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A TROUBLESOME MATERNAL-FETAL CONFLICT: LEGAL, ETHICAL, AND SOCIAL ISSUES SURROUNDING MANDATORY AZT TREATMENT OF HIV POSITIVE PREGNANT WOMEN

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I. INTRODUCTION

The notion of an innocent child born with a fatal disease evokes great sympathy. Particularly with a devastating disease such as pediatric AIDS, there is a moral impetus for society to attempt to reduce the likelihood of perinatal HIV transmission, not only to protect the unborn child, but to protect the populace at large from the further spread of AIDS. Fairly recently, a breakthrough in the medical community demonstrated that the perinatal administration of the antiviral drug zidovudine (ZDV) (more commonly known by its brand name, AZT) to HIV-positive pregnant women can substantially reduce the likelihood of perinatal transmission. In response, some members of the medical community, as well as state and federal officials have endorsed mandatory HIV testing of pregnant women on the premise that women with positive test results would be able to make informed choices about their pregnancies. Certainly it is conceivable that the next rational step to help eradicate pediatric AIDS could be mandatory AZT treatment of HIV-positive pregnant women. However, despite good intentions, the mandatory treatment of pregnant women raises a number of ethical, medical, and legal dilemmas.

This paper will explore the complex issues surrounding the mandatory treatment of HIV-positive pregnant women and will

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discuss the myriad of ethical, legal, and public health issues embodied in this subject matter. It will attempt to resolve the conflict that exists between the state’s benevolent interest in the health of the fetus and society at large, and the constitutional rights of the mother. Ultimately, this paper concludes that mandatory AZT treatment of HIV-positive pregnant women would be too great an infringement on the constitutional rights of the mother. If such infringements are allowed in this context, it is likely that there will be a greater trampling on women’s liberty interests with future public health concerns. As a result, the moral impetus to foster the health of children and society must be distinguished from the legal right to intervene in a pregnant woman’s medical decision making. Overall, pregnant women must be treated the same as other members of society and be afforded the same right to refuse medical treatment.

II. BACKGROUND

A. Brief Overview of the Problem

The fastest growing group of Americans with reported HIV infection is women in their childbearing years.\(^1\) At the end of 1996, there were 581,429 individuals diagnosed with AIDS in the United States, with women accounting for 15% of this total and for 20% of the new cases diagnosed in 1996.\(^2\) Although researchers originally believed that pregnancy was a factor in HIV progression,\(^3\) more recent studies have indicated that pregnancy has no adverse effects on the progression of HIV.\(^4\) Instead, poor maternal and infant outcomes are related to such factors as drug use, lack of prenatal care, and an advanced HIV-disease state.\(^5\) Not

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1 Laura Hoyt, M.D., HIV Infection in Women and Children: Special Concerns in Prevention and Care, POSTGRADUATE MED., Oct. 1997, at 165.
2 See id.
4 See Hoyt, supra note 1, at 165.
5 See id. at 166.
surprisingly, among HIV-positive mothers, there is a high risk of fetal loss, and advanced maternal HIV disease can have adverse effects on the infant, regardless of whether the infant becomes infected with the disease. However, despite this risk, one study conducted in Italy indicated that 65% of 331 HIV-infected pregnant women decided to carry their pregnancy to term.

1. Perinatal Transmission

A mother can transmit HIV to her infant in a number of ways and a number of factors increase the risk of transmission. Essentially, maternal antibodies to HIV cross the placenta barrier during pregnancy. The result is that all babies born to HIV-infected mothers will test positive to the disease at birth and several months thereafter. However, a positive test does not indicate that the infant has the disease, since only one-in-four children born to HIV-positive women will be infected. Some studies suggest that perinatal transmission of HIV usually occurs during labor and delivery, when the infant is exposed to membrane ruptures and maternal blood. In addition, factors such as advanced HIV-disease, drug use during pregnancy, and maternal vitamin A deficiency have all been found to contribute to the mother-child transmission of HIV. Finally, breast-feeding increases the risk of transmission of HIV from mother to infants by about 10% to 19%.

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6 See Scarpinato, supra note 3, at 2543.
7 See Hoyt, supra note 1, at 166.
8 See Scarpinato, supra note 3, at 2543.
9 See Hoyt, supra note 1, at 166, 169.
10 Lawrence D. Frenkel, M.D. & Sunanda Gaur, M.D., Perinatal HIV Infection and AIDS, 21 CLINICS IN PERINATOLOGY 95, 97 (1994).
11 See Hoyt, supra note 1, at 171.
13 See Hoyt, supra note 1, at 169.
14 See id.
15 See id.
2. Protocol 076

Currently, HIV disease is among the leading causes of death among children in the United States, and perinatal transmission of HIV accounts for almost all new HIV infections in children. However, in February 1994, the National Institutes of Health announced a medical breakthrough: the AIDS Clinical Trials Group Protocol 076 demonstrated that AZT administered to a group of HIV-infected women during pregnancy and labor and to their newborns reduced the risk for perinatal HIV transmission by two-thirds, from about 25% to 8%. The findings of this study had a major impact on perinatal transmission of HIV in the United States and prompted the Public Health Service to recommend that health care providers counsel pregnant women regarding the benefits of voluntary HIV testing and the use of antiretroviral drugs during pregnancy. As a result, an increased use of AZT by HIV-infected pregnant women resulted in a substantial reduction in the number of perinatally acquired AIDS cases. For example, from 1984 through 1992, the estimated number of children with perinatally acquired AIDS diagnosed each year increased, then declined 43% during 1992 - 1996. However, despite these positive statistics, it must be kept in mind that the results of Protocol 076 did not prove that AZT could prevent a young child

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18 See Connor, supra note 12, at 1176; Hoyt, supra note 1, at 166; Simonds & Rogers, supra note 16, at 1514.
19 See Hoyt, supra note 1, at 166.
20 See id.
22 See Amer. Med. Assoc., supra note 17, at 257.
23 See id.
from being infected with HIV.\textsuperscript{24} The study demonstrated that AZT treatment could reduce the risk of perinatal transmission from about 25\% to 8\%.\textsuperscript{25} Thus, any assertion that a particular infant's infection with HIV could be prevented is speculative at best.

3. AZT Treatment and Maternal-Fetal Health

Generally, HIV-positive pregnant women begin taking AZT after their first trimester and continue to take it throughout the pregnancy and intravenously during labor.\textsuperscript{26} The infant then receives AZT syrup for six weeks after birth.\textsuperscript{27} Although further studies have confirmed the efficacy of AZT for reduction of perinatal transmission and have extended this efficacy to children of women with advanced disease,\textsuperscript{28} there are a number of important medical considerations surrounding the use of antiretroviral drugs in pregnancy.\textsuperscript{29} The original study (Protocol 076) indicated that the short-term effects of exposure to AZT caused reversible anemia in infants.\textsuperscript{30} However, it is largely unknown what the long-term effects of exposure to AZT will be on both newborns and their mothers.\textsuperscript{31} While it has not been shown that AZT use during pregnancy causes premature birth, fetal distress, or birth defects, few long-term studies have been conducted on its potential side effects.\textsuperscript{32} Furthermore, there are

\textsuperscript{24} ZDV therapy reduced the infection rate from 25.5\% to 8.3\%. See Connor, supra note 12, at 1176.

\textsuperscript{25} See Hoyt, supra note 1, at 166.

\textsuperscript{26} Newborn AIDS Cases Decline 43 Percent: Health Officials Say AZT Treatments Reduce Mother-Infant Infection Rate, AUSTIN AMER.-STATESMAN, Nov. 21, 1997, at A18.

\textsuperscript{27} See id.


\textsuperscript{29} See Mofenson, supra note 21, at 3-9.

\textsuperscript{30} See Hoyt, supra note 1, at 169-70.

\textsuperscript{31} See Mofenson, supra note 21, at 1.

known short-term effects to taking AZT, which include bone marrow suppression, malaise, nausea, headaches, and seizures.\textsuperscript{33} In addition, the potential long-term effects of AZT may include cancer, toxicity, and adverse effects on certain tissues and the reproductive system.\textsuperscript{34} Moreover, the use of AZT during pregnancy could be associated with the development of AZT-resistance, which could reduce the drug's therapeutic benefit for the mother.\textsuperscript{35} Additionally, it is possible that the use of AZT during one pregnancy will adversely affect the efficacy of the drug for any subsequent pregnancies.\textsuperscript{36} Finally, since only women with mildly or moderately symptomatic HIV disease with no history of antiretroviral therapy were enrolled in Protocol 076 (women who had previously undergone antiviral drug treatment were excluded from this study), some women, such as those with depressed immune systems, may not benefit from AZT treatment at all.\textsuperscript{37} Overall, the question of how or whether women should take antiretroviral drugs during pregnancy has been difficult to address because of a lack of safety and efficacy data.\textsuperscript{38} Thus, health care providers should proceed with caution when recommending AZT therapy for HIV-positive pregnant women.

B. Mandatory HIV Testing

The success of Protocol 076 has prompted some members of the medical profession, as well as state, local, and federal

\textsuperscript{33} See id. at 494.
\textsuperscript{35} See id. at 6.
\textsuperscript{37} See David Lowe, Recent Development, HIV Study Raises Ethical Concerns for the Treatment of Pregnant Women, 10 BERKELEY WOMEN'S L.J. 176, 178 (1995).
\textsuperscript{38} See Hoyt, supra note 1, at 169.
legislators to recommend the mandatory HIV testing of all pregnant women.\textsuperscript{39} There are many supporters of this proposal, particularly because the majority of people in the United States who are infected with HIV are unaware of their status, and because it is possible for an HIV-positive woman to conceive and bear a child without becoming aware of her own status or that of her child.\textsuperscript{40} As one commentator noted, "Indeed, it is indisputable that pregnant women who do not know that they are HIV-positive are unlikely to seek ZDV treatment to prevent transmission to their infants. The issue has thus been presented: Is requiring women to take a simple blood test a greater evil than increasing the risk that an infant will be born HIV-positive?"\textsuperscript{41}

The difficulty in arriving at a simple answer to this question demonstrates the numerous and troubling legal, ethical, and moral issues that are embodied in the controversy over whether to mandate HIV testing of pregnant women.

1. Federal Mandatory Testing Initiatives

In 1996, Congress addressed the issue of mandatory HIV testing of newborns and pregnant women by amending the Comprehensive AIDS Resources Emergency Act, also known as the Ryan White CARE Act.\textsuperscript{42} Essentially, the Ryan White CARE Act was enacted to provide emergency funding for cities that are disproportionately affected by the AIDS epidemic to ensure greater access to health care for poor persons infected with the HIV virus.\textsuperscript{43} The goals of the 1996 amendments are to reduce the number of HIV-infected infants by requiring all states to conform to the amended Act or risk losing available federal financing.\textsuperscript{44}

\begin{footnotes}
\item[39] See Halem, supra note 32, at 491.
\item[41] Lowe, supra note 37, at 177.
\item[44] See id. at 196-97.
\end{footnotes}
The 1996 amendments specifically required that states adopt the Centers for Disease Control (CDC) Public Health Service guidelines recommending HIV counseling and voluntary testing of all pregnant women by September 1996. However, a heavy burden is placed on states to prove that women are consenting to testing or that there has been a substantial reduction in the rate of HIV-positive newborns. The amendments provide that if the Health and Human Services Secretary determines that mandatory testing has not become routine practice, each state will have eighteen months to demonstrate one of the following or lose its Ryan White CARE Act funds: (1) a 50% reduction in the rate of new AIDS cases resulting from perinatal transmission; (2) HIV testing of at least 95% of the women who have received at least two prenatal visits prior to thirty-four weeks gestation; (3) a program of mandatory testing of all newborns whose mothers have not undergone prenatal HIV testing. As one author described the 1996 amendments, "[C]ongress has in effect invited states to impose mandatory testing measures or lose all their Ryan White funding."

2. State Mandatory Testing Initiatives

State legislatures have also considered legislation that would mandate HIV testing of all pregnant women. For example, Delaware and Tennessee require prenatal testing for HIV, and Arkansas, Florida, and Missouri allow mandatory testing for pregnant women in most cases. Rhode Island strongly encourages neonatal HIV testing, and New York requires the state to test all newborns for HIV and inform the mother of the results. The medical rationale for mandatory testing is that pregnant women with positive test results would be able to make informed choices about their pregnancy by being able to choose AZT

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45 See id. at 195-96.
47 See McGovern, supra note 36, at 471.
48 See Halem, supra note 32, at 495.
49 See id. at 495-96.
50 See id. at 496.
treatment or abortion, and that mothers of newborns could refrain from breast feeding.\textsuperscript{51}

3. The Debate Surrounding Mandatory Testing/Treatment of HIV+ Pregnant Women

The public debate surrounding mandatory HIV testing of pregnant women has been characterized as a conflict between fetal rights and women's rights, and as a conflict between protecting the public health on the one hand, and the civil liberties and privacy rights of women on the other.\textsuperscript{52} One author characterized this debate quite well:

[W]hile opponents of mandatory testing have argued that mandatory testing is bad public health policy that harms women and children, proponents have ignored these assertions and drawn attention to opponents' legal arguments, that mandatory testing violates women's privacy rights, autonomy and freedom of choice. Proponents of mandatory testing argue that civil libertarians and feminists who seek to preserve women's rights have failed to consider the public health consequences of allowing women to seek testing voluntarily. For proponents, the health of an infant and the general public is paramount and infants, as 'innocents,' have rights that are more important than the privacy rights of women. Proponents argue that a woman has a 'right to know' that she is infected with HIV, as opposed to the idea that a woman has the right to decide for herself. Further, proponents believe that protecting a woman's 'right not to know' her HIV status is a 'perversion of human rights' that injures both women and the general public health.\textsuperscript{53}

\textsuperscript{51} See id. at 496.
\textsuperscript{52} See Sinton, supra note 43, at 188.
\textsuperscript{53} Id. 188-89 (footnotes omitted).
Another justification for mandatory HIV testing of pregnant women is that since it is already performed on blood donors, military and Foreign Service personnel, federal prisoners, federal job corps applicants, and immigrants, it should be lawful to test pregnant women as well. Finally, mandatory HIV testing of pregnant women has been likened to mandatory screening for syphilis, which is still required by forty-five states.

Despite the arguments advanced for the mandatory HIV testing of pregnant women, the CDC intentionally rejected such coercive measures because it might encourage women to avoid prenatal care. In addition, organizations of experts such as the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics have opposed proposals for mandatory HIV testing regimes for pregnant women because they are potentially harmful to women and their relationship with their health care providers. These experts agree that routine counseling and voluntary testing during prenatal care has proven to be the most effective way of identifying HIV-infected women and engaging them in care. This position is also reflective of the approach taken in the first decade of the AIDS epidemic by public health officials who, out of a concern that discrimination against infected individuals was widespread, felt that it would be unjust to forcibly compel testing; the consensus was that people at risk of HIV infection are more likely to seek health care when testing is consensual and anonymity or confidentiality is assured. Moreover, it would be particularly damaging to discourage pregnant women from seeking medical care with coercive measures since HIV infection may be most prevalent in those women who already lack access to medical care. Since coercive testing creates an environment of distrust and fails to encourage a

54 See Halem, supra note 32, at 496.
55 See id. at 496-97.
57 See Mcgovern, supra note 36, at 473-74.
58 See id. at 474.
60 See id. at 201-02.
cooperative relationship between medical providers and patients,61 opponents of mandatory HIV testing of pregnant women argue that it will actually harm women and their children. Moreover, mandatory HIV testing could cause women to become generally mistrustful of medical care since improper disclosure could result in family violence, or discrimination in health care, insurance, employment, and housing.62 Finally, many commentators agree that mandatory HIV testing of pregnant women or newborns significantly infringes on a woman’s constitutionally protected rights by abridging privacy rights, violating equal protection, and opening the door to future trampling on reproductive autonomy for women.63

4. Is the Next Logical Step Mandated Treatment of HIV-positive Pregnant Women?

As one commentator noted, “If women are forced to be tested for HIV as a means of protecting their infants, it is a short and slippery slope to the conclusion that women should be forced to undergo treatment toward the same end.”64 As the movement for mandatory HIV testing of pregnant women gains momentum, certainly it is conceivable that the next step could be a movement toward mandatory AZT treatment of HIV-positive pregnant women.65 “[M]andatory testing provides a means for the government to initiate a coercive approach requiring pregnant women who test positive to begin AZT therapy.”66 However, as the next section of this paper will illustrate, such an approach raises a host of serious ethical, legal, and social issues, which typify the maternal-fetal conflict at issue.

61 See id. at 206.
62 See Mcgovern, supra note 36, at 475.
63 See generally Grizzi, supra note 40; Halem, supra note 32; Lowe, supra note 37; Mcgovern, supra note 36; Linda Farber Post, Note, Unblinded Mandatory HIV Screening of Newborns: Care or Coercion?, 16 CARDOZO L. REV. 169 (1994); Sinton, supra note 43.
64 Lowe, supra note 37, at 177.
65 “Building upon the movement for mandatory testing, mandatory treatment seems to be the next logical step.” Halem, supra note 32, at 492.
66 Grizzi, supra note 40, at 475.
III. BROAD ETHICAL, LEGAL, AND SOCIAL ISSUES

A. The Maternal-Fetal Conflict: Analytic Framework

1. Moral & Ethical Principles Surrounding a Mandated AZT Treatment Regime

The maternal-fetal relationship is a unique and delicate one. Because the fetus is physically located inside the woman, the actions of one person are literally and figuratively intertwined with those of a potential person. Although medical practitioners normally recommend treatment to benefit both the mother and fetus, the welfare of the two can be at odds. “Conceptually, the medical care of each can be approached independently, but practically, neither can be treated without affecting the other.”

Because of this unique situation, conflicts arise when the interests of the woman and the fetus clash. In such situations, there is often societal impetus to promote the well being of both the mother and the fetus, or to even choose between them. The issues surrounding mandatory HIV testing and treatment of pregnant women exemplify this situation. As one commentator noted with regard to this issue: “The political dimension to the debate over mandatory testing, mandatory treatment, or both is the fight over who gets the power to make medical decisions for pregnant women.”

Further, another author pointed out, “[g]iven the trend in medicine toward treating the fetus as a patient, it is foreseeable that women infected with HIV who decide to become pregnant will be more likely than most other pregnant women to be subject to forced medical interventions on behalf of the fetus.” However, as one author noted, “It is unethical for a physician to substitute his or her ethical determination for that of the mother where there are

68 See id.
69 Lowe, supra note 37, at 180.
potential conflicts between the mother’s interests and the infant’s or fetus’ interests.”

This paper argues that when there is discordance between the interests of the pregnant woman and the fetus she is carrying, the interests of the mother should almost always prevail.

2. Mandatory Treatment Regime: What Would it Look Like?

Governmental efforts to coerce HIV-positive pregnant women to initiate and continue AZT therapy could take a couple of different forms. First, a pregnant woman would go to her local health care provider to receive care, and while there, she would undergo an HIV test. Her physician might then inform her that she is HIV-positive and that the law requires her to submit to AZT treatment in order to prevent the transmission of HIV to her fetus. Legislation could either directly require women to initiate and continue therapy as medically indicated, with penalties inflicted upon women who refused to cooperate, or could require the physician to direct the woman to initiate therapy, with the physician facing penalties for a failure to do so. Either scenario could mean that the woman would be monitored up to five times a day during her pregnancy to ensure that she is taking the drug as directed. Therefore, aside from having the choice of whether to have the baby, the woman’s medical decisions would all be made by the state, which would essentially “police” pregnant women into compliance with its medical directives. In this way, the state would transform an ethical duty to intervene on behalf of the fetus into a legal duty by enforcing maternal compliance with a coercive, legally required treatment regime. However, this interventionist scenario, which epitomizes the maternal-fetal conflict, is unconstitutional.

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71 Lowe, supra note 37, at 181.
72 This scenario was predicted by Michael A. Grizzi. See supra note 40, at 487.
73 This scenario was also predicted by Michael A. Grizzi. See supra note 40, at 487.
74 See Halem, supra note 32, at 499.
A. Legal/Constitutional Issues

1. The Right to Privacy

The right to privacy is grounded in both constitutional doctrine and popular public discourse. In our society, notions of self-determination are very important and are reflected in both legislative and judicial reasoning. Often termed the "right to be let alone," it is frequently invoked in many contexts involving personal decision-making. The Supreme Court cases *Griswold v. Connecticut*, *Eisenstadt v. Baird*, and *Roe v. Wade* solidly define the sanctity of the individual against an overreaching government in matters involving procreative choices. Specifically, in *Griswold*, the Supreme Court articulated a substantive right to the privacy of personal decision making by finding a "right to privacy" in the "penumbras" of the First, Third, Fourth, Fifth, and Ninth Amendments. The Court recognized that the right to privacy as autonomy is violated when the individual is deprived of the right of personal decision-making and action.

This individual right to privacy in matters concerning personal dignity and autonomy was more recently affirmed by the Supreme Court in *Planned Parenthood v. Casey*. In *Casey*, the Court stated, "These matters, involving the most intimate and personal choices a person can make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected

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75 For example, in *Whalen v. Roe*, 429 U.S. 589 (1977), the Supreme Court upheld a statute requiring copies of prescriptions for certain drugs and recognized an "interest in independence in making certain kinds of important decisions." *Id.* at 599.

76 This concept was first articulated by Justice Brandeis in his dissent in *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting).

77 381 U.S. 479 (1965) (recognizing a right to marital privacy).

78 405 U.S. 438 (1972) (expanding the right to privacy per *Griswold* to include individual procreative privacy rights).

79 410 U.S. 113 (1973) (holding that the right of personal privacy includes a woman's right to have an abortion).

80 *Griswold*, 381 U.S. at 479 (1965).

81 See *id*.

by the Fourteenth Amendment." The Court has interpreted these "matters" to include marriage, procreation, contraception, family relationships, child rearing, and education, where the personal privacy rights of the individual in making important decisions are paramount to state interference. Furthermore, any state action that infringes upon this fundamental right to privacy is subjected to the most exacting level of scrutiny; namely, the state has to show that the challenged policy is justified by a compelling state interest and that the means used to achieve that interest are narrowly tailored.

2. Informed Consent

Particularly in the health care setting, the right to privacy underscores the priority given to the values and wishes of the individual patient. For example, in Whalen v. Roe, the Supreme Court recognized a right to informational privacy and a right to privacy in medical decision-making. Intertwined with this notion of privacy in health care decision-making is the concept of informed consent, which reflects the belief that competent adults are entitled to refuse medical intervention. This doctrine "has developed out of strong judicial deference toward individual autonomy, reflecting a belief that an individual has a right to be free from nonconsensual interference with his or her person, and a basic moral principle that it is wrong to force another to act against his or her will." Thus, informed consent dictates that all adult patients have the right to accept or reject medical recommendations based on their own personal priorities and values. In fact, at

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83 Id. at 851.
85 See, e.g., id. at 686.
87 See id. at 598-99 (1977).
common law, a refusal to recognize this right could result in physician liability for assault on the patient. 90

3. Substantive Due Process

"[W]hen considering forced medical treatment of pregnant women, state courts have typically looked to two types of Supreme Court substantive due process precedent: cases analyzing the right to refuse medical treatment, and those examining reproductive rights." 91 Generally, in order to prevail on a substantive due process argument, a plaintiff must prove that the state action infringes on an interest protected by the Due Process Clause of the Fourteenth Amendment: a fundamental right or a liberty interest. 92 If a right is fundamental, the state regulation will be subject to the most exacting scrutiny: the state will have to produce a compelling interest for the infringement on the fundamental right and demonstrate that the regulation is narrowly tailored to achieve that interest. 93 If a liberty interest is found, the test is not strict—the type of judicial scrutiny offered is usually the undue burden standard that was advanced in Planned Parenthood v. Casey. 94 This test looks at whether the state’s action has created an undue burden on the individual. 95 The state’s action will be upheld if it is reasonably related to an important and legitimate or substantial government interest. 96

4. The Right to Refuse Medical Treatment

The right to reject medical treatment was first articulated by the Supreme Court in Cruzan v. Director, Missouri Dep’t. of Health, 97 where the Court recognized an individual’s Fourteenth

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90 See id. at 93.
91 Halem, supra note 32, at 502.
92 See id. at 503.
94 See id.
95 See id. at 877-78.
96 See id., at 877-79.
Amendment liberty interest in refusing medical treatment. Although the Court in Cruzan did not recognize that the right to refuse medical treatment is a fundamental right, it clearly set forth the notion that "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment." However, this liberty interest is not absolute: the Court in Cruzan held that the lawfulness of the state action "must be determined by balancing the [individual's] liberty interests against the relevant state interests." Thus, because the state has a legitimate interest in the preservation of human life, it is unclear under what circumstances a patient's desire to refuse unwanted procedures may be outweighed by the interests advanced by the state. While the Cruzan facts are different from compelled AZT treatment of pregnant women, Cruzan's holding strongly suggests that an HIV-positive pregnant woman could refuse AZT therapy.

However, it is also necessary to consider the Cruzan balancing test, where the legitimacy of the state action must be determined by balancing the individual's liberty interests against the relevant state interests. The relevant state interests in the protection of the public health are significant: the state has a legitimate interest in forced medication which will help save the lives of innocent children and help eradicate the spread of AIDS. However, a woman has a powerful interest in preserving her bodily integrity and controlling her reproductive destiny. Therefore, in balancing all the relevant interests, one could conclude that if a state is allowed to justify an invasion of women's rights, it opens the door for a further invasion of women's rights with future health concerns. Thus, in this instance, a woman's right to control her own body far outweighs the state's interest in the public health.

5. Reproductive Rights Analysis

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98 See id.
99 Id. at 262.
100 Id. at 279 (quoting Youngberg v. Romeo, 457 U.S. 307 (1982)).
101 See id. at 280.
102 See id. at 279.
103 See id.
Reproductive rights analysis has frequently been used to resolve cases involving a pregnant woman’s right to refuse various forms of medical treatment.\textsuperscript{104} Often, the consistent issue in such cases is whether the fetus has rights.\textsuperscript{105}

Although \textit{Roe v. Wade} dealt with a woman’s right to privacy in the abortion context,\textsuperscript{106} state courts have often cited dicta in the case to justify an intrusion on pregnant women’s medical decision making.\textsuperscript{107} To assert support for compulsory medical treatment of pregnant women, state courts seize upon the language in \textit{Roe} that declares that the state has a compelling interest in protecting the potentiality of human life at the point of viability.\textsuperscript{108} However, while \textit{Roe} acknowledged the state’s compelling interest in the fetus at viability, it placed a limit on the exercise of this interest by permitting a woman to obtain an abortion even after fetal viability if “it is necessary to preserve [her] life or health.”\textsuperscript{109} Thus, it is inaccurate to maintain that \textit{Roe} grants the state unlimited discretion in protecting a viable fetus. Moreover, in \textit{Doe v. Bolton}\textsuperscript{110} and \textit{United States v. Vuitch},\textsuperscript{111} the Court upheld statutes that allowed the physician to consider all attendant circumstances that might be relevant to the well being of the mother and concluded that the health of the pregnant woman must be broadly defined.\textsuperscript{112} In addition, in \textit{Colautti v. Franklin},\textsuperscript{113} the Court struck down a Pennsylvania abortion statute because it failed to clearly specify that the woman’s health must always prevail over the fetus’ life and health when they conflict.\textsuperscript{114} Similarly, in \textit{Thornburgh v. American College of Obstetricians and Gynecologists},\textsuperscript{115} the Court

\begin{thebibliography}{99}
\bibitem{104} See Nelson & Milliken, \textit{supra} note 67, at 1065.
\bibitem{105} See Halem, \textit{supra} note 32, at 516.
\bibitem{107} See Halem, \textit{supra} note 32, at 516.
\bibitem{108} See \textit{id}.
\bibitem{110} 410 U.S. 179 (1973).
\bibitem{111} 402 U.S. 62 (1971).
\bibitem{112} See \textit{id}.; \textit{Bolton}, 410 U.S. 179.
\bibitem{113} 439 U.S. 379 (1979).
\bibitem{114} See \textit{id}.
\end{thebibliography}
struck down another Pennsylvania statute because it required a
woman to bear an increased medical risk to save her viable fetus,
thus violating the ruling in Colautti which forbid statutes that
require trade-offs between a woman’s health and that of her
fetus.116 These cases solidly support the notion that when the
health interests of a woman and her fetus conflict, a state is
constitutionally bound to place the woman’s interests above the
fetus. Hence, it would be impermissible for a state to force a
pregnant woman to undergo medical treatment for the benefit of
the fetus if that treatment endangers her life or health in any way.
Therefore, in light of some of the serious medical concerns that
AZT treatment may pose to pregnant women, it is likely that
compelled AZT treatment of HIV-positive pregnant women would
not pass constitutional muster. Finally, although the most recent
Supreme Court abortion case, Planned Parenthood v. Casey,
limited the right to an abortion as established in Roe and advanced
the undue burden standard, it upheld a woman’s “ultimate control
over her destiny and her body”117

All of these reproductive rights cases suggest that although
there is a state interest in a developing fetus, a woman who chooses
to continue her pregnancy and not abort does not give up her right
to control her own body.

6. Equal Protection

HIV-positive pregnant women could also challenge a
mandatory AZT treatment regime under the Equal Protection
clause, in that the regime constitutes pregnancy or sex
discrimination.118 However, the Supreme Court has only

116 See id.
118 The Fifth Amendment (covering federal government activity) states that
"No person shall be ... deprived of life, liberty, or property, without due process
of law." U.S. CONST. amend. V. The Fourteenth Amendment (relating to state
involvement) states,
No state shall make or enforce any law which shall abridge the
privileges or immunities of citizens of the United States; nor
shall any State deprive any person of life, liberty, or property,
recognized that discrimination based on pregnancy is prohibited under the Equal Protection Clause in the employment context.\textsuperscript{119} If a court found that pregnancy discrimination is per se sex discrimination, then the appropriate level of scrutiny is the intermediate level.\textsuperscript{120} Under this standard, the policy or statute will be found constitutional if the state establishes that the regulation serves an important government objective and the regulation is substantially related to that end.\textsuperscript{121} Therefore, a state seeking to compel a pregnant woman to undergo AZT treatment would have to show that such treatment would serve the important government objective of preventing children from being born with HIV and that AZT therapy is substantially related to this objective. Women could counter this argument by proving that the state's objective could be better achieved through less intrusive means, and that the program of mandatory treatment is not sufficiently tailored to fulfill the state's goals.

On the other hand, if the court finds that singling out pregnant women for treatment is not per se sex discrimination, then the rational basis standard of review would be applied.\textsuperscript{122} This standard of review represents the minimum level of inquiry and requires only that the regulation have a rational relationship to the state's purpose.\textsuperscript{123} Traditionally, this standard has generally been an easy obstacle for the state to overcome.\textsuperscript{124} However, as \textit{UAW v. Johnson Controls, Inc.}\textsuperscript{125} held, employment discrimination on the basis of pregnancy or the ability to become pregnant is sex

\begin{itemize}
  \item without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.
  \item U.S. CONST. amend. XIV.
\end{itemize}

\textsuperscript{120} See \textit{Craig v. Boren}, 429 U.S. 190, 197 (1976) (stating that "classifications by gender must serve important governmental objectives and must be substantially related to achievement of those objectives").
\textsuperscript{121} See \textit{id}.
\textsuperscript{122} See \textit{Geduldig v. Aiello}, 410 U.S. 484 (1974) (finding that excluding pregnancy-related disabilities from a state-sponsored disability program was not sex discrimination).
\textsuperscript{124} See Halem, \textit{supra} note 32, at 525.
discrimination. Moreover, *Nashville Gas Co. v. Satty* found that an employer’s policy that denied women their accumulated seniority when returning from pregnancy violated Title VII of the Civil Rights Act of 1964. Although this case did not deal directly with the Equal Protection Clause, its reasoning is quite persuasive: namely, the *Satty* court held that an employer who penalized women because they were pregnant should be held to the intermediate level of scrutiny. This is quite logical since penalizing a woman for her pregnancy status certainly amounts to sex discrimination.

Therefore, applying this reasoning, since a mandatory treatment regime would penalize pregnant women for being pregnant by forcing them to bear the risk of the side effects of AZT and abridging their right to bodily autonomy, the intermediate level of scrutiny should apply. Subsequently, women could most likely prove that the state’s objective of reducing the risk that children will be born with HIV could be better achieved through less intrusive means, and that the program of mandatory treatment is not sufficiently tailored to fulfill the state’s goals.

7. The State’s Role in Protecting the Public Health

Although individual privacy rights are paramount in our society, the state can interfere with these rights by invoking its police powers to protect the public health, safety, and welfare. For example, in *Jacobson v. Massachusetts*, the Supreme Court upheld a statute mandating vaccination even though it infringed upon individual rights. While the Court in *Jacobson* held that states may enact quarantine laws to preserve the public health, it

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126 See id.
128 See id.
129 See id.
131 See id.
132 See id.
also held that the state must not act arbitrarily but must have a "real or substantial relation" to a public health objective.\footnote{\textit{Id}. at 31.}

One of the well-known uses of public health laws related to the treatment of individuals with tuberculosis. Today, about 40 states have public health laws that require the quarantine of infected individuals.\footnote{See Lawrence O. Gostin, \textit{Controlling the Resurgent Tuberculosis Epidemic: A 50-State Survey of Tuberculosis Statutes and Proposals for Reform}, 269 JAMA 255 (1993).} Thus, in order to safeguard the public health, the state may require that individuals give up certain liberty interests. For example, in \textit{In re Halko}\footnote{54 Cal. Rptr. 661 (Cal. Ct. App. 1966).} the California Court of Appeals ruled that the confinement of people with tuberculosis to a public hospital did not violate their constitutional rights.\footnote{See \textit{id}.}

Similarly, in \textit{City of N.Y. v. New Saint Mark's Bath},\footnote{497 N.Y.S.2d 979 (N.Y. Sup. Ct. 1986).} the court invoked \textit{Jacobson} and upheld a restrictive law aimed at stemming HIV transmission by shutting down gay bathhouses.\footnote{See \textit{id}.}

In light of these cases, states could claim an interest in the public health by compelling HIV-positive pregnant women to be treated with AZT in order to decrease the number of infectious carriers of a recognized fatal disease. However, given the invasiveness and the potential dangers of AZT treatment to both mothers and infants, it is unlikely that a mandated AZT treatment regime could be justified. Moreover, as one commentator noted, "[c]ourts have allowed public health concerns to trump individual liberties to an extent equivalent to a program of forced AZT treatment only when they were confronted with diseases far more contagious than AIDS. Precedent does not support such an extensive infringement of women's interests on public health grounds where the risk of transmission is so limited."\footnote{Halem, \textit{supra} note 32, at 512.}

8. State Parens Patriae Power

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\item \footnote{\textit{Id}. at 31.}
\item \footnote{See Lawrence O. Gostin, \textit{Controlling the Resurgent Tuberculosis Epidemic: A 50-State Survey of Tuberculosis Statutes and Proposals for Reform}, 269 JAMA 255 (1993).}
\item \footnote{54 Cal. Rptr. 661 (Cal. Ct. App. 1966).}
\item \footnote{See \textit{id}.}
\item \footnote{497 N.Y.S.2d 979 (N.Y. Sup. Ct. 1986).}
\item \footnote{See \textit{id}.}
\item \footnote{Halem, \textit{supra} note 32, at 512.}
\end{itemize}
On occasion, the state may even intervene into the constitutionally protected rights of parents to bring up their children in the name of public health.\textsuperscript{140} For example, in \textit{Prince v. Massachusetts},\textsuperscript{141} the Supreme Court affirmed the right of the state to invoke its parens patriae power.\textsuperscript{142} In \textit{Prince}, the Court held that a State has the power to intervene in family affairs to protect the welfare of the children, even if doing so infringes on the parent’s right to practice their religion freely.\textsuperscript{143} Finding that a parent’s interest in keeping a young child out on the street distributing religious literature threatened the health and well-being of the child, the Court found: “The right of parents to rear their children in accordance with their personal and religious beliefs gives way when the health or safety of children is threatened or when parental conduct poses some substantial threat to public safety.”\textsuperscript{144} Thus, under its parens patriae power, a state could attempt to override a pregnant woman’s decision to refuse AZT treatment since such treatment could potentially save the life of her fetus. However, although state courts have relied on the Supreme Court’s decision in \textit{Prince} to override a parent’s refusal to consent to medical treatment,\textsuperscript{145} one commentator noted,

It would be difficult for a court to conclude that the child’s best interest is clearly served by treatment with AZT therapy as opposed to non-treatment. Because the risk of HIV infection to the child, absent antiviral treatment is approximately one in four, a decision by a mother to ‘play the odds’ cannot clearly be characterized as not in the child’s best interest.\textsuperscript{146}

\textsuperscript{141} See id.
\textsuperscript{142} See id.
\textsuperscript{143} See id. at 166-67.
\textsuperscript{144} Id. at 166.
\textsuperscript{145} See, e.g., \textit{In re Cabrera}, 552 A.2d 1114 (Pa. Super. Ct. 1989) (holding that \textit{Prince} grants the state the ability to act to promote interests related to a child’s well-being).
\textsuperscript{146} Gruzzi, \textit{supra} note 40, at 489-90.
In addition, the courts are in conflict as to whether the state can override a parent’s refusal to consent to medical treatment for a child when the danger to the child’s health is not imminent or the proposed treatment is not likely to cure the underlying condition.\(^\text{147}\) For example, in *In re Green*,\(^\text{148}\) where a mother refused to permit blood transfusions for her son during an operation to correct a spinal deformity, which may have shortened his life span, the court declined to override the mother’s withholding of consent.\(^\text{149}\) In contrast, in *In re Cabrera*, the court permitted the override of a parental refusal to provide consent to blood transfusions where, without such treatment, the illness had a 16-18% chance of causing death within a year and a 70% likelihood of severely disabling the child.\(^\text{150}\)

While disagreement among the courts over when a state can override a parent’s refusal to consent to medical treatment for a child makes it difficult to predict how a court would rule on an HIV-positive pregnant woman’s refusal to undergo AZT treatment, one commentator noted, “[A]ZT’s being unnecessary to prevent HIV transmission in 75% of cases means that the danger to the fetus is less imminent than required by the standards that the *In re Green* and *In re Cabrera* courts established.”\(^\text{151}\) Moreover, there is a serious flaw with the argument that a state may rely upon its parens patriae power to override an HIV-positive pregnant woman’s decision to forego medical treatment. The cited parens patriae cases, which deal with a child, and a mandatory treatment regime for pregnant women, which deals with a fetus, are distinguishable scenarios. “The rationale for the doctrine--that the state interest in protecting a child’s life may outweigh, in extraordinary circumstances, the parent’s right to withhold consent for medical treatment of that child--may not be mechanically asserted to justify an override in the context of pregnancy.”\(^\text{152}\)


\(^{148}\) See id.


\(^{150}\) See *Cabrera*, 552 A.2d at 1114.

\(^{151}\) Haler, supra note 32, at 515.

\(^{152}\) Grizzi, supra note 40, at 491.
Generally, a fetus has no rights under our current legal system until it is born alive. Moreover, it is impossible to separate the right to withhold consent to the treatment of the fetus from the right of the pregnant woman to withhold treatment for herself. And, given the invasiveness and the potential dangers of AZT treatment to both mothers and infants, it is unlikely that a mandated AZT treatment regime could be justified using the parens patriae doctrine.

9. State Court Cases

Studies have shown that physicians have been willing to seek court orders compelling pregnant women to undergo treatment for the sake of their fetuses. Generally, when courts consider the forced medical treatment of pregnant women, the degree of intrusiveness of the procedure is evaluated and weighed with the state's interest in healthy babies. State courts have intervened on behalf of a fetus to compel women to undergo blood transfusions, take medications such as insulin, and submit to cesarean sections. Generally, the less intrusive the procedure, the more likely the state will prevail. Courts have commonly considered forced blood transfusions to be small enough invasions.

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154 See, e.g., Veronika E.B. Kolder, M.D. et al., Court Ordered Obstetrical Interventions, 316 NEW ENG. J. MED. 1192 (1987).

155 See Halem, supra note 32, at 506.


159 See Halem, supra note 32, at 506.
on pregnant women to justify their use.\textsuperscript{160} For example, in \textit{InRe Jamaica Hospital},\textsuperscript{161} the court found that the state interest in protecting the life of the fetus warranted a forced blood transfusion that was necessary to stabilize a woman in her eighteenth week of pregnancy and save the life of her unborn child.\textsuperscript{162} To date, there have been only three appellate court decisions involving forced cesarean sections upon non-consenting pregnant women, and one involving a forced blood transfusion.\textsuperscript{163} For example, in \textit{In re A.C.},\textsuperscript{164} the District of Columbia Court of Appeals decided the legality of a lower court’s order that a terminally ill woman who was unable to state her wishes clearly must undergo a cesarean section to save her fetus.\textsuperscript{165} Finding that in virtually all instances a woman’s right to refuse invasive medical treatment outweighs the state’s interest in the fetus, the lower court’s decision was subsequently vacated upon a showing that neither the woman’s rights nor her decisional competence had been correctly evaluated because she had been so heavily medicated.\textsuperscript{166} Similarly, in \textit{In re Baby Boy Doe},\textsuperscript{167} the Illinois Appellate Court agreed with the reasoning in \textit{In re A.C.} when it held that “a woman’s competent choice to refuse medical treatment as invasive as a cesarean section during pregnancy must be honored, even in circumstances where the choice may be harmful to the fetus.”\textsuperscript{168} However, in \textit{Jefferson v. Griffin Spalding County Hosp. Auth.},\textsuperscript{169} the court ordered a woman in her thirty-ninth week of pregnancy to undergo a cesarean section where it was necessary to save the life of the fetus and the doctors believed that the mother would have an almost 100%
chance of surviving the procedure. However, even though there was a competent refusal of consent, the Jefferson ruling can be distinguished from In re A.C. and In re Baby Boy Doe because the evidence in Jefferson showed that performance of the cesarean section was clearly in the medical interests of both the mother and the fetus.

In light of these state court cases, a court could conceivably find forced AZT treatment acceptable since it only involves swallowing a pill five times a day and is therefore fairly noninvasive. However, since AZT has both known and unknown significant side effects, there may be powerful medical reasons for a pregnant woman to decline such treatment. Therefore, by allowing a state to mandate AZT treatment for pregnant women, the rights and health of the mother may be compromised in favor of the health of the fetus. Particularly because AZT treatment could seriously endanger the mother’s health, mandated treatment regimes would likely be found unjustified. Moreover, “The indications that AZT use may cause harm to otherwise healthy infants and may precipitate severe illness and death more rapidly in HIV-positive infants make it clear that the potential benefits of AZT come with a high cost to some fetuses, even if it prevents HIV infection in others.” Thus, it is not even certain that the unborn child will safely benefit from AZT treatment in the long run.

V. CONCLUSION

As this paper illustrates, mandatory AZT treatment of HIV-positive pregnant women raises a host of legal, political, medical, and public health policy issues. State implementation of such a regime would have severe detrimental effects on the rights of women. Such a policy would in effect place greater weight on the interests of the state and the fetus than the pregnant woman and

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170 See id.
171 See discussion infra Part III.
172 See discussion infra Part II.
173 See discussion infra Part II.
174 McGovern, supra note 36, at 469.
would create a legal atmosphere that could lead to further restrictions on women's rights. Further, such a coercive treatment regime could fail to encourage a cooperative relationship between physicians and their patients and would likely lead to an environment of distrust between the pregnant woman and her doctor. This could be particularly damaging because most women who are infected with HIV already lack access to care. As a result, there would likely be a "chilling" effect on pregnant women seeking health care. Finally, a mandatory AZT treatment regime runs afoul of basic constitutional protections including the right to privacy, equal protection, and the right to informed consent. Thus, instead of considering a mandatory approach to health care, states should consider offering voluntary, comprehensive, and confidential health care support services for HIV-positive pregnant women. For example, at Harlem Hospital in New York City, more than 90% of pregnant women and postpartum mothers consented to testing where HIV related counseling was offered universally, was voluntary and confidential, and was linked to available care and services. Therefore, if a flexible and comprehensive public health approach to the problem of pediatric AIDS existed, our society might truly be able to assist those who are plagued with such a devastating disease.

175 See discussion infra Part II.
176 Similar results have been achieved under similar conditions at Cook County Hospital in Chicago, Johns Hopkins in Baltimore, and Grady Hospital in Atlanta. See Baldacci, supra note 28.