Control of Childbearing by HIV-Positive Women: Some Responses to Emerging Legal Policies

Suzanne Sangree
New York City Commission on Human Rights

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Control of Childbearing by HIV-Positive Women: Some Responses to Emerging Legal Policies

SUZANNE SANGREE*

Introduction........................................................................................................311
I. The Historical Context of Controlling Women's Childbearing........................................319
   A. Early Twentieth Century Eugenics..........................................................320
   B. Post-Eugenics Reproductive Coercion..................................................323
   C. "Fetal Protection" as a Form of Control..................................................326
II. Outlawing Pregnancy For HIV-Positive Women..................................................333
   A. The Experts Speak..................................................................................335
   B. Expert Opinion Reflects and Influences Medical Practice........................341
   C. Criminal Transmission Statutes: Do They Outlaw Childbearing for HIV-Positive Women?...........................................................344
   D. Public Health Law and Control of Childbearing.....................................356
   E. Summary.................................................................................................361
III. The Right to Informed Consent to Medical Care..................................................362
   A. Overview of Informed Consent Law.......................................................364
   B. The Knowledge Requirement Prohibits Coercion....................................365
   C. The Requirement of Voluntariness........................................................368
   D. The Requirement of Competence..........................................................370

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E. The Doctrine of Override of Parental Refusal to Consent .................................................. 374
F. Public Health and the State Police Power ................................................................. 381
  1. The History of Public Health Police Power ....................................................... 383
  2. Civil Commitment Substantive and Procedural Protections .................................. 389
  4. Summary ....................................................................................................... 394
G. Conclusion ........................................................................................................ 394

IV. The Fourteenth Amendment Protects Childbearing By HIV-Positive Women .................. 395
A. The Right to Bear Children Continues to Be Fundamental Post Casey .................... 398
  1. The Doctrine of Government Allocation of Funds to Encourage Childbearing .............. 402
  2. No State Interest Justifies Outlawing HIV Childbearing ......................................... 404
  3. Constitutional Protections of Childbearing Rights Are Not Diminished by Disability .......... 407
B. Equal Protection Prohibits Outlawing Childbearing by HIV-Positive Women ............... 410
C. Mandatory HIV Antibody Testing of Pregnant and Post-Partum Women .................... 414
  1. Forced Disclosure of HIV Status Constitutes Significant Interference with Procreation ........ 418
  2. State Interests and Compulsory Disclosure and Reporting ........................................ 420
D. Summary ........................................................................................................ 423

V. Control of Childbearing and the Fourth Amendment .................................................. 424
A. The Fourth Amendment Imposes Substantive Limits on Bodily Intrusions ................. 425
B. Forced Sterilization, Abortion, or Contraception Should Never Pass Judicial Review ........ 428
C. No State Interest Outweighs Severe Intrusions ....................................................... 432
D. The Fourth Amendment Prohibits Mandatory HIV-Testing .......................................... 435
E. Forced Testing and Probable Cause ........................................................................ 438
F. Summary ........................................................................................................ 440

VI. Conclusion ........................................................................................................ 441
Experience should teach us to be most on our guard to protect liberty when the government's purposes are beneficent. . . . The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding.¹

INTRODUCTION

The human immunodeficiency virus (HIV)² can be transmitted from a pregnant woman to her fetus during pregnancy and childbirth. In fact, up to one-third of all children born to HIV-positive women will themselves be infected.³ Currently, in the United States, the incidence of AIDS by population group is growing fastest among women, and as a direct result, is also rapidly accelerating among children.⁴ Alarmed by the increase in AIDS among children, some sectors of the public and, more significantly, a vocal minority of influential medical experts,⁵ are calling for measures to prevent perinatal transmission. Among the recommended measures are some which intrude upon the rights of women in ways which are at the least inappropriate, and are most likely unconstitutional. Such measures include mandatory HIV testing of all pregnant women and directive counseling or compulsion of HIV-positive women to “postpone pregnancy” by accepting contraception,⁶ abortion, or steriliza-

¹. Olmstead v. United States, 277 U.S. 438, 479 (1928) (Brandeis, J., dissenting) (footnote omitted).

². To receive a diagnosis of Acquired Immune Deficiency Syndrome (AIDS), one must be infected with HIV and have a T-Cell count of less than 200 and/or exhibit one of a list of symptoms determined by the federal Centers for Disease Control (CDC). See Centers for Disease Control, 1993 Revised Classification System for HIV Infection and Expanded AIDS Surveillance Case Definition for AIDS Among Adolescents and Adults, 41(RR-17) MORBIDITY & MORTALITY WKLY REP. 1 (Dec. 18, 1992).

³. There are conflicting data on the rate of perinatal transmission. See infra note 94. Briefly, early studies indicated relatively high transmission rates, generally 30% to 50%. As more data has been collected, this figure has declined. Current estimates indicate that the rate is 25% to 30%, although some studies of isolated groups have yielded rates as low as 12.9%. Id. For the purposes of this Article, the actual rate is important only in relation to weighing any state interest associated with the risk of transmission. This paper will therefore utilize a one-third transmission rate, referred to interchangeably as a 30% transmission rate, which is slightly higher than the most widely accepted rate. 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 29 (Ruth R. Faden et al. eds., 1991).


⁶. An HIV-positive woman could be ordered to ingest birth control pills, to utilize
In addition, prosecutors and public health authorities have begun to consider applying civil and criminal HIV containment laws against HIV-positive women. Containment laws generally target behaviors presenting risk of disease transmission. Thus, the mere fact of pregnancy might be used as evidence of either risking transmission to the fetus, or of exposing the impregnating male to the virus.

This Article presents an overview of state laws, enacted as of April 19, 1993, that have the potential to be applied to HIV-positive women. Although most of these laws have not been so applied, the danger that some may be directed toward pregnant women is very real. In fact, one such law has already been used against a pregnant, HIV-positive woman. This Article is intended as a preemptive

condoms or a diaphragm in conjunction with contraceptive cream or jelly, or to utilize contraceptive sponges. In fact, some state health departments have already employed these methods against HIV-positive women. E.g., State v. McLellan, No. 92 CR 05684 (Gen. Ct. Justice Cumberland County, N.C. Mar. 25, 1992), aff'd, No. 92 CR 05684 (N.C. Super. Ct. Mar. 17, 1993). An HIV-positive woman could also simply be ordered not to become pregnant. The possibility that a court would issue such an order is very real. In analogous situations, where courts have desired to prevent individuals from bearing children out of wedlock, many courts have ordered women not to become pregnant unless they are married. See, e.g., People v. Dominquez, 64 Cal. Rptr. 290 (Cal. Ct. App. 1987) (invalidating condition of probation imposed by trial court that defendant refrain from becoming pregnant unless she first married as not reasonably related to conviction or to deterring future criminality); Rodriguez v. State, 378 So. 2d 7 (Fla. Dist. Ct. App. 1979) (invalidating, as not reasonably related to rehabilitation, conditions to ten year probation on a robbery plea, that defendant refrain from becoming pregnant, and marry only with the court's permission); Thomas v. State, 519 So. 2d 1113 (Fla. Dist. Ct. App. 1988) (striking condition of probation on conviction for grand theft and battery that defendant not become pregnant unless she married, finding condition "grossly erroneous" as it related to noncriminal conduct and was unrelated to rehabilitation); State v. Norman, 484 So. 2d 952 (La. Ct. App. 1986) (invalidating condition of forgery conviction probation that defendant "not give birth to any children out of wedlock" as unrelated to criminal rehabilitation and forbidding noncriminal conduct); see also Wiggins v. State, 386 So. 2d 46 (Fla. Dist. Ct. App. 1980) (invalidating condition on forgery and stealing probation that defendants refrain from out-of-wedlock sexual intercourse as not reasonably related to rehabilitation); State v. Mosburg, 768 P.2d 313 (Kan. Ct. App. 1989) (striking condition of probation on a child abandonment charge that defendant refrain from becoming pregnant because the condition unduly intrudes upon right to childbearing); People v. Pointer, 199 Cal. Rptr. 357 (Cal. Ct. App. 1984) (invalidating a condition of probation on conviction for child abuse that defendant refrain from becoming pregnant because it infringed upon a fundamental right and was not the least restrictive way of protecting potential fetuses and children; criminal sanctions on pregnancy would discourage prenatal care); State v. Livingston, 372 N.E.2d 1335 (Ohio 1976) (striking as unconstitutional infringement of right to childbearing a condition of probation for conviction of felony child abuse that defendant refrain from giving birth for five years).

strike against any escalation in the use of the law to coerce HIV-positive women in their childbearing decisions. This Article also reviews evidence that when treating HIV-positive women, health care professionals may be relaxing the standards of informed consent traditionally required for reproductive health care delivery, and argues that such relaxation is unjustified and improper.

Although the goal of preventing pediatric AIDS is laudable, policies advocating involuntary control of childbearing by HIV-positive women are modern examples of the historical illegal coercion of childbearing choices by women who are poor, disabled, and/or of color. Such policies contravene constitutional and medical consent law. Additionally, they are unlikely to succeed in their preventive goals.

Admittedly, control measures may often seem necessary and compelling. Media images of HIV-infected babies garner practically universal sympathy; these children suffer intensely during their short lives and their mothers frequently appear morally oblivious. Unfortunately, the alternative to oppressive control measures, effective preventive education, has been virtually paralyzed by the political force of conservative sexual views. Meanwhile, the incidence of

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8. There appear to be two types of children born with HIV infection. Some children are very sick at birth and die before they reach the age of 15 months. Children in the second group, however, become ill later and live longer, often into their eighth year of life. Written comments to the Author from Sarmistha H. Hauger, M.D., Columbia University Medical Center (Oct. 27, 1992) (on file with the Buffalo Law Review).

9. HIV infected mothers are frequently condemned as immoral for choosing to bear children who are at risk for developing HIV themselves. See, e.g., John D. Arras, AIDS and Reproductive Decisions: Having Children in Fear and Trembling, 68 MILBANK Q. 353, 370-71 (1990) (expressing the opinion that it is "seriously irresponsible and wrong" to have a child, if one is a homeless drug-addicted woman whose HIV disease is quite advanced, and who has no family support structure); Judith Grad, Ethics and AIDS, in HIV POSITIVE PERSPECTIVES ON COUNSELING 37, 39 (Margot Tallmer et al. eds., 1991) ("Some people believe, as I do, that it is morally wrong to risk bearing a child who has so high a likelihood of living a short life that will end in excruciating pain."); A.M. Rosenthal, Suffer Little Children, N.Y. TIMES, June 16, 1989, at A27 (unsympathetically reporting that an mother had second AIDS baby despite being warned after her first AIDS baby that there was a 50 to 70% chance that any subsequent child she chose to have would also be born with the AIDS virus).

10. For example, historically, the CDC has restricted AIDS educational programs and prevented use of many of the materials shown to be most effective among gay men and intravenous drug users. In 1986, the CDC announced an AIDS education funding program disallowing funds for programs which utilized materials which would be reasonably judged to be offensive to most educated adults outside the intended audience. 51 Fed. Reg. 3427, 3431 (1986). However, these regulations were initially quite successfully challenged by one AIDS educator. See Gay Men's Health Crisis v. Sullivan, 733 F. Supp. 619 (S.D.N.Y. 1989). Interim revisions by the CDC provided that the CDC Program Review Panel could approve potentially offensive material if it determined that the probable "effectiveness in communicating an important HIV prevention message" outweighed the possible offensiveness. 55 Fed. Reg. 23,414, 23,416 (1990). Subsequently,
HIV infection in babies grows at an alarming rate. However, not all babies born with HIV antibodies actually have HIV themselves—only one third of these children will develop HIV infection. Moreover, because the vast majority of HIV-infected women are poor, HIV-positive babies present a tremendous economic burden to the state.

even the modified regulations were ultimately invalidated as beyond the agency's scope and as unconstitutionally vague, and thus violative of the First Amendment. Gay Men's Health Crisis v. Sullivan, 792 F. Supp. 278 (S.D.N.Y. 1992). In response to the 1992 Southern District Court order, the restrictions were further revised and made more liberal, but still require emphasis on abstinence, monogamous sexual relationships, and the danger of intravenous drug use and promiscuity. 57 Fed. Reg. 26,742 (1992).

Commentators have noted that the public response to AIDS would have been more compassionate and effective had the disease not first infected groups stigmatized by conservative morality. See, e.g., David E. Rogers, Report Card on Our National Response to the AIDS Epidemic—Some A's, Too Many D's, 82 AM. J. PUB. HEALTH 522, 523 (1992); Ronald Bayer, AIDS Privacy, and Responsibility, DAEDALUS, Summer 1989, at 79, 92-94 [hereinafter Bayer, AIDS]; Ronald Bayer, The Kid Who Has It, 251 NATION 324 (1989) (book review) [hereinafter Bayer, Kid] ("Thus the historical accident that HIV first established itself among gay men and intravenous drug users in the United States marked the epidemic's course not only in terms of who would bear the burden of disease and death but of the social reaction it would engender.").

It has also been asserted that the spread of AIDS to other groups makes the control of the disease more urgent. William Bennet has stated:

Already AIDS has spread from its primary risk groups, homosexuals and intravenous drug users, to heterosexuals; now it is attacking the unborn and the newborn as well. Furthermore, as the disease spreads, children will become increasingly at risk. This danger to our children makes it all the more urgent that we do everything in our power to protect the uninfected members of our society.


11. One study, concluded in September of 1990, estimated that nationally, 1800 newborns acquired HIV infection perinatally over a 12-month period. Marta Gwinn et al., Prevalence of HIV Infection in Childbearing Women in the United States, 265 JAMA 1704, 1706 (1991). This figure exceeded the total of 1614 children with perinatally acquired AIDS reported to the CDC from 1981-1989. Id.; see also Database, U.S. NEWS & WORLD REP., Feb. 22, 1993, at 8 (estimating that five to ten million babies will be born infected with HIV by the year 2000, and that the rank of HIV as a cause of death among children ages one to four will increase from ninth to within the top five by that time). In New York State during 1988, AIDS was the leading cause of death for Hispanic children one to four years of age and the second leading cause of death for Black children in that age group. Centers for Disease Control, Mortality Attributable to HIV Infection/AIDS - United States, 1981-1990, 40 MORBIDITY & MORTALITY WKLY. REP. 41, 44 (1991). In New York City, one in thirty-two African-American babies have HIV antibodies at birth. Celia W. Dugger, HIV Incidence Rises Among Black Mothers, N.Y. TIMES, May 1, 1992 at B3 (indicating that 356 of the 11,395 babies born to New York City Black women between the ages of 25 and 29 in 1991 tested positive for the HIV antibody).

12. Gwinn, supra note 11; see infra note 94.

13. See infra note 16.

This burden is intolerable in these times of scarce resources and particularly restricted medical resources for the poor. Based on these facts and statistics and, in the absence of alternatives, the harms to be prevented—the suffering of infants and the social costs incurred in caring for HIV-infected infants—may initially seem to be much greater than the harm of controlling HIV-positive women. Upon a close evaluation of the implications of controlling women's childbearing decisions, however, this balance shifts in the opposite direction.

The likelihood that control measures ranging from mandatory testing and directive counseling to prosecution for pregnancy will soon be widely adopted must not be discussed ahistorically or in isolation. The overwhelming majority of HIV-infected women are in their childbearing years, poor, and African- or Latin-American—groups which repeatedly have suffered from illegal reproductive control in the past. Part I of this Article discusses this history to provide a perspective on the impulse to control childbearing by HIV-positive women. The history of illegal reproductive coercion is a

As ethicist John D. Arras notes, the cost of care for the children of the HIV-infected adults often falls to the state. The majority of children with HIV are poor and thus, unlikely to be covered by private health insurance. In addition, because their parents are also likely to be infected or to have died, even healthy offspring are often abandoned in hospitals or turned over to foster care. Arras, supra note 9, at 356-57; see also Kathleen Nolan, Ethical Issues in Caring for Pregnant Women and Newborns at Risk for Human Immunodeficiency Virus Infection, 13 SEMINARS PERINATOLOGY 55, 63 (1989) ("The major grounds for societal objection [to HIV-positive women bearing children] appear, strictly speaking, to be economic rather than moral.").


16. See Stephen W. Nicholas et al., Human Immunodeficiency Virus Infection in Childhood, Adolescence and Pregnancy: A Status Report and National Research Agenda, 83 PEDIATRICS 293, 304 (1989) (reporting that the profile of an HIV-infected child includes "poverty, poor education, unemployment, single-parent households, ... and often drug use by one or both parents").

powerful indication that the potential for using criminal transmission and civil disease containment laws against pregnant HIV-positive women will indeed be realized.

Part II provides an overview of HIV criminal transmission and civil disease containment laws and analyzes their potential application to HIV-positive women. In misguided attempts to prevent the spread of HIV, prosecutors and public health authorities may soon use transmission and containment laws to target pregnant HIV-positive women. Such use of these laws is theoretically possible because many of these laws are vaguely-worded. Additionally, law enforcement authorities may be willing to stretch the law to demonstrate they are acting to prevent the spread of HIV. Under transmission and containment laws, a woman’s pregnancy could represent the commission of the offense of risking transmission either to her fetus or to her sex partner. Law enforcement officials may seek to invoke criminal transmission and civil disease control laws in order to punish or prevent such “offenses” with compulsory contraception, abortion, sterilization, civil detention, or criminal prosecution. This part also discusses the first prosecution of an HIV-positive woman for becoming pregnant.18

Prior to examining HIV criminal transmission and civil disease containment laws, Part II of the Article reviews the medical literature calling for reproductive control of HIV-positive women. This literature has provided the medical backdrop for legislative and prosecutorial action despite the fact that the medical experts favoring such coercion are a minority. Most AIDS experts advocate using voluntary measures in the fight to eradicate the disease.19 Despite their relatively small numbers, however, doctors who advocate coercive tactics are a vocal minority with potential for both great public appeal and influence in current medical practice. Additionally, while only three states permit or mandate HIV testing for childbearing women without consent, there are indications that even in the absence of legal authority, some health care providers routinely test pregnant women for HIV without consent and sometimes even coerce HIV-positive women into having abortions.20

The next three parts of the Article discuss how the exercise of coercive control over childbearing and HIV testing infringes upon various basic individual rights. Specifically, parts III, IV, and V of this Article argue that control measures contravene legally established norms of informed consent, civil rights protections for the disabled, and

19. See discussion infra part II.B.
Part III argues that absent statutory authority, HIV testing of a woman, her umbilical cord, or her newborn child, without the woman’s specific informed consent, violates the woman’s right to informed medical consent. Compulsory abortion, sterilization, or contraception would likewise violate the norms of informed consent law. Such violations could be redressed through medical malpractice actions. Part III also reviews the doctrine used to override parental refusal to authorize low risk health care procedures necessary to save the life of a child or to greatly alleviate the child’s suffering; it then reviews the doctrine used to disregard informed consent in the name of protecting public health. Although these doctrines have been asserted to justify the exercise of control over the pregnancy decisions of HIV-positive women, this part concludes that neither theory justifies such intrusions upon a woman’s rights.

Part IV argues that while state-imposed anonymous HIV testing of pregnant women may possibly pass constitutional muster, all of the following government-imposed actions would violate the Fourteenth Amendment right to bear children: directed or compulsory HIV testing linked to names and/or publicly reported; directed or forced contraception, abortion, or sterilization; and criminal prosecution for becoming pregnant. Despite recent Supreme Court rulings, and even if the Supreme Court overturns Roe v. Wade, the right to bear children remains, and is likely to remain, a fundamental constitutional right. Accordingly, there must be a compelling state interest to justify government interference with childbearing. No such compelling state interest exists. Certainly, preventing the birth of disabled children is not a valid state purpose. Nor could a state argue that it had a compelling interest in either preventing children from being born into inadequate homes or preventing the birth of children that the state may be called upon to support. A state simply cannot presume that all HIV-positive mothers will be incapable of providing adequate homes for their children. Indeed, this part argues that the Fourteenth Amendment, the Americans With Disabilities Act (ADA), and local civil rights protections for disabled people explicitly prohibit differential treatment on the basis of HIV status. Thus, the Fourteenth Amendment and civil rights laws will effectively invalidate government control of HIV-positive women’s childbearing.

21. 42 U.S.C. §§ 12101-12213 (Supp. III 1991). Protections against disability discrimination also apply to private delivery of health care services. See 42 U.S.C. § 12181(7)(F) (Supp. III 1991) (defining public accommodation to mean a facility, operated by a private entity, whose operations affect commerce, and which may include the "professional office of a health care provider, hospital, or other service establishment").
Part V argues that compulsory contraception, abortion, and sterilization of HIV-positive women to prevent their childbearing constitute bodily intrusions which would be prohibited by the Fourth Amendment under all circumstances because such intrusions "shock the conscience" of a civilized society and will therefore, always outweigh a compelling governmental interest. Additionally, Part V explores the theory that compulsory testing of women carried out pursuant to governmental statute, regulation, or policy, and government encouraged unconsented testing are prohibited by the Fourth Amendment. This part argues in the alternative that if a government interest in forced testing is found to outweigh a woman's privacy rights, testing would be permissible only if performed pursuant to a warrant. This warrant must be based upon probable cause or individualized suspicion that the woman is HIV-positive and pregnant, and that confirmed knowledge of her HIV status will fulfill the government interest.

In conclusion, this Article argues that attempts to control HIV-positive women's childbearing are not only prohibited by law, but are also misguided public policy. Policy arguments calculating that the benefits of preventing the birth of HIV-infected infants outweigh the dangers of violating the medical and constitutional rights of HIV-positive women are incorrect. Additionally, reproductive control of HIV-infected pregnant women will not achieve its primary purported goal of lessening children's suffering. Such control will merely make examples of a few, and force the many who flee such control farther from the preventive counseling, drug treatment, prenatal care, and the general health care services they so desperately need. The ultimate effect of coercing HIV-positive women not to bear children, or punishing them for doing so, will be not only to increase the suffering of HIV-infected women, but also to jeopardize the lives of their children, two thirds of whom will not have HIV.

Even in purely economic terms, a cost-benefit analysis does not justify exercise of coercive control. When HIV-positive pregnant women forego institutional support and medical care in order to avoid either private or state-imposed reproductive control, ultimately the state will have to absorb a higher cost. It will have to provide the expensive medical care, education, and perhaps, disability support, to the resulting population of children who might have been born healthier and less needy of public support had their mothers obtained prenatal care, drug treatment, and other health services.

It is important to anticipate the likely coercive responses to the growing incidence of perinatal transmission of HIV. With careful

forethought, we can learn from history and avoid repeating the mis-
takes of past attempts to forcibly control childbearing in other con-
texts. This Article attempts to contribute to this forethought by both
anticipating avenues for reproductive control of HIV-positive women
and by evaluating several legal theories which may be used to de-
fend women from such attempts. The delineation of these theories
may influence the public policy debate against use of the law to
coerce HIV-positive women.

The inefficacy of reproductive control of HIV-positive women in
the campaign to curb perinatal transmission of HIV should prove
dispositive to health care providers, legislatures, health boards,
prosecutors, and all those who fashion and carry out health policy.
Moreover, the probability that such measures will be challenged
successfully or redressed through litigation further supports argu-
ments against reproductive control.

I. THE HISTORICAL CONTEXT OF CONTROLLING WOMEN’S
CHILDBEARING

While reproductive coercion of HIV-positive women may per-
suasively appear to present the best short-term option for contend-
ing with the heart-wrenching problem of HIV-infected babies, the
history of efforts to control childbearing by women who are poor,
disabled,23 or of color24 suggests coercion will produce only odious
results.

The passage and implementation of eugenic sterilization laws
throughout the United States, principally from the 1920s through
the 1940s, is a dramatic example of the odious results that repro-
ductive coercion creates. The revelation of sterilization abuse in the
1970s is another such example. The government has also sought to
exert control over childbearing through welfare and medicaid fund-
ing schemes that shape the reproductive choices of poor women, a
class which is disproportionately comprised of women of color and
disabled women.25 Unfortunately, government impulses to control

23. See generally Adrienne Asch, Reproductive Technology and Disability, in
REPRODUCTIVE LAWS FOR THE 1990S 69 (Sherrill Cohen & Nadine Taub eds., 1989);
24. See generally Dorothy E. Roberts, Punishing Drug Addicts who Have Babies:
Women of Color, Equality, and the Right of Privacy, 104 HARV. L. REV. 1419, 1437-44
(1991) (describing control of African-American women’s childbearing from slavery to the
present); PAULA GIDDINGS, WHERE AND WHEN I ENTER: THE IMPACT OF BLACK WOMEN ON
RACE AND SEX IN AMERICA 46 (1984); MIMI ABRAMOVITZ, REGULATING THE LIVES OF
WOMEN, SOCIAL WELFARE POLICY FROM COLONIAL TIMES TO THE PRESENT (1989).
(noting that while 34.5% of all female-headed families live in poverty, the poverty rate for
white female-headed families is 27% and for Black or Spanish-origin female-headed fami-
childbearing remain strong and have recently resulted in efforts to control childbearing by drug-addicted women.

A. Early Twentieth Century Eugenics

In the early twentieth century, eugenicist ideology took hold in this country and throughout Western Europe.\(^2\) States enacted compulsory sterilization laws based on the assumption that a host of social ills, from crime to poverty to physical disability and disease,\(^2\) could be cured with minimal expense by preventing certain people from reproducing.\(^2\)

Originally, some states attempted to control the reproduction of "defective" populations by "segregating" them in institutions pursuant to the state's public health police powers.\(^2\) But as the costs of lies the poverty rate is over 50%). "In 1984, fifty percent of all adults with disabilities had household incomes of $15,000 or less. Among non-disabled persons, only twenty-five percent had household incomes in this wage bracket." H.R. REP. No. 485, 101st Cong., 2d Sess., pt. 2, at 32 (1990), reprinted in 1990 U.S.C.C.A.N. 303, 314. In fact, President Bush, upon signing the Americans With Disabilities Act on March 31, 1990, stated that "[t]he statistics consistently demonstrate that disabled people are the poorest, least educated and largest minority in America."\(^{Id}\).


27. The conditions subject to compulsory sterilization under eugenics laws across the United States ran the gamut from homelessness to epilepsy, mental retardation, mental illness, drug addiction including alcoholism, blindness or seriously impaired vision, deafness, and syphilis. Helen Rodrigues-Triaz, Sterilization Abuse, in BIOLOGICAL WOMAN THE CONVENIENT MYTH 147-48 (Ruth Hubbard et al. eds., 1982); see also HARRY H. LAUGHLIN, THE LEGAL STATUS OF EUGENICAL STERILIZATION 65 (1929).

The socially inadequate classes, regardless of etiology or prognosis, are the following: (1) feeble-minded; (2) insane (including the psychopathic); (3) criminalistic (including the delinquent and wayward); (4) epileptic; (5) inebriate (including drug habitues); (6) diseased (including the tuberculous, the syphilitic, the leprous, and others with chronic, infectious, and legally segregable diseases); (7) blind (including those with seriously impaired vision); (8) deaf (including those with seriously impaired hearing); (9) deformed (including the crippled); and (10) dependent (including orphans, neer-do-wells, the homeless, tramps and paupers).

\(^{Id}\).


29. See, e.g., Pennsylvania Ass'n for Retarded Children v. Pennsylvania, 343 F. Supp. 279, 294 (E.D. Pa. 1972) (crediting in dicta trial testimony that in the recent past mentally retarded women of childbearing age were institutionalized to prevent them from having children and were also subject to compulsory sterilization). Robert Cynkar states that "the majority of eugenists . . . concentrated on organizing programs to segregate the feebleminded during their reproductive period." Cynkar, supra note 26, at 1429.
maintaining these ever-expanding institutionalized populations increased, legislatures proposed laws authorizing sterilization as a cost-cutting measure which would permit the release of inmates without fear that they would have children. Some laws mandated sterilization for anyone in a mental institution or diagnosed with syphilis, while others specified sterilization as punishment for certain non-white collar crimes, including prostitution. As one historian has noted, "[t]he systematic character of sterilization procedures reached the point where 'many mentally retarded or unstable persons were being admitted to the institutions merely to be sterilized and then released.'\footnote{32}

In the past, poor women were often institutionalized and sterilized for bearing children out of wedlock.\footnote{33} Such was the case of Carrie Buck, the appellant in the infamous case \textit{Buck v. Bell}.\footnote{34} Buck was institutionalized in the Virginia Colony for Epileptics and Feebleminded. Born to an uneducated mother, who was herself later

\footnote{30. For example, from its inception in 1910, the Virginia Colony for Epileptics was concerned with limiting the state's costs. One of the Superintendent's first reports on the Colony declared that "it is reasonable to anticipate a rapid increase in epileptics and mental defectives ... and to infer that the State of Virginia is rapidly accumulating a greater population of these defectives and dependents than her resources will permit the comfortable care and support of." Paul A. Lombardo, \textit{Three Generations, No Imbeciles: New Light on Buck v. Bell}, 60 N.Y.U. L. Rev. 30, 35 n.25 (1985) (quoting Report of the Virginia Epileptic Colony 10 (1911)). Legislation passed in 1912 appropriated funds for the expansion of the Colony to "include residential space for people suffering from the ill-defined malady of 'feeblemindedness.'" Id. at 36. This legislation specifically directed that "women of child-bearing age, from twelve to forty-five years of age" be given priority. This emphasis on segregating women of child-bearing age exemplifies the belief that feeblemindedness was hereditary. Id.; see Cynkar, supra note 26, at 1430 (noting that Margaret Sanger has maintained that the public perceived that they were being overtaxed in order to support a growing class of morons, and hence supported sterilization as a means to lower taxes). The desire to deinstitutionalize mentally retarded people is now used to justify involuntary sterilization. See Sandra S. Coleman, Comment, \textit{Involuntary Sterilization of the Mentally Retarded: Blessing or Burden?}, 25 S.D. L. Rev. 55, 56 (1980). As recently as 1975, the laws of 11 states continued to authorize the involuntary sterilization of the mentally retarded, despite the fact that less than five percent of all mental retardation stems from abnormal genes or chromosomes. Id. at 58. Today only three states continue to permit eugenic considerations in determinations of whether to sterilize mentally retarded persons. See infra note 341 and accompanying text.}

\footnote{31. Petcheschky, supra note 28, at 85.}

\footnote{32. Id. at 87 (quoting \textbf{MARK HALLER}, \textit{EUGENICS: HEREDITARIAN ATTITUDES IN AMERICAN THOUGHT} 138 (1963)).}

\footnote{33. It was not until 1967 that a legal finding was made in North Carolina prohibiting sterilization on the grounds of promiscuity. 2540 Op. Att'y Gen. 223 (1967-68); see also Elizabeth S. Scott, \textit{Sterilization of Mentally Retarded Persons: Reproductive Rights and Family Privacy}, 1986 DUKE L.J. 806, 810 n.14 (noting that sterilization was perceived as a means to achieve social control of the poor).}

\footnote{34. 274 U.S. 200 (1927).}
committed to the same institution, Carrie had been raped and impregnated by a relative of her foster parents.\footnote{35} In a lawsuit seeking judicial validation of Virginia's recently enacted eugenic sterilization law,\footnote{36} the respondents argued that Carrie Buck should be sterilized, relying heavily on questionable expert testimony that she was "a potential parent of socially inadequate offspring."\footnote{37} In upholding Virginia's compulsory sterilization law, the United States Supreme Court, in an opinion authored by Oliver Wendell Holmes, concluded:

We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices, \ldots in order to prevent our being swamped with incompetence. It is better for all the world, if instead of waiting to execute degenerate offspring of crime, or to let them starve of their own imbecility, society can prevent those who are manifestly unfit from continuing their kind.\footnote{38}

Thus, the Court reasoned that coerced sterilizations were justified both for the general good of preventing the resources of the state from being sapped or overwhelmed by taking care of people deemed worthless, and for the good of the potential offspring whose lives would not be worth living. These same rationales surface today regarding HIV-positive women.\footnote{39}

Between the years 1907, when the first compulsory sterilization

\footnote{35} The following account of Buck v. Bell relies heavily on the excellent primary source research conducted by Paul A. Lombardo. See Lombardo, supra note 30; see also Stephen J. Gould, Carrie Buck's Daughter, 93 NAT. HIST. 14 (1984).

\footnote{36} Buck v. Bell, 274 U.S. 200 (1927). Though never explicitly overruled, revelations of the litigation's collusive nature have discredited the decision. Moreover, the development of constitutional protections for individual rights has effectively overruled it. See discussion infra part IIIF. The Colony's Board of Directors financed the litigation for both sides all the way to the Supreme Court. At trial, despite ample opportunity to do so, Buck's attorney neither presented witnesses or documentary evidence, nor attempted to conduct effective cross-examination of the numerous Colony witnesses. Lombardo, supra note 30, at 50-55. Moreover, Lombardo has documented that most of the key reasons given to justify Buck's sterilization were demonstrably untrue. She was not illegitimate since her parents were married when she was born; they later divorced. A review of the records of her education through the sixth grade indicates she was of average intelligence. She left school in the sixth grade, as did many other poor children in the early twentieth century. Additionally she could not even be considered "immoral" according to the prevailing standards of the day, because her pregnancy was the result of rape. She also attended church and church school, and sang in two church choirs. Id.; see Cynkar, supra note 26, at 1457. Commentators have asserted that the trial distinctly lacked the adversarial nature that is inherently characteristic of trials and upon which our legal system is premised. CLEMENT VOSE, CONSTITUTIONAL CHANGE: AMENDMENT POLITICS AND SUPREME COURT LITIGATION SINCE 1900, at 16 (1972).

\footnote{37} Cynkar, supra note 26, at 1439 (citing Record at 34-35, Buck v. Bell, 274 U.S. 200 (1927)).

\footnote{38} Buck, 274 U.S. at 207.

\footnote{39} See discussion infra part II.A.
law was passed in the United States, and 1945, over 45,000 people were involuntarily sterilized in the United States.\textsuperscript{40} The great majority of these people were poor women.\textsuperscript{41} With the development of informed consent law in the latter part of the twentieth century, as well as the development of constitutional protections for reproductive choice and bodily integrity, eugenic sterilization laws fell into disuse,\textsuperscript{42} were judicially invalidated,\textsuperscript{43} or were legislatively repealed.\textsuperscript{44}

B. *Post-Eugenics Reproductive Coercion*

After World War II, other forms of control over poor women replaced legally compelled sterilizations. In the late 1950s and 1960s, several states proposed laws which required sterilization of unwed welfare mothers with more than two or three children because they were not "fit to parent."\textsuperscript{45} None of these laws were passed.\textsuperscript{46} In the early 1970s, similar laws calling for compulsory sterilization of welfare recipients were proposed but rejected in ten different states.\textsuperscript{47} Though this legislation was not enacted, adminis-

\begin{itemize}
\item \textsuperscript{40} Petchesky, supra note 28, at 87.
\item \textsuperscript{41} Id.
\item \textsuperscript{42} Julius Paul, *Return of Punitive Sterilization Proposals: Current Attacks on Illegitimacy and the AFDC Program*, 3 L. & SOC. REV. 77, 78 (1968) ("From the peak period of the 1930s, when nearly 25,000 operations were performed for eugenic or other considerations... the present annual rate of reported state sterilizations has been running close to 400 or less, with nearly half these coming from one state, North Carolina.").
\item \textsuperscript{43} E.g., Skinner v. Oklahoma, 316 U.S. 535 (1942); Motes v. Hall County Dep't of Family and Children Servs., 306 S.E.2d 260 (Ga. 1983).
\item \textsuperscript{45} See Paul, supra note 42, at 78-99 (noting that such laws were proposed in Delaware, Illinois, Iowa, Louisiana, Mississippi, North Carolina, Pennsylvania, Virginia, and Wisconsin).
\item \textsuperscript{46} Id. at 79.
\item \textsuperscript{47} Allan Chase, *The Legacy of Malthus: The Social Costs of the New Scientific Racism* 15-16 (1977). The fact that such legislation always failed is remarkable given the widespread support for such measures among the public and the medical profession. See id. at 22 (reporting that a 1965 Gallup poll indicated that approximately 20% of people surveyed favored compulsory sterilization for unwed women on welfare); Morton A. Silver, *Birth Control and the Private Physician*, 4 FAM. PLAN. PERSP. 42, 44 (1972) (noting that a survey of private physicians showed that 34% favored withholding public assistance when women gave birth to illegitimate children and 30% favored denying women welfare if they refused sterilization); Note, *Coerced Sterilizations Under*
trative practice and private initiative often effectuated the intent behind these proposed laws by placing economic pressure on poor women. Widespread sterilization abuse against poor women came to light in the seventies. In 1974, Federal District Judge Gesell found in Relf v. Weinberger:

Over the past few years, an estimated 100,000 to 150,000 low-income persons have been sterilized annually under federally funded programs. . . . [M]inors and other incompetents have been sterilized with federal funds and . . . an indefinite number of poor people have been improperly coerced into accepting a sterilization operation under the threat that various federally supported welfare benefits would be withdrawn unless they submitted to irreversible sterilization.

Other documented practices of reproductive coercion in the 1970s include Southern doctors who required poor black patients to submit to sterilization if they had the sickle cell trait or as a condition of receiving medical assistance for pregnancy and childbirth.

Federally Funded Family Planning Programs, 11 NEW ENG. L. REV. 595 (1976) (noting that 85% of doctors were found to favor sterilization for welfare mothers with three or more children).

This era also spawned consideration of compulsory implantation of IUD's for unwed mothers. See e.g., Don J. Young et al., Court-Ordered Contraception, 55 A.B.A. J. 223, 226 (1969); Note, Court-Ordered Contraception—A Reasonable Alternative to Institutionalization for Juvenile Unwed Mothers? 1970 WIS. L. REV. 889; Michael A. Lotman, Note, Court-Ordered Contraception in California, 23 HASTINGS L.J. 1505 (1972).


49. Relf v. Weinberger, 372 F. Supp. 1196, 1199 (D.D.C. 1974); see Cox v. Stanton, 529 F.2d 47, 49-50 (4th Cir. 1975) (holding that statute of limitations did not bar complaint by unmarried, 18 year-old, black woman who was permanently sterilized after a social worker threatened to cut her family's welfare grant unless she was "temporarily" sterilized).

50. Avery v. County of Burke, 660 F.2d 111, 114-15 (4th Cir. 1981) (denying summary judgment when black woman alleged that she was forced to be sterilized because county nurses and social workers believed she had sickle cell trait).

51. See, e.g., Walker v. Pierce, 560 F.2d 609 (4th Cir. 1977), cert. denied, 434 U.S. 1075 (1978). The court held that the plaintiff, a black welfare recipient, failed to establish requisite state action in her claim that her constitutional rights were violated when her doctor refused to deliver her baby unless she consented to sterilization. Id. at 613. Her physician, Dr. Pierce, publicly pursued a policy of refusing medical care to women who were "unable to financially support themselves, whether they be on Medicaid or just unable to pay their own bills, if they were having a third child," unless they agreed to be surgically sterilized. Id. at 611. Dr. Pierce performed 17 of the 18 Medicaid sterilizations performed at one hospital during the period considered by the court. Of the 18 sterilizations, all but one were performed on black women. Id. at 612 n.4.
In California, public hospitals obtained Mexican-American patients' "consent" to sterilization while they were in labor. In Alabama, welfare workers threatened to terminate the benefits of an illiterate public assistance recipient unless she authorized the sterilization of her daughters.

Additionally, beginning in the late 1960s, the federal government began funding family planning services, including sterilizations, for poor people. Sterilization quickly became one of the main forms of contraception for poor people. During the first ten years of Medicaid funding of tubal ligations, the number performed on poor women increased tenfold. The overall sterilization rate in the United States increased three-fold in the seventies, the largest increase of any method of contraception. Female sterilizations were performed disproportionately on poor women and women of color, particularly Native-Americans, Puerto Ricans, and African-Americans.

52. LINDGREN & TAUB, supra note 28, at 415.
53. Id.
54. At this time abortion was still criminalized in most states and the availability of contraception was severely restricted for poor people and teenagers. Joy G. Dryfoos, Family Planning Clinics-A Story of Growth and Conflict, 20 FAM. PLAN. PERSP. 282, 282-83 (1988); Harriet Pilpel, A Dissenting Viewpoint: Should Public Policy Give Incentives to Welfare Mothers to Limit the Number of Their Children?, 4 FAM. L. Q. 146, 146-47 (1970) (noting that the 1967 amendments to the Social Security Law directing welfare departments to inform recipients of public assistance about family planning had not been implemented, and that contraceptive devices were not widely available to poor women and were completely inaccessible to teenagers); Clyde Spillenger, Reproduction and Medical Interventionism: An Historical Comment, 13 NOVA L. REV. 385, 385 (1989); Robert P. Kavanaugh, Note, Minors and Contraceptives: The Physician's Right to Assist Unmarried Minors in California, 23 HASTINGS L.J. 1486 (1972).


57. Roberts, supra note 24, at 1442-43 n.125 (citing sources which state that 43% of the women sterilized in 1973 under federally financed family programs were African-American, despite the fact that African-Americans represented only 33% of the patients, and that Spanish-speaking women were twice as likely to be sterilized as English-speaking women); Rodrigues-Triaz, supra note 27, at 158 (citing estimates that as many as 42% of Native American women of child-bearing age have been surgically sterilized);
To date, economic coercion has been an important factor in the incidence of sterilization among the poor. The federal government has effectively limited poor women's access to abortion while making sterilization readily available. Once legalized in 1973, abortion was reimbursed by the federal government through Medicaid at only fifty percent of its cost. The passage of the Hyde Amendment in 1976 discontinued all federal reimbursement for abortion except "where the life of the mother would be endangered if the fetus were carried to term." \[58\] This resulted in most states cutting Medicaid coverage of abortion. In contrast, full federal Medicaid coverage of sterilization continues to the present. For many women, Medicaid coverage provides the only access to health services. \[59\] For poor women, the right to freely choose a method of controlling fertility means nothing without guaranteed access to the means to effectuate their choices. \[60\]

C. "Fetal Protection" as a Form of Control

The national trend toward curtailing pregnant women's rights of informed consent and reproductive autonomy indicates the likelihood that laws will be used, absent legislative intent, to punish or prevent childbearing by HIV-positive women. \[61\] Recently, under the

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\[59\] Female Medicaid recipients are between two and four times more likely (depending on geographic region) to be sterilized than are women not dependent on Medicaid. Petchesky, supra note 28, at 180. This may be explained, in part, because the only way that Medicaid will pay for abortion in most states is by the patient agreeing to be sterilized through hysterectomy or tubal ligation at the same time the abortion is performed. Rodrigues-Triaz, supra note 27, at 152.


\[61\] See Roberts, supra note 24, at 1431-32 ("Creative statutory interpretations that once seemed little more than the outlandish concoctions of conservative scholars are now used to punish women."); see generally COMMITTEE FOR ABORTION RIGHTS AND AGAINST STERILIZATION ABUSE, WOMEN UNDER ATTACK: VICTORIES, BACKLASH AND THE FIGHT FOR REPRODUCTIVE FREEDOM (Susan E. Davis ed., 1988); Jacqueline Berrion, Pregnancy and Drug Use: The Dangerous and Unequal Use of Punitive Measures, 2 Yale J. L. & Feminism 239 (1990); Dawn E. Johnsen, From Driving to Drugs: Governmental Regulation of Pregnant Women's Lives After Webster, 138 U. Pa. L. Rev. 179 (1989) (hereinafter Johnsen, Driving to Drugs); Dawn E. Johnsen, Note, The Creation of Fetal Rights: Conflict with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection, 95 Yale L.J. 599 (1986); Janet Gallagher, Fetus as Patient, in REPRODUCTIVE LAWS FOR THE 1990'S, supra note 23, at 185 (hereinafter Gallagher, Fetus as Patient);
guise of protecting children, pregnant women have been prosecuted pursuant to controlled substance laws never intended to apply to the woman-fetus relationship. These drug-related prosecutions are directly analogous to potential prosecutions of HIV-positive women. The vast majority of these drug prosecutions target drug-dependent women of color, a population which also has high incidence of HIV infection.

A resounding theme among current advocates of reproductive coercion of HIV-positive women is that pregnant women are adversaries of their fetuses; that women's "culpable" conduct causes "innocent" suffering and must be stopped. This theme is also prevalent in descriptions of childbearing by women addicted to drugs. Dr. Jan Bays, Director of Child Abuse Programs at Emanuel Hospital in Portland, Oregon, articulated this view:

We must up the ante to criminalize or impose reproductive controls on people who are out of control.... We thought we were getting in touch when we tried voluntary contracts that required the parents to go into drug treatment, gave the state legal custody or allowed it to monitor the child. But it doesn't work. In a few weeks, the family disappears from the system and the child protection agencies are too overwhelmed to follow through. In a year, the family shows up again with another drug-affected baby.... But we can't force people into treatment, even if they're in jail. She can go out and have more children. So, people are talking about sterilization and that gets into reproductive rights. Eventually society will get fed up with the huge burden of drug-affected babies. We can't say forever that people have unlimited rights to have a child....


62. See infra notes 77-79.

63. See Bayer, Kid, supra note 10, at 324 (arguing that the most ardent victim-blamers cannot "in conscience blame the children who were infected").

It is no accident that the theme that women are adversaries to their fetuses presently carries great currency and power in our society—its predominance is one of the greatest successes of the anti-abortion movement. See Nan D. Hunter, Time Limits on Abortion, in REPRODUCTIVE LAWS FOR THE 1990S, supra note 23, at 131, 146-47.

In the late 1980s and early 1990s, a wave of prosecutions and incarcerations of pregnant women addicted to drugs occurred for the asserted purpose of protecting children. This type of prosecution was pursued and continues to be initiated, despite the fact that many addicted women would voluntarily attempt to stop using drugs if they had access to treatment. However, drug treatment programs for poor people, generally, and for pregnant women and primary parents in particular, are woefully unavailable. Additionally,

65. See Paltrow, Criminal Prosecutions, supra note 61, at i, ii. Paltrow canvasses 96 cases in 24 states involving prosecutions of pregnant women during the late 1980s and early 1990s. Of the 96 cases, 73 involved charges under statutes intended to protect children. In 33 cases, charges were brought under child endangerment or abuse laws, and in 39 cases, charges of dealing a controlled substance to a minor were brought. Although many of the charges were subsequently dropped, the cases provide an indication of how local authorities have attempted to use existing laws to prosecute expectant mothers. Id.; see also Lynn M. Paltrow & Suzanne Shende, Memorandum: State by State Case Summary of Criminal Prosecutions Against Pregnant Women and Appendix of Public Health and Public Interest Groups Opposed to These Prosecutions (ACLU/Reprod. Freedom Project), Oct. 29, 1990, reprinted in Laurie Rubenstein, Prosecuting Maternal Substance Abusers: An Unjustified and Ineffective Policy, 9 YALE L. & POL'Y REV. 130, 157-60 (1991).

The ground-breaking defenses carried out by Lynn M. Paltrow, an attorney of the Center on Reproductive Law and Policy in New York, beginning with her defense of Pamela Rae Stewart in 1986 and culminating with her defense of Jennifer Johnson, has spawned much of the scholarship in this area. See, e.g., Dwight L. Greene, Abusive Prosecutors: Gender, Race & Class Discretion and the Prosecution of Drug-Addicted Mothers, 39 BUFF. L. REV. 737 (1991); Kary Moss, Legal Issues: Drug Testing of Postpartum Women and Newborns as the Basis for Civil and Criminal Proceedings, 25 CLEARINGHOUSE REV. 1406 (1991); Roberts, supra note 24; Rubenstein, supra.


One commentator summarized the studies relevant to this issue as follows: The lack of facilities for pregnant addicts in two cities illustrates the problem. A recent survey of 78 drug treatment programs in New York City revealed that 54% denied treatment to pregnant women, 67% refused to treat pregnant addicts on Medicaid, and 87% excluded pregnant women on Medicaid specifically addicted to crack. Less than half of those programs that did accept pregnant addicts provided prenatal care, and only two provided child care. . . . Similarly, drug-addicted mothers in San Diego must wait up to six months to obtain one of just 26 places in residential treatment programs that allow them to live with their children . . . . Furthermore, because Medicaid covers only 17 days of a typical 28-day program, poor women may not be able to afford full treatment even at centers that will accept them.

Roberts, supra note 24, at 1448 n.147.

A congressional survey found that 12 out of 18 hospitals reported they have no place to refer pregnant women for drug treatment. Born Hooked: Confronting the Impact of Perinatal Substance Abuse Hearings Before the Select Committee on Children, Youth and Families, 101st Cong., 1st Sess. 2 (1989); see How to Protect Babies from Crack, N.Y. TIMES, March 11, 1991, at A16 (recommending that Medicaid make an exception for
prosecutors often seek to jail pregnant drug addicted women for the sake of their fetuses despite the inadequacy of prenatal care in women's prisons. The law enforcement option has been chosen despite the opposition of major medical associations to the use of criminal sanctions to address problems of addiction and pregnancy.

To accomplish these misguided prosecutions, overzealous prosecutors have utilized statutes intended to regulate drug trafficking, laws on child neglect and abuse, and other statutes never intended to apply to prenatal behavior. To date, every defendant who has challenged the application of these laws to prenatal behavior has succeeded in invalidating her prosecution.

The Florida Supreme Court, the highest court to address this issue, reversed the conviction of Jennifer Johnson, a young Florida woman addicted to crack. Johnson was convicted on two counts of delivery of a controlled substance to a minor, a crime meant to deter drug dealers from selling drugs to children or using children as drug pregnant addicts and pay for residential drug treatment which it does not currently cover).

67. Monmouth County Correctional Inst. Inmates v. Lanzaro, No. 82-1934 (D.N.J. March 11, 1985) (ordering by consent judgment the provision of prenatal care and adequate living conditions for pregnant inmates); Susan Stefan, Whose Egg Is It Anyway?: Reproductive Rights of Incarcerated, Institutionalized and Incompetent Women, 13 NOVA L. REV. 405, 441-443 (1989) (referring to numerous prison cases alleging inadequate prenatal care, as well as one study showing that one jail in California had infant mortality rates 50 times greater than the state as a whole).

68. These groups include the American Medical Association and the American Public Health Association. Johnson v. State, No. 77,831, slip op. at 14 (Fla., July 23, 1992).

69. See generally Greene, supra note 65 Cf. PALTROW, CRIMINAL PROSECUTIONS, supra note 61 (reporting that of 167 arrests of women for behavior during pregnancy, 24 were in Escambia County, Florida and more than 87 were in Greenville and Charleston, South Carolina).

70. PALTROW, CRIMINAL PROSECUTIONS, supra note 61, at i-ii.


It is important to note that several women have been convicted of such offenses after either pleading guilty or losing at trial on defenses which did not challenge the validity of applying the prosecuting statute to pregnancy. See Roberts, supra note 24, at 1420 (citations omitted).

The fact that all challenged prosecutions have been invalidated has not prevented individual prosecutors from continuing to initiate new prosecutions for child abuse against women who use drugs or alcohol during pregnancy. E.g., Complaint for Child Abuse, State v. Deborah Arandus, CR92-05-557 (Adams County Ct., Neb. May 1, 1992) (charging woman with child abuse for using alcohol while pregnant); see also Laurie Casady, Mother Charged with Passing Cocaine to Newborns, TULSA TRIB., May 8, 1992, at A3 (stating that a mother was charged with unlawful delivery of a controlled drug to a minor after using crack cocaine while pregnant and transmitting the drug via the placenta). See generally Barbara Kantrowitz et al., The Pregnancy Police, NEWSWEEK, Apr. 29, 1991, at 52.
couriers. The state acknowledged that under the law, a fetus is not a child, but argued that Johnson had “delivered” a metabolite of cocaine to her child in the seconds after birth when the umbilical cord was still attached.\textsuperscript{72} Johnson received a sentence of one year in a drug treatment program, fourteen years of probation, and 200 hours of community service.\textsuperscript{73} This contorted application of the statute was validated by both the trial and intermediate appellate courts before the state’s highest court reversed her conviction as contrary to legislative intent.\textsuperscript{74}

Consistent with this nation’s history of reproductive coercion, the prosecutions of pregnant drug-addicted women have targeted women of color, despite the prevalence of drug addiction among white women.\textsuperscript{75} One survey reports that thirty-eight of fifty-two prosecutions involved women of color.\textsuperscript{76} Another review found that of sixty women charged, eighty percent were minorities.\textsuperscript{77}

Judges have also utilized their sentencing powers in attempts to control drug use by pregnant women.\textsuperscript{78} In 1988, District of Columbia Superior Court Judge Peter Wolf sentenced Brenda Vaughan to incarceration for the duration of her pregnancy after she pled guilty to forging checks, reasoning that such a sentence could protect her fetus from maternal drug use. Normally her plea would not have incurred any jail time.\textsuperscript{79}


\textsuperscript{73} In addition, the court imposed restrictions on her behavior including court supervised prenatal care in the event that she becomes pregnant again, and prohibitions on the use of alcohol or other drugs, visiting bars, and associating with people who use drugs or alcohol. PALTROW, CRIMINAL PROSECUTIONS, supra note 61, at 3.

\textsuperscript{74} State v. Johnson, No. 77,831, slip op. at 3.

\textsuperscript{75} See generally Gallagher, Fetus as Patient, supra note 61, at 185-235; Veronika Kolder et al., Court-Ordered Obstetrical Interventions, 316 NEW ENG. J. MED. 1192 (1987); Roberts, supra note 24.

\textsuperscript{76} Paltrow & Shende, supra note 65.


\textsuperscript{78} See, e.g., People v. Moore, No. 90CF1931 (Winnebago County Court, Illinois Dec., 1990) (holding a pregnant woman on $10,000 bond for alleged violation of conditions of probation resulting from prostitution conviction; the alleged violation was that she was a drug addict and decided to continue her pregnancy).

\textsuperscript{79} PALTROW, CRIMINAL PROSECUTIONS, supra note 61, at 3 (citing United States v. Vaughan, Crim. No. F-2172-88B (D.C. Super. Ct. Aug. 23, 1988)); Kary Moss, Pregnant? Go Directly to Jail, A.B.A. J., Nov. 1, 1988, at 20 (noting that at sentencing, Judge Wolf stated: “I'm going to keep her locked up until the baby is born because she's tested positive for cocaine when she came before me . . . and I'll be darned if I'm going to have a baby born that way.”); see also Roberts, supra note 24, at 1431 n.54 (citing Cox v. Court, 537 N.E.2d 721, 723 (Ohio Ct. App. 1988) (reversing juvenile court order placing a pregnant woman in a “secure drug facility” to protect the fetus from the woman's cocaine use)).

Four judges have used their sentencing powers to attempt to control women’s child-
The circumvention of the rights of drug dependent women occurs not only in the name of protecting children, but also is sometimes asserted as a way to save tax-payers from the burdens of supporting poor women's children. Both justifications recall those used to require eugenic sterilization. Purportedly beneficial to children and society, such measures are seriously damaging to the women involved. Many women have not been able to challenge the basis of their prosecutions and have been convicted and served lengthy prison terms. Even women who are successful in having charges against them dropped can suffer greatly from prosecution. As a result of the publicity surrounding these prosecutions, many women will avoid health care and drug treatment facilities out of fear. Consequently, these measures do not fulfill their goals.

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bearing through Norplant insertion. They imposed Norplant insertion as a condition of probation for women pleading guilty to child abuse or manslaughter. See, e.g., Darlene Johnson v. California, No. 29390, appeal dismissed (5th Dist. Court of Appeals Apr. 13, 1992). A judge in Austin, Texas ordered a woman pleading guilty to child abuse to have Norplant inserted as a condition of probation. When she suffered an adverse reaction, she had the Norplant removed and had a tubal ligation. She did not appeal her sentence. Women's Legal Defense Fund, Legislation and Litigation Involving Norplant 5 (June 1992) (unpublished document on file with the Buffalo Law Review). Another judge in Jacksonville, Florida sentenced a woman convicted of manslaughter to two years in prison, and ten years of probation, with Norplant insertion a condition of probation. Again, no appeal was taken. Id. In March, 1992, Texas District Judge Pat Lykos sentenced Ida Jean Tovar to ten years of probation on the condition that she use Norplant. Tovar was convicted on charges relating to the violent shaking of her two year old son who suffered brain damage. Reproductive Freedom Project, ACLU, Update vol. 4, no. 2, Mar. 27, 1992, at 5.

80. See supra note 64 and accompanying text.
81. See supra note 71.
82. Consider the ordeal of Pamela Rae Stewart, prosecuted for refusing to follow her doctor's orders pursuant to a statute intended to obligate absentee fathers to provide support to women they impregnated. Though the court dismissed the prosecution as an improper use of the statute five months after the charges were filed, Stewart had already suffered considerable damage. As one commentator observed, she not only spent six days in jail before she could make bail, but "the most intimate details of her personal life became a staple for the national press... the media held back nothing, not even the details of her last sex act before the baby was delivered." Johnsen, Driving to Drugs, supra note 61, at 208-09 (citation omitted).

83. Publicity about these prosecutions evokes a strong deterrent effect on pregnant addicts and low-income women of color who are pregnant; they become dissuaded from seeking prenatal care and drug treatment for fear of prosecution. Thus, tragically and paradoxically, the women and fetuses most at risk are driven from the reaches of the services they desperately need. See Johnson v. Florida, No. 77,831, slip op. at 14-16 (Fla. Sup. Ct. July 23, 1992); U.S. General Accounting Office, Drug Exposed Infant's, A Generation At Risk, Report to the Chairman, Committee on Finance, U.S. Senate 9 (1990) (identifying "[t]he increasing fear of incarceration and losing children to foster care" as a deterrent to pregnant women needing drug treatment, because "[w]omen are reluctant to seek treatment if there is a possibility of punishment"); Roberts, supra note 24, at 1449-50.
The long history of reproductive coercion of poor women, women of color and disabled women—groups currently disproportionately affected by HIV—is perhaps the most powerful indication that HIV-positive women are likely targets for control. The history of eugenics demonstrates that a committed, vocal minority of medical experts can galvanize sufficient public concern about childbearing by poor women to support repressive legislation. The scientific community was never united in support of eugenic theory. There were always outspoken, respectable opponents. However, the eugenists successfully marshalled public outrage that "socially undesirable" women were having babies and successfully converted this public support into political power. As a result, the fact that most public health officials today oppose the use of coercive measures against those infected with HIV does not preclude the growth of control over childbearing by HIV-positive women. The virtually unanimous voice of the medical community opposing coercion is fissured by a minority of experts advocating coercion as a means to curtail perinatal transmission. These few influential authorities have the potential to galvanize public support and political power to effectuate and institutionalize measures to control childbearing by HIV-positive women.

Doubt is cast on the professed altruism and wisdom of involuntary control of HIV-positive women when such potential control is viewed in light of the history of eugenics and the more recent coerced sterilization of poor women, disabled women, and women of color. Given this history, it is little wonder that coercive measures against these populations can cause widespread avoidance of institutional health care.

84. Scott, supra note 33, at 811 & nn.15-16.
85. This is so because policy makers who currently favor coercion are most often responding to political pressures and usually do not consult health officials. See Scott H. Isaacman, Are We Outlawing Motherhood for HIV-Infected Women?, 22 LOY. U. CHI. L.J. 479 (1991). Although numerous public health organizations do oppose mandatory testing, several states have enacted mandatory testing statutes. See infra notes 203-04; see also Larry Gostin, The Politics of AIDS: Compulsory State Powers, Public Health, and Civil Liberties, 49 OHIO ST. L.J. 1017, 1017 (1989).
86. See discussion infra Part II.A.
ment, the alarm evoked by the rising incidence of AIDS in infants is likely once again to undermine that concern.

Part II presents evidence of the emergence and the potential risk of growth of the reproductive control of HIV-positive women in a vocal minority of medical experts, in legislation, and in incipient prosecutorial practice.

II. OUTLAWING PREGNANCY FOR HIV-POSITIVE WOMEN

Following the first reported case of HIV in an infant born to an infected mother, medical attention began to focus on perinatal transmission as a mode of spreading the virus. The fact that the large majority of HIV-positive women are in their childbearing years, coupled with preliminary information indicating that women's awareness of HIV infection apparently does not affect their childbearing decisions, understandably creates grave concerns for prevention of pediatric AIDS. Though medical knowledge about

89. This country is currently experiencing a resurgence of efforts to prevent certain women from bearing children at all. For example, New Jersey is attempting to discourage poor women from procreating through its recently-enacted limitation on welfare funds. The new law prevents parents from obtaining increases in grants based on family size for any child born while the family was on welfare. N.J. STAT. ANN. §44:10-3.5 to -3.6 (West Supp. 1992); see Letter from Julius Chambers, NAACP Legal Defense and Education Fund, et al., to Secretary Louis Sullivan, Department of Health and Human Services et al. (June 26, 1992) (challenging proposed legislation) (on file with the Buffalo Law Review). A Kansas legislator recently proposed that the state pay five hundred dollars to any mother on welfare who submits to the insertion of Norplant. Tamar Lewin, A Plan to Pay Welfare Mothers for Birth Control, N.Y. TIMES, Feb. 9, 1991, at A9.

Bills to provide financial incentives to encourage women on public assistance to accept Norplant implants were also introduced in 1991 in Louisiana, and in 1992 in Tennessee. A 1992 bill was introduced in Mississippi which would require women to have Norplant implanted if they are found to have exposed their fetuses to controlled substances or alcohol. Similar bills were introduced in Ohio, in 1991 and 1992, in South Carolina in 1991, and in Washington in 1992. To date, all such legislative efforts have been defeated. Women's Legal Defense Fund, supra note 79. See generally Changes in State Welfare Reform Programs: Hearing Before the Subcomm. on Social Security and Family Policy of the Senate Comm. on Finance, 102d Cong., 2d Sess. 55 (1992) (prepared statement of Douglas J. Besharov, Scholar in Residence, American Enterprise Institute).


91. Gwinn et al., supra note 11, at 1704.

92. See, e.g., Frank D. Johnstone et al., Women's Knowledge of their HIV Antibody Status: Its Effect on Their Decision Whether to Continue the Pregnancy, 300 Brit. Med. J. 23, 24 (1990) (noting that among HIV-positive women in Edinburgh, Scotland, "[w]hen the pregnancy was wanted the desire to have the baby overrode all other considerations."); Peter A. Selwyn et al., Knowledge of HIV Antibody Status and Decisions to Continue or Terminate Pregnancy Among Intravenous Drug Users, 261 JAMA 3567 (1989); Mary E. Guinan, Reply to Letter to the Editor, 258 JAMA 2693-94 (1987).

93. HIV infection is currently a leading cause of death in children ages one through four in some locations in the United States. Centers for Disease Control, Mortality
perinatal transmission is still severely limited, debate has mush-

Attributable to HIV Infection/AIDS-United States, 1981-1990, 40 MORBIDITY & MORTALITY WKLY. REP. 41, 44 (1991). During 1990 and 1991, approximately 87% of all children with AIDS were born to women with or at risk for HIV infection. Centers for Disease Control, The Second 100,000 Cases of Acquired Immunodeficiency Syndrome - United States, June 1981 - December 1991, 41 MORBIDITY & MORTALITY WKLY REP. 28, 29 (1992); see also John T. Repke & Timothy R. B. Johnson, HIV Infection and Obstetric Care, in AIDS, WOMEN AND THE NEXT GENERATION, supra note 3, at 40 ("Now that the risk of HIV infection from transfused blood or blood products is extraordinarily low, it is probable that virtually all newly acquired pediatric HIV infections will occur via vertical transmission.").

94. There is some dispute about the HIV transmission rate from woman to fetus. However, through the passage of time and the increase in knowledge about perinatal transmission, the estimates of transmission rates have markedly decreased. In 1985, the CDC estimated that "of women seropositive for the HIV virus, about 30 to 50% of the children will be born infected." Listernick, supra note 15, at 509. "However, this estimate ... was based on a small number of studies," thereby leaving much uncertainty. Id. A 1988 survey of studies concerning transmission rates also warned that this rate had not been accurately determined, and summarized the demonstrated risks as "33% to 46%." Vertical Transmission of HIV, 2 LANCET 1057, 1058 (1988). The most recent estimates set the rate of perinatal transmission in Western industrialized countries at 30%, with the individual transmission rates ranging from 7% to 33%. Modlin & Saah, supra note 3, at 41; Phillip A. Pizzo & Karina M. Butler, In the Vertical Transmission of HIV, Timing May be Everything, 325 NEW ENG. J. MED. 652, 652 (1991) (reporting that there is a range of findings on perinatal transmission with a high rate of 45% from Nairobi, Kenya, and a low of 12.9% reported by the European Collaborative Study Group); Susanne Lindgren et al., HIV and Child-Bearing: Clinical Outcome and Aspects of Mother-to-Infant Transmission, 5 AIDS 1111 (1991) (stating that studies indicate a range of 15 to 40% for perinatal transmission); see also European Collaborative Study, Children Born to Women with HIV-1 Infection: Natural History and Risk of Transmission, 337 LANCET 253 (1991).

Medical uncertainty concerning how HIV is transmitted from women to children adds to the general gap in understanding perinatal infection. For example, some investigators suggest that the perinatal transmission rates may be greater during a woman's primary infection—when she is first infected with HIV. Pizzo & Butler, supra, at 653. Others have hypothesized that the rate increases in mothers who have more advanced HIV disease. Id. (citing David D. Ho et al., Quantitation of Human Immunodeficiency Virus Type 1 in the Blood of Infected Persons, 321 NEW ENG. J. MED. 1621 (1989)). See generally, Marie-Louise Newell et al., HIV-Infection in Pregnancy: Implications for Women and Children 4 AIDS S111 (1990).

The exact time during pregnancy or delivery when HIV transmission occurs is also unknown, though some authorities believe that like hepatitis B, HIV is transmitted primarily during childbirth. Modlin & Saah, supra note 3, at 41; Repke & Johnson, supra note 93, at 94; Joseph Palca, HIV Risk Higher for First-Born Twins, 254 SCI. 1729 (1991).

Part of the difficulty in determining the perinatal transmission rate also stems from the difficulty of diagnosing HIV infection in infants. All babies born to HIV-infected women will test positive for the HIV antibody, although most of them are not infected. "Because passively acquired maternal antibody may persist in the uninfected infant of an HIV-seropositive mother, serologic tests are not considered diagnostic of HIV infection until the infant reaches 15 months of age." Modlin & Saah, supra note 3, at 38. Earlier infant diagnosis relies upon identification of an AIDS-defining illness or the presence of signs or symptoms suggestive of HIV infection. Id. Other tests which identify the HIV antigen or viral genome are unreliable for infants less than 6 months of age, are extremely expensive and labor
roomed among medical policy theorists concerning the necessity, efficacy, and ethics of using coercive measures to prevent HIV-positive women from bearing children. As unlikely as such policies may initially appear, most of them have already been seriously proposed. Mandatory HIV testing has been incorporated into law in three states. There is anecdotal evidence that directive counseling, if not coercion, has become the medical practice for obtaining consent for HIV-testing and for abortion for women testing HIV-positive. Indeed, given our society’s long history of coercive medical intervention into women’s reproductive biology, and given the current vogue of distrust of women’s moral agency with regard to reproduction, these HIV policy proposals are not surprising. These practices, however, have serious ramifications for the ability of medicine to alleviate the human suffering imposed by the AIDS epidemic. These developments are particularly ominous for infected women, and for the humanity and equality of women whose rights are under attack.

A. The Experts Speak

Most authorities on HIV health care issues advocate education and voluntary measures as the most effective methods for contend-
ing with the AIDS epidemic. Nonetheless, coercive measures have public support, particularly when designed to target prostitutes, "recalcitrant individuals," or women's childbearing potential. Consequently, despite the fact that historical precedent has proved such measures ineffective in curtailing the spread of epidemics, several influential health policy makers have endorsed coercion. In 1988, the Presidential Commission on the Human Immunodeficiency Virus Epidemic recommended criminalizing conscious acts which risk HIV transmission. Although this recommendation does not specifically mention perinatal transmission through planned or voluntarily continued pregnancy, it does not specifically exclude it, and becoming or choosing to remain pregnant when one's child has a 30% chance of becoming infected with HIV might be considered a conscious act risking transmission. Therefore, the Commission report arguably could be cited as support for criminalizing childbear-

98. See Ronald Bayer, As the Second Decade of AIDS Begins: An International Perspective on the Ethics of the Epidemic, 6 AIDS 527, 528 (1992) ("All democratic nations have emphasized that fostering voluntary behavior change represents the most effective strategy for altering the course of the AIDS epidemic."); see also Gostin, supra note 85, at 1017.


101. Gostin, supra note 85, at 1017 n.1.

102. See discussion supra part I.C.


ing for HIV-positive women.

Recommendations on perinatal transmission of HIV issued by the CDC in 1985 specify that HIV-positive women should “postpone pregnancy,” but do not mention the fact that an HIV-positive woman has choices to make once she is pregnant. Because infection with HIV is now assumed to be life-long, the call to postpone is really a call to forego having children completely. While a proposal was made to include advice that women be counseled on the abortion option and that their decisions be respected, the final recommendations do not contain any mention of choice. This omission is the result of the influence of both anti-abortion forces and consultants concerned about American practices of coercing minority women in public clinics to have abortions. Hence, the CDC has been silent concerning whether its call for HIV-positive women to desist from reproducing extended to directing those already pregnant to have abortions. However, the 1985 CDC recommendations have been influential in the development of many AIDS programs and have served as the basis for subsequent recommendations issued by state health departments across the country.

105. Centers for Disease Control, Recommendations for Assisting in the Prevention of Perinatal Transmission of Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus and Acquired Immune Deficiency Syndrome, 34 MORBIDITY & MORTALITY WKLY. REP. 721 (1985). The CDC recommends, however, that HIV testing of pregnant women be undertaken only with the woman’s consent and always in conjunction with counseling and confidentiality. Id. at 724. The advice to avoid pregnancy altogether when a woman is HIV-positive is common. For example, former Surgeon General C. Everett Koop advised that every woman be voluntarily tested for HIV antibodies before becoming pregnant because “[one of the greatest concerns was the potential threat to the babies of infected mothers. The virus can pass from mother to infant in the womb.” AIDS Test for Women Urged Before Pregnancy, N.Y. TIMES, Mar. 25, 1987, at B4. In 1988, Dr. James Curren, Director of the CDC’s AIDS Programming, was quoted as saying that “[t]here is no reason that the number of [HIV-infected infants] shouldn’t decline . . . . Someone who understands the disease and is logical will not want to be pregnant.” Ethics of Prevention, supra note 95, at 501.


107. Ethics of Prevention, supra note 95, at 502.

108. Id. at 501-03 (citing San Francisco Dep’t of Public Health as one state health department which has urged women to “postpone” pregnancy pending further study of prenatal transmission). For example, advice distributed to local Californian health officials in 1985 stressed “the potentially disastrous result for the fetus when an expectant mother is infected with the AIDS virus” and counseled that women at increased risk be identified, followed by serologic examination, and educated about AIDS. Ethics of Prevention, supra note 95, at 500 (citations omitted). Other literature mirrored the CDC directive. See, e.g., Gina Pugiese & Thomas Lampinen, Prevention of Human Immunodeficiency Virus Infection: Our Responsibilities as Health Care Professionals, 17 AM. J. INFECTION CONTROL 1, 17 (1989) (“Because of the potential high risk of infant infection and the preliminary evidence that pregnancy itself may accelerate the develop-
In 1987, the American College of Obstetricians and Gynecologists issued a policy statement recommending, "Women infected with HIV... should be strongly encouraged not to become pregnant... those who do become pregnant should be counseled again about the risks to themselves and their child and should be informed about the option of pregnancy termination."

The professional medical opinion that HIV-positive women should not have children has surfaced in other forums. One of the few panels addressing women and AIDS at the Fifth International Conference on AIDS held in Montreal in June, 1989, was "HIV Infection, Reproduction and Parenthood." Commentators report that panelist John Arras, a medical ethicist and Director of the Department of Social Medicine at Montefiore Hospital in Bronx, New York, responded negatively to the question, "Should HIV-Positive Women Have Children?" Commentators summarize,

[He] concluded that society's interest in avoiding the costs of babies with AIDS outweighed the judgment of many [HIV-positive] ... women that a one third chance of bearing a child with HIV infection was a risk worth taking in light of the significant cultural premium placed on child bearing.111

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109. American College of Obstetricians and Gynecologists, Prevention of Human Immunodeficiency Syndrome, 53 ACOG COMMITTEE STATEMENT, 1, 1-4 (1987). However, ACOG does not endorse mandatory testing. See American College of Obstetricians and Gynecologists, Human Immune Deficiency Virus Infectious, ACOG TECHNICAL BULL. Dec. 1988, at 5 (recommending HIV testing and counseling with informed consent only "in any medical setting in which women at risk are encountered"); see also S.E. Hassig & R.W. Ryder, The Epidemiology of Perinatal Transmission of HIV, 2 AIDS S83, S87 (1988) (noting that prevention requires "screening women who are anticipating pregnancy and encouraging them not to become pregnant. Alternatively, and much less acceptable, would be the screening of pregnant women for HIV antibodies in the first trimester with subsequent therapeutic abortion of fetuses of seropositive women.").

110. E.g., Norman Hearst & Stephen B. Hulley, Preventing Heterosexual Spread of AIDS: Are We Giving Our Patients the Best Advice?, 259 JAMA 2428 (1988) ("Preventing the perinatal transmission of infection to newborn babies involves testing prospective mothers for HIV antibodies and advising those who test positive to avoid pregnancy or, if already pregnant, to consider abortion."); see, e.g., The Ethics of Prevention, supra note 95.

111. Arleen Zarembka & Katherine M. Franke, Woman in the AIDS Epidemic: A Portrait of Unmet Needs, 9 ST. LOUIS U. PUB. L. REV. 519, 525 n.24 (1990) (citing John Arras, Director of the Department of Social Medicine at Montefiore Hospital, Bronx, N.Y., Address at V International AIDS Conference (June 1989)).

In a 1990 article, Arras argued that because nondirective counseling of HIV-positive women does not effectively result in decisions to abort pregnancies, altering norms of informed consent for counseling HIV-positive women concerning childbearing may be justified. For example, rather than merely describing the risks of HIV transmission to her future child, and describing what HIV illness is like for most children, health care providers...
The obvious implication of such a conclusion is that the legal protections of reproductive autonomy of HIV-positive women must give way to society's need to prevent proliferation of HIV-positive babies.\textsuperscript{112}

Another prominent physician voiced similar sentiments at a 1989 conference focusing on AIDS among Puerto Ricans. Dr. Carmen Zorrilla, an Associate Professor at the University of Puerto Rico School of Medicine, urged that "the sterilization option" be relied upon to reduce the numbers of children with AIDS.\textsuperscript{113} Similar advice is evident in the medical literature.\textsuperscript{114} One commentator out-
lined a radical potential policy path:

A central issue is the right of an infected woman to be pregnant. The right to become pregnant and to maintain a pregnancy could be seen as part of a woman's right to control her body. However, as more child-bearing women become infected and give birth to infected children, child-bearing could come under the surveillance of the state. Women of child-bearing age could be among the first groups to undergo mandatory testing as part of an attempt to control women's reproductive choices. . . . The State's duty to protect potential life tends to shift to the interest of protecting society from another person with AIDS. In this view, seropositive women do not have the right to become pregnant and should be sterilized automatically. Seropositive pregnant women do not have the right to maintain a pregnancy and should undergo abortions. Sterilization and abortion would be advocated for health reasons alone.  

In a May 1991 editorial to the New England Journal of Medicine, Dr. Marcia Angell proposed, contrary to traditional norms of informed consent, that routine, if not mandatory, HIV screening should be conducted on all pregnant women and newborns. She reasoned that pregnant women and newborns are accessible to the health care system because most babies are born in hospitals. Thus, mandatory testing could allow "[i]nfected women [to] make more-informed choices about family planning, and infected newborns could be treated earlier." Physicians have also pushed to classify AIDS and HIV infection as sexually transmitted and communicable diseases, thus permitting application of state laws permitting mandatory testing, treatment, and quarantine of those known or suspected of being infected.
For example, in *New York State Society of Surgeons v. Axelrod*,¹¹⁸ four local clinical medical societies, including the New York Medical Society, unsuccessfully sued the New York State Commissioner of Health to compel him to define AIDS and HIV infection as sexually transmitted and communicable diseases. In addition, the House of Delegates of the American Medical Association in 1990 issued a policy statement labeling HIV infection as a sexually transmitted disease.¹¹⁹

Moreover, as noted earlier, the Presidential Commission issued a policy favoring criminalization of certain intentional transmission behaviors, without specifically addressing perinatal transmission. When such a medical authority, well-versed in the modes of HIV transmission, neglects to specifically address perinatal transmission when formulating policy, it is perhaps understandable that state legislators neglect to exempt perinatal transmission when considering civil and criminal transmission bills. As explained below, such oversight could encourage overzealous law enforcement authorities to violate the rights of HIV-positive women.

**B. Expert Opinion Reflects and Influences Medical Practice**

The public comments of the minority of medical authorities endorsing relaxation of informed consent protections for HIV-positive women suggest that substantially more physicians are following the advice in practice. One commentator posits that “with HIV, directive counseling is not advocated but assumed.”¹²⁰

One survey of 247 physicians and nurses in neonatal intensive care units in New York City found marked opprobrium for childbearing by HIV-positive women. The study found that “65 percent of the respondents agreed with the statement ‘women should not have babies who will be at risk for [AIDS],’ whereas 25 percent agreed when the risk was for Tay-Sachs disease and only 15 percent agreed when the risk was for cystic fibrosis.”¹²¹ Such opprobrium will inevitably affect delivery of reproductive health care to HIV-positive women. Indeed, even in the absence of statutes or regulations

¹¹⁹ *Ethics of Prevention*, supra note 95, at 150.
¹²⁰ Nolan, *supra* note 14, at 60.

Tay-Sachs and cystic fibrosis can be diagnosed prenatally with 99% accuracy. Moreover, parents can be screened to determine whether they carry genes for these diseases, and thus, it can be determined, even prior to conception, whether their offspring would face a 25% or higher risk of having these diseases. *See* discussion *infra* notes 411-12 and accompanying text.
authorizing it, several studies have found widespread surreptitious HIV testing in hospitals.122 In addition, a medical trade magazine article explaining how doctors should counsel HIV-positive patients about childbearing states only that they should follow the practice of one internist who tells his HIV-positive patients that “it would be unwise, imprudent, and unfair” for them to have a child.123

While concrete data are not available, anecdotal evidence suggests that women, particularly low income women of color, may often be denied the right to refuse testing and may be pressured to avoid conception and/or terminate pregnancies. A former HIV counselor reports that because her agency, a large provider of prenatal care to low income women in her city, was reimbursed more generously for counseling sessions resulting in a woman’s decision to be tested than for sessions in which she refused consent, counselors felt tremendous pressure to obtain consent. Even the most ethical counselors were swayed. She stated that “to call what they did ‘counseling’ is a complete misrepresentation. Informed consent counseling is meant to facilitate a patient’s free will. They had the explicit agenda to obtain consent for testing.”124 Moreover, because reimbursement was greater when the test results were positive, women who acknowledged a history of high-risk behavior or who were members of groups with high incidence of HIV infection (i.e. African-American or Latin-American) were even more likely to be pressured to accept testing. One woman was even tested after refusing consent.125 The counselor explained that funding for HIV-testing has become the life-blood of the prenatal clinics, three of which have already been closed due to budget cuts. “If the clinics had not become HIV-testing mills, more would have been closed.”126

An AIDS service provider in South Carolina reports that in 1992, two of its women clients who were HIV-seropositive were denied free or low cost abortions by the sole provider of such abortions, unless they consented to tubal ligations. Both women eventually consented to the ligations because they needed abortions and had no other alternatives.127 A Native-American woman in Minnesota re-

125. Id. at 2, 3.
126. Id. at 2.
127. Response to survey conducted by the Center for Women Policy Studies, 2000 P
ports that because she was HIV-positive, two different doctors in the clinic where she was obtaining prenatal care pressured her to have an abortion. One "strongly recommended" an abortion because her "baby would have AIDS" and "would die within the first year." The other doctor told her, "Who do you think you are to bring a baby into this world only to watch it suffer and die?" The woman reports that she refused to have an abortion, and that her baby was not infected with HIV.

A New York case currently being litigated presents allegations of coercion in its most severe form. In *Doe v. Jamaica Hospital* the plaintiff alleges that she was tested for HIV antibodies as part of the care she was receiving in Jamaica Hospital's prenatal clinic for high risk pregnancies. Doe alleges that when Jamaica Hospital personnel informed her that she had tested HIV-positive, she was then heavily pressured to have an abortion and denied continued prenatal care. When she finally succumbed to the pressure and submitted to the abortion, she was subjected to improper medical procedures because of the health care providers' fears of HIV infection.

It is impossible to determine how widespread unauthorized HIV-testing of pregnant and post-partum women has become. However, the indications are that the incidence of unauthorized testing is significant. Directive counseling regarding contraception, abortion, and sterilization, ranging from encouragement to coercion, might also occur in more than isolated instances.

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131. A former HIV counselor reports that abortion referral rates for HIV-positive women obtaining prenatal care at the agency where she worked apparently varied according to the views of the social workers and nurses in charge of the particular facility where they obtained prenatal care. The counselor's impression was that abortion referral rates for HIV-positive women were higher at a facility where health care providers held strong views that HIV-positive women should not have babies, than at facilities where health care providers strongly supported agency policy of free choice for HIV-positive women regarding pregnancy. Interview, supra note 124, at 3-4.
C. Criminal Transmission Statutes: Do They Outlaw Childbearing for HIV-Positive Women?

A large body of developing criminal law authorizes the prosecution of HIV-positive individuals for engaging in certain behaviors which risk transmitting the virus to others. From 1987 through 1989, twenty states enacted statutes that specifically criminalized behavior posing a risk of HIV transmission. In addition, many prosecutions have been brought under pre-existing non-AIDS-specific criminal law.

HIV criminal transmission statutes generally do not require proof of actual transmission of the virus. Instead some criminal statutes apply when an HIV-positive person donates blood, semen or organs, engages in risky sexual contact, or shares needles, regardless of whether anyone else actually contracts HIV. Other more generally worded statutes prohibit the intentional infliction of risk of transmission. Some states have criminalized behaviors which risk HIV transmission by amending preexisting public health statutes regarding the knowing exposure of another person to a sexually transmitted or venereal disease to include HIV.

In addition, prosecutors have interpreted pre-existing criminal laws, not specific to AIDS or public health, to apply to HIV-infected individuals. For example, prosecutors have used attempted murder to prosecute HIV-positive individuals for engaging in behaviors thought to risk transmission to others. One conservative estimate

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133. See table III.
134. See table III.
135. See table III.
136. See table III.
137. E.g., IDAHO CODE § 39-601 (1988) (classifying HIV infection as a venereal disease and prohibiting infected persons from knowingly exposing another person to the infection); ILL. ANN. STAT. ch. 111 1/2 para. 7403 3(3) (Smith-Hurd 1991) (defining HIV as "sexually transmissible disease"); MISS. CODE ANN. § 41-23-2 (1992) (stating that any person "knowingly or willfully violating health department order who is afflicted by life threatening communicable disease or the causative agent thereof shall be guilty of a felony"); FLA. STAT. ANN. § 384.24 (West Supp. 1993) (adding AIDS and HIV to general venereal disease statute and prohibiting an infected person from having sexual intercourse without informing his partner).
posits that as of 1989, there had been fifty to one hundred criminal cases relating to HIV transmission. These prosecutions have had limited success, however, with the majority of them being dropped prior to conviction, acquitted at trial, or reversed on appeal.

More states can be expected to enact criminal transmission statutes in order to become eligible for federal funding. The 1990 Ryan White Comprehensive AIDS Resources Emergency Act requires that all states receiving funds for AIDS services have the statutory capacity to prosecute those who knowingly engage in behavior linked with HIV transmission to unknowing partners. Though the Act's legislative history specifies that it does not intend to criminalize perinatal transmission, the wording of the Act itself does not make this clear. Furthermore, the Act does not prohibit states from interpreting their own laws to include perinatal transmission.

None of the state laws reviewed above specify application to HIV perinatal transmission. Nor do they explicitly prohibit HIV-positive women from becoming pregnant. However, the general and sometimes vague wording of the statutes could allow a creative or misinformed prosecutor to act against a pregnant or post-partum HIV-positive woman. The only way to become pregnant, other than through artificial insemination, is to engage in sexual intercourse in which bodily fluids are exchanged. Therefore, an HIV-positive woman's pregnancy could be used as evidence that she had engaged in acts which risk transmitting the virus to her sex partner. Moreover, HIV-positive women who elect to continue their pregnancies might be subject to prosecution for risking transmittal of the virus to the fetus because perinatal transmission is one of the few medically recognized modes of transmission of HIV. Due to the public opprobrium against the women who are infected by HIV, sometimes even clearly-worded statutes may be misapplied by law enforcement authorities intent on punishing HIV-positive women. Such was the case in a recent North Carolina prosecution.

In light of recent prosecutions of women who used drugs during

139, 156-57 (1988); see also United States v. Moore, 669 F. Supp. 289 (D. Minn. 1987) (convicting prisoner of assault with a deadly weapon for biting a guard), aff'd, 846 F.2d 1163 (8th Cir. 1988).
139. Gostin, supra note 85, at 1039.
140. Id. at 1041.
143. H.R. CONF. REP. NO. 652, 101st Cong., 2d Sess. 83 (1990), reprinted in 1990 U.S.C.C.A.N. 862, 920 ("The Conferees do not intend that conception or pregnancy or other means of transmission from mother to child be construed as a 'donation' that is subject to criminal action.").
144. See discussion infra notes 187-94 and accompanying text.
pregnancy, under statutes prohibiting the supply of controlled substances to minors, such misapplication of law in an HIV context is not surprising. In addition, dicta in several cases reveal a tendency among judges, even some who are eloquently sympathetic to the discrimination suffered by HIV-infected people, to disapprove of childbearing by HIV-positive women. The legal literature has begun to contemplate the application of criminal transmission statutes against HIV-positive pregnant women. Indeed, such application was considered so likely by both the Texas and Oklahoma state legislatures that they explicitly exempted perinatal transmission from the prohibited transmission risk behaviors in their recently enacted HIV criminal transmission statutes.

Analysis of several HIV laws already enacted, and of the ability of prosecutors to gain evidence of HIV status necessary to use such laws, demonstrates that such statutes could be misapplied to prose-

145. See supra note 65 and accompanying text.
148. The Texas criminal transmission statute criminalizes any conduct likely to cause HIV-infected blood to transfer through the skin or other membrane into the blood of another, except during in utero transmission of blood or bodily fluids. TEX. PENAL CODE ANN. § 22.012 (West Supp. 1992). Oklahoma law contains a similar exception. Its statute makes it a crime to knowingly and with intent to infect another, engage in conduct reasonably likely to result in transfer of bodily fluids containing HIV to another, "except during in utero transmission of blood or body fluids." OKLA. STAT. ANN. tit. 21, § 1192 (West Supp. 1993).

Given the current uncertainties concerning how mother-to-child transmission occurs, see supra note 94, exceptions which specify "in utero" transmission may not technically exempt all mother-to-child infections. For example, the exceptions to the Texas and Oklahoma laws do not account for transmission occurring during childbirth, at a time when the fetus has left the uterus and is traveling through the vaginal channel, during the moments before the umbilical cord is severed, or after birth when the child is still covered with the birthing blood and fluids. The legislatures' intents are clear, however, that women should not be prosecuted for transmitting HIV to their fetus or child through pregnancy and childbirth.
ecute pregnant HIV-positive women. Such prosecutions, similar to
the prosecutions of pregnant women for the transmission of con-
trolled substances, are likely to be judicially invalidated when chal-

lenged.\textsuperscript{149} However, despite this likelihood, prosecutors might still
attempt to proceed against HIV-positive women who become preg-
nant and/or have babies. Many of the targeted women will be unable
or unwilling to challenge the underlying legality of their prosecu-

tion.

Facially, the transmission statutes of Illinois, Arkansas, Idaho,
and Missouri appear most susceptible to application against child-
bearing women. The Illinois criminal transmission statute,\textsuperscript{150} en-
acted in 1989 and touted by one commentator as a “model” HIV-
specific criminal law,\textsuperscript{151} is susceptible to misapplication to perinatal
transmission. The statute defines as a felony, punishable by not less
than three and not more than seven years in prison,\textsuperscript{152} the act of
engaging in “intimate contact with another” when knowingly in-
fected with HIV. “Intimate contact with another” is defined as “the
exposure of the body of one person to a bodily fluid of another person
in a manner that could result in the transmission of HIV.”\textsuperscript{153} Two
commentators have already speculated that this law could be read to
criminalize childbearing for HIV-positive women in Illinois.\textsuperscript{154}

Without the cooperation of the state health department, how-
ever, an Illinois prosecutor intent on applying the transmission
statute to pregnant or post-partum women would have a difficult
time amassing proof of HIV infection. HIV test results are not read-
illy accessible. Anonymous testing is available,\textsuperscript{155} and the law re-
quires specific consent.\textsuperscript{156} In addition, unauthorized disclosure of
HIV information is punishable as a class A misdemeanor\textsuperscript{157} and is

\textsuperscript{149} See infra note 195.
\textsuperscript{150} ILL. REV. STAT. ch. 38, para. 12-16.2 (1989).
\textsuperscript{151} Donald H.J. Hermann, Criminalizing Conduct Related to HIV Transmission, 9
ST. LOUIS U. PUB. L. REV. 351, 373-74 (1990). Hermann states that the only significant
problem with this statute is the overbreadth and vagueness of the definition of “intimate
contact.” He suggests correcting this problem by giving the definition a judicial
construction which limits it to the transmission of HIV by means recognized by medical
and scientific authorities. Such construction would still include perinatal transmission.
\textit{Id.}

\textsuperscript{152} ILL. REV. STAT. at para. 1005-8-1.
\textsuperscript{153} \textit{Id.} at para. 12-16.2(b). Another section of Illinois law which could be interpreted
by an overzealous prosecutor to apply to perinatal transmission is: “transfers, donates or
provides his or her blood, tissue, semen, organs, or other potentially infectious body fluids
for transfusion, transplantations, inseminations or other administration to another.” \textit{Id.}
at para. 12-16.2(a)(2).
\textsuperscript{154} Isaacman, supra note 85, at 479; Closen & Isaacman, supra note 147.
\textsuperscript{155} ILL. ANN. STAT. ch. 111 1/2, para. 7306 (Smith-Hurd Supp. 1992).
\textsuperscript{156} \textit{Id.} at para. 7304.
\textsuperscript{157} \textit{Id.} at para. 7312 (Smith-Hurd 1988).
subject to civil suit.\textsuperscript{158} Although HIV-positive test results must be reported to the health department,\textsuperscript{159} that information is exempt from the Freedom of Information Act.\textsuperscript{160} It can only be released by court order upon a finding of a compelling need which cannot be otherwise accommodated. That need must be found to outweigh both the test subject's privacy interest and the "public interest which may be disserved by disclosure which deters blood, organ and semen donation and future HIV-related testing."\textsuperscript{161} However, if a prosecutor were to obtain knowledge of a woman's HIV-positive status, the fact that she is pregnant could be construed as evidence that she is likely to engage in unprotected sexual intercourse, that she thus presents a public health threat and that there is a compelling need for disclosure. Thus, it is not inconceivable that such a petition could be brought and granted by a judge unversed in or hostile to the complexities of constitutional protections for childbearing rights.\textsuperscript{162}

Similarly, under Arkansas law, pregnant HIV-positive women might be prosecuted for "exposing another person to [HIV infection] ... through the parenteral transfer of blood."\textsuperscript{163} The law does not limit or explain the phrase "parenteral transfer of blood." Therefore, it might be interpreted to encompass the birthing blood which bathes the child during childbirth or blood which might cross the placenta during gestation.\textsuperscript{164}

Unlike Illinois, a woman's HIV status is easily accessible to prosecutors in Arkansas. First, state law requires all HIV-positive patients, including pregnant women, to inform their physicians that they are HIV-positive prior to receiving any health care.\textsuperscript{165} In turn, the law requires all physicians, laboratories, hospitals and state agencies to report all persons infected by HIV to the State Department of Health.\textsuperscript{166} Prosecutors may then obtain that information by subpoena in order to enforce the criminal transmission statute.\textsuperscript{167}

Even when a woman does not know her HIV status prior to seeking health care, prosecutors can easily obtain this information.
Under state law, physicians may imply a patient's consent to an HIV test from her consent to receive general prenatal or obstetric care.\textsuperscript{168} Thus, a physician might decide that an HIV test is "medically indicated" for a pregnant woman because the doctor does not believe a responsible person would continue a pregnancy if she had the knowledge that she was HIV-positive. The doctor would then perform the test without the patient's consent or knowledge; if the result is positive, state law requires the physician to inform both the woman and the health department.\textsuperscript{169} Such a scenario is more likely to occur when the pregnant woman is poor, African-American, or Latin-American because of doctors' perceptions of risk groups and because doctors tend to have less respect for the reproductive autonomy of these women.\textsuperscript{170} Thus, Arkansas prosecutors would conceivably have access to information identifying all known HIV-positive women receiving prenatal care or medical assistance at birth.

Idaho's criminal transmission statute could also be misapplied to prosecute a pregnant HIV-positive woman. The statute punishes the act of "expos[ing] another [to HIV] in any manner with the intent to infect" with up to fifteen years in prison and/or a fine of up to five thousand dollars.\textsuperscript{171} Under this law, a prosecution might proceed on the theory that the woman must have had the specific intent to infect her sexual partner because pregnancy reflects that she engaged in unprotected sex. However, many factual issues can be argued to raise reasonable doubt for crimes requiring the intent to infect.

With respect to risk of perinatal transmission, an Idaho prosecution theory might be that a woman intended to infect her offspring with HIV, knowing she had HIV, and knowing pregnancy and childbirth would expose and possibly infect the fetus and the newborn, she nonetheless decided to continue the pregnancy. However, because the odds are one in three that their offspring will be infected, HIV-positive women who continue pregnancy arguably do so in the hope that their children will be healthy.\textsuperscript{172} Therefore, it seems unlikely that a jury would find that a woman held the statutory requi-

\begin{footnotesize}
\begin{enumerate}
\item A patient's specific informed consent to an HIV test is not required when "in the judgment of the physician, such testing is medically indicated to provide appropriate diagnosis and treatment to the subject of the test, provided that the subject of the test has otherwise provided his or her consent to such physician for medical treatment." Id. § 20-15-905(c).
\item Id. § 20-15-905(c), 906(b)(1).
\item See supra note 47 and accompanying text.
\item IDAHO CODE § 39-608 (Supp. 1992).
\end{enumerate}
\end{footnotesize}
site of specific intent to infect.\textsuperscript{173} On the other hand, Idaho juries may indeed convict because of the widespread disapprobation for HIV childbearing and because intent may be inferred from "the circumstances connected with the offense."\textsuperscript{174}

Idaho law implicitly requires specific informed consent for HIV-testing.\textsuperscript{175} However, state health authorities have wide discretion to test those "reasonably suspected of being infected."\textsuperscript{176} Once a health care provider learns that a patient is HIV-positive, the provider must report the patient's name to state health authorities.\textsuperscript{177}

Missouri's criminal transmission statute could also be misapplied to prosecute pregnant or post-partum HIV-positive women. The statute criminalizes the act of "[d]eliberately creat[ing] a grave and unjustifiable risk of infecting another with HIV through sexual or other contact when an individual knows that he is creating that risk."\textsuperscript{178} Thus, if a woman continues her pregnancy when she knows that she is HIV-positive and that the virus can be transmitted perinatally, she has arguably "deliberately" and "knowingly" created a risk of transmission. It would be up to a jury to decide whether a one in three chance of infecting one's offspring is a "grave" risk, and whether such a risk is "unjustifiable" because "grave" and "unjustifiable" are not defined by the statute.\textsuperscript{179} Likewise, a prosecu-

\textsuperscript{173} See, e.g., IDAHO CODE § 18-114 (1992) (making mental intent or criminal negligence an element of every crime); see also State v. Carter, No. 89-6274 (Fla. Cir. Ct., Escambia County, July 23, 1990) (dismissing delivery of illegal substance charges because defendant could not, as a matter of law, have had the intent to deliver cocaine through the umbilical cord to a person when she ingested cocaine while pregnant).

\textsuperscript{174} IDAHO CODE § 18-115 (1987); see also State v. Booton, 375 P.2d 536, 539 (Idaho 1962). Idaho law on jury charges may make convictions more likely. A judge must charge the jury on the specific intent required for specific intent crimes. However, a court's addition of general intent language—for example, "every person of sound mind is presumed to intend the natural and probable consequences of his acts"—is not reversible error on appeal. State v. Rutter, 245 P.2d 778, 783 (Idaho 1952). Notwithstanding, an Idaho prosecution will probably not survive a motion to dismiss brought at the earliest stages of litigation on the basis that the statute was not intended to criminalize childbearing.

\textsuperscript{175} Although Idaho law does not explicitly require specific informed consent to precede an HIV test, the law waives the requirement of informed consent for testing only in specific limited circumstances. See IDAHO CODE §§ 39-4303A(a)(1), (2) (1992).

\textsuperscript{176} IDAHO CODE § 39-603 (1985) (permitting compulsory examination, treatment and quarantine of those suspected of infection with venereal disease); see also IDAHO CODE § 39-601 (Supp. 1992) (defining HIV to be venereal disease).

\textsuperscript{177} IDAHO CODE §§ 39-602, 606 (Supp. 1992).


\textsuperscript{179} The jury's evaluation of the risk may depend in great part on socioeconomic factors. Some scholars hypothesize that people respond to numeric risks differently based on racial, cultural, and socioeconomic differences. For example, poor women whose offspring face elevated health and life risks regardless of the possibility of HIV infection would be more likely to find a 30% risk of perinatal HIV transmission justifiable. See Kass, \textit{supra} note 5, at 318; Zarembka & Franke, \textit{supra} note 111, at 524-25.
tor determined to punish childbearing HIV-positive women could proceed on the theory that in order to have become pregnant, the woman must have engaged in unprotected sexual intercourse which constituted a criminal risk. A conviction could draw a sentence of up to five years imprisonment or a fine of five thousand dollars or both.

Although anonymous testing is available in three cities in Missouri, once a person learns she has tested HIV-positive, she is required by law to give notice of her HIV status to any health care professional before the professional provides her with care. In turn, health care professionals who "perform or conduct HIV blood sampling" are required to report to the Department of Health the identity of any individual confirmed to be infected with HIV. In addition, courts are authorized to order HIV testing on nonconsenting individuals when the Department of Health demonstrates that there "are reasonable grounds to believe that an individual is infected with HIV and there is clear and convincing evidence of a serious and present health threat to others posed by the individual if infected." In sum, Missouri law creates several avenues through which a pregnant woman's HIV status could become known to state health authorities and/or prosecutors.

Such application of criminal transmission statutes is not limited to theoretical possibility. On March 25, 1992, in Cumberland County, North Carolina, Cassandra McLellan, an HIV-positive pregnant woman, was sentenced to two years in prison for violation of criminal transmission regulations issued by the state health commission. The regulations specified that she utilize condoms and inform her partners of her HIV status whenever she engaged in sexual intercourse. The evidence supporting this conviction was

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181. Id. at § 560.011.1(1).
182. Id. at § 191.686.
183. Id. at § 191.656.5.
184. Id. § 191.653.3.
185. Id. at § 191.674.1. Pursuant to the same theory as that discussed regarding Illinois, it is not impossible that a judge would issue an order to test a pregnant woman.
186. Missouri's criminal penalties are triggered if the Department of Health files a complaint with the prosecuting attorney "alleging that an individual has violated a provision" of the criminal transmission statute. Id. at § 191.677.3.
188. In this hastily conducted trial, District Court Judge Sol G. Cherry entered his verdict at the close of the evidence by stating merely, "All right. Stand up. Stand up.
testimony by the director of the county health department.189

Despite allegations that McLellan had been violating the criminal transmission regulations since she was first informed of them, no charges were brought against her until she came to the public health clinic requesting a pregnancy test which proved to be positive.190 The State used McLellan's pregnancy as evidence that she had violated the regulations requiring her to use a condom. While the prosecution stressed that the criminal transmission regulations were designed to protect the health of the HIV-infected person as much as to prevent the transmission of the virus to others,191 the punitive aspect of enforcing the regulations belies this assertion. Two years in the North Carolina Central Prison are unlikely to benefit McLellan's health.192 Indeed, because her appeal was unsuccessful,193 she could spend the rest of her life in prison.194

Enter a verdict of guilty." Transcript of proceedings at 28-29, McLellan (No. 92 CR 05684). At the opening of the trial, the assistant district attorney listed the charges against Ms. McLellan as violations of N.C. GEN STAT. §§ 130A-144, 130A-145. These charges were based on her failure to comply with quarantine and isolation orders and her violation of health department control orders. Id. at 2. See N.C. ADMIN. CODE tit. 15A, r. 19A.0202 (Dec. 1991) (stating that control measures for HIV require that infected persons shall: "(a) refrain from sexual intercourse unless condoms are used; exercise caution when using condoms due to possible condom failure. . . . (e) notify future sexual intercourse partners of the infection").

189. When asked by the prosecutor: "If you're pregnant, you've had sex, basically?", Dr. Jesse F. Williams, the Director of the County Health Department, answered affirmatively. Transcript of proceedings at 9, McLellan (No. 92 CR 05684). The prosecutor continued: "And would that be in violation of the rules that you had promulgated to Ms. McLellan, Sir?" "That would be in violation of the rules," Dr. Williams replied. Id. However, Dr. Williams did acknowledge under questioning that conception could result from either artificial insemination, id., or condom failure. Id. at 5, 15-16. Additionally, he admitted that the Health Department regards condoms as "more efficacious in prevention of disease than they are in birth control." Id. at 15.

The only other trial witness was the public health nurse assigned to Ms. McLellan's case who alleged that McLellan had initially refused to use condoms in April of 1990 when she was first informed of the criminal penalties attached to the health department regulations requiring that she use them. Id. at 18, 24, 26. However, "she did come around" and used them thereafter, id. at 26, though she was not informing her sex partners of the fact that she was HIV-positive. Id. at 23-24.

190. Transcript of proceedings at 22, McLellan (92 CR 05684).

191. Id. at 11.

192. See Bruce Lambert, Prisons Criticized on AIDS Programs, Health and Legal Experts Say Inmates with Disease Face a Disastrous Situation, N.Y. TIMES, Aug. 19, 1990, at A16 (reporting that "among the problems health and prison officials cited [in testimony before the National Commission on AIDS] were poor medical care and lack of medicine, ostracism and harassment by prison employees and other prisoners"); see also T. Ford Brewer & Janice Derrickson, AIDS in Prison, A Review of Epidemiology and Preventive Policy, 6 AIDS 623 (1992) ("Each year, AIDS is becoming the leading cause of death for more prison inmate populations.").

Fortunately, prosecution of HIV-positive women for becoming pregnant is likely to be judicially invalidated. As discussed in parts IV and V respectively, such prosecutions would violate the Fourteenth Amendment right to bear children and the Fourth Amendment right to bodily integrity. In addition, the application of particular state transmission statutes to pregnancy and perinatal transmission could be vulnerable to invalidation on several other grounds. First, the legislative history of the applied transmission statute must be reviewed to determine whether application to pregnancy and perinatal transmission was intended. If not, lack of legislative intent is a powerful argument against such application. To date, in fact, every single challenged prosecution of women for using drugs while pregnant has been dismissed, usually on the grounds of lack of legislative intent.195 In addition, since no transmission sta-

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194. Depending upon the course of Ms. McLellan's HIV disease, her life expectancy could be two years or less. The adverse health conditions inside prison may well shorten that expectancy. See generally ROSEMARY L. GINO & WILLIAM GAUNAY, NEW YORK STATE COMMISSION OF CORRECTION, UPDATE ACQUIRED IMMUNE DEFICIENCY SYNDROME A DEMOGRAPHIC PROFILE OF NEW YORK STATE INMATE MORTALITIES 1981-1986 (September, 1987) (stating that HIV-infected inmate survival rates in the New York State prison system were less than half that of non-incarcerated HIV-infected people); Lambert, supra note 192.

195. For cases citing lack of legislative intent, see Reyes v. Superior Court, 75 Cal. App. 3d 214 (1977) (unanimously holding that state felony child endangerment statute was not intended to apply to unborn child, or to woman's prenatal conduct); People v. Stewart, No. M508197 (San Diego, Cal., Mun. Ct. Feb. 26, 1987) (holding that criminal child support statute that explicitly covered "child conceived but not yet born" was not intended by legislature to impose additional legal duties on pregnant women); Johnson v. State, 602 So.2d 1288, 1290 (Fla. 1992) (reversing conviction, finding unanimously "that the legislative history does not show a manifest intent to use the word 'delivery' in the context of criminally prosecuting mothers for delivery of a controlled substance to a minor by way of the umbilical cord"); State v. Gethers, 585 So.2d 1140 (Fla. Dist. Ct. App. 1991) (holding that state child abuse law was not intended to apply to pregnant woman who uses drug); State v. Luster, No. A92A0233, and Luster v. State, No. A92A0415 (Ga. Ct. App. April 23, 1992) (affirming trial court's dismissal of drug delivery charges, on grounds that legislature did not intend statute to apply to perinatal transfer of cocaine); Welch v. Commonwealth, No. 90-CA-1189-MR (Ky. Ct. App. Feb. 7, 1992) (reversing criminal child abuse conviction of woman for using drugs during pregnancy, on grounds that statute did not mention fetus and thus was not intended to apply to prenatal conduct); Commonwealth v. Pellegrini, No. 87970 (Mass. Oct. 15, 1990) (holding that state drug delivery statute was not intended to apply to women who give birth to substance-exposed infants); People v. Hardy, 469 N.W.2d 50 (Mich. Ct. App. 1991), appeal denied, 471 N.W.2d 619 (Mich. 1991) (holding that statute prohibiting delivery of cocaine to children crime not intended to apply to prenatal conduct); People v. Cox, No. 90-53545 FH (Mich. Cir. Ct., Jackson County July 9, 1990), appeal docketed, No. 131 999 (Mich. Ct. App., Aug. 21, 1990) (granting motion to dismiss, on grounds that state drug delivery statute was not intended to regulate prenatal conduct); People v. Morabito, 530 N.Y.S.2d 843 (N.Y. Mun. Ct. 1992) (dismissing child welfare endangerment charge against woman who allegedly smoked cocaine during pregnancy, on grounds that legislature excluded unborn children from the statute); Commonwealth v. Smith, No. CR-91-05-4381 (Va. Cir. Ct., Franklin
ute explicitly covers pregnancy or perinatal transmission, statutes so applied would be vulnerable to vagueness challenges.196

A further compelling argument for cases involving prosecution for risk of perinatal transmission relies upon the fact that under current law the fetus is not a person.197 Yet all criminal transmission

County Sept. 23, 1991) (granting motion to dismiss, finding that state’s child abuse statute was not intended to apply to fetuses or prenatal conduct); Commonwealth v. Turner, No. 91-054382 (Va. Cir. Ct., Franklin County, Sept. 16, 1991) (also granting motion to dismiss, on same grounds as in Smith). Commonwealth v. Wilcox, No. A-44116-01 (Va. Norfolk Juv. & Dom. Rel. Dist. Ct. Oct. 9, 1991) (dismissing child abuse charges against a woman who allegedly used cocaine during pregnancy, finding that its application to these facts would contravene intent of the legislature).

See also, Greene, supra note 65, at 744 (noting that “developing weight of state court authority rejects these criminal prosecutions of drug-addicted mothers as beyond the legislative intent of general drug prohibition and other statutes”). The only case cited by Professor Green as an exception to this trend has been reversed by the Florida Supreme Court, sub nom. Johnson v. State, 602 So.2d 1288 (Fla. 1992).

Charges have occasionally been dismissed on other grounds. See, e.g., State v. Carter, No. 89-6274 (Fla. Cir. Ct., Escambia County July 23, 1990) (dismissing delivery of illegal substance charges, on grounds that defendant could not, as a matter of law, have had the intent to deliver cocaine through the umbilical cord to a person when she ingested cocaine while pregnant); State v. Bremer, No. 90-32227-FH (Mich. Cir. Ct., Muskegon County Jan. 31, 1991) (dismissing drug delivery charges on principles of statutory construction, due process and privacy, holding that drug delivery law did not cover ingestion of cocaine by pregnant woman); State v. Inzar, Nos. 90CRS6960 & 61 (Robeson County, N.C., Super. Ct. April 9, 1991) (dismissing charges of assault and cocaine delivery, on grounds that a fetus is not a “person” within meaning of relevant statutes); People v. Morabito, 580 N.Y.S.2d 843 (N.Y. Mun. Ct. 1992) (finding, in addition to lack of legislative intent, that woman’s due process rights would be denied by reading the term “child” to include a fetus); State v. Gray, 584 N.E.2d 710 (Ohio 1992) (dismissing child endangerment charge, on grounds that a fetus is not a “person,” nor is a woman a “parent,” until time of birth).

196. The standard for vagueness is that:
[A] criminal statute that “fails to give a person of ordinary intelligence fair notice that his contemplated conduct is forbidden by the statute” or is so indefinite that “it encourages arbitrary and erratic arrests and convictions,” is void for vagueness. This appears to be especially true where the uncertainty induced by the statute threatens to inhibit exercise of constitutionally protected rights.

Colautti v. Franklin, 439 U.S. 379, 390-91 (1979) (citations omitted) (holding that a Pennsylvania statute imposing a standard of care on a person performing an abortion was void for vagueness). Application of this principle could be extended to statutes which inhibit the constitutionally protected right of free choice in childbearing.

Clearly the ambiguity in criminal transmission statutes fails to give adequate notice as to whether they apply to perinatal transmission. Enforcement is likely to depend upon the views of local prosecutors, or, in election years, their understanding of public views regarding childbearing by HIV-positive women. See Roberts, supra note 24, at 1419 (regarding discriminatory enforcement in Pinellas County, Florida). Allowing such application of criminal transmission laws would thus “impermissibly delegate[] basic policy matters to [prosecutors,] policemen, judges and juries for resolution on an ad hoc and subjective basis, with the attendant dangers of arbitrary and discriminatory application.”


statutes require risking transmission of HIV to "another person." The requirement of exposing another "person" to the virus should thus prevent such prosecutions.

In addition to challenging the application of a criminal transmission statute to pregnancy, cases may present factual issues which can lead to acquittal. For example, pregnancy does not constitute proof beyond a reasonable doubt that the defendant engaged in unprotected sexual intercourse and risked infecting her partner. First she may have been artificially inseminated. Second, she and her partner may have used condoms in order to avoid transmission, but the condom failed. Third, the woman's partner may already have been infected with HIV before the sex act which resulted in conception. Fourth, because the risk of transmitting the virus during one particular act of sexual intercourse is estimated to be only one in 500, the woman could have engaged in the act with the specific intent of not infecting her partner, and the statistics would demonstrate that this was not an unreasonable intent.

(Blackmun, J., concurring in part, dissenting in part). "No member of this Court... has ever questioned our holding in Rose that an abortion is not 'the termination of life entitled to Fourteenth Amendment protection.'" Id. (quoting Roe v. Wade, 410 U.S. 113, 159 (1973)); id. at 2839 (Stevens, J., concurring in part, dissenting in part) ("[T]he unborn have never been recognized in the law as persons in the whole sense.... [I]ndeed no member of the Court has ever questioned this fundamental proposition.").

198. See discussion supra notes 131-41 and accompanying text.

199. See supra note 94.

200. See supra note 201.

201. See Elise F. Jones & Jacqueline D. Forrest, Contraceptive Failure Rates Based on the 1988 NSFG, 24 FAM. PLAN. PERSP. 12, 12 (1992) (noting that 15% of condom users became pregnant in the first year of use); Philip Kestelman & James Trussell, Efficacy of the Simultaneous Use of Condoms and Spermicides, 23 FAM. PLAN. PERSP. 226, 226 (1991) (noting that the first-year failure rate for typical condom user is 12%); James Trussell et al., Condom Slippage and Breakage Rates, 24 FAM. PLAN. PERSP. 20, 20 (1992) (noting that 7.9% of condoms either broke during intercourse or withdrawal, or slipped off during intercourse; in addition, 7.2% slipped off during withdrawal).

202. Kestelman & Trussell, supra note 201, at 227 (stating that infectivity of HIV per act of intercourse is 0.2%, regardless of sex of infected partner). It is considerably less likely that an HIV-positive woman will transmit the virus to a man during sexual intercourse than vice versa. Nancy S. Padian et al., Female-to-Male Transmission of Human Immunodeficiency Virus, 266 JAMA 1604 (1991).
D. Public Health Law and Control of Childbearing

HIV-positive women, and indeed all childbearing women, could be subject to a growing body of civil law which adopts or permits coercive measures. These measures could range from mandatory testing and treatment, to civil confinement.\(^{203}\)

Florida and Delaware require that all pregnant women be tested for HIV, regardless of consent.\(^{204}\) Additionally, New York and

\(^{203}\) Several state legislatures have acknowledged the deterrent effect of compulsory HIV health measures. See, e.g., DEL. CODE ANN. tit. 16, § 711(a) (Supp. 1992) (stating that no court order for unconsented release of information on HIV infection shall be issued unless the court finds that a compelling need for release outweighs, \textit{inter alia}, the harm to the public of deterring future testing and treatment); FL. STAT. ANN. § 381.004(1) (West Supp. 1992) ("The Legislature finds that despite existing laws, regulations, and professional standards which require or promote the informed, voluntary, and confidential use of [HIV] tests ... many members of the public are deterred from seeking such testing because they ... fear that test results will be disclosed without their consent."); GA. CODE ANN. § 24-9-47(s)(2) (Michie Supp. 1992) (allowing court to order release of HIV test results after weighing "compelling need" for disclosure against the "privacy interest of the person identified by the information and the public interest which may be disserved by disclosures which may deter voluntary tests"); IOWA CODE ANN. § 141.23(g)(1) (West 1989) (allowing a person demonstrating a compelling need, which cannot be accommodated by other means, to access test results); KY. REV. STAT. ANN. § 214.181(9)(a) (Michie/Bobbs-Merrill 1991) (providing that a person demonstrating a compelling need, which cannot be accommodated by other means, can obtain a court order to have an individual tested); N.Y. PUB. HEALTH LAW § 2785(5) (McKinney Supp. 1993) (providing that the court shall weigh, \textit{inter alia}, the "public interest which may be disserved by disclosure which deters future testing or treatment"); OHIO REV. CODE ANN. § 3701.243(c)(1)(b) (Anderson Supp. 1990) (providing that the court shall weigh, \textit{inter alia}, the public interest which may be disserved by disclosure which deters future testing or treatment); PA. STAT. ANN. tit. 35, § 7602(c) (1993) (explaining that legislative intent in providing guarantees of voluntariness and confidentiality in HIV testing is to "encourage those most in need to obtain testing and appropriate counseling"); S.C. CODE ANN. § 44-29-136(a) (Law. Co-op. Supp. 1992) (permitting release of HIV records to law enforcement agencies if the need for disclosure outweighs the potential harm from possible future deterrence of HIV testing); VT. STAT. ANN. tit. 12, § 1705(a) (Supp. 1991) (requiring disclosure of individually-identified HIV related testing or counseling information if there is a demonstration of compelling need).

\(^{204}\) DEL. CODE ANN. tit. 16, §708 (Supp. 1992) (requiring prenatal blood test for sexually transmitted diseases (STDs)); DEL. CODE ANN. tit. 16, §711 (Supp. 1992) (requiring that Division of Public Health records regarding STDs, "including infection with human immunodeficiency virus ... shall be strictly confidential."); DEL. CODE ANN. tit. 16, §1202(c)(5) (Supp. 1992) (providing for exception to specific consent requirement for HIV testing pursuant to Chapter 7 when "[n]ecessary to control the transmission of HIV infection"); FLA. STAT. ANN. § 384.31 (West Supp. 1993) (mandating that anyone giving prenatal care to a woman must take the woman's blood sample and have it tested for sexually transmitted diseases, "as required by the rule of the department"); FLA. STAT. ANN. § 384.23 (West Supp. 1993) (defining sexually transmissible disease to include human immune deficiency virus infection). Florida reportedly plans to screen only "high risk women." Martha A. Field, \textit{Testing for AIDS, Uses and Abuses}, 16 AM. J. L. & MED. 33, 95 (1990) (citing 1 MONA ROWE & CAITLIN RYAN, A PUBLIC HEALTH CHALLENGE: STATE ISSUES, POLICIES AND PROGRAMS 2-28 (1987)). Because of the demographics of HIV
New Jersey have considered, and Rhode Island has enacted, laws which allow a health care provider to conduct an HIV test on an infant without parental consent. Such laws could have the same effect as identifiable mandatory HIV-screening of all women who give birth in hospitals. North Carolina has enacted a measure which permits mandatory testing of children upon "reasonable suspicion" of HIV infection. Louisiana allows unconsented testing of children when the attending physician "believes it is necessary to treat the child."

Mandatory testing policies specifying that newborns be tested infection among women, targeting "high risk women" is equivalent to targeting poor women and women of color. See supra notes 16-17.

Several other states have enacted statutes governing informed consent for HIV testing which remove it from the common law norms of medical consent and could result in unconsented HIV testing without the consent of childbearing women. See, e.g., Ala. Code § 22-11A-52 (Supp. 1992) (providing that consent to HIV test may be implied when physician determines it is necessary because 1) patient is, "based upon reasonable medical judgment at high risk for HIV infection; 2) [patient's] medical care may be modified by the presence or absence of HIV infection; 3) the HIV status of [patient] shall be necessary in order to protect health care personnel from HIV infection"); Ky. Rev. Stat. Ann. § 214.181 (Michie/Bobbs-Merrill 1991) (providing that general written consent to health care is sufficient as long as the consent form specifies that HIV antibody testing might be among the testing administered); Mich. Comp. Laws Ann. § 333.5133(2) (West Supp. 1992) (requiring written informed consent for HIV testing unless the doctor or hospital believes it necessary to test "for diagnostic purposes to provide appropriate care or treatment" or in order to protect the health and or safety of other patients or persons providing care and treatment to the person to be tested); Ohio Rev. Code Ann. § 3701.242(E)(5) (Anderson Supp. 1990) (requiring specific informed consent for HIV testing, except that consent may be implied when general consent to health care is given and the physician "determines the test is necessary for providing diagnosis and treatment" to the subject of the test).

205. R.I. Gen. Laws § 23-6-12 to -14(a) (Supp. 1992) (providing that a health care provider may conduct an HIV test without consent on a patient "under one year of age"); But see R.I. Gen. Laws § 23-6-15 (1989) ("No involuntary testing for the AIDS virus shall take place under any of the exceptions set forth in § 23-6-14 until reasonable efforts have been made to secure voluntary informed consent."). In New York, all babies born in hospitals have been tested for HIV antibodies without the knowledge or consent of the mother since December, 1987. The results have been doubly blinded, and thus are not traceable to the mother or the baby and have been used only epidemiologically. In June, 1989, however, the State Department of Health announced that it would unblind the newborn testing program and offer mothers the option of learning their babies’ results. When greeted by strong opposition from women’s advocates, this change of policy was tabled in July, 1989. Babies AIDS Test to Remain Secret, Newsdays, July 7, 1989, at 6, 24. No changes in the previous testing policy were made and thus consent is still not necessary prior to testing. State of N.Y. Dep’t of Health, Press Release 1 (June 15, 1989) (on file with the Buffalo Law Review).

206. North Carolina permits testing without consent when a “parent or guardian has refused consent to such testing and there is reasonable suspicion that the minor has AIDS virus or HIV infection or that the child had been sexually abused.” N.C. Gen. Stat. § 130A-148 (1989).

definitively reveal only a mother's antibody status. Although all infants born to HIV-positive women will carry the HIV antibody until approximately their eighth month of life, only thirty percent of those infants will themselves develop the HIV infection. Newborns do not develop immune systems independent of their mothers until months after birth.

Many states also have laws which, although not intended to apply to perinatal transmission of HIV, might be misinterpreted to permit health authorities to take action against pregnant or post-partum HIV-positive women. Since 1987 a number of states have enacted civil isolation measures authorizing the imposition of testing, health care treatment, and/or confinement of people infected by HIV. In some states, this has been accomplished by amending existing isolation laws dealing with "sexually transmitted" or "venereal" disease so as to include HIV infection. Some of these laws permit treating or confining HIV-positive people based solely on the fact that they are infected with a contagious disease. Other

208. See discussion supra note 94 and accompanying text.

209. Id. "Tests that detect ... antibodies ... accurately reflect maternal infection but do not specifically identify infections in newborns and infants, who may carry passive maternal antibody well into the second year of life." Nolan, supra note 14, at 56.

210. Bayer, supra note 131, at 1502. E.g., IND. CODE ANN. §§ 16-1-9.5-4 to 9.5-9, 16-1-10.5-8.5 to 10.5-20 (Burns Supp. 1992) (authorizing mandatory testing, treating, detaining, and isolating upon court order, when the court finds either that: a person 1) is a mentally ill carrier of dangerous communicable disease, including HIV, and is gravely disabled or dangerous; or 2) is a carrier who presents a serious and present health threat and who has violated a restrictive order issued by a health official); MICH. COMP. LAWS ANN. §§ 333.5201 -.5205 (West Supp. 1992) (authorizing testing and treatment when an individual infected with HIV is a "health threat to others"); N.C. GEN. STAT. § 130A-145 (1989) (granting health authorities power to quarantine and isolate so long as public health is endangered, all other reasonable means for correcting the problems have been exhausted, and no less restrictive alternative exists); N.D. CENT. CODE § 23-07.4-01 (1991) (providing that health officers can examine anyone "reasonably believed to be infected with or to have been exposed to" HIV); N.D. CENT. CODE § 23.07.4-02 (Supp. 1990) (permitting the state health officer or designee to petition the county court for injunction and the court may take other appropriate measures including taking the person into custody, when imminent danger to the public health by HIV-positive person's behavior exists); S.C. CODE ANN. § 44-29-70 to -115 (Law. Co-op. Supp. 1991) (providing for mandatory reporting, examination, treatment, isolation, and confinement of people with sexually transmitted disease, including HIV); WYO. STAT. § 35-4-133 (Supp. 1991) (authorizing health officers to isolate, examine, and treat individuals suspected of infection with sexually transmitted disease).


212. See e.g., IDAHO CODE § 39-603 (Supp. 1992) (authorizing health authorities, when in their judgment it is necessary to protect the public health, to treat and or confine "persons reasonably suspected of being [HIV]-infected"); N.C. GEN. STAT. § 130A-144, -145
states have passed public health laws dealing with the AIDS virus, that empower authorities to take action against known or suspected HIV-positive individuals when they are believed to have engaged in dangerous behavior.\footnote{213} There are also public health laws in several states which do not specifically mention HIV or AIDS, but which would probably justify imposing health care on HIV-positive people.\footnote{214} In addition, several public health laws impose criminal penal-

\begin{itemize}
\item \textbf{(1989)} (providing that the Commissioner for Health Services can order control measures for HIV and other communicable disease, which doctors must impose on "patients reasonably suspected of being infected or exposed"); TENN. CODE ANN. § 68-5-104 (Supp. 1992) (obligating local health officials to take steps to quarantine or isolate someone suspected or known to be infected with "communicable contagious disease"). These laws seem to permit the internment of almost any HIV-infected person for any reason, or indeed, for no reason. Such status-based laws have been convincingly criticized and would have little chance of surviving constitutional review. Gostin, supra note 85, at 1028, 1033-35; see also Sullivan & Field, supra note 138, at 144-52 (addressing the shortcomings of a statute-based quarantine). Indeed, that these status-based laws survive at all is due to the fact that they have yet to be challenged in court. Once challenged, at the very least, a court should require that health authorities provide due process to the individual charged and demonstrate that the HIV-infected individual presents a "significant risk" to the public health. Gostin, supra note 85, at 1029-31, 1036-38. Because HIV is difficult to transmit and does not spread through casual contact, health authorities would need to demonstrate that the individual has engaged in behaviors which pose a risk of transmission. Thus, if status-based statutes survive judicial scrutiny, they are likely to take on the form and substance of behavior-based statutes. See Gostin, supra note 85, at 1033-35.

\footnote{213} \textit{See}, e.g., ALA. CODE § 22-11A-32 (1990) (permitting civil commitment if "the person is dangerous to himself and the health of the community" or if "the person conducts himself so as to expose others to the disease"); COLO. REV. STAT. ANN. §§ 25-4-1406, -1407 (West Supp. 1992) (holding that when a person is or is reasonably believed to be infected with HIV, the state or local health department may order the person to be examined and tested, to visit a health worker's officer for counseling, or to cease and desist from specified dangerous conduct; if a person violates a cease and desist order, personal restrictions can be imposed as necessary to prevent dangerous conduct; and failure to comply with the statute can result in criminal penalty); FLA. STAT. ANN. § 384.28 (West Supp. 1993) (permitting a quarantine to prevent the "probable spread of a sexually transmitted disease, until such time as the condition can be corrected or the threat to the public's health eliminated or reduced"); FLA. STAT. ANN. § 384.281 (West Supp. 1993) (permitting prehearing detention of someone alleged to require quarantine if, \textit{inter alia}, the suspect engages "in behaviors which create an immediate and substantial threat to the public" and refuses to conduct herself in such a manner as to not place others at risk); NEV. REV. STAT. ANN. § 441A.300 (Michie 1991) (permitting confinement when a person with AIDS violates an order of a health authority or "engages in behavior through which the disease may be spread").

\footnote{214} Gostin, supra note 85, at 1028; Sullivan & Field, supra note 138, at 144 n.18. A number of state statutes authorize health officials to control people with communicable diseases and define communicable disease in such a way as to include HIV. \textit{E.g.}, CONN. GEN. STAT. ANN. § 19a-221(b) (West Supp. 1992) (authorizing health directors to order that an individual be confined if there are reasonable grounds to believe he or she is infected with a communicable disease and is unwilling or unable to act in a manner so as not to expose others to danger of infection); MINN. STAT. ANN. § 144.4171-4186 (West 1989) (authorizing public health officials to issue orders and to apply for court enforce-
ties for violations of quarantine or control orders. 215

AIDS-specific laws that are susceptible to misapplication to childbearing include those which authorize civil confinement when an HIV-positive person either generally engages in "dangerous conduct," 216 or performs specified dangerous acts such as refusing "to comply with treatment measures." 217 In the context of childbearing, conceiving and/or continuing a pregnancy, thereby risking transmission to sex partners or risking the birth of HIV-infected children, could be argued to be "dangerous conduct." Likewise, refusal to use contraception or to submit to sterilization could be argued to be a refusal of "treatment measures," and therefore, held to justify civil confinement.

Unfortunately, civil containment laws could be misused to require mandatory HIV-testing or contraceptive use, or to compel abortion or sterilization. In addition, because the broad public health powers have not been widely tested or circumscribed in recent times, an ambitious or misinformed public health commissioner could use them to attempt to quarantine or incarcerate an HIV-positive woman.

ment of such orders for, inter alia, compulsory testing, treatment, and confinement when they reasonably believe someone has a "communicable disease" and is a health threat to others); OKLA. STAT. ANN. tit. 63 § 1-501, 1-502 (West 1984) (permitting the prevention and control of communicable disease); PA. STAT. ANN. tit. 35, § 521.1-20 (1993) (authorizing health officers to isolate any person infected with a communicable disease for safekeeping and treatment).

215. See, e.g., ALA. CODE § 22-12-22 (1990) (stating that it is a misdemeanor to knowingly transport person or thing in violation of quarantine regulations); ARIZ. REV. STAT. ANN. § 36-630 (1986); CONN. GEN. STAT. ANN. § 19a-230 (West 1990) (making violations of quarantine regulations subject to fines and imprisonment); GA. CODE ANN. § 31-17-8 (Michie 1991); ILL. ANN. STAT. ch. 111 1/2, para. 24 (Smith-Hurd 1988) (making it a misdemeanor to refuse to obey a rule of the Department of Public Health); KAN. STAT. ANN. § 65-6005 (Supp. 1991) (including violating secretaries' rules as misdemeanors); N.C. GEN. STAT. §§ 130A-25, -144, -145 (1992) (providing that a violation of a quarantine, isolation, or control order is a misdemeanor); PA. STAT. ANN. tit. 35, § 521.19 (1993) (making it a misdemeanor for a person who is quarantined to leave the place of isolation without the consent of the medical director); R.I. GEN. LAWS § 23-11-16 (1989) (stating that a violation of quarantine regulations is subject to fines and imprisonment); TENN. CODE ANN. § 68-5-104(b) (Supp. 1992) (making willful escape from lawful quarantine a misdemeanor); WASH. REV. CODE ANN. §§ 70.24.024, .034 (West Supp. 1993) (making it a gross misdemeanor to violate health department orders regarding compulsory examination, treatment, and detention); see also KAN. STAT. ANN. § 65-6003-6005 (Supp. 1991) (permitting the Secretary to adopt rules for the prevention and control of AIDS and providing that a violation of such rules is a misdemeanor).

216. See supra note 213.

E. Summary

A vocal minority of health policy experts now call for mandatory HIV-testing of all pregnant or post-partum women. Some policy experts have proposed policies which would diminish informed consent protections, and thus protections of bodily integrity, for HIV-positive women regarding their childbearing. Thus, one expert advocates directive counseling and another urges us to "rely on the sterilization option." The view that HIV-positive women should not have children is widespread. Included among the adherents to this view is the CDC, which recommends that pregnancy be "postponed" if one is HIV-positive. Anecdotal evidence suggests that such opinions are reflected in gynecological obstetrical practice, though the extent of the coercion of HIV-positive females has not yet been ascertained.

Concurrently, there is a move throughout the states to use law enforcement powers to attempt to curb the spread of AIDS. Over twenty states have passed laws specifically criminalizing behaviors which risk HIV transmission. In addition, over twenty states have passed public health laws authorizing the imposition of health care on or the isolation of individuals who are HIV-positive and likely to transmit the infection. It appears probable that law enforcement authorities committed to using their power to prevent children from becoming HIV-infected will attempt to apply such laws to the risks of transmission associated with conception and childbearing.

In all likelihood, legal protections against state interference with an individual's right to bear children will eventually be applied to invalidate prosecution of pregnant HIV-infected women. These protections will prevent the imposition of compulsory medical treatment which would regulate an individual's childbearing. The common law right to informed consent, the Fourteenth Amendment protection from state interference in childbearing, and the Fourth Amendment protection from state interference with bodily integrity are powerful legal doctrines which should act to check the impulse to control "socially unacceptable" childbearing. However, as this Article predicts, we are likely to observe an increase of such prosecutions before they are curbed. History has a way of repeating itself.

218. See discussion infra parts III.V.

219. Additionally, like the criminal statutes, the civil statutes authorizing such prosecutions may be vulnerable to challenges for lack of legislative intent and on vagueness grounds. See Hoffman Estates v. Flipside, Hoffman Estates Inc. 455 U.S. 489 (1981). Although the Supreme Court has "expressed greater tolerance of enactments with civil rather than criminal penalties because the consequences of imprecision are qualitatively less severe," when civil measures, such as those affecting HIV childbearing, "threaten to inhibit the exercise of constitutionally protected rights," they are required to be exacting precisely to avoid vagueness invalidation. Id. at 499.
III. THE RIGHT TO INFORMED CONSENT TO MEDICAL CARE

This part argues that the imposition of HIV testing, forced contraception, and involuntary abortion or sterilization will usually violate state informed consent law, whether the health care provider is a private or state actor. Although a patient’s right to consent or refuse medical care varies from state to state, and some states have enacted exemptions affecting the medical rights of HIV-positive childbearing women, most states follow common law consent doctrine. Under this doctrine, health care cannot be provided to a patient absent consent which is knowing, voluntary, and competent. Thus, health care providers who impose unconsented HIV testing (absent statutory authority), and those who pressure or compel women to accept contraception, abortion or sterilization, will be liable for medical malpractice. Health care procedures can be per-

220. The specific legal requirements for informed consent vary from state to state as it is determined either by the common law of each state, or as is increasingly the case, by state statute. See Fay A. Rozovsky, CONSENT TO TREATMENT: A PRACTICAL GUIDE § 1.13.3 (2d ed. 1990); see also Ruth R. Faden ET AL., A HISTORY AND THEORY OF INFORMED CONSENT 30-34 (1986); Thomas Grisso, EVALUATING COMPETENCIES 311 (1986); Sharon Rennert ET AL., AM. BAR ASS'N, AIDS AND PERSONS WITH DEVELOPMENTAL DISABILITIES: THE LEGAL PERSPECTIVE 37-42 (1989). Currently, the American Medical Association (AMA) directs that "[t]he patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice...The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice." The Council on Ethical and Judicial Affairs of the American Medical Association, Current Opinions para. 8.08 (1989); see also 1 President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Making Health Care Decisions: A Report on the Ethical and Legal Complications of Informed Consent in the Patient-Practitioner Relationship 70 (1982) [hereinafter Study of Ethical Problems]; American College of Obstetricians and Gynecologists, Standards for Obstetric-Gynecological Services 88 (7th ed. 1989).

221. Depending upon state law and the circumstances of the case, civil actions could be brought for assault, battery, violation of informed consent, and intentional or negligent infliction of emotional distress. While it is difficult to predict how juries will evaluate HIV-positive women's claims, damage awards in several related cases are instructive.

A woman contending that she had been forcibly tested for HIV when arrested in 1988 on charges of prostitution and reckless endangerment attained a tentative settlement of her suit against the City of Honolulu in the amount of $50,000. Woman Settles Suit Claiming Test for HIV Was Forced, N.Y. Times, Aug. 9, 1992, § 1, at 36.

In 1990, a woman negligently subjected to an abortion without her consent was awarded $5,000 in actual damages and $25,000 in punitive damages. In affirming the jury's award, the South Carolina Court of Appeals noted that she had sought only a second opinion about whether to have an abortion when the doctor who examined her performed the abortion. In sustaining the jury verdict, the court noted that "she suffered pain from the procedure without anesthesia; she was deprived of her right to choose the doctor to perform her D & C; in addition she sustained emotional injury." Tisdale v. Pruitt, 394 S.E.2d 857, 860 (S.C. Ct. App. 1990).

Although not specifically involving unconsented medical procedures, damages
formed on a person absent her express consent pursuant to the doctrine of implied consent. Implied consent is applicable in certain emergency circumstances or when a person is not competent to consent. However, none of these traditional exceptions to the need for a patient’s express consent would justify intrusive medical procedures such as compelled testing, contraception, or abortion. In states which have legislatively removed portions of health care services from consent law (i.e. by permitting unconsented HIV testing of pregnant women or newborns), medical malpractice claims may be limited. However, even in states with such statutory exemptions, informed consent norms still govern the administration of most types of health care, including the prescription or implant of contraceptives, abortion, or sterilization. In the absence of statutory override, traditional informed consent norms are powerful deterrents to imposing unwanted health care procedures upon HIV-positive women.

This part also explains in detail why two exceptions to the requirement of informed consent—that of overriding a parent’s refusal to consent to health care for a child, and that of the state’s power to impose medical treatment when there is a proven compelling need to protect the public health—are unlikely to justify impos-

awarded in other pregnancy related cases may shed some light on the amounts that might be obtained. A judge delineated $450,000 of a pain and suffering award as compensation for the mental anguish of losing a fetus through miscarriage when a woman bus driver was not assigned to light duty when she requested the assignment as an accommodation to her high risk pregnancy. New York City Transit Authority v. State Division of Human Rights, 581 N.Y.S.2d 426 (App. Div. 1992); see also Planned Parenthood of N.W. Indiana v. Vires, 543 N.E.2d 654 (Ind. Ct. App. 1989) (awarding $60,000 to a woman who had an IUD negligently inserted while pregnant; insertion of the IUD caused her to miscarry, which necessitated a follow up D & C). See generally Schneck v. Government of Guam, 609 F.2d 387 (9th Cir. 1979) (reversing judgment that hospital had no duty to supervise treatment given by a private physician); Danos v. St. Pierre, 383 So. 2d 1019 (La. Ct. App.) (awarding $20,000 for pain and suffering to a woman for the loss of her six month pregnancy as a result of a blow sustained to her abdomen in a car accident).

One would expect relatively greater awards when interference with childbearing is intentional, when it is carried out with force, and when it involves higher degrees of intervention. Thus, damages from unconsented HIV testing would be valued lower than damages from unconsented abortion. Damages from a medical procedure carried out after a patient “consents” where she had been momentarily persuaded by directive counseling would be valued lower than damages from a procedure carried out by forcibly anesthetizing a patient who had refused consent.

222. Informed consent analysis will often be crucial to Fourth and Fourteenth Amendment analyses. While this Article argues that government imposed Norplant insertion and compulsory abortion violate both the Fourteenth Amendment right to bear children and the Fourth Amendment right to bodily integrity, a complete defense against such claims would be that the woman freely consented to these health care procedures. See discussion infra parts IV-V.
ing coercive measures on HIV-positive women to prevent their childbearing.

A. Overview of Informed Consent Law

The right to medical consent derives from the common law right to bodily integrity and self-determination.\(^{223}\) It has been recognized in United States law for over one hundred years,\(^{224}\) and in the 1970's became codified in more than half of the states.\(^{225}\)

In one of the earliest informed consent decisions, the Appellate Court of Illinois in *Pratt v. Davis*\(^{226}\) recognized the fundamental role of medical consent in our democracy:

> [U]nder a free government at least, the free citizen's first and greatest right, which underlies all others—the right to the inviolability of his person, in other words, his right to himself—is the subject of universal acquiescence, and this right necessarily forbids a physician or surgeon, however skillful or eminent . . . to violate without permission the bodily integrity of his patient . . . .\(^{227}\)

While the earliest cases stood for the proposition that surgery could not be performed unless the patient specifically agreed to the procedure, informed consent doctrine has developed\(^{228}\) to require that consent to all medical treatments be knowing, voluntary and competent.

A final general point relevant to this discussion is that a

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223. "[The] notion of bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment." Cruzan v. Director, Mo. Dept' of Health, 497 U.S. 261, 269 (1990).

224. "No right is held more sacred . . . than the right of every individual to the possession and control of his own person." Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891) (holding that civil plaintiff could not be compelled to undergo medical examination). The Supreme Court quoted this language almost 100 years later. Cruzan v. Director, Mo. Dept' of Health, 497 U.S. at 269.

The protections afforded by the doctrine of informed consent are intimately connected to the right to self-determination and are recognized as essences of liberty. Samuel D. Warren & Louis D. Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193 (1890) ("That the individual shall have full protection in person and in property is a principle as old as the common law."); Natanson v. Kline, 350 P.2d 1093, 1104 (Kan. 1960) ("Anglo-American law starts with the premise of thorough-going self determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment.").


227. Id. at 166.

228. See generally KATZ, supra note 225, at 48-84 (tracing the historical development of the right to informed consent).
woman's right to medical consent is not diminished by pregnancy.229 Medical treatment cannot be forced upon or withheld from a pregnant woman without her consent in the purported interest of the fetus. This is because a person cannot be compelled to undergo "a significant intrusion upon his or her bodily integrity for the benefit of another person's health."220 In addition, the fetus has not even been held to be a person. As the District of Columbia Court of Appeals explained, "[s]urely... a fetus cannot have rights... superior to those of a person who has already been born."221 Moreover, the United States Supreme Court has repeatedly held that the state's interest in fetal life cannot justify imposing increased health risks on women.232 Thus, the governmental interest in the fetus cannot override a woman's right to refuse medical intervention.

B. The Knowledge Requirement Prohibits Coercion

The goal of the informed consent dialogue is to ensure that the health professional imparts all of the relevant medical knowledge to the patient concerning her health situation and treatment options which will enable the patient to make an informed choice about the best course of action to pursue.233 The treatment options discussed

229. Roe v. Wade, 410 U.S. 113, 153 (1973); In re A.C., 573 A.2d 1235, 1237 (D.C. 1990). Indeed, because many informed consent protections have developed from cases concerning women subjected to reproductive coercion, it would be inconsistent if reproductive health were accorded lesser protection. See, e.g., Pratt v. Davis, 79 N.E. 562 (Ill. 1906) (holding a doctor liable for performing an operation without consent when a woman sought treatment for epilepsy; the physician told her he needed to do surgery in order to repair a few superficial cervical and rectal tears, and the physician subjected her to a hysterectomy and removal of her ovaries); see also Sard v. Hardy, 379 A.2d 1014 (Md. 1977) (discussing whether physician had disclosed information necessary for informed consent decision in tubal litigation operation).

230. In re A.C., 573 A.2d at 1243-44 (citations omitted); see also McFall v. Shimp, 10 Pa. D. & C.3d 90 (Allegheny County Ct. 1978) (holding that a person could not be compelled to donate bone marrow necessary to save life of a cousin).

231. In re A.C., 573 A.2d at 1244 (holding that compelling a woman to undergo a Cesarean section in the interest of her fetus violated her medical consent and constitutional rights).


must also include the alternative of foregoing any treatment at all.\textsuperscript{234} Moreover, except in a limited set of exceptions discussed below, the option of rejecting all treatment is the patient's to pursue. This is true even if the health care provider disagrees and even when such a course is likely to result in the patient's death.\textsuperscript{235}

The knowledge element requires that information concerning treatment alternatives be communicated "in language as simple as necessary" for the particular patient to understand.\textsuperscript{236} The aims of this requirement are twofold. First, it ensures that the patient understands the information conveyed by the professional. Second, simple language encourages the patient to engage in candid dialogue with the provider about her health history and life circumstances. This dialogue enhances the professional's ability to accurately evaluate the patient's condition and describe the possible risks and benefits of various treatments. This maximizes the accuracy of the description of the risks and benefits, and therefore, better fulfills the knowledge requirement.

Varying levels of specificity of consent are required depending upon the type of procedure involved. In circumstances when a routine health care procedure promises practically universal benefit and minimal risk, a patient's consent may be implied when the patient has consented to receiving general health care from that provider.\textsuperscript{237} Many types of routine blood tests, such as those gener-

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\textsuperscript{234} Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 270, 277 (1990).
\textsuperscript{235} Id. at 281 (observing that "an interest in refusing life sustaining medical treatment" is protected by the Due Process Clause of the Fourteenth Amendment); In re A.C., 573 A.2d 1235, 1243-47 (D.C. 1990); In re Storar, 420 N.E.2d 64, 71 (N.Y. 1981), cert. denied, 454 U.S. 858 (1981); see President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment 44 (1983); Norman L. Cantor, A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life, 26 Rutgers L. Rev. 228, 237 (1973); Edward A. Lyon, Comment, The Right to Die: An Exercise of Informed Consent, Not an Extension of the Constitutional Right to Privacy, 58 U. Cin. L. Rev. 1367 (1990).
\textsuperscript{236} Natanson v. Kline, 350 P.2d 1093, 1106 (Kan. 1960); see, e.g., 42 C.F.R. \textsection\textsection 441.257(a)(2), (3) (1991) (specifying that, in the case of sterilization of a Medicaid patient, suitable arrangements be made to ensure effective communication "to any individual who is blind, deaf or otherwise handicapped," and, if the "individual to be sterilized did not understand the language used on the consent form or the language used by the person obtaining consent," an interpreter must be provided); President's Commission for the Study of Ethical Problems in Medical and Behavioral Research, The Values Underlying Informed Consent (1982), reprinted in The Crisis in Health Care: Ethical Issues 217, 220 (Nancy F. McKenzie ed., 1990); see also Grisso, supra note 220, at 323 (noting that a patient's lack of awareness of her own treatment and condition might be a consequence of the manner in which the treating professional disclosed the information to the patient, as opposed to the patient's incompetency).
\textsuperscript{237} Rennert, supra note 220, at 42. But see Gerald F. Tietz, Informed Consent in the Prescription Drug Context, 61 Wash. L. Rev. 367 (1986) (arguing that specific
ally administered in a woman's first prenatal checkup, do not currently require specific consent.\textsuperscript{238} However, consent should never be implied for sterilization, abortion, contraception, or HIV testing.

For over one hundred years the law has held that consent cannot be implied for surgical intervention.\textsuperscript{239} Thus, prior to sterilization or abortion, there must be a detailed dialogue between health professional and patient culminating with the granting of specific consent by the patient.\textsuperscript{240} Although the insertions of Norplant or of an intrauterine contraceptive device (IUD) are arguably less invasive, they are still surgical procedures. Thus, specific consent would be required prior to insertion of these devices.\textsuperscript{241} Significantly, while not invasive at all, the prescription of birth control pills is recognized to require a woman's specific informed consent.\textsuperscript{242}

Finally, the HIV antibody test should also require specific consent because of its potentially grave psychological and social significance. Indeed, as of April 14, 1993, thirty states recognized this by enacting statutes requiring that physicians ordinarily obtain specific consent before conducting an HIV antibody test.\textsuperscript{243} Many hospitals also have issued their own HIV testing consent policies.\textsuperscript{244}

Informed consent should be required for all proposed drug treatments because all drugs present risks and are "dangerous," drug therapy is less predictable than surgery, drugs are grossly over utilized, and the potential benefits of drugs vary widely).

\textsuperscript{238} See \textit{RENNERT, supra} note 220, at 42.
\textsuperscript{239} Katz, \textit{supra} note 225, at 48-84.
\textsuperscript{240} In some jurisdictions, sterilization has been recognized to be so integral to the right to self-determination and so susceptible to coercion, that specific informed consent is mandated by statute or regulation. \textit{E.g.}, MD. \textsc{Code Ann.}, \textsc{Health-Gen.} § 20-107(f)(1)(i) & (ii) (1990) (disallowing consent of substitute decisionmaker for abortion or sterilization). Following the revelations of widespread sterilization abuse against Medicaid patients in the 1970's, the New York City Health and Hospitals Corporation adopted regulations mandating specific informed consent for sterilization. \textit{LINDGREN & TAUB, supra} note 28, at 415-16. These regulations were later enacted as local law by the New York City Council, N.Y.C. \textsc{Admin. Code} § 17-404 (1991) (requiring, along with both Health and Hospital regulations, that specific consent for the procedure be obtained from the patient in writing thirty days before the actual operation and that the patient not be hospitalized at the time the consent is given). The regulations served as the basis for federal regulations for Medicaid funded sterilization and hysterecomies. 42 \textsc{C.F.R.} §§ 441.257, 258 (1991).

\textsuperscript{241} \textit{See} \textit{Tresemer v. Barke, 86 Cal. App. 3d 656 (Cal. Ct. App. 1978)} (holding that a physician's failure to warn a woman of the risks of an IUD violated his duty to obtain informed consent).

\textsuperscript{242} \textit{Klink v. G.D. Searle & Co., 614 P.2d 701 (Wash. 1980)} (holding that physician's failure to warn a woman of risk of stroke from contraception pill violated physician's duty to obtain informed consent); \textit{see also} \textit{Hamilton v. Hardy, 549 P.2d 1099 (Colo. 1976)} (holding that a physician's failure to warn women of risk of birth control pills violated his duty to obtain informed consent).

\textsuperscript{243} \textit{RENNERT, supra} note 220, at 42 (citations omitted); \textit{see infra} table II.

\textsuperscript{244} \textit{Charles E. Lewis \& Kathleen Montgomery, The HIV-Testing Policies of U.S. Hospitals, 264 \textsc{Jama} 2764 (1990)} (concluding from survey that 78% of nonfederal
the major legal and medical bodies that have considered the question concur that consent to the HIV antibody test must be specific. These include the American Public Health Association, AMA Commission on the Mentally Disabled, and the AMA Center on Children and the Law, and the National Academy of Sciences’ National Institute of Health.245

C. The Requirement of Voluntariness

A physician is not permitted to “[s]ubstitute his own judgment for that of the [competent] patient by any form of artifice or deception.”246 Because we as a people attach “profound importance and authority to the words of advice spoken by the physician,”247 the hospitals nation-wide have promulgated policies requiring specific informed consent prior to conducting an HIV antibody test.

245. The following groups oppose testing without the consent of the woman: The Committee on Prenatal and Newborn Screening for HIV Infection of the Institute of Medicine: HIV Screening of Pregnant Women and Newborns (Hardy ed., 1991); The Working Group on HIV Testing of Pregnant Women and Newborns, HIV Infection, Pregnant Women and Newborns, 264 JAMA 2416 (1990); American Academy of Pediatrics, Task Force on Pediatric AIDS, Perinatal Human Immunodeficiency Virus Infection, 82 PEDIATRICS 941 (1988); American Pub. Health Ass., APHA Policy Statement #8814, 79 AM. J. PUB. HEALTH 340, 359 (1989) (specifying that counseling and testing for perinatal transmission of AIDS should be “voluntary,” the provision of information should be “nonjudgmental and sensitive to cultural, parous, life-status and age factors,” and that counseling and health care be available regardless of the decisions a woman makes; calling on CDC to develop standards for HIV test counseling for pregnant and childbearing age women, “noting cases where women have been denied funding for abortion of “alleged HIV-positive fetus unless it is part of a sterilization procedure”); RENNERT ET AL., supra note 220; SECRETARY’S WORK GROUP ON PEDIATRIC HIV INFECTION AND DISEASE, DEPT. OF HEALTH & HUMAN SERVICES, FINAL REPORT (1988) [hereinafter WORKING GROUP, POLICY PROPOSAL]; NEW PERSPECTIVES ON PRENATAL CARE (Irwin R. Merkatz et al. eds., 1990); Ruth R. Faden et. al., supra note 14, at 331 (rejecting “implementation of counseling and screening policies that interfere with women's reproductive freedom or result in the stigmatization of vulnerable social groups” and endorsing informed consent for HIV testing, which consent should include an explanation of the “limits of confidentiality, associated social risks, available antidiscrimination protections, ... available anonymous testing services”, and available health care for her and/or any child she may birth); see also Health and Policy Committee, American College of Physicians & The Infectious Diseases Society of America, The Acquired Immunodeficiency Syndrome (AIDS) and Infection with the Human Immunodeficiency Virus (HIV), 108 ANNALS INTERNAL MED. 460, 464 (1988) (opposing mandatory HIV testing because “it is widely believed, that such an approach would only drive potentially HIV-infected persons away from the health care system”).


247. Rust v. Sullivan, 111 S.Ct. 1759, 1785 (1991) (Blackmun, J., dissenting). “In our society, the doctor/patient dialogue embodies a unique relationship of trust. The specialized nature of medical science and the emotional distress often attendant to health-related decisions requires that patients place their complete confidence, and often their very lives, in the hands of medical professionals.” Id. In the majority opinion, Chief Justice Rehnquist did not disagree with Justice Blackmun, but avoided the issue by find-
health care provider must exercise great care to impart knowledge to the patient without attempting to direct the result. Evidence of coercion, duress, undue influence, or deceit negate a person's consent.248

When the patient has restricted access to alternative sources for treatment, health professionals are not permitted to deliver ultimata that a patient must accept a particular course of treatment or seek treatment elsewhere.249 Nor may professionals invoke the retraction of any other benefit from the patient (i.e., welfare subsidies, child custody) as a consequence of refusing a recommended treatment.250 Several states have specifically codified this principle in regard to HIV testing and prohibit conditioning the receipt of health care on the acceptance of HIV testing or proof that one is HIV negative.251

The aspect of voluntariness also requires that professionals may not withhold or give inaccurate information about potential
risks and benefits because this might sway a patient's decision. Hence, a pregnant HIV-positive woman should be informed in comprehensible terms of the range of odds that her child might be HIV-infected. She should also be told that while the impact of continuing a pregnancy is unknown, there is some evidence that pregnancy can jeopardize her health through escalation of HIV replication and the normal suppression of the immune function associated with pregnancy.252

In one particularly relevant case, a court held that a cause of action was stated for medical malpractice and violation of civil rights when a doctor allegedly engaged in extensive directive counseling. An HIV-positive woman alleged that her doctor counseled her that there was a "very high chance" that her baby would be born with AIDS, that AIDS was worse than spina bifida for a child, that her baby would suffer and be a burden to society, and that she should have an abortion and could not continue receiving prenatal care in his hospital.253

A far subtler pressure than that exerted in Doe v. Jamaica Hospital can undermine a woman's free will. In the words of Justice Blackmun: "One seeks a physician's aid not only for medical advice or diagnosis, but also for guidance, professional judgment, and vital emotional support."254 A woman could be particularly susceptible to such pressure when she is confronting the emotionally-laden decision about whether to become pregnant or to continue a pregnancy despite HIV infection.

D. The Requirement of Competence

The element of competence is of vital importance to understanding the consent rights of HIV-infected women.255 "[C]ompetency... turns on the patient's ability to function as a decision-

252. See Lindgren et al., supra note 94, at 1115.
255. An HIV-positive woman's competence to consent or refuse health care may often be at issue. Forty-nine percent of reported HIV-positive women had been intravenous drug users. See Centers for Disease Control, Childbearing and Contraceptive Use Plans Among Women at High Risk for HIV-Infection - Selected U.S. Sites - 1989-1991, 41 MORBIDITY & MORTALITY WKLY REP. 135, 135 (1992). Presumably, many of these women are addicted to drugs, and the course of HIV disease often includes toxoplasmosis or other dementia-inducing conditions. Because of the practically universal disapproval for HIV-positive women's decisions to bear children, those decisions themselves might be relied upon to label particular women incompetent and to seek to override their decisions.
maker, acting in accordance with her preferences and values." In order for consent to be informed, it must be delivered by a patient capable of "the informed exercise of a choice and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each." A patient is presumed to be capable of providing consent or refusal in the absence of a legal decree of incompetency or some other legal status of incompetence (i.e. infancy). However, in cases where the patient is not competent to decide, either permanently or temporarily, the duty of health care providers to obtain informed consent is altered. The diminution of this duty depends on the nature of the incapacity, the urgency of the need for the proposed treatment, and the availability of a substitute decisionmaker.

When a patient is temporarily incapacitated and the health care is not of an emergency nature, the proposed health care must be delayed until such time as the patient is capable of providing either informed consent or refusal. However, the law is different

258. "It is improper to presume that a patient is incompetent." In re A.C., 573 A.2d at 1247. A patient "is entitled to the benefit of a presumption that he is medically competent until such time as his incompetence is properly adjudicated." United States v. Charters, 829 F.2d 479, 495 (4th Cir. 1987). This presumption applies even when a patient is committed to a mental hospital and even when a patient is undergoing electroshock treatment.

259. See, e.g., Wis. STAT. § 146.025(3) (Supp. 1992) (permitting HIV tests without consent on institutionalized mentally ill or developmentally disabled people who engage in behavior posing a significant risk of transmitting HIV).
260. If a woman is so intoxicated that she is incompetent to make health care decisions, the non-emergency decision must be postponed until the effect of the drug has worn off and the patient is again capable. ROZOVSKY, supra note 220, § 1.6; see also 41 AM. JUR.
when a patient is unable to provide consent or refusal in emergency care circumstances, and a legally-authorized substitute decision-maker is not readily available to provide consent, or when the time constraints of the emergency care preclude dialogue. Then, healthcare professionals are authorized to proceed with the emergency care under the guise of implied consent. However, they cannot also carry out an elective procedure that is not essential to the emergency care under the guise of implied consent. Implied consent for emergency treatment is deemed to exist when an incompetent patient is suffering from a life or health threatening disease or injury that requires immediate treatment.

Thus, emergency circumstances will rarely, if ever, justify testing a woman for HIV antibodies. There are no cures for HIV infec-

2d Incompetent Persons § 78 (1968) (noting that people addicted to drugs are at times mentally infirm and at other times sober and rational—a deed or contract executed by an alcoholic, for example, would be valid if executed while she was sober and in possession of her faculties). There are varying degrees of intoxication and “mere intoxication” does not render someone incompetent to enter contracts or execute deeds. A person must be so intoxicated that she is unable to grasp or comprehend the consequences of her acts before she is deprived of contractual capacity. Id. § 76. Likewise, a patient temporarily incapacitated by shock or a temporary physical condition, such as childbirth, must be given time to physically recover and make her own non-emergency decisions. See ROZOVSKY, supra note 220, § 1.6; see also Relf v. Weinberger, 372 F. Supp. 1196, 1199 (1974) (holding consent to be invalid where women had been induced to give consent to tubal ligations while in labor).

261. ROZOVSKY, supra note 220, §§ 1.16.3, 2.3 (noting that some states have codified this doctrine); see also Crouch v. Most, 432 P.2d 250, 254 (N.M. 1967) (holding that no consent is necessary in actual emergency where the patient is in no condition to make a judgement).

262. ROZOVSKY, supra note 220, § 2.2.2.

263. Id. at 106-10.

264. Nor would emergency circumstances justify unconsented emergency testing of newborn children. See infra part III.E for a discussion of substitute decision-making for health care treatment for children.

In addition, the fact that a woman needs emergency medical care for a non-HIV related condition would not, under traditional norms, justify conducting an HIV antibody test without her consent due to temporary incapacity. All medical procedures require employing universal precautions. Thus, concern for the protection of the patient or the health care provider should not justify imposing an HIV antibody test on an incapacitated patient. However, several states have statutes authorizing emergency testing to facilitate the care of a patient. See, e.g., IND. CODE ANN. § 16-1-9.5-2.5 (Burns Supp. 1992); KY. REV. STAT. ANN. § 214.181(3) (Michie/Bobbs-Merrill 1991); N.H. REV. STAT. ANN. § 141-F:5(V) (1990) (permitting HIV test to be administered if patient is incapable and when test is “immediately necessary to protect the health of the person”); N.M. STAT. ANN. § 24-2B-5(B) (Michie 1991) (permitting lack of informed consent when subject is unable to grant or withhold consent and test is “necessary for medical diagnostic purposes to provide appropriate emergency care or treatment”); N.C. GEN. STAT. § 130A-148(h) (Supp. 1991) (authorizing health care providers to conduct an HIV antibody test in emergency circumstances when a patient is incapacitated and it is “necessary for appropriate diagnosis or care of the person”); OHIO REV. CODE ANN. § 3701.24.2(E)(1) (Baldwin Supp.
tion, and none of the HIV related treatments are known to dramatically increase their efficacy when administered without any delay.\(^\text{265}\) Waiting to test until after consent has been obtained, after the emergency situation has passed, will not be detrimental to a patient’s condition relative to HIV. Emergency circumstances would thus only justify unconsented HIV testing when the knowledge of the patient’s HIV status is necessary to treat the emergency condition itself.

When emergency circumstances do not preclude it, the consent of a substitute decision-maker must be sought when a patient is incapable of understanding the nature and consequences of authorizing treatment.\(^\text{266}\) In a majority of states, the substitute decision-

1990) (allowing HIV test to be administered absent consent when “medically necessary to avoid or minimize immediate danger to the health or safety of the individual to be tested or another individual”). Some statutes authorize emergency testing to inform a health care worker of a patient’s HIV status after accidental exposure. N.M. STAT. ANN. § 24-2B-5(D) (Michie 1991) (permitting unconsented testing when test is necessary to provide appropriate care to health care worker exposed to blood or body fluids and subject is incapable of consent); OHIO REV. CODE ANN. § 3701.24.2(E)(6) (Baldwin Supp. 1990) (permitting unconsented testing when health care worker or emergency worker has sustained a significant exposure to body fluids of individual while rendering assistance to him and he has refused consent). The existence of such laws implies that these legislatures believe that emergency circumstances may occur which could justify conducting an HIV antibody test without specific consent.

265. Although the administration of AZT may delay the immune system’s decline, and aerosolized pentamidine may prevent PCP pneumonia, the efficacy of these treatments has not been shown to be significantly compromised if administered a day or so later. Mark H. Jackson, The Criminalization of HIV, in AIDS AGENDA: EMERGING ISSUES IN CIVIL RIGHTS, supra note 97, at 239, 255; see Steven Eisenstat, An Analysis of the Rationality of Mandatory Testing for the HIV Antibody: Balancing the Governmental Public Health Interests with the Individual’s Privacy Interest, 52 U. Pitt. L. Rev. 327, 360 (1991) (stating that AZT has not been shown to be more effective when commenced within two weeks rather than six months after exposure to the virus).

266. Many state legislatures define who is authorized to act on behalf of an incapacitated patient. See infra table I. In the absence of specific statutes defining who can provide substitute consent for health care, state law addressing the appointment of a guardian or conservator would determine who should make health care decisions. E.g., D.C. CODE ANN. §§ 21-2001 to -2085 (1989).

Even when a substitute decision-maker has been authorized to provide consent for an incapacitated patient, a court order is required in many states for particularly intrusive medical treatments which affect fundamental rights (i.e. sterilization, abortion and refusal of life-saving treatment). RENNERT ET AL., supra note 220, at 40; e.g., Cruzan v. Director, Mo. Dept of Health, 110 S.Ct. 2841, (1990) (permitting withdrawal of life-saving treatment with a court order); Ruby v. Massey, 452 F. Supp. 361 (D. Conn. 1978) (requiring a court order to perform sterilization despite consent of authorized substitute decision-maker); Lefebvire v. North Broward Hosp. Dist., 566 So. 2d 568 (Fla. Dist. Ct. App. 1990) (stating that a court, before granting incapacitated person’s guardian authority to consent to an abortion, must be persuaded by clear and convincing proof that it is in the best interests of the incapacitated person); D.R. v. Daughters of Miriam Center for the Aged, 589 A.2d 698 (N.J. Sup. Ct. 1990) (granting guardian permission to obtain
maker has a duty to attempt to replicate the choice that the patient herself would have made. Thus, when a patient’s actual wishes are unknown, a substitute decision maker could consent to a particular health care procedure in the belief that the patient herself would have consented. However, substitution can never be utilized to override a patient’s known informed refusal of a particular treatment.

E. The Doctrine of Override of Parental Refusal to Consent

The inviolate right to refuse medical treatment is tempered when a parent refuses care for a child, as opposed to care for her-

abortion for incompetent ward requires examination of ward’s best interests); In Re Grady, 426 A.2d 467 (N.J. Sup. Ct. 1981) (holding that sterilization is a privacy right protected by federal and state constitutions, and may not be authorized for an incompetent unless there is clear and convincing proof that sterilization is in person’s best interests).

267. RENNERT ET AL., supra note 220, at 40; see City Bank Farmers Trust Co. v. McGowan, 323 U.S. 594, 599 (1946). Other jurisdictions require the decision-maker to act in the best interest of the ward based on what a “reasonable, competent person” would do under the circumstances. A third approach requires the guardian to carry out the wishes of the ward when they are known, and otherwise to do what is in the best interest of the ward. RENNERT ET AL., supra note 220, at 39-40.

268. In re A.C., 573 A.2d 1235, 1249 (D.C. 1990); STUDY OF ETHICAL PROBLEMS, supra note 220, at 56; see also RENNERT ET AL., supra note 220, at 40.

269. Several states also recognize a “therapeutic privilege exception” to the requirement of obtaining a patient’s informed consent. See ROZOVSKY, supra note 220, § 2.4. See, e.g., ALASKA STAT. § 09.55.556 (1976). Under this doctrine, a physician is relieved of the duty to disclose risks of a proposed procedure when he or she makes the professional judgment that the patient will be so upset by the disclosure that it would have a serious adverse impact on the patient’s health. However, this “exception” cannot be invoked to justify withholding information from a patient in order to induce the patient to consent or to disregard a patient’s consent or refusal. It merely permits the professional to make a medical judgment (which must conform to professional standards) about the appropriate information to disclose for a particular patient, given her circumstances. For this reason, this Article does not address the therapeutic privilege as an exception to the requirement for a patient’s informed consent.

270. Children are generally deemed incapable to consent to health care until they reach the age of majority. In most states the age of majority is 18. RENNERT ET AL., supra note 220, at 39. However, many states have enacted statutes enabling capable minors to consent to health care under various circumstances. Some statutes give minors that are judged by the health care professional to be mature enough to fulfill the requirements of informed consent authority to consent to any type of health care. See AIDS Policy Center, George Washington Univ., States That Specifically Allow Minors to Consent to HIV/STD Testing, August 1992 (unpublished data on file with the Buffalo Law Review). Many states recognize the “emancipation” of minors who can then consent to their own health care and some permit minors to consent to health care for their own children. RENNERT ET AL., supra note 220, at 39; e.g., CAL. HEALTH SAFETY § 199.27(a)(1) (West 1990) (deeming minor incompetent to consent to HIV test only if under 12 years of age); IOWA CODE ANN. § 141.22(6) (West Supp. 1992) (stating that minor can consent to contraceptive services, or screening or treatment for AIDS and other sexually transmitted diseases, but parent or guardian will then be informed of a positive HIV test); MICH. COMP. LAWS ANN.
The Supreme Court has recognized that the state’s interest in safeguarding children’s health is sufficiently weighty to justify infringing on a parent’s fundamental rights in certain strictly circumscribed situations. In *Prince v. Massachusetts*, the Court held that a parent could be prohibited from using a child to distribute religious literature on the street for long hours. In so holding, the Court stated that “the right to practice religion freely does not include liberty to expose... the child... to ill health or death.”

State courts have relied upon this holding to override a parent's refusal to consent for medical care for a child if the child's life is greatly and immediately endangered and the proposed medical treatment is likely to alleviate the danger by curing the underlying condition. Thus, court orders have been obtained to override par-

§ 333.9132 (West Supp. 1992) (stating that a minor may consent to prenatal and pregnancy related health care or to health care for her own child); MICH. COMP. LAWS ANN. §§ 333.5127 (West Supp. 1992) (stating that a minor may consent to treatment for venereal disease or HIV infection); MISS. CODE ANN. § 41-41-3(g), (h), (i) (Supp. 1991) (allowing minor to consent to health care when emancipated when minor possesses sufficient intelligence to render informed consent, and when consent pertains to pregnancy or childbirth); N.J. Stat. Ann. § 19:17A-1, -4 (Supp. 1991) (permitting a minor to consent to health care if the minor is married, is pregnant, is actually or allegedly afflicted with a venereal disease, appears to have been sexually assaulted, or is suffering from drug or alcohol dependency); Or. Rev. Stat. §§ 109.610, 433.045(5) (1991) (permitting minor to consent to treatment for venereal disease, including HIV); W. VA. CODE § 16-4-10 (1991) (permitting minor to consent for treatment of venereal disease). *But see* NEV. REV. STAT. § 441A.310 (1991) (mandating that any minor suspected of having or of having been exposed to a sexually transmitted disease can be examined and treated by a health authority “regardless of whether the minor or either of his parents consent to the examination and treatment”).

In the absence of statutes enabling minors to consent to health care, the child’s parent or guardian is generally authorized to consent to or refuse care. *Rennert et al., supra* note 220, at 39.


273. Id. at 166-67.

274. Jennifer Lew, Note, *Terminally Ill and Pregnant: State Denial of a Woman’s Right to Refuse a Cesarean Section*, 38 BUFF. L. REV. 619, 638 (1990). Some states statutorily provide for the override of a parent's refusal of nonelective medical care for a child. E.g., IDAHO CODE § 16-1616 (1976); ME. REV. STAT. ANN. tit. 22, § 4071 (West 1979). Other states govern such decisions pursuant to statutes prohibiting medical neglect. E.g., Mass. Family Court Act § 1012, Subd. [f], par. [i], cl. [A] (child’s “condition has been impaired as a result of the failure of his parent... to exercise a minimum degree of care in supplying the child with adequate... medical... care, though financially able to do so.”); N.J. STAT. ANN. §§ 9:6-8:9 (West 1993) (including in definition of abused child “a child whose physical, mental, or emotional condition is impaired or is in imminent danger of becoming impaired as the result of the failure of his parent... in supplying the child with adequate... medical or surgical care”). *See generally* ROZOVSKY, *supra* note 220, §§ 5.16 to 5.17.

The doctrine of override never justifies the imposition of treatment on the parent for the alleged benefit of the child. For example, though it might be in a child's interest for an
ents' refusal of medically necessary blood transfusions for their children. On the other hand, courts will not override a parent's refusal of consent even though the child's life is endangered if the proposed health care presents significant risks and is not likely to cure the health problem. There have been mixed results when courts have

alcohol dependent parent to receive drug treatment, a court could not override that parent's informed consent right to refuse treatment. However, in some instances the parent could be prosecuted for abuse or neglect, or declared unfit and have the child removed from his or her custody. Furthermore, in a custody proceeding in which clear and convincing evidence demonstrated that a parent mistreated a child because of substance abuse, the court could set drug treatment as a condition for continued custody. However, child neglect or abuse would not justify violation of the parent's bodily integrity. But see Miss. CODE ANN. § 41-41-3 (Supp. 1991) (stating that the right to refuse consent for medical treatment may be limited to refusal which is not arbitrary, obstinate or without reasonable medical justification when the patient is pregnant). This statute would likely be invalidated on constitutional grounds if challenged. See In re A.C., 573 A.2d 1235, 1237 (D.C. 1990).

275. E.g., Jehovah's Witnesses v. King County Hosp., 278 F. Supp. 488 (W.D. Wash. 1967), aff'd per curiam, 390 U.S. 598 (1968) (holding that Washington statutes empowering superior court judges to declare children to be dependent for the purpose of authorizing blood transfusions against expressed objections of parents were not invalid under Constitution of United States); People v. Labrenz, 104 N.E.2d 769 (1952), cert. denied, 344 U.S. 824 (1952) (upholding actions of state circuit court in appointing a guardian for 8-day-old child suffering from erythroblastosis fetalis and in granting guardian the authority to consent to a blood transfusion for the child whose parents were Jehovah's Witnesses); ROZOVSKY, supra note 220, § 5.16.

Additionally, criminal prosecutions and convictions of parents whose children die from readily curable conditions because their parents denied them medical care for religious reasons have been sustained. See Walker v. Superior Court, 763 P.2d 852, 873 (Cal. 1988), cert. denied, 491 U.S. 905 (1989) (permitting state to proceed with prosecution of Christian Scientist mother for involuntary manslaughter and felony child endangerment arising from death of four year-old daughter due to meningitis after mother refused scientific medical treatment and relied on spiritual healing); Paula A. Monopoli, Allocating the Costs of Parental Free Exercise: Striking a New Balance Between Sincere Religious Belief and a Child's Right to Medical Treatment, 18 PEPP. L. REV. 319, 321 n.7 (1991). But see State v. Miskimens, 490 N.E.2d 931, 937-38 (C.P. Ohio, Coshocton County 1984) (dismissing charges of child endangerment against Christian Scientist parents when their son died of readily treatable medical condition, because religious exemption to child endangerment law was unconstitutionally vague and therefore parents were not on notice that their actions were criminal).

276. See, e.g., Bowen v. American Hosp. Ass'n, 476 U.S. 610, 647 (1986) (holding that the withholding of treatment from a handicapped infant where there is no parental consent does not violate Section 504 of the Rehabilitation Act of 1973; without the parents' consent the infant has not been denied care "solely by reason of his handicap"); In re Philip B., 156 Cal. Rptr. 48 (Cal. Ct. App. 1979), cert. denied, 445 U.S. 949 (1980); In re Hofbauer, 393 N.E.2d 1009 (N.Y. 1979) (permitting parents of a child suffering from Hodgkin's disease to refuse chemotherapy and radiation, and opt for injections of laetrile, despite objections of physician); In re Infant Doe, No. GU 8204-004A (N.Y. Monroe County Cir. Ct. April 12, 1982), mandamus denied, State ex. rel. Infant Doe v. Baker, No. 482 S 140 (May 27, 1982), cert. denied, Infant Doe v. Bloomingtom Hosp., 464 U.S. 981 (1983) (refusing to override parental refusal to consent to removal of an infant's esophageal obstruction that was preventing oral feeding when the infant had Down's Syndrome and
been asked to override parental refusals when the danger to the child's life is not immediate or the proposed low risk treatment is likely to greatly alleviate suffering though not cure the underlying condition. Some courts have refused override in such circumstances.277 Others have permitted override when there is significant chance of death or the "most basic quality of the child's life is endangered," even if the child is not certain to die without the proposed treatment.278 While courts will not override parental refusal to impose risky treatments on children, they might when low risk treatments are available. The greater the harm to the child to be averted, and the more lasting protection the treatment will provide, the more likely the override becomes.

Traditional override doctrine does not provide a basis for imposing medical treatment on a pregnant woman in the interest of protecting the life of her fetus. Abortion is the only currently avail-

other handicaps and would soon die); see also Custody of a Minor B., 434 N.E.2d 601 (Mass. 1982) The Court decided to withhold medical treatment for an abandoned child.

There is no treatment or surgical procedure available, proven or experimental, which offers any hope for the minor's cure. Death for a child with this minor's diagnosis normally occurs within the first year of life, with or without treatment. There is no research or study which holds promise of aid in the child's condition, nor is there a reasonable hope of a treatment being developed before this child's death.

Id. at 604; cf. In re Dinnerstein, 380 N.E.2d 134 (Mass. 1978) (upholding children's decision to withhold treatment for terminally-ill incapacitated parent because treatment would do nothing to cure or relieve the underlying illness).

277. For example, in 1972 the Supreme Court of Pennsylvania declined to override a mother's refusal of blood transfusions for her son, reasoning that his life was not imminently endangered. He had polio and required surgery to correct a spinal curvature which threatened to shorten his life. He was likely to need the blood transfusions during or after the surgery. In re Green, 292 A.2d 387 (Pa. 1972). In 1955, the New York Court of Appeals reached a similar result, refusing to override a father's refusal to consent to non-emergency surgery to correct his son's cleft palate and harelip. In re Seiferth, 127 N.E.2d 820 (N.Y. 1955).

278. In re Cabrera, 552 A.2d 1114 (Pa. Sup. Ct. 1989) (ordering low risk blood transfusions over parents' objection to treat sickle cell anemia, which presented a 16-18% chance of dying within a year and an 80% chance of severely disabling the child, despite the fact that no cure for disease exists); In re Eric B., 235 Cal. Rptr. 22 (Cal. Ct. App. 1987) (permitting override although child's life not imminently endangered where there was a 40% chance of death and the availability of low risk treatment was highly likely to avert risk); In re Jensen, 633 P.2d 1302 (Or. 1981) (ordering surgery over parents' objections for child with hydrocephalus when surgery was likely to avert severe mental and physical effects and to allow child to live normal life, despite lack of outright cure); Muhlenberg Hospital v. Patterson, 320 A.2d 518 (N.J. Sup. Ct. 1974) (ordering low risk blood transfusions for child to avert imminent danger of serious irreparable harm—not death); State v. Perricone, 181 A.2d 751 (N.J. 1962), cert. denied sub nom., Perricone v. New Jersey, 371 U.S. 890 (1962) (validating state's appointment of guardian for child of Jehovah's Witnesses for purposes of consenting to blood transfusions when child's life imminently endangered, treatment not risky, and treatment likely to alleviate problem though not entirely correct it).
able treatment for preventing perinatal transmission of HIV. Thus, the state would be in the position of arguing that it must kill the fetus to protect its life—that it must prevent a child from coming to life in order to ensure it will not endure a thirty percent risk of suffering HIV infection and an untimely death. Proposed interventions to prevent an HIV-positive woman from conceiving are both too remote and too invasive of a woman's bodily integrity and privacy to be permissible under the doctrine of overriding parental refusal. Moreover, they do not "benefit" the child because there is clearly no child prior to conception.

Override arguably justifies HIV testing of a pregnant woman. Some health analysts assert that a pregnant woman's HIV status is relevant to the care of the fetus during pregnancy and to the preparation for the child's care following birth. However, under current legal standards, testing a pregnant woman without her consent to discover whether her child might be HIV-infected, in order to prepare to treat the child at birth, is impermissible. There are currently no medical treatments available for newborns which cure HIV infection and fulfill the legal requirement of low risk treatment with a high likelihood of alleviating the danger to the child's life. Additionally, there is no way to determine whether the fetus of an HIV-infected woman is itself HIV-infected. Moreover, even if one could determine that a fetus would ultimately be HIV-infected, there are currently no treatment modalities available for administration in utero.

Override doctrine presents more of an argument to justify testing a newborn for HIV absent maternal consent. One commentator predicts that the recently promulgated recommendations for prophylaxis of Pneumocystis Carinii Pneumonia (PCP) in children could


280. Indeed, one medical commentator notes that "there are currently no treatment modalities with proven benefits for neonates." Isaacman, supra note 85, at 483 n.39. The FDA recently approved use of AZT for symptomatic children older than six months. It has been asserted that children receiving oral AZT "for long periods have improved growth, and appear to have fewer hospitalizations and serious infections." Modlin & Saah, supra note 3, at 49. However, AZT as a treatment clearly falls far short of a cure or a treatment which would justify parental override. Moreover, because it is recommended for symptomatic children who are older than six months, AZT could not justify screening all newborns.

281. See supra note 94.

present a treatment which would arguably justify override of a parent's refusal to have a newborn tested. By administering an HIV antibody test to a newborn, a health care provider could at least determine whether the baby is at risk of HIV infection. Prophylaxis could then be administered to at-risk babies presenting symptoms of HIV infection. However, this treatment could only reduce the risk of death from PCP for those infants actually HIV-infected. It would not cure HIV, and the child would still be likely to die at a young age from other opportunistic diseases.

If health care providers seek to impose HIV testing over a parent's objection in order to administer PCP prophylaxis, courts will have to weigh the risks of the treatment both for babies that are HIV-infected and those that are not, and of the revelation of the mother's and infant's HIV status, against the possible benefit of temporarily extending the child's life and alleviating its suffering. This potential benefit is quite tenuous because unless a child otherwise exhibits symptoms of HIV infection, it has only a 30% chance of being HIV-infected if the mother is infected. Even in areas of high incidence of HIV infection, only one in thirty-two women giving birth are infected and preliminary information indicates that only thirty-six of 1800 HIV-infected babies contract PCP.

Override doctrine would not justify imposing HIV testing in the name of such an attenuated potential benefit. Furthermore, the antibody test results from umbilical cord or newborn blood samples reveal the antibody status of the mother and do not indicate whether the infant itself is HIV-infected. As a result, a woman's medical consent rights would attach with equal force to the testing of the newborn and the cord as they do to testing of her own body.

Two medical developments on the horizon could widen the parameters of the debate in this regard. The first is a test, which has proven effective in small scale samples, that can separate maternal HIV anti-bodies from the newborn's antibodies. Such a test would permit diagnosis of newborn HIV infection without specifically revealing the mother's HIV status. The authors of the study recom-

283. Bayer, supra note 132, at 1501.
284. In New York State, of the approximately 1800 babies born exposed to HIV each year, approximately 36 contract PCP pneumonia; 12 to 18 of them die even when treated. Letter from Dr. Sarmistha B. Hauger, Columbia University Medical Center to author, (Oct. 27, 1992) (on file with the Buffalo Law Review).
285. See supra note 94.
286. See supra note 11; see supra note 284.
287. See supra note 94.
288. See generally Faden et. al., supra note 14, at 350-54.
mand large scale clinical verification of the test prior to submitting
to the FDA for approval. If this test proves effective on a large
scale, its availability might lessen the concerns of the mother's pri-
vacy interest in her own HIV status and the concerns of treating
infants for HIV disease who are not themselves infected. Thus, the
potential for infant diagnosis would alter the balance of factors
involved in evaluating whether override would be appropriate for
PCP prophylaxis. When infant diagnosis becomes available, there
will also likely exist more reliable data concerning the risks PCP
poses to infected infants and the risks and efficacy of prophylaxis
treatment. Courts will have to weigh these factors at that time.
However, the question of whether to override a parent's refusal to
have an asymptomatic child tested for HIV infection still would
present a level of attenuation for potential benefit to the child that
would be unlikely to justify override even when early HIV diagnosis
is possible. It would still not eliminate the reality that there is no
cure for HIV infection and the child is likely to die at a young age.

The second potential medical development is the use of AZT to
prevent perinatal transmission. Currently, the National Institute of
Health is conducting a placebo controlled study to determine
whether early administration of AZT to pregnant HIV-positive
women will prevent transmission to the fetus. If proven effective,
and preliminary theories that AZT causes birth anomalies are
proven wrong, the availability of this treatment to prevent perinatal
transmission will present a complex case for analysis under override

290. Id. at 301; see also Philip J. Hilts, Effective Test Is Developed to Find AIDS in
Newborns, N.Y. TIMES, Feb. 4, 1993, at B8 (reporting that the FDA should speedily
approve the new test).

291. Even if treatments for an HIV-positive child are developed which would fulfill
the requirements to override parental refusal, the informed consent doctrine would re-
quire the health care provider to engage in the informed consent dialogue with the
parent. Thus, health care providers would have to explain the treatment options, benefits,
risks and alternatives in understandable terms and seek override via court order only af-
ter the parent's informed refusal. Moreover, in the event such treatments are developed, a
decision whether to override a parent's refusal to allow the child to be tested would have
to be based on the availability of these treatments to the child at issue. See Faden et al.,
supra note 14, at 334. One of the Group's recommendations is that a necessary component
of any program testing pregnant women or newborns for HIV is that
[ever effort should be made to secure specialized medical interventions for the
management of HIV infection, appropriate social services and supports, and in-
tensive primary care and abortion services (where requested by pregnant
women) for all women and infants identified as HIV-positive as a result of pre-
natal or newborn testing.

Id.

292. Modlin & Saah, supra note 3, at 49; see Rhoda S. Sperling et al., A Survey of
Zidovudine Use in Pregnant Women with Human Immunodeficiency Virus Infection, 325
CONTROL OF HIV-POSITIVE WOMEN

This analysis would require fulfillment of the requirements necessary to override parental refusal of health care for children before administration of AZT to pregnant HIV-positive women. AZT can have potent side effects and therefore is contraindicated for many HIV-positive people. Consequently, ingesting AZT is riskier for most HIV-positive people than donating blood is for most healthy people. By analogy, no court should order a pregnant woman to ingest AZT because courts fail to compel people to donate blood. This analogy is persuasive even if the court believes AZT will save the child from a thirty percent chance of becoming infected with HIV. This same analysis would apply to any in utero treatment developed for the fetus of an HIV-positive woman.

Given the current state of medical knowledge concerning perinatal transmission and the lack of treatments available for HIV-infected (or potentially infected) newborns, no sufficient justification exists for overriding the woman's right to refuse reproductive health care, including HIV testing for herself or her newborn child. Additionally, traditional override doctrine will not permit any in utero treatment for the fetus, for a court will not impose medical treatment on one person (the mother) for the benefit of another and it certainly will not impose it for a nonperson (the fetus).

F. Public Health and the State Police Power

The police power of state governments permits governmental restrictions on individual liberty in order to protect the public health and safety. This power presents a narrowly circumscribed exception to the requirement of informed consent to medical care. This exception is limited to circumstances where an individual's refusal to accept medical treatment endangers other people. It would not justify negating HIV-positive women's informed consent rights in order to prevent them from bearing children.

Traditionally, the police power to legislate measures to control

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293. Patients with impaired renal function "may be at greater risk of toxicity from zidovudine [AZT]." PHYSICIANS' DESK REFERENCE 827 (47th ed. 1993) [hereinafter PDR]. Warnings for the drug indicate that therapy with AZT "is often associated with hematologic toxicity including granulocytopenia and severe anemia requiring transfusions." Id. at 788.

294. Furthermore, kidney transplants from parent to child have never been ordered.

295. Police power is retained by the states upon entry into the Union. U.S. CONST. amend. X; Jacobson v. Massachusetts, 197 U.S. 11, 25 (1905). It is a power founded "[u]pon the principle of self-defense." Id. at 27; Railroad Co. v. Husen, 95 U.S. 465, 471 (1877) (citing The Passenger Cases, 48 U.S. (7 How.) 282, 456 (1849)). A state's police power "can only arise from a vital necessity for its exercise, and cannot be carried beyond the scope of that necessity." Chy Lung v. Freeman, 92 U.S. 275, 280 (1875).
contagious disease epidemics was practically boundless in its ability to impose quarantine and mandatory treatment on persons with infectious diseases. Though statutes authorizing these measures survive in most states, recent developments have significantly curtailed the power. These include medical science's ability to treat disease and pinpoint modes of transmission,296 the expansion of constitutional protections for individual liberty against government interventions, and the development of the doctrine of informed consent and self-determination in medical treatment.297

Currently, states rely upon the public health police power to impose regulations which do not significantly encroach upon individual liberties and which provide proven benefits to both the affected individual and to society at large. For example, state governments may regulate health care procedures to safeguard public safety and hygiene298 and require children to be vaccinated for certain diseases prior to attending school.299

When state health measures infringe upon employment rights or the right of children to attend public school, they must be justified by proof that they actually protect the public from a significant health risk.300 On the other hand, contemporary law for disease control measures, like quarantine or compulsory medical treatment, which drastically infringe upon fundamental liberties, has been less clearly delineated. These archaic doctrines remain almost com-

296. Gostin, supra note 85, at 1027.
297. See Wendy E. Parmet, AIDS and Quarantine: The Revival of an Archaic Doctrine, 14 HOFSTRA L. REV. 53, 54-55 (1985) [hereinafter Parmet, AIDS]; see also Greene v. Edwards, 263 S.E.2d 661, 661-62 (W. Va. 1980) (granting a writ of habeas corpus to one whose constitutional rights were violated when petitioner with tuberculosis was involuntarily confined).
298. Roe v. Wade, 410 U.S. 113, 162-63 (1973) (stating that a state has a legitimate interest in ensuring safety of health care procedures).
300. School Bd. of Nassau County v. Arline, 480 U.S. 273, 288 (1987) (holding that a public school teacher could not be fired for having tuberculosis if she did not pose a "significant risk" of transmitting the disease); New York State Ass'n for Retarded Children v. Carey, 612 F.2d 644, 650 (2d Cir. 1979) (holding that children testing positive for hepatitis B could not be excluded from a public school program because they did not present a significant risk of transmitting the disease to others); District 27 Community Sch. Bd. v. Board of Educ., 502 N.Y.S.2d 325, 335 (Sup. Ct. 1987) (invalidating a public school policy excluding all children with AIDS from school on the basis that it did not effectuate a valid state purpose); In re Westchester County Medical Center, No. 91-504-2, Dec. No. 191 at 40 (Dept of Health and Human Servs. Appeals Bd., April 20, 1992) (ruling, by an administrative law judge, that hospital violated the Rehabilitation Act of 1974 by imposing employment restrictions on HIV-infected pharmacist when risk of exposure "is so small as not to be measurable"); Gostin, supra note 85, at 1021.
pletely untested by courts applying contemporary legal standards. However, some state legislatures have repealed or amended their statutes authorizing quarantine and mandatory medical treatment—including unconsented HIV testing—to comply with modern procedural protections of individual liberty. The appropriate judicial limits on government disease control powers should be influenced by two related areas: 1) the law on civil commitment of the mentally retarded and mentally ill and 2) the law on unconsented sterilization.

1. The History of Public Health Police Power. Historically, the Supreme Court has recognized that the state’s police power to mandate public health measures could be exercised to the extent that it did not unjustifiably encroach upon individual rights. However, the case law demarcating the bounds of this power developed during the epidemics of the nineteenth and early twentieth centuries, before the emergence of the doctrine of informed consent and when individual constitutional rights were in their infancy. Moreover, the undeveloped state of medical science permitted states wide discretion to impose coercive measures in the name of health, due to ignorance about how the diseases at issue were actually transmitted. As a result, the case law fails to map proper boundaries for contemporary use of the state public health power in the AIDS epidemic.

At the turn of the century, constitutional protections for individuals against intrusive actions by their government were not fully developed. However, some courts reviewing government measures aimed at controlling devastating epidemics of smallpox, yellow fever, cholera, and other diseases nonetheless recognized the supremacy of these protections. In 1900, in two separate cases, a California federal court circuit panel invalidated public health measures promulgated by the city of San Francisco, finding that the measures were a mere guise for enforcing racially discriminatory practices. In Wong

301. See supra notes 327-30.
302. Jacobson v. Massachusetts, 197 U.S. 11, 25 (1905), stating: Such measures are within the discretion of the State, subject of course, so far as Federal power is concerned, only to the condition that no rule prescribed by a State . . . shall contravene the Constitution of the United States or infringe any right granted or secured by that instrument. A local enactment or regulation, even if based on the acknowledged police powers of a State, must always yield in case of conflict with . . . any right which that instrument gives or secures.
303. Wendy E. Parmet, Legal Rights and Communicable Disease: AIDS, the Police Power, and Individual Liberty, 14 J. HEALTH, POL., POLY & L. 741, 745-46 (1989) [hereinafter Parmet, Legal Rights]; Parmet, AIDS, supra note 297, at 58, 75. See generally Bergman, supra note 103, at 788 n.58 (citing “a litany of cases upholding the state’s police power to quarantine”).
Wai v. Williamson, the court struck down a city ordinance that all Asians be inoculated for bubonic plague before leaving the city because there was no evidence that Asians contract the disease more than other races or that such inoculations would serve any valid health interest. In response to this decision, the city issued an order quarantining the Asian community to predominantly Asian neighborhoods. The order specifically exempted Caucasian residences within Asian areas. In Jew Ho v. Williamson, the court applied strict equal protection scrutiny and invalidated the quarantine order, noting that it was based on racial bias and not a genuine public health necessity.

In 1905, in the landmark vaccination case, Jacobson v. Massachusetts, the United States Supreme Court affirmed the states' power to enact compulsory vaccination, quarantine and "health laws of every description." While the Court specifically upheld the imposition of a five dollar fine on a person who refused to obtain a vaccination, it limited its holding by noting that "the police power of a State ... may be exerted in such circumstances or by regulations so arbitrary and oppressive in particular cases as to justify the interference of the courts to prevent wrong and oppression." Despite these limitations, however, Jacobson was later

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304. 103 F. 1 (C.G.D. Cal. 1900).
305. Id. at 10 ("[T]he [police] power, however broad and extensive, is not above the constitution. When it speaks, its voice must be heeded. It furnishes the supreme law ... and, so far as it imposes restraints, the police power must be exercised in subordination thereto." (citation omitted)).
306. 103 F. 10 (C.C.N.D. Cal. 1900).
307. Id. at 26. The court stated:
[This quarantine cannot be continued, by reason of the fact that it is unreasonable, unjust, and oppressive, and therefore contrary to the laws limiting the police powers of the state and municipality in such matters; and, second, that it is discriminating in its character, and is contrary to the provisions of the fourteenth amendment of the constitution of the United States.

Id.; see also Railroad Co. v. Husen, 95 U.S. 465, 471-73 (1877) (holding that a statute prohibiting entry of any Texas, Mexican or Indian cattle into Missouri during 8 months of the year was an invalid exercise of police power because it was ineffective in keeping diseased cattle out of the state and infringed upon constitutionally protected commerce and transportation rights).
308. 197 U.S. 11 (1905).
309. Id. at 25 (citing Gibbons v. Ogden, 22 U.S. (9 Wheat.) 1, 203 (1824)).
310. Id. at 12-14 (stating that Mr. Jacobson was fined $5.00 and "committed until the fine was paid" upon refusing a smallpox vaccination, absent evidence that his health would be damaged by the vaccination).
311. Id. at 38; see also Compagnie Francaise de Navigation a Vapeur v. Louisiana St. Bd. of Health, 186 U.S. 380, 397 (1902) (Brown, J., dissenting) (rejecting the majority's affirmation of Louisiana law barring entry of even healthy immigrants from southern Europe and the West Indies for the purpose of controlling the yellow fever epidemic on the ground that it was a sham for oppressing immigrants),
relied upon to justify a more drastic and physically invasive imposi-
tion—eugenic sterilization,\textsuperscript{312} one method employed in the notorious campaigns against "social undesirables."\textsuperscript{313}

Apart from eugenics, the primary area of coercive public health legislation during the twentieth century concerned venereal diseases. Most of the laws targeted prostitutes either facially or as applied. These laws have largely been condemned by contemporary scholars as "ineffective, discriminatory and invidious."\textsuperscript{314} During the first two decades of the twentieth century, local governments closed down more than a hundred "red light districts" and had thousands of prostitutes forcibly examined for venereal disease, quarantined and treated, in the name of curtailing the syphilis epidemic.\textsuperscript{315} During World War I, more than 30,000 prostitutes were incarcerated in federally-supported institutions.\textsuperscript{316} In the few instances when these measures were challenged, they were always upheld,\textsuperscript{317} despite the fact that they did not reduce the incidence of syphilis. Indeed, syphilis increased dramatically during the years of the War.\textsuperscript{318}

\textsuperscript{312} Buck v. Bell, 274 U.S. 200, 207 (1922) (stating that "[t]he principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes").

\textsuperscript{313} See discussion \textit{supra} part II.

\textsuperscript{314} Gostin, \textit{supra} note 85, at 1019.

\textsuperscript{315} ALLAN M. BRANDT, NO MAGIC BULLET, A SOCIAL HISTORY OF VENEREAL DISEASE IN THE UNITED STATES SINCE 1880 85-95 (1987) [hereinafter BRANDT, VENEREAL DISEASE]. Brandt reports that "[b]y March 1918, thirty-two states had passed laws requiring compulsory examinations of prostitutes for venereal disease." \textit{Id.} at 85 (citations omitted).

Many state or local regulations were passed during this same period, empowering health officers to examine "persons reasonably suspected of having syphilis, gonorrhea or chancroid." \textit{Id.}


\textsuperscript{317} See Bergman, \textit{supra} note 103, at 797, and sources cited therein.

In the 1930s, states began to enact blood testing laws. In 1938, Connecticut and Rhode Island became the first states to enact laws requiring syphilis blood tests for all pregnant women, and other states soon followed suit. Because syphilis, once detected, could be treated and cured, these laws greatly reduced the infant mortality rate caused by congenital syphilis. Although some states now require that women consent to be tested and have the right of refusal, no legal challenges have been brought against statues


Despite this information, at least twenty-eight states have acted on the unfounded belief that prostitutes are likely to spread HIV infection and currently mandate HIV antibody testing of prostitutes. Jackson, supra note 264, at 239, 258 & n.60 (citing unpublished data of the Intergovernmental Health Policy Project); see, e.g., supra note 100. Several states have also enhanced the penalties for criminal prostitution offenses when committed by someone with knowledge that she or he is HIV-positive. E.g., Col. Rev. Stat. § 18-7-201.7 (Supp. 1992). Colorado also criminalizes the patronization of a prostitute by a person who knows he or she is HIV-positive. Col. Rev. Stat. § 18-7-205.7 (Supp. 1992); see also Fla. Stat. chs. 796.06(5)-(6) (1986); Nev. Rev. Stat. § 201.358 (1987). Though government policies concerning pregnancy and HIV have been slower to develop, those now under consideration which are discussed in this Article may be just as misinformed as those concerning prostitution.

319. In 1935, Connecticut passed the nation's first law requiring a premarital blood test and physical examination. If either party was found to be infected by a number of diseases, including syphilis, no marriage license would be issued until that party had been cured of the infection. Brandt, Venereal Disease, supra note 315, at 147-48. "By . . . 1938, twenty-six states had enacted provisions prohibiting the marriage of infected individuals." Id.

320. Id. at 149-50; 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 3, at 59; see infra table IV.

321. Salvarsan, the first effective treatment for syphilis, was discovered in 1909, modified in 1912, and widely used by 1920. Brandt, Venereal Disease, supra note 315, at 40-41. Penicillin was discovered to be effective for treating syphilis and gonorrhea in 1943. Id. at 161; Acuff & Faden, supra note 320, at 65.

322. This Article contends that the same effect in reducing infant mortality would result if the law mandated health care providers to recommend rather than require prenatal syphilis tests for all pregnant women. Originally, such syphilis testing laws were necessitated by physicians' refusal to offer the test to patients for fear of offending them. Brandt, Venereal Disease, supra note 315, at 150; Acuff & Faden, supra note 319. Physician reluctance to test is unlikely to be a problem today; the risk of malpractice liability is an effective incentive for physicians to routinely offer such tests to their pregnant patients. At any rate, reluctance to carry out their professional duty on the part of health care providers is hardly a justification for undermining the informed consent rights of pregnant women. Furthermore, allowing patients to make this health care decision could reap substantial benefits. "Testing in pregnancy should be used as an opportunity to educate patients about prenatal care and the impact of maternal behavior on fetal outcomes, and should be conducted with at least the affirmation of the patient." Faden et al., supra note 14, at 336.

323. Curtan et al., AIDS: Legal and Regulatory Policy 310 (1988); e.g., Kan.
which authorize involuntary testing.

States have enacted few new mandatory public health measures in the latter half of the twentieth century due to the evolution of medical science and enhanced constitutional protection for individual rights, including the right to informed consent. Further- more, states have rarely applied existing mandatory health measures. As cures were developed and the epidemics of the nineteenth and early twentieth centuries were stanched, quarantine laws for communicable diseases were no longer utilized. Other

STAT. ANN. §. 65-153f (Supp. 1991) (permitting testing for syphilis of each pregnant woman "with the consent of such woman"); OR. REV. STAT. § 433.017 (1991) (requiring every licensed physician attending a pregnant woman for conditions relating to her pregnancy to obtain informed consent prior to testing blood for any infectious conditions "which may affect a pregnant woman or fetus"); PA. STAT. ANN. tit. 35, § 521.13 (1993) (requiring prenatal syphilis exam except when the woman "dissents"); see also infra table IV.

324. As tests to detect disease and courses of treatment were developed for Tay-Sachs, cystic fibrosis, neural tube defects, and the Hepatitis B virus, legislatures declined to interfere with the medical establishment and did not determine how and when such tests and treatment be administered. One exception is the New York Legislature, which has required prenatal screening for Hepatitis B since 1990. N.Y. PUB. HEALTH LAW § 2500-e(1) (McKinney Supp. 1992). California makes prenatal testing for genetic disorders and birth defects available to all women, but requires that it be "wholly voluntary and shall not be a prerequisite to eligibility for, or receipt of, any other service or assistance from, or to participation in, any other program." CAL. HEALTH & SAFETY CODE § 156.2 (West Supp. 1992).

Statutes enacted in the 1960s and 1970s mandated screening newborns for pku and sickle cell anemia, but imposed no punishment for non-compliant parents. See generally Acuff & Faden, supra note 320, at 65. Originally statutes concerning sickle cell screening were mandatory; however, these became increasingly controversial, and in 1972, a federal law was passed offering funding only to states with voluntary sickle cell screening programs. Most states amended their screening laws to provide for voluntary testing. Id. at 67-71. E.g., CAL. HEALTH & SAFETY CODE § 308 (West 1984); FLA. STAT. ANN. § 383.14(4) (West Supp. 1993); ILL. ANN. STAT. ch. 111, paras. 4801, 4905 (Smith-Hurd 1989); N.Y. PUB. HEALTH LAW § 2500-a(b) (McKinney 1991); TEX. HEALTH & SAFETY CODE ANN. § 33.001 (West 1992); see also infra table IV.

Statutes permitting a parent only the right to refuse pku or sickle cell testing do not provide full informed consent protections. However, these simple blood tests detect treatable conditions which could be quite disabling to affected children who are not promptly treated. They provide universal benefit and minimal intrusion, and as a result there has been no motivation to challenge them and they remain on the books. For similar reasons, consent to testing newborns for these conditions could be implied from a mother's consent for general health care services for her newborn; as a result there is no need for statutory override of informed consent doctrine.

325. See Mireya Navarro, Gauging Threat of Recalcitrant TB Patients, N.Y. TIMES, April 14, 1992, at A1, B2; Mireya Navarro, Grappling With the Care of Problem TB Patients, N.Y. TIMES, April 14, 1992, at B2 (both articles describe the use of compulsory health measures in extreme cases of patients with infectious TB who either refuse consent to treatment, or who are unable or unwilling to pursue treatment).

326. BRANDT, VENEREAL DISEASE, supra note 315, at 191; Sullivan & Field, supra note 138, at 143-44.
laws, like some requiring premarital syphilis testing, were recognized as costly and ineffective\(^{327}\) and were repealed.\(^{328}\)

In one of the few recently published opinions addressing the state power to quarantine, the West Virginia Supreme Court relied upon recent civil commitment case law, rather than archaic disease control law, as precedent for its ruling.\(^{329}\) In *Greene v. Edwards*, the court held that the potential loss of liberty resulting from quarantine is as serious as that of civil confinement and mandated that the stringent procedural standards applied to mental health civil commitment proceedings should also apply to litigation initiated by those subject to quarantine.\(^{330}\)

Other aspects of civil commitment law, discussed below, further delineate restrictions on state power to enact public health measures. In addition, this Article reviews laws on unconsented sterilization—another area where compulsory health measures have been subjected to judicial scrutiny under modern standards of individual rights. Developments in these areas confirm that with the advent of constitutional protections for individual rights, the public health police power has been radically curtailed.\(^{331}\) As the following two

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328. Maine and Texas, for example, have repealed statutes mandating testing. *See* ME. REV. STAT. ANN. tit. 22 § 1181 (West 1992) (repealed 1985); TEX. HEALTH CODE ANN. § 1.25 (West 1975) (repealed 1989).

There have been numerous calls to utilize coercive health powers to deal with the AIDS epidemic. *See* Lawrence O. Gostin, *Public Health Strategies for Confronting AIDS, 261* JAMA 1621 (1989). Some coercive AIDS measures have already proven ineffective and been repealed. For example, Illinois and Louisiana both enacted laws requiring premarital testing for the HIV antibody before a marriage license could be issued. ILL. ANN. STAT., ch. 40, para. 204 (Smith-Hurd 1980) (amended 1989); LA. REV. STAT. ANN. § 9:230 (West 1991) (repealed 1988). In both states, the measure proved to be exorbitantly costly and to produce questionable benefit. The Illinois law, which was in effect for 20 months before being amended, identified only 23 new cases of HIV infection at a cost of $243,000 per case identified. Field, *supra* note 204, at 73. The amendment effectively replaced the old statute with a simple requirement that all persons applying for marriage licenses receive a brochure concerning sexually transmitted diseases. ILL. ANN. STAT., ch. 40, para. 204 (Smith-Hurd Supp. 1992). The Louisiana law was in effect for only six months before being repealed because it had similar results. *Id.*


330. *Id.* at 663. The court ultimately granted a man confined to a hospital with active tuberculosis a new hearing, complete with appointed counsel, written notice detailing grounds and underlying facts on which commitment had been sought, the right to be present to cross-examine, confront, and present witnesses, a clear and convincing evidence standard of proof, and a transcript for appeal. *Id.*

331. *E.g.*, Ky. Rev. Stat. § 214.181(c)(9)(a) (Michie/Bobbs-Merrill 1992) (permitting court ordered HIV testing only when a compelling need for testing is demonstrated which cannot be accommodated by other means and when adhering to due process protections for test subject); OR. REV. STAT. § 433.019 (1991) (requiring that, before ordering the im-
sections explain, the law in these areas clarifies that neither the state’s police power, nor its powers to provide health care to incompetent people, will justify overriding women’s informed consent rights to prevent HIV-positive women from bearing children.

2. Civil Commitment Substantive and Procedural Protections. Throughout much of the nineteenth and twentieth centuries, the state parens patriae power332 to safeguard incompetent people, coupled with the police power to protect society at large, provided the bases for committing people to mental institutions for indefinite periods of time, often based upon scant factual findings. Until recently, those committed had little legal recourse.333 More recently, civil commitment statutes were challenged and invalidated or modified in a series of cases reaching the U.S. Supreme Court.334 In its

position of a measure to control the behavior of an individual infected with a communicable disease, a circuit court must hold a hearing and find by clear and convincing evidence that the proposed measure is necessary and is the least restrictive alternative). 332.

'Parens patriae,' literally means 'parent of the country,' refers traditionally to role of state as sovereign and guardian of persons under legal disability, such as juveniles or the insane, and in child custody determinations, when acting on behalf of the state to protect the interests of the child. It is the principle that the state must care for those who cannot take care of themselves. BLACK'S LAW DICTIONARY 1114 (6th ed. 1990) (citations omitted).

333. E.g., Jackson v. Indiana, 406 U.S. 715, 736 (1972) (noting that "the states have traditionally exercised broad power to commit persons found to be mentally ill"); see supra part I. See generally James W. Ellis, Volunteering Children: Parental Commitment of Minors to Mental Institutions, 62 CAL. L. REV. 840 (1974); Note, Civil Commitment of the Mentally Ill: Theories and Procedures, 79 HARV. L. REV. 1288, 1288 (1966) [hereinafter Civil Commitment].

The case of "Mrs. Packard" is emblematic of the historic power to commit. In 1860, Mr. Packard, a Calvinist minister, had his wife committed to a mental hospital because she disagreed with his theological views in public. Ellis, supra, at 842. He "could not manage her at home" where he kept her imprisoned in her room. He utilized a state statute which permitted a husband to petition to have his wife committed "without evidence of insanity or distraction [as] required in other cases." Ralph Slovenko, Criminal Justice Procedures in Civil Commitment, 24 WAYNE L. REV. 1, 3 n.10 (1977). After securing her release from the hospital, she became an effective crusader for reform of civil commitment law and for regulation of mental hospital conditions. Unfortunately, many of her reforms were short-lived. Ellis, supra, at 842-44.

334. E.g., Fouche v. Louisiana, 112 S. Ct. 1780, 1784 (1992) (holding that person acquitted under an insanity defense, who was no longer insane, could not continue to be held in confinement simply because he continued to be dangerous to himself and others); Parham v. J.R., 442 U.S. 584, 603, 606 (1979) (requiring that commitment of minor by parents be held to "exacting constitutional scrutiny, including a formal, adversary, pre-admission hearing decided by a neutral fact-finder"); Addington v. Texas, 441 U.S. 418, 431-33 (1979) (holding that in a civil commitment proceeding, mental illness must be shown by "clear and convincing" evidence, rather than a mere "preponderance" of the evidence); O'Connor v. Donaldson, 422 U.S. 563, 575 (1975) (holding that commitment may last only as long as there is a "constitutionally adequate basis" for it); Jackson v. Indiana,
decisions, the Court recognized that "civil commitment for any purpose constitutes a significant deprivation of liberty" and thus is subject to rigorous due process requirements including the rights to counsel, to confront adverse witnesses, to neutral factfinders, and to appeal. In addition, the Court imposed the weighty substantive requirement that the state show, "in a sufficiently reliable way, that the goal it seeks to achieve outweighs the person's loss of liberty and other costs."

Applying these civil commitment principles to the hypothetical mandatory measures preventing HIV-positive women from child-bearing demonstrates that such measures are unlikely to survive this substantive threshold test, because neither preventing conception nor forced abortion benefit fetuses or future children. Incarceration or quarantine of HIV-positive pregnant women would have no effect on their likelihood of transmitting the virus to the fetus. Moreover, HIV-infected babies are highly unlikely to engage in behaviors which might transmit the virus to others, and thus present no danger to the community. Therefore, the purported goal of curbing HIV transmission would not be furthered and there would be no justification for the woman's loss of liberty.

406 U.S. 715, 738 (1972) (holding that the "nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed"); Specht v. Patterson, 386 U.S. 605, 610 (1967) (requiring a hearing for initial civil commitment including rights to counsel, to confront witnesses, to cross-examination, to offer evidence, and to appeal).


336. Foucha v. Louisiana, 112 S. Ct. at 1781 (ruling that a candidate for involuntary civil commitment was entitled to "constitutionally adequate procedures"); Vitek v. Jones, 445 U.S. 480, 494-96 (1980) (holding that a prisoner being transferred to a mental hospital was entitled to the same due process protections as a civil committee, including the rights to notice, to present evidence, to confront adverse witnesses, to an independent factfinder, and to counsel).

337. Gary Gleb, Washington's Sexually Violent Predator Law: The Need to Bar Unreliable Psychiatric Predictions of Dangerousness from Civil Commitment Proceedings, 39 UCLA L. Rev. 213, 218 (1991) (citing Addington, 441 U.S. at 425); see also Foucha v. Louisiana, 112 S. Ct. 1780, 1788 (1992) (holding that mental health confinement on the basis of an antisocial personality where there is no evidence of mental illness violates due process). In Addington, the Court held that a state could civilly commit a person only when it was proven to be necessary to fulfill the state goals of protecting the individual from harming himself or others. Addington v. Texas, 441 U.S. at 426.

338. Even assuming arguendo that a compelling state interest for reproductive coercion of HIV-positive women exists, civil commitment law establishes the necessity for applying strict procedural protections, including the right to counsel, written notice, presentation of evidence, confrontation of adverse witnesses, and verbatim transcript for appeal. Civil commitment law also provides guidance concerning the appropriate standard of proof for reproductive coercion proceedings. These strict procedural protections will make it difficult to ever secure court orders to control HIV-positive women's childbearing. The Supreme Court requires the standard of proof in civil commitment proceedings to be greater than that of other civil proceedings because of the importance of the liberty inter-
3. Substantive and Procedural Protections of State Law Governing Unconsented Sterilization. Although the Supreme Court at one time found that the state police power encompassed “cutting the Fallopian tubes” forming the basis for eugenic sterilization laws in thirty-two states, the modern trend deviates from this ruling. Only four states—Delaware, Georgia, North Carolina, and Mississippi—allows consideration of either a woman’s likely ability to est at stake. Addington v. Texas, 441 U.S. at 427. The Addington Court held, however, that “[g]iven the lack of certainty and fallibility of psychiatric diagnosis, there is a serious question as to whether a state could ever prove beyond a reasonable doubt that an individual is both mentally ill and likely to be dangerous.” Id. at 429 (citations omitted). In addition, the Court noted that the standard of proof must fairly allocate the risks of erroneous determinations. The Court reasoned that it was worse to allow some dangerous mentally ill people to remain untreated than to commit some mentally ill people even though they were not dangerous. In so finding, the Court noted its belief that civil commitment was “likely to benefit” erroneously committed mentally ill people. Id. at 428-29; see also Civil Commitment, supra note 333, at 1290 (noting that “due explanation for the different treatment of mentally ill persons is the assumption that hospitalization of someone suffering from mental illness is likely to benefit him even if he is not dangerous”). But see Mary L. Durham & John Q. LaFond, A Search for the Missing Premise of Involuntary Therapeutic Commitment: Effective Treatment of the Mentally Ill, 40 RUTGERS L. REV. 303 (1988) (disputing the Court’s premise in Addington that involuntary commitment necessarily benefits mentally ill people); David Ferleger, Anti-Institutionalization and the Supreme Court, 14 RUTGERS L.J. 595, 603-13 (1983) (disputing the Court’s premise regarding institutionalization of mentally retarded people).

On the above grounds the Court rejected the criminal standard of proof and adopted the intermediate “clear and convincing evidence” standard. Addington v. Texas, 441 U.S. at 431-33 (stating that “clear and convincing proof” is required for indefinite involuntary commitment). Several states have adopted a “clear and convincing evidence” standard in hearings to determine whether compulsory measures, including HIV testing should be ordered for an individual alleged to engage in behavior presenting imminent danger to the public health, and whether the proposed compulsory measure is the least restrictive means necessary to protect public health. E.g., ALA. CODE §§ 22-11A-24 to -36 (1990) (providing procedural guarantees for civil commitment which include notice, hearing, right to appointment of attorney, and the clear and convincing evidence standard). The West Virginia Supreme Court adopted the clear and convincing evidence standard for proceedings concerning the quarantine of a person suspected of having active tuberculosis. Greene v. Edwards, 263 S.E.2d 661 (W.Va. 1980).

Government infringement upon the right to bear children is equally invasive as the infringements imposed in civil commitment or confinement. Since both pregnancy and HIV serostatus are readily ascertainable, the government should be required, at a minimum, to meet the standard of “beyond a reasonable doubt” for commitment or mandatory treatment. Moreover, unlike the confinement of the mentally ill, the procedures forced upon these defendants would produce no benefit for those erroneously subjected to them. In fact, impositions such as a forced sterilization or abortion would produce irreparable damage. Although forced implantation of intrauterine devices or Norplant do not carry the same permanence, the psychological effects of enduring such an experience cannot be erased. For these reasons also, reasonable doubt is the appropriate standard of proof.


340. The transformation of sterilization law is a direct result of the elaboration of
care for any children she might bear, or the likely "fitness" of the offspring, in determining whether she should be sterilized. With the exception of these four states, however, one of which has not constitutional protections for the right to bear children, which began in 1942 with the Supreme Court's declaration that sterilization involved "one of the basic civil rights of man [sic]." Skinner v. Oklahoma, 316 U.S. 535, 541 (1942). By 1980, only eleven states permitted compulsory sterilization of the mentally retarded and mentally ill in order "to protect society." Coleman, supra note 30, at 56 & n.13 (listing the eleven states: California, Connecticut, Delaware, Maine, Mississippi, North Carolina, Oklahoma, Oregon, South Carolina, Utah, and Virginia). However, California repealed its eugenic sterilization law effective January 1, 1980. CAL. WEL. & INST. CODE § 7254 (West 1984) (repealed 1979)). Georgia was actually the eleventh state: GA. CODE ANN. § 31-20-3 (Michie 1991). Georgia's statute was enacted in 1970, declared unconstitutional by the Georgia Supreme Court in 1983 in Motes v. Hall County Dep't of Family and Children Servs., 306 S.E.2d 260 (Ga. 1983), and amended in 1985. See Sidney P. Wright, Note, Involuntary Sterilization in Georgia: The Aftermath of Motes v. Hall County Dep't of Family and Children Servs., 1 GA. ST. U. L. REV. 75, 75-76 (1984) [hereinafter Involuntary Sterilization in Georgia].

As of 1991, all but four of these state statutes were repealed: only Delaware, Georgia, Mississippi, and North Carolina continued to allow compulsory sterilization of the mentally ill. See infra note 341 and accompanying text.

341. State statutes, with the exception of those of Georgia, North Carolina, and Mississippi, do not authorize sterilization absent the patient's consent unless findings are made, at a legal proceeding employing stringent due process protections, that the patient is incompetent to consent and that it is in his or her best interests to be sterilized. The Georgia Code authorizes sterilization of irreversibly and incurably mentally incompetent [persons who] ... with or without economic aid (charitable or otherwise) from others, could not provide care and support for any children procreated by them in such a way that such children could reasonably be expected to survive to the age of 18 years without suffering or sustaining serious mental or physical harm.

GA. CODE ANN. § 31-20-3 (Supp. 1992). The North Carolina Code permits sterilization of mentally retarded or mentally ill person absent a finding of incompetence, even if a capable person refuses consent and sterilization is not in the person's best interest. Such sterilization is permitted, if the court finds the sterilization to be in the "public good" or that the person is likely to produce offspring "who would have a tendency to serious physical, mental or nervous disease or deficiency." N.C. GEN. STAT. §§ 35-43 (1991). The Mississippi Code requires a finding, prior to sterilization of an inmate of a mental institution, that the inmate is a "probable potential parent of socially inadequate offspring." MISS. CODE ANN. §§ 41-45-9 (Supp. 1992). Although such sterilization must be found to promote "the welfare of the inmate and society," the statute does not require that the best interest of the inmate take precedence. Id.

In addition to Mississippi, only two other state statutes, those of North Carolina and Delaware, continue to allow eugenic considerations to enter into the determination of whether a woman will be sterilized absent her consent. DEL. CODE ANN. tit. 16, § 5707 (1991) (requiring that a petition to sterilize a mentally incompetent person shall include, inter alia, "[w]hether: ... The respondent, if not sterilized, is likely to procreate a child who would have any probability of serious physical, mental or nervous disease or deficiency"); N.C. GEN. STAT. § 35-43 (1991) (authorizing unconsented sterilization of mentally retarded or mentally ill persons who either will not be capable of caring for a child, or are likely to produce "a child or children which probably would have serious physical, mental, or nervous diseases or deficiencies").
amended its statute since the elaboration of constitutional protections for childbearing rights, state statutory authority to sterilize emanates solely from *parens patriae* power rather than from state police power. Unlike the state police power, *parens patriae* cannot be exercised against people competent to make their own medical decisions, and it cannot be invoked to impose measures damaging to the individual because they are good for society. In states without governing statutes, either involuntary sterilizations are not conducted, or courts rule on petitions pursuant to their inherent *parens patriae* authority.

Because *parens patriae* powers permit state governments to act only in the "best interests" of people who are legally incompetent to make their own health care decisions, these powers are entirely consistent with traditional informed consent doctrine. A woman's com-


343. Scott, *supra* note 33, at 817 & n.32. North Carolina's statute, however, derives its authority from the police power, N.C. Gen. Stat. §§ 35-36 (1991), and its explicit eugenic purpose has been repeatedly upheld by both the state's highest court and a federal trial court during the 1970s and 1980s. North Carolina Ass'n for Retarded Children v. North Carolina, 420 F. Supp. 451, 457-58 (M.D.N.C. 1976) (upholding statute as narrowly drawn, the court stated that "[t]he legislative dual purpose—to prevent the birth of a defective child, or the birth of a nondefective child that cannot be cared for by its parent—reflects a compelling state interest"); *In re Truessdell*, 304 S.E.2d 793 (N.C. Ct. App. 1983), modified and aff'd, 329 S.E.2d 630 (N.C. 1985) (upholding the statute and the disposition of the case but modifying the language used by the appellate court in paraphrasing the statute); *In re Johnson*, 263 S.E.2d 805 (N.C. Ct. App. 1980), cert. denied, 267 S.E.2d 686 (N.C. 1980) (holding that where involuntary sterilization was sought for mildly mentally retarded women, evidence regarding woman's morals and sexual activity were relevant); *see also In re Moore*, 221 S.E.2d 307, 312 (N.C. 1976) (while validating eugenic purpose of earlier statute, state Supreme Court quoted an intermediate court in Oregon holding that "[t]he state's concern for the welfare of its citizenry extends to future generations and when there is overwhelming evidence . . . that a potential parent will be unable to provide a proper environment for a child because of his own mental illness or mental retardation, the state has sufficient interest to order sterilization" (citation omitted)).

Delaware presents a special case, because it amended its law in 1985 to draw upon both the *parens patriae* and police powers of the state. The statute requires that sterilization of a mentally incompetent person be performed only when in her overall best interests, but requires eugenic consideration of whether that person is likely to produce a child "who would have any probability of serious physical, mental or nervous disease or deficiency." Del. Code Ann. tit. 16, § 5707 (1991). Delaware also requires consideration of whether the person to be sterilized is permanently incapable of caring for a child and likely to endanger the welfare of a child, even if provided with instruction or training. *Id.* Thus, it includes eugenic considerations which would indicate its source as the police power, but it also requires a finding of whether the benefits to the women outweigh the risks, which would indicate *parens patriae* as the source. See Slovenko, *supra* note 332, at 6. The statute supplies no cues to indicate which considerations are paramount.


petent refusal must be respected and an incompetent woman’s fate can only be determined by a substitute decisionmaker’s decision as to what is best for her. The practice of imposing sterilization on incompetent women for the benefit of others has been soundly condemned and virtually discarded in practice.

4. Summary. Over the course of the twentieth century, the scope of the power to legislate public health measures has been gradually circumscribed as the doctrines of individual rights and informed consent have evolved. This trend is evident in the evolution of civil commitment and unconsented sterilization law, both of which now provide stringent procedural and substantive protections to protect individuals from government coercion. One commentator describes the evolution of boundaries on the state public health police power as shifting from accepting whatever “science” might justify to protection of individual rights to self-determination from what “science” might want to do. These stringent protections should be applied to government measures sought to be imposed upon HIV-positive childbearing women pursuant to the police power. If and when they are, the police power will only justify circumventing informed consent rights when such measures are proven, under conditions of stringent due process protections, to be the least restrictive ways to avert a significant public health risk. Control of childbearing by HIV-positive women does not fulfill these criteria. Indeed, as the evolution of sterilization law shows, the police power should never be the basis for imposing sterilization absent freely given consent.

G. Conclusion

Adherence to traditional norms of informed consent should prevent legislatures from enacting, and courts from permitting, compulsory HIV testing of women, their umbilical cords, or their newborns. Under these norms, an HIV test cannot be forced upon a patient “for her own good” so long as she is competent and has refused consent for such a test. Her refusal, no matter how unreasonable, must be respected, even if the doctor believes that her health will be seriously jeopardized by the refusal. The same is true for her refusal of contraceptive devices, abortion or sterilization, regardless of the risks health professionals believe she would face in pregnancy and childbirth. Indeed, a person has a legal right to refuse even life-saving treatment.

346. See infra note 381.
For the foreseeable future of medical science, there is no basis in informed consent law for overriding an HIV-positive woman's informed refusal of testing or fertility control either on the basis of providing care to a child or of protecting the public health.

Informed consent law will often provide legal redress through medical malpractice actions to HIV-positive women subjected to reproductive coercion. Moreover, the threat of such actions should encourage individual health care providers to respect HIV-positive women's health care rights.

IV. THE FOURTEENTH AMENDMENT PROTECTS CHILDBEARING BY HIV-POSITIVE WOMEN

The application of laws to prohibit HIV-positive women from procreating, or to penalize them for doing so, should not survive constitutional challenge based on the Fourteenth Amendment substantive due process right to bear children. As subpart A argues, this

348. Hodgson v. Minnesota, 497 U.S. 417, 434 (1990) (stating that "[a] woman's decision to beget or to bear a child is a component of her liberty that is protected by the Due Process Clause of the Fourteenth Amendment"); Carey v. Population Servs. Int'l, 431 U.S. 678, 686 (1977) (ruling that regulations that impose a burden on "a decision as fundamental as that of whether to bear or to beget a child" may only be justified by compelling state interests); Roe v. Wade, 410 U.S. 113, 152 (1973) (recognizing that the Fourteenth Amendment protects zones of privacy deemed fundamental which includes the right to procreate); Eisenstadt v. Baird, 405 U.S. 438, 453 (1972) ("If the right of privacy means anything it is the right of the individual . . . to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or to beget a child.").

The Fourteenth Amendment "nullifies and makes void all state legislation, and state action of every kind, which . . . injures [the citizens of the United States] in life, liberty or property without due process of law." The Civil Rights Cases, 109 U.S. 3, 11 (1883). Regardless of the intent of a legislature, when state officials enforce state or local laws that infringe upon childbearing rights, such enforcement clearly constitutes state action. Ex parte Virginia, 100 U.S. 339, 347 (1879) ("Whoever by virtue of public position under a State government, deprives another of property, life, or liberty . . . violates the constitutional inhibition; and as he acts in the name and for the State, and is clothed with the State's power, his act is that of the State."); see also Home Tel. & Tel. Co. v. Los Angeles, 227 U.S. 278, 287 (1913) (noting that "whether the State has authorized the wrong is irrelevant").

When private health care providers enforce state laws, such as those requiring HIV testing of all pregnant women, they are state actors. Zinermon v. Burch, 494 U.S. 113 (1990) (holding that physicians, staff, and administrators who admitted a man who was incompetent to consent, into a state mental hospital under the voluntary commitment authority delegated by the state were state actors); see also Flagg Bros. v. Brooks, 436 U.S. 149, 154 (1978) (ruling that the "state is responsible for the . . . act of a private party when the State by its law, has compelled the act").

Hence, Fourteenth Amendment challenge will be sustainable on behalf of women who are prosecuted for childbearing pursuant to criminal transmission statutes, or those who are subjected to forced testing, contraception, abortion, or sterilization pursuant to civil HIV containment law.
is likely to be true despite the fact that restrictions on abortion are no longer reviewed under strict scrutiny, and would continue to be true even should the Supreme Court overturn Roe v. Wade, an event which Justice Blackmun has forewarned could be imminent.

The extent to which federal constitutional protection for women's reproductive autonomy has been undermined stems from...
the states' interest in safeguarding the potential life of the fetus. With the blessing of the Supreme Court, many state legislatures will attempt to use this interest to further drastically curtail a woman's right to elect to terminate a pregnancy. However, the right to bear children—to conceive, gestate, and give birth—without state interference will nonetheless likely remain a fundamental constitutional right. Childbearing prohibitions for HIV-positive women do not fulfill the compelling state interest required to justify government measures infringing upon a fundamental right, and consequently can be expected to be invalidated by Fourteenth Amendment challenge.

Part II.B argues that state action directing or compelling HIV-positive women to undergo sterilization, abortion, or contraception, or punishing them for becoming pregnant, should be invalidated pursuant to a Fourteenth Amendment equal protection challenge. Under this theory, control measures would be subjected to the strictest scrutiny. Therefore, the fact that childbearing by women who will potentially birth offspring with similarly predictable and disabling diseases, like Tay-Sachs, are not similarly controlled, would prove the control measures to be underinclusive and thus unconstitutional.

Part II.C argues that the right to bear children should provide fundamental protection against compelling a woman to disclose information concerning her decision to procreate. Thus, compulsory testing measures which force a woman to confront information about her HIV status in order to influence her procreation decisions would infringe upon this fundamental right without effectuating a compelling purpose. Unconsented HIV testing of a freely-drawn blood sample from a pregnant or post-partum woman for epidemiological purposes, where results are not traceable to the woman or her newborn, imposes a minor infringement upon her childbearing right while fulfilling the legitimate state purpose of monitoring the prevalence of HIV among childbearing women. However, as noted in Part III of this Article, when such testing is conducted absent statutory authority, it violates informed consent law and thus, could be actionable under state law.

351. Planned Parenthood of Southeastern Pa. v. Casey, 112 S. Ct. at 2817 (joint opinion) (reestablishing "the States' important and legitimate interest in potential life" (quoting Roe v. Wade, 410 U.S. at 163)); Webster v. Reproductive Health Servs., 492 U.S. at 519 (stating that "we do not see why the States' interest in protecting potential human life should come into existence only at the point of viability").

352. Law & Pine, supra note 60, at 424, 445 n.162; see also Dawn E. Johnsen & Marcy J. Wilder, Will Roe v. Wade Survive the Rehnquist Court?, 13 NOVA L. REV. 457, 460 (1989) (stating that "$t\text{he anti-choice minority has . . . lobbied successfully for the enactment of unconstitutional anti-abortion legislation at the state level}").
A. The Right to Bear Children Continues to Be Fundamental Post Casey

In 1942, the Supreme Court struck down a state's compulsory sterilization law and recognized for the first time "the right to have offspring" as a fundamental constitutionally-protected right. The Supreme Court has since expanded this fundamental right to autonomously control reproduction without state interference in a long line of cases recognizing that decisions about childbearing lie at "the very heart" of the constitutional "right of personal privacy."  

353. Skinner v. Oklahoma, 316 U.S. 535, 536 (1942). "We are dealing here with legislation which involves one of the basic civil rights of man. Marriage and procreation are fundamental to the very existence and survival of the race." Id. at 541.


The decision whether or not to beget or bear a child is at the very heart of this cluster of constitutionally protected choices. That decision holds a particularly important place in the history of the right of privacy . . . . This is understandable, for in a field that by definition concerns the most intimate of human activities and relationships, decisions whether to accomplish or to prevent conception are among the most private and sensitive.

Id. at 685 (citations omitted); see also Arnold v. Board of Educ., 880 F.2d 305, 311 (11th Cir. 1989); Avery v. County of Burke, 660 F.2d 111, 115 (4th Cir. 1981) (noting that a woman's claim that she was wrongfully sterilized involved the fundamental right of procreation); Downs v. Sawtelle, 574 F.2d 1, 11 (1st Cir. 1978) (holding that "irrevocably terminating a patient's ability to bear children without her consent is a deprivation of a fundamental constitutional right"); Poe v. Lynchburg Training Sch. & Hosp., 513 F. Supp. 789, 793 (W.D. Va. 1981) (denying a motion to dismiss a cause of action seeking an order that all individuals who were sterilized pursuant to Virginia's eugenics law be notified because of the "fundamental nature of [the] personal interest"); North Carolina Ass'n for Retarded Children v. North Carolina, 420 F. Supp. 451, 458 (M.D.N.C. 1976) (noting that "[t]he right to procreate is a fundamental one").

The historic recognition of the importance in our democracy of freedom from government interference in childbearing weighs heavily toward recognition of its fundamental nature, even according to the most restrictive view of fundamental rights. See Planned Parenthood of Southeastern Pa. v. Casey, 112 S. Ct. at 2859 (Rehnquist, C.J., concurring in part, dissenting in part). The only time in this nation's history that states had widely-enacted laws explicitly restricting childbearing was during the eugenics era—an era resoundingly criticized and eschewed in the public conscience. See Scott, supra note 33, at 809-10; Ethics of Prevention, supra note 95, at 497. Many state courts have also interpreted the Federal Constitution to consider protecting the right to bear children as a fundamental right. See, e.g., Foy v. Greenblott, 190 Cal. Rptr. 84, 90 (1983); Motes v. Hall County Dep't of Family and Children's Servs., 306 S.E.2d 260, 262 (Ga. 1983) (holding that sterilization statute involved termination of fundamental right); In re Truesdell, 304 S.E.2d 793, 799 (N.C. 1983) ("[S]terilization not only affects the individual's fundamental right to procreate . . . it forever deprives the individual of that basic liberty." citations omitted)); In re M.K.R., 515 S.W.2d 467, 470 (Mo. 1974) ("[W]e are faced with a request for sanction by the state of . . . a routine operation which would irreversibly deny to a human being a fundamental right, the right to bear or beget a child.").

State law in many states provides independent fundamental protections for childbearing and abortion rights. Law & Pine, supra note 60, at 434-35, 448; see also Anita L.
This fundamental right has traditionally encompassed the right to control conception without interference from the state and the right of an individual woman to decide autonomously whether to continue a pregnancy or to abort.

The Fourteenth Amendment protects a woman's decision to continue a pregnancy and bear a child, even when that child is certain to be born into a status which will guarantee its suffering. In Zablocki v. Redhail, the Supreme Court held that the right to marry could not be denied because the party desiring to marry was behind on child support payments. The Court reasoned that because "the woman whom appellee desired to marry [who was already pregnant] had a fundamental right... to bring the child into life to suffer the myriad of social, if not economic, disabilities that the status of illegitimacy brings,... a decision to marry and raise the child in a traditional family setting must receive equivalent protection." Applying this principle to childbearing by HIV-positive women compels the conclusion that the state may not prevent HIV-positive women from giving birth. Just as the state could not outlaw out-of-wedlock births in order to protect children from suffering the opprobrium of illegitimacy, the state cannot outlaw the birth of potentially

Allen, Legal Issues in Nonvoluntary Prenatal HIV Screening, in AIDS, WOMEN AND THE NEXT GENERATION, supra note 3, at 182-87 (asserting that state law also presents possibilities for tort and contract actions which can also serve to protect reproductive rights).

Moreover, international law, binding on the United States, also protects the right to bear children. E.g., International Covenant on Civil and Political Rights, adopted by the United Nations Dec. 19, 1966, art. 23, 999 U.N.T.S. 171, 179 ("The right of men and women of marriageable age to marry and found a family shall be recognized."). This treaty was ratified by the United States on June 1, 1992, deposited at the U.N. by the United States on June 8, 1992, and entered into force for the United States on September 8, 1992. Treaty Actions, 3 DEP'T ST. DISPATCH 817, 817 (1992). See generally Isaacman, supra note 85, at 487-89 (considering international law analysis of childbearing as a fundamental right). A complete presentation of international and state law grounds for challenging interference with childbearing rights of HIV-positive women is beyond the scope of this Article.


356. Roe v. Wade, 410 U.S. 113 (1973); see also Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 60 (1976) (holding inter alia that the state cannot require spousal consent for an abortion); Eisenstadt v. Baird, 405 U.S. 438, 453 (1972) (invalidating a state law prohibiting distribution of contraceptives to unmarried persons). The Eisenstadt Court declared that "[i]f the right of privacy means anything, it is the right of the individual to be free from unwarranted governmental intrusion into matters so fundamental as the decision whether to bear or beget a child." Id. at 453.


358. Id. at 379.

359. Id. at 386 (citations omitted).
HIV-infected children. While losing one's mother to HIV infection at a young age will likely cause a child to suffer emotionally and socially, preventing that pain does not justify prohibiting an HIV-positive woman from having children. Likewise, though an HIV-infected infant will suffer intense physical pain and discomfort, the government cannot compel a woman to terminate a pregnancy for the purpose of preventing the infant's suffering. This conclusion is further compelled when considered in light of medicine's inability to predict infant infection and the fact that children born to HIV-positive women have only a thirty percent chance of being infected by HIV themselves.360

Fundamental protections for the right to bear children survive361 despite the fact that the current Supreme Court emphasizes the state's interest in safeguarding the life of the fetus throughout a pregnancy and no longer evaluates restrictions on abortion under strict scrutiny.362 Fundamental constitutional protections for child-

360. See discussion supra note 94.
361. See Planned Parenthood of Southeastern Pa. v. Casey, 112 S. Ct. at 2859 (Rehnquist, C.J., concurring in part, dissenting in part) (listing the right to procreate and the right to use contraceptives as liberty interests the Court has recognized as fundamental); see also Laurence H. Tribe, The Curvature of Constitutional Space: What Lawyers Can Learn from Modern Physics, 103 HARV. L. REV. 1 (1989). Tribe quoted Charles Fried's argument on behalf of the Bush Administration in Webster urging that Roe be overruled. Justice O'Connor asked, "Do you think that the state has the right to, if... we had a serious overpopulation problem... require women to have abortions after so many children?" Mr. Fried answered, "I surely do not. That would be quite a different matter... because unlike [the prevention of abortion... that would involve not preventing an operation but violently taking hands on, laying hands on a woman and submitting her to an operation]." Id. at 14-15. See generally Roberts, supra note 24, at 1464 (noting that "punishing drug-addicted mothers unconstitutionally burdens the right to choose to bear a child"); John A. Robertson, Procreative Liberty and the Control of Conception, Pregnancy and Childbirth, 69 VA. L. REV. 405 (1983).
362. Planned Parenthood of Southeastern Pa. v. Casey, 112 S. Ct. 2791 (1992). The Casey decision illustrates the bitter disagreement among the Justices over the appropriate standard of review and the weight to be given to each interest in abortion restriction cases. Though no majority was attained in Casey, it is clear that strict scrutiny no longer applies uniformly. Only Justices Stevens and Blackmun applied and would always apply strict scrutiny. See id. at 2838-43. Justices Rehnquist, White, Scalia, and Thomas applied rational basis review. Id. at 2867 (Rehnquist, C.J., concurring in part, dissenting in part). Justices O'Connor, Kennedy, and Souter essentially decided the case with their "joint opinion" and applied an "undue burden" standard. Id. at 2804.

Pursuant to the "undue burden" standard, strict scrutiny is applied only if, in a threshold question, a restriction is found to make an abortion virtually impossible for at least some women to obtain. Otherwise, rational basis review applies. They found only the spousal consent provision, and the reporting requirements related to it, to be such an undue burden and applied strict scrutiny to invalidate them. Id. at 2826-30. The rest of the statute was reviewed under rational basis because it was found not to be an undue burden. Id. at 2822-26.

In their joint opinion in Casey, Justices O'Connor, Kennedy, and Souter state that
bearing require that any measure infringing upon a woman's childbearing be demonstrated to be narrowly-tailored and necessary to effectuate compelling government interests.

Even when abortion was perceived as a fundamental right subject to strict scrutiny, two lines of case law arose which permitted governmental regulation in this area. The first permitted the government to design funding schemes to further its legitimate interests, based on the theory that funding decisions do not "affirmatively" restrict a woman's abortion options. The second permitted state regulation of abortion when such regulation fulfills the compelling state interest of protecting viable fetal life. A review of these doctrines is necessary because these two lines of case law are

"there is a substantial state interest in potential life throughout pregnancy." 112 S. Ct. at 2820. They rely upon this interest to eschew the trimester framework of Roe, and to sustain restrictions on abortion which the Court in recent years had invalidated. Id. at 2816-21. But see id. at 2850 (Blackmun, J., concurring in part, dissenting in part) ("Indeed, as this Court has invalidated virtually identical provisions in prior cases, stare decisis requires that we again strike them down.").

Chief Justice Rehnquist, joined by Justices White, Scalia, and Thomas, state that abortion must be treated differently from "marriage, procreation and contraception" because it "involves the purposeful termination of potential life." Id. at 2859 (Rehnquist, C.J., concurring in part, dissenting in part) (citing Harris v. McRae, 446 U.S. 297, 325 (1980)); see also Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747, 792 n.2 (1986) (White, J., dissenting) (stating that a woman's right to privacy in abortion is not fundamental because abortion involves the destruction of a fetus; the right to prevent conception is fundamental because no fetal destruction occurs), cited with approval in Webster v. Reproductive Health Servs., 492 U.S. 490, 532 (1989) (Scalia, J., concurring in part).

Provisions potentially outlawing pregnancy by HIV-positive women bear no relation to these state interests. These statutes aim to prevent the spread of HIV infection, and thus do not bear any relation to protecting the health and welfare of the pregnant, HIV-positive minor. Pregnancy may pose health risks for the HIV-positive woman beyond the risks all women face. But because outlawing pregnancy for HIV-positive minors would entail a complete circumvention of family integrity, parental authority, and the right to childbearing, the state interest in protecting minors' health should not justify such measures. These laws take decisions about childbearing out of the hands of the family entirely and place them in the hands of the government.
relevant to analyzing HIV containment law and pregnancy. As the following two sections demonstrate, neither the criminalization of pregnancy for HIV-positive women nor the imposition of civil measures to prevent them from bearing children can be justified under either doctrine.

1. The Doctrine of Government Allocation of Funds to Encourage Childbearing. It is possible that government may seek to justify restricting childbearing by HIV-positive women pursuant to the abortion funding doctrine. The Supreme Court has repeatedly held that government may pursue resource allocation strategies to encourage childbirth and discourage abortion. This is because "[a] refusal to fund protected activity, without more, cannot be equated with the imposition of a 'penalty' on that activity."\(^3\) The Rehnquist Court perceives "a basic difference between direct state interference with a protected activity and state encouragement of an alternative activity consonant with legislative policy."\(^3\) Hence, government may decline to pay for abortions for poor women, while paying for medical care associated with continuing a pregnancy to term.\(^6\) In addition, government may prohibit the use of public facilities for performing abortions.\(^7\)

However, imposing criminal sanctions on a woman for exercising her choice to have an abortion is precisely the type of penalty that the Court recognizes as unconstitutional.\(^8\) Clearly, the HIV

\(^{364}\) Rust v. Sullivan, 111 S. Ct. 1759, 1772 (1991) (quoting Harris v. McRae, 448 U.S. 297, 317 n.19 (1980)). Theoretically this doctrine could be inverted to permit the government to allocate funds to encourage abortion over childbirth. However, the government could not selectively fund childbirth services only for women free of HIV. See discussion infra notes 384-415 and accompanying text.


\(^{366}\) Harris v. McRae, 448 U.S. at 325 (upholding the Hyde Amendment, which withheld federal funds from states under the Medicaid program which were targeted to reimburse abortion costs, except where the mother's life would be endangered if the fetus was carried to term); Maher v. Roe, 432 U.S. at 474 (upholding Connecticut welfare regulation granting medicaid coverage for medical services related to childbirth, but not for abortion); Poelker v. Doe, 432 U.S. 519, 521 (1977) (permitting St. Louis to provide publicly-financed hospital services for childbirth without providing corresponding services for nontherapeutic abortions).

\(^{367}\) Rust v. Sullivan, 111 S. Ct. at 1771-78 (upholding federal regulations preventing recipients of Title X funds from counseling, referring, or providing information regarding abortion); Webster v. Reproductive Health Servs., 492 U.S. 490, 507-11 (upholding Missouri's restriction on the use of public employees and facilities for the performance or assistance of nontherapeutic abortions).

\(^{368}\) Colautti v. Franklin, 439 U.S. 379, 386 n.7 (1979) (holding that "a State . . . may not impose direct obstacles [prior to viability]—such as criminal penalties—to further its interest in the potential life of the fetus"); Roe v. Wade, 410 U.S. 113, 117-18, 164 (1973) (invalidating Texas state law criminalizing the performance of all abortions except when
criminal transmission statutes applied to perinatal transmission impose a direct "government obstacle"\textsuperscript{369} to childbearing and would not be justified under this doctrine. Likewise, state-mandated sterilization, abortion, and contraception all constitute affirmative government obstacles to exercising the right to bear children. These measures do more than "encourage[] alternative activity deemed in the public interest."\textsuperscript{370} They do not leave an HIV-positive woman with the same range of options she would have had absent government activity,\textsuperscript{371} but rather, they effectively preclude her from bearing children. Thus, courts should scrutinize mandatory treatment statutes as applied against childbearing, as severe infringements upon a woman's childbearing right.

Moreover, government could not permissibly condition funding of prenatal care services for indigent women upon either the exclusion of HIV-positive women or a requirement of counseling that would direct HIV-positive women to use contraception, abortion, or sterilization.\textsuperscript{372} Indeed, such regulations, unlike those validated in \textit{Rust v. Sullivan}, would impermissibly discriminate against a class of disabled women. Although government could arguably decline to fund provision of prenatal care to all women,\textsuperscript{373} it could no more refuse prenatal care to all HIV-positive women, than it could to all sight-impaired women or all African-American women. Such restrictions would violate both the Equal Protection Clause and civil rights protections for the disabled.\textsuperscript{374} For the same reasons, government could not require directive counseling in prenatal care for HIV-positive women while providing prenatal care that fully respects the informed consent rights of all other women.

Directive counseling provisions would also be invalidated because they do not further a legitimate state interest. While under

\textsuperscript{369} Harris v. McRae, 448 U.S. at 315.
\textsuperscript{370} Id.
\textsuperscript{371} Id.
\textsuperscript{372} See \textit{Rust v. Sullivan}, 111 S. Ct. at 1765. Under the regulations upheld in \textit{Rust}, providers receiving federal grants may not refer a pregnant woman to an abortion provider, "even upon specific request. One permissible response to such an inquiry is that 'the project does not consider abortion an appropriate method of family planning and therefore does not counsel or refer for abortion.'" \textit{Id.} (quoting 42 C.F.R. § 59.8(b)(5) (1991)).
\textsuperscript{373} Rust v. Sullivan, 111 S. Ct. at 1772 (observing that "[a] doctor who wished to offer prenatal care to a project patient who became pregnant could properly be prohibited from doing so because such service is outside the scope of the . . . program").
\textsuperscript{374} See discussion \textit{infra} parts IV.A.3, IV.B.
the recently-enunciated standard in *Casey*, the state can regulate the informed consent dialogue to promote its legitimate interest in protecting fetal life, it cannot manipulate this dialogue to prevent, harm, or destroy fetal life.

2. *No State Interest Justifies Outlawing HIV Childbearing.* Since *Roe v. Wade*, the Supreme Court has permitted restrictions on abortion rights to safeguard the potential life of the fetus, so long as the restrictions do not endanger the woman’s health or life. State governments might attempt to rely upon this interest in fetal health to justify interference with HIV-positive women’s rights. In addition, a state’s interest in protecting child welfare might be asserted to justify reproductive coercion. A state might also assert its interest in protecting its citizenry from the fiscal burden of supporting the children of parents unlikely to be able to care for their children. None of these interests, however, should survive strict scrutiny.

In *Casey*, the Supreme Court held that the state has a legitimate interest in protecting fetal life throughout pregnancy. However, statutes seeking to penalize HIV-positive women for becoming pregnant or continuing their pregnancies do not further this

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376. Arguably, using directive counseling to discourage or prevent pregnancy of HIV-positive women would violate the principle articulated in *Skinner v. Oklahoma*. See *Skinner v. Oklahoma*, 316 U.S. 535 (1942) (invalidating a statute which sought to prevent the birth of “socially undesirable offspring”). See infra note 381 and accompanying text for a discussion of the state’s economic interest.
377. *Roe v. Wade*, 410 U.S. 113, 164-65 (1973). Despite the Supreme Court’s rejection in *Casey* of the trimester structure, and its recognition that the state has a legitimate interest in fetal life throughout pregnancy, it retained the principle that the state’s interest in the life of the fetus is not compelling until after viability. Planned Parenthood of Southeastern Pa. v. Casey, 112 S. Ct. 2791, 2804 (1992) (joint opinion) (stating “at the outset and with clarity that *Roe’s* essential holding, the holding we reaffirm... is the State’s power to restrict abortions after fetal viability, if the law contains exceptions for pregnancies which endanger a woman’s life or health”). Accordingly, states have been permitted to criminalize post-viability abortion. See *Colautti v. Franklin*, 439 U.S. 379, 386-87 (1979); Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 60-65 (1976); *Roe v. Wade*, 410 U.S. at 163-64. States may also require that a second physician be present when post-viability abortions are performed, Planned Parenthood Ass’n of Kansas City v. Ashcroft, 462 U.S. 476 (1983). Additionally, states may require that testing be performed, when consistent with prudent medical practice, to determine whether a post twenty-week fetus is viable. *Webster v. Reproductive Health Servs.*, 492 U.S. 490, 513-21 (1989). However, even when recognized as compelling, the state’s interest in fetal life has not been permitted to justify imperiling the health or life of the woman. *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986) (invalidating a requirement that post-viability abortions utilize methods most likely to preserve the life of the fetus because such methods endangered the woman’s health).
378. Planned Parenthood of Southeastern Pa. v. Casey, 112 S. Ct. at 2804 (joint opinion); see also *Webster v. Reproductive Health Servs.*, 492 U.S. at 519 (holding that a state’s interest in potential life is compelling throughout pregnancy).
interest, since prohibiting conception will prevent any fetal life from coming into being, including the seventy percent who will not become infected with their mothers’ HIV. 379 Just as a state could not, in the name of safeguarding children’s health, order the execution of all sick children, so too a state cannot seek to eliminate pediatric AIDS by forcibly preventing HIV-positive women from giving birth. Indeed, prevention of the birth of “socially undesirable offspring” was the state’s purpose in enacting the statute invalidated fifty years ago in Skinner v. Oklahoma, 380 and has been widely condemned as an improper state interest. 381 Once pregnant, the only

379. See John A. Robertson, Procreative Liberty and Human Genetics, 39 EMORY L.J. 697 (1990). He states that:

Negligently or even intentionally bringing a genetically handicapped child into the world cannot really be considered a wrong to offspring. The “responsible” reproductive behavior urged as the preferable alternative would have prevented birth altogether, hardly a gain for the offspring being protected. . . . If the life were truly wrongful, then there would be a duty to immediately cease all treatment and maintenance. The period of time alive would then be so small that it would hardly seem sufficient to justify intrusion into procreative choice. Id. at 716-17.


381. North Carolina Ass’n for Retarded Children v. North Carolina, 420 F. Supp. 451, 464 (M.D.N.C. 1976) (“Most competent geneticists now reject social Darwinism and doubt the premise implicit in Mr. Justice Holmes’ incantation that ‘. . . three generations of imbeciles is enough.’”); Scott, supra note 33, at 807; Sherlock & Sherlock, supra note 44, at 947, 949-51. “The eugenic justifications [for compulsory sterilization statutes] originally articulated are now repudiated by most medical experts and hardly would provide a compelling state interest.” Id. (citing American Ass’n on Mental Deficiency, Sterilization of Persons Who Are Mentally Retarded: Proposed Official Policy Statement of the American Ass. on Mental Deficiency, MENTAL RETARDATION, Apr. 1974, at 59); see, e.g. Elyce Z. Ferster, Eliminating the Unfit - Is Sterilization the Answer?, 27 OHIO ST. L.J. 591 (1966); Charles W. Murdock, Sterilization of the Retarded: A Problem or Solution?, 62 CAL. L. REV. 917 (1974); DKT Memorial Fund Ltd. v. Agency for Int’l Development, 887 F.2d 275, 277 (D.C. Cir. 1989) (recognizing that Congress’ intent in challenged law was to limit use of funds for international family planning to prevent involuntary sterilizations); Alan Guttmacher Inst. v. McPherson, 805 F.2d 1088 (2d Cir. 1986) (challenging the agency decision to deny funding for publishing articles that tended to proselytize the legalization of abortions); Population Inst. v. McPherson, 797 F.2d 1062 (D.C. Cir. 1986) (recognizing that Congress’ intent in challenged law was to prohibit use of international family planning funds for coerced abortions); Mildred G. v. Valerie N., 707 P.2d 760, 782 (Cal. 1985) (Bird, J., dissenting) (perceiving the majority opinion, by invalidating state law prohibiting sterilization of mentally incompetent women, as opening “the door to abusive sterilization practices which will serve the convenience of conservators, parents and service providers rather than incompetent conservatees. The ugly history of sterilization abuse against developmentally disabled persons in the name of seemingly enlightened social policies counsels a different choice.”); see also Furman v. Georgia, 408 U.S. 238, 356 (1972) (rejecting the objective of preventing criminals from procreating as justification for the death penalty, noting that “this Nation has never formally professed eugenic goals, and the history of the world does not look kindly upon them”). But see George P. Smith II, Limitations on Reproductive Autonomy for the Mentally Handicapped, 4 J. CONTEMP. HEALTH L. & POL’Y 71 (1988) (arguing that the concept of reproductive
way for an HIV-positive woman to avoid violating criminal transmission laws would be to abort the pregnancy. Thus, such statutes would actually serve to discourage the creation of or to destroy fetal life, rather than to preserve it.382

Similarly, civil statutes seeking to prevent HIV-positive women from conceiving or from continuing pregnancies cannot be said to fulfill the state interest in protecting fetal life because such statutes promote fetal destruction or prevent the possibility that a fetus will come to life at all. For example, Casey held that directive counseling seeking to deter pregnant women from obtaining abortions fulfilled the state's interest in preserving fetal life and therefore was permissible.383 However, directive counseling to HIV-positive women encouraging them not to conceive or to abort would not further the state's interest in protecting fetal life. No fetus is helped by such counseling.

State governments might also attempt to justify laws against HIV childbearing as a means of preventing the birth of children who are likely to be inadequately cared for by their mothers and thus to become wards of the state.384 However, the state's desire to save money is not a compelling interest which justifies denial of fundamental constitutional rights.385 As such, courts should not permit the
fundamental right to bear children to be curtailed merely on the basis of economic efficiency.

Moreover, the state cannot presume that a particular class of people is incapable of parenting and deny members of the class that right because the right to rear one's children is fundamental. Instead, the state must prove by clear and convincing evidence that the individual has been an unfit parent to a particular child. Thus, state policies seeking to preempt HIV-positive women from becoming parents based on a presumption of unfit parenting should fail constitutional scrutiny.

3. Constitutional Protections of Childbearing Rights Are Not Diminished by Disability. A woman's right to have a child is not diminished by the fact that she is HIV-positive. Though no court has directly ruled on this issue, court holdings on analogous issues, principles of equality and equal protection, and general civil rights pro-

abortion cannot be denied because prison views cost of providing off-site surgery prohibitive), cert. denied, 486 U.S. 1006 (1988); Society for Goodwill to Retarded Children v. Casey, 572 F. Supp. 1298 (E.D.N.Y. 1983) (holding that budgetary constraints could not justify refusal to provide constitutionally-required level of care for institutionalized retarded children); Involuntary Sterilization in Georgia, supra note 340, at 84-85 (explaining that Georgia General Assembly's legislative intent in passing its involuntary sterilization law, to prevent itself from being saddled with support of children of mental incompetent parents, is impermissible).

386. Stanley v. Illinois, 405 U.S. 645, 658 (1972) (holding that the Equal Protection Clause is violated when unwed fathers' parental rights can be terminated without hearing, while all other parents are accorded hearing on fitness to parent prior to termination); see also Zablocki v. Redhail, 434 U.S. 374, 386 (1978) (holding that a statute requiring prior court approval for the marriage of anyone already having an obligation to support minor children violated the Equal Protection Clause in that it impermissibly restricted the fundamental right of the affected class to marry and raise children).

387. See, e.g., Santosky v. Kramer, 455 U.S. 745, 753 (1982) (holding that termination of parental rights affects a fundamental liberty interest); Stanley v. Illinois, 405 U.S. 645, 649 (1972) (holding that, due to the importance of the right, due process is violated if parental rights of an unwed father are denied without a hearing).

388. See Santosky v. Kramer, 455 U.S. at 768-70 (requiring clear and convincing evidence standard in proceedings to terminate parental rights); Stanley v. Illinois, 405 U.S. at 656-57 (insisting that an individualized determination of parental fitness be made).

389. This is true even if most HIV-positive women do not prove to be fit parents. The Court has held that the state may not presume that unmarried fathers are unfit parents even if "most unmarried fathers are unsuitable and neglectful parents." Stanley v. Illinois, 405 U.S. at 654. A number of appellate courts have invalidated attempts by trial courts to make pregnancy or childbearing a violation of probation for women convicted of child endangerment or child abuse. See State v. Mosburg, 768 P.2d 313 (Kan. Ct. of Appeals 1989); People v. Pointer, 199 Cal. Rptr. 357, 362-66 (Ct. App. 1984); State v. Livingston, 372 N.E.2d 1335 (Ohio Ct. App. 1976). Although such women may be prevented from retaining custody of the children they bear, People v. Pointer, 199 Cal Rptr. at 365, they may not be constitutionally prevented from bearing them.
tectons for the disabled compel this result.

The District of Columbia Court of Appeals has held that a terminally-ill pregnant woman could not be compelled to undergo a Cesarean section for the alleged benefit of her viable fetus. In reaching its decision, the court ruled that "the right to bodily integrity is not extinguished simply because someone is ill, or even at death's door."

Indeed, as the body of law regarding sterilization of mentally incompetent women makes clear, the fact that a woman is disabled actually *heightens* rather than diminishes the procedural legal protections afforded her right to bear children. This heightened protection arises from repudiation of state policies authorizing eugenic sterilization of the disabled and from the recognition that third parties often seek to infringe upon disabled women's childbearing wishes in order to serve those parties' sense of fiscal austerity, convenience, morality, and other interests. Government is prohibited from sterilizing a mentally incompetent person in order to protect itself from the potential genetic and financial burden of children who might be born absent sterilization.

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391. *Id.* at 1247; see also *In re Conroy*, 466 A.2d 1209 (N.J. 1985) (acknowledging that the right to self-determination should not be lost merely because an individual is unable to sense a violation of it and holding that incompetent individuals retain the right to refuse treatment).

392. Some jurisdictions have banned sterilization of incompetent persons altogether because of the history and current potential for abuse of mentally incompetent women's childbearing rights. The majority of states, however, permit sterilization provided certain conditions are met which protect the disabled person's interest in autonomy and other interests. When a woman is mentally incompetent to make a decision about whether to be sterilized, the state may not disregard her right to autonomy in childbearing decisions. Instead, a substitute decision-maker must make the decision for her, based upon what her wishes are, if they are known, or based upon her best interests. Scott, *supra* note 33, at 807-25; Smith, *supra* note 390, at 79-82. *See In re Guardianship of Hayes*, 608 P.2d 635 (Wash. 1980) The *Hayes* court established a rigorous substantive and procedural standard for authorizing sterilization of the mentally incompetent. The standard requires, *inter alia*, that the person be found not competent to make her own decision, that other forms of contraception be impracticable, and that it be in her own best interest not to have a child, as opposed to the best interest of her caretaker. In addition, the court must attempt to elicit the woman's views about whether she wants to be sterilized, and must evaluate her capacity to care for her child. *Id.* at 641.

393. *See Scott*, *supra* note 33, at 821-22; *see also*, *Wyatt v. Aderholt*, 368 F. Supp. 1383, 1384 (M.D. Ala. 1974) (holding that sterilizations of mentally incompetent residents of a mental institution are permissible only when in the "best interest of a resident," which interest shall not be determined "on the basis of institutional convenience or purely administrative considerations"); *In re Truesdell*, 329 S.E.2d 630 (N.C. 1985) (noting, among other things, that the fact that menstruation of mentally retarded woman who was incapable of caring for herself caused problems for her caretaker was not an interest justifying performing a hysterectomy on her).

Moreover, a policy that diminishes a woman's reproductive rights because she is HIV-positive contravenes civil rights protections for the disabled. Under the Americans With Disabilities Act (ADA), a policy that diminishes a woman's reproductive rights because she is HIV-positive contravenes civil rights protections for the disabled. Under the Americans With Disabilities Act (ADA), 395 discrimination against handicapped people, including those who are HIV-positive, 396 is prohibited by government entities 397 and in certain public accommodations. 398 Congress specifically envisioned the government entity provisions to apply to law enforcement agencies. 399 The ADA might also apply to substantive acts of judges and legislatures, though congressional intent on this point is not explicit. 400 The public accommodations sections explicitly cover

1981)); In re Grady, 426 A.2d 467, 481 n.8 (N.J. 1981); Scott, supra note 33, at 821; Smith, supra note 381, at 80-81; Deborah D. Davis, Note, Addressing the Consent Issue Involved in the Sterilization of Mentally Incompetent Females, 43 ALB. L. REV. 322, 326 (1979). But see supra note 341.


396. Chai R. Feldblum, The Americans With Disabilities Act Definition of Disability, 7 LAB. LAW. 11, 20 n.34 (1991) (summarizing legislative history in which supporters state that the Act will cover and offer protection to HIV-positive workers); see also HENRY H. PERRIT JR., AMERICANS WITH DISABILITIES ACT HANDBOOK § 3.5, at 30-32 (2d ed. 1991) (noting that discrimination of persons with "contagious diseases based on unsubstantiated perceptions of the threat of a contagion" violates the ADA).


398. 42 U.S.C. § 12,182(a) (Supp. III 1991) (The ADA states that ".[n]o individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages or accommodations of any place of public accommodation.").


Since the statutory language does not limit its application to executive activities of state and local governments, judicial and legislative actions may also be subject to the nondiscrimination requirements of the Act. ... Arguably, the coverages of the Act may extend even to substantive legislative and judicial action of state and local governments. A state law or local ordinance that blatantly discriminates against a class of individuals with disabilities presumably would be subject to challenge under the statute. Likewise, a judge whose rulings evince prejudice or malice against litigants on account of their disability would be
health care providers. Interpreting the Act to prevent discrimination against disabled people in childbearing would comport with its overall legislative intent to "assure equality of opportunity, [and] full participation... in those opportunities for which our free society is justifiably famous.

Most states and many localities also provide civil rights protections against discriminatory treatment of disabled people. Some of these laws may strengthen the argument that preventing HIV-positive women from fully enjoying their fundamental rights is unlawful.

B. Equal Protection Prohibits Outlawing Childbearing by HIV-Positive Women

The Equal Protection Clause of the Fourteenth Amendment guarantees that government will not inflict invidious discrimination upon its people. Pursuant to this clause, courts apply strict scrutiny within the purview of the statute. Of course, such scrutiny of judicial and legislative acts must be tempered by constraints of federalism and must be carried out with due regard for principles of legislative and judicial immunity where applicable.

Id.; see also 42 U.S.C. § 12,202 (Supp. III 1991) (specifying that a state shall not be immune under the Eleventh Amendment to the U.S. Constitution from an action in federal court for a violation of the Act and that all remedies will be available against the state as are available against any other private or public entity).

401. 42 U.S.C. § 12,181(7)(F) (Supp. III 1991) ("The following private entities are considered public accommodations... pharmacy,... professional office of a health care provider, hospital, or other service establishment.").


See generally Asch, supra note 23. Cf. Marian Blackwell-Stratten et al., The Abortion/Baby Doe Controversy: A Disability Perspective, in FROM ABORTION TO REPRODUCTIVE FREEDOM, supra note 87, at 241 ("Disabled women..., have never been considered fit as mothers..., Historically child custody suits almost always have ended with custody being awarded to the non-disabled parent, regardless of whether affection or socioeconomic advantages could have been offered by the non-disabled parent."(citation omitted)).


404. "No state shall... deny to any person... the equal protection of the laws." U.S. CONST. amend. XIV, § 1.
to classifications affecting a "suspect class" of people or those burdening a fundamental right or interest. Laws or governmental policies restricting the childbearing rights of HIV-positive women would be subject to strict scrutiny under the Equal Protection Clause not because they involve a suspect classification, but rather be-

405. See, e.g., Graham v. Richardson, 403 U.S. 365 (1971) (applying strict scrutiny to hold that state statutes denying welfare benefits to resident aliens based on citizenship violate the Equal Protection Clause); Loving v. Virginia, 388 U.S. 1 (1967) (applying strict scrutiny to hold that statutes prohibiting and punishing marriage on the basis of race are unconstitutional); Brown v. Board of Educ., 347 U.S. 483 (1953) (applying strict scrutiny to hold that the segregation of children in public schools based solely on race denies equal protection); Shelley v. Kramer, 334 U.S. 1 (1948) (applying strict scrutiny to hold that state court enforcement of private agreements restricting use or occupancy of certain real estate on the basis of race violates the Fourteenth Amendment); Korematsu v. United States, 323 U.S. 214 (1944) (stating that all legal restrictions curtailing the civil rights of a single race are suspect and must be subjected to rigid scrutiny); Strauder v. West Virginia, 100 U.S. 303 (1880) (holding that the selection or exclusion of jurors on the basis of race or color violates the Equal Protection Clause).

406. Zablocki v. Redhail, 434 U.S. 374 (1978) (recognizing a fundamental right to marry); San Antonio Indep. Sch. Dist. v. Rodriguez, 411 U.S. 1, 35 n.78 (1973) (recognizing the fundamental right to participate in elections on equal basis with other qualified voters); Eisenstadt v. Baird, 405 U.S. 438, 447-49 (1972) (recognizing the fundamental right to control procreation and that such right calls for strict equal protection scrutiny; the court did not apply strict scrutiny because "the law fails to satisfy even the more lenient equal protection standard"); Loving v. Virginia, 388 U.S. 1 (1967) (holding a state law prohibiting interracial marriage to strict scrutiny and, in light of this standard, invalidating such a law on due process and equal protection grounds); Shapiro v. Thompson, 394 U.S. 618, 638 (1969) (applying strict scrutiny to statutory provision denying welfare assistance unless applicant resided within the state for more than a year because it infringed upon the fundamental right to travel, despite the fact that indigents are not a suspect class); Williams v. Rhodes, 393 U.S. 23, 31 (1968) (implying that the fundamental right of political association encompasses right of candidates and political parties to be listed on election ballots among voters' choices by examining whether government has a compelling interest in regulating such conduct); Skinner v. Oklahoma, 316 U.S. 535, 541 (1942) (recognizing the fundamental right to procreate and invalidating restrictions by applying strict scrutiny review).

407. The class of people with disabilities has never been held to be suspect. Since 1985, measures impacting upon people with disabilities are accorded only rational basis review under the Equal Protection Clause. City of Cleburne v. Cleburne Living Ctr., 473 U.S. 432 (1985). However, in the Findings and Purposes Section of the recently enacted ADA, Congress inserted a constellation of phrases used to denote the qualifications of a constitutionally "suspect" classification entitled to strict judicial scrutiny. Burgdorf, supra note 400, at 436-37. The Act states:

Individuals with disabilities are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society, based on characteristics that are beyond the control of such individuals and resulting from stereotypic assumptions not truly indicative of the individual ability of such individuals to participate in, and contribute to, society....

42 U.S.C. § 12,101(a)(7) (Supp. III 1991). While this Article's analysis presumes that discrimination on the basis of HIV status would be accorded only the lowest level of equal protection review, the reader is alerted to this argument for application of a higher level...
cause they interfere with a woman's fundamental right to bear children. Courts should invalidate such laws or governmental policies on equal protection grounds because such measures substantially interfere with the right to bear children and do not fulfill a compelling state interest.

Even assuming *arguendo* that courts found that the application of HIV containment law to childbearing fulfilled a compelling state interest, such application would necessarily be both grossly over and under inclusive. Therefore, it should still be found unconstitutional under an equal protection strict scrutiny analysis. The fact that a statute affecting a fundamental right is over or underinclusive is not necessarily fatal in constitutional review. However, when a measure targets a group that is the object of fear, prejudice, and hatred, such as HIV-positive women, doubt is cast as to the sincerity of the public objective it purportedly serves. Moreover, unless overbreadth is a necessary outcome of fulfilling the state interest—which is not the case here—it will serve to invalidate a statute.

Prohibiting the class of women known to be HIV-infected from childbearing and allowing all other women to freely procreate is not a sufficiently narrowly-tailored policy for several reasons. Such policies should be found to be fatally underinclusive for two reasons. First, if prohibitions or punishments are enforced only against women known to be HIV-positive, then all infected women who do not know their serostatus will escape coercion, and could freely give birth to potentially infected children. Second, some disabilities, including Tay-Sachs, sickle cell anemia, neural tube defects, and of scrutiny. See, e.g., Plyer v. Doe, 457 U.S. 202 (1982) (finding an equal protection invalidation of a law requiring undocumented immigrants to pay tuition to public schools); see also Russell W. Galloway, Jr., *Basic Equal Protection Analysis*, 29 *Santa Clara L. Rev.* 121, 158 (1989).

Additionally, given the demographics of the AIDS epidemic, a race based equal protection challenge might also be possible to the extent that HIV containment law has a disproportionate impact on African-American and Latin-American women. A prima facie case of intent to discriminate on the basis of race might be established under a statistical disparity approach to an equal protection violation claim. This approach has been argued to provide a basis to challenge the prosecution of drug addicted African-American women who become pregnant. See Roberts, *supra* note 24, at 1451-54.

408. Strict scrutiny review for fundamental rights under equal protection is the same as strict scrutiny review for Fourteenth Amendment substantive due process. Galloway, *supra* note 407, at 150.

409. See discussion *supra* part IV.A.2.


411. See, e.g., Hodgson v. Minnesota, 497 U.S. 417 (1990) (acknowledging that although some teenagers who already communicate with family will be burdened by parental consent law, this fact does not invalidate the law because that outcome is necessary to fulfill purpose of the statute).
cystic fibrosis, are just as serious as HIV infection for infants.\textsuperscript{412} These disabilities can be detected either pre-conception or prenatally with greater precision than HIV.\textsuperscript{413} Hence, a policy targeting only known HIV-positive women in an effort to prevent the suffering of future children would be grossly underinclusive in reaching the goal of preventing detectable childhood disabilities.

Such policies should also be found to be fatally overinclusive. If all known HIV-infected women are subjected to coercion, such as mandatory contraceptive implants, many women will be unnecessarily subjected to drastic bodily intervention. Many HIV-positive women will never become pregnant and others will voluntarily abort when they become pregnant.

Outlawing HIV childbearing is also both under and overinclusive as to the asserted state interest in protecting children from inadequate parenting. Although most HIV-positive women will die before their children reach the age of majority, some children of HIV-positive women will be cared for by their fathers, extended family members, or friends when their mothers die or become too sick to care for them. Thus, the policy would be overinclusive be-

\textsuperscript{412} Tay-Sachs almost certainly causes a short, painful life for affected offspring. See Acuff & Faden, \textit{supra} note 320, at 71-72. "Babies born with Tay-Sachs face inevitable death at the age of three to five years. There is no cure, and the disease is very painful." Cynthia S. Adelman, \textit{The Constitutionality of Mandatory Genetic Screening Statutes}, 31 \textit{CASE W. RES. L. REV.} 897, 913 n.112. Children with sickle cell anemia, after six months of age, typically have "symptoms such as failure to thrive, serious infections, and severe anemia." Kass \textit{supra} note 5, at 310 (citing HARRISON'S PRINCIPLES OF INTERNAL MEDICINE at 1877-78 (Robert G. Petersdorf et al. eds., 10th ed. 1983). Anencephaly makes up 60% of all cases of neural tube defects and is uniformly fatal. Spina bifida, the other major form of neural tube defects, affects offspring to varying degrees. Surviving infants experience disabilities ranging from weakness of the limbs to paralysis with incontinence, and, occasionally, mental retardation. Repeated corrective surgery is not uncommon. Acuff & Faden, \textit{supra} note 319, at 72-75. Although children with cystic fibrosis now survive, on the average, to 20 years of age, "for many, the disease remains fatal in childhood and early adult life. Classically, a child with cystic fibrosis presents with intestinal problems in the first year of life. Other obstructions of organ passages cause additional problems later in life due to abnormal composition of the mucus." Kass, \textit{supra} note 5, at 310.

Seventy-five percent of HIV-infected children will have symptoms by two years of age. Twenty-five percent of these children will die within the first two years, and 75% will die by age five. \textit{Id.}

\textsuperscript{413} Amniocentesis is a type of prenatal screening that can be used to detect Tay-Sachs, sickle cell anemia, spina bifida, and cystic fibrosis. Robertson, \textit{supra} note 379, at 709. The technique is 99.4% accurate, Adelman, \textit{supra} note 412, at 902 n.36, and is utilized to detect these diseases 14 to 16 weeks into the pregnancy. Robertson, \textit{supra} note 379, at 709. Prenatal screening may be performed even earlier, at eight to ten weeks, via chorion villi sampling. \textit{Id.}

Currently, prenatal screening of HIV would prove futile. All babies born to HIV-infected women will test positive for the HIV antibody, but most are not actually infected. Serologic tests are only considered diagnostic of HIV infection after the infant reaches 15 months of age. See discussion \textit{supra} note 94.
cause children of some HIV-positive mothers will be well-cared for by their families. On the other hand, this policy would be underinclusive because many children are surrendered, abandoned, orphaned, or mistreated for reasons completely unrelated to HIV infection. On both of these grounds, policies prohibiting or penalizing only HIV childbearing in order to protect children from inadequate parenting should fail an equal protection challenge. The under and overinclusiveness of policies restricting childbearing to HIV-positive women are not necessary outcomes of fulfilling compelling state interests. Indeed, a more effective way to prevent perinatal transmission of HIV would be to use voluntary measures.

C. Mandatory HIV Antibody Testing of Pregnant and Post-Partum Women

The fundamental right to bear children protects information relating to childbearing decisions from government compelled disclosure. As the Supreme Court, in Whalen v. Roe, has explained, "[t]he cases sometimes characterized as protecting 'privacy' have in fact involved at least two different kinds of interests. One is the individual interest in avoiding disclosure of personal matters, and another is the interest in independence in making certain kinds of important decisions." The interest in nondisclosure is particularly acute regarding constitutionally protected "unpopular activities." Indeed, the Court has repeatedly stated that a person is entitled to "anonymity" in the exercise of unpopular fundamental rights.

Fundamental protections apply to any health care procedure

414. In addition, such policies are underinclusive because they do not address the parenting needs of children whose mothers contracted HIV infection after giving birth.
415. See Wright, supra note 339, at 85-88 (explaining that Georgia’s involuntary sterilization law would fail an equal protection challenge because it is underinclusive in its protection of children from neglect and abuse).
416. See, e.g., Bellotti v. Baird, 443 U.S. 622, 655 (1979) (Stevens, J., concurring) ("It is inherent in the right to make the abortion decision that the right may be exercised without public scrutiny and in defiance of the contrary opinion of the sovereign or other third parties."); see also Skinner v. Railway Labor Executives’ Ass’n, 489 U.S. 602, 617 (1989) (holding that railway employees have a reasonable expectation of privacy as to such medical facts as whether one “is epileptic, pregnant or diabetic.”); Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 80 (1976) (permitting statute requiring reports concerning abortions if used only for statistical purposes and assured anonymity of patients); Jones v. Superior Court, 174 Cal. Rptr. 148, 156-57 (1981).
418. Id. at 598-600.
420. Id. at 766; Bellotti v. Baird, 443 U.S. at 655 (Stevens, J., concurring).
1993] CONTROL OF HIV-POSITIVE WOMEN 415

which by virtue of its link to the right to bear children is targeted by the state.421 Thus, a policy of unconsented HIV antibody testing of pregnant or post-partum women and/or of reporting positive results will invoke the fundamental right to privacy because testing is triggered by women's childbearing decisions. This heightened constitutional protection enhances the privacy interest that anyone has in information concerning their HIV status, irrespective of childbearing.422

The state has no interest to justify forced disclosure and public reporting of pregnant women's HIV status because government cannot permissibly interfere in an HIV-positive woman's decision to continue a pregnancy.423 Nor should the state's interest in curbing perinatal transmission, its interest in treating potentially-infected children, or its interest in monitoring the incidence of perinatal transmission be found to justify forced testing of pregnant or post-partum women.

421. Thus, legal regulation of standards for all health care procedures, only incidentally applicable to childbirth, do not invoke the right to bear children. However, as was true in the abortion context prior to Casey, regulations targeting childbearing-related health care for special treatment should be scrutinized for their "impact on the woman's exercise of her right." City of Akron v. Akron Ctr. Reprod. Health, 462 U.S. 416, 430 (1983); see Adelman, supra note 411, at 926. Cf., Planned Parenthood of Southeastern Pa. v. Casey, 112 S.Ct. 2791, 2824 (1992) (joint opinion):

[We depart from the holdings of Akron I and Thornburgh to the extent that we permit a State to further its legitimate goal of protecting the life of the unborn by enacting legislation aimed at ensuring a decision that is mature and informed, even when in so doing the State expresses a preference for childbirth over abortion.

422. The privacy interest attached to HIV status is generally recognized as great. See Eisenstat, supra note 264, at 357. Indeed, several state legislatures have enacted fundamental protections for disclosure of HIV status that are unrelated to childbearing status or activities. E.g., OHIO REV. CODE ANN. § 3701.243(c)(b) (Baldwin Supp. 1990) (stating that in order for a court to order disclosure of HIV status, it must find that there is a compelling need that cannot be accommodated in any other way which outweighs both the individual's privacy interest and the public interest in noncoercion); PA. STAT. ANN. tit. 35, § 760B (1993) (stating that a court cannot order testing of unconsenting individual or unconsented release of information concerning HIV status unless it finds there is "a compelling need for that information which cannot be accommodated by other means"); S.C. CODE ANN. § 44-29-136 (Law Co-op. 1991) (requiring, in the law enforcement context, a court order for disclosure of sexually transmitted disease records, including HIV, to be based on finding that release is necessary to enforce regulations concerning the control and treatment of a sexually transmitted disease and that it fulfills a compelling need which outweighs the person's privacy interest and the public interest in nondisclosure); VT. STAT. ANN. tit. 12, § 1705 (Supp. 1991) (prohibiting a court from ordering release of HIV information unless it finds a compelling need for release which cannot be accommodated by other means); W. VA. CODE § 16-3C-3(a)(8) (1991) (allowing court ordered disclosure of HIV-related test recipient's identity or test results upon a showing of compelling need).

423. See discussion supra part IV.A.1-2.
The fundamental nature of the "right to have offspring" has paradoxical legal implications. On the one hand, government regulation must fulfill weighty interests to justify burdening a woman's exercise of the right to bear children because of the importance of the right. Courts have struck down laws allegedly passed to safeguard informed consent to abortion as unjustified burdens on the right to abortion. On the other hand, because of the importance of the right, it is appropriate for government to take measures to ensure that the right will be protected. The promulgation of elaborate informed consent regulations for tubal ligations following revelations of sterilization abuse demonstrate the lengths to which government can go to protect informed consent involving fundamental rights.

Abortion cases regarding informed consent prior to *Casey* treated abortion as a fundamental right. The Supreme Court had allowed medical regulations which comported with standard medical practice, if the regulations had "no significant impact on the woman's exercise of her right...[and were] justified by important state health objectives." In addition, regulations were required to "properly respect a patient's confidentiality and privacy." The Court held, in *Planned Parenthood of Central Missouri v. Danforth*, that it was permissible to require a woman's prior written consent to

425. *E.g.*, Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. at 759-65; City of Akron v. Akron Ctr. Reprod. Health, 462 U.S. at 442-51. *But see* Planned Parenthood of Southeastern Pa. v. Casey, 112 S. Ct. at 2823 (joint opinion). *Casey* explains that *Akron* and *Thornburgh* incorrectly held as unconstitutional requirements that "truthful and nonmisleading information about the nature of the [abortion] procedure, the attendant health risks and those of childbirth, and the 'probable gestational age' of the fetus" be given. However, insofar as *Akron* and *Thornburgh* describe requirements by the state to impart information which is not truthful, or is misleading, those cases limit the state from enacting such requirements. Thus, post-*Casey*, bona fide informed consent laws would be upheld, while laws designed to burden, rather than to inform, a woman in this decision would be struck down.

426. See statutes cited *supra* note 243, requiring informed consent for HIV antibody testing.
427. See discussion *supra* part I.B.
428. *City of Akron v. Akron Ctr. Reprod. Health*, 462 U.S. at 430 (ruling that procedures having a direct and significant impact must be justified by strict scrutiny). *See e.g.*, Webster v. Reproductive Health Servs., 492 U.S. 490, 514-515 (1989) (holding that the viability determination requirement must be read to only compel those tests which according to "reasonable professional judgment" are safe and necessary); *id.* at 530 (O'Connor, J., concurring) (asserting that requiring ultrasound examination when medically prudent was permissible based upon amici statement that it is "standard medical practice" to conduct such tests to determine viability prior to performing an abortion when the woman is thought to be farther along than twenty weeks gestation); *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. at 762.
abortion, even when such consent was not required for any other medical procedure, because of the importance of the abortion decision.\textsuperscript{430} This requirement did not "interfere with physician-patient consultation or with the woman's choice between abortion and childbirth"\textsuperscript{431} and furthered the state's interest in ensuring that a woman had freely consented to the abortion procedure.\textsuperscript{432} However, when the effect of abortion informed consent regulations was to "influence the woman's informed choice between childbirth and abortion," they were considered "obstacles" to the exercise of her right and were invalidated.\textsuperscript{433} After \textit{Casey}, however, states may regulate informed consent dialogues with the objective of attempting to influence a woman to forego abortion in favor of childbirth. \textit{Casey} permits such dialogue because of the state's interest in protecting fetal life. The dialogue is permitted so long as the regulations do not impose an "undue burden" on the woman and the woman is provided only "truthful and not misleading" information.\textsuperscript{434}

\textit{Casey} purportedly preserves the standard regarding reporting medical information related to the exercise of the right to abortion enunciated in \textit{Danforth}. The \textit{Danforth} Court stated that "recordkeeping and reporting provisions 'that are reasonably directed to the preservation of maternal health and that properly respect a patient's confidentiality and privacy are permissible.'\textsuperscript{435} Hence, reporting of abortion-related information could be required when it is to be used "only for statistical purposes,"\textsuperscript{436} which would advance legitimate state interests.\textsuperscript{437} A state can require that records be kept and submitted to public health authorities which document the statistical incidence of abortion without revealing the identities of the women involved.\textsuperscript{438} Prior to \textit{Casey}, regulations requiring recordkeeping which would potentially reveal identification of patients obtaining or physicians rendering abortions were impermissible, even though the patient's name and address were not

\begin{thebibliography}{9}
\bibitem{430} Id. at 85.
\bibitem{432} Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. at 67.
\bibitem{433} City of Akron v. Akron Ctr. Reprod. Health, 462 U.S. at 445; \textit{see also} Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. at 759-64.
\bibitem{434} Planned Parenthood of Southeastern Pa. v. Casey, 112 S. Ct. at 2832 (joint opinion).
\bibitem{435} Id. at 2832 (quoting Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. at 80).
\bibitem{436} Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. at 87.
\bibitem{437} Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. at 766.
\bibitem{438} Planned Parenthood of Southeastern Pa. v. Casey, 112 S. Ct. at 2832 (joint opinion); Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. at 80-81.
\end{thebibliography}
Moreover, requiring reports of medically irrelevant information was unconstitutional.440

As explained in the next two parts, state-mandated unconsented HIV-testing and publicly reporting HIV-positive women's identities constitute impermissible interference with the childbearing right. Such requirements serve no compelling state purpose and only attempt to influence HIV-positive women to abort or to increase their anxiety for choosing to bear a child. Compelled knowledge of one's HIV status inherently implicates the childbearing right.

1. Forced Disclosure of HIV Status Constitutes Significant Interference with Procreation. Compulsory HIV antibody testing of pregnant or post-partum women constitutes direct and substantial interference with childbearing regardless of whether physical coercion is involved in extracting the blood sample. Such action requires a compelling state interest to withstand Fourteenth Amendment scrutiny.

Clearly, the forcible taking of blood is a significant bodily intrusion.441 However, even when blood has been freely given,442 subjecting the blood to unconsented HIV antibody testing implicates the right to bear children because that right provides protection for the information contained in the blood.443

On the other hand, offering women, pregnant or not, the opportunity to be tested for HIV antibodies, and providing full information to them about the mechanics of the test and its health and social implications, would clearly enhance informed consent.

439. Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. at 766-7. In the context of diminished constitutional status for abortion rights, Casey permits requiring physicians' names to be reported, as well as the state and county of residence of women obtaining abortions. Planned Parenthood of Southeastern Pa. v. Casey, 112 S. Ct. at 2832-33 (joint opinion). These two provisions had previously been invalidated. Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. at 766-67.

440. Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. at 766. Again within the context of diminished protections for abortion, Casey allows the most restrictive reporting requirements since 1973, stating that "[t]he collection of information with respect to actual patients is a vital element of medical research, and so it cannot be said that the requirements serve no purpose other than to make abortion more difficult. Nor do we find that the requirements impose a substantial obstacle to a woman's choice." Planned Parenthood of Southeastern Pa. v. Casey, 112 S. Ct. at 2832-33 (joint opinion).

441. See discussion infra part V.

442. Prenatal HIV antibody testing could be performed on a blood sample freely given by the woman. Post-partum testing could be conducted on the umbilical cord blood sample or from the blood sample of the newborn, both of which are routinely taken for testing upon the birth of the child.

443. See discussion infra part V.D.
Moreover, all women should be told about HIV, its modes of transmission, and the availability of HIV testing and treatments as part of pregnancy-related health care. States are free to require physicians to counsel pregnant women about HIV and to offer testing. However, it is impermissible to force a pregnant woman to learn her HIV status, and to undergo the informed consent dialogue concerning the fact that she is HIV-positive, when she chooses not to know.

Forcing knowledge of HIV status upon a woman and publicly recording it because she decides to continue a pregnancy will significantly interfere with her right to make procreation decisions free from state intimidation and public scrutiny. Such information may be irrelevant for a woman determined to continue her pregnancy regardless of HIV status. Indeed, foisting knowledge of HIV status upon her could impermissibly cause her anxiety, which could affect both her own and her baby's well-being.

In addition, forcing such a woman to know her HIV status while pregnant will have the effect of impermissibly "officially structuring" the "dialogue between the woman and her physician." A

444. E.g., MICH. COMP. LAWS ANN. § 33.5123 (West Supp. 1992) (requiring prenatal testing for HIV, Hepatitis B, and venereal disease after obtaining informed consent unless the health care provider's professional opinion is that these tests are medically inadvisable); R.I. GEN. LAWS § 23-11-19(a) (1989) (requiring that "[e]very physician or health care provider attending any person for prenatal or family planning services shall offer testing for human immunodeficiency virus (HIV) unless deemed inappropriate by the physician"); WASH. REV. CODE ANN. § 70.24.095 (West 1992) (requiring AIDS counseling for all pregnant women).

445. She may be opposed to abortion on religious grounds, or for a host of other reasons. Levine & Dubler, supra note 172, at 331-36; see Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. at 763 (noting that it is impermissible to tell all women seeking abortion that father of fetus is liable for child support because some women seek abortion as result of rape); Planned Parenthood of Southeastern Pa. v. Casey, 112 S. Ct. 2823 (joint opinion) (noting that it is permissible to require women obtaining abortions to be told "truthful, nonmisleading information about the nature of the procedure, the attendant health risks and those of childbirth, and the 'probable gestational age' of the fetus" as well as that materials concerning the consequences to the fetus be made available if the woman desires to see them).

446. See Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. at 762 ("This is not medical information that is always relevant to the woman's decision, and it may serve only to confuse and punish her and to heighten her anxiety, contrary to accepted medical practice.").

447. As such, it is unconstitutional "state medicine imposed on the woman." Id. at 763. An anonymous HIV counselor has cited one compelling example of such anxiety. One woman, who was pregnant with twins and lived in a homeless shelter, repeatedly told her pre-test counselor that she would kill herself if she found out she was HIV-positive. Despite these warnings, and with what the counselor considers less than adequate consent, the woman was tested for HIV. When informed of her positive status she disappeared from the shelter. Interview, supra note 124, at 3-4.

health care provider who knows a pregnant woman's HIV status would be obligated to counsel her on the risks to herself and her fetus that HIV and pregnancy may pose, as well as her options regarding the pregnancy. In today's climate of stigmatization of HIV infection and especially of childbearing by HIV-positive women, it is possible that such counseling could include attempts to impermissibly "influence the woman's informed choice between abortion and childbirth."449

Accordingly, heightened privacy protections for women would accrue particularly in contexts where they would be subject to differential treatment with respect to their childbearing potential if their HIV status were known.450 Thus, the fundamental right to childbearing should clearly attach to information about HIV sero-status and accordingly, to HIV antibody testing procedures, in the context of a state or locality which would prosecute an HIV-positive woman for becoming pregnant and/or for continuing her pregnancy. The same should be true in the context of a health care setting where women known to be HIV-positive are subjected to directive counseling to forego childbearing.

2. State Interests and Compulsory Disclosure and Reporting. Mandatory disclosure of HIV status requires the state to have a compelling interest in such disclosure. Strict scrutiny applies because forced HIV-antibody testing constitutes significant interference with the fundamental right to bear children. However, no such compelling interest exists.

The state's interest in protecting women's health and children's health does not justify forced disclosure to a pregnant or post-partum woman. Medicine cannot cure the woman of HIV infection; it cannot prevent the child from facing a thirty percent chance of be-

opinion) (holding that requiring physician to inform patient seeking abortion of risks of abortion and childbirth is part of reasonable licensing and regulation of the practice of medicine).

449. City of Akron v. Akron Ctr. Reprod. Health, 462 U.S. at 443-444; see also supra part II.A-B.

As the severity of the... disease [discovered prenatally] increases, the goal of objectivity becomes more difficult to maintain. In counseling a client, for example, who is pregnant with a fetus with Tay-Sachs disease, a genetic counselor's opinion about the severity and hopelessness of the disease might lead him or her to counsel aborting the fetus.... [A] mandatory screening program is only one step in the implementation of any eugenics program.

Adelman, supra note 411, at 908-09.

450. See Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. at 767-68 (invalidating abortion reporting statute which "raise[d] the specter of public exposure and harassment of women who choose to exercise their personal, intensely private, right, with their physician, to end a pregnancy").
coming infected; and it cannot cure an infected child or currently effectively treat the potentially-infected fetus or child so that the suffering associated with HIV infection would be substantially alleviated. The promise of treatment to prevent newborns from developing PCP may change the parameters of the debate on this score. It could be argued that the possibility of treating an HIV-infected child would outweigh the post-partum woman’s privacy interest in her HIV status. Knowledge that an infant tested HIV-positive, while not indicating that the child is infected, could alert its health care providers to the potential that it is infected and any HIV-related symptoms would be more likely to form the basis for prescribing the pneumonia prophylaxis. However, even the availability of this treatment is unlikely to justify override of informed consent rights. Such override would allow the state interest in treating the child to outweigh the woman’s fundamental constitutional right.

Even if the state does have a compelling interest in monitoring the AIDS epidemic, and particularly in monitoring the incidence of HIV infection among childbearing women and their children, these interests can be served by conducting antibody tests on blood samples routinely given for prenatal or postnatal tests. The HIV test results can be recorded so that they are not traceable to the mother or child. Such statistical monitoring is all that is required to fulfill the state’s epidemiological purposes, and would least intrusively encroach upon a woman’s privacy interests. Moreover, monitoring perinatal transmission is best accomplished by requiring reports of diagnosed HIV infection among children, particularly infants; the reports need not be traceable to the child. Thus, the state has no health interest in knowing a particular childbearing woman’s or infant’s status sufficient to outweigh the woman’s fundamental right to pursue childbearing unimpeded by state-imposed disclosure of HIV status. Furthermore, forced testing does not comport with

451. See discussion supra note 282 and accompanying text.
452. See discussion part III.E-F.
454. One of the criticisms of epidemiological surveys of HIV in childbearing women is that because they are conducted without consent, and therefore, their results must be unlinked, women who are HIV-infected do not learn that they are positive through the survey. Thus, despite the huge commitment of resources that national neonatal surveillance entails, no direct health services are provided to a population which seriously needs them. See Scott H. Isaacman, Neonatal Testing: Governmental Inspection of the Baby Factory, 24 J. MARSHALL L. REV. 571, 595-96 (1991). It is important to note, however, that the purposes of the surveillance project are good ones: to gather data by which to target re-
standard medical procedure.\textsuperscript{455}

The government also has a legitimate interest in ensuring informed consent in medical care generally, and in medical services concerning the decision to continue a pregnancy in particular.\textsuperscript{466} However, forcing a woman to submit to a test or to receive information about her HIV status does not in any way further these interests. Indeed, forced medical care is the antithesis of informed consent.\textsuperscript{457}

Forced disclosure and reporting of names of pregnant HIV-positive women serves no health purpose. The only purposes that such disclosure and reporting would fulfill, even in the absence of coercive counseling, would be to pressure a woman to abort the pregnancy and to "punish" her for her decision to give birth by forcing her to confront the potentially devastating knowledge of HIV infection.\textsuperscript{458} Forcing a post-partum woman to know her HIV status would likewise serve no health purpose and would only serve to punish her for giving birth. The Supreme Court "consistently has refused to allow government to chill the exercise of constitutional rights."\textsuperscript{469}

source allocations, to monitor the impact of existing programs and to convince politicians and health officials to commit sufficient resources. Id. at 593.

455. None of the major medical policy bodies recommend mandatory testing of women in regard to child-bearing. See supra note 245; A number of states participate in the CDC monitoring of HIV incidence among childbearing women through freely-given blood samples and double-blinded test results not traceable to the women. Isaacman, supra note 454.

456. See Planned Parenthood of Southeastern Pa. v. Casey, 112 S. Ct. at 2823-24 (joint opinion) (holding that a state may require that truthful, nonmisleading information about the abortion procedure, including its risks and alternatives, be made available to a woman in order to ensure that her consent is informed and to preserve her physical and psychological well being; other informed consent requirements may be justified by a state's interest in preserving fetal life).

457. Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. at 764; see discussion supra part III.


459. Id. at 767 (stating that government is not permitted to "chill the exercise of constitutional rights by requiring disclosure of protected, but sometimes unpopular activities").

Even if forced disclosure is viewed as only a \textit{de minimis} burden on her right to bear a child, it is unlikely to survive constitutional review. Compelled knowledge of HIV status might be viewed as leaving the woman with the same range of options she had prior to the state's imposing knowledge upon her. Forced disclosure of HIV status would then be required to be reasonably directed to further a legitimate state health objective. City of Akron v. Akron Ctr. Reprod. Health, 462 U.S. at 430; see also Planned Parenthood of Southeastern Pa. v. Casey, 112 S. Ct. at 2824 (joint opinion). However, no legitimate health interest is served by forced knowledge. Thus, such measures should still be invalidated.
D. Summary

State-inflicted penalties on HIV-positive women's childbearing rights, whether they be criminal punishment or civil measures imposing HIV-testing, contraception, abortion or sterilization, will not survive Fourteenth Amendment review. They constitute significant interference with procreative freedom and do not further a compelling state interest.

While the majority of today's Supreme Court would not deem measures requiring directive counseling (to discourage childbearing) significant interference on their face, such counseling should not survive constitutional review because it fails to further any legitimate state interest. Such counseling, as well as compulsory testing, contraception, abortion or sterilization, also runs afoul of equal protection, and civil liberties protections of the disabled.

Constitutional protections bear particular force in relation to childbearing by HIV-positive women, both because they are disabled and thus subject to the heightened civil rights protections accorded that class and because HIV childbearing is stigmatized and unpopular. The constitutional lessons of the eugenics era are instructive: social ills are compounded, not cured by government attempts to prevent a group from exercising this basic civil right. Fortunately, constitutional protections for procreation have developed considerably and should prevent a repetition of the national tragedy originally validated in *Buck v. Bell*.

460. However, after such regulations have been in effect for a period of time, it might be possible to mount a case to prove that such counseling has constituted a significant burden to the childbearing right "as applied." In this regard, Justice Blackmun noted in *Casey*:

> The joint opinion makes clear that its specific holdings are based on the insufficiency of the record before it. I am confident that in the future evidence will be produced to show that "in a large fraction of the cases in which [these regulations are] relevant, [they] will operate as a substantial obstacle to a woman's choice to undergo an abortion."

Planned Parenthood of Southeastern Pa. v. Casey, 112 S. Ct. at 2845 (Blackmun, J., concurring in part, dissenting in part) (citations omitted).

461. While the rational basis test is considerably deferential to government interference with individual rights, it is not always a "toothless" standard. *Trimble v. Gordon*, 430 U.S. 762, 767 (1977). State action regulating childbearing has been invalidated pursuant to this test. *E.g.*, *Cleveland Bd. of Educ. v. LaFleur*, 414 U.S. 632, 639-50 (1974) (considering mandatory maternity leave policy as penalty on fundamental choice to procreate and invalidating it under rational basis standard); *Eisenstadt v. Baird*, 405 U.S. 438, 447 n.7 (1972) (invalidating state restriction on distribution of contraception based on rational relation test, and noting that because it failed this low level of scrutiny there was no need to analyze statute under compelling interest test, which would apply to the statute at issue because procreation is fundamental right).

462. See discussion supra part IV.B.

463. See supra notes 33-39 and accompanying text.
V. CONTROL OF CHILDBEARING AND THE FOURTH AMENDMENT

The "overriding function of the Fourth Amendment is to protect personal privacy and dignity against unwarranted intrusion by the state." Specific individual rights are awarded varying degrees of Fourth Amendment protection depending upon their perceived importance. Among the most highly guarded of entitlements is the right to bodily integrity. When the government seeks to inflict surgery or other invasive medical procedures upon an individual, the Fourth Amendment's command that government intrusions be "reasonable" requires that the state demonstrate a need to conduct the intrusion that is substantial enough to outweigh the individual's "significantly heightened privacy in bodily integrity."465

Part V.A discusses the Fourth Amendment protections of bodily integrity that prevent the government from imposing certain intrusions on its citizens when such intrusions are deemed unreasonable. Part V.B argues that the bodily intrusions incurred by compulsory sterilization, abortion, or contraception are significant, if not severe. Such government intrusions will always be prohibited by the Fourth Amendment, regardless of the purported justification, because the privacy value attached to procreation potential is great. Further, the methods which would be necessary to actually implement such policies would be unconstitutional because, as Part V.C then posits, even if these severe intrusions are found to be tolerable when justified by a compelling need, no such compelling need exists. Part V.D addresses unconsented HIV antibody testing relating to perinatal transmission and revelation of the woman's identity after testing. It

The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated, and no Warrants shall issue, but upon probable cause, supported by Oath or affirmation, particularly describing the place to be searched, and the persons or things to be seized.

argues that courts are likely to conclude that the Fourth Amendment prohibits all such testing and reporting of identity. Alternatively, Part V.E argues that courts might allow mandatory HIV testing when there is a showing of probable cause that a law has been violated. This section also concludes that unlinked HIV antibody testing that is conducted on freely given blood samples would be permitted by the Fourth Amendment. Such testing infringes minimally upon a person's bodily integrity and privacy interest in the information one's blood analysis reveals and furthers the legitimate governmental purpose of monitoring the incidence of HIV.

A. The Fourth Amendment Imposes Substantive Limits on Bodily Intrusions

The prohibitions of the Fourth Amendment apply only to governmental actions and not to the actions of private individuals.466

466. In Skinner, a case involving mandatory blood and urine testing of employees, the Rehnquist Court declared that “the Fourth Amendment does not apply to a search or seizure, even an arbitrary one, effected by a private party on his own initiative.” Skinner v. Railway Labor Executives' Ass'n, 489 U.S. 602, 614 (1990); see In re Noah, 260 Cal. Rptr. 309 (Cal. Ct. App. 1989) (holding that the Fourth Amendment was not invoked when a private hospital performed a toxicology screen on a newborn without the consent of the mother to see if the newborn had been exposed to drugs). Consequently, the determination of whether a compelled sterilization, abortion, contraceptive implant, or HIV test violates the Fourth Amendment requires a threshold inquiry concerning the level of state involvement in those practices. If any of these measures are mandated by federal, state, or local law, then Fourth Amendment protections would attach even if the actual person who conducts the surgery, implants the contraceptive device, or draws the blood is a private person rather than a government employee. See Skinner v. Railway Labor Executives' Ass'n, 489 U.S. at 614-15; see also Mapp v. Ohio, 367 U.S. 643 (1961) (holding that the Fourth Amendment was incorporated through the Due Process Clause of the Fourteenth Amendment to cover all actions attributable to state and local governments). Similarly, if the coercive practice is carried out pursuant to the policy or practice of a government health care provider (such as the Veteran's Administration or a state or city health facility), sufficient state action would also be present. See discussion supra note 348.

However, determinations of state action for Fourth Amendment violations by individual state-employed physicians who are not following public hospital policy or state or local law will ordinarily be made according to the same rules used for privately employed health care providers. See Padilla v. d'Avis, 580 F.Supp. 403, 407-08 (N.D. Ill. 1984); see also supra note 348. But see United States v. Attson, 900 F.2d 1427 (9th Cir.), cert. denied, 498 U.S. 961 (1990) (finding that a doctor employed by the federal government was a state actor but, because the blood test he administered was purely for the benefit of a patient's medical treatment and was not to be divulged to law enforcement authorities, the test did not constitute a search).

A private party's actions may still be limited by the Fourth Amendment depending on “the degree of the Government's participation in the private party's activities.” Skinner v. Railway Labor Executives' Ass'n, 489 U.S. at 614. The Supreme Court held that government policy does not require a private entity to conduct a bodily intrusion, but makes "plain not only [the Government's] strong preference for testing, but also its desire
Once state action has been established, a state may justify bodily intrusion only by presenting a substantial or compelling state interest sufficient to overcome the individual's rights. Moreover, in some situations privacy interests are so great that even weighty state interests cannot thwart them. Our system of constitutional law requires that government "respect certain decencies of civilized conduct." Consequently, conduct by the state which "shocks the conscience" is not tolerated. For example, in *Rochin v. California*, the Supreme Court held that the pumping of a criminal suspect's stomach absent his or her consent violated the Due Process Clause of the Fourteenth Amendment, despite the existence of probable cause that the suspect had committed a crime.

In determining whether surgical intrusions violate an individual's Fourth Amendment rights, the Supreme Court has held that "[t]he reasonableness of surgical intrusions beneath the skin depends on a case-by-case approach, in which the individual's interest in privacy and security are weighed against society's interests in conducting the procedure." The Court has found that because "surgical probing beneath the skin can be so severely and substantively intrusive," a compelling state interest is necessary to justify such action.

Mere assertion of a compelling state interest is not sufficient to justify an intrusion. Rather, the interest must be demonstrably

to share the fruits of such intrusions. . . . These are clear indices of the Government's encouragement, endorsement, and participation, and suffice to implicate the Fourth Amendment." Id. at 615-16. Thus, in states that require reporting of HIV test results or patient identification, sufficient state action would be present regardless of whether the tester was a private health care provider. However, in states that require reporting of positive HIV test results for epidemiological purposes, without reporting information identifying the patient, the Fourth Amendment would not apply. Were the private health care provider to conduct mandatory HIV antibody tests of pregnant women on its own initiative, and routinely submit the test results to the state for use in criminal prosecution or for civil penalties, sufficient state action would also be present to invoke Fourth Amendment protections.

467. *Id.* at 173.


469. *Id.* at 165.


471. *Winston v. Lee*, 470 U.S. at 766 (holding that surgery to remove bullet from criminal suspect, while "apparently not extremely [risky]," was prohibited by the Fourth Amendment because the government "failed to demonstrate a compelling need" to perform the surgery); *see also Washington v. Harper*, 494 U.S. 210, 229 (1990) (holding that "[t]he forcible injection of medicines into a nonconsenting person's body represents a substantial interference with that person's liberty"); *id.* at 241 (Blackmun, J., concurring in part, dissenting in part) (stating that "[t]here is no doubt . . . that a competent individual's right to refuse such medication is a fundamental liberty interest deserving the highest order of protection").
fulfilled by the intrusion.\textsuperscript{472} Even when a compelling state interest is fulfilled by a proposed surgical intervention, the state must show that the compelling interest cannot be fulfilled in a less intrusive manner. Thus, the Supreme Court has prohibited surgery to extract a bullet from a criminal defendant's shoulder because the state had other ways of proving he committed the crime. The intrusion was not necessary to fulfill the compelling interest of enforcing criminal law and therefore, the Court refused to permit the surgery despite the fact that having the bullet as evidence might strengthen the state's case.\textsuperscript{473}

Under the Fourth Amendment, the nature of the state's interest must be weighed against the privacy right of the individual. With respect to the area of bodily intrusions, a court must evaluate, \textit{inter alia}, the "extent to which the procedure may threaten the safety or health of the individual"\textsuperscript{474} and whether the procedure involves any "risks, trauma, or pain."\textsuperscript{475} Hence, the fact that blood tests for blood alcohol content are "commonplace" and not experimental or risky weighs in favor of permitting the procedure.\textsuperscript{476}

A court must also weigh "the extent of the intrusion upon the individual's dignitary interests in personal privacy and bodily integrity."\textsuperscript{477} For example, blood tests for drug or alcohol content are not considered unduly intrusive when probable cause exists that a crime involving alcohol or drug impairment was committed.\textsuperscript{478} However, as

\textsuperscript{472} For example, the Supreme Court has held that unconsented building inspections are allowed only when they are likely to lead to an effective government remedy for the hazards they seek to reveal. \textit{Camara v. Municipal Court}, 387 U.S. 523, 535-36 (1967); \textit{see also New Jersey v. T.L.O.}, 469 U.S. 325, 340 (1985) (holding that warrants or evidence of probable cause are not required for school authorities to search a child suspected of an infraction of school rules because of the widely recognized need for school officials to maintain swift and informal disciplinary procedures, and because of child's diminished privacy expectations and protections in school context). The Court has also held that urine tests are allowed only where they are demonstrated to effectuate the state's asserted reasons for protecting the public health and welfare. \textit{National Treasury Employees' Union v. Von Raab}, 489 U.S. 656, 676-77 (1989) (permitting testing of customs employees guarding the nation's borders). In a highly instructive case, \textit{Glover v. Eastern Nebraska Community Office of Retardation}, the Eighth Circuit invalidated a public employer's mandatory HIV testing policy. 867 F.2d 461 (8th Cir. 1989), \textit{cert. denied}, 493 U.S. 932 (1989). The circuit court affirmed the conclusion of the district court that the asserted interest of protecting patient safety is not fulfilled where the risk of transmission was "minuscule, trivial, extremely low, extraordinarily low, theoretical, and approaches zero." \textit{686 F. Supp} 243 (1988), \textit{aff'd} 867 F.2d 461 (8th Cir. 1989), \textit{cert. denied}, 493 U.S. 932 (1989).


\textsuperscript{474} \textit{Id.} at 761.

\textsuperscript{475} \textit{Id.} (citing \textit{Schmerber v. California}, 384 U.S. 757, 771 (1966)).

\textsuperscript{476} \textit{Schmerber v. California}, 384 U.S. at 771 n.13.

\textsuperscript{477} \textit{Id.} at 761.

\textsuperscript{478} \textit{Id.} at 772; \textit{Breithaupt v. Abram}, 352 U.S. 432, 436 (1957).
the *Winston* case demonstrates, even the existence of probable cause of a criminal violation does not necessarily justify compelling an individual to undergo surgery.\(^{479}\)

### B. Forced Sterilization, Abortion, or Contraception Should Never Pass Judicial Review

Assuming *arguendo* that a compelling state interest could be demonstrated that would possibly justify the regulation of childbearing, such an interest would most certainly be outweighed by the rights of the individual because of the highly intrusive nature of the procedures involved in curtailing or limiting the right to bear children. State-mandated sterilizations and abortions are such severely invasive surgical procedures that the highly protected privacy interest in childbearing would outweigh any compelling interest that could possibly be asserted.\(^{480}\) Consequently, such forced sterilizations and abortions fall within the parameters of bodily integrity protected under the Fourth Amendment, whether or not the state has proof of individualized suspicion or guilt that a woman is HIV-positive or that an HIV-positive woman is pregnant or intends to become pregnant.

Likewise, the insertion of any IUD would be considered highly invasive because it involves a surgical intrusion into an otherwise inaccessible body cavity.\(^{481}\) While IUD insertion is minor surgery

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\(^{479}\) *Winston v. Lee*, 470 U.S. 753 (1985); *see also* *Doe v. Renfrew*, 631 F.2d 91 (7th Cir. 1980), *cert. denied*, 451 U.S. 1022 (1981) (holding that the Fourth Amendment prohibited a strip search of a 13-year-old in high school student after a dog sniffing raid focused suspicion on her for possession of a controlled substance, despite the fact that the search was conducted in the highly regulated high school environment where a student's privacy expectations are somewhat diminished). *But cf.* *Bell v. Wolfish*, 441 U.S. 520 (1979) (holding that strip searches of convicted prisoners after visits with relatives or friends were justified under the Fourth Amendment because of severely diminished privacy rights of prisoners and the prison's legitimate and important security concerns).

\(^{480}\) *See discussion infra part V.C.*

\(^{481}\) In *Rochin v. California*, the Supreme Court held that the pumping of a criminal suspect's stomach absent his consent violated the Due Process Clause of the Fourteenth Amendment, despite the existence of probable cause that the suspect had committed a crime. 342 U.S. 165 (1952). The stomach pumping was effectuated by the forced injection of an endemic solution which induced vomiting. The Court noted that although the stomach pumping did not require cutting into the body, the intrusiveness of the procedure was not negated and that this was conduct by the state which "shocks the conscience." *Id.* at 172.

If conduct which only involves the temporary ingestion of a solution has been classified as conduct which "shocks the conscience," then surely the Court must find that the insertion of an IUD against the woman's wishes is conduct that also "shocks the conscience" and is highly invasive.

There are currently two IUDs on the U.S. market: Lippes Loop and Paragard. Each one requires a physician to insert and remove it. *PDR, supra* note 293, at 1076.
which does not normally present high risks to the patient, IUD use is contraindicated for many women. In addition, IUDs pose serious health risks to a small percentage of all women using them. Moreover, removal of an IUD must be performed by a clinical practitioner and can sometimes be difficult and painful. The Fourth Amendment does not permit the government to impose such health risks upon its people.

In determining the intrusiveness of mandatory IUD insertion, courts should consider that each of the manufacturers of IUDs currently marketed in the United States prohibits the use of their products absent elaborate informed consent procedures, including distribution of a federally required informed consent pamphlet. Clearly, neither the manufacturers nor the FDA would sanction the compulsory use of IUDs—nor should courts.

The bodily intrusion and health risks involved in IUD insertion are obviously significant. More importantly, the privacy interest at stake—childbearing—is crucial. Mandatory IUD insertion, similar to the stomach pumping in Rochin, is conduct which arguably

482. See Winston v. Lee, 470 U.S. 753, 764 n.8 (holding that Fourth Amendment protection is not controlled by "[t]he question whether the surgery is to be characterized in medical terms as 'major' or 'minor'... no specific medical categorization can control the multifaceted legal inquiry that the court must undertake").

483. The Food and Drug Administration and the manufacturers of IUDs in this country restrict use of IUDs so that a large percentage of all HIV-positive women are ineligible. The manufacturer of Paragard, GynoPharma Inc., explicitly states that it is contraindicated for women with "conditions associated with increased susceptibility to infections with microorganisms. Such conditions include, but are not limited to... acquired immune deficiency syndrome." PDR, supra note 293, at 1074. Additionally, GynoPharma specifies that Paragard should not be inserted in women who are not in a stable, monogamous relationship, or who have one of several conditions including: a history of pelvic inflammatory disease, an abnormal Pap smear, an abnormal uterus, or cervicitis. Id. See also 21 C.F.R. § 310.502 (1991) (regarding Lippes Loop contraindications).

Given the association of HIV infection in women with pelvic inflammatory disease, venereal disease, cervical cancer and abnormal Pap smears, and other chronic infections of the reproductive tract, the Lippes Loop is contraindicated for large numbers of HIV-positive women. Even for those women for whom the Lippes Loop is not contraindicated, insertion and adjustment to implantation of the device can be quite painful. 21 C.F.R. § 310.502 (1991); PDR, supra note 293, at 1076.

484. The Lippes Loop presents significant risks to all women who use it, including perforation of the uterus, tubal infertility, and pelvic infection. PDR, supra note 293, at 1590. See also 21 C.F.R. § 310.502 (listing adverse reactions reported by women subsequent to IUD insertion).


486. PDR, supra note 293, at 1655 (articulating a patient brochure requirement and detailed procedures for the insertion of the Lippes Loop); id. at 1074, 1076 (stating that patients receiving the Paragard IUD must receive an informed decision brochure, detailing the insertion process).

487. See Rochin v. California, 342 U.S. at 172.
Even the most compelling state interest should not justify such intrusions.

The Fourth Amendment should likewise prohibit compulsory insertion of Norplant, the new contraceptive device which is inserted under the skin of a woman's arm. Norplant insertion is a bodily intrusion of high magnitude. Insertion requires repeated "probing beneath the skin" in order to insert and remove the device. Additionally, compulsory insertion of Norplant is the equivalent of the forcible ingestion of drugs because the contraceptive capsules release hormones into the bloodstream of the recipient steadily for up to five years. Norplant also invokes the weighty privacy right to bear children because it prevents conception. Such highly intrusive bodily and privacy interventions should be found to be unreasonable and thus prohibited by the Fourth Amendment.

Compulsory Norplant insertion will also fail Fourth Amendment analysis because Norplant is not a "routine" or "commonplace" part of "everyday life." Norplant is a new device with relatively new medical and psychological implications. See discussion infra note 504.

488. Winston v. Lee, 470 U.S. at 759, 767. Prisoners are afforded diminished Fourth Amendment protection. See, e.g., Bell v. Wolfish, 441 U.S. 520, 557-58 (1979) (stating that "given the realities of institutional confinement, any reasonable expectation of privacy that a detainee retained necessarily would be of a diminished scope"). Therefore, mandatory insertion of IUDs with respect to prisoners might seem to present a stronger case. However, because prisoners retain their fundamental right to procreation, the Fourth Amendment balance of the individual's privacy interest against the state's interest still weighs toward protection of the individual. When matched against the individual's fundamental privacy interest, the state cannot prove that forced contraception fulfills any asserted compelling need, including the protection of children, the protection of prison security, and the imposition of a permissible punishment for having committed a crime. See discussion infra note 504.

489. To function as a contraceptive, six match-stick-sized Norplant silicon tubes must be inserted under the skin of a woman's upper arm. PDR, supra note 293, at 2484-88. Insertion can only be performed by a clinical practitioner, trained in its technique, and utilizing local anesthetic. Id. at 2486. Removal of Norplant is somewhat more complicated than the initial insertion and may require more than one session on different days utilizing local anesthetic, in order to remove all six capsules. Id. at 2486. Moreover, because Norplant remains effective for only five years, id. at 2484, and because many HIV-positive individuals live for ten years or more after becoming HIV-positive, insertion and removal would have to be performed repeatedly for some women.

490. Norplant prevents conception by suppressing ovulation and by preventing sperm from entering the cervical canal through the slow release of minute amounts of the synthetic hormone levonorgestral into the woman's bloodstream. Hatcher et al., Implants, Injections & Other Progestin-Only Contraceptives, in CONTRACEPTIVE TECHNOLOGY at 303-04; PDR, supra note 292, at 2484.


492. Schmerber v. California, 384 U.S. at 771 (reasoning that blood tests are commonplace and therefore the bodily intrusion is not great); see also Winston v. Lee, 470 U.S. at 766 (stating that "the very uncertainty" of medical risks "militates against finding the operation to be 'reasonable'").
unknown risks. In addition to the unknown risks which could affect all women, Norplant is known to present serious risks to health and life for women with many different health conditions. Imposing these health risks upon a woman is constitutionally impermissible.

Compelling an HIV-positive woman to comply with laws mandating contraception, abortion, or sterilization would also have

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493. The Food and Drug Administration has approved Norplant. However, many of the potential risks identified by the manufacturer are couched in the unknown. E.g., PDR, supra note 293, at 2485 (stating that the risk of cigarette smoking, risk for inter alia thromboembolic disorders, cerebrovascular disorders, and cardiovascular disease are all "unknown").

The human suffering caused by unforeseen risks can be great. Over four million Dalkon Shields were distributed between 1971 and 1975 resulting in a world-wide rash of pelvic inflammatory infections, miscarriages, congenital birth defects, and maternal deaths before they were banned and withdrawn from the market. ANGUS MCLAREN, A HISTORY OF CONTRACEPTION 252 (1990) (citing MORTON MINTZ, AT ANY COST: CORPORATE GREED, WOMEN AND THE DALKON SHIELD (1985)); see also KATHLEEN MCDONNELL, ADVERSE EFFECTS: WOMEN AND THE PHARMACEUTICAL INDUSTRY 170-71 (1986).

Silicon breast implants were widely assumed to be safe and were surgically implanted into an estimated one to two million American women, beginning in 1976. In January 1992, it was revealed that safety studies indicating risks of the devices had been suppressed and other critical studies were not conducted by the manufacturer of the implants, Dow Corning, for fear of profit loss. Philip J. Hilts, Maker of Implants Balked at Testing, Its Records Show, N.Y. TIMES, Jan. 13, 1992, at A1, B10.

494. Presently Norplant is recognized as unsafe and contraindicated for women with a history of thromboembolic disorders, undiagnosed abnormal genital bleeding, known or suspected pregnancy, acute liver disease, benign or malignant liver tumors, and known or suspected carcinoma of the breast, liver disease, heart disease, blood clots, or high blood pressure. PDR, supra note 293, at 2484; Hatcher et al., supra note 490, at 307-08. In addition, women who use Norplant are advised by the manufacturer that they should not smoke cigarettes, and that Norplant "could mask the symptoms of cervical or endometrial cancer." PDR, supra note 293, at 2484. Norplant may also be inadvisable for women with breast nodules, fibrocystic disease of the breast, or an abnormal breast x-ray or mammogram, or for women with diabetes, elevated cholesterol or triglycerides, migraine or other headaches, epilepsy, mental depression, or gall bladder or kidney disease. Hatcher et al., supra note 490, at 308.

495. See supra notes 483-85.

496. While contraceptive implants present the most reliable mechanism, other than sterilization, for the state to prevent conception, any method of contraception could be forced upon an HIV-positive woman. See supra note 486.

Requiring the ingestion of contraceptive pills would be analogous to forcing an emetic solution into someone's stomach and would clearly be prohibited under the Fourth Amendment. See discussion supra notes 487-488 and accompanying text. Moreover, contraceptive pills carry with them potentially serious health risks and would be prohibited for that reason. PDR, supra 293, at 2190.

Condoms and diaphragms used with cream or jelly present substantially fewer health risks and state actors are unlikely to physically place these barriers inside a woman, or in the case of a condom, onto her partner. However, a court or a health department could order an HIV-positive woman to use such methods and penalize her upon proof that she refused to comply. E.g., State v. McLellan, No. 92 CR 05684 (Gen. Ct.
constitutionally impermissible "practical consequences." To enforce contraception, a noncompliant woman would have to be imprisoned for life or subjected to extreme physical force. She "would have to be fastened with restraints to the operating table, or perhaps involuntarily rendered unconscious by forcibly injecting her with an anesthetic" in order to permit the abortion, sterilization, or implantation of a contraceptive device. "Such actions would surely give one pause in a civilized society." This type of forcible government conduct would be more shocking than stomach pumping or surgery to remove a bullet. "[T]o sanction [such] brutal conduct... would be to afford brutality the cloak of law."

C. No State Interest Outweighs Severe Intrusions

In addition to being severely intrusive, forced sterilization, abortion, or contraceptive implantation cannot be justified by the state interest required in the Fourth Amendment inquiry. "Determination of the standard of reasonableness... requires 'balanc[ing] the nature and quality of the intrusion on the individual's Fourth Amendment interests against the importance of the government interests alleged to justify the intrusion.'" While the

Justice Cumberland County, N.C. Mar. 25, 1992), aff'd, No. 92 CR 05684 (N.C. Super. Ct. Mar. 17, 1993) (convicting an HIV-positive woman for failing to comply with a health department order to use condoms) (transcript of bench trial, judge's order of conviction and sentencing, and oral notice of appeal on file with the Buffalo Law Review); see also supra note 382. However, Fourth Amendment protections are arguably invoked equally when the state compels a person to violate her own bodily integrity and when state actors impose the bodily intrusion. Clearly, the result in Winston v. Lee would not have been different if government officials had required Mr. Winston to cut open his own chest in order to extract the bullet. 470 U.S. 753, 765 (1985) (balancing the respondent's interest in control over his body against the Commonwealth's need to intrude). Thus, even state ordered or compelled contraception which does not physically involve a state actor will be prohibited by the Fourth Amendment. The fact that all of these methods invoke the weighty privacy interest in childbearing, requiring a correspondingly weighty government interest to justify them, will result in their prohibition.

498. Winston v. Lee, 470 U.S. 753, 764 n.9 (1985) (citing State v. Lawson, 453 A.2d 556 (N.J. Super. Ct. App. Div. 1982)) (stating that a fundamental liberty interest is invoked when general anesthesia, although not medically necessary, is used to subdue an uncooperative patient in order to perform a medical procedure); see, e.g., Gallagher, Prenatal Invasions, supra note 61, at 10 (describing the case of a woman who refused to consent to a Cesarean section when her physician decided it was necessary for the health of the fetus; she was physically strapped to a surgical table and cut open to deliver her baby).
499. In re A.C., 573 A.2d at 144 n.8.
interest of punishing criminal behavior is certainly compelling, forced abortions, sterilization, or contraception are not permissible punishments. The Eighth Amendment prohibits compulsory medical procedures as a form of punishment. Just as the state cannot deny inmates necessary medical treatment, it cannot impose unnecessary medical treatment. Moreover, while the law enforcement interest

503. U.S. CONST. amend. VIII.

504. Estelle v. Gamble, 429 U.S. 97, 104 (1976) (holding that "deliberate indifference to inmates' serious medical needs constitutes unnecessary and wanton infliction of pain" proscribed by the Eighth Amendment); Washington v. Harper, 494 U.S. 210, 243 (1990) (holding that administration of psychotropic drugs to inmate must be medically necessary to survive constitutional scrutiny); Battle v. Central State Hosp., 898 F.2d 126, 129-30 (11th Cir. 1990) (holding that administration of unnecessary or excessive medication gives rise to an Eighth Amendment claim, just as deprivation of needed medications does). The Eighth Amendment proscribes punishments pursuant to the "evolving standards of decency that mark the progress of a maturing society." Estelle v. Gamble, 429 U.S. at 102 (citing Trop v. Dulles, 356 U.S. 86, 101 (1958)). It is also important to note that medical experimentation on human subjects without their consent has been universally condemned since the promulgation of the Nuremberg Principles in 1949. 2 TRIALS OF WAR CRIMINALS BEFORE THE NUERNEMBERG MILITARY TRIBUNALS UNDER CONTROL COUNCIL LAW No. 10, at 181-82 (1949); see United States v. Stanley, 483 U.S. 669, 709-10 (1987) (O'Connor, J., concurring in part, dissenting in part).

Moreover, because those convicted of crimes retain their fundamental right to privacy in childbearing decisions, Monmouth County Correctional Inst. Inmates v. Lanzaro, 834 F.2d 262, 333-44 (D.N.J. 1987), the state cannot infringe upon exercise of those rights unless the state action is "reasonably related to legitimate penological interests." Turner v. Safely, 482 U.S. 78, 87 (1987); see also O'Lone v. Estate of Shabazz, 482 U.S. 342, 349 (1987). Legitimate penological interests include internal prison security and public safety, but have never been held to include the prevention of births of babies to prisoners, whether or not the babies are potentially infirmed. See Archer v. Dutcher, 733 F.2d 14, 15 (2d Cir. 1984) (holding that allegation that miscarriage was caused by prison officials' delay in granting pregnant inmate access to medical treatment could sufficiently state a cause of action under the Eighth Amendment); see also Jordan v. Gardner, No. 90-35307, 1993 WL 46630 (9th Cir. Feb. 25, 1993) (finding prison policy of cross-gender clothed searches of female prisoners violative of the Eighth Amendment because the search deliberately inflicted wanton pain and suffering).

The Eighth Amendment's proscription against "punishments grossly disproportionate to the severity of the crime," Gregg v. Georgia, 428 U.S. 153, 173 (1976); Weems v. United States, 217 U.S. 349, 367 (1910), and "[i]t[s] ... substantive limits on what can be made criminal and punished," Estelle v. Gamble, 429 U.S. at 103 n.7 (citing Robinson v. California, 370 U.S. 660 (1962)), also provide potential challenges. Surgical sterilization, abortion, and mandatory contraception might be deemed punishments grossly disproportionate to the "crime" of imposing a 30% risk of giving birth to a sick child. See Skinner v. Oklahoma, 316 U.S. 535 (1942) (holding that surgical sterilization could not be imposed upon an inmate as punishment for theft because it was a violation of equal protection). Just as in Robinson a person could not be punished for being addicted to drugs, so too a person cannot be punished for engaging in the ordinarily lawful activity of giving birth to a child, simply because of her status as HIV-positive.

An additional Eighth Amendment approach to challenging these measures derives from the Amendment's prohibition against "unusual" punishments. When punishments have been previously unknown as penalties for a given offense, they may be constitution-
will sometimes justify bodily intrusions to obtain evidence that a person has committed a crime in the past, it is unlikely to justify physically incapacitating someone whom law enforcement officials suspect might violate a criminal transmission statute in the future. Thus, the interest of enforcing HIV criminal transmission statutes could never justify forced sterilization, abortion, or contraception.

The Supreme Court has recently held that the state has a substantial interest in safeguarding the potential life of the fetus throughout a pregnancy. However, even if preventing perinatal transmission is a legitimate state interest, the Court did not find it to be a compelling one. Certainly, this "substantial interest" is by no means strong enough to outweigh the individual right to be free from invasive bodily intrusions. In any event, this interest is not fulfilled by measures denying the fetuses all possibility of life. The state cannot legitimately make the judgment that it is better not to live at all, than to be born with a thirty percent chance of being infected by HIV.

505. See Schmerber v. California, 384 U.S. 757, 770-71 (1966) (holding that a blood alcohol test is permissible when likely to produce evidence of a past crime); WAYNE R. LAFAVE & AUSTIN W. SCOTT, JR., CRIMINAL LAW § 1.2(e) (2d. ed. 1986).

506. The Supreme Court has permitted the detention of known organized crime figures likely to continue their criminal enterprises while awaiting prosecution. See United States v. Salerno, 481 U.S. 739, 749, 751 (1987) (noting general rule that government cannot detain a person prior to adjudication of guilt in a criminal trial and discussing certain special circumstances including proof by clear and convincing evidence that arrestee cannot be released without endangering any person or the community).

However, HIV-positive women do not present risks to the community comparable to organized crime figures. First, as to pregnant HIV-positive women, they do not endanger fetuses or future children by bringing them to life. Second, potential sex partners are not endangered in the way that victims of organized crime are because they have assumed risk by agreeing to engage in sex, whether or not for money. Moreover, if they decline to use condoms and spermicides, as is recommended for safer sex with all sex partners, they have further assumed risk of transmission. Whether the HIV-positive woman is likely to inform her sex partners of her HIV status is not dispositive. Safe sex educators stress that universal precautions must be followed. Many people are unaware of their HIV status, some lie about it, and some are in the approximately six-month long window period when they are HIV infected but test negatively for HIV antibodies.


508. See discussion supra note 378 and accompanying text.

509. See discussion supra note 381 and accompanying text.
state's interest in fiscal restraint is legitimate, it is not compelling and has never been held to outweigh fundamental rights. Thus, these measures cannot be justified by the state's desire to avoid the expense of caring for the children of HIV-positive mothers.

D. The Fourth Amendment Prohibits Mandatory HIV-Testing

HIV antibody testing coerced or compelled by the state would invoke the Fourth Amendment's protections. Compulsory HIV testing invokes substantial privacy interests which are not outweighed by the government's interest in testing, even though the bodily intrusion is less severe than contraception, abortion, and sterilization. The U.S. Supreme Court recently reiterated its long-standing recognition "that a 'compelled intrusion[n] [sic] into the body for blood to be analyzed' for alcohol content must be deemed a Fourth Amendment search." Accordingly, mandatory HIV antibody testing conducted with state imprimatur would be required to comply with Fourth Amendment standards of reasonableness as well.

Two separate searches subject to the Fourth Amendment are involved when the government conducts or compels a blood test for use in enforcing or investigating breaches of criminal laws or other statutory or regulatory standards. First is the physical intrusion of the needle penetrating the skin; second is the subsequent laboratory analysis of the physiological data which that blood sample contains. Thus, the fact that a pregnant woman consented to a series of prenatal tests, or consented to having a blood sample taken from her umbilical cord or from her newborn child, would not end the Fourth Amendment inquiry. Fourth Amendment rights would also be implicated by the type of laboratory analysis performed on the blood. Absent specific or implied consent to an HIV antibody test, an HIV analysis of a lawfully-extracted blood sample would itself

510. Supra note 385.
514. Id.
515. See supra part III.B.
invoke Fourth Amendment protections.

Mandatory blood testing for the purpose of prohibiting an HIV-positive woman from childbearing, or punishing her for doing so, is arguably the type of government intrusion that "shocks the conscience." Such outrageous government conduct and infringement upon an individual's rights should outweigh any governmental interest, no matter how compelling. Thus, such conduct should never be permissible under the Fourth Amendment. HIV testing reveals HIV antibody status which carries with it potentially serious psychological and social impacts. Arguably, HIV testing of a consensually given blood sample is substantially intrusive because of the potentially serious impact revelation of HIV status could have on the woman and her ability to bear children. No court has yet found blood testing to be prohibited outright by the Fourth Amendment, although no court has addressed blood testing in the context of childbearing.

Assuming arguendo that compulsory HIV antibody testing is not an intrusion which "shocks the conscience," the privacy interests regarding childbearing and HIV status which are at stake should require fulfillment of a substantial, if not compelling, government interest to justify such testing. One governmental interest which could be asserted to justify unconsented testing would be the state's interest in enforcing the criminal law. Information derived from HIV tests would be utilized in the investigation and prosecution of violations of criminal transmission statutes. However, the state's interest in enforcing a valid criminal law is arguably insufficient to justify imperilling the suspect's psychological health through forced disclosure of HIV status. Furthermore, if, as this Article predicts,
applications of such statutes to perinatal transmission are invalidated, this government interest will be nullified.

Moreover, the fact that only a small percentage of women are infected attenuates the practice of HIV testing all childbearing women from fulfilling any potential government interests. Even if unconsented testing were conducted only in geographic areas with a high prevalence of HIV, the incidence of HIV infection in women giving birth is approximately one in thirty-two births. Additionally, only one third of children born to those mothers infected with HIV will ultimately develop HIV infection.

When an accurate test becomes available to detect actual newborn infection immediately after birth, the connection between the state’s interest in safeguarding children’s health and compulsory HIV testing of infants will be more direct. The state could then seek to test a newborn who manifests symptoms that indicate possible HIV infection. However, the required Fourth Amendment balancing will still weigh against allowing such testing. The state’s interest in safeguarding children’s health will always be high. However, its ability to cure childhood AIDS will remain weak until discovery of a cure for HIV or low risk treatments which greatly alleviate the effects of the disease. The mother’s interest in freedom from unconsented testing of either herself or her child is correspondingly strong. Courts presented with analogous situations in the informed consent context have refused to allow compulsory medical care.

The government’s legitimate interest in monitoring the incidence of HIV infection among childbearing women can be fulfilled by a far less intrusive measure—unlinked testing of freely-given blood samples. Unlinked testing would neither be a search nor a bodily intrusion for Fourth Amendment purposes. Such testing involves neither the compulsory extraction of blood, nor the compulsory revelation of a woman’s HIV status to herself or to others. Because the far less intrusive method of unlinked consensual testing meets the needs of the state, there is no reason to allow more intrusive schemes of testing.

weighing heavily against allowing the government to impose the risk on a criminal defendant); see Schmerber v. California, 384 U.S. at 771 (indicating that a crucial factor in determining whether an intrusion is permissible is the level of “risk, trauma or pain” involved).

521. See discussion supra parts I.C, IV.A, IV.B, V.A-C.

522. Dugger, supra note 11.

523. Such an accurate test is apparently on the horizon. See discussion supra note 290 and accompanying text.

524. See supra part III.E.
E. Forced Testing and Probable Cause

The Fourth Amendment would impose several restrictions on mandatory HIV testing of childbearing women even if a weighty government interest is found to justify such testing. The Supreme Court recently reiterated that "as a general matter, . . . a search must be supported by a warrant upon probable cause." When the fruits of searches are used in criminal prosecutions, the warrant requirement may be waived only where recognized exigent circumstances exist. In addition, individuals effectuating a search must possess sufficient evidence to establish probable cause to believe that the person being searched committed a crime. Under these principles, use of HIV antibody results to prosecute a woman for criminal transmission of HIV requires a warrant, issued upon probable cause, prior to compelling her to give a blood sample and prior to the analysis of her blood sample. The HIV antibody will not fade and become undetectable with time, unlike blood alcohol or drug content. Therefore, it is difficult to imagine any exigent circumstances which would vitiate the warrant requirement.

The requirement of probable cause may be less stringent when the fruits of a search are not used for criminal prosecution, but to further some other governmental interest. This will depend upon the government interest served, the extent of the search's intrusion, and the privacy interest compromised. As the Supreme Court observed in National Treasury Employees' Union v. Von Raab:

[W]here a Fourth Amendment intrusion serves special governmental needs, beyond the normal need for law enforcement, it is necessary to bal-

526. Schmerber v. California, 384 U.S. 757, 770 (1966) (holding that the warrant requirement is waived only when officer reasonably believes she "is confronted with an emergency, in which the delay necessary to obtain a warrant, under the circumstances, threatened 'the destruction of evidence'"); see also Mincey v. Arizona, 437 U.S. 385, 392-93 (1978) (observing exceptions to warrant requirement as encompassing reasonable belief on the part of the police officer that a person is in need of immediate aid, reasonable suspicion by officer at homicide scene that other victims or the killer is still on premises, or reasonable belief that action is necessary to protect or preserve life or avoid serious injury); Michigan v. Tyler, 436 U.S. 499, 509-10 (1978) (permitting seizure of plain view evidence of arson upon warrantless entry by fire fighter to extinguish blaze); Warden v. Hayden, 387 U.S. 294, 298-99 (1967) (holding that warrant is not necessary if delay would gravely endanger lives of officers or others); Johnson v. United States, 333 U.S. 10, 15 (1948) (finding that the threat of flight by a suspect or destruction or removal of contraband constitute exceptional circumstances which would dispense with the need for a warrant).
527. See Schmerber v. California, 384 U.S. 757, 770-71 (holding that exigent circumstances existed because blood alcohol level would quickly diminish shortly after alcohol consumption ceased).
Individualized suspicion or a warrant are unnecessary in certain exceptional employment contexts where employees are highly-regulated and supervised, and thus have a diminished expectation of privacy. Thus, the Court found that warrantless urine testing of railway workers is justified because it is a low level intrusion which fulfills the government's interest in protecting public safety. In dramatic contrast, HIV testing of women based on childbearing status would always require a warrant. The level of intrusion would be great because privacy interests in childbearing decisions, reproductive autonomy, and parenting are protected as fundamental rights, and because HIV positivity is an immutable characteristic. Moreover, no compelling government interest is demonstrably served by such testing. Hence, the warrant requirement should not be waived even for non-criminal uses of HIV antibody test results.

The Fourth Amendment effectively prohibits routine HIV antibody testing because, prior to testing, there must be a determination


530. National Treasury Employees' Union v. Von Raab, 489 U.S. at 665-66. Thus compulsory urine tests are permissible when the Government has a compelling interest "in preventing the promotion of drug users to positions where they might endanger the integrity of our Nation's borders or the life of the citizenry, [which] outweigh[s] the privacy interests of those [customs service employees] who seek promotion to [specific positions in which these dangers are present], who enjoy diminished expectation of privacy by virtue of the special, obvious, physical and ethical demands of those positions." Id. at 679. However, because the Government failed to demonstrate a compelling interest as to employees seeking promotions to positions where they would handle "classified" material, the Court refused to validate that portion of the urine test policy. Id. at 679; see also, New York v. Burger, 482 U.S. 691, 703 (1987) (holding that warrantless searches of junkyards for stolen automobile parts acceptable because junkyards are closely-regulated businesses).

531. Compulsory warrantless testing of railway workers' urine for alcohol or controlled substances is permissible when the employees may urinate in private, unobserved, because the regulation of railroad employees' conduct to ensure safety is a significant governmental interest. Skinner v. Railway Labor Executives' Ass'n, 489 U.S. at 626-27. A routine periodic building inspection for code violations has been found justified by the government's interest in preventing the development of hazardous conditions, even though there was no individualized suspicion. Camara v. Municipal Court, 387 U.S. 523, 537 (1967).

532. See discussion supra part IV.A.

533. See supra notes 528-531 and accompanying text.
that the requirement of probable cause exists in the criminal context or a finding of individualized suspicion in the civil context. Mandatory testing laws\(^\text{534}\) not requiring probable cause before testing should also be invalidated.

A prosecutor may attempt to apply a criminal transmission statute to perinatal transmission and seek to compel a pregnant or post-partum woman to undergo an HIV test. The prosecution would have to establish probable cause that a woman committed the crime of risking transmission of HIV to another. The prosecutor could attempt to do so by assembling evidence that a woman is known to be HIV-infected and that she is pregnant or gave birth. Alternatively, probable cause of actual transmission could be demonstrated by gathering evidence that an infant exhibits symptoms of HIV infection.\(^\text{535}\) Because eighty percent of children with AIDS were infected perinatally, evidence of HIV symptoms in an infant may very well establish probable cause. Similarly, a health authority seeking to impose HIV testing on a woman pursuant to public health law could attempt to demonstrate individualized suspicion in the same ways. If such probable cause or individualized suspicion were established, then compelled HIV testing subject to a valid warrant should not be prohibited by the Fourth Amendment.

F. Summary

Clearly, compelled contraception, abortion, and sterilization are government intrusions which "shock the conscience" and, therefore, are violative of Fourth Amendment norms. Even if held to not "shock the conscience," such intrusions will not be permitted because they do not fulfill a compelling state interest. They serve only to destroy fetal life or prevent conception. Additionally, compulsory HIV testing is arguably a government intrusion which "shocks the conscience" and, therefore, is intolerable to Fourth Amendment norms because of the profound and pervasive social and psychological repercussions of positive HIV antibody test results. Should courts find that mandatory HIV testing of pregnant or post-partum women does not shock the conscience, the Fourth Amendment would permit testing only when state interests clearly outweigh the privacy interests of the individual. In the civil context, testing is likely to be invalidated because such testing fails to fulfill the asserted government

\(^{534}\) See supra part I.D.

\(^{535}\) In most states, the doctor-patient privilege and confidentiality of medical records would prevent medical professionals from divulging evidence of a child's symptoms or diagnosis to law enforcement authorities. However, several states permit discovery of AIDS-related health records for a "compelling need" such as enforcing HIV containment law.
interests of preventing perinatal transmission or safeguarding the health of children. In the event that the application of criminal transmission statutes to perinatal transmission withstands judicial scrutiny, enforcement of these laws could provide a basis for compulsory HIV-testing.

If forced testing is not categorically invalidated either because it shocks the conscience or because it does not fulfill a government interest, the Fourth Amendment would require probable cause or individualized suspicion that a criminal or civil law, respectively, has been violated to justify compelled testing. Thus, routine HIV antibody testing should never be permitted under the Fourth Amendment. In some specific cases, however, it may be possible to establish the requisite probable cause or individualized suspicion in order to secure a warrant for an unconsented HIV antibody test.

VI. CONCLUSION

Fetus and woman and mother and child should not be adversaries. The dependency of the fetus upon the woman, and the ultimate dependency of a child upon its parents, predominantly its mother, calls for a harmonious relationship. Yet an adversarial approach is now lauded as a means for preventing perinatal transmission of HIV. While all agree that pediatric AIDS must be eliminated as soon as possible, this end will not be furthered by circumventing the basic human rights of HIV-positive women.

Members of the lay public tend to sympathize with infants while blaming their mothers. There is evidence that a large segment of the medical community also perceives drug-dependent women as adversaries. However, as one commentator has stated: "The exclusive focus on the fetus, or even on babies, is a cheap emotional distraction from the more difficult and complicated tasks at hand. We cannot effectively love babies and treat their mothers badly."

Several authors predict that attempts to compel HIV-positive women not to have children will discourage them from contact with health providers. For pregnant women, this will mean avoidance

538. One woman voiced her opposition to a neighborhood home for babies, many of them HIV-infected, waiting for foster care placement: "We love babies. We just hate drug addicts." Gallagher, Fetus as Patient, supra note 61, at 216.
537. See supra part II.A.
538. Gallagher, Fetus as Patient, supra note 61, at 216.
of prenatal care and an increase in non-hospital births. Such behavior is undesirable, as it would present acute problems in a population at high risk for complications. These women will gestate absent prenatal care and will give birth without the medical attention provided by a hospital. As a result, they will incur great risk to themselves and their potential offspring. Attempts to coerce HIV-positive women not to have children will prevent few pregnancies, but will likely drive great numbers of medically underprivileged women away from prenatal care and hospitals.

Only thirty percent of all offspring of HIV-positive women will become infected themselves. Thus, the seventy percent of uninfected babies of HIV-positive women are jeopardized by a climate of coercion which diminishes their survival chances by exposing them to the diseases, disabilities, and death associated with inadequate prenatal, childbirth, and postnatal medical care. If HIV-positive women choose not to use the health care system during pregnancy, their rates of premature and low weight births will dramatically increase. If they avoid hospitals altogether when giving birth to these premature babies, infant mortality and complication rates are likely to increase. Thus, even according to an exclusive fetal focus, reproductive coercion remains unjustifiable because no asserted compelling state interest will be fulfilled by these methods.

Perhaps the issue of preventing perinatal transmission has been misframed. Rather than debating whether HIV-positive women should have babies, the question should be posed: “Why do they?” Based on the answers to that question, the further question, “what do women need?” should be addressed. These questions will produce real answers to question of how to prevent perinatal transmission. As the gay male response to the AIDS epidemic has proven, the most accurate and productive answers to such questions come from the affected population itself.540

The structure of the U.S. health care system—the system where women of means patronize private physicians and poor women receive care in hurried, overcrowded clinics541—dictates that

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540. Dalton, supra note 88, at 205-07; see also Maria L. Ekstrand, Safer Sex Maintenance Among Gay Men: Are We Making Any Progress?, 6 AIDS 875, 875-76 (1992) (documenting “drastic risk reduction” following prevention programs “delivered in culturally sensitive fashion that responds to the needs of the target population”).

541. See PETCHESKY, supra note 28, at 82 (stating that upper and middle class married women are the principle clientele of the medical profession); see also Repke & Johnson, supra note 93, at 98.
poor women are unlikely to obtain the careful, culturally appropriate counseling which will assist them to make informed choices tailored to their life circumstances. Though some HIV-positive women may have limited choices concerning their pregnancies because they have no access to contraception, abortion, or prenatal care, others may have limited choices because of inadequate counseling.

Inquiry may also reveal that for some women, particularly minority women, the one in three odds of losing a child to HIV infection are reasonably and rationally evaluated as an acceptable risk. Often these women have few avenues for personal fulfillment and treasure their ability to have children. Additionally, they face terrifying odds of losing offspring. Lead poisoning, accidents, violent crime, disease and inadequate health care, drug addiction, and incar-

Prenatal care affords important opportunities to educate women about how they can protect themselves from contracting HIV, and about the relationship between HIV infection in women and HIV infection and infants. However, education and counseling require resources that are often in short supply in obstetric settings, particularly those that serve disadvantaged women. These resource constraints include inadequate access to experts and materials for training of staff, insufficient staff time and inadequate space for counseling, and the absence of financial reimbursement for counseling. 


Nationally only 74% of women receive adequate prenatal care. Inadequate care is often associated with being poor, uninsured, Black, Hispanic, or Native American, and/or under the age of 18. Martha B. Witwer, Prenatal Care in the United States: Reports Call for Improvements in Quality and Accessibility, 22 FAM. PLAN. PERSP. 31 (1990).

Herbert L. Needleman, The Persistant Threat of Lead: A Singular Opportunity 79 AM. J. PUB. HEALTH 643, 644 (1989) (stating that while 17% of white children above poverty level have dangerous blood lead levels, 55% of poor black children exhibit such levels).

Rates of death due to accidental injury for black children are 55% higher than injury death rates for white children. PUBLIC HEALTH SERVICE, U.S. DEPT. HEALTH & HUMAN SERVS., HEALTH, UNITED STATES 13 (1990).

Nationally, although African-Americans represent only 12% of the population, they constituted 49% of all victims of murders. FBI, U.S. DEP'T OF JUSTICE, CRIME IN THE UNITED STATES 9 (1990). In 1988, homicide was the second leading cause of death among African-American children ages 1 to 14. The homicide rate for these children is three or four times greater than that of any other racial group. Id. at 13.

Report Cites Racial Discrepancies in Medical Care, N.Y. Times, May 2, 1990, at A21; Children, Especially Minority Children, Threatened by Immunization Slump, CHILDREN'S DEFENSE FUND REPORTS, Jan. 1988 at 1, 2 (stating that 15% of nonwhite children are not vaccinated for polio, while 4% of all races do not receive such vaccines; 35% of nonwhite children have inadequate diphtheria, tetanus, and pertussis vaccine, while 17% of all races receive inadequate vaccines for these diseases; 33% of nonwhite children are not vaccinated for mumps, while 23% of all races do not receive mumps vac-
All contribute to infant mortality and morbidity rates rivaling those of underdeveloped countries. Thus, it is understandable why they would attempt to have a baby despite the threat of HIV infection.

Other HIV-infected women may indeed bear children with such complete moral oblivion that no understanding of the context can explain it. However, even these cases cannot justify eviscerating the constitutional rights to procreation, privacy, equality, and bodily integrity, and the common law right to medical consent, which are so vitally fundamental to our democracy. This is especially important because the government has failed to take even some of the most obvious steps such as providing accessible prenatal care,

548. While Blacks constituted only 12% of the total U.S. population, they comprised nearly half of the prison population in 1986. Walter Stafford, Economy Offers Few Exits from Poverty, GUARDIAN, Feb. 20, 1991, at 8; While African-Americans and Latin-Americans comprised 23% of New York State population, they comprised 82% of New York State prison population in 1989. Sixty to 70% of inmates have a history of drug abuse. CORRECTIONAL ASS'N OF NEW YORK, PRISONER PROFILE, Sept. 1992 (on file with the Buffalo Law Review).

549. Levine & Dubler, supra note 172; see Mitchell, supra note 123; see M. Klitsch, Women Who Lack Health Insurance Coverage Are More Likely to Bear Seriously Ill Newborns, 22 FAM. PLAN. PERSP. 41 (1990) (finding that uninsured African-American women are twice as likely as insured African-American women, and four times as likely as insured Caucasian women, to give birth to infants who die or are seriously ill). The study concludes that this is due to the reduction in access to publicly-funded services during the 1980's. Id.

Low-birth-weight babies experience elevated risks of morbidity and mortality. African-American babies have three times the incidence of very low-birth-weight, and Puerto Rican infants have 1.8 times the incidence as that of Caucasian newborns. PUBLIC HEALTH SERVICE, supra note 545, at 10. Close to 20 African-American babies die per 1,000 births, whereas fewer than 10 Caucasian babies die per 1,000 births. Id. at 11; Robert Pear, Study Says U.S. Needs to Attack Infant Mortality, N.Y. TIMES, Aug. 6, 1990, at A1, B9 (reporting infant mortality rate for U.S. African-Americans is twice that for U.S. Caucasians; 40,000 African-American babies die each year, one quarter of them from readily preventible causes).

550. Roberts, supra note 24, at 1446-47 ("The main reason for... high [African-American infant mortality] rates is inadequate prenatal care. Most poor Black women face financial and other barriers to receiving proper care during pregnancy."). Nadine Brozan, Poor Are Rocked by Closing of Gynecological Clinics, N.Y. TIMES, Mar. 25, 1991, at B1 ("Providers [of prenatal care and birth control services] have been tightening their belts and trying to combine services rather than totally close them off, because they must
drug treatment,\textsuperscript{551} and general health care. Such measures could voluntarily and substantially reduce the number of HIV-positive women who become pregnant, increase the number who choose to discontinue pregnancies, and increase the number of women who obtain prenatal medical care. Such programs would also greatly reduce the number of women who become infected by HIV. Keeping women free from HIV infection would not only prevent the suffering and death of women, but it is now the “only effective approach to preventing HIV infection in future generations of children and stemming the tide of this terrible epidemic.”\textsuperscript{552}

The belief that babies born into lives of poverty and disease are worthy of protection, whereas women born into lives of poverty and dislocation—some of whom go on to become HIV-infected, drug-addicted, and/or pregnant—are not worthy of public help, is a strange and illogical ordering of priorities and blame. Allocating such blame only serves to obscure the fact that socio-economic structures determine that women born into poverty are likely to also die in poverty. Heightened control of women who succumb to the symptoms of poverty—drug abuse, disease, lack of adequate prenatal care, and HIV infection—merely perpetuates their dehumanization and contributes to the cycle of despair. Our democracy can deliver better answers to the problem of perinatal transmission. Our laws command that we do so.

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\textsuperscript{551} “Treatment on demand” for intravenous drug users, with special accommodations made for “addicted women, addicted pregnant women and their children” was recommended by the Presidential Comm’n on the Human Immunodeficiency Epidemic in 1988. The Presidential Commission on the Human Immunodeficiency Epidemic, \textit{Drug Abuse and the HIV Epidemic, in AIDS: THE IMPACT ON THE CRIMINAL JUSTICE SYSTEM} (Mark Blumberg ed., 1990). Despite the passage of nearly five years, this goal has not been fulfilled. Rogers, \textit{supra} note 10, at 528. Indeed, the Bush Administration became increasingly committed to a law enforcement response to drug addiction. Philip J. Hilts, \textit{Experts Call for U.S. to Expand Drug Treatment; Bush Aides Are Receptive}, \textit{N.Y. Times}, Sept. 20, 1990, at B5 (noting that “[i]n 1989, about one in seven federal dollars spent on anti-drug programs was spent on treatment, down from one in two dollars for treatment in 1976”); cf. Kathleen Teltch, \textit{In Detroit a Drug Recovery Center That Welcomes the Pregnant Addict}, \textit{N.Y. Times}, Mar. 20, 1990, at A14 (noting that the center looked beyond the drug issue “to women and children facing life stresses, medical, financial and social needs, and . . . shape[d] a holistic approach toward helping. ‘The therapy works as well as it does . . . because women are treated in a program designed for women.’”(citation omitted)).

\textsuperscript{552} Modlin & Saah, \textit{supra} note 93, at 50.
# TABLE I

**STATUTES ALLOWING CERTAIN MINORS TO CONSENT TO HIV TESTING**

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<thead>
<tr>
<th>Statute</th>
<th>State/Code</th>
<th>Year(s)</th>
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# TABLE II

**STATUTES REQUIRING INFORMED CONSENT PRIOR TO CONDUCTING HIV ANTIBODY TESTS**

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<th>Statute</th>
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<tr>
<td>Ind. Code Ann. § 16-1-9.5-2.5</td>
<td>Burns 1990</td>
<td>(1990)</td>
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Many of the above statutes provide exceptions to the informed consent requirement when, in the judgment of the physician, HIV testing is medically indicated to provide appropriate diagnosis and treatment and/or for the purpose of research. Also, many statutes require that consent be written or if oral, that written documentation be made in the patient's record. Finally, Kentucky requires only general consent to HIV testing when testing is medically indicated for diagnosis and treatment. Ky. Rev. Stat. Ann. § 214.181 (Michie/Bobbs-Merrill 1991).
### TABLE III
**STATES WITH CRIMINAL STATUTES APPLYING TO ACTIONS BY AN HIV-POSITIVE PERSON**

<table>
<thead>
<tr>
<th></th>
<th>Donating Bodily Fluids or Organs</th>
<th>Engaging in Risky Sexual Contact</th>
<th>Sharing Needles</th>
<th>Intentionally Inflicting a Risk of HIV Transmission on Others</th>
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### TABLE IV
**DISEASE AND DISORDER TESTING OF PREGNANT WOMEN**

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<th>Permissive Syphilis Test</th>
<th>Sickle Cell Anemia</th>
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1. New York requires testing for Hepatitis B
2. Virginia requires testing for PKU.