MANDATORY HIV SCREENING OF NEWBORNS: A PROPOSITION WHOSE TIME HAS NOT YET COME

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TABLE OF CONTENTS

> History teaches that grave threats to liberty often come in times of urgency, when constitutional rights seem too extravagant to endure.[1]

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1. Skinner v. Railway Labor Executives' Ass'n, 489 U.S. 602, 635 (1989) (Marshall, J., dissenting).

INTRODUCTION

Human Immunodeficiency Virus (HIV),[2] the virus that causes Acquired Immune Deficiency Syndrome (AIDS),[3] is always fatal.[4] The virus may give no sign of its presence for years,[5] and, furthermore, neither a cure[6] nor a vaccine exists.[7] HIV infection is the seventh leading cause of death in children aged one to four in the United States[8] and the World Health Organization estimates that over one million children are infected worldwide.[9] These grim statistics, and public reaction to them, have resulted in legislative attempts to mandate newborn screening for HIV.[10]

For example, in 1993, the "Baby AIDS Bill"[11] was introduced by New York Assemblywoman Nettie Mayersohn.[12] The bill would

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2. Helena Brett-Smith & Gerald H. Friedland, *Transmission and Treatment, in* AIDS LAW TODAY 18, 37 (Scott Burris et al. eds., 1993). HIV infection manifests itself as AIDS in the most severe end of the clinical spectrum of a person with HIV. *Id.*

3. *See* A. Plaut, *Microbial Subversion of Host Defenses, in* MECHANISMS OF MICROBIAL DISEASE 139, 144 (Moselio Schaechter et al. eds., 1989).

4. *See id.*

5. Brett-Smith & Friedland, *supra* note 2, at 38.

6. Brett-Smith & Friedland, *supra* note 2, at 30.

7. Brett-Smith & Friedland, *supra* note 2, at 30.

8. Martha F. Rogers & Harold W. Jaffe, *Reducing the Risk of Maternal-Infant Transmission of HIV: A Door Is Opened*, 331 NEW ENG. J. MED. 1222, 1222 (1994).

9. Mhairi G. MacDonald et. al., *Overview of Medical Management of HIV-Seropositive Pregnant Woman*, 4 PEDIATRIC AIDS & HIV INFECTION: FETUS TO ADOLESCENT 3, 3 (1993).

10. COMMITTEE ON PRENATAL SCREENING FOR HIV INFECTION, INSTITUTE OF MEDICINE, HIV SCREENING OF PREGNANT WOMEN AND NEWBORNS 22 (Leslie M. Hardy ed., 1991). Mandatory screening encompasses the testing of "all individuals within a defined population . . . without an opportunity for refusal." *Id.* For purposes of this Comment, "voluntary screening with the right of refusal" means that an individual will be informed that the test will be performed unless he or she explicitly refuses. "Voluntary screening with informed consent" means that an individual will be told that the test is available but that the test will be performed only with his or her specific informed consent. *Id.*

11. New York State Assembly Bill No. 6747, 215th Gen. Assembly, 1st Reg. Sess. (1993). This bill was subsequently amended in June 1993, March 1994, and April 1994. The latest version is New York State Assembly Bill No. 6747-C, 215th Gen. Assembly, 1st Reg. Sess. (1994). *See also* Linda Farber Post, *Unblinded Mandatory HIV Screening of Newborns: Care or Coercion?*, 16 CARDOZO L. REV. 169, 172 (1994) (citing N.Y. Assembly Bill No. 6747 (1993) (proposed)). On March 30, 1993, Assembly Bill No. 6747 was introduced in the New York State Assembly, seeking to amend the state's AIDS confidentiality laws. In part, the bill requires:

> The Department shall disclose to the parents or prospective adoptive parents of a newborn child confidential HIV-related information obtained as a result of a testing done on such child by the Department or any other person, partnership, corporation or association authorized to obtain confidential HIV-related information including, but not limited to, a subsidiary agency of the Department, a health care provider or a health facility.

Id.

12. *See* Post, *supra* note 11, at 172 n.20 (citing Press Release from the Office of State Senator Mayersohn, *It's a Baby, Not a Statistic, Stupid* (July 1993) (presenting view of Sen. Mayersohn that state legislature should stand in place of infant and make determination that infants should be tested for their protection)).

require hospitals to disclose the results of every newborn's HIV test to the child's parent or guardian.[13] Since the introduction of the Baby AIDS Bill more than two years ago, it has enjoyed wide support in the New York General Assembly and New York Senate[14] but has not yet reached the floor for a vote.[15] More recently, in July 1995, the Coburn Amendment[16] to the Ryan White CARE Act[17] was discussed in the United States Senate.[18] First introduced in 1990, the Ryan White CARE Act provides grants to states for the treatment and support of AIDS patients.[19] The Coburn Amendment would require, as a condition of Ryan White CARE Act funding, that states create laws mandating HIV antibody testing of all newborn infants.[20] On July 27, the Senate reauthorized the program through fiscal year 2000 only after, however, the Coburn Amendment was withdrawn.[21]

Medical advances in HIV testing procedures[22] and in treatment for HIV-infected individuals[23] compel reevaluation of current legal standards.[24] To evaluate the legality of mandating HIV screening of

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13. *See supra* note 11 (setting forth operative portion of Baby AIDS Bill); *see also infra* notes 127-29 and accompanying text (discussing newborn screening currently employed for epidemiologic purposes).

14. *See* John Riley, *AIDS Baby Bill Favored by GOP Guv Hopeful*, NEWSDAY, June 11, 1994, at A12.

15. *Id.* The bill must first go to the General Assembly's Health Committee where it must receive a majority of votes before it can reach the General Assembly. *Id.* Currently, the bill is stalled in the Health Committee. *Id.*

16. Ryan White Comprehensive AIDS Resources Emergency (CARE) Act Amendments of 1995, H.R. 1872, 104th Cong., 2d Sess. (1995).

17. Ryan White Comprehensive AIDS Resources Emergency Act of 1990, Pub. L. No. 101-381, 104 Stat. 576 (codified as amended at 42 U.S.C. §§ 300ff-11 to -88 (1996)).

18. 141 CONG. REC. S10,702, S10,707 (daily ed. July 26, 1995).

19. Ryan White Comprehensive AIDS Resources Emergency Act of 1990, Pub. L. No. 101-381, 104 Stat. 576 (codified as amended at 42 U.S.C. §§ 300ff-11 to -88 (1996)); *see also* Colette Fraley, *Senate Votes to Reauthorize Ryan White AIDS Program*, 53 CONG. Q. 2277, 2277 (1995) (noting that Congress approved "such sums as necessary" for fiscal years 1996 through 2000 for treatment and support of AIDS patients).

20. Statement by The National Alliance of State and Territorial AIDS Directors (July 22, 1995) (on file with *The American University Law Review*).

> In order to implement the testing laws, substantial costs would be borne by the states to conduct the following activities: (1) HIV testing of newborns or in the case of prenatal testing, pregnant women; (2) Confirmatory laboratory tests for those testing HIV-positive; (3) Disclosure of test results and appropriate HIV counseling to individuals tested; (4) Community outreach and follow-up for non-compliant or hard to reach patients; (5) State monitoring, assurance, surveillance and evaluation of testing, counseling and outreach programs.

Id.

21. S. 641, 104th Cong., 1st Sess., 141 CONG. REC. S10,760 (daily ed. July 27, 1995).

22. *See infra* notes 39-50 and accompanying text (reviewing antibody and virologic testing for HIV).

23. *See infra* notes 51-61 and accompanying text (discussing new therapeutic interventions available to HIV-infected newborns).

24. *See generally* Barbara Ruhe Grumet, *It's Time for Selected Routine Testing of Newborns for Human Immunodeficiency Virus*, 2 WOMEN'S HEALTH ISSUES 12 (1992) (stating that availability of

the newborns, it is necessary to understand the limitations as well as the advantages of medical technology.

This Comment discusses the medical and legal issues surrounding the mandatory HIV testing of newborns. Part I describes the medical principles of the HIV disease, including the testing procedures and therapies currently available to HIV-infected infants. Part II examines whether the state may use its police power to impose a mandatory HIV screening program for newborns. This issue is analyzed within the context of existing mandatory screening programs to explore the feasibility of mandatory HIV screening. This section also considers whether mandatory HIV screening falls within the language of existing state mandatory screening statutes. Part III explores the constitutionality of a mandatory screening policy and whether such a policy violates the Fourth Amendment right to privacy. Part IV analyzes whether the state's interest or the individual's interest should prevail in the context of mandatory HIV testing. The Comment concludes that the level of current medical technology, including testing procedures and effective treatment, does not legally or medically justify the mandatory screening of newborns for HIV disease. Finally, this Comment recommends that states, with the full support of the medical community, adopt legislation to establish and fund programs that combine mandatory HIV counseling for pregnant women, with voluntary HIV testing, follow-up, and treatment for HIV positive women and their children. The goal of treating HIV-infected children can only be accomplished when the mother's efforts are combined with those of the state and the medical community.

I. BACKGROUND OF HIV DISEASE

A. Medical Principles of HIV Disease

HIV attacks the immune system and results in the progressive decline of the infected individual's immune function.[25] Consequent-

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new treatments for HIV and opportunistic diseases in newborns mandates routine testing of HIV-risk infants, with or without parental consent).

25. *See* Plaut, *supra* note 3, at 144. The CD4+ T-lymphocyte (T-cell) is the primary target for HIV infection because of the virus' affinity for the CD4 receptor protein on the surface of the T-cell. William G. Powderly, *Acquired Immunodeficiency Syndrome, in* MECHANISMS OF MICROBIAL DISEASE, *supra* note 3, at 823, 828 (2d ed. 1993). The virus enters and infects a new organism by attaching itself to this CD4 receptor-protein. Brett-Smith & Friedland, *supra* note 2, at 21. The virus reproduces inside the T-cells, causing the cell's destruction. *Id.* Because T-cells coordinate a number of important immunologic functions, destruction of T-cells causes the loss of these functions, resulting in the progressive impairment of the immune response system. Plaut, *supra* note 3, at 144. This gradual impairment is known as AIDS. *Id.*

ly, an individual with HIV disease[26] is unable to fight off infections normally defeated by a healthy immune system.[27] AIDS is the most severe end of the clinical spectrum of HIV disease.[28] Because of the overwhelming defects in the immune system of an individual with AIDS, AIDS patients succumb to "opportunistic infections"[29] that ultimately prove fatal.[30]

Presently, the most common ways of contracting HIV are: (1) sexual contact;[31] (2) percutaneous exposure to contaminated needles or other sharp instruments (i.e., intravenous drug use);[32] and (3) mother-to-infant (perinatal) transmission before, during, or soon after the time of birth.[33] The rate of transmission of HIV from infected mothers to their newborns ranges from 12.9% to 39% in various studies.[34] Perinatal transmission currently accounts for at least

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26. INSTITUTE OF MEDICINE, CONFRONTING AIDS: UPDATE 1988 (1988). The term "HIV disease" reflects the underlying pathology and accurately reflects the medical disorder because HIV eventually progresses from asymptomatic HIV infection to severe symptomatic AIDS. *Id.*

27. *See supra* note 25 and accompanying text (explaining how individual's body reacts to HIV).

28. *See* Centers for Disease Control, *1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults*, 41 MORTALITY & MORBIDITY WKLY. RPT. 1, 1 (1994). To be classified as having "AIDS," an infected individual must meet certain criteria established by the Centers for Disease Control (CDC). The CDC classification system categorizes persons on the basis of clinical conditions associated with HIV infection T-cell count. *Id.* An individual who exhibits specific illness, as listed by the CDC, combined with a designated T-cell count, will receive a clinical AIDS diagnosis. *Id.*

29. *Id.* "Opportunistic infections" take advantage of a compromised immune system. These infections are not normally fatal in healthy persons, but are extremely dangerous in a person with AIDS. *Id.*

30. Brett-Smith & Friedland, *supra* note 2, at 23. HIV-infected individuals, who are immunosuppressed, become more vulnerable to common bacterial infections and to certain types of cancers, such as Kaposi's sarcoma and cervical cancer. *Id.*

31. Brett-Smith & Friedland, *supra* note 2, at 25. In this context, sexual contact includes both homosexual and heterosexual behavior. *Id.* Studies repeatedly have shown that the receptive partner in homosexual male anal sex has the highest risk, as does the woman in heterosexual vaginal sex. *Id.* In both instances, the receiving partner is more at risk because the penetrating partner's fluids remain deposited in the receptive partner's mucous membranes. *Id.*

32. Cody Meisner & John M. Coffin, *The Retroviruses and AIDS*, *in* MECHANISMS OF MICROBIAL DISEASE, *supra* note 3, at 435, 440. Transmission among drug abusers occurs from the sharing of contaminated needles and syringes that contain a residue of blood, including infected white blood cells. *Id.* at 440.

33. *See* AMERICAN ACADEMY OF PEDIATRICS, THE 1994 RED BOOK: REPORT OF THE COMMITTEE ON INFECTIOUS DISEASES 257 (Georges Peter et al. eds., 1994) [hereinafter THE RED BOOK] (stating that while exact timing of transmission from infected mother to infant is uncertain, evidence suggests that transmission may occur either in utero, around time of delivery, or postpartum, through breast-feeding).

In addition to these common methods of transmission, HIV can be contracted via transfusion of either blood, blood components, or clotting factor concentrates. These methods of transmission are rare, however, because infected donors are excluded and effective blood treatments are available. *Id.*

34. Task Force on Pediatric AIDS, American Academy of Pediatrics, *Guidelines for Human Immunodeficiency Virus (HIV)-Infected Children and Their Foster Families*, 89 PEDIATRICS 681, 682 (1992). The Pediatric AIDS Clinical Trials Group found that the risk of transmission from

eighty-five percent of all pediatric AIDS cases.[35] Furthermore, "seventy-nine percent of all children born infected with HIV have mothers who are either [intravenous] drug users or who have had sexual relations with an [intravenous] drug user."[36]

Globally, as many as one-fifth of all perinatally infected infants die by eighteen months of age.[37] In the United States, the death rate of HIV-infected children in their first two years of life is lower than the worldwide rate and the median age of onset of symptoms for perinatally infected children is three years.[38] This number should decrease with advances in testing techniques and more effective intervention.

B. Testing for HIV

The most commonly utilized HIV tests detect the presence of HIV antibodies rather than the actual virus.[39] A positive HIV antibody test result means that the individual has been exposed to the virus.[40] In adults, exposure to HIV results in production of antibodies to the virus, therefore the presence of the antibodies provides proof that the person has the AIDS virus.[41] Unlike adults, newborns are unable to create their own antibodies until they reach a few months of age and,

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mother to infant can be dramatically reduced by two-thirds when the pregnant mother is treated with AZT during her pregnancy. Edward M. Connor et al., *Reduction of Maternal-Infant Transmission of Human Immunodeficiency Virus Type I with Zidovudine Treatment*, 331 NEW ENG. J. MED. 1172, 1172 (1994).

35. Mhair G. MacDonald et al., *Overview of Medical Management of HIV-Seropositive Pregnant Women*, 4 PEDIATRIC AIDS & HIV INFECTION: FETUS TO ADOLESCENT 3, 3 (1993).

36. Carol Beth Barnett, *The Forgotten and Neglected: Pregnant Women and Women of Childbearing Age in the Context of the AIDS Epidemic*, 23 GOLDEN GATE U. L. REV. 863, 870 (1993); *see also* Nancy Hutton & Lawrence S. Wissow, *Maternal and Newborn HIV Screening: Implications for Children and Families*, *in* AIDS, WOMEN AND THE NEXT GENERATION 105, 105 (Ruth R. Faden et al. eds., 1991) (stating that "[p]rior to the introduction of blood-product testing and treatment, the majority of pediatric HIV infections were attributable to transfusions").

37. MacDonald et al., *supra* note 35, at 6.

38. THE RED BOOK, *supra* note 33, at 258.

39. Brett-Smith & Friedland, *supra* note 2, at 32. Enzyme immunoassays (EIA) are the most widely used method to screen for HIV antibodies. *Id.* Such tests are highly sensitive and specific, but false positive results do occur in a small percentage of cases. *Id.* EIA testing of initially reactive specimens is repeated to reduce the likelihood of laboratory error. Repeatedly reactive tests are highly reliable. *Id.* Normally, Western Blot or immunofluorescent antibody tests are used for confirmation of a positive EIA result. *Id.* These tests are designed to detect the presence of HIV antibodies, which are substances manufactured by the immune system in response to HIV infection. *Id.* Currently, HIV antibody tests are the most appropriate instrument for screening purposes, even though these tests may falsely indicate that a newborn is infected. James R. Hughes, *HIV Screening in Newborns*, 5 PEDIATRIC AIDS & HIV INFECTION: FETUS TO ADOLESCENT 112, 112 (1994); *see also infra* text accompanying notes 41-45 (explaining that uninfected newborns may carry antibodies because their mothers are infected).

40. *See* Brett-Smith & Friedland, *supra* note 2, at 32 (indicating that blood tests may be positive four to six weeks after exposure to virus and that 95% of infected individuals will test positive within six months).

41. Hughes, *supra* note 39, at 113.

as a result, they carry only their mother's antibodies.[42] Any antibodies to HIV detected in the newborn are necessarily the mother's, which have been transplacentally transmitted[43] to the infant. Accordingly, if a mother has HIV, until about six months of age, her newborn will always test positive for HIV when tested with the antibody test.[44] These positive test results are often inaccurate because fewer than thirty percent of the infants with HIV-positive mothers will actually become HIV-infected.[45] When the antibody test is used, the mother's HIV status is revealed while the newborn's status remains in question. Therefore, the mother is essentially tested without her consent, without the benefit of HIV counseling,[46] and without ever having her own blood drawn.[47] Moreover, it takes up to six months following exposure before an individual's blood tests positive for the virus,[48] regardless of the mode of transmission. Therefore, a new mother who has recently been infected may falsely test negative for the virus.

Recent developments in HIV testing allow for direct detection of the virus ("virologic testing") rather than detection of HIV antibodies.[49] Virologic testing, however, is complex and expensive and,

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42. Hughes, *supra* note 39, at 113.

43. THE RED BOOK, *supra* note 33, at 259. Transplacentally means "across the placenta," indicating that the mother transmitted her antibodies to the child while the child was in utero. *Id.*

44. *See* THE RED BOOK, *supra* note 33, at 259 (stating that, although seropositive when born, correct diagnosis of infant's HIV status cannot usually be made until three to six months of age).

45. *See* The European Collaborative Study, *Mother-to-Child Transmission of HIV Infection*, 1 LANCET 1039, 1039 (1988) (stating that study's overall average of mother-newborn transmission was 24%); *see also supra* note 34 and accompanying text (discussing HIV transmission from mothers to infants).

If a newborn tests positive for HIV, then the mother is undoubtedly infected. If the baby is part of the 75% of infants who are not truly infected, he or she may still be at risk if breast-fed by the infected mother. *Id.*

46. *See* F.C. Fraser, *Genetic Counseling*, 26 AM. J. HUMAN GENETICS 636, 636 (1974) (emphasizing increased demand and need for counseling patients diagnosed with serious diseases). Counseling is necessary when testing may reveal a serious disease, to help the mother (1) understand the medical facts; (2) understand the options available for dealing with the risk of transmission; (3) select a plan of action appropriate for her in light of her goals; (4) follow through with that plan; and (5) adjust to the presence of infection in her infant. *Id.* at 636-59.

47. W. Harry Hannon et al., *A Quality Assurance Program for Human Immunodeficiency Virus Seropositivity Screening of Dried-Blood Spot Specimens*, 10 INFECTION CONTROL & HOSP. EPIDEMIOLOGY 8, 8 (1989).

48. Brett-Smith & Friedland, *supra* note 2, at 32.

49. *See* Leonardo Renna, *New York State's Proposal to Unblind HIV Testing for Newborns: A Necessary Step in Addressing a Critical Problem*, 60 BROOK. L. REV. 407, 413-16 (1994) (discussing polymerase chain reaction and p24 antigen tests as eventual successors to Western Blot and Elisa techniques). Polymerase Chain Reaction (PCR) testing allows for the detection of HIV DNA, rather than just antibodies to HIV. *Id.* at 414. Similarly, p24 antigen test detects a protein found in HIV. *Id.* These two tests are not as widely used as Western Blot and Elisa but are becoming more popular. *Id.*

therefore, infrequently used.[50] Although definitive HIV test results allow for immediate treatment of infected newborns, they do not address the issue of having the mother's HIV status exposed without her consent. As only thirty percent of infected mothers transmit the disease to their children, the problem of the mother being tested without her consent is restricted to those mothers.

C. Current Therapy for HIV Infection in Newborns

In 1991, the Institute of Medicine's Committee on Prenatal and Newborn Screening for HIV Infection reported that "[i]f seropositive[51] infants are carefully monitored from birth . . . signs and symptoms that may herald the onset of more severe opportunistic infections can be identified early and treated more vigorously."[52] Pneumocystis carinii pneumonia (PCP) remains the most common serious opportunistic infection in children with HIV,[53] and is associated with high mortality.[54] The prognosis for children infected perinatally who become symptomatic in the first year of life is especially poor.[55] Studies have shown, however, that aggressive early treatment of PCP prolongs survival.[56] Therefore, identification of early symptoms to avoid severe disease, is undoubtedly beneficial.[57]

Research and therapeutic trials are ongoing in an effort to combat bacterial infections, the second most common AIDS-defining condition in HIV positive[58] American children.[59] For example,

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50. *Id.* "[T]hese tests are generally available at referral centers caring for HIV-infected children." THE RED BOOK, *supra* note 33, at 259.

51. *See* Hughes, *supra* note 39, at 112 (noting that seropositive refers to individuals who have tested positive for HIV virus (citing National Institute of Medicine Committee on Prenatal and Newborn Screening for HIV Infection, HIV SCREENING OF PREGNANT WOMEN AND NEWBORNS (L.M. Hardy ed., 1991))).

52. Hughes, *supra* note 39, at 116.

53. *See* THE RED BOOK, *supra* note 33, at 254 (stating that pneumocystis carinii pneumonia (PCP) frequently "occurs in infants between 3 and 12 months of age who acquired infection before or at birth, but can occur in infants younger than 3 months").

54. THE RED BOOK, *supra* note 33, at 254.

55. The CDC has issued guidelines for the prevention of PCP in infants. *See* Grumet, *supra* note 24, at 14 (citing Working Group on PCP Prophylaxis in Children, *Guidelines for Prophylaxis Against Pneumocystis Carinii Pneumonia for Children Infected with Human Immunodeficiency Virus*, 40 MORBIDITY & MORTALITY WKLY. RPT. 1, 1-13 (1990)). While the available drugs pose risks, these risks are significantly lower than the risk of AIDS itself. *Id.* In addition, a pediatrician who knows a child is HIV-positive is likely to treat other illnesses more aggressively. *Id.*

56. THE RED BOOK, *supra* note 33, at 254.

57. *See* THE RED BOOK, *supra* note 33, at 254 (noting that chance of survival is likely to improve with early treatment).

58. *See* Stephen A. Spector et al., *A Controlled Trial of Intravenous Immune Globulin for the Prevention of Serious Bacterial Infections in Children Receiving Zidovudine for Advanced Human Immunodeficiency Virus Infection*, 331 NEW ENG. J. MED. 1181, 1181 (1994) (characterizing studies of effects of intravenous immune globulin as using small samples and failing to control variables).

treatment with intravenous immune globulin was recently shown to decrease the risk of serious bacterial infections in children with HIV.[60] The seventy percent of newborns who test positive for HIV but who are not actually infected will unnecessarily receive prophylactic treatment for bacterial infections because current testing does not differentiate between those newborns who are truly infected and those who are not.[61]

II. THE POWER OF THE STATES TO IMPOSE MANDATORY TESTING

A. Police Power

States have the authority to impose mandatory health measures under what is traditionally referred to as their "police power."[62] This power, reserved to the states in the Tenth Amendment,[63] allows states to take any steps necessary to ensure the public health and welfare, to foster prosperity, and to maintain public order.[64] While many state actions seek to promote the public health by creating a safer, less toxic environment,[65] or by expanding access to medical care,[66] states have also relied on their police power to intervene

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59. Rogers & Jaffe, *supra* note 8, at 1222 (citing 5 CDC HIV/AIDS SURVEILLANCE REP. 16 (1994)).

60. *Id.*

61. Hughes, *supra* note 39, at 115 (quoting National Institute of Medicine Committee on Prenatal and Newborn Screening for HIV Infection, HIV SCREENING OF PREGNANT WOMEN AND NEWBORNS (L.M. Hardy ed., 1991)).

62. *See infra* notes 80-88 and accompanying text (stating that pursuant to their police power, states may delegate to boards of health authority to pass health regulations necessary to protect public).

63. "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." U.S. CONST. amend. X.

64. *See* Moore v. Draper, 57 So. 2d 648, 650 (Fla. 1952) (determining that enacting and enforcing necessary and appropriate health laws and regulations is legitimate exercise of state's police power, which it cannot surrender); Kirk v. Wyman, 65 S.E. 387, 388 (S.C. 1909) (holding that creation of boards of health, and delegation of powers to them, is reasonable exercise of police power).

65. *See* John M. Last, *Scope and Methods of Prevention, in* PUBLIC HEALTH AND PREVENTIVE MEDICINE 3, 5 (John M. Last ed., 12th ed. 1986) (describing positive effects of 19th century "sanitary revolution" on patterns of disease in industrialized countries).

66. *See* GEORGE J. ANNAS ET AL., AMERICAN HEALTH LAW 17-25 (1990). Prior to World War II, most people paid for medical care out of their own pockets. *Id.* at 19. The rich received care from private practitioners, the middle class often went without care and the very poor received care from charity hospitals. *Id.* at 22. The system has changed in the last 40 years due to (1) the emergence of federal and state governments as major payers for health care, and (2) the increased importance of employer-based health insurance. *Id.* at 17-22. Preferential treatment by the government has helped enhance the growth of employer-based health insurance. *Id.* at 20-22.

directly in the lives of their citizens.[67]

Mandatory testing, enacted to protect the public health and welfare, seems to fall directly within a state's police power. Primarily as a response to the fear engendered from HIV disease,[68] leaders and governmental bodies have called for mandatory testing[69] of individuals in high risk groups[70] and individuals who function in a regulated environment.[71] Among those groups that have been targeted for mandatory HIV testing are applicants for marriage licenses,[72] aliens,[73] military personnel,[74] hospital patients,[75] prison inmates,[76]

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67. *See* Dowell v. City of Tulsa, 273 P.2d 859, 864 (Okla. 1954) (upholding city ordinance authorizing water fluoridation to prevent dental cavities), *cert. denied*, 348 U.S. 912 (1955).

68. *See supra* notes 25-38 and accompanying text (describing HIV disease and some of its consequences).

69. *See* Martha A. Field, *Testing for AIDS: Uses and Abuses*, 16 AM. J.L. & MED. 34, 45 n.44 (1990). In California, Lyndon LaRouche gained sufficient voter support to place Proposition 64 on the November 1986 ballot, although the proposition was soundly defeated. *Voters Have Say on Referendums*, CHI. TRIB., Nov. 6, 1986, at 12. Proposition 64 would have required public officials to quarantine anyone carrying the AIDS virus, and would have forbidden AIDS-infected individuals from teaching or attending public school. *Id.* The state health director recognized that the language of the proposition could be interpreted to mandate testing of all 27 million California voters. *Id.* at 45. Echoing views similar to Proposition 64, North Carolina Senator Jesse Helms commented that, in order to contain the spread of AIDS, quarantine would be necessary. *Bennett Would Detain Some Carriers of AIDS*, N.Y. TIMES, June 15, 1987, at A13.

70. *See supra* notes 31-33 and accompanying text (describing behavior that determines placement in high-risk group).

71. *See Prevention and Control of Acquired Immune Deficiency Syndrome: An Interim Report*, 258 JAMA 2097, 2101 (1987) (noting that in 1987, Board of Trustees of American Medical Association recommended mandatory AIDS testing of blood, tissue, and semen donors for: immigrants, federal and state prison inmates, and military personnel).

72. ILL. REV. STAT. ch. 40, para. 204 (1988), *repealed by* P.A. 86-884, § 1 (effective Sept. 11, 1989) (requiring applicants to undergo HIV testing as condition of obtaining marriage license).

73. *See* 8 C.F.R. § 245a.4(9)(ii) (1995) (stating that all applicants who file for temporary resident status must include results of HIV test and that applicants testing positive may apply for waiver).

74. *See* 32 C.F.R. §§ 58.4, 58.6 (1995) (requiring HIV testing for all military recruits and excluding from service those who test positive). Under current regulations, active duty personnel who test positive are not retired if "fit for duty." *Id.* § 58.4(c). These individuals are advised, however, not to donate blood. *Id.*; *see also* Field, *supra* note 69, at 49 (acknowledging Defense Department policy that military personnel's confidential test results can be released to "the commander of the infected soldier, medical personnel, spouses, local authorities and others on a 'need to know' basis"); *cf.* Donna I. Dennis, *HIV Screening & Discrimination: The Federal Example*, *in* AIDS LAW TODAY, *supra* note 2, at 187, 197-98 (noting that U.S. State Department was second governmental agency to begin mandatory HIV testing for all applicants and current Foreign Service employees (and family members) who serve overseas).

75. *See* Field, *supra* note 69, at 77 (noting that all hospital patients' blood is screened for HIV).

76. *See* Alexa Freeman, *HIV in Prison*, *in* AIDS LAW TODAY, *supra* note 2, at 263, 269 (citing HAMMETT & DAUGHERTY, 1991 UPDATE: AIDS IN CORRECTIONAL FACILITIES 15 (1991)). As of 1991, 18 prison systems, including the Federal Bureau of Prisons, require HIV testing of all prisoners in order to identify those who are positive. *Id.*; *see also* Dunn v. White, 880 F.2d 1188, 1198 (10th Cir. 1989) (upholding AIDS testing of prisoners), *cert. denied*, 493 U.S. 1059 (1990); Harris v. Thigpin, 727 F. Supp. 1564, 1568-72 (M.D. Ala. 1990) (holding that AIDS testing of prison inmates does not constitute unreasonable search and seizure violation or violation of privacy right), *aff'd in part, vacated in part on other grounds*, 941 F.2d 1495 (11th Cir. 1991); Lynn Sanders Branham, *Opening the Bloodgates: The Blood Testing of Prisoners for the AIDS Virus*, 20

prostitutes,[77] alleged sex offenders,[78] and foster children.[79]

By virtue of their police power, states have the authority to legislate and enforce regulations to preserve the public health and safety.[80] State-sponsored, mandatory vaccination programs are a well-recognized illustration of the use of the police power over children to prevent the spread of infectious diseases.[81] For example, in *Jacobson v. Massachusetts*,[82] the Supreme Court held that the police power of a state permits compulsory smallpox vaccinations because the public health and safety is at stake.[83] Moreover, the Court asserted that a parent may not reject this compulsory vaccination for his or her child, even on religious grounds.[84]

The Court recognized that while the state's power to enact and administer health laws is founded in the Constitution,[85] the exercise

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CONN. L. REV. 763, 802 (1988) (concluding that mandatory testing of inmates is unlikely to violate due process rights).

77. *See, e.g.*, ILL. REV. STAT. ch. 38, para. 1005-5-3(g) (1988) (requiring persons convicted of either prostitution or soliciting prostitution to submit to AIDS test); NEV. REV. STAT. §§ 201.354, 201.356 (1991) (mandating AIDS testing of anyone arrested for prostitution outside confines of licensed establishment).

78. *See* People v. Cook, 532 N.Y.S.2d 940, 941 (App. Div. 1988) (holding that constitutional rights of defendant who pled guilty to rape were not violated by mandatory AIDS test).

79. *See* Field, *supra* note 69, at 98 (discussing current New York City policy offering HIV testing to foster children).

80. *See* Kleid v. Board of Educ., 406 F. Supp. 902, 905 (W.D. Ky. 1976) (upholding state statute requiring inoculation of school children and affirming state legislature's authority to enact legislation to improve health and welfare of citizens).

81. *See* Hughes, *supra* note 39, at 112-13 (describing state-adopted screening programs for phenylketonuria (PKU)). Vaccinations prevent debilitating and fatal diseases by the "administration of all or part of a microorganism . . . to evoke an immunologic response" that mimics the body's response to the actual infection, but which presents little or no risk to the patient. THE RED BOOK, *supra* note 33, at 10. For example, smallpox has been eradicated as a direct result of a global vaccination effort. *Id.* at 7. While vaccinations can have significant benefits, vaccinations are not always effective, and may produce adverse side effects or consequences. Harold M. Ginsburg, *Legal Issues Involved in Developing HIV Vaccines: Part I*, 5 PEDIATRIC AIDS & HIV INFECTION: FETUS TO ADOLESCENT 118, 118 (1994). As a result, the administration of a vaccine has been surrounded by legal controversy. *Id.* A vaccine for HIV is currently being developed. *Id.* A discussion of the legal issues surrounding the development and marketing of an HIV vaccine is beyond the scope of this Comment, for a more detailed discussion, see Ginsburg, *supra*.

82. 197 U.S. 11 (1905).

83. Jacobson v. Massachusetts, 197 U.S. 11, 25 (1905) ("[T]he police power of a State must be held to embrace, at least, such reasonable regulations established directly by legislative enactment as will protect the public health and the public safety.").

84. *Id.* The Court stated that the liberty guaranteed by the Fourteenth Amendment does not prohibit that state from forcing an individual to take actions against his political or religious convictions. *Id.* at 29.

85. *Id.* at 25 (recognizing that "a local enactment or regulation, even if based on the acknowledged police powers of a State, must always yield in case of conflict with the exercise by the Central Government of any power it possesses under the Constitution"); *see also* McCartney v. Austin, 298 N.Y.S.2d 26, 27 (App. Div. 1969) (examining statute requiring children to present certificate of immunization prior to admission to school and holding that statute clearly falls within police power and thus constitutionalality has been well established).

of this power in any particular case is also subject to all other rights guaranteed by the federal and state constitutions.[86] The test for a particular enactment's constitutionality is whether the means prescribed by the state through its regulations bears a reasonable relationship to its goal of protecting public health and safety.[87]

States clearly have a legitimate interest in protecting the public health by controlling the spread of AIDS. To justify mandatory HIV screening of newborns as a valid legislative action based on a state's police power, however, the proposed legislative action must alleviate some identifiable risk to the public health. In *Jacobson*, for example, the smallpox epidemic was the identifiable threat and a mandatory vaccine was the legislative response.[88] The current HIV test, however, because it does not reveal the true HIV status of the newborn,[89] does not accurately identify children who are infected with the virus and who, therefore, pose a threat to the public health. In this respect, the threat to the public health remains indeterminable and, consequently, unmeasurable.

Moreover, even if testing properly identified an HIV-infected child, an infected infant does not pose a significant risk to the public health.[90] For example, in the health care setting, the risk of transmission is exceedingly low[91] and the majority of exposures of all kinds are preventable through barrier precautions and changes in techniques.[92] Furthermore, HIV-positive newborn children do not pose a risk of transmission to their families[93]—even changing diapers

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86. *See* Baker v. Strauss, 54 N.E.2d 441, 444 (Ill. 1944) (holding that although legislature has authority to regulate all matters relating to preservation of public health, such regulations cannot be "arbitrary, oppressive or unreasonable").

87. *Jacobson*, 197 U.S. at 37-39. In *Jacobson*, the Court applied this test and determined that because vaccinations prevented the spread of smallpox, the regulations were constitutional. *Id.* at 37.

88. *Id.* at 30-31.

89. *See supra* notes 42-50 and accompanying text (discussing deficiencies in HIV testing of newborns).

90. *See infra* notes 91-94 (detailing transmissibility of HIV in infants).

91. *See* Troyen A. Brennan, *Patients and Health Care Workers, in* AIDS LAW TODAY, *supra* note 2, at 377. The risk of acquiring HIV from patients is a function of several factors, including the nature of the exposure, the likelihood that the patient is infected, the level of the virus in the infected patient's blood, and the efficacy of the virus in infecting an exposed person. *Id.* For example, the risk of infection from a stick with a hollow needle carrying the blood of a patient in the advance stages of HIV disease has been quantified at between 0.3 and 0.4%. *Id.*

92. *See generally* Edward S. Wong et al., *Are Universal Precautions Effective in Reducing the Number of Occupational Exposures Among Health Care Workers?: A Prospective Study of Physicians on a Medical Service*, 265 JAMA 1123 (1991) (examining efficacy of barrier precautions and finding high degree of effectiveness).

93. *See* Brett-Smith & Friedland, *supra* note 2, at 23-24 (noting that several studies tracking over 700 people who have had close, non-sexual, contact with family members infected with AIDS reveal that no instance of HIV transmission has been detected that could not be explained by more traditional routes of exposure).

soiled with feces and urine does not present a risk to parents.[94] In summary, this low transmission risk, coupled with the fact that current testing methods cannot accurately identify HIV-infected infants, means that the risk to the public health posed by the infants, when measurable at all, is insignificant. Therefore, the State's proposed interest in protecting the public health cannot justify use of the state's police power to mandate HIV screening of newborns.

B. Statutorily Mandated Screening Programs

Newborn screening programs[95] for serious but treatable diseases have achieved success[96] and wide acceptance over the past thirty years.[97] Currently, every state and the District of Columbia have newborn screening for phenylketonuria (PKU) and congenital hypothyroidism.[98] These existing screening programs struggled with many of the same legal and medical issues associated with proposed HIV screening programs.[99]

Newborn "metabolic" screening programs evolved out of the study of "inborn errors of metabolism."[100] One such "error," PKU, is characterized by levels of phenylalanine that become abnormally high

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94. Brett-Smith & Friedland, *supra* note 2, at 23-24. *But see* Rodica Matusa, *The Transmission of HIV from Child to Parent*, 5 PEDIATRIC AIDS & HIV INFECTION: FETUS TO ADOLESCENT 130, 130 (1994) (presenting case of pediatric HIV infection that appears to have resulted from transmission from child to mother and subsequently from mother to father).

95. For purposes of this Comment, "metabolic newborn screening" is the testing of the newborn population for a particular disorder.

96. *See infra* notes 103-06 and accompanying text (discussing the successful PKU screening program).

97. *See* Alexander Morgan Capron, *Which Ills to Bear?: Reevaluating the "Threat" of Modern Genetics*, 39 EMORY L.J. 665, 689 (1990). Newborn screening first gained universal acceptance in the 1960s and currently, routine testing of newborns for genetic disorders has become a "part of common practice and accepted public policy with little thought having been given to the implications." *Id.*

98. Hughes, *supra* note 39, at 113.

99. *See* Katherine L. Acuff & Ruth R. Faden, *A History of Prenatal and Newborn Screening Programs: Lessons for the Future*, *in* AIDS, WOMEN AND THE NEXT GENERATION, *supra* note 36, at 59. The New York legislature passed the first type of mandatory screening program in 1938. *Id.* at 62. The "Baby Health Bill" required that physicians test all pregnant women for syphilis and record the test on the birth certificate or explain why the test had not been performed. *Id.* At the time of this bill's passing, the only effective treatment for syphilis was arsenic and bismuth, both highly toxic therapies. *Id.* at 63. Not until the 1950s was it possible to treat syphilis effectively with a single injection of penicillin. *Id.* Penicillin first became available in 1944, but was not a practical solution for outpatient use because the treatment required intramuscular shots every two to three hours for a 24 hour period. *Id.*

100. Hughes, *supra* note 39, at 112. Two major reasons for newborn screening exist: practicality and efficacy of treatment. *Id.* at 112-13. Because most children in the United States are born in a hospital or health care facility, the newborn period remains the most practical time to perform such testing. *Id.* Additionally, a number of diseases or inborn errors of metabolism have severe consequences for the affected child unless treatment is initiated in the newborn period. *Id. See generally* Louis J. Elsas, II, *Newborn Screening*, *in* RUDOLPH'S PEDIATRICS 281 (Abraham M. Rudolph et al. eds., 19th ed. 1991).

after the newborn is introduced to milk feedings.[101] Without prompt diagnosis and treatment, newborns with PKU will develop severe mental retardation.[102] The testing procedure is relatively simple,[103] however, and once diagnosed, treatment is relatively uncomplicated.[104] As a general screening model,[105] the PKU test is considered the model screening program because (1) the severe mental retardation that results from PKU is largely avoidable through early medical intervention; (2) the PKU test is a reliable screen for the condition; (3) the test is cost-effective and those newborns who test negative are not harmed; (4) the screening advances public health; and (5) the test is conducted via the least intrusive method possible, in this case, a "heel stick—a simple extraction with a needle of a blood specimen from a newborn's heel."[106]

Implementation of the PKU screening program, while effective, illustrated the inherent dangers of ignoring the risks of mandatory screening.[107] During the infancy of PKU treatment, the medical significance of high blood phenylalanine was not completely understood and some infants with a benign condition that resembled PKU[108] were falsely labeled as suffering from PKU.[109] The result was that those infants were unnecessarily treated for PKU by withholding milk feedings.[110] The toxic effects of a restricted phenylalanine intake, however, were not fully appreciated during the infancy of the PKU program and, consequently, some normal children who were mistakenly diagnosed with the disease became retarded as a consequence of phenylalanine deficiency.[111]

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101. Hughes, *supra* note 39, at 112.

102. Hughes, *supra* note 39, at 112.

103. Hughes, *supra* note 39, at 112. PKU screening involves a blood test for elevated levels of phenylalanine obtained by a heel stick of the newborn. *Id.* False-positive results do occur, but can be identified easily with confirmatory testing. *Id.*

104. Hughes, *supra* note 39, at 112. The early restriction of dietary phenylalanine accomplished by restricting milk feedings, ideally beginning before four weeks of age and continuing indefinitely can prevent retardation. Acuff & Faden, *supra* note 99, at 64.

105. Acuff & Faden, *supra* note 99, at 64. A screening program is considered "model" when: (1) the individual screened is expected to benefit from detection of the condition; (2) a reliable test is available to screen for the condition; (3) the harm (financial or otherwise) done to those testing negative is not excessive; (4) the screening advances public health; and (5) the screening test is conducted by the least intrusive method. *Id.* at 65.

106. *See* John M. Naber & David R. Johnson, *Mandatory HIV Testing Issues in State Newborn Screening Programs*, 7 J.L. & HEALTH 55, 57 (1992-93) (listing five criteria to satisfy before considering particular disease appropriate candidate for newborn screening).

107. *See* RICHARD E. BEHRMAN, NELSON TEXTBOOK OF PEDIATRICS 8 (Robert M. Kliegman et al. eds., 14th ed. 1992).

108. *Id.*

109. *Id.*

110. *See supra* note 104 and accompanying text (explaining that traditional treatment for PKU is restriction of milk feedings).

111. Hughes, *supra* note 39, at 112.

There are significant distinctions to be made between PKU screening, when used as a general model, and the proposed HIV screening program. Unlike PKU screening, the HIV antibody test does not definitively ascertain whether the newborn is infected[112] because only one-third of the newborns who test positive actually have the disease.[113] In addition, there exists a highly effective medical intervention for PKU—PKU babies identified through the screening can be cured.[114] In contrast, there is no cure for HIV, the most effective medical intervention merely delays a child's inevitable death.[115] More importantly, PKU screening does not reveal socially stigmatizing medical information about the mother.[116] State legislation, mandating HIV screening of newborns, therefore, not only fails to conform to the general screening model presented by PKU screening, but also poses greater risks and fewer benefits than other routine screenings.

C. Implementing HIV Screening Under Existing Statutes

Because medical providers are currently unable to either cure AIDS or prevent HIV transmission to newborns, it would be constitutionally problematic for courts to uphold a mandatory newborn screening program in the absence of congressional authorization.[117] The statutory language in some existing screening legislation, however, may be sufficiently broad to encompass newborn HIV screening.[118]

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112. THE RED BOOK, *supra* note 33, at 259 (noting that infants of HIV-infected mothers are always seropositive at birth whether or not they are truly infected).

113. *See* Hughes, *supra* note 39, at 133 (stating that only one third of newborns screened positive will prove to be infected while all mothers of these babies are infected).

114. *See* Hughes, *supra* note 39, at 113 (noting that PKU is treatable metabolic disorder).

115. *See supra* notes 51-61 and accompanying text (discussing limitations of current treatments for HIV-infected newborns).

116. *See infra* notes 219-27 and accompanying text (providing full discussion of social ramifications of HIV-positive result).

117. *See infra* notes 158-211 and accompanying text (discussing constitutional implications of mandatory screening program).

118. *See* Katherine L. Acuff, *Prenatal and Newborn Screening: State Legislative Approaches and Current Practice Standards, in* AIDS, WOMEN AND THE NEXT GENERATION, *supra* note 36, at 123 (stating that existing legislation related to prenatal and newborn screening could be interpreted to include HIV screening). Currently, all 50 states and the District of Columbia provide for newborn PKU screening by statute or other regulation. *Id.* The degree of specificity in each statute varies significantly. *Id.* For example, Alabama's statute requires all newborns to be tested for hypothyroidism, PKU, sickle cell trait, and/or hemoglobinopathies. ALA. CODE § 22-20-3 (Supp. 1987). The Alabama statute does not include a "catchall" phrase, however, which would allow for expansion to cover screening for other diseases, such as HIV. *Id.* The statutory and regulatory newborn screening statutes often include a "catchall" clause that allows for the testing of additional disorders upon recommendations from the departments of health or specially appointed committees or advisory boards. *See* Acuff, *supra*, at 123. The language of these catchall phrases may be interpreted to encompass HIV screening, however, the pivotal factor lies in the language of the clause, which varies substantially. *Id.*

Along with hypothyroidism, PKU is the most commonly mandated newborn screen,[119] and a growing number of states have extended mandatory screening to other disorders including syphilis and sickle cell anemia.[120] Hawaii and New York, for example, have the broadest mandatory screening statutes;[121] they provide that newborn screening may be undertaken for any diseases that are specified by the department of health.[122] A literal reading of these provisions could permit HIV screening, if recommended by the department of health. In order for a health department to mandate newborn HIV screening, however, accurate diagnostic tests for newborns would need to be developed and HIV treatments improved. Any HIV screening program commenced prior to such developments would run afoul of current medical and legal standards for mandatory screening programs.[123] Additionally, an HIV screen instituted under current medical standards would infringe on constitutional protections afforded to individuals.[124]

III. MANDATORY NEWBORN SCREENING AND THE CONSTITUTION

In 1988, the Center for Disease Control (CDC) began a surveillance study to anonymously measure the HIV infection rate of childbearing women in the United States and Puerto Rico.[125] "Serosurvellience,"

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119. *See supra* notes 95-111 and accompanying text (describing PKU screening).

120. *See* Acuff, *supra* note 118, at 124-25 tbl. 6.1 (listing screening programs in 50 states and District of Columbia).

121. HAW. REV. STAT. § 321 (1988) (providing that all newborns be tested for PKU, hypothyroidism, "and any other disease that may be specified by the department of health"); N.Y. PUB. HEALTH LAW § 2500(a) (McKinney 1988). Section 2500(a) provides for newborn testing for "phenylketonuria, homozygous sickle cell disease, hypothyroidism, branched-chain ketonuria, galactosemia, homocystinuria and such other diseases and conditions as may from time to time be designated by the commissioner in accordance with rules or regulations prescribed by the commissioner." *Id.*

122. *See supra* note 121 (quoting specific statutory language).

123. *See supra* notes 105-16 (discussing criteria necessary for screening program to be considered appropriate).

124. *See* Nancy Hutton & Lawrence S. Wissow, *Maternal and Newborn HIV Screening: Implications for Children and Families*, *in* AIDS, WOMEN AND THE NEXT GENERATION, *supra* note 36, at 105, 116 (suggesting that advances in treatment may strengthen case for prenatal and neonatal screening).

125. *See* 57 Fed. Reg. 39691 (1992) (citing U.S. Dep't of Health & Human Serv., *National Seroprevalence Surveys, Summary of Results: Data from Serosureillance Activities Through 1981*, HIV/CID/9-90/006, 1, 1-2 (1990)). The CDC has advanced several purposes for the HIV surveillance programs. *See* Marguerite Pappaioanou, *HIV Seroprevalence Surveys of Childbearing Women—Objectives, Methods, and Uses of the Data*, 105 PUB. HEALTH REP. 147, 148 (1990). These goals include (1) targeting geographical areas for resource allocations, Timothy J. Dondero et al., *Monitoring the Levels and Trends of HIV Infection: The Public Health Services HIV Surveillance Program*, 103 PUB. HEALTH REP. 213, 213 (1988); (2) targeting population groups for services, *id.*; (3) tracking disease trends, Ida M. Onorato et al., *Using Seroprevalance Data in Managing Public Health Programs*, 103 PUB. HEALTH REP. 163, 164 (1990); and (4) estimating population of HIV-infected persons in the United States, Marguerite Pappaioanou et al., *The Family of HIV*

the term used to describe this systematic study of blood tests, is done without the subjects' knowledge or consent.[126] Using blinded samples[127] from the newborn metabolic screening samples,[128] the CDC tests almost every American newborn for HIV.[129] Stripping samples of identifiers, known as "blinding," makes it theoretically impossible to link particular results with a particular individual.[130]

Currently, the CDC screening of newborns is performed without parental notice or consent.[131] Proponents of the CDC screening argue that because the samples are "blinded," the results are not linked to particular individuals and the data produced can only offer statistical information and, accordingly, the individual's privacy is not threatened.[132] Infected mothers and children who do not know their HIV status, however, cannot get treatment. Moreover, infected individuals, who are ignorant of their status, are unaware of the transmission hazard they pose to others.[133]

Proponents of unblinding the CDC screening results point out that the mother is not subjected to any invasive procedure because it is the infant whose blood is tested, and that even testing the infant's blood does not require an additional needle stick as part of the routine batch of neonatal screenings.[134]

In addition to the moral obstacles posed by blind testing, screening programs must also conform to constitutional requirements as

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Seroprevalence Surveys: Objectives, Methods, and Uses of Sentinel Surveillance for HIV in the United States, 105 PUB. HEALTH REP. 113, 113-19 (1990).

126. *See* Scott H. Isaacman & Lisa A. Miller, *Neonatal HIV Seroprevalence Studies*, 14 J.L. & MED. 413, 423 (1993). The blood that is subject to screening is drawn for other metabolic screening purposes, presumably with the knowledge and consent for those tests, but without consent for an HIV screen. *Id.*

127. *See* Dondero et al., *supra* note 125, at 215. In a "blinded" survey, identification markers on blood specimens that have been collected for other purposes are removed and then serologically tested for HIV. *Id.*

128. *See* Isaacman & Miller, *supra* note 126, at 423 (describing metabolic screening process). For newborn screens, around the end of the first week of the baby's life, blood is removed from the baby's heel through a procedure referred to as a "heel stick." *Id.* The blood is then analyzed in a specialized laboratory. Abnormal results are promptly reported to the parents along with a referral to centers specializing in caring for infants with metabolic disorders. *Id.* The parents receive counseling and the child receives treatment for the metabolic disorder in these medical centers. *Id.*

129. *See* Hughes, *supra* note 39, at 114.

130. *See* Hughes, *supra* note 39, at 113 (stating that blinded samples only retain demographic indicators).

131. *See* Isaacman & Miller, *supra* note 126, at 433-51 (enumerating details of CDC "blinded" screening program).

132. *See infra* notes 140-211 and accompanying text (discussing privacy right and mandatory AIDS testing).

133. Mothers who do not know that they are carrying the AIDS virus may still engage in indiscriminate drug use and unprotected sexual contact, and possibly become pregnant again.

134. *See* Isaacman & Miller, *supra* note 126, at 423 (explaining metabolic screening test); *see also supra* note 128 (describing method of obtaining blood for a series of screenings).

interpreted by the courts.[135] Courts have shown considerable reluctance to question legislative enactments that seek to protect public health through measures such as compulsory testing,[136] vaccination,[137] limited detention in jail,[138] and even isolation.[139] The HIV epidemic, however, has spurred a reexamination of the personal restrictions often invoked as necessary for the protection of public health.

A. The Right to Privacy

The United States Supreme Court has recognized a "zone of privacy,"[140] encompassed in the Constitution,[141] that protects an individual against unwarranted governmental intrusions.[142] This "zone" includes the disclosure of personal information.[143] Screening newborns for HIV implicates the privacy interests of both mother and child because it necessarily reveals the HIV status of the mother.[144]

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135. *See* Marbury v. Madison, 5 U.S. (1 Cranch) 137, 177-78 (1803) (stating that when constitutional right is implicated, court's role is to serve as check on legislature).

136. *See* Leckelt v. Board of Comm'rs, 909 F.2d 820, 833 (5th Cir. 1990) (holding that employer's requirement that employee submit results of his voluntary HIV antibody test did not violate Federal Rehabilitation Act of 1973, Louisiana Civil Rights for Handicapped Persons Act, Equal Protection Clause of Fourteenth Amendment, or right to privacy under Fourth and Fourteenth Amendments).

137. *See* Jacobson v. Massachusetts, 197 U.S. 11, 35 (1905) (holding that mandatory smallpox vaccinations are constitutional).

138. *See* Reynolds v. McNichols, 488 F.2d 1378, 1383 (10th Cir. 1973) (upholding ordinance requiring compulsory detention and examination of prostitutes for venereal disease).

139. *See* Moore v. Draper, 57 So. 2d 648, 649-50 (Fla. 1952) (finding that requirement of compulsory isolation and hospitalization was proper exercise of police power and did not violate confined individual's constitutional rights).

140. *See* Whalen v. Roe, 429 U.S. 589, 598 (1977) (recognizing that while individuals have privacy in certain areas of their lives, it was constitutional for state to require copies of certain drug prescriptions).

141. *See* Mapp v. Ohio, 367 U.S. 643, 660 (1961) (noting that "the right to be secure against rude invasions of privacy by state officers is . . . constitutional in origin").

142. *See* Roe v. Wade, 410 U.S. 113, 164 (1973) (holding that criminal laws prohibiting woman's right to abortion violated woman's constitutional right to privacy); Eisenstadt v. Baird, 405 U.S. 438, 453 (1972) (determining that right of privacy "is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision to bear or beget a child"); Griswold v. Connecticut, 381 U.S. 479, 483 (1965) (finding that "the First Amendment has a penumbra where privacy is protected from government intrusion").

143. *See Whalen*, 429 U.S. at 598-600 (noting that courts have recognized privacy interest in making certain types of decisions (decisional privacy) and in disclosing personal matters (informational privacy)). In *Whalen*, however, the Supreme Court upheld legislation that required pharmacists to report to the state all prescriptions issued and the names and addresses of the patients to whom they were issued because disclosure of medical information was an essential part of medical practice. *Id.* at 602-03; *cf.* Plowman v. United States Dep't of Army, 698 F. Supp. 627, 631, 635 (E.D. Va. 1988) (deciding that there is no constitutional right to privacy in medical information when asserted by civilian employee of army who had been tested for HIV without consent and then had test results disclosed to his superior).

144. *See supra* notes 39-48 and accompanying text (detailing manner in which HIV test of infant can reveal presence of infection in mother).

Adults and children who meet the surveillance definition of AIDS,[145] as defined by the CDC, may have their names reported to the public health department in all fifty states and the District of Columbia.[146] The rules for reporting a positive HIV result vary from state to state.[147]

Privacy protection is particularly necessary for HIV-related information.[148] The right to privacy, however, is not absolute.[149] The Supreme Court, in *Roe v. Wade*,[150] stated that the right to privacy "is

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145. *See supra* note 28 (defining AIDS classification system).

146. *See* John Modlin & Alfred Saah, *Public Health and Clinical Aspects of HIV Infection and Disease in Women and Children in the United States*, *in* AIDS, WOMEN AND THE NEXT GENERATION, *supra* note 36, at 29, 30 (stating that all states require reporting of certain "notifiable" diseases to public health departments, and that many jurisdictions classify AIDS as notifiable disease); *see also* Lawrence O. Gostin et al., *The Case Against Compulsory Casefinding in Controlling AIDS—Testing, Screening and Reporting*, 12 AM. J.L. & MED. 7, 22-23 (1987) (proposing general standards for compulsory screening). While mandatory reporting laws interfere with an individual's privacy interests, they will be upheld so long as certain criteria are met. *Id.* at 21. Such criteria include heightened severity of HIV infection, high risk of transmission, and effective use of test results. *Id.* at 21-23.

147. Lawrence O. Gostin, *Traditional Public Health Strategies*, *in* AIDS LAW TODAY, *supra* note 2, at 71 (noting that state reporting requirements can be divided into three categories: those specifying reporting of all cases meeting CDC definition of AIDS; those specifying reporting that positive HIV test results be reported; and general provisions requiring reporting of any "case," "condition," or "carrier state" relating to listed diseases). Although determining the constitutionality of mandatory reporting of HIV status is beyond the scope of this Comment, it is generally believed that the reporting requirements would "likely withstand constitutional challenge as long as the information sought is reasonably related to a valid public health purpose and is limited to public health departments, and statutory confidentiality protections are in place." *Id.* at 72.

148. *See, e.g.*, Doe v. City of Cleveland, 788 F. Supp. 979, 985 (N.D. Ohio 1991) (holding that information related to AIDS is of fundamental nature and should be protected); Inmates of N.Y. State with Human Immunodeficiency Virus v. Cuomo, No. 90-CV-252, 1991 WL 16032, at *3 (N.D.N.Y. Feb. 7, 1991) (recognizing that Constitution protects against unwarranted disclosure of identity of HIV-infected individuals and their medical records); Doe v. Borough of Barrington, 729 F. Supp. 376, 384 (D.N.J. 1990) (stating that privacy interest in exposure to AIDS is greater than privacy interest in ordinary medical records); Woods v. White, 689 F. Supp. 874, 876 (W.D. Wis. 1988) (noting that because AIDS is widely publicized, AIDS diagnosis is highly personal information), *aff'd*, 899 F.2d 17 (7th Cir. 1990). *But see* Harris v. Thigpen, 727 F. Supp. 1564, 1581 (M.D. Ala. 1990) (finding that identity of AIDS carriers is matter reasonably related to legitimate state interest), *aff'd in part, vacated in part*, 941 F.2d 1495 (11th Cir. 1991).

In *Borough of Barrington*, the court discussed the sensitivity of HIV information, stating:

> Society's moral judgments about the high-risk activities associated with the disease, including sexual relations and drug use, make the information of the most personal kind. Also, the privacy interest in one's exposure to the AIDS virus is even greater than one's privacy interest in ordinary medical records because of the stigma that attaches with the disease. The potential for harm in the event of a nonconsensual disclosure is substantial . . . [including] the stigma and harassment that comes with public knowledge of one's affliction with AIDS.
>
> The hysteria surrounding AIDS extends beyond those who have the disease. . . . The stigma attaches not only to the AIDS victim, but to those in contact with AIDS patients and to those in high risk groups who do not have the disease.

729 F. Supp. at 384 (citations omitted).

149. *See* Whalen v. Roe, 429 U.S. 589, 598-99 (1977) (holding that New York State Controlled Substances Act was not invasion of right or liberty protected by Fourteenth Amendment).

150. 410 U.S. 113 (1973).

not unqualified and must be considered against important state interests in regulation."[151] States must have a compelling interest[152] for enacting regulations that limit any fundamental right.[153] All legislation that would infringe on an individual's privacy must be narrowly drawn to express the legitimate state interest at stake.[154] Any mandatory screening program that has a significant impact on the fundamental right to privacy, therefore, must be narrowly tailored to meet the government's legitimate objectives.[155] In the arena of mandatory HIV testing of newborns, the compelling state interest is twofold: the protection of the public health[156] and the protection of the health of the newborn.[157] In light of the medical principles surrounding HIV disease, specifically the testing and treatment limitations, it is unlikely that a mandatory screening policy would adequately address these interests. Because testing only reveals the HIV status of the mother, effective medical intervention in the newborn's life is unlikely.

B. The Fourth Amendment

Privacy is also protected by the Fourth Amendment of the United States Constitution, which protects people from unreasonable governmental searches and seizures.[158] In *Schmerber v. California*[159] the Supreme Court recognized that "[t]he overriding function of the

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151. Roe v. Wade, 410 U.S. 113, 154 (1973).

152. *See* Kramer v. Union Free Sch. Dist. No. 15, 395 U.S. 621, 627 (1969) (stating that determination of whether or not voting exclusions are constitutional requires finding of compelling state interest).

153. *See* Joanna L. Weissman & Mildred Childers, *Constitutional Questions: Mandatory Testing for AIDS under Washington's AIDS Legislation*, 24 GONZ. L. REV. 433, 461 (1988-89) (listing procreation, contraception, marriage, child-rearing, family relationships, and education as other rights that have been recognized as fundamental).

154. *See* Whalen v. Roe, 429 U.S. 589, 598 (1977) (stating that New York had "a vital interest in controlling the distribution of dangerous drugs").

155. *See* Skinner v. Railway Labor Executives' Ass'n, 489 U.S. 602, 633 (1989) (holding that railway employees' privacy rights were outweighed by compelling government interest in determining cause of train accidents and preventing future accidents that result from drug and alcohol impaired employees); *see also* National Treasury Employees Union v. Von Raab, 489 U.S. 656, 677 (1989) (holding that government's interest in safeguarding borders and public safety outweighed individual employee's privacy interests and justified warrantless and suspicionless drug testing).

156. *See* Weissman & Childers, *supra* note 153, at 472 (stating that right to privacy is subject to state's compelling interest in protecting public health, such as reducing spread of AIDS).

157. *See* Jean R. Sternlight, *Mandatory Non-Anonymous Testing of Newborns for HIV: Should It Ever Be Allowed?*, 27 J. MARSHALL L. REV. 373, 374 (1994) (arguing that mandatory testing of newborns is necessary to ensure that doctors can provide newborns with adequate care).

158. The Fourth Amendment provides 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." U.S. CONST. amend. IV.

159. 384 U.S. 757 (1966).

Fourth Amendment is to protect personal privacy and dignity against [unreasonable] intrusion by the State."[160] The Fourth Amendment has been interpreted to apply to both state and federal governmental actions.[161]

Before government action will constitute a "search" under the Fourth Amendment, two criteria must be met.[162] The person who is the object of the search must have a subjective expectation of privacy in the area to be searched,[163] and that expectation must be reasonable and societally recognized.[164] The Supreme Court in *Schmerber* held that a compulsory blood test by the government[165] constituted a search and seizure under the Fourth Amendment.[166] In determining the reasonableness of a search, the Supreme Court balances the government's need to conduct the search against the invasion of the individual's rights occasioned by the search.[167] Employing this "balancing test," the Court in *Schmerber* weighed the defendant's privacy interest in not undergoing a blood test against the state's interest in obtaining evidence of a crime.[168] Consequently, the Court upheld the involuntary blood test as minimally intrusive and a reasonable Fourth Amendment search.[169]

Furthermore, in *Glover v. Eastern Nebraska Community Office of Retardation*,[170] the Eighth Circuit affirmed a district court finding that a mandatory HIV test for employees "plainly involves the broadly conceived reach of a search and seizure under the Fourth Amendment."[171] In light of *Glover* and *Schmerber*, a mandatory HIV newborn screening program would qualify as a "seizure" and the testing

160. Schmerber v. California, 384 U.S. 757, 767 (1966).

161. *See* Mapp v. Ohio, 367 U.S. 643, 655 (1961) (stating that Fourth Amendment right to privacy is enforceable against states through Due Process Clause).

162. *See* Katz v. United States, 389 U.S. 347, 352, 359 (1967) (holding that person who is object of search must have subjective expectation of privacy, which is reasonably recognized by society, in place searched).

163. *Id.* at 359.

164. *Id.* at 352.

165. *Schmerber*, 384 U.S. at 759. After a vehicular homicide, the arresting officer compelled the defendant to undergo a blood alcohol test. *Id.*

166. *See* Johnetta J. v. Municipal Court, 267 Cal. Rptr. 666, 675 (Ct. App. 1990). According to *Johnetta J.*, the U.S. Supreme Court has found that compulsory blood tests are searches subject to the Fourth Amendment because they involve (1) physical penetration to withdraw bodily fluid; and (2) subsequent chemical testing, which may disclose confidential medical information. *Id.*

167. Skinner v. Railway Labor Executives' Ass'n, 489 U.S. 602, 619 (1989) (holding that warrantless drug-testing meets Fourth Amendment reasonableness requirement because compelling governmental interest in regulation outweighed employees' privacy concerns).

168. *See Schmerber*, 384 U.S. at 770.

169. *Id.* at 772.

170. 867 F. 2d 461 (8th Cir 1988).

171. Glover v. Eastern Neb. Community Office of Retardation, 686 F. Supp. 243, 250 (D. Neb. 1988), *aff'd*, 867 F.2d 461 (8th Cir.), *cert. denied*, 493 U.S. 932 (1989).

of the blood as a "search" for Fourth Amendment purposes[172] because screening involves withdrawal of blood from an infant's heel. The Fourth Amendment does not protect individuals from *all* state searches, only searches that are "unreasonable."[173] Because the HIV screening involves a blood test, which constitutes a search under the Fourth Amendment, its constitutionality should be tested by a determination of whether or not it is reasonable.[174]

A search is presumptively unreasonable unless it is accomplished pursuant to a judicial warrant issued upon probable cause.[175] The Supreme Court, however, has developed a broad exception to the warrant requirement for cases in which "'special needs, beyond the normal need for law enforcement, make the warrant and probable cause requirement impracticable.'"[176] In *Skinner v. Railway Labor Executives' Association*,[177] and its companion case, *National Treasury Employees Union v. Von Raab*,[178] "special needs" justified a departure from the warrant and probable cause requirement for mandatory drug testing of railroad employees[179] and United States Customs Agents,[180] respectively. In *Skinner*, the special needs that justified dispensing with the warrant and probable cause requirement were based largely on the threat to public safety presented by operation

172. *See Schmerber*, 384 U.S. at 767 (holding that blood test implicated Fourth Amendment protections).

173. *See* New Jersey v. T.L.O., 469 U.S. 325, 338 (1985) (noting that Fourth Amendment does not protect unreasonable expectations of privacy). In *T.L.O.*, a student's purse was searched by school officials. *Id.* at 328. Although searching for cigarettes, the officials found drugs. *Id.* The Supreme Court found that the Fourth Amendment did apply to school officials but that the search, in this instance, was reasonable. *Id.* at 328-33.

174. *See id.* (noting that Fourth Amendment mandates that searches and seizures be reasonable).

175. Skinner v. Railway Labor Executives' Ass'n, 489 U.S. 602, 619 (1989).

176. *Id.* at 619-20 (quoting Griffin v. Wisconsin, 483 U.S. 868, 873 (1987) (internal quotation marks and citation omitted)); *see also* National Treasury Employees Union v. Von Raab, 489 U.S. 656, 665 (1989) (stating that "special needs" demand exception to warrant requirement); *T.L.O.*, 469 U.S. at 351 (Blackmun, J., concurring) (agreeing that limited exceptions to warrant requirement exist).

177. 489 U.S. 602 (1989).

178. 489 U.S. 656 (1989).

179. Skinner v. Railway Labor Executives' Ass'n, 489 U.S. 602, 635 (1989). In *Skinner*, the Supreme Court reviewed a mandatory drug-testing program initiated by the Federal Railroad Administration. *Id.* at 606. The policy was established in the wake of several drug-related train accidents. *Id.* at 607. The Court recognized that the drug tests were a search and seizure for Fourth Amendment purposes, but found that "special needs" existed regarding the government's interest in preventing serious train accidents. *Id.* at 620.

180. National Treasury Employees Union v. Von Raab, 489 U.S. 656, 660 (1989). In *Von Raab*, the Court upheld mandatory drug testing of U.S. Customs Service agents because drug-impaired customs agents presented a threat to the national war on drugs and thus constituted a special need that justified obviation of the usual Fourth Amendment warrant and probable cause requirements. *Id.* at 666-67.

of a train by a person under the influence of drugs or alcohol.[181] The Court took notice of strong evidence that abuse of controlled substances presented a significant threat to the safe operations of the nation's railroads.[182] The Court cited an eight-year Federal Railroad Administration study showing drug use to be a causative factor in at least twenty-one train accidents resulting in twenty-five fatalities, sixty-one injuries, and nineteen million dollars in property damage.[183] The Court found the existence of "special needs," which justified departure from the warrant and probable cause requirements.[184] The Court concluded that mandatory drug testing of railroad employees in certain situations would further safe operation of trains by assisting in accident investigation.[185]

Similarly, in *Von Raab*, where employees of the U.S. Customs Service were drug tested, the Court recognized "special needs" in several government interests. These interests included: (1) preventing the promotion of drug users to sensitive positions,[186] (2) protecting the integrity and safety of U.S. borders as well as guarding against drug smuggling,[187] (3) deterring employee drug use,[188] and (4) preventing armed, drug-impaired employees from posing a danger either to fellow agents or the public.[189]

Because a mandatory HIV screening policy would not require a warrant based on probable cause, the state must demonstrate that "special needs" exist.[190] This exception has been applied only where the privacy interests implicated by the search are minimal, and where "an important governmental interest furthered by the intrusion would be placed in jeopardy."[191] In *Skinner* and *Von Raab*, the social need that prompted the mandatory drug testing was the protection of the

181. *Skinner*, 489 U.S. at 607.
182. *Id.*
183. *Id.*
184. *Id.* at 620.
185. *Id.* at 630.
186. National Treasury Employees Union v. Von Raab, 489 U.S. 656, 666 (1989).
187. *Id.* at 668-69.
188. *Id.* at 670.
189. *Id.*
190. *See* Skinner v. Railway Labor Executives' Ass'n, 489 U.S. 602, 619 (1989) (noting that special needs may make warrant requirement impracticable). In *Skinner*, the Court emphasized its adherence to the "special needs" doctrine and held that railroad employees involved in major train accidents may be compelled to submit to blood alcohol testing without a warrant and without probable cause. *Id.* at 630. The Court found that the government's interest in promoting railroad safety was a "special need," which justified departing from the warrant requirement. *Id.* at 619.
191. *Id.* at 624.

public health and safety.[192] The Court in these cases balanced the need to protect the public health and safety against the magnitude of the intrusion into the individuals' privacy and concluded that a drug test was only minimally intrusive when the interest of the government was the safety of the public.[193]

In the context of HIV testing, courts have used the special needs approach to uphold mandatory testing schemes that served the public health.[194] In *Johnetta J. v. Municipal Court*,[195] for instance, a California appellate court found "special needs" in the government's interest in protecting the health of public safety employees.[196] Specifically, the court held that mandatory AIDS testing of a defendant who bit a police officer did not violate the Fourth Amendment because the government's need to protect the health of its public servants outweighed the privacy interest of the defendant.[197] The articulated rationale behind the need to protect the public, however, was to minimize the bitten officer's *fear* of HIV exposure.[198] The court dismissed well-documented medical evidence[199] that HIV was not transmissible through a bite.[200] Moreover, in *Leckelt v. Board of Commissioners of Hospital District Number One*,[201] the Fifth Circuit, although accepting that "the probability that a health care worker will transmit HIV to a patient may be extremely low,"[202] upheld testing

192. *See id.* at 619 (noting that concern for public safety prompted drug testing); *Von Raab*, 489 U.S. at 670 (stating that public safety concern warranted drug testing of Customs Service employees).

193. *Von Raab*, 489 U.S. at 666; *Skinner*, 489 U.S. at 628.

194. *See* Anonymous Fireman v. City of Willoughby, 779 F. Supp. 402, 417-18 (N.D. Ohio 1991) (holding that local fire department had "special need" to prevent spread of AIDS by high risk employees); Johnetta J. v. Municipal Court, 267 Cal. Rptr. 666, 680-81 (Ct. App. 1990) (noting that local government has "special need" to protect health of its employees);

195. 267 Cal. Rptr. 666 (Ct. App. 1990).

196. Johnetta J. v. Municipal Court, 267 Cal. Rptr. 666, 683 (Ct. App. 1990).

197. *Id.*

198. *Id.* at 681 (asserting that testing will minimize officers fear and will enable officer to secure best available treatment); *see also* Syring v. Tucker, 498 N.W.2d 370, 377 (Wis. 1993) (finding that plaintiff's need to discover HIV status of assaultive defendant, was compelling).

199. *Johnetta J.*, 267 Cal. Rptr. at 681. The court found that although the possibility of saliva transfer of HIV is extremely low, because "medicine is still 'unraveling the mysteries' of the disease, . . . the available evidence is insufficient to determine conclusively that HIV cannot be transferred through a bite." *Id.*

200. *See, e.g.*, United States v. Moore, 846 F.2d 1163, 1168 (8th Cir. 1988) ("[T]here are no well-proven cases of AIDS transmission by a bite; and . . . contact with saliva has never been shown to transmit the disease; . . . in one case a person who had been deeply bitten by a person with AIDS tested negative several months later."); Thomas v. Atascadero Unified Sch. Dist., 662 F. Supp. 376, 380 (C.D. Cal. 1987) ("The overwhelming weight of medical evidence is that the AIDS virus is not transmitted by human bites, even bites that break the skin.").

201. 909 F.2d 820 (5th Cir. 1990).

202. Leckelt v. Board of Comm'rs, 909 F.2d 820, 829 (5th Cir. 1990).

of a licensed practical nurse because of the lethal consequences of HIV.[203]

A contrary result was reached in *Glover v. Eastern Nebraska Community Office of Retardation*.[204] The Eighth Circuit affirmed a lower court decision to strike down a state employer's requirement of an AIDS test because the court considered it an unreasonable search under the Fourth Amendment.[205] The employer, a health services agency providing services to the mentally retarded, required AIDS testing of employees who had direct patient contact because of numerous past incidents of biting, scratching, and hitting.[206] The hospital's rationale was that this type of aggressive behavior increased the risk that a patient would contract a disease from an infected employee.[207] The court balanced the employees' reasonable expectation of privacy in their blood against the agency's interest in promoting a safe working environment and determined that the mandatory AIDS testing policy was not justified in light of its constitutional intrusion upon the employees.[208] Specifically, the appellate court relied on the district court finding that, because the risk of transmission had been shown to be negligible,[209] the employer's articulated interest in requiring testing (i.e., protecting its clients from its employees) did not justify requiring employees to submit to a mandatory HIV test.[210] By analogy, in order for a mandatory HIV newborn screening program to pass constitutional scrutiny, courts will have to balance the government's interest in testing newborns for HIV against the privacy interests and consequences of testing on the newborn and the mother.

C. The Balancing Test

While there has not yet been agreement among courts regarding the appropriate scope of mandatory testing, all courts balance the government's interest in protecting the public health against the

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203. *Id.* at 832.
204. 867 F.2d 461 (8th Cir.), *cert. denied*, 493 U.S. 932 (1989).
205. Glover v. Eastern Neb. Community Office of Retardation, 867 F.2d 461, 464 (8th Cir.), *cert. denied*, 493 U.S. 932 (1989).
206. *Id.* at 462-63.
207. *Id.* at 463.
208. *Id.* at 464.
209. *Id.* The court reasoned that "[t]he medical evidence is undisputed that the disease is not contracted by casual contact. The risk of transmission of the disease to clients as a result of a client biting or scratching a staff member, and potentially drawing blood, is extraordinarily low." *Id.*
210. *Id.*

individual's interest in being free from an unreasonable search.[211] Mandatory screening of newborns and "unblinding" of the current CDC serosurveillance screen[212] should be subject to the same balancing analysis.

1. The government interests

Protection of the public health by prevention of AIDS transmission is one of the governmental interests implicated by mandatory HIV screening. Although infected newborns do not pose a significant threat of transmission,[213] the infected mother, who is unaware of her HIV status, remains a transmission threat.[214] She can transmit the disease to sexual partners and even to her newborn if she decides to breast-feed.[215] This risk should be weighed against the consequences of mandating an HIV test that will reveal the HIV status of the mother.

Protecting the health of HIV-infected newborns is also a legitimate governmental interest. Proponents of mandatory testing maintain that testing newborns will result in early detection of a newborn's HIV status, which in turn would ensure that an infected infant would receive treatment[216] and probably extend and improve the child's quality of life.[217] Unfortunately, proponents of mandatory testing have not proposed legislation that would guarantee that every child with a positive HIV result would, in fact, receive treatment. Moreover, because a newborn's status remains questionable until at least six months of age, the infant either does not receive needed treatment soon enough or the infant receives unnecessary treatment because he or she is not really infected.

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211. *See infra* notes 214-17 and accompanying text (discussing balancing tests used in determining constitutionality of mandatory testing).

212. *See supra* notes 125-27 and accompanying text (providing details of CDC study measuring infant HIV infection rate).

213. *See supra* notes 90-94 and accompanying text (discussing low possibility of infant transmission of HIV).

214. *See* Grumet, *supra* note 24, at 13 (noting that HIV testing will protect third parties from being exposed to HIV).

215. *See supra* note 5 and accompanying text (discussing newborn's risk of postnatal HIV reform).

216. *See* Winifred J. Pinch, *Caregivers' Perspectives on Confidentiality for Mothers and Newborns with HIV/AIDS*, 4 PEDIATRIC AIDS & HIV INFECTION: FETUS TO ADOLESCENT 123, 125 (1993) (noting that health of HIV-infected newborns was tracked more closely and discussed more frequently among clinical staff consequently, pneumonia was treated differently, AZT was started earlier, and psychiatric services were more readily available for patient with known HIV diagnosis).

217. Grumet, *supra* note 24, at 15.

2. Consequences of HIV screening for the family

While the HIV screening procedure is not overly intrusive or intrinsically risky,[218] there are risks for "HIV positive" infants that do not exist for an infant with a treatable condition, such as PKU or hypothyroidism.[219] Screening newborns for HIV actually identifies mothers who are infected with HIV, whereas the screening for metabolic diseases merely reveals that the mother is a healthy carrier of an autosomal recessive gene. A mother who is identified as infected with HIV carries a far weightier burden than one identified as simply the healthy carrier of a metabolic disorder. The newborn, as well as the newly identified HIV-infected mother, both face social and institutional discrimination.[220]

A recent study of HIV-infected mothers and health care providers revealed that disclosure of a patient's HIV status can result in severe social and economic repercussions, such as job loss[221] or eviction from their homes.[222] Many HIV-infected individuals also suffered physical abuse[223] and public shunning.[224] Additionally, there are

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218. *See supra* note 134 and accompanying text (describing blood-drawing process).

219. *See* AIDS Project of the American Civil Liberties Union, AIDS AGENDA: EMERGING ISSUES IN CIVIL RIGHTS 283 (Hunter & Rubinstein eds., 1992) (noting that there are real risks associated with HIV testing of newborns). Added to the risks of HIV testing is the social stigma attached to an HIV-infected individual. *Id.* at 25. HIV infection continues to evoke strong negative feelings in our society and carries the risk of discrimination for those who are diagnosed, or even suspected of, carrying the virus. *Id.*

220. *See* Grumet, *supra* note 24, at 13 (recognizing that HIV-infected mothers and newborns are subject to social stigma).

221. Pinch, *supra* note 216, at 125.

222. Pinch, *supra* note 216, at 125. Although eviction and job termination based on a person's HIV status are illegal, mothers who are sick and dealing with sick children are often too weak to undertake the legal battles that would undoubtedly jeopardize confidentiality and use scarce time and money. *Id.*

223. Pinch, *supra* note 216, at 125. The study contained numerous reports of HIV-infected women who were physically abused by their spouses and lovers. *Id.* The fear of being beaten sometimes led to withholding information about HIV status from a sexual partner when it might otherwise be important to disclose such information. *Id.*

224. *See* Pinch, *supra* note 216, at 125 (presenting Table of Frequencies of Discrimination Against Mothers with HIV, Questionnaire Result).

TYPE OF DISCRIMINATION	% Often	% Sometimes	% Never
Employment	34	63	3
Housing	26	69	5
Physical Abuse	13	76	11
Psychological Abuse	36	61	3
Rejection by family	35	65	
Rejection by friends	37	63	0
Rejection by neighbors, co-workers and others	39	62	0

Id.

reported cases of mothers and infants who were rejected, abandoned, and isolated by families, friends, neighbors, health care providers,[225] and teachers when such individuals learned that the mothers and infants were infected.[226]

The government's interest in protecting HIV-infected newborns and protecting the public health by preventing the spread of AIDS is not justifiable when balanced against the privacy interests of the mother and child. Mandatory HIV screening of infants is not justifiable because current testing is not accurate and virologic testing is not medically feasible.[227] Infants do not engage in risky behavior nor do they pose a significant risk of transmission. Moreover, the social stigmatization and discrimination that results does not support such a policy. The goal of protecting the newborn and the public is only served if the newborn is screened to determine the mother's HIV status because only the infected mother poses a transmission threat. Ideally, if the mother is informed of her status she will abstain from risky behavior. Discovering the HIV status of a new mother, however, should not be accomplished via screening newborns; rather it should be accomplished through voluntary testing of the mother.

IV. RECOMMENDATIONS

Involuntary, unblinded newborn HIV screening as proposed in the New York "Baby AIDS Bill" focuses only on the element of identification, and in so doing, infringes on important protected rights of women with little demonstrated benefit. Due to the present state of testing technology and the level of discrimination that results from knowledge that an individual is HIV positive, an alternative to demanding HIV tests on newborns is necessary. One alternative is to educate new parents about the HIV epidemic and inform them of the availibilty of HIV testing.[228] Moreover, new parents should be

225. The American Civil Liberties Union has reported several studies that have documented such discrimination: (1) a survey of more than 500 dentists in which 63% of the respondents did not want to treat persons considered to be at risk for AIDS; (2) a survey of nursing home administrators in which 47% said they would refuse to accept a person with AIDS as a patient; (3) a Virginia study of paramedics in which 40% of the respondents said they were unwilling to administer treatment to HIV-infected persons; (4) another study reporting that more than 90% of 1000 surgeons surveyed endorsed a policy of refusing to operate on HIV-infected individuals; and (5) a recent study in which 20% of the hospitals surveyed reported at least one instance of a staff member refusing to care for an HIV-infected patient, and in which at least 25% of the hospitals had a policy of immediately transferring any such patient. *Epidemic of Fear*, (ACLU/AIDS Project, New York, N.Y. 1990), at 31, 78-80.

226. *Id.*

227. *See* Grumet, *supra* note 24, at 13 (discussing inaccuracy of HIV testing).

228. *See* THE RED BOOK, *supra* note 33, at 260 (recommending that policies ensure education and counseling for mothers). The American Academy of Pediatrics recommends that doctors

informed that an HIV test will be performed on their children unless they expressly refuse to allow it.

Additionally, if a mandatory screening program is to be beneficial, the enacting legislation must also provide for the counseling and treatment of infected children because mandatory screening of newborns does not necessarily mean mandatory treatment or counseling. If the rationale for HIV testing is that testing is necessary in order to provide appropriate medical treatment,[229] then any legislator who proposes mandatory HIV testing should bear the burden of demonstrating that a child who tests positive will receive such treatment. Legislators must also show that mandatory testing is in the best interests of the child who tests positive.

Perhaps the most effective approach to this complex problem is mandatory counseling. Recent figures from the New York State Health Department show that eighty-five to ninety-one percent of women participating in three state-sponsored initiatives agreed to voluntary testing.[230] It seems that when women are guided by well-trained professionals whom they trust and are confident that they and their infants will receive the care they need, the vast majority of women opt for what is best for their babies and themselves—testing.[231] Before a state resorts to mandatory screening, therefore, a bill calling for mandatory counseling of pregnant women and new mothers remains the most feasible option.

Should new medical technology become available that would allow for a cost-effective virologic test that would definitively ascertain the infant's status, the balance may tip in favor of mandatory screening. Currently, however, the medical and legal evidence is not sufficient to support a policy of mandatory newborn screening.

CONCLUSION

The growing epidemic of AIDS and the fear and panic engendered therefrom has resulted in calls for the mandatory HIV screening of newborns. A mandatory blood test that advances only the narrow

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routinely encourage testing in mothers with known high-risk behavior or who are from high-seroprevalent areas and who have not yet been tested. *Id.*

229. *See* Riley, *supra* note 14, at A12. Riley recounts comments of Governor of New York, George Pataki, when asked in an interview about new "Baby AIDS" bill. Pataki is reported to have said "I'm for it. It's a matter of saving lives. It doesn't make sense to risk the lives of newborns in the interests of privacy, and it's also in the interest of mothers to know their own HIV status so they can receive treatment." *Id.*

230. *See* Post, *supra* note 11, at 182 (espousing beneficial results of New York City counseling programs).

231. Post, *supra* note 11, at 182.

government interest of identifying seropositive individuals, however, cannot be justified in light of the enormous intrusion into individual privacy that the test implicates. Mandatory HIV screening does not conform to pre-existing screening programs and is not medically justified in light of current technology. Although Fourth Amendment jurisprudence and evolving case law have carved out a "special needs" doctrine that may tolerate intrusion, mandatory testing for HIV would still fall outside that exception.

Undoubtedly, the public would benefit from the identification of HIV-infected individuals. Knowing that they are infected with HIV, those individuals could abstain from activities which could lead to further transmission of the disease. Moreover, the infected infant could receive treatment which may prolong its life. This conclusion, however, presupposes that when an infant tests HIV positive, effective treatment and counseling will follow and that a mother, upon discovering her own status, will tailor her own behavior appropriately.