AN ARGUMENT FOR UNIVERSAL PEDIATRIC HIV TESTING, COUNSELING AND TREATMENT

BY
COLIN CRAWFORD*

I. INTRODUCTION

This symposium was called to address constitutional concerns raised by the controversy over the issue of mandatory pediatric testing, counseling and treatment for the human immuno-deficiency virus (HIV). In due course, I will turn to those concerns,[1] and explain my view that the need to test and treat newborns for HIV constitutes a medical emergency that overrides the most serious constitutional concerns. However, before doing so, it is helpful to put the debate in perspective, to explain what, in ABC's view, the controversy is really all about, and to indicate why our organization has so strenuously advocated mandatory pediatric HIV testing and treatment.

The federal Centers for Disease Control estimates that in 1994 alone "1,017 pediatric AIDS cases were reported, an 8 percent increase from the number reported in 1993. Of these, 92 percent were acquired perinatally. . . . For 34 percent of mothers, the risk of exposure was not reported."[2] New York continues to account for approximately one-fourth of the nation's pediatric HIV cases, over 221 were *reported* in 1994 alone. By December 31, 1993, there were 1,395 cases of pediatric AIDS in New York State, more than 87 percent of them in New York City. From November 1987 — when blind infant HIV testing began in New York — until August 1993,

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* Counsel, Association to Benefit Children (ABC). Founded in 1986, ABC provides primary care services to children and their families. ABC's programs are designed to be replicated nationally. ABC also engages in advocacy efforts on behalf of the population it serves. I would like to thank Anne Reilly, a second-year student at Brooklyn Law School, who provided invaluable research and copy editing assistance in the final stages of manuscript preparation.

[1] In fact, interestingly, at the actual symposium none of the speakers — myself included — gave particular attention to the constitutional issues, serious though they are. This reflects, I think, the fact that to a great extent, this continues to be a policy debate about how to approach problems associated with HIV, and one that does not consistently challenge basic constitutional principles.

[2] CENTERS FOR DISEASE CONTROL AND PREVENTION, 6 HIV/AIDS SURVEILLANCE REP. NO. 2, at 5 (1994) [hereinafter CDC report]. The CDC report cryptically adds that "[f]uture trends in AIDS incidence among children will be affected by current Public Health Service recommendations for routine counseling and voluntary prenatal HIV treatment for women . . . ." *Id.*

at least 10,323 HIV-infected women gave birth in New York.[3] Approximately a quarter of the children born to those women will eventually present an authentic HIV diagnosis, often within the first precious months of life.[4]

Clearly, there is a public health emergency at hand. The tragic fact is that this continuing loss of young life could be stemmed significantly; HIV-positive children could now have healthy childhoods — and perhaps more than that. This is not happening largely due to political wrangling by those who, ignoring the fact that we can now test and treat these children, insist that newborns not be tested at birth for HIV.

In 1989, Susan Sontag wrote a little book called *AIDS and Its Metaphors.* It is worth quoting in full a section of her conclusion which underscores the argument advanced here. Sontag observed as follows:

> That even an apocalypse can be made to seem part of the ordinary horizon of expectation constitutes an unparalleled violence that is being done to our sense of reality, to our humanity. But it is highly desirable for a specific dreaded illness to come to seem ordinary. Even the disease most fraught with meaning can become just an illness. It has happened with leprosy . . . . It is bound to happen with AIDS, when the illness is much better understood and, above all, treatable. For the time being, much in the way of individual experience and social policy depends on the struggle for rhetorical ownership of the illness: how it is possessed, assimilated in argument and in cliche. The age-old, seemingly inexorable, process whereby diseases acquire meanings (by coming to stand for the deepest fears) and inflict stigma is always worth challenging, and it does seem to have more limited credibility in the modern world, among people willing to be modern - the process is under surveillance now.[5]

These remarks address my belief that Sontag has got it absolutely right: that AIDS must come to seem ordinary, to be treated and experienced as just another illness — a serious and often incapacitating one, to be sure, but nonetheless just another illness. Similarly, what follows will aim — in the spirit of Sontag's observations

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[3] *Report of the Subcommittee on Newborn Screening of the New York State AIDS Advisory Council* 5-6, Feb. 10, 1994 [hereinafter Advisory Council Report].

[4] Although estimates vary, upwards of 25% of all children born to HIV-positive mothers will eventually develop the disease. The remainder merely carry HIV antibodies at birth and will shed them by about 15-18 months. *See, e.g.,* Committee on HIV Prenatal/Newborn Testing of the Association of the Bar of the City of New York, *Prenatal/Newborn HIV Testing,* 49 RECORD OF THE ASS'N OF THE BAR OF THE CITY OF N.Y. 420, 421 (1994) [hereinafter Association Report].

[5] SUSAN SONTAG, AIDS AND ITS METAPHORS 94 (1989).

— to challenge the perpetuation of stigma associated with HIV and AIDS.

The sad thing is that, although AIDS and HIV are better understood and more treatable since Sontag wrote the words quoted above,[6] they are still not viewed as just another illness, and too often remain cloaked in shame and fear. This continues to be true because, despite the availability of life-sustaining treatments for HIV, the struggle for rhetorical ownership of HIV continues unabated. As if important improvements in treatment did not exist, many of those who work unflaggingly for better HIV prevention and care nonetheless continue to promote a culture of secrecy around HIV and AIDS.[7] This leads, in my view, to the overpoliticization of the disease at the expense of a less hysterical, less stigmatized, frank assessment of the illness' medical reality. Nowhere is this more true than in the case of pediatric HIV.

II. BACKGROUND

In November 1987, New York State joined forty-three other states as participants in "blind" seroprevalence tests for all live births.[8] These tests are blind in the sense that, unlike a host of other diseases for which infants are routinely tested at birth,[9] the infant HIV test results are immediately separated from the child and are not revealed to either the mother, the legal guardian, or the mother's physician. Instead, they are identified only with certain basic demographic markers[10] and used for the purpose of epi-

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6 *Id.*

7 *See, e.g.*, Elizabeth Cooper, *Mandatory HIV-Antibody Testing of Newborns and Pregnant Women: A Public Policy and Legal Analysis*, paper presented at the Tenth International Conference on AIDS, Yokohama, Japan, Aug. 9, 1994 (concluding, *inter alia*, that "state intervention" in infant HIV testing "sets the stage for broader intrusions into the lives of women and their children"); Nan Hunter, *Women and HIV Disease, in* AIDS AGENDA: EMERGING ISSUES IN CIVIL RIGHTS 5, 16 (N. Hunter and W. Rubenstein, eds., 1992).

8 These tests are conducted and administered by the state departments of health. Advisory Council Report, *supra* note 3, at Appendix F ("Current Procedure for Newborn Congenital Disease Screening and the HIV Newborn Seroprevalence Survey in New York State").

9 As required by N.Y. PUB. HEALTH L. § 2500-a and 10 NYCRR Sub-part 69-1.2, the illnesses for which newborn screening is mandated include, phenylketonuria ("PKU"), branched-chain ketonuria, homocystinuria, galactosemia, homozygous sickle cell disease, hypothyroidism and biotinidase deficiency. In addition, it is worth noting in this context that, pursuant to N.Y. PUB. HEALTH L. §§ 2500-a and 2308(1), a physician treating a pregnant woman is required to take a blood sample testing, respectively, for syphilis and antigens for hepatitis B, both once highly stigmatized, sexually-transmitted diseases. *See also* testimony of Vicki Peters, M.D. at AIDS Institute hearings on newborn testing (Nov. 8, 1993) (citing fact that incidence of neonatal HIV is higher than incidence of these diseases for which tests are routinely conducted).

10 Including the hospital of delivery, location, race or ethnicity of mother and child. *See* G.J. STINE, M.D., ACQUIRED-IMMUNO DEFICIENCY SYNDROME: BIOLOGICAL, MEDICAL, SOCIAL AND LEGAL ISSUES 113 (1993).

demiologically tracking the spread of HIV and AIDS. Ideally, blind test results are both confidential and anonymous.

When it began, this practice reflected very real concerns about stigmatization from a HIV-positive result, not only for infants — but perhaps even more importantly — for their mothers who, by implication, are identifiable as HIV-positive in the event of a positive test result of their newborn. In late 1987, ABC and most other care providers and advocacy organizations supported the collection of anonymous "blind" pediatric HIV results. Why potentially imperil society's treatment of mother and child when there appeared to be little that could be done on their behalf? ABC and others reasoned that if a mother was concerned that she and her child might carry HIV, they could voluntarily elect to be tested.

For ABC, this situation changed dramatically, within two years, once New York began participating in the seroprevalence study. The change in position resulted from an increase of evidence that newborns could be successfully treated for HIV, but only if the virus was detected early enough.[11] In fact, available evidence continues to suggest that if infants are to be treated successfully for HIV, the presence of the virus must be detected within the first three months of life; before the onset of one of the most fatal of pediatric HIV-related opportunistic infections, *pneumocystis carinii pneumonia* ("PCP").[12] In addition, medical studies continue to suggest that early detection can help doctors and other medical care professionals develop aggressive strategies to prevent some of the most destructive opportunistic infections affecting HIV-positive newborns and infants, such as failure to thrive.[13]

The fact that children's lives could be significantly improved if their HIV infection was identified promptly at birth was the decisive factor that led ABC to reverse position and advocate the un-

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[11] I refer specifically to the medical recognition of the success of several antibiotic treatments for pediatric HIV, and in particular administration of the antimicrobial therapies, such as administration of the antibiotic commonly known as bactrim. *See, e.g.*, Centers for Disease Control, *Guidelines for Prophylaxis Against Pneumocystis carinii Pneumonia for Children Infected with Human Immunodeficiency Virus*, 40 CENTERS FOR DISEASE CONTROL MORBIDITY AND MORTALITY WEEKLY REPORT NO. RR-2 (Mar. 15, 1991); *Prophylaxis Against Pneumocystis Carinii Pneumonia Among Children With Perinatally Acquired Human Immunodefiency Virus Infection in the United States*, 332 NEW ENG. J. OF MED. 786 (Mar. 23, 1995).

[12] See, e.g. Lawrence K. Altman, *AIDS Is Now the Leading Killer of Americans From 25 to 44*, N.Y. TIMES, Jan. 31, 1995, at C7 (reporting, *inter alia*, that a new CDC study shows "that the risk of P.C.P. was highest in young infants, with more than half of such cases occurring in children 3 to 6 months old."); Colin Crawford, *Protecting the Weakest Link: A Proposal for Unblinded Pediatric HIV Testing, Counseling and Treatment*, 26 J. OF COMMUNITY HEALTH 125, 128 (1995).

[13] *See* Association to Benefit Children, A PREVENTABLE CRISIS (1993) (documenting cases of children classified as failing to thrive, who later turned out to be HIV-positive).

binding of pediatric HIV tests.[14] Morally and medically the opportunity to prolong and improve the quality of human lives merits this decision. This is not to say that the civil liberties concerns raised by the nonconsensual testing of a child, and by implication her mother, are not serious ones. On the contrary, as ABC has repeatedly acknowledged, the concerns about mothers' civil liberties are important.[15] ABC continues to recognize that for anyone — mothers included — learning of a positive HIV diagnosis can be an anguish-filled and fearful event. Nonetheless, ABC continues to conclude that the possibility of giving an HIV-positive newborn the chance of a childhood, and perhaps of an adolescence as well, presented and continues to present a compelling argument that — on moral and medical grounds — deserves priority over these civil liberties concerns.[16] With respect to children at least, the nonconsensual nature of the test is also rendered untroubling by the realization that, if faced with the opportunity to take steps to prolong and improve the quality of their lives, most newborns would make the choice to test and treat if they could.

In light of this situation, ABC therefore began in 1990, along with others, to advocate for some form of unblinded pediatric HIV testing.[17] The more ABC spoke with officials and examined the justifications for not performing any kind of unblinded test, the

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14 Technically, there is some question as to whether actual results conducted in connection with the CDC seroprevalence study can be unblinded. The Deputy Director of Policy at New York's AIDS Institute reports that CDC staff have made "verbal indications" that funding would be withdrawn if the results were not blinded. Telephone Interview with Trilby DeJung, Deputy Director of Policy at New York's AIDS Institute (Mar. 1995). In such an event, it would be ABC's position that a portion of the blinded blood sample should be separated and used to effect the ends argued for in this paper.

15 *See, e.g.*, Gretchen Buchenholz, *HIV Babies Have Rights Too*, N.Y. DAILY NEWS, Jan. 18, 1994, at 7 (Gretchen Buchenholz is ABC's Executive Director). *But see* Anna Quindlen, *The Baby Bill*, N.Y. TIMES, June 8, 1994, at A25.

16 The civil liberties concerns are outlined. Hunter, *supra* note 7. *But see, e.g.*, Leonardo Renna, *New York State's Proposal to Unblind HIV Testing for Newborns: A Necessary Step in Addressing a Critical Problem*, 60 BROOK. L. REV. 407, 408 (1994); Association to Benefit Children, *supra* note 13, at 15-18.

17 In New York State, the most highly publicized such effort was that by Queens Assemblywoman Nettie Meyersohn, who introduced a mandatory pediatric HIV testing bill. *See* Renna, *supra* note 16, at 453-58. The bill never made it out of a sharply divided committee. *See, e.g.*, Jim Dwyer, *Politics is Killer of HIV Babies*, NEWSDAY, Sept. 21, 1994, at 2; Nat Hentoff, *The Blindness of the Fundamentalist Left*, VILLAGE VOICE, July 5, 1994, at 20. A similar bill was introduced by Assemblywoman Nettie Meyersohn and New York State Senator Guy Velella in 1995. *See* 1995 S. 2704/A. 4413, introduced Feb. 27, 1995; *see also* Kevin Sack, *Senate Votes to Require Telling Mothers of H.I.V. Results*, N.Y. TIMES, Apr. 5, 1995, at B4 (reporting that the N.Y. Senate "overwhelmingly approved" the bill). A related bill has also been introduced at the federal level by United States Congressman Gary Ackerman of New York. *See* 1995 H.R. 1289, introduced Mar. 22, 1995. *See also* 1995 H. Con. Res. 62, introduced Apr. 7, 1995 by Congressman Jose Serrano ("[e]xpressing the sense of the Congress with respect to pediatric and adolescent AIDS").

more ABC became convinced that they were unsatisfactory.[18] ABC was encouraged in its view when it saw that in its own service population, a HIV-positive result typically meant that a mother took strengthened interest in managing her health and that of her child rather than, as some have alleged, avoiding any prenatal care or other intervention by the medical system.[19]

As a foster care provider, ABC focused in particular on the inadequacies of New York City and State regulations relating to infant HIV testing. ABC then concluded that these were unduly cumbersome and overly bureaucratic. For a child in foster care whose parents were not always easily located ABC recognized that the applicable regulations unnecessarily hampered the ability of the foster care provider to help secure needed medical assistance for an HIV-positive child.[20] ABC thereafter secured the *pro bono* legal services of a major New York City law firm, and was poised to bring a lawsuit against New York Governor Cuomo and his Commissioner for Social Services, Michael Dowling, along with various New York City officials, for their failure to exercise adequate care for the health and well being of New York's pediatric HIV population.

The need for a lawsuit with regard to the foster care population was rendered unnecessary with Commissioner Dowling's decision to issue regulations mandating the HIV testing and treatment of all children in foster care with risk factors for HIV infection.[21] Although these regulations do not remove ABC's concern about the non-foster care pediatric population, they did represent a great

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18 For example, we concluded that the so-called Mohunk Principles, which outlined four conditions that would have to be met before universal testing was appropriate, had been met. *See* Ass'n to Benefit Children, *supra* note 13, at 23; Crawford, *supra* note 12, at 135-36.

19 Cooper, *supra* note 7, at 12 (citations to source of anecdotal information omitted) (pointing to "anecdotal reports of numerous HIV-positive women that implementation of a mandatory testing program would result in more women avoiding pre-natal care and avoiding hospital deliveries."). Cooper's statement stands at variance, however, with her own statement elsewhere that "there is every indication that seropositive women, like other women tend to put the well-being of their children ahead of all other concerns they may have." Elizabeth Cooper, *When Being Ill is Illegal: Women and the Criminalization of HIV*, 22 HEALTH/PAC. BULL. 10, 12 (1992).

20 ABC's view of the regulations is treated in detail in Crawford, *supra* note 12, at 131-34.

21 The regulations were filed on an emergency basis effective December 1, 1994, for final revision and adoption on February 1, 1995. *See* Letter from Frank Puig, Office of Commissioner of Department of Social Services (Dec. 20, 1994). The regulations would amend 18 NYCRR Secs. 428.3, 441.22 and 507.2. The regulations are described in detail in Dep't of Social Services, 26 SPECIAL DELIVERY TO FOSTER AND ADOPTIVE PARENTS 1 (1994). Risk factors meriting compulsory pediatric HIV testing include, as indicated in the regulations, a positive toxicology for drugs, a positive syphilis test or the absence of a medical history for the newborn and its parents.

step forward. Importantly, the regulations looked forward to the world urged by Susan Sontag in the passage quoted earlier. That is, they recognized that HIV need not be surrounded by a culture of secrecy that, while in part stemming from a well-intentioned desire to protect the privacy of people with HIV, also serves to reinforce the stigma attached to the virus, rather than recognizing that it is a treatable — if not a curable — condition.

Sadly, the regulations, which were in temporary emergency effect until January 6, 1995, are now in limbo again pending review by regulators in the wake of New York Governor George Pataki's ninety-day moratorium on regulations.[22] This moratorium, combined with ABC's continuing concern that this important issue of the need for HIV and AIDS care for poor children, their mothers and families was not being adequately addressed, led to the filing of a lawsuit seeking to compel the Governor, and his Commissioners of Health and of Social Services, to provide testing, counseling and treatment for all newborns in New York State.[23]

III. Constitutional Issues[24]

Possible areas of constitutional concern related to the issue of mandatory pediatric HIV testing and treatment include privacy and Fourth Amendment search and seizure law, in addition to Equal Protection jurisprudence. With respect to each of these constitutional concerns, however, the question of whether to test and treat for pediatric HIV is easily answered in the affirmative.

A. *Privacy Concerns.* The privacy argument against pediatric HIV testing would presumably go as follows: everyone has a right to make choices about his or her own health. Because a mother is entitled to this protection as much as anyone else, testing her child — and thus identifying the mother's HIV status — is an impermissible infringement on her constitutionally protected right to privacy.

This argument fails, however, because of a key exception to privacy doctrine, the compelling state interest exception, which provides that the overriding public interest in protecting the public

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22 Exec. Order No. 2, Governor George E. Pataki, (Ordering A Moratorium on Proposed Rules and Regulations (Jan. 6, 1995).

23 Baby Girl Doe v. Pataki et al., Index No. 106661-95 (Sup. Ct. N.Y. County, Mar. 17, 1995). *See, e.g.*, Felicia R. Lee, *Suit Seeks Release of Babies AIDS Test Results*, N.Y. Times, Mar. 15, 1995, at B6.

24 In preparation of this section, I am greatly indebted to Leonardo Renna's treatment of these issues, *see supra* note 16, at 442-52. *See generally* Mary Anne Bobinski & William S. LeMaistre, *HIV Testing and Confidentiality, in* AIDS And Governmental Liability 8-43 (Brenda T. Strama ed., 1993).

health and welfare supersedes nearly all personal rights.[25] Typically, privacy law has been bifurcated into two main lines of case law: those cases dealing with confidentiality, and those concerned with related questions of autonomy. Again, even if the pediatric HIV testing issue is examined in light of these cases, no constitutional concern would argue against ABC's position as outlined in these remarks.

1. *Confidentiality Analysis.* Confidentiality law can be interpreted either broadly or narrowly. Under a broad interpretation, a balancing of interests takes place. If this were to occur, the overriding public interest in protecting the public health and welfare, described above, would have to trump the concern with possible infringements of confidential test results.[26] Conversely, in the more likely situation in this case, even under a narrow application of the confidentiality strand of privacy law, ABC's position should prevail. Because, in any politically and morally acceptable testing and treatment regime, the test results would be kept strictly confidential (available to only a small number of vitally interested parties), there would be no serious reason to feel that mandatory pediatric HIV testing and treatment seriously compromises constitutional concerns about confidentiality.[27]

2. *Autonomy Analysis.* Constitutional cases dealing with the autonomy strand of privacy law are typically concerned with protecting a person's individual autonomy, and with her or his right to make decisions about her or his own life. As such, case law has recognized that procreative decisions, including all aspects of childbearing and childrearing, merit constitutional protection. If these rights are threatened, moreover, courts are obliged to apply the highest possible level of constitutional inquiry, namely strict scrutiny analysis.[28]

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[25] *See, e.g.*, Barnes v. Glen Theater, Inc., 501 U.S. 560 (1991) (nude dancers); Michigan Dept. of State Police v. Sitz, 496 U.S. 444 (1990) (sobriety test); Jones v. United States, 463 U.S. 354 (1983) (insane may be confined if dangerous to society).

[26] Whalen v. Roe. 429 U.S. 589, 592 (1977) (no confidentiality violation by a New York State statute requiring pharmacists to disclose identifying information about dispensing of dangerous drugs); Nixon v. Administrator of Gen. Servs., 433 U.S. 425, 458 (1977) (President has no privacy interest in papers given overriding public importance, especially when law protects "undue dissemination of private materials"). However, it must be noted that the Second Circuit has found that a there is a "recognized constitutional right to privacy in personal information." Doe v. City of New York, 15 F.3d 264, 267 (2d Cir. 1994). *But see* Doe v. Wigginton, 21 F.3d 733 (6th Cir. 1994); National Fed'n of Employees v. Greenberg, 983 F.2d 286 (D.C. Cir. 1993); J.P. v. DeSanti, 653 F.2d 1080 (6th Cir. 1981) (all questioning claimed basis of any such right).

[27] *Nixon*, 433 U.S. 425. *See also* Renna, *supra* note 16, at 451.

[28] Meaning that the law must serve a compelling governmental interest and be narrowly tailored to meet that interest. *See, e.g.*, Griswold v. Connecticut, 381 U.S. 479, 495-96 (1965) (Goldberg, J., concurring, joined by Warren, C.J. and Brennan, J.).

In the case of pediatric HIV testing and treatment, however, the government-endorsed action in question does not rise to a level meriting strict scrutiny. This is because the action does not interfere with procreative rights. Instead, a lesser standard of constitutional review, the rational basis test, should apply, inasmuch as the government action is only related to a legitimate government interest — the protection of public health and welfare. Nonetheless, it is worth adding that even if strict scrutiny applied, the view endorsed here would survive constitutional challenge on the grounds that, as suggested above, there is a compelling government interest in pediatric health.[29]

B. *Fourth Amendment Concerns.* Under the Fourth Amendment to the U.S. Constitution, a blood test can constitute an unlawful search.[30] However, the "special needs" exception to this finding would in this case obviate the need to obtain a warrant and demonstrate probable cause so as to conduct a search. This is true, once again, because privacy concerns — and the right to consent to a blood test — are overridden by the need to balance them against critical government interests, namely interests in protecting public health. Moreover, in New York State such concerns are especially unnecessary; state and local laws protect the privacy of HIV test results by providing civil and criminal penalties for violations of confidentiality requirements.[31]

C. *Equal Protection Concerns.* The most difficult aspect of any Equal Protection challenge is of course the requirement that a complainant show an intent to discriminate so as to result in unequal protection of the laws. Accordingly, any Equal Protection challenge to a regime of mandatory HIV testing and treatment would have to show that a protected class of individuals had been singled out for discrimination by means of a testing, counseling and treatment requirement. Because neither newborns nor children are a protected class under Fourteenth Amendment jurisprudence, a case would have to be made by using other possible affected classes, presumably women or members of a racial or ethnic minority group.[32] Once again, however, this argument would

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29 *See supra* note 25. *But see* Kathryn Boockvar, *Beyond Survival: The Procreative Rights of Women With HIV*, 14 B.C. THIRD WORLD L.J. 1, 30-34 (1994) (arguing that HIV testing cannot withstand strict scrutiny analysis). Boockvar concedes elsewhere in the same article, however, that "courts have often held that a state's interest in protecting public health and welfare supersedes nearly all personal rights." *Id.* at 26.

30 Skinner v. Railway Labor Executives' Ass'n, 489 U.S. 602, 616 (1989); Schmerber v. California, 384 U.S. 757, 767-68 (1966).

31 N.Y. PUB. HEALTH L. Sec. 2783 (McKinney 1994).

32 Women with HIV are disproportionately women of color, particularly African-American women and Latinas. *See* Advisory Council Report, *supra* note 3 at 5-6.

fail, and would do so for a simple reason: specifically, where is the discrimination? The goal of a mandatory testing and treatment plan would be to test in order to treat for a deadly illness. That is, the goal is not punitive, and it is not the first step in a grand scheme of eugenic social policy. On the contrary, it is an important step in de-stigmatizing HIV and AIDS, of forcing recognition that this is a treatable medical condition, and that the lives of children and others can be prolonged.

As for any possible Equal Protection claim on the basis of gender, it is extremely difficult to know how such a claim would be formulated so as to succeed. A report by the Association of the Bar of the City of New York trenchantly noted that such a claim would dubiously have to assert that the gender discrimination existed either against those who had been pregnant, or against those who gave birth.[33] There being no clear precedent for any such claim, it seems hard to imagine that courts would be especially receptive.

In sum, in each of the areas where at first glance a proposal for mandatory pediatric HIV testing and treatment might seem most vulnerable to constitutional attack, it seems likely that the compelling state interest in protecting the public health and welfare — in light of effective pediatric HIV treatments — would override other concerns.

IV. Conclusion

If the AIDS epidemic has taught us anything, it is the need to be responsive to the changing medical landscape. As indicated at the beginning of this essay, three years ago ABC did not support unblinded pediatric HIV testing because there was little that could be done through treatment to improve the quality and extend the lives of HIV-positive newborns, infants and children. That situation changed decisively when it became clear that aggressive measures could help give HIV-positive newborns a childhood, and perhaps more than that.[34] It now seems quite likely that new devel-

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[33] Association Report, *supra* note 4 at 444 n. 76. It is worth noting that the Committee on HIV Prenatal/Newborn Testing that issued this report on behalf of the Association of the Bar of the City of New York included Elizabeth Cooper, one of the panelists in this symposium who advocated the position against mandatory testing, counseling and treatment. Committee on HIV Prenatal/Newborn Testing of ABC, 49 Record of the Ass'n. of the Bar of the City of N.Y. 420 (1994).

[34] *See* 332 New Eng. J. of Med. 786, *supra* note 11 (concluding that "In the United States the incidence of PCP among HIV-infected infants has not declined. If this infection is to be prevented, infants exposed to HIV must be identified earlier, and prophylaxis must be offered to more children than the guidelines currently recommend"). The above-cited paper was prepared under authority of the Division of HIV/AIDS, National Center for Infectious Diseases, Centers for Disease Control and Prevention. Using this information,

opments in prenatal HIV treatment will change the necessary response yet even further.[35] The failure to adjust one's notion of the disease and break free of outdated political rhetoric in favor of the best current medical science is clear: pitched political battles and more needless litigation continues.[36] To cite but one such example, in Maine a woman recently sued her physician for negligent infliction of emotional distress, wrongful birth and wrongful death for the doctor's failure to test the mother for HIV prior to the child's conception.[37] This example suggests the extent to which people yearn for honest, unashamed discussion of known medical science about HIV and AIDS. If we fail to take every opportunity to make such information available — including implementation of a regime of mandatory testing, counseling and treatment for newborns and their mothers and families — it is likely that the courts will see more of such cases.

To recall Susan Sontag's words once again, these cases will be directly traceable to our failure to approach this illness as one that is ordinary and treatable.[38] In short, the position advocated herein is all but one important step towards further medicalizing (and thereby de-politicizing and de-stigmatizing) the discourse employed about HIV and AIDS.

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the Public Health Service of the Department of Health and Human Services began in February, 1995, soliciting comment on draft recommendations for HIV Counseling and Testing for Pregnant Women. The draft recommendations recommend testing and counseling as the standard of care, although they do not recommend mandatory newborn testing and counseling. (Not for Publication Draft of Recommendations, on file with author).

35 I refer specifically to the use of zidovudine, commonly known by its trade name, AZT, in the reduction of maternal transmission of HIV during pregnancy. *See, e.g., Pregnancy and HIV Reduction of HIV Transmission From Mothers to Newborns,* AIDS WEEKLY, July 11, 1994 (reporting California study indicating that "HIV-positive women who took AZT (zidovudine) during pregnancy and/or delivery had significant reduction of HIV-transmitted infection to their infants."); *Birth Outcomes Following Zidovudine Therapy In Pregnant Women; AZT, From the Centers for Disease Control and Prevention,* 272 J. AM. MED. ASS'N 17 (1994).

36 It is worth stressing again that ABC sought a sane governmental response to this problem for three years before resorting, reluctantly, to the courts. *See supra* note 23 and accompanying text.

37 Anastosopoulos v. Perakis, 644 A.2d 480 (Me. 1994).

38 *See supra* note 5. Importantly, the U.S. Public Health Service recently issued new recommendations arguing that HIV testing and counseling for pregnant women should be the medical standard of care throughout the country. *See* U.S. Public Health Service Recommendations for HIV Counseling and Testing for Pregnant Women (Feb. 23, 1995) (Prepublication draft, on file with author). Although the recommendations do not include provision for mandatory newborn testing, the fact that they argue for testing, counseling and treatment as the routine standard of care is an important development.