reduce the transmission rate.<sup>121</sup> All states increase the Medicaid eligibility limits for pregnant women to provide for prenatal care. Medicaid eligibility also continues for up to 90 days after delivery, thus covering the costs of AZT that would need to be administered to the newborn.<sup>122</sup>

The shorter regimen coupled with the fact that fetuses as young as 23-24 weeks have survived outside of the womb<sup>123</sup> increase the likelihood that the states would be successful in asserting an interest in protecting a fetus from perinatal transmission of HIV. States have already upheld mandatory c-sections and mandatory blood transfusions to protect the fetus. These have simply laid the groundwork for mandatory HIV testing and treatment of pregnant women. A cesarean section is a very invasive procedure; however, courts have mandated that a woman deliver her fetus that way.<sup>124</sup> A regimen of AZT, which consists of one pill taken five times a day, is much less intrusive than a forced cesarean section.

## VI. POLICY ARGUMENTS FOR AND AGAINST MANDATORY HIV TESTING OF PREGNANT WOMEN

Although mandatory HIV testing of pregnant women would likely be found constitutional by the current Supreme Court, it is not necessarily the best way to curb perinatal transmission. There are many issues that need to be considered before mandatory HIV testing becomes the norm, such as: the risk that women will not seek prenatal testing for fear of being subjected to an HIV test, the likelihood of voluntary testing having equal or greater success in perinatal reduction, and the risks associated with AZT.

First, will voluntary and routine testing curb the perinatal spread of HIV? In 1998, 3.9% of all women who gave birth re-

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<sup>121</sup> See Health Care Financing Admin., *supra* note 12.

<sup>122</sup> See *id.*

<sup>123</sup> See E-mail from Dr. Karina Carlson, Pediatrician (Kansas City, Mo.), to Dorian Stables [Eden] (Oct. 25, 2000) (on file with author) (discussing fetal survival).

<sup>124</sup> See, e.g., *Jefferson v. Griffin Spalding County Hosp. Auth.*, 274 S.E.2d 457 (Ga. 1981).



ceived late or no prenatal care.<sup>125</sup> Of these women, 8.8% were teenagers.<sup>126</sup> In contrast, in 1993, 4.8% of pregnant women received late or no prenatal care.<sup>127</sup> While the trend to not seek prenatal care is decreasing, forcing women to undergo mandatory testing (and possibly treatment) is likely to increase the rate of those not seeking care.

The number of women diagnosed with AIDS increased by 63% between 1991 and 1995. The number of men diagnosed during that same time period was only 12.8%.<sup>128</sup> African-American and Latina woman are much more likely to contract HIV than Caucasian women.<sup>129</sup> These women are more likely to be low-income who have historically been faced with coercion regarding reproductive choices and are less likely to obtain prenatal care even without mandatory testing.<sup>130</sup> "Most experts also agree that the threat of mandatory or involuntary HIV testing and/or treatment will drive some women already mistrustful of the health care system even further from care. The fear of improper disclosure...is already a powerful disincentive to HIV testing for many women at risk."<sup>131</sup> The doctor-patient relationship is based on trust and absent that, many women may not seek prenatal counseling and HIV testing.

The Centers for Disease Control has issued guidelines recommending voluntary testing and counseling as opposed to mandatory testing.<sup>132</sup> Such voluntary programs have proven ef-

<sup>125</sup> See National Center for Health Statistics, *Prenatal Care*, (visited Mar. 5, 2001) <<http://www.cdc.gov/nchs/fastats/prenatal.htm>> (providing figures on pregnant women's health care).

<sup>126</sup> See *id.*

<sup>127</sup> See Inaam A. Nakchbandi et al., *A Decision Analysis of Mandatory Compared With Voluntary HIV Testing in Pregnant Women*, 128 ANNALS INTERNAL MED. 760, 762 (1998) (finding voluntary HIV testing preferable over mandatory HIV testing for pregnant women).

<sup>128</sup> See Williams, *supra* note 88, at 494 (citing *HIV Cases in Women May Soar*, ALBUQUERQUE J., Apr. 22, 1998, at C3).

<sup>129</sup> See *id.* (summarizing previous reports from the Centers of Disease Control and Prevention).

<sup>130</sup> See Cooper, *supra* note 2, at 20-21.

<sup>131</sup> McGovern, *supra* note 88, at 475 (discussing dangers inherent in mandatory testing).

<sup>132</sup> See Centers for Disease Control & Prevention, *Recommendations of the U.S. Public Health Service Task Force on the Use of Zidovudine to Reduce Perinatal Transmission of Human Immunodeficiency Virus*, MORBIDITY & MORTALITY WKLY. REP., Aug. 5, 1994, at 1, 7; see also American Civil Liberties Union, *ACLU Position Statement on Prenatal and Newborn HIV Testing*, (visited Oct. 3, 2000) <<http://www.aclu.org/issues/aids/newborn.html>> (summarizing the similarities and

fective. When offered testing and counseling 90% of pregnant women accepted the test.<sup>133</sup> In an inner-city study in Harlem, New York City, there was a 97% acceptance rate after counseling of the effects of HIV on a fetus and newborn.<sup>134</sup> Other major cities, such as Chicago, Baltimore, and Atlanta, boast similar statistics.<sup>135</sup> The majority of the patients at each hospital are “overwhelmingly poor and African-American, women who stereotypically—and falsely—are perceived as being ‘non-compliant’ or ‘difficult’ patients. Yet, consent-to-testing rates and rates of bringing HIV-positive children and their mothers into care are consistently high. In other words, these programs work.”<sup>136</sup>

However, when mandatory testing has been implemented, people have fled the tests. For example, in the 1980s, Illinois enacted a law requiring HIV testing of all people applying for marriage licenses. During the two years of the law’s existence approximately 40,000 people left Illinois and got married in other states.<sup>137</sup> Many opponents to mandatory HIV testing have used the Illinois law to demonstrate that mandatory testing actually deters people from the very thing the legislators were trying to encourage—HIV testing.

People in general, especially pregnant women, may seek to not have an HIV test because of fear of discrimination and a negative stigma attached to the disease.<sup>138</sup> Although it is now widely known and accepted that HIV is not only a disease afflicting homosexuals or drug-users, there is still a negative stigma attached to it. The lack of “access to care and services for those who test positive, and continuing discrimination

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differences between the ACLU recommendations and the aforementioned CDC proposed guidelines); Grimes, *supra* note 79, at 259; Michael Saccente, *Preventing Perinatal HIV: Prenatal HIV Testing and Strategies to Reduce the Risk of Maternal-Fetal HIV Transmission*, J. ARK. MED. SOC’Y, June 2000, at 97 nn.11-12.

<sup>133</sup> See Nakchbandi et al., *supra* note 127, at 762 (discussing an overwhelming positive response to voluntary HIV testing observed in one study).

<sup>134</sup> See *id.* (citing M.K. Lindsay et al., *Determinants of Acceptance of Routine Voluntary Human Immunodeficiency Virus Testing in an Inner-City Prenatal Population*, 78 OBSTETRICS & GYNECOLOGY 678 (1991)).

<sup>135</sup> See Cooper, *supra* note 2, at 22.

<sup>136</sup> *Id.*

<sup>137</sup> See Robert Endstad, *AIDS Test Has 40,000 Fleeing State to Wed*, CHI. TRIB., Jan. 4, 1989, at C1 (discussing Illinois’ mandatory pre-marital HIV testing program).

<sup>138</sup> See Cooper, *supra* note 2, at 21.

against people (and their families) with HIV”<sup>139</sup> may also deter a pregnant woman from wanting an HIV test. However, counseling and information has been shown to encourage women to get an HIV test.

Voluntary testing is not going to magically stop all perinatal transmission, despite its previous successes. The Institute of Medicine has acknowledged several barriers to achieving full universal counseling and testing of pregnant women:

- Financial and other access barriers for women seeking prenatal care;
- Time and other constraints that may discourage providers from counseling women appropriately about HIV disease and the importance of testing;
- Language and cultural barriers at prenatal care sites that may cause women to refuse testing;
- Financial and logistical problems that may make testing and treatment difficult.<sup>140</sup>

Without focusing on eliminating these barriers, even universal and voluntary testing is not going to be completely successful in its goals.

There are other concerns besides a woman not seeking prenatal care if there is mandatory HIV testing. In particular, if mandatory HIV testing does become the norm, will mandatory treatment follow? If it does, how will it be enforced? In the cases of tuberculosis, an infected patient was subjected to mandatory treatment by quarantine. Quarantining a pregnant woman from potentially her 28th until six weeks after the baby is born, or the 35th week until three days after birth (depending on which regimen is used) seems a little excessive. In addition, it would be extremely expensive. It is also hard to justify since tuberculosis is airborne, while HIV is only transmittable through an exchange of bodily fluids. The fetus, once born, is unlikely to engage in behavior that will cause another to contract the disease. It seems much more reasonable to encourage a woman to seek both testing and treatment, rather than force her to comply with both.

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<sup>139</sup> *Id.*

<sup>140</sup> Project Inform, *Striking a Balance: HIV Testing for Pregnant Women and Newborns*, PERSPECTIVE (Aug. 2000) <<http://www.thebody.com/pinf/aug00/testing.html>>.

In addition to the constitutional and ethical attacks on mandatory testing, there may also be problems with the treatment itself. AZT is not a completely risk-free drug and can pose risks to the mother. Patients develop an immunity to AZT over time and thus "physicians often recommend that AZT treatment be initiated only when medically necessary...requiring AZT treatment during pregnancy could cost a woman valuable years of her own life."<sup>141</sup> In addition, it forces a woman to take five daily doses of the drug, which can cause such side effects as: "bone marrow suppression, malaise, nausea, headaches, and occasional seizures. Known long-term side effects include AZT toxicity, cancer, and damage to the reproductive system."<sup>142</sup> While AZT has not been shown to cause deformation, premature birth, or fetal distress, there are few studies examining the effects on the fetus.<sup>143</sup> One possible side effect is anemia, but it has been determined to be mild.<sup>144</sup> Other studies have "indicated that children exposed to AZT were 8.4 times more likely to develop a heart muscle disease than children who had never taken AZT...."<sup>145</sup> In addition, the National Cancer Institute recently studied the effects of AZT on pregnant mice.<sup>146</sup>

The study found an increased cancer rate among the offspring of the mice treated with AZT, including an eight fold increased risk of lung cancer in males. Seventeen percent of the female mice developed rare reproductive tumors, similar to those caused by the controversial drug DES that women once took to prevent miscarriages.<sup>147</sup>

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<sup>141</sup> Halem, *supra* note 52, at 508.

<sup>142</sup> *Id.* at 494 (citations omitted).

<sup>143</sup> *See id.* at 495.

<sup>144</sup> *See* McNeil, *supra* note 54, at 314 (citing Centers for Disease Control & Prevention, U.S. Dept. of Health & Hum. Servs., *U.S. Public Health Service Recommendations for Human Immunodeficiency Virus Counseling and Voluntary Testing for Pregnant Women*, 44 MORBIDITY & MORTALITY WKLY. REP. 3, 4 (1995)).

<sup>145</sup> McGovern, *supra* note 88, at 481 (discussing use of AZT by expectant mothers and effects on offspring).

<sup>146</sup> *See id.*; *see also* Nakchbandi et al., *supra* note 127, at 766.

<sup>147</sup> McGovern, *supra* note 88, at 481 (discussing research on mice linking AZT use with cancer). Note, however, that tests done on mice involved longer AZT treatment. It is unclear how the risks to the mother or the fetus change with the shorter regimen.

This study only calls attention to the lack of knowledge about the long-term effects of AZT when administered in utero<sup>148</sup> and suggests that before this treatment becomes mandatory, more studies should be devoted to examining the long-term consequences. A choice between cancer or heart disease and HIV is hardly a choice at all.

## VII. CONCLUSION—WHAT DO WE DO NOW?

This topic evokes many feelings of sympathy and a desire to prevent innocent children from contracting the virus, in addition to concern over the effects of the possibility of mandatory HIV testing of pregnant women. Despite surviving a constitutional attack, mandatory HIV testing or treatment of pregnant women is not the most effective way to curb perinatal transmission. Studies have shown that universal counseling and voluntary testing are the most effective ways to increase prenatal HIV testing and treatment. The best way to help the children is to encourage their mothers to obtain proper prenatal care, including HIV testing. Mandatory HIV testing is not the answer to the outbreak of HIV among children and pregnant women.

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<sup>148</sup> See Nakchbandi et al., *supra* note 127, at 766 (emphasizing uncertainty with regard to effects of in utero exposure to AZT).