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NEW YORK STATE'S PROPOSAL TO UNBLIND HIV TESTING FOR NEWBORNS: A NECESSARY STEP IN ADDRESSING A CRITICAL PROBLEM

INTRODUCTION

Imagine the tragedy of a mother who rushes her sick infant to the hospital because the child is suffering from chest congestion and fever and learns that her child is infected with Human Immunodeficiency Virus ("HIV"), the causative agent of Acquired Immune Deficiency Syndrome ("AIDS"). Imagine the greater tragedy when the mother also learns that, if her child had been diagnosed with the HIV infection earlier, the deadly pneumonia her child has developed as a result of the infection could have been prevented.¹

Each year in the United States, approximately 6000 babies are born to mothers who are HIV-positive. About one-third of these babies, or 2000 newborns, will be infected with the virus through perinatal transmission (transmission from mother to child *in utero* or during birth).² In New York State, the situation is especially distressing: the state has one-fourth of the nationally reported cases of perinatal HIV transmissions.³ Even more disturbing is that, of the approximately 500 children who are perinatally infected in New York State annually, about 200 to 300 babies each year will leave New York State hospitals without having their infection identified.⁴ These children will receive no treatment for their illnesses until some time later when they begin to show symptoms of their deadly

¹ See *Test All Newborns for AIDS*, N.Y. NEWSDAY, Apr. 21, 1991, at 31 (editorial).

² ASSOCIATION TO BENEFIT CHILDREN, A PREVENTABLE CRISIS: A SPECIAL REPORT ON THE FAILURE TO TEST AND TREAT INFANTS AND CHILDREN FOR HIV 10-11 & nn.5-8 (1993) [hereinafter PREVENTABLE CRISIS].

³ *Id.* at 12 & n.12.

⁴ *AIDS Babies Pay the Price*, N.Y. TIMES, Aug. 13, 1993, at A26 (editorial); Gretchen Buchenholz, *HIV Babies Have Rights, Too*, N.Y. DAILY NEWS, Jan. 18, 1994, at 15.

infection.⁵ By then, it may be too late.

The shocking fact is that New York State *does* test all newborns for HIV, but because the purpose of this testing is to acquire data for epidemiological studies, the test results are blinded—i.e., anonymous—and neither the mothers nor the doctors of the newborns are informed of the newborns' HIV status.⁶ Until recently, legislators have been unwilling to unblind the results of these tests because, by revealing the HIV-positive ("seropositive") status of the newborn, the seropositive status of the mother is also revealed.⁷ Thus far, the civil liberties and privacy interests of the mothers have been deemed to outweigh the potential benefits of early treatment for the children.⁸

Recent advances in medical treatments, however, have shifted the balance between these competing interests. In the past few years, for example, effective treatments have become available for *pneumocystis carinii* pneumonia ("PCP"), one of the prime killers of children with AIDS. Both the United States Centers for Disease Control ("CDC") and the New York State Department of Health ("NYSDOH") have recommended that treatment for PCP be administered early, beginning in the first month of a newborn's life, to be most effective.⁹

In March 1993, Assemblywoman Nettie Mayersohn of Queens introduced a bill in the New York State Assembly that would require the results of newborn HIV tests to be released to the parents of the tested newborns.¹⁰ Because of its contro-

⁵ Symptoms associated with HIV infection include pneumonia, swollen lymph glands, persistent diarrhea and failure to thrive. GERALD J. STINE, *ACQUIRED IMMUNE DEFICIENCY SYNDROME: BIOLOGICAL, MEDICAL, SOCIAL, AND LEGAL ISSUES* 113 (1993).

⁶ *Id.* at 317. New York began blinded newborn testing for HIV in 1987. When a blinded test is performed on a newborn, the newborn's name is removed from his or her blood sample and replaced with a bar code, leaving only hospital information and the newborn's demographic data on the sample. After the newborn's name is removed, it is impossible to trace the test result back to the newborn. *Id.*

⁷ See *infra* notes 26-41 and accompanying text.

⁸ PREVENTABLE CRISIS, *supra* note 2, at 15; *AIDS Babies Pay the Price*, *supra* note 4, at A26; Nan D. Hunter, *Complications of Gender: Women and HIV Disease*, in *AIDS AGENDA: EMERGING ISSUES IN CIVIL RIGHTS* 5, 23-27 (Nan D. Hunter & William B. Rubenstein eds., 1992).

⁹ PREVENTABLE CRISIS, *supra* note 2, at 14, 19-20 & nn.25-27; see *infra* note 150.

¹⁰ New York State Assembly Bill No. 6747, 215th Gen. Assembly, 1st Sess. (1993). This bill was subsequently amended in June 1993, March 1994 and April

versial nature, the bill has remained stalemated in the Assembly Health Committee since its introduction.¹¹

This Note argues that, given the current availability of effective treatments for newborns infected with HIV, unblinded mandatory testing is supported by state informed-consent principles, federal constitutional principles, and policy considerations. Accordingly, this Note urges the New York State Assembly to pass Assemblywoman Mayersohn's bill when it is presented again.

In Parts I and II, this Note provides the pertinent medical and legal background, respectively, for analyzing the issues related to HIV. Part III analyzes the right of a mother to give informed consent to an HIV test for her child and argues that the benefits of early detection and treatment for a newborn provide a basis for overriding this right of informed consent. Part IV assesses the need for mandatory testing, in light of the failure of voluntary testing, and favorably balances the benefits of such testing against the costs. Part V then analyzes the Fourth Amendment, equal protection and privacy issues implicated by unblinded mandatory newborn testing for HIV and concludes that such testing is constitutional. Finally, Part VI critically analyzes Assemblywoman Mayersohn's bill and suggests how it should be improved.

I. MEDICAL BACKGROUND

A. *The Nature of HIV Infection*

HIV is the virus that causes AIDS.¹² Although it has be-

1994. The latest version is New York State Assembly Bill No. 6747-C, 215th Gen. Assembly, 1st Sess. (1994).

¹¹ Last year, the bill was blocked by a narrow ten-to-nine vote. John Riley, *Testing Newborns For AIDS Debated*, N.Y. NEWSDAY, Nov. 11, 1993, at 22. This year, the bill was blocked by an even nine-to-nine vote. Jim Dwyer, *You Call This A Compromise?*, N.Y. NEWSDAY, July 4, 1994, at A2. The bill has been so controversial that Senator Michael Tully of Port Washington removed the Senate version from the Senate Health Committee's agenda, preventing that committee from voting on their version. *Id.* Nonetheless, if Assemblywoman Mayersohn is re-elected this year, she will introduce the bill again next year. Telephone Interview with William Viscovich, General Counsel to Assemblywoman Nettie Mayersohn, 27th Dist. of Queens (Aug. 8, 1994). See *infra* part VI. (discussing Assemblywoman Mayerson's proposed bill).

¹² STINE, *supra* note 5, at 44. There is a small minority in the scientific com-

come common to speak of the "spread of AIDS,"¹³ this phrase is misleading because it is HIV that is transmitted, not AIDS. AIDS is the term that describes the late stage of illness brought on by HIV infection.¹⁴

HIV (the human immunodeficiency virus) is so named because the virus attacks and destroys a person's CD4 cells—cells that play an essential role in the proper functioning of a person's immune system.¹⁵ These CD4 cells are a type of lymphocyte, or white blood cell. Together with other lymphocytes, they recognize foreign substances in the body (called antigens) and attempt to eliminate them by producing special proteins (called antibodies) that either destroy the antigens or mark them for destruction by other cells.¹⁶ When the CD4 cells themselves are destroyed, the ability of the body's immune system to produce antibodies, and thus the body's ability to defend itself against antigens, is impaired.¹⁷

munity that does not believe HIV is the causative agent of AIDS. *Id.* at 41. One of the most vocal and well-known of these critics is Peter Duesberg, a molecular biologist at the University of California at Berkeley and a member of the National Academy of Sciences, who believes that factors such as drug abuse and malnutrition—not HIV—cause AIDS. *Id.* Other scientists, including Luc Montagnier, the codiscoverer of HIV, have taken the more moderate position that there are certain bacterial cofactors that are necessary to activate HIV. Lamar Graham, *The Heretic*, GENTLEMEN'S Q., Nov. 1993, at 242, 269. After years of research on this issue, one scientist has written a book detailing what he believes are the shortcomings of the HIV theory. ROBERT S. ROOT-BERNSTEIN, *RETHINKING AIDS: THE TRAGIC COST OF PREMATURE CONSENSUS* (1993). Nonetheless, most scientists believe that the high correlation between HIV infection and the development of AIDS is compelling evidence that HIV is the cause of AIDS. STINE, *supra* note 5, at 41-44.

¹³ See, e.g., *Only ABC Has Used Them: Gov't Condom Ads Seldom Used*, N.Y. NEWSDAY, Jan. 28, 1994, at 81 ("Federal Health officials made front-page news earlier this month with the unveiling of a new series of TV commercials that for the first time frankly advocate the use of latex condoms to prevent the spread of AIDS.") (emphasis added); Deborah Wallace, *Regional Plan Needed To Stop AIDS Spread*, N.Y. NEWSDAY, Feb. 1, 1994, at 73 ("A great reform . . . must be undertaken if we are to deal with the spread of AIDS in the New York metropolitan area.") (emphasis added).

¹⁴ STINE, *supra* note 5, at 33-35; 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, 329 n.10 (1991).

¹⁵ STINE, *supra* note 5, at 35; Eisenstat, *supra* note 14, at 329. CD4 cells are also called T4 helper cells. STINE, *supra* note 5, at 6 (Table 1-1).

¹⁶ STINE, *supra* note 5, at 5.

¹⁷ STINE, *supra* note 5, at 35. Once a person is infected with HIV, the progression of the disease may be monitored by tracking the person's CD4 cell count. Nancy Wade, *Immunologic Considerations in Pediatric HIV Infection*, 119 J. PEDI-

As the HIV infection progresses, and the body's immune system becomes weaker, HIV-infected persons become susceptible to opportunistic infections. Opportunistic infections refer to infections from fungi, bacteria and viruses (other than HIV) that are typically present in the body, but are normally non-pathogenic because the immune system is capable of controlling them.¹⁸ These opportunistic infections cause the death of the great majority of HIV-infected individuals.¹⁹

B. *Transmission of HIV in Children*

In adults, HIV is usually transmitted in one of three ways: through sexual contact with infected persons, through the receipt of contaminated blood transfusions, or through the use of shared contaminated intravenous needles.²⁰ In contrast, the leading mode of infection in children,²¹ accounting for 93% of the cases, is perinatal transmission from infected women.²²

ATRICS S5, S5 (1991).

¹⁸ STINE, *supra* note 5, at 12.

¹⁹ STINE, *supra* note 5, at 71 ("About 88% of deaths related to HIV infection and AIDS are caused by [opportunistic infections], compared with 7% due to cancer and 5% due to other causes.") (statistics are for the general population of HIV-infected persons); Margaret H. Burroughs & Paul J. Edelson, *Medical Care of the HIV-Infected Child*, 38 PEDIATRIC CLINICS N. AM. 45 (1991).

Opportunistic infections are the cause of death in more than 60% of patients. The case fatality rate after diagnosis of an opportunistic infection is 85%. Seventy-five percent of children who develop an opportunistic infection will not survive longer than a year. . . . [O]pportunistic infections and not HIV infection per se are the cause of death in HIV-infected children.

Id. at 63 (statistics are for pediatric HIV cases).

²⁰ Eisenstat, *supra* note 14, at 330-31.

²¹ The CDC defines pediatric AIDS cases as those cases occurring in children under 13 years of age. CENTERS FOR DISEASE CONTROL AND PREVENTION, HIV/AIDS SURVEILLANCE REP., July 1993, at 18 [hereinafter CDC SURVEILLANCE]. Unless otherwise stated, reference to children in this Note should be understood to refer to children under 13 years of age.

²² NEW YORK STATE AIDS ADVISORY COUNCIL, REPORT OF THE SUBCOMMITTEE ON NEWBORN HIV SCREENING 5 (1994) [hereinafter SUBCOMMITTEE REPORT]; see STINE, *supra* note 5, at 249 ("Eventually, 99% of newborn AIDS cases will result from parental transmission."); Working Group on Antiretroviral Therapy, National Pediatric HIV Resource Center, *Antiretroviral Therapy and Medical Management of the Human Immunodeficiency Virus-Infected Child*, 12 PEDIATRIC INFECTIOUS DISEASE J. 513, 514 (1993) [hereinafter *Medical Management of HIV*] ("essentially all new cases of HIV infection in young children occur as a result of maternal to infant transmission"); Burroughs & Edelson, *supra* note 19, at 45 (among the cases

Perinatal HIV infection can occur either *in utero* (similar to perinatally transmitted rubella) or at the time of delivery, when the infant is exposed to large volumes of infected fluids (similar to perinatally transmitted hepatitis B). Fortunately, not all infants born to infected mothers will become infected themselves. Studies have shown that the rate of perinatal transmission is approximately one-in-three, with estimates ranging from 15 to 39%.²³

Nevertheless, even when infants born to infected mothers are not perinatally infected, they are still at risk for other modes of infection. For example, an infant may become infected through breastfeeding.²⁴ As a result, both the CDC and the NYSDOH currently recommend that HIV-infected mothers avoid breastfeeding their children.²⁵

C. HIV Testing Methods

Pediatric HIV is diagnosed in one of two ways: a child either displays symptoms associated with the infection or tests positive for HIV by a Federal Drug Administration ("FDA")-approved testing method.²⁶ Currently, the most widely available tests are the Enzyme-Linked Immunosorbent Assay ("ELISA") and the Western blot. These tests do not detect the presence of HIV, but instead detect the presence of antibodies to HIV. Adults usually develop antibodies to HIV ("seroconversion") within six to twelve weeks after exposure to

of pediatric AIDS collected by the CDC through April 1990, 82% of children nationally were infected perinatally; as of April 1990, New York City Department of Health surveillance data showed 88% of pediatric AIDS cases in New York City were perinatally transmitted).

²³ Compare SUBCOMMITTEE REPORT, *supra* note 22, at 9 (estimate of 15% to 25%) with Burroughs & Edelson, *supra* note 19, at 46 (estimate of 21% to 39%). Burroughs and Edelson point out that the "[e]stimates of transmission in general favor children with lower incubation periods and, thus, probably underestimate the true rate of transmission." *Id.* On the other hand, Martha Field, a professor of law at Harvard Law School and a well-respected commentator on women's and children's issues, points out that the transmission rate has dropped over time and that some believe that the current rate of 30% is too high. Martha A. Field, *Pregnancy and AIDS*, 52 MD. L. REV. 402, 406 n.12 (1993).

²⁴ Burroughs & Edelson, *supra* note 19, at 46; Field, *supra* note 23, at 407.

²⁵ See Hermann Mendez, *Ambulatory Care of HIV-Seropositive Infants and Children*, 119 J. PEDIATRICS S14, S17 (1991); *Medical Management of HIV*, *supra* note 22, at 520.

²⁶ See STINE, *supra* note 5, at 317.

the virus. Some infected persons, however, may not develop detectable antibodies for as long as eighteen months.²⁷ Although these infected persons will test negative until seroconversion occurs, they are capable of transmitting the virus prior to seroconversion.²⁸

Properly performed, the ELISA and Western blot tests are highly accurate. These tests have a sensitivity (the percentage of infected persons who actually test positive) and a specificity (the percentage of uninfected persons who actually test negative) of greater than 99%.²⁹ In addition, to safeguard against a false positive result (a positive test result for an uninfected person), a person is usually considered HIV-positive only after positive results from two ELISA tests and one confirmatory Western blot test.³⁰ It is expected that future improvements to these tests will further increase their accuracy.³¹

Although these antibody tests have been used with great success in adults, the use of these tests in newborn infants has been problematic. Because newborns acquire their mothers' antibodies at birth, all infants born to seropositive mothers will test positive to an HIV-antibody test even though they are not themselves infected with the virus. The median time for loss of these maternal antibodies by infants ("seroreversion") has been estimated to be seven to ten months, but it may take as long as fifteen to sixteen months.³² Any diagnosis before

²⁷ Stephen Arpadi & William B. Caspe, *HIV Testing*, 119 J. PEDIATRICS S8, S8 (1991).

²⁸ Eisenstat, *supra* note 14, at 332.

²⁹ Arpadi & Caspe, *supra* note 27, at S9.

³⁰ STINE, *supra* note 5, at 294; Arpadi & Caspe, *supra* note 27, at S9. The false positive rate is related to the specificity and varies inversely with the seroprevalence rate of the tested population. The seroprevalence rate is the number of people infected with HIV per 1000. As the seroprevalence rate increases, the false positive rate decreases. See STINE, *supra* note 5, at 296; Eisenstat, *supra* note 14, at 332-33 & n.38. Some commentators have noted that testing a population with a low seroprevalence rate would be a problem because of the correspondingly high false positive rate. See STINE, *supra* note 5, at 296; Eisenstat, *supra* note 14, at 332-33 & n.38. Newborn testing in New York would not suffer from this difficulty because the HIV seroprevalence rate of these newborns is the highest in the country. Marta Gwinn et al., *Prevalence of HIV Infection in Childbearing Women in the United States*, 265 JAMA 1704, 1704 (1991); Lloyd F. Novick et al., *HIV Seroprevalence in Newborns in New York State*, 261 JAMA 1745, 1745 (1989).

³¹ Arpadi & Caspe, *supra* note 27, at S9.

³² COMMITTEE ON INFECTIOUS DISEASES, AMERICAN ACADEMY OF PEDIATRICS,

this time by an ELISA or Western blot test reveals only the infants who are potentially infected, not those who are truly infected.

Because of the shortcoming of the ELISA and Western blot tests, several other techniques have been developed that are useful in the early detection of the infection in newborns. While these techniques are not yet as widely available as the ELISA or Western blot, they are rapidly becoming more popular. One of these techniques, called the polymerase chain reaction ("PCR") test, is used to amplify small quantities of HIV DNA to a level at which it can be detected. The PCR test is so sensitive that it can detect one molecule of HIV DNA in ten microliters of blood.³³ Moreover, the PCR test produces no false positive results, can identify greater than 90% of infected infants by three months of age, and takes only a few days to perform.³⁴ For these reasons, the PCR test is quickly becoming the preferred method of early diagnosis in newborns.³⁵

Another technique for early detection of HIV infection in infants is called the p24 antigen test. This test detects p24, a protein found in the core of HIV.³⁶ Originally, this test had a very low sensitivity when performed on infants less than one month old,³⁷ but in a recent study that used a simple variation on the test, the test succeeded in correctly identifying the HIV infection status of 100% of infants tested by three weeks of age.³⁸ This recently modified p24 antigen test promises to

REPORT ON THE COMMITTEE OF INFECTIOUS DISEASES 121 (George Peter et al. eds., 22d ed. 1991); Arpadi & Caspe, *supra* note 27, at S8; Burroughs & Edelson, *supra* note 19, at 47.

³³ STINE, *supra* note 5, at 302.

³⁴ See Field, *supra* note 23, at 424 n.82 (PCR can detect greater than 90% of infected infants by three to six months of age); *HIV Detected in Babies as Young as One Month of Age*, AIDS ALERT, Jan. 1993, at 9 (PCR can detect 50% of infected infants during the first week of life, 70% of infected infants by three weeks of life, 95% of infected infants by three months of life, and 100% of infected infants after six months of life).

³⁵ Field, *supra* note 23, at 424 n.82 ("The PCR is likely soon to become the preferred method of early diagnosis. It is already becoming more widely used and can be performed by some commercial laboratories. Within the year, a kit for HIV diagnosis using PCR is likely to be available.").

³⁶ STINE, *supra* note 5, at 103-04; Field, *supra* note 23, at 424 n.82.

³⁷ See Marianne Burgard et al., *The Use of Viral Culture and P24 Antigen Testing to Diagnose Human Immunodeficiency Virus Infection in Neonates*, 327 NEW ENG. J. MED. 1192, 1194 (1992) (the sensitivity of the p24 antigen test at birth was only 18%).

³⁸ Steven A. Miles et al., *Rapid Serologic Testing With Immune-Complex-Disso-*

be an accurate, inexpensive and rapid diagnostic technique for HIV infection in newborns.³⁹

A third test, called the IgA test, is similar to the ELISA and Western blot tests in that it detects antibodies to HIV. Unlike the other two antibody tests, however, the IgA test detects antibodies that do not cross the placenta.⁴⁰ With the IgA test, 66% of newborns can be identified before three months of age and close to 99% of newborns can be identified before six months of age.⁴¹

D. Treatments Available for HIV-Infected Children

Although there is as yet no cure for HIV infection, there are a variety of treatments today that will enhance the duration and the quality of life of an infected child.⁴² Moreover,

ciated HIV P24 Antigen For Early Detection of HIV Infection in Neonates, 328 NEW ENG. J. MED 297, 299-300 (1993). This study tested twenty-nine infants. The researchers took a blood sample from the umbilical cord of each infant at birth and a follow-up blood sample from each infant before his or her three-week birthday. *Id.* The testing conducted on the umbilical cords produced only a sensitivity of 63% and a specificity of 91%, but the testing conducted on the follow-up samples correctly identified the HIV infection status of all of the newborns (sensitivity and specificity of 100%). *Id.*

³⁹ *Id.* at 301; *Test Determines HIV Status of Infants at Early Stage*, AIDS WEEKLY, Feb. 8, 1993, at 7 (test could be performed by any commercial lab in the United States and would cost only about \$80).

⁴⁰ STINE, *supra* note 5, at 306-07; Field, *supra* note 23, at 425 n.82. IgA refers to the type of antibody tested. Even though there are an endless variety of antigens, there are only five general types of antibodies—gamma (IgG), mu (IgM), alpha (IgA), delta (IgD), and epsilon (IgE). STINE, *supra* note 5, at 15. The ELISA and Western blot tests detect the presence of the IgG antibody, which has the unfavorable characteristic (for newborn testing purposes) of crossing the placenta. *Id.* at 306-07.

⁴¹ STINE, *supra* note 5, at 306-07.

⁴² See PREVENTABLE CRISIS, *supra* note 2, at 16 ("In [the view of the Association to Benefit Children] there are now effective treatments for pediatric HIV that can 'substantially ameliorate the disease for the child,' if not yet cure the *in utero* child and its mother. . . ."); SUBCOMMITTEE REPORT, *supra* note 22, at 32 ("It is clear that significant improvements in quality and possibly length of life, especially as a result of PCP prevention, can be achieved once an infant is identified and under medical supervision."); STINE, *supra* note 5, at 113 ("Few children infected as fetuses live beyond two years and survival past three years used to be rare; but with better therapy now available, some children born with HIV are still alive at five, 10 and 12 years old."); *Medical Management of HIV*, *supra* note 22, at 513-14 ("Childhood infection with [HIV], like certain childhood cancers, cystic fibrosis, diabetes, sickle cell disease and other chronic illnesses, is incurable but not untreatable. A variety of interventions are now available which have been shown

the literature is nearly unanimous in recognizing that early diagnosis and intervention is essential in maximizing the benefits of available treatments.⁴³ These benefits include the ad-

to improve the quality and duration of life for HIV-infected children and new advances are continuing.”); Burroughs & Edelson, *supra* note 19, at 61 (“Although there is currently no cure for pediatric HIV disease, early recognition and improved medical care have changed the face of pediatric HIV disease from an acutely fatal illness to a chronic disease of childhood.”); *see also* Fredrick Z. Bierman, *Guidelines for Diagnosis and Management of Cardiac Disease in Children with HIV Infection*, 119 J. PEDIATRICS S53 (1991); Carolyn Butler et al., *Approach to Neurodevelopmental and Neurologic Complications in Pediatric HIV Infection*, 119 J. PEDIATRICS S41 (1991); Sarmistha B. Hauger, *Approach to the Pediatric Patient with HIV Infection and Pulmonary Symptoms*, 119 J. PEDIATRICS S25 (1991); Margaret Hilgartner, *Hematologic Manifestations in HIV-Infected Children*, 119 J. PEDIATRICS S47 (1991); Keith Krasinski, *Retroviral Therapy and Clinical Trials for HIV-Infected Children*, 119 J. PEDIATRICS S63 (1991); Stephen W. Nicholas et al., *Guidelines for Nutritional Support of HIV-Infected Children*, 119 J. PEDIATRICS S59 (1991); Stephen W. Nicholas, *Management of the HIV-Positive Child with Fever*, 119 J. PEDIATRICS S21 (1991); Keith R. Powell, *Approach to Gastrointestinal Manifestations in Infants and Children with HIV Infection*, 119 J. PEDIATRICS S34 (1991); Neil Prose, *Guidelines for Treatment of Skin Diseases in Children with HIV Infection*, 119 J. PEDIATRICS S57 (1991). *But cf.* Working Group on HIV Testing of Pregnant Women and Newborns, *HIV Infection, Pregnant Women, and Newborns—A Policy Proposal for Information and Testing*, 264 JAMA 2416, 2418-19 (1990) [hereinafter *HIV Infection, Pregnant Women, and Newborns*] (although medical benefits for 30% of newborns who are infected are significant, “benefit-to-harm calculus” may tip in the opposite direction for 70% of newborns who are not infected).

⁴³ Burroughs & Edelson, *supra* note 19, at 63 (“[P]rophylaxis, early recognition, and improved treatment of opportunistic infections are likely to improve the survival of HIV-infected children.”); Miles et al., *supra* note 38, at 297 (“Because early intervention with antiretroviral therapy can substantially decrease the risk of opportunistic infections and may improve the survival of patients with HIV infection, the rapid determination of whether a child is infected with HIV is important.”) (footnotes omitted); R.J. Simonds et al., *Pneumocystis Carinii Pneumonia Among US Children With Perinatally Acquired HIV Infection*, 270 JAMA 470, 473 (1993) (“Thus, effective efforts to prevent PCP in HIV-infected children will require early identification of potentially infected children, either by diagnosis of maternal HIV infection before birth or by identification of the HIV-exposed infant as soon as possible after birth.”); Larry Wissow & Nancy Hutton, *Testing Newborns for Exposure to Human Immunodeficiency Virus (HIV): Not Mandatory but Highly Recommended*, 2 PEDIATRIC AIDS & HIV INFECTION 123, 125 (1991) (“There are clear benefits to children if identified early in the course of HIV infection.”); *Medical Management of HIV*, *supra* note 22, at 514 (“[T]he HIV infection status of the infant must be determined as soon as possible after birth.”); *HIV Infection, Pregnant Women, and Newborns*, *supra* note 42, at 2418-19 (“[W]e are persuaded that for the approximately 30% of newborns who are infected, the prospects for medical benefits are significant and would be enhanced by early identification of ‘at risk’ status.”); Letter from Nilsa Gutierrez, Medical Director of NYSDOH, to the Health Care Community 1 (Feb. 1993) (“The enclosed protocols emphasize early medical intervention as essential to the improvement of both survival and quality of life.”)

ministration of prophylaxis, antiretroviral drugs, intravenous immunoglobulin, specialized immunization schedules and close nutritional monitoring.

An early HIV diagnosis in children is of major benefit because it permits the prompt application of prophylaxis for various opportunistic infections including PCP, tuberculosis, varicella, meningitis, *mycobacterium avium* complex and thrush.⁴⁴ Of these, PCP is by far the most common and serious opportunistic infection that afflicts children infected with HIV. One recent study conducted by the CDC's Division of HIV/AIDS reported that PCP occurred in 37% of the perinatally acquired AIDS cases collected by the CDC.⁴⁵ As of the date of the study, 67% of the children infected with PCP had died and the estimated median survival after diagnosis was a short nineteen months.⁴⁶ The study reported that most children contract PCP at a very early age: 53% of all perinatally acquired AIDS cases with PCP occurred in children three to six months of age. Furthermore, the study estimated that the risk of contracting PCP by an HIV-infected child was 7 to 20% in the first year of life.⁴⁷ These horrifying statistics demonstrate the urgency of identifying infected infants and administering effective prophylaxis as early as possible.⁴⁸

(on file with author).

⁴⁴ *Medical Management of HIV*, *supra* note 22, at 521 (Table 6).

⁴⁵ Simonds et al., *supra* note 43, at 471.

⁴⁶ Simonds et al., *supra* note 43, at 471-72. Interestingly, this study found that the median survival for children diagnosed with PCP after 1990 (21 months) was longer than for those diagnosed with PCP before 1990 (12 months). *Id.* at 472. The survival period for children diagnosed before 1990 was closer to the survival period of one to eight months that had been reported in earlier studies. *Id.* at 473. The authors of this study suggest that the longer survival period for the children diagnosed after 1990 indicates that PCP is being successfully diagnosed and treated earlier and that the use of antiretroviral therapy has become more widespread. *Id.* If this is indeed the case, then it is further evidence of the value of early intervention.

⁴⁷ Simonds et al., *supra* note 43, at 471-72.

⁴⁸ Simonds et al., *supra* note 43, at 473. PCP prophylaxis is not administered to all infants because it produces adverse reactions in some patients. For this reason, prophylaxis is administered only after a child tests positive for HIV and his or her CD4 cell count drops below a level at which the child is considered vulnerable to opportunistic infections. See AIDS INST., NYSDOH, HIV MEDICAL EVALUATION AND PREVENTATIVE CARE FOR CHILDREN 5 (1993) (Table 3) [hereinafter AIDS INST., MEDICAL EVALUATION]; *Medical Management of HIV*, *supra* note 22, at 515; Centers for Disease Control and Prevention, *Guidelines for Prophylaxis Against Pneumocystis Carinii Pneumonia for Children Infected With Human Immu-*

An early diagnosis of pediatric HIV infection also provides the opportunity to administer antiretroviral drugs sooner. These drugs, the most popular of which is zidovudine ("ZDV"),⁴⁹ have been shown to delay the progression of HIV infection, decrease the frequency of opportunistic infections, and improve cognitive and neurological functions in adults.⁵⁰ It is not known whether ZDV will prolong survival for children as it has in adults, but studies indicate that ZDV treatment improves children's appetites, weight gain and CD4 cell counts.⁵¹ Most importantly, ZDV significantly improves the mental and cognitive development of children.⁵² In one investigation, two-thirds of the children studied showed mental deterioration after HIV infection.⁵³ With ZDV treatment, all of the children improved. In fact, one child whose IQ had fallen to twenty-eight points after HIV infection improved to ninety-nine points after ZDV treatment.⁵⁴ Antiretroviral treatment has been recommended both for children who show symptoms of HIV infection⁵⁵ and for those who have low CD4 cell counts (indicating significant immunodeficiency).⁵⁶

odeficiency Virus, 265 JAMA 1637, 1640 (1991) [hereinafter *CDC Guidelines*].

⁴⁹ Formerly azidothymidine ("AZT").

⁵⁰ See AIDS INST., NYSDOH, ANTIRETROVIRAL THERAPY MANAGEMENT FOR ADULT AND PEDIATRIC PATIENTS 1 (1993) [hereinafter AIDS INST., ANTIRETROVIRAL THERAPY]; STINE, *supra* note 5, at 131-37. Between 1982 and 1989 in New York City, ZDV doubled the life expectancy of patients with AIDS. *Id.* at 132. ZDV has side effects, however, including nausea, rash, insomnia, vomiting, headaches, and severe loss of red blood cells that may require a blood transfusion. *Id.* at 133.

⁵¹ STINE, *supra* note 5, at 136. Moreover, the results from one recent clinical trial show that infants less than three months old can safely receive ZDV in doses considered sufficient for anti-HIV activity. *Phase-1 Evaluation of Zidovudine Administered to Infants Exposed at Birth to the Human Immunodeficiency Virus*, AIDS WEEKLY, Mar. 1, 1993, at 22.

⁵² AIDS INST., ANTIRETROVIRAL THERAPY, *supra* note 50, at 9; STINE, *supra* note 5, at 136; Pim Brouwers et al., *Effect of Continuous-Infusion Zidovudine Therapy on Neuropsychologic Functioning in Children with Symptomatic Human Immunodeficiency Virus Infection*, 117 J. PEDIATRICS 980 *passim* (1990).

⁵³ STINE, *supra* note 5, at 136.

⁵⁴ STINE, *supra* note 5, at 136.

⁵⁵ AIDS INST., ANTIRETROVIRAL THERAPY, *supra* note 50, at 9.

⁵⁶ *Medical Management of HIV*, *supra* note 22, at 515. The authors recommend that antiretroviral therapy be initiated slightly before PCP prophylaxis is initiated. For example, CDC guidelines indicate that for a child less than one year old PCP prophylaxis should be initiated when the child's CD4 cell count falls below 1500/mm³. The authors recommend that, in children of this age, antiretroviral therapy should begin when the CD4 cell count falls below 1750/mm³.

In addition to prophylactic and antiretroviral drugs, an early diagnosis of HIV infection in children permits a doctor to provide intravenous immunoglobulin ("IVIG") to infected children. IVIG is a drug containing antibodies that help boost a person's immune system.⁵⁷ Children using IVIG have shown a reduced occurrence of bacterial infection and a reduced need for hospitalization.⁵⁸

Another reason early identification of HIV infection in children is important is that the schedule of immunizations for infected children calls for significant modifications from the schedule for uninfected children. For example, the live or Sabin polio vaccine should be replaced with the inactivated, injectable Salk polio vaccine.⁵⁹ In addition, the influenza vaccine should be administered every two months until the infant is six months old and then should be administered annually.⁶⁰ Acceleration of the measles vaccination schedule is also warranted in high HIV seroprevalence areas, and increased frequency of the vaccine may also be warranted during measles season or during an outbreak of the disease.⁶¹ Furthermore, because some HIV-infected children do not respond to the measles vaccine, close supervision of these children is necessary and IVIG should be administered if the measles vaccine has no effect.⁶²

Finally, early identification of HIV infection in children makes possible close nutritional monitoring, an essential component of care for these children. HIV-infected children commonly suffer from metabolic and digestive problems that lead to growth problems, poor weight gain and malnutrition.⁶³ In

⁵⁷ STINE, *supra* note 5, at 136.

⁵⁸ STINE, *supra* note 5, at 136-37; *Medical Management of HIV*, *supra* note 22, at 520.

⁵⁹ AIDS INST., MEDICAL EVALUATION, *supra* note 48, at 6 (Table 4); *Medical Management of HIV*, *supra* note 22, at 520 (Table 5); Burroughs & Edelson, *supra* note 19, at 61-62.

⁶⁰ AIDS INST., MEDICAL EVALUATION, *supra* note 48, at 6 (Table 4); *Medical Management of HIV*, *supra* note 22, at 520 (Table 5); Burroughs & Edelson, *supra* note 19, at 62.

⁶¹ AIDS INST., MEDICAL EVALUATION, *supra* note 48, at 6 (Table 4); *Medical Management of HIV*, *supra* note 22, at 520 (Table 5); *Monitor Serostatus to Prevent Measles in Vaccinated Children*, AIDS ALERT, Jan. 1993, at 8.

⁶² *Medical Management of HIV*, *supra* note 22, at 520; *Monitor Serostatus to Prevent Measles in Vaccinated Children*, *supra* note 61, at 8.

⁶³ AIDS INST., NYSDOH, NUTRITION IN HIV INFECTION 1 (1993) [hereinafter

turn, these problems may lead to a reduction of a child's functional ability and a diminishment of his or her immunity.⁶⁴ Close nutritional monitoring is important to prevent these problems. In addition, close nutritional monitoring is important because HIV-infected children are at a greatly increased risk of infection from contaminated food. Thus, infected children should avoid undercooked eggs, meat and fish and should avoid unpasteurized milk products.⁶⁵ For this reason, parents of HIV-infected children must be educated on clean preparation techniques and careful storage of leftovers.⁶⁶ Utilizing these precautions greatly diminishes an infected child's risk of infection from food.

In short, current treatments for HIV-infected children are of significant benefit to these children. The availability of these treatments strongly support early identification of HIV infection in children. Nonetheless, while the medical benefits are clear, a determination of the appropriateness of mandatory newborn testing is clouded by complex legal and social issues.

II. CURRENT LAW RELATED TO HIV TESTING

A. *Informed Consent*

Under the law of every state, a patient must give informed consent prior to the initiation of any non-emergency medical procedure.⁶⁷ The right to medical consent derives from the common law right to bodily integrity and self-determination.⁶⁸ In New York, Judge Cardozo is credited with first recognizing such a right in *Schloendorff v. Society of New York Hospi-*

AIDS INST., NUTRITION]; Burroughs & Edelson, *supra* note 19, at 62-63.

⁶⁴ AIDS INST., NUTRITION, *supra* note 63, at 1.

⁶⁵ AIDS INST., NUTRITION, *supra* note 63, at 5; Burroughs & Edelson, *supra* note 19, at 62-63.

⁶⁶ AIDS INST., NUTRITION, *supra* note 63, at 5.

⁶⁷ See 61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* § 187 & n.77 (1981). In New York, see N.Y. PUB. HEALTH LAW §§ 2504, 2805-d (McKinney 1993).

⁶⁸ See Catherine M. V. Barrad, *Genetic Information and Property Theory*, 87 NW. U. L. REV. 1037, 1063 (1993); Suzanne Sangree, *Control of Childbearing by HIV-Positive Women: Some Responses to Emerging Legal Policies*, 41 BUFF. L. REV. 309, 364 (1993); Sharon N. Perley, Note, *From Control Over One's Body to Control Over One's Body Parts: Extending the Doctrine of Informed Consent*, 67 N.Y.U. L. REV. 335, 338 (1992).

tals,⁶⁹ when he wrote: "Every human being of adult years and sound mind has a right to determine what shall be done with his [or her] own body."⁷⁰ Consequently, a doctor must disclose all pertinent information to a patient so that the patient may knowledgeably choose which course of action is best for him or her. This right entitles a person to refuse medical treatment even when that treatment is necessary to preserve a person's life.⁷¹

Currently, thirty states recognize that testing for HIV infection requires informed consent.⁷² In New York, the legislature enacted an independent article of the Public Health Law—Article 27-F⁷³—to address HIV testing. Among its requirements, Article 27-F prohibits the performance of an HIV test without a signed, written statement of consent that includes at least an explanation of the test, the procedures to be followed, and the confidentiality of the result.⁷⁴ In addition, New York requires a test administrator to provide counseling to the subject of an HIV test before performing the test. Such counseling must include information on the nature of the HIV illness, the methods of transmission of HIV, the potential stigmatizing effect and discriminatory consequences of a positive result, and the availability of anonymous testing.⁷⁵

⁶⁹ 211 N.Y. 125, 105 N.E. 92 (1914).

⁷⁰ *Id.* at 129, 105 N.E. at 93. For similar language in other leading cases, see *Pratt v. Davis*, 79 N.E. 562 (Ill. 1906), and *Mohr v. Williams*, 104 N.W. 12 (Minn. 1905).

⁷¹ *Sangree*, *supra* note 68, at 365; *Perley*, *supra* note 68, at 338-39. In one case, for example, a Jehovah's Witness who had just given birth by a Caesarean-section operation was allowed to refuse an essential blood transfusion. *Fosmire v. Nicoleau*, 75 N.Y.2d 218, 551 N.E.2d 77, 551 N.Y.S.2d 876 (1990).

⁷² See *Sangree*, *supra* note 68, at 446-47 (Table II; listing statutes in states requiring informed consent for HIV-related testing).

⁷³ N.Y. PUB. HEALTH LAW §§ 2780-2787 (McKinney Supp. 1993) (effective Feb. 1, 1989). See *infra* note 236 for the text of § 2782 of Article 27-F.

⁷⁴ N.Y. PUB. HEALTH LAW § 2781(1)-(2) (McKinney Supp. 1993). For other states that require written consent, see ALA. CODE § 22-11A-51 (Supp. 1992); ARIZ. REV. STAT. ANN. § 36-663 (Supp. 1993); CAL. HEALTH & SAFETY CODE § 199.22 (West 1990); HAW. REV. STAT. § 325-16 (Supp. 1992); ILL. ANN. STAT. ch. 410, para. 305/4 (Smith-Hurd 1993); LA. REV. STAT. ANN. § 40:1300.13 (West Supp. 1992); MICH. COMP. LAWS ANN. § 333.5133 (West Supp. 1991); MONT. CODE ANN. § 50-16-1007 (1991); PA. STAT. ANN. tit. 35, § 7605 (1993); WIS. STAT. ANN. § 146.025 (West Supp. 1991).

⁷⁵ N.Y. PUB. HEALTH LAW § 2781(3)-(4) (McKinney Supp. 1993). For other states that require pre-test counseling, see MICH. COMP. LAWS ANN. § 333.5133 (West Supp. 1991); MONT. CODE ANN. § 50-16-1007(3) (1991); PA. STAT. ANN. tit.

Although the requirements for informed consent under Article 27-F are strict, there are exceptions. Informed consent is not necessary for testing conducted on human body parts used in transplants or research, testing conducted for the purpose of autopsies, testing conducted in connection with legal actions in which the physical condition or blood relationship of a party is in controversy, and testing conducted anonymously for the purpose of research.⁷⁶ Generally, the New York courts have narrowly interpreted these exceptions.⁷⁷

35, § 7605(b) (1993).

New York also requires post-test counseling or counseling referrals to any person who tests HIV-positive. Such counseling is provided:

- (a) for coping with the emotional consequences of learning the result; (b) regarding the discrimination problems that disclosure of the result could cause; (c) for behavior change to prevent transmission or contraction of HIV infection; (d) to inform such person of available medical treatments; and (e) regarding the test subject's need to notify his or her contacts.

N.Y. PUB. HEALTH LAW § 2781(5) (McKinney Supp. 1993). For other states that require post-test counseling, see ALA. CODE § 22-11A-53 (Supp. 1992); FLA. STAT. ANN. § 381.004 (West Supp. 1993); MICH. COMP. LAWS ANN. § 333.5133 (West Supp. 1991); MONT. CODE ANN. § 50-16-1007(3) (1991); OHIO REV. CODE ANN. § 3701.242(C) (Baldwin Supp. 1992); PA. STAT. ANN. tit. 35, § 7605(e) (1993).

⁷⁶ N.Y. PUB. HEALTH LAW § 2781(1), (6) (McKinney 1993). The last exception is the one that permits the current, blinded newborn testing program. In comparison to laws in other states, New York State's HIV informed-consent statute has few exceptions. For example, New York does not allow involuntary testing of prison inmates, see ALA. CODE § 22-11A-17 (Supp. 1991); CAL. PENAL CODE § 7511 (West 1990); CONN. GEN. STAT. ANN. § 19a-582 (West. Supp. 1993); GA. CODE ANN. § 42-5-52.1 (1991); KY. REV. STAT. ANN. § 197.055 (Baldwin 1991 & Supp. 1992); MD. CODE ANN., HEALTH GEN. § 18-338 (1990 & Supp. 1992); R.I. GEN. LAWS § 42-56-37 (Supp. 1991); TEX. CRIM. PROC. CODE ANN. § 46A.01 (West Supp. 1994); UTAH CODE ANN. § 64-13-36 (Supp. 1992); persons charged or convicted of assault on law enforcement officers and firefighters, see ARIZ. REV. STAT. ANN. § 16-82-102 (Supp. 1992); CAL. HEALTH & SAFETY CODE § 199.97 (West Supp. 1993); or persons whose bodily fluids have come into contact with those of a health care worker, law enforcement officer or firefighter, see WASH. REV. CODE § 70.24.105(2)(h) (1992); WIS. STAT. ANN. § 146.025(5) (Supp. 1993). In addition, New York does not allow doctors to test patients without informed consent, as a few states do, when it is "medically indicated to provide appropriate diagnosis and treatment." See ARK. CODE ANN. § 20-15-905 (Michie 1993); ILL. ANN. STAT. ch. 410, para. 305/8 (Smith-Hurd 1993).

⁷⁷ See *Doe v. Connell*, 179 A.D.2d 196, 583 N.Y.S.2d 707 (4th Dep't 1992) (county court had no authority under Article 27-F to order defendant charged with rape and sodomy to submit to HIV test and to order disclosure of results to victim and her husband); *In re Harry G.*, 157 Misc. 2d 959, 960, 599 N.Y.S.2d 425, 426 (Fam. Ct. 1993) (denying application in child abuse proceeding to order person charged with sexually abusing minor to submit to HIV test; "A Court's power to order an HIV related test is limited."), *aff'd sub nom. In re Michael "WW"*, 611 N.Y.S.2d 47 (App. Div. 3d Dep't 1994). For cases before the enactment of Article

27-F in which courts refused to order parties to be involuntarily tested for HIV, see *Doe v. Roe*, 139 Misc. 2d 209, 526 N.Y.S.2d 718 (Sup. Ct. 1988) (showing of need for HIV test of father in custody action was insufficient where, even if father had AIDS, such condition would not justify removing children from his custody); *Anne D. v. Raymond D.*, 139 Misc. 2d 718, 528 N.Y.S.2d 775 (Sup. Ct. 1988) (husband's mere allegations that wife engaged in extramarital affairs not sufficient showing to order HIV testing of wife).

Both before and after the enactment of Article 27-F, courts have struggled with cases involving defendants charged with assault or rape. Before Article 27-F, courts generally applied a balancing approach to these cases. For example, in *People v. Thomas*, 139 Misc. 2d 1072, 529 N.Y.S.2d 429 (County Ct. 1988), a case involving a defendant charged with rape, the court explained:

Considering the equities of this entire situation, this Court holds and determines that the victim has a right to know whether she may have been exposed to the AIDS virus by reason of having been exposed to the body and sexual fluids of the defendant. This Court finds and determines that it has inherent discretionary power to order the defendant to submit to such a blood test simply because it is the intelligent, humane, logical, and proper course of action under the circumstances. The mental anguish suffered by the victim knowing that she was forcibly raped and sodomized by a former inmate of the New York State Department of Correctional Services is real and continuing, and the intrusion upon defendant of a routine drawing of a blood sample is very minimal and commonplace.

Id. at 1074-75, 529 N.Y.S.2d at 431; see also *People v. Cook*, 143 A.D.2d 486, 532 N.Y.S.2d 940 (3d Dep't 1988).

Although Article 27-F does not provide an exception to informed consent for the testing of defendants charged with assault or rape, courts nonetheless have ordered defendants to undergo HIV testing when that defendant communicates his or her HIV status to the victim of the assault or rape. In those situations, courts have found that the defendants' HIV status has become a material element of the crime or has been placed "in controversy." See *In re Anonymous*, 156 A.D.2d 1028, 549 N.Y.S.2d 308 (4th Dep't 1989) (affirming county court's order to compel defendant to provide blood sample to prosecutor where defendant was charged with attempted murder for attempting to infect three police officers with HIV by biting them), *aff'd*, 76 N.Y.2d 766, 559 N.E.2d 670, 559 N.Y.S.2d 976 (1990); *People v. Anonymous*, 153 Misc. 2d 436, 582 N.Y.S.2d 350 (County Ct. 1992) (ordering HIV test of defendant charged with assault who, while trying to avoid arrest, bit a security guard and a manager of a retail store and told them she was HIV-positive); *People v. Durham*, 146 Misc. 2d 913, 553 N.Y.S.2d 944 (Sup. Ct. 1990) (ordering HIV test of defendant who raped his victim and afterwards told her that he had AIDS). Recently, the New York State Assembly introduced a bill that would amend Article 27-F to allow testing of certain sex offenders. New York State Assembly Bill No. 9295, 215th Gen. Assembly, 2d Sess. (1994).

For legal commentary on involuntary HIV testing in assault and rape cases, compare Kimberly A. Harris, Note, *Death at First Bite: A Mens Rea Approach in Determining Criminal Liability for Intentional HIV Transmission*, 35 ARIZ. L. REV. 237, 263 (1993) ("AIDS is a new phenomenon and AIDS-related crimes are even newer. The occasion, and therefore the need, has arisen in the criminal law to find criminal liability for criminal acts of AIDS transmission. Legislators must draft new statutes to establish a proper deterrence precedent for HIV carriers who

B. Confidentiality of Test Results

In addition to strict informed consent requirements for HIV testing, Article 27-F also includes strong confidentiality requirements for HIV test results.⁷⁸ As the New York legislature has recognized, confidentiality encourages voluntary testing, protects a person's privacy, and limits the risk of discrimination.⁷⁹ Besides the protected individual, there are few persons and institutions to whom disclosure of confidential HIV information is authorized. For example, disclosure is permitted to attending health care providers, third party reimbursers or insurance companies authorized by the protected individual to receive such information, and certain employees of correctional facilities.⁸⁰ If a person discloses confidential HIV information

choose to use the virus to threaten a person's life. The gravity and incurability of the AIDS virus demands these legislative steps.") and Eisenstat, *supra* note 14, at 370-71 (a victim's fear of infection added to the trauma suffered as a result of sexual assault militates in favor of testing sex offenders because a negative result provides hope for the victim during an emotional crisis) with Paul H. MacDonald, Note, *AIDS, Rape, and the Fourth Amendment: Schemes for Mandatory AIDS Testing of Sex Offenders*, 43 VAND. L. REV. 1607 (1990) (questioning the benefit of involuntarily testing sex offenders) and Lisa Simotas, Note, *In Search of A Balance: AIDS, Rape, and the Special Needs Doctrine*, 66 N.Y.U. L. REV. 1881 (1991) (involuntary testing of sex offenders is unconstitutional). See also Larry Gostin, *The Politics of AIDS: Compulsory State Powers, Public Health, and Civil Liberties*, 49 OHIO ST. L.J. 1017 (1989).

Spitting, biting, or splattering blood at a person in anger can be a serious assault. But prosecutors across the country are viewing the same behavior among persons with HIV as attempted murder or assault with a deadly weapon. By viewing assaultive behavior as much more serious when exhibited by AIDS patients, prosecutors make two fundamental errors in judgment: they wrongly assume that persons with HIV have a desire to kill when they behave irresponsibly, and they significantly overestimate the danger presented by the behavior.

Id. at 1046.

⁷⁸ N.Y. PUB. HEALTH LAW § 2782 (McKinney Supp. 1993). See *infra* note 236 for the text of § 2782, in pertinent part.

⁷⁹ HIV and AIDS Related Information Act, 1988 N.Y. Laws 584, § 1, *reprinted in* N.Y. PUB. HEALTH LAW § 2780 (McKinney Supp. 1993) (historical and statutory notes).

⁸⁰ N.Y. PUB. HEALTH LAW § 2782(1) (McKinney Supp. 1993). Other states also provide exceptions to exposed law enforcement officers, firefighters and health care workers, see *supra* note 76, and to victims of sex crimes. See ARIZ. REV. STAT. ANN. § 16-82-101 (Supp. 1993); CAL. PENAL CODE § 1202.1 (West 1990); COLO. REV. STAT. ANN. § 18-3-415 (West Supp. 1993); FLA. STAT. ANN. § 960.003 (West Supp. 1993); GA. CODE ANN. § 17-10-15 (1990 & Supp. 1993); IDAHO CODE § 39-604 (Supp. 1992); IND. CODE ANN. § 35-38-1-10.5 (Burns 1990); KY. REV. STAT.

in violation of the statutory provisions, New York provides both civil and criminal penalties.⁸¹ A violation can result in a fine of \$5000 and, if committed willfully, a misdemeanor prosecution.⁸²

Unlike the informed consent section of Article 27-F, the confidentiality section has provisions for the use of discretionary power. Under one provision, a physician may disclose an infected person's HIV test result to that person's spouse or sexual partner or hypodermic-needle sharer if the physician reasonably believes that there exists a significant risk of infection between the infected person and his or her contact.⁸³ Under another provision, a court may order a person to disclose confidential HIV information if the court finds a compelling need for such action in the adjudication of a criminal or civil proceeding, or if the court finds that a clear and imminent danger exists to an individual or the public.⁸⁴

ANN. § 510.320 (Baldwin Supp. 1992); ME. REV. STAT. ANN. tit. 5, § 19203-E (West Supp. 1993); MICH. COMP. LAWS ANN. § 333.5129 (West Supp. 1991); MISS. CODE ANN. § 99-19-203 (Supp. 1993); MO. REV. STAT. § 191.663 (Supp. 1993); NEV. REV. STAT. § 209.385 (1992 & Supp. 1993); S.C. CODE ANN. § 16-3-740 (Law. Co-op. Supp. 1993); S.D. CODIFIED LAWS ANN. § 23A-35B-4 (Supp. 1993); VA. CODE ANN. § 18.2-62 (Michie Supp. 1993); WASH. REV. CODE § 70.24.340 (1992).

⁸¹ N.Y. PUB. HEALTH LAW § 2783 (McKinney 1993). Although there is no explicit statutory provision granting a protected person a private cause of action against a person who unlawfully discloses his or her HIV information, New York courts have determined that a private action may be maintained. *See, e.g., Doe v. Roe*, 190 A.D.2d 463, 599 N.Y.S.2d 350 (4th Dep't 1993). Other states have explicitly provided for a private cause of action. *See, e.g., ARIZ. REV. STAT. ANN. § 36-668* (Supp. 1993); *DEL. CODE ANN. tit. 16, § 1204* (Supp. 1990); *ILL. ANN. STAT. ch. 410, para. 305/13* (Smith-Hurd 1993).

⁸² N.Y. PUB. HEALTH LAW § 2783(1)(b), (2) (McKinney Supp. 1993).

⁸³ N.Y. PUB. HEALTH LAW § 2782(4) (McKinney Supp. 1993). This statute also contains other provisions, including the requirements that a physician encourage an infected person to reveal his or her test result to a contact personally and that a physician inform an infected person of the physician's intention to notify the contact. *Id.* For other states that have similar provisions, see *ARIZ. REV. STAT. ANN. § 36-664* (Supp. 1993); *CAL. HEALTH & SAFETY CODE § 199.22* (West 1990); *HAW. REV. STAT. § 325-101* (Supp. 1992); *LA. REV. STAT. ANN. § 40:1300.14(E)(1)(a)* (West Supp. 1992); *MICH. COMP. LAWS ANN. § 333.5131* (West Supp. 1991); *MONT. CODE ANN. § 50-16-1009* (1991); *PA. STAT. ANN. tit. 35, § 7609* (1993).

⁸⁴ N.Y. PUB. HEALTH LAW § 2785(2) (McKinney Supp. 1993).

C. *Applicability of HIV-Related Testing Laws to Mandatory Newborn Testing*

Certainly, mandatory newborn testing violates the informed consent section of Article 27-F as it is now written. Mandatory newborn testing, however, is unlike any of the exceptions that currently exist under that section. Therefore, there is little insight to draw from the current law as it applies to mandatory newborn testing. One observation is, nonetheless, in order. The issues surrounding a mandatory newborn testing program involve the complex balancing of social, political and medical issues, which the legislature is better able to handle than the courts. It is likely that courts will be deferential to the legislature's resolution of these controversial issues and, thus, uphold such a program should it be enacted and subsequently challenged.⁸⁵

III. OVERRIDING INFORMED CONSENT

Mandatory newborn testing implicates parents' rights under state common law to give informed consent on behalf of their children.⁸⁶ Unlike the right to determine the course of medical treatment for themselves, however, the parents' right to determine the course of treatment for children is limited. A parent may not deprive a child of life-saving treatment. Courts consistently have allowed the state to intervene when a child's health is in imminent danger.⁸⁷

Although the courts in some states have restricted the right to intervene only to those decisions involving life-and-death situations, New York courts have allowed much broader

⁸⁵ See Eisenstat, *supra* note 14, at 380 (noting judicial deference to involuntary HIV-related testing statutes in other states).

⁸⁶ Sangree, *supra* note 68, at 374.

⁸⁷ *In re Storar*, 52 N.Y.2d 363, 381, 420 N.E.2d 64, 73, 438 N.Y.S.2d 266, 275 (1981); Elizabeth J. Sher, Note, *Choosing for Children: Adjudicating Medical Care Disputes Between Parents and the State*, 58 N.Y.U. L. REV. 157, 162 (1983). For example, when a child had a malignant growth in her eye that caused blindness and likely would have killed her if left unattended, the state was allowed to proceed with the removal of the eye over the parents' objection. *In re Vasko*, 238 A.D. 128, 263 N.Y.S. 553, 555 (1933).

intervention.⁸⁸ The New York approach can be described as the "beneficial effect" approach.⁸⁹ For example, one New York court allowed an operation to correct the deformity of a child's right foot.⁹⁰ The operation was needed not to save the life of the child, but only to "stabilize the foot and prevent aggravation and extension of the deformity."⁹¹ In granting the operation over the objection of the father, the court explained:

The physical well being of children is the basis for the moral care, proper training and guidance. A child who is deprived of the use of its limb which becomes progressively worse cannot have a sense of security. It feels itself different from others. It suffers from a sense of rejection. It cannot take its proper place in the group in which it lives. To the extent that medical science can correct the deformity or the limitation of the use of a limb, that service should be accorded.⁹²

In fact, a child's well-being is sufficiently important that it will, in some circumstances, outweigh a parent's constitutional rights. For example, in *In re Sampson*,⁹³ the court ordered a boy to undergo a dangerous surgical procedure over the religious objections of his mother. The boy suffered from extensive neurofibromatosis which had caused a serious deformity of the right side of his face and neck. Although the boy's disease could not be cured and the boy's health was in no immediate threat, the boy's surgeons recommended that he undergo plastic surgery to correct the condition of his face and neck. The surgeons would not proceed, however, without permission from the mother to administer blood transfusions to the boy during the risky operation. The mother, a Jehovah's Witness, believed that the transfusion of blood was prohibited by the Bible and refused to consent to such a procedure. In overriding the mother's religious objections, the court stated:

[T]he massive deformity of the entire right side of his face and neck is patently so gross and so disfiguring that it must inevitably exert a

⁸⁸ Sher, *supra* note 87, at 163.

⁸⁹ See *In re Ray*, 95 Misc. 2d 1026, 1029, 408 N.Y.S.2d 737, 739 (1978) ("Court intervention may be justified not only where there is an emergency, but also whenever medical intervention will have a beneficial effect."); Sher, *supra* note 87, at 163 & n.29.

⁹⁰ *In re Rotkowitz*, 175 Misc. 948, 25 N.Y.S.2d 624 (1941).

⁹¹ *Id.* at 951, 25 N.Y.S.2d at 627.

⁹² *Id.* at 950, 25 N.Y.S.2d at 626.

⁹³ 65 Misc. 2d 658, 317 N.Y.S.2d 641 (1970).

most negative effect upon his personality development, his opportunity for education and later employment and upon every phase of his relationship with his peers and others.

... [T]he conclusion is inescapable that the marked facial disfigurement from which this boy suffers constitutes such an overriding limiting factor militating against his future development that unless some constructive steps are taken to alleviate his condition, his chances for a normal, useful life are virtually nil.⁹⁴

In contrast to *Sampson*, courts have refused to allow intervention where a child is able to decide for himself or herself whether to pursue the recommended state treatment. In *In re Seiferth*,⁹⁵ a fourteen-year-old boy had a cleft palate and harelip that could be rectified by surgery. The boy's father imparted the decision to the boy, who chose not to undergo the operation.⁹⁶ In denying the state's request to intervene, the *Seiferth* court considered significant that the boy's consent was necessary for his rehabilitation after the surgery and that his condition was not urgent or life-threatening.⁹⁷

Similarly, courts have not been receptive to state intervention where the parent decides a reasonable course of treatment from among several alternatives. In *In re Hofbauer*,⁹⁸ the parents of an eight-year-old boy who was suffering from Hodgkin's disease refused to follow the recommendations of the attending

⁹⁴ *In re Sampson*, 65 Misc. 2d 658, 660, 317 N.Y.S.2d 641, 644 (1970). The interests of a child outweigh the interests of the mother even when the blood transfusion must be performed on the mother to save the child. See *In re Jamaica Hosp.*, 128 Misc. 2d 1006, 491 N.Y.S.2d 898 (1985) (ordering blood transfusion for mother over her religious objections where transfusion was necessary to save the life of her mid-term fetus).

⁹⁵ 309 N.Y. 80, 127 N.E.2d 820, 148 N.Y.S.2d 45 (1955).

⁹⁶ *Id.* at 84, 127 N.E.2d at 822, 148 N.Y.S.2d at 47. The court indicated that the boy probably turned down the operation because his father had inculcated him with the values of "mental healing." *Id.*

⁹⁷ *Seiferth* had a strong, three-judge dissent. The dissent argued:

[The boy] is afflicted with a massive harelip and cleft palate which not only grievously detract from his appearance but seriously impede his chances for a useful and productive life. . . . [N]ormalcy and happiness, difficult of attainment under the most propitious conditions, will unquestionably be impossible if the disfigurement is not corrected.

Id. at 86-87, 127 N.E.2d at 823-24, 148 N.Y.S.2d at 48-49 (dissenting opinion). Although *Seiferth* may clearly be distinguished from cases allowing state intervention, the majority's decision in that case nevertheless was later called into question by the *Sampson* court, which quoted the dissent with approval.

⁹⁸ 47 N.Y.2d 648, 393 N.E.2d 1009, 419 N.Y.S.2d 936 (1979).

physician to have the child's disease treated by radiation and chemotherapy.⁹⁹ Worried about the harmful effects of these treatments, they placed him instead under the care of duly licensed physicians who advocated nutritional and metabolic therapy.¹⁰⁰ In deciding the case, the court phrased the inquiry as

whether the parents, once having sought accredited medical assistance and having been made aware of the seriousness of their child's affliction and the possibility of cure if a certain mode of treatment is undertaken, have provided for their child a treatment which is recommended by their physician and which has not been totally rejected by all responsible medical authority.¹⁰¹

Finding that numerous qualified doctors had contributed to the child's care, that the parents had both serious and justifiable concerns about the harmful effects of radiation treatments and chemotherapy, that the nutritional treatment being administered to the child was controlling his condition, and that the parents agreed conventional treatments would be administered if the child's condition worsened, the court denied the state's request to intervene.¹⁰²

These cases reveal that the benefits of newborn testing provide a sufficient basis to override a parent's informed consent. Currently available treatments improve HIV-infected newborns' quality and duration of life by preventing infections, reducing hospitalizations, and improving physical and mental development.¹⁰³ In addition, the risks associated with these treatments are low.¹⁰⁴ These treatments provide benefits that are surely as important as those derived by correcting the deformity of a child's foot¹⁰⁵ or face and neck.¹⁰⁶ Furthermore, while reasonable alternative choices of treatments exist,

⁹⁹ *Id.* at 652, 393 N.E.2d at 1011, 419 N.Y.S.2d at 938.

¹⁰⁰ *Id.*

¹⁰¹ *Id.* at 656, 393 N.E.2d at 1014, 419 N.Y.S.2d at 941.

¹⁰² *Id.* at 657-58, 393 N.E.2d at 1014-15, 419 N.Y.S.2d at 941-42.

¹⁰³ See *supra* notes 42-66 and accompanying text.

¹⁰⁴ Although prophylactic and antiretroviral drugs have toxic side effects, these drugs are not dangerous as long as the patient is monitored and the drugs discontinued once the effects appear. See STINE, *supra* note 5, at 133; *CDC Guidelines*, *supra* note 48, at 1638-39 (fatal reaction to TMP-SMX, a popular PCP prophylaxis, occur in less than 1 in 100,000 children).

¹⁰⁵ *In re Rotkowitz*, 75 Misc. 984, 25 N.Y.S.2d 624 (1941).

¹⁰⁶ *In re Sampson*, 65 Misc. 2d 658, 317 N.Y.S.2d 641 (1970).

if newborns are not tested, they are left with no treatment at all.

IV. ANALYSIS OF THE NEED, BENEFITS AND COSTS OF NEWBORN TESTING

A. *Need for Mandatory Newborn Testing*

Mandatory testing is necessary because data from the New York State Department of Health ("NYSDOH") shows that voluntary testing has been unsuccessful. In 1989, the NYSDOH introduced the Obstetrical Initiative, a program designed to expand access to HIV counseling and testing in hospitals statewide.¹⁰⁷ Data collected from this program shows that between the beginning of August 1990 and the end of March 1992, 16,436 women were counseled to be tested.¹⁰⁸ Of this number, only 6754 women, or 41%, consented to be tested.¹⁰⁹ Thus, the program succeeded in testing fewer than one-half of the women counseled. Furthermore, of the women who consented to be tested, only 198 were HIV-positive; of those who did not consent to be tested, only 276 were aware that they were HIV-positive on admittance.¹¹⁰ Accordingly, these numbers indicate that the program identified approximately 474 potentially infected newborns.¹¹¹ Yet, according to a New York State seroprevalence study, about 3280 children were born to seropositive mothers during this time.¹¹² Therefore, the program merely identified 15% of the HIV-infected children born in the state.¹¹³

¹⁰⁷ AIDS INST., NYSDOH, HIV COUNSELING AND TESTING OF CHILDBEARING WOMEN: A REPORT OF NEW YORK STATE POLICY AND EXPERIENCE WITH A STATE-WIDE POST-PARTUM PROGRAM 2 (1993) (the hospitals selected accounted for the care of 62% of HIV-infected women giving birth).

¹⁰⁸ *Id.*

¹⁰⁹ *Id.* In addition to this number, the data shows that 276 women were aware that they were HIV-positive on admittance. *Id.*

¹¹⁰ Cumulative Data on Obstetrical Initiative from NYSDOH (Jan. 1993) (on file with author).

¹¹¹ *Id.* Data was unavailable on the exact number of infants born to each HIV-infected mother. The estimate assumes that one child was born to each HIV-infected mother.

¹¹² SUBCOMMITTEE REPORT, *supra* note 22, at 7 (estimate based on data in Table 1).

¹¹³ This estimate assumes that the perinatal transmission rate of the mothers

In a more recent NYSDOH study, which gathered data from July 1993 through September 1993, 120 seropositive women were identified.¹¹⁴ In the same period, state seroprevalence data shows that 228 infants were born to seropositive mothers.¹¹⁵ Therefore, this second study identified about 53% of the HIV-infected children born in the state. Although the number of infants identified in this second study was a marked improvement over the previous one, the number remains unacceptably low.¹¹⁶

Notwithstanding these statistics, the New York State AIDS Advisory Council recently issued a report advocating state-wide voluntary testing programs based on a program in effect at Harlem Hospital.¹¹⁷ While this program has achieved a 90% test consent rate,¹¹⁸ the council's recommendation is problematic for two reasons. First, the Harlem Hospital program appears to be a directive counseling program,¹¹⁹ and it is unclear that such programs are indeed truly volun-

giving birth at the program hospitals is approximately the same as that of mothers giving birth throughout the state.

¹¹⁴ Testing of HIV Positive Women by NYSDOH-Funded Programs, July 1, 1993 to September 30, 1993 (on file with author). This number includes 84 women who knew their HIV-positive status on hospital admittance, as well as those women identified by the NYSDOH-funded programs.

¹¹⁵ *Id.*

¹¹⁶ The percentage may actually be lower than 53% because the study data does not reveal whether the women who were reported as aware of their seropositive status on hospital admittance included any of the women identified by the NYSDOH-funded programs. The New York State AIDS Advisory Council reports that, through New York State's Obstetrical Initiative and Prenatal Care Assistance Program, about 46% of HIV-infected pregnant women have learned their HIV status prior to delivery. SUBCOMMITTEE REPORT, *supra* note 22, at 31-32. However, the council fails to report the estimated number of HIV-infected newborns identified through these programs. The number given by the council is misleading because the percentage of women who consent to be tested does not necessarily correspond to the percentage of infected women and newborns identified by the tests.

¹¹⁷ SUBCOMMITTEE REPORT, *supra* note 22, at 32.

¹¹⁸ SUBCOMMITTEE REPORT, *supra* note 22, at 32.

¹¹⁹ Directive counseling encourages a person to make one choice over others; in contrast, nondirective counseling simply informs a person of all alternative choices. STINE, *supra* note 5, at 334. While the council's report does not provide details of the Harlem Hospital program, the program has been described as an "aggressive voluntary program," SUBCOMMITTEE REPORT, *supra* note 22, at 32, and an "intensive and closely supervised counseling program." Peter Hellman, *Suffer the Little Children: The Rising Storm Over the Law that Keeps HIV-Positive Newborns From Early AIDS Treatment*, NEW YORK, Feb. 21, 1994, at 31.

tary. For example, in one article describing the Harlem Hospital program, one author wrote: "If all else fails, counselors may ask another mother who's already agreed to testing to 'soften up' the resisting mother with a private chat."¹²⁰ This type of "softening up" borders on coercion. Second, as the four-member dissent to the council's majority position pointed out, there is no evidence that the Harlem Hospital program could be replicated across the state.¹²¹ As the director of Harlem Hospital's family-care center admitted, when asked whether the program could be cloned elsewhere, "Like your grandmother's recipe, the chemistry at our site is very complicated."¹²² Given the questions regarding the Harlem Hospital program and the poor, state-wide statistics on voluntary testing, mandatory testing is the only way to identify all HIV-infected infants born in the state.¹²³

¹²⁰ *Id.*; see also Taunya L. Banks, *Women and AIDS—Racism, Sexism, and Classism*, 17 N.Y.U. REV. L. & SOC. CHANGE 351, 375 (1990) (noting that prenatal directive counseling of pregnant women may be coercive to some women).

¹²¹ LOUIS Z. COOPER ET AL., DISSENTING COMMENTS TO THE REPORT OF THE SUBCOMMITTEE ON NEWBORN SCREENING OF THE AIDS ADVISORY COUNCIL 3 (1994); *Keeping a Baby's HIV Status Secret Puts Privacy Ahead of Infant Health. That's Crazy.*, N.Y. NEWSDAY, Mar. 2, 1994, at 48 (questioning the ability to replicate the Harlem Hospital program state-wide).

¹²² Hellman, *supra* note 119, at 31.

¹²³ The method of newborn testing advocated by this Note is universal newborn testing—that is, testing of *all* newborns. Another approach that has been suggested is selective mandatory testing—testing only infants born to women in high-risk categories. This type of testing presents two problems. First, it will be difficult in practice to identify those women who are in a high-risk category because it is unlikely that many of these women will reveal their high-risk behavior. COMMITTEE ON PRENATAL AND NEWBORN SCREENING FOR HIV INFECTION, INSTITUTE OF MEDICINE, HIV SCREENING OF PREGNANT WOMEN AND NEWBORNS 39 (Leslie M. Hardy ed., 1991) [hereinafter INSTITUTE OF MEDICINE REPORT]; MAHRUKH BAMJI ET AL., HIV TESTING AMONG WOMEN AND CHILDREN: VARIABLES ASSOCIATED WITH ACCEPTING OR DECLINING TESTING—LESSONS FROM AN INNER CITY HOSPITAL 6 (1992) (pre-publication draft on file with author) (in one study, about one-half of HIV-infected women did not acknowledge previous high-risk behavior). Second, high-risk testing is discriminatory because the targeted women are mostly from poor and minority populations. Targeting these populations would unjustly add to their plight by labeling them as "sources of contagion." Field, *supra* note 23, at 435; INSTITUTE OF MEDICINE REPORT, *supra*, at 39.

B. *Benefits of Newborn Testing*

As previously discussed, there are a variety of treatments today that will enhance the duration and quality of life of an infected child.¹²⁴ Therefore, both the CDC and the NYSDOH, the two governmental bodies that provide the most influence and leadership on these issues, have recognized that early diagnosis is critical for treating HIV-infected newborns.¹²⁵

Benefits from early diagnosis include the timely administration of prophylaxis to prevent deadly opportunistic infections such as PCP. Other benefits include the timely administration of antiretroviral therapy and IVIG to improve physical and mental development and to decrease the incidence of recurrent bacterial infections and hospitalizations.¹²⁶ Early diagnosis also enables a health care provider to adjust the immunization schedule to provide an HIV-infected child with aggressive treatment.¹²⁷ Finally, early diagnosis allows the implementation of close nutritional monitoring. This monitoring is a crucial component of HIV-infected child care because nourishment problems are common in HIV-infected children and, left unattended, can accelerate the breakdown of an infected child's immune system.¹²⁸

Early diagnosis also enables newborn participation in clinical trial programs.¹²⁹ These programs test the safety and efficacy of the newest treatments for HIV.¹³⁰ Participation in these programs provides children with various benefits: first, children have access to state-of-the-art medicine before it is generally available; second, children who are not responding

¹²⁴ See *infra* notes 42-62 and accompanying text.

¹²⁵ CDC Guidelines, *supra* note 48, at 1640 ("an optimal prophylaxis program will involve identification of HIV-exposed infants as soon as possible so that prophylaxis can be initiated, when indicated, to prevent PCP"); Letter from Nilsa Gutierrez, *supra* note 43 at 1 ("The enclosed protocols emphasize early medical intervention as essential to the improvement of both survival and quality of life.").

¹²⁶ See *supra* notes 44-58 and accompanying text.

¹²⁷ See *supra* notes 59-62 and accompanying text.

¹²⁸ See *supra* notes 63-66 and accompanying text.

¹²⁹ AIDS INST., NYSDOH, EXPERIMENTAL TREATMENTS FOR HIV AND AIDS 3-4 (1993).

¹³⁰ Clinical trials are divided into three phases. During Phase I of a trial, a new drug is tested for safety and dose tolerance in patients. After a drug has been shown to be reasonably safe, it may advance to Phase II and III trials, in which the efficacy of the drug is tested. *Id.*

well to the usual medication have access to alternative medication; and third, treatments tested in these trials are usually provided free of charge to the participant.¹³¹

Furthermore, medical science's experience with HIV and knowledge of the disease are still in the early stages. The first cases of people diagnosed with AIDS were reported in 1981.¹³² Since that time, medical science has made great strides in treatment for both adults and children afflicted with the disease. Although cures and vaccines have been elusive,¹³³ progress has been made in these areas and there is hope that solutions will be found.¹³⁴ For example, following promising results with adult vaccines, several vaccines for children currently are being tested in national clinical trials.¹³⁵ Considering the speed with which progress has been made and the promise of current experiments, any additional time a child survives is of great value.

Early diagnosis provides benefits to the mother as well. Al-

¹³¹ See *id.*

¹³² STINE, *supra* note 5, at xxiv.

¹³³ See, e.g., Murray B. Gardner, *Acquired Immunodeficiency Syndrome Vaccines*, 158 W. J. MED. 296, 296 (1993) (describing that experimental vaccines have produced mixed results in clinical trials and that these vaccines have been found to have two shortfalls: they require multiple injections over several months and they provide only short-lived immunity).

¹³⁴ See STINE, *supra* note 5, at 149.

X-ray studies on the HIV proteinase enzyme have allowed for replicating its three-dimensional structure. This is the opening salvo in what may be the second front of the therapeutic war on AIDS. . . . As research progresses, scientists have found that HIV protease is distinctly different from other protease enzymes in the body, so a drug that blocks the enzyme in HIV probably will not affect normal cells.

Id.; see also Gardner, *supra* note 133, at 296 (although efficacy of vaccines used to prevent infection in uninfected people have been disappointing, vaccines used to delay or prevent onset of disease in infected people have shown promise); *HIV Advance Cited*, N.Y. NEWSDAY, Oct. 31, 1993, at 18 (researchers at the Aix-Marseille University in southern France have found a molecule that could stop HIV from penetrating healthy cells).

¹³⁵ *HIV Vaccines to Be Tested in HIV Positive Children*, AIDS WEEKLY, Apr. 5, 1993, at 5. The United States National Institutes of Health announced that three vaccines are to be administered to children ages one month to 12 years in at least 12 hospitals located nationwide. At least half of the participants will be children ages two years or younger. *Id.* "The tests will be used to help researchers determine whether the vaccines slow the progress of the disease by triggering immunological responses to HIV in children who are not yet sick." *Id.* These vaccines follow on the heels of preliminary trial results of vaccines in adults that show that they increase the body's immunological response to HIV. *Id.*

though the purpose of newborn testing is to identify infected newborns, such testing also necessarily reveals the seropositive status of a newborn's mother. While this identification is the source of many problems associated with newborn testing,¹³⁶ it also provides many benefits.

First, identification of a mother's seropositive status enables her to obtain treatment for herself. The benefits from treatments available to HIV-infected adults are similar to those available to HIV-infected children.¹³⁷ In addition, adults gain the further benefit that ZDV therapy has been proven to prolong their survival.¹³⁸ These treatments not only benefit the mother, but also indirectly benefit the newborn, who may depend on her care.

Second, identification of a mother's seropositive status helps her to make informed decisions about her future family plans. She may, for example, use the knowledge of her seropositive status to determine whether to give birth to additional children.¹³⁹ She may also use this knowledge to make arrangements for the care of her children, both infected and uninfected, who survive her.¹⁴⁰

¹³⁶ See *infra* notes 153-62 and accompanying text.

¹³⁷ See *supra* notes 48-66 and accompanying text.

¹³⁸ See *supra* notes 49-50 and accompanying text.

¹³⁹ If a woman knows she is HIV-positive before giving birth, she may elect to receive ZDV during pregnancy. In a recent study, researchers observed a perinatal transmission rate of 8% in women who received ZDV during pregnancy as compared to a perinatal transmission rate of 26% in women who received a placebo. Lawrence K. Altman, *In Major Finding, Drug Curbs H.I.V. Infection in Newborns*, N.Y. TIMES, Feb. 21, 1994, at A1, A13; *Study: AZT Can Block HIV in Fetus*, N.Y. NEWSDAY, Feb. 21, 1994, at 14. While this new finding highlights the importance of prenatal counseling and testing of pregnant women, newborn testing remains important because many women do not use prenatal care. Jim Dwyer, *AIDS Babies Lose in Game of Politics*, N.Y. NEWSDAY, Apr. 18, 1994, at A2.

¹⁴⁰ The surge in motherless children due to the HIV epidemic has been called "an unavoidable social catastrophe." *JAMA Study Calls Orphans of HIV/AIDS Epidemic an "Unavoidable Social Catastrophe,"* INTERGOVERNMENTAL AIDS REP., Sept. 1993, at 4 (quoting David Michaels & C. Levine, *Estimates of the Number of Motherless Youth Orphaned by AIDS in the United States*, 248 JAMA 3456 (1992)). By 1995, it is estimated that more than 37,000 children will be left motherless by the disease. This number could soar to as high as 125,000 by the year 2000. *Id.* It is not unreasonable to expect that many of these orphaned children will be HIV-infected themselves given that many infected children are now surviving into their teens. See STINE, *supra* note 5, at 113 ("[W]ith better therapy now available, some children born with HIV are still alive at five, 10 and 12 years old."); Mireya Navarro, *Growing Up in the Shadow of the AIDS Virus*, N.Y. TIMES, Mar. 21,

Finally, HIV-infected mothers benefit from education about the modes and prevention of HIV transmission. Although studies have shown that the sexual behavior of many women does not change after they learn of their HIV infection status,¹⁴¹ some women do take advantage of this information by protecting their sexual partners from infection.¹⁴²

Education about the modes and prevention of HIV transmission also allows a woman to prevent transmission of the virus to her uninfected children. Although it is widely accepted in the scientific community that the virus cannot be transmitted by casual contact in the household,¹⁴³ precautions must be taken so that the blood of infected family members does not come into contact with that of uninfected family members. Recently, two well-publicized cases of HIV transmission between siblings raised public concern about the risk of infection through casual contact.¹⁴⁴ This concern is mostly unwarranted because plausible explanations of transmission exist in both cases. In one case, the siblings shared a toothbrush and had bleeding gums;¹⁴⁵ and in the other, the siblings shared a shaving razor.¹⁴⁶ Therefore, in both cases, the potential for blood exposure between infected and uninfected siblings existed. While scientists reassure us that these types of cases are very rare,¹⁴⁷ they nonetheless underscore the importance of household caution in preventing the transmission of HIV. A household may lack such care if its members are unaware of their HIV infection status.

1993, at 33 ("In New York City, with nearly a quarter of the nation's pediatric AIDS cases, doctors say they have seen infected children as old as 14. Officials at the Federal Centers for Disease Control and Prevention say most children infected from birth now survive beyond age 5.").

¹⁴¹ See Eisenstat, *supra* note 14, at 341-42 & n.81.

¹⁴² See Field, *supra* note 23, at 413. Furthermore, one cost-benefit analysis concluded that "screening medium- and high-risk women is likely to be cost-beneficial, even under a wide range of assumptions about program cost and behavioral changes in response to screening." Margaret L. Brandeau et al., *Screening Women of Childbearing Age for Human Immunodeficiency Virus: A Cost-Benefit Analysis*, 152 ARCHIVE INTERNAL MED. 2229, 2229 (1992).

¹⁴³ See, e.g., STINE, *supra* note 5, at 160-61.

¹⁴⁴ Laurie Garrett, *HIV Transmitted Between Siblings: Two Child-to-Child Cases Reported*, N.Y. NEWSDAY, Dec. 5, 1993, at 3, 61.

¹⁴⁵ *Id.*

¹⁴⁶ *Id.*

¹⁴⁷ *Id.*

C. Costs of Newborn Testing

Learning that one is HIV-positive can have enormous economic, social and personal consequences. For example, one recent study has estimated that the average cost of treating a person infected with HIV who has not yet progressed to AIDS is \$10,000 per year.¹⁴⁸ The same study estimated that the average cost of treating a person with AIDS is \$38,300 per year and the estimated lifetime cost of treating such a person totals \$102,000.¹⁴⁹ Moreover, because of the need to monitor HIV-infected children closely, the cost of their treatment is estimated to exceed that for adults.¹⁵⁰ As exorbitant as these costs are, they are nonetheless expected to rise over time.¹⁵¹ This high cost of care is all the more troublesome because most infected people are from poor communities.¹⁵²

In addition to the economic costs, the specter of stigma and discrimination by the public¹⁵³ and the potential loss of personal and family relationships¹⁵⁴ that are associated with a positive HIV test result continue to be serious concerns for the HIV-infected individual. Children, because they are often seen as "innocent victims" of the disease, are less prone to be stigmatized than adults.¹⁵⁵ Nevertheless, one author has not-

¹⁴⁸ Fred J. Hellinger, *Forecasts of the Costs of Medical Care for Persons with HIV: 1992-1995*, 29 INQUIRY 356, 356 (1992). The study cited the costs in 1991 dollars and accounted for both inpatient care (hospital visits) and outpatient care (clinical visits, home care and drugs). *Id.* at 361.

¹⁴⁹ *Id.* at 361.

¹⁵⁰ INSTITUTE OF MEDICINE REPORT, *supra* note 123, at 107 n.6; Robert H. Parrott, *Childhood Human Immunodeficiency Virus Infection: The Spectrum of Costs*, 4 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES 122, 128 (1991).

¹⁵¹ Parrott, *supra* note 150, at 127.

¹⁵² See Sangree, *supra* note 68, at 315; Joelle S. Weiss, *Controlling HIV-Positive Women's Procreative Destiny: A Critical Equal Protection Analysis*, 2 CONST. L.J. 643, 649 (1992).

¹⁵³ Banks, *supra* note 120, at 370 ("The stigma of a positive HIV antibody test—loss of employment, insurance, housing, and other economic or social harm—provides another reason for women who suspect they are infected with HIV to avoid routine prenatal screening."). For a discussion of the public response to AIDS and HIV, see generally STINE, *supra* note 5, at 345-52 (discussing how fear and misconceptions have fueled discrimination against HIV-infected people).

¹⁵⁴ Field, *supra* note 23, at 410.

¹⁵⁵ The stigma attached to HIV infection and AIDS is thought to arise, in part, from a public association of the infection with homosexuality, promiscuity or drug abuse, and the attendant public disapproval of these behaviors. J. David Butts, *HIV/AIDS-Related Information and the Rule of Confidentiality: Can We Accept*

ed that "there is no vaccination against discrimination, even for the youngest and most helpless of those with HIV disease."¹⁵⁶ For example, children have been barred from attending public schools because of their HIV infection.¹⁵⁷ Moreover, any discrimination that HIV-infected mothers suffer also adversely affects their children.¹⁵⁸

Finally, learning that one is HIV-positive can cause a great deal of psychological distress.¹⁵⁹ This distress may be caused by a number of factors. First, a person is compelled "to confront the prospect of a painful and ultimately fatal disease."¹⁶⁰ Second, a person is forced to confront the large attendant economic and social costs of the disease. Third, notwithstanding confidentiality laws, a person may live in fear of unauthorized disclosures.¹⁶¹ The stress caused by these factors is dangerous because it may contribute to the acceleration of the disease.¹⁶²

D. *Balancing Needs, Benefits and Costs*

Although there are potentially significant costs associated with newborn testing, these costs are manageable. For exam-

Exceptions?, 40 MED. TRIAL TECH. Q. 1, 13 (1993). Since children are incapable of these behaviors, they escape these negative perceptions.

¹⁵⁶ Hunter, *supra* note 8, at 24-25.

¹⁵⁷ STINE, *supra* note 5, at 347.

¹⁵⁸ *HIV Infection, Pregnant Women, and Newborns*, *supra* note 42, at 2418-19 ("[N]ewborns and their mothers are a family unit; when HIV-infected mothers experience social or institutional discrimination, their infants suffer as well.").

¹⁵⁹ Field, *supra* note 23, at 411 n.33.

¹⁶⁰ Eisenstat, *supra* note 14, at 365; see Field, *supra* note 23, at 411 (noting some people are afraid to face a terrible disease).

¹⁶¹ See Field, *supra* note 23, at 409 ("Even in places where, in theory, a test would be confidential, the reality may be that it is difficult to maintain total confidentiality once a person is found to be HIV positive."). In addition, some states also have exceptions to confidentiality laws. For example, both Arkansas and Missouri require a person who knows her seropositive status to inform her health care provider prior to receiving care. *Id.* at 410 & n.30. Furthermore, New York allows a doctor to reveal a person's seropositive status to the person's spouse, sexual partner or intravenous-needle sharer. See *supra* note 83 and accompanying text.

¹⁶² Michael L. Closten, *Mandatory Disclosure of HIV Blood Test Results to the Individuals Tested: A Matter of Personal Choice Neglected*, 22 LOY. U. CHI. L.J. 445, 464 (1991) ("[S]tress may itself be a factor contributing to a decline of the immune system and to the onset of symptoms of AIDS in those who are HIV-infected.").

ple, the economic burden of HIV-related treatments is currently eased by state health care programs, federal funding and Medicaid insurance.¹⁶³ Opponents of mandatory newborn testing have noted, however, that these programs cannot guarantee treatment to all mothers and newborns identified through testing.¹⁶⁴ They have argued, therefore, that unless treatment is available to all, mandatory testing is useless.¹⁶⁵ This argument falls short on several grounds. First, a lack of resources is problematic for voluntary as well as for mandatory testing. Thus, an argument that mandatory testing should not be implemented unless guaranteed resources exist is an argument that *all* testing should not be implemented unless such resources exist.¹⁶⁶ In addition, even though it is possible that the care received by some mothers and newborns identified through mandatory testing will not be completely adequate, the treatment they *do* receive is better than *no treatment at all*. Finally, the New York State Assembly has shown that it is committed to improving and expanding health services for HIV-infected children and their families.¹⁶⁷ The current version of Assemblywoman Mayersohn's bill, for example, appropriates five million dollars to enhance services for HIV-infected families.¹⁶⁸

¹⁶³ See STINE, *supra* note 5, at 374-90; INSTITUTE OF MEDICINE REPORT, *supra* note 123, at 106-09 (81% of children and 43% of adults hospitalized with AIDS in New York were covered by Medicaid).

¹⁶⁴ Elizabeth Cooper et al., *Pregnancy and HIV*, 327 NEW ENG. J. MED. 645, 645-46 (1992) (correspondence); Field, *supra* note 23, at 413; Hunter, *supra* note 8, at 25.

¹⁶⁵ Cooper et al., *supra* note 164, at 645-47; Field, *supra* note 23, at 413; Hunter, *supra* note 8, at 25.

¹⁶⁶ In the context of voluntary testing, it has been recognized that the identification of HIV infection in pregnant women and newborns is sufficiently important to proceed with programs of prenatal and newborn testing notwithstanding the lack of adequate resources. See INSTITUTE OF MEDICINE REPORT, *supra* note 123.

The committee decries the inherent inadequacies in the current health services and financing system and recognizes that prenatal HIV screening may identify more women and children who need care than the system can currently accommodate. Nevertheless, it believes that the benefits of screening pregnant women for HIV infection in high-prevalence areas are sufficient to justify proceeding with program implementation, even though the present health and social services infrastructure may not be completely adequate.

Id. at 5-6.

¹⁶⁷ New York State's allocation of funds for HIV and AIDS care is one of the highest in the nation. See STINE, *supra* note 5, at 377.

¹⁶⁸ New York Assembly Bill No. 6747-C, 215th Gen. Assembly, 2d Sess. (1994).

Another economic argument often leveled against mandatory testing is that it is not cost-effective. One often-cited example of the inefficiency of mandatory testing is the case of a 1987 Illinois marriage license law requiring applicants to be tested for HIV before a license could be issued.¹⁶⁹ This law was eventually repealed because it identified only one positive person for every 7000 people tested, resulting in a program cost of nearly \$243,000 for each person identified.¹⁷⁰ Although some have argued that even this high price was cost-effective,¹⁷¹ analogies between the Illinois law and New York's mandatory newborn testing bill are inappropriate for several reasons.

First, Illinois's seroprevalence rate (the number of people infected with HIV per 1000) is much lower than that in New York.¹⁷² Second, the mobility of marriage applicants in Illinois was probably a major source of the poor identification rate of the state's testing program.¹⁷³ Since Illinois's seroprevalence rate suggests that more people should have been identified, a reasonable explanation for the poor identification rate is that high-risk couples not wishing to be identified obtained their marriage licenses from other states. In contrast, the mobility of pregnant women is much more limited than that of marriage applicants. It is unlikely that women will move out of state to give birth. Lastly, while Illinois's law implemented a new testing procedure, anonymous newborn testing already exists in New York. Thus, mandatory newborn testing will not incur the costs of starting a completely new procedure in the state.¹⁷⁴

Of course, even the increased allocation of funds can not eliminate all problems in health care access for affected families. See SUBCOMMITTEE REPORT, *supra* note 22, at 21-22. But it would be unreasonable to demand that all health care service problems be resolved before proceeding with a necessary step in the care of HIV-infected infants and their families.

¹⁶⁹ Eisenstat, *supra* note 14, at 351; Sangree, *supra* note 68, at 388 n.328.

¹⁷⁰ Eisenstat, *supra* note 14, at 351.

¹⁷¹ STINE, *supra* note 5, at 311 (citing comments of one proponent who stated that if identifying one HIV-infected person prevented the birth of one HIV-infected child, the state could save more than \$100,000 in life-time medical costs for the HIV-infected child).

¹⁷² Cf. CDC SURVEILLANCE, *supra* note 21, at 3 (Table 1) (the cumulative cases of AIDS reported to the CDC through June 1993 was 59,312 for New York and 9880 for Illinois).

¹⁷³ See Eisenstat, *supra* note 14, at 354.

¹⁷⁴ Mandatory newborn testing will require that some modifications be made to

Although the risk of stigma and discrimination is a serious concern, this risk is considerably minimized by the strict confidentiality laws in New York State. While some critics have argued that unauthorized disclosures are inevitable,¹⁷⁵ the risk of such disclosures is not likely to be a major problem because of both the medical community's excellent history of handling confidential information¹⁷⁶ and the civil and criminal penalties associated with violations of the confidentiality laws.¹⁷⁷ Furthermore, it is unlikely, as some critics have argued, that the fear of stigma and discrimination will drive women away from health care institutions or cause them to abandon their infected children. As critics of mandatory newborn testing admit, most mothers are very caring and will take the necessary steps to ensure the well-being of their children.¹⁷⁸ In fact, in the long run, mandatory testing may "dilute some of the stigma attached to positive test results by demonstrating that the problem is not restricted to a small segment of the population" but occurs in low-risk and non-minority groups as well.¹⁷⁹

Finally, it must be noted that, in the case of a mother who gives birth to an HIV-infected newborn, the reality is that she

the current testing procedure. For example, newer, more accurate tests, like PCR, will need to be implemented. In addition, a procedure to contact parents after hospital discharge will need to be implemented. SUBCOMMITTEE REPORT, *supra* note 22, at 30-31. While these will add cost to the current anonymous newborn testing program, these modifications are necessary for both mandatory and voluntary testing programs.

¹⁷⁵ See *supra* note 161 and accompanying text.

¹⁷⁶ Telephone Interview with Dr. Louis Z. Cooper, Director of Pediatric Service, St. Luke's-Roosevelt Hospital Center, New York, NY (Oct. 18, 1993).

¹⁷⁷ See *supra* notes 81-82 and accompanying text.

¹⁷⁸ Elizabeth B. Cooper, *When Being Ill is Illegal: Women and the Criminalization of HIV*, 22 HEALTH/PAC BULL. 10, 12 (1992) ("[T]here 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."); Catherine A. Lynch et al., *Don't Test Newborns for AIDS*, N.Y. NEWSDAY, May 19, 1991, at 37 (letter to the editor) ("Women are not their children's enemies, nor are they the obstacles blocking their children's access to health care. In fact, women are more likely to bring their children in for care than to get care for themselves."). Advocates of mandatory newborn testing also share these views. PREVENTABLE CRISIS, *supra* note 2, at 34 ("[I]t has been [the Association to Benefit Children's] experience that when a woman learns that she and her child are HIV-positive, the mother responds in an affectionate and caring manner towards her child.").

¹⁷⁹ INSTITUTE OF MEDICINE REPORT, *supra* note 123, at 86-88 (discussing universal screening).

is likely to learn of her and her newborn's HIV status in short order even if she decides not to test her child. Without treatment, the probability that an HIV-infected infant will develop an opportunistic infection within the first year is great.¹⁸⁰ At that point, the mother may be overwhelmed by the ensuing situation. She not only will be forced to deal with the sudden revelation of her and her infant's HIV status, but will be forced to deal with her infant's serious HIV-related illness (and possibly her own), as well as the realization that this illness might have been prevented.

In sum, the analysis shows that the case for mandatory newborn testing is a strong one. Both the need and the benefits of mandatory testing are great. In addition, whether or not a mother consents to test herself or her child, the high risk of opportunistic infection within the first year of life for a perinatally infected child means that the mother will be forced to face her and her infant's infection status sooner rather than later. Furthermore, the potential costs of testing have been properly addressed through funding and strict confidentiality laws. While these measures cannot eliminate all problems, they provide a solid foundation upon which Assemblywoman Mayersohn's recently proposed bill may build.

V. CONSTITUTIONAL ISSUES

The New York State AIDS Advisory Council and various commentators have raised questions concerning the constitutionality of mandatory newborn testing.¹⁸¹ The following

¹⁸⁰ INSTITUTE OF MEDICINE REPORT, *supra* note 123, at 77 ("[C]hildren with perinatally acquired infection most often develop signs and symptoms of disease within the first year of life, although the true median age at diagnosis is probably closer to two years."); Burroughs & Edelson, *supra* note 19, at 46 ("The mean age of diagnosis of perinatally infected children is 17 months."); Gwendolyn B. Scott et al., *Survival in Children with Perinatally Acquired Human Immunodeficiency Virus Type 1 Infection*, 321 NEW ENG. J. MED. 1791, 1791 (1989) ("The children presented with symptomatic disease at a median age of eight months; only 21 percent presented after the age of two years. . . . [M]ost become symptomatic before one year of age."); see *supra* notes 45-48 and accompanying text (noting that half of all perinatally infected children who contracted PCP developed the infection between three and six months of age).

¹⁸¹ SUBCOMMITTEE REPORT, *supra* note 22, at 25-26 (possible equal protection and right to privacy violations); John M. Naber & David R. Johnson, *Mandatory HIV Testing Issues in State Newborn Screening Programs*, 7 J.L. & HEALTH 55

analysis addresses Fourth Amendment, equal protection and privacy issues implicated by mandatory newborn testing.

A. Fourth Amendment

Today, it is well-established that a blood test is a search within the meaning of the Fourth Amendment.¹⁸² Thus, mandatory HIV testing of newborns could be challenged on Fourth Amendment grounds.¹⁸³ Such a challenge most likely would be unsuccessful because mandatory newborn testing satisfies the requirements of the Fourth Amendment special-needs doctrine.

The Fourth Amendment states that "[t]he right of the people to be secure in their persons, houses, papers and effects, against unreasonable searches and seizures shall not be violated."¹⁸⁴ The purpose of this amendment is to "guarantee[] the privacy, dignity, and security of persons against certain arbitrary and invasive acts by officers of the Government or those acting at their direction."¹⁸⁵ To guard against these types of acts, most government searches require a warrant issued by a judge upon probable cause to satisfy the Fourth Amendment.¹⁸⁶ However, the Supreme Court of the United States has recognized an exception to this general rule when "special

(1992-1993) (possible violation of right to privacy); Sangree, *supra* note 68 (Fourth Amendment violation for mandatory testing of pregnant women and newborns and Fourteenth Amendment violation for mandatory testing of pregnant women); Kevin J. Curnin, Note, *Newborn HIV Screening and New York Assembly Bill No. 6747-B: Privacy and Equal Protection of Pregnant Women*, 21 FORDHAM URB. L.J. 857 (1994) (violation of privacy and equal protection).

¹⁸² *Skinner v. Railway Labor Executives' Ass'n*, 489 U.S. 602, 616 (1989); *Schmerber v. California*, 384 U.S. 757, 767-68 (1966).

¹⁸³ SUBCOMMITTEE REPORT, *supra* note 22, at 26; see also Anonymous Fireman v. City of Willoughby, 779 F. Supp. 402, 415 (N.D. Ohio 1991) ("HIV testing on blood already drawn from public employees as part of an annual physical examination constitutes an intrusion and a search and seizure within the meaning of the Fourth Amendment."); Sangree, *supra* note 68, at 435-36 ("Fourth Amendment rights would also be implicated by the type of laboratory analysis performed on the blood [sample taken from a pregnant woman's umbilical cord or from her newborn child]. Absent specific or implied consent to an HIV antibody test, an HIV analysis of a lawfully-extracted blood sample would itself invoke Fourth Amendment protections.").

¹⁸⁴ U.S. CONST. amend. IV.

¹⁸⁵ *Skinner*, 489 U.S. at 613-14; see also *Delaware v. Prouse*, 440 U.S. 648, 653-54 (1979); *Camara v. Municipal Court*, 387 U.S. 523, 528 (1967).

¹⁸⁶ See, e.g., *Skinner*, 489 U.S. at 619.

needs, beyond the normal need for law enforcement, make the warrant and probable-cause requirement impractical."¹⁸⁷

The principal case setting forth the special-needs doctrine is *Skinner v. Railway Labor Executives' Ass'n*.¹⁸⁸ *Skinner* involved regulations promulgated by the Federal Railroad Administration ("FRA") requiring alcohol and drug tests for railroad employees who were involved in train accidents or violated safety rules.¹⁸⁹ The purpose of the FRA regulations was not to promote the needs of law enforcement, but "to prevent accidents and casualties in railroad operations that result from impairment of employees by alcohol or drugs."¹⁹⁰ Because it was not associated with police or criminal functions, this need triggered a balancing test of "governmental and privacy interests to assess the practicality of the warrant and probable-cause requirements in the particular context."¹⁹¹

The Supreme Court found that a warrant and probable-cause requirement were unnecessary. The Court weighed the societal cost of not requiring a warrant—and, therefore, not having a neutral magistrate present to protect the privacy interests of citizens—against the likelihood of frustrating the government's purposes if a warrant were required.¹⁹² Because the FRA testing program demanded little discretion on the part of administrators of the program, the Court found that a neutral magistrate would have very few facts to evaluate. Accordingly, the detriment caused to privacy interests by not requiring a warrant was small.¹⁹³ The Court also found that the delay in obtaining a warrant could result in the disappearance of alcohol and drug traces from a person's body and that the imposition of warrant requirements on railroad administra-

¹⁸⁷ *Id.* (quoting *Griffin v. Wisconsin*, 483 U.S. 868, 873 (1987)).

¹⁸⁸ 489 U.S. 602 (1989). A companion case to *Skinner*, decided on the same day, is *National Treasury Employees Union v. Von Raab*, 489 U.S. 656 (1989).

¹⁸⁹ *Skinner*, 489 U.S. at 606.

¹⁹⁰ *Id.* at 620-21 (quoting 49 C.F.R. § 219.1(a) (1987)).

¹⁹¹ *Id.* at 619. Other cases that have triggered a special-need analysis include *National Treasury Employees Union*, 489 U.S. at 656 (drug-testing of Custom Service employees); *Griffin v. Wisconsin*, 483 U.S. 868 (1987) (search of a probationer's house); *O'Connor v. Ortega*, 480 U.S. 709 (1987) (work-related searches of government employees' desks and offices); *New Jersey v. T.L.O.*, 469 U.S. 325 (1965) (search of student's purse by school officials).

¹⁹² *Skinner*, 489 U.S. at 622-24.

¹⁹³ *Id.* at 622.

tors unfamiliar with such requirements would be burdensome. These factors worked to frustrate and hinder the government's purposes.¹⁹⁴ Therefore, since the privacy interests were not harmed by eliminating the warrant and the government's purposes were frustrated by requiring one, elimination of the warrant requirement was reasonable under the circumstances.¹⁹⁵

The Supreme Court also found that neither probable cause nor individualized suspicion (a lesser showing of cause) was essential in this case.¹⁹⁶ Again, the Court conducted a balancing test of privacy interests against governmental purposes. On the one hand, the Court found that the railroad employees' privacy interests were minimal because they were tested using nonintrusive methods¹⁹⁷ and worked in a highly regulated industry.¹⁹⁸ Correspondingly, the government's interest in protecting public safety by identifying impaired employees was great.¹⁹⁹ Under these circumstances, the Court concluded that a warrantless search, conducted without probable cause or individualized suspicion, was reasonable.

Applying the *Skinner* analysis to mandatory HIV testing of newborns demonstrates that mandatory newborn testing is a constitutional special-needs search. Initially, it is clear that the purpose of mandatory HIV testing of newborns is to protect the health of infected newborns, not to serve law enforcement or criminal prosecution goals. Thus, newborn testing passes the first hurdle of the Supreme Court's *Skinner* test. Next, a balancing of governmental interests against privacy interests demonstrates that the requirement of a warrant supported by

¹⁹⁴ *Id.* at 623.

¹⁹⁵ *Id.* at 624.

¹⁹⁶ *Id.* at 624-33.

¹⁹⁷ *Skinner*, 489 U.S. at 624-27. Testing was conducted using blood, breath and urine tests. *Id.* The Court found that blood tests are commonplace and "involve[] virtually no risk, trauma, or pain." *Id.* at 625 (quoting *Schmerber v. California*, 384 U.S. 757, 771 (1966)). Similarly, breath tests "do not require piercing of the skin and may be conducted safely outside a hospital environment and with a minimum of inconvenience or embarrassment." *Id.* In contrast, the Court was hesitant to find that urine tests implicated minimal privacy concerns. Nonetheless, because the FRA procedures required the urine tests to be conducted in a medical environment without direct observation, the Court found these tests to be noninvasive as well. *Id.* at 626-27.

¹⁹⁸ *Id.* at 627-28.

¹⁹⁹ *Id.* at 628-29.

probable cause is impractical for the purposes of mandatory newborn testing. Like the administration of alcohol and drug tests to railroad employees in *Skinner*, the administration of HIV tests to newborns requires little or no discretion. Therefore, the value of a warrant and a neutral magistrate's case-by-case evaluation would be small in this situation. In addition, the requirement of a warrant would burden hospital personnel charged with administering the tests because, like the railroad administrators in *Skinner*, these personnel are unfamiliar with warrant procedures. Furthermore, in the context of newborn testing, hospital personnel would be burdened with a great many warrant applications. Therefore, under the circumstances, a warrant requirement would be impractical.

Likewise, it is reasonable to dispense with the requirements of probable cause and individualized suspicion. The privacy interests of the mothers and newborns in their HIV test results are minimal because they are protected by strict confidentiality laws, which provide for both criminal and civil penalties.²⁰⁰ Furthermore, the state has a strong interest in protecting the health of its HIV-infected newborns. Without testing for the virus, HIV-infected newborns are not able to take advantage of all the beneficial treatments available to them today. Thus, warrantless, suspicionless newborn testing is a constitutional Fourth Amendment search.

B. *Equal Protection*

Mandatory HIV testing of newborns raises concerns about discrimination against minority women,²⁰¹ as currently these women are disproportionately affected by HIV. Nationally, almost three-quarters of all women with AIDS are black or Hispanic.²⁰² This percentage increases to as high as 84% in high-prevalence urban areas.²⁰³

²⁰⁰ See *supra* notes 78-84 and accompanying text. For a more complete balancing of interests, see *supra* notes 163-80.

²⁰¹ See SUBCOMMITTEE REPORT, *supra* note 22, at 25-26.

²⁰² INSTITUTE OF MEDICINE REPORT, *supra* note 123, at 14 (52% of women with AIDS were black, 20% were Hispanic and 27% were white); Sangree, *supra* note 68, at 315 n.17 ("Over 72% of U.S. women with HIV are Black and or Hispanic."); Weiss, *supra* note 152, at 649 n.28 (black women comprise 53% and Hispanic women comprise 21% of women with AIDS in the United States).

²⁰³ NEW YORK CITY DEP'T OF HEALTH, AIDS SURVEILLANCE UPDATE, Oct. 1992,

While these statistics clearly show a disproportionate impact on minority women, this showing is not sufficient by itself to establish an equal protection violation.²⁰⁴ The key issue in an equal protection analysis is whether the law has a discriminatory intent. Disproportionate impact is only one factor in determining this question.²⁰⁵ Arguably, minority women could claim that the disproportionate impact of newborn testing should be viewed in light of previous health laws that have adversely affected them. For example, one commentator has written:

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. . . .

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 sterilizations of poor women, disabled women, and women of color.²⁰⁶

This argument is likely to fail. Prior laws that sought to interfere directly with a woman's procreative decisions are not relevant to mandatory newborn testing because such testing occurs after birth and does not interfere with a woman's procreative choices. To the extent that such testing plays a role in a woman's decision regarding whether to bear a child, it is one of

at 6 (black women comprised 51%, Hispanic women comprised 33%, and white women comprised 14% of women with AIDS in New York City).

²⁰⁴ *Mobile v. Bolden*, 446 U.S. 55 (1980) (no equal protection violation notwithstanding that city's at-large voting scheme was shown to dilute blacks' voting strength); *Washington v. Davis*, 426 U.S. 229, 239 (1976) (no equal protection violation where four times as many blacks than whites failed an employment examination: "our cases have not embraced the proposition that a law or other official act, without regard to whether it reflects a racially discriminatory purpose, is unconstitutional solely because it has a racially disproportionate impact"); *Wright v. Rockefeller*, 376 U.S. 52 (1964) (no equal protection violation in irregularly drawn district lines, even though the challenged districts were made up predominantly of whites).

²⁰⁵ See *Washington*, 426 U.S. at 242 ("Necessarily, an invidious discriminatory purpose may often be inferred from the totality of the relevant facts, including the fact, if it is true, that the law bears more heavily on one race than another.").

²⁰⁶ Sangree, *supra* note 68, at 332; see also Hunter, *supra* note 8, at 17 (expressing suspicion about motivation for mandatory testing of newborns given the government's lack of zeal in insuring the health of babies in minority communities).

the many costs and responsibilities that a woman must weigh in making a decision regarding childbirth. In short, the sole purpose of mandatory newborn testing is to identify and to treat HIV-infected newborns. There is no indication of a legislative intent to discriminate against minority women and thus no violation of equal protection.

C. *Right to Privacy*

In *Whalen v. Roe*,²⁰⁷ the Supreme Court held that the Fourteenth Amendment provides for the protection of two different kinds of privacy: "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."²⁰⁸ The former interest is commonly referred to as a person's confidentiality interest and the latter as a person's autonomy interest.²⁰⁹ Mandatory newborn testing violates neither interest.

The confidentiality strand of privacy was established by the Court in *Whalen* and *Nixon v. Administrator of General Services*,²¹⁰ each decided in the same term. *Whalen* involved a New York State statute that required pharmacists to file a form with the State Health Department identifying the prescribing physician, the dispensing pharmacy, the drug and dosage, and the patient's name any time the pharmacist dispensed a drug classified as dangerous.²¹¹ The purpose of the law was to prevent potential abuse in prescribing and dispensing drugs such as opium and cocaine.²¹² The Health Department stored the data retrieved from the forms in a central computer system, which was protected by tight security measures and to which only a limited number of department em-

²⁰⁷ 429 U.S. 589 (1977).

²⁰⁸ *Id.* at 599-600 (footnote omitted).

²⁰⁹ See *Doe v. City of New York*, 15 F.3d 264, 267 (2d Cir. 1994) ("There is, therefore, a recognized constitutional right to privacy in personal information. More precisely, this right to privacy can be characterized as a right to 'confidentiality,' to distinguish it from the right to autonomy and independence in decision-making for personal matters also recognized in *Whalen*.").

²¹⁰ 433 U.S. 425 (1977).

²¹¹ *Whalen v. Roe*, 429 U.S. 589, 592 (1977).

²¹² *Id.* at 592-93.

ployees had access.²¹³ In addition, the statute prohibited public disclosure of the data and provided both criminal and civil penalties for violations.²¹⁴ In rejecting the confidentiality challenge to the statute, the Supreme Court first found that the security provisions of the statute provided adequate protection from public disclosure of the data.²¹⁵ Addressing the disclosure to the Health Department, the Court next explained:

[D]isclosures of private medical information to doctors, to hospital personnel, to insurance companies, and to public health agencies are often an essential part of modern medical practice even when the disclosure may reflect unfavorably on the character of the patient. Requiring such disclosures to representatives of the State having responsibility for the health of the community does not automatically amount to an impermissible invasion of privacy.²¹⁶

The Court thus found no invasion of the confidentiality interest.²¹⁷

In *Nixon*, the issue before the Court was whether an act of Congress directing the Administrator of General Services to take custody of President Nixon's papers and tape recordings, screen them, and allow public access to the non-private portions violated the president's right to privacy.²¹⁸ The Court found that "any intrusion must be weighed against the public interest in subjecting the Presidential materials of appellant's administration to archival screening."²¹⁹ Because the act contained provisions "aimed at preventing undue dissemination of private materials" and mandated the return of private papers and recordings to the president, the Court held that no constitutional privacy interest was violated.²²⁰

Although it has been years since the Supreme Court decided *Whalen* and *Nixon*, the scope of the confidentiality interest

²¹³ *Id.* at 593-94.

²¹⁴ *Id.* at 594-95.

²¹⁵ *Id.* at 601.

²¹⁶ *Whalen*, 429 U.S. at 602.

²¹⁷ *Id.* at 603-04.

²¹⁸ *Nixon v. Administrator of Gen. Servs.*, 433 U.S. 425, 429 (1977). In *Nixon*, the President based his challenge on the First, Fourth and Fifth Amendments. *Id.* at 455. Nonetheless, the Court's decision relied in part on *Whalen*, which grounded its analysis in the Fourteenth Amendment. *Id.* at 457. See *Whalen*, 429 U.S. at 603-04.

²¹⁹ *Nixon*, 433 U.S. at 458.

²²⁰ *Id.* at 458-59.

articulated in those cases remains unclear. The Supreme Court has not addressed confidentiality since then and, in the interim, the courts of appeals have divided on their interpretation of the two cases. At least four circuits—the Second, Third, Fifth and Ninth—have recognized a right to confidentiality.²²¹ Relying on language in *Nixon*, these circuits have balanced the public interest served by an intrusion against the harm to an individual's privacy caused by that intrusion.²²² In contrast, the Sixth Circuit has explicitly rejected a general right to confidentiality,²²³ and the District of Columbia Circuit has questioned the scope and basis of such a right.²²⁴

Regardless of how *Whalen* or *Nixon* are interpreted, mandatory newborn testing does not violate the confidentiality strand of privacy. Under a broad interpretation as dictated by the Second, Third, Fifth and Ninth Circuits, a general balancing of interests, as discussed above, weighs in favor of mandatory newborn testing.²²⁵ Under a narrower interpretation,

²²¹ See *Doe v. City of New York*, 15 F.3d 264 (2d Cir. 1994); *Thorne v. City of El Segundo*, 726 F.2d 459 (9th Cir. 1983), *cert. denied*, 469 U.S. 979 (1984); *United States v. Westinghouse*, 638 F.2d 570 (3d Cir. 1980); *Plante v. Gonzalez*, 575 F.2d 1119 (5th Cir. 1978), *cert. denied*, 439 U.S. 1129 (1979).

²²² See, e.g., *Westinghouse*, 638 F.2d at 578-80.

²²³ *Doe v. Wigginton*, 21 F.3d 733 (6th Cir. 1994); *J.P. v. DeSanti*, 653 F.2d 1080 (6th Cir. 1981).

Absent a clear indication from the Supreme Court we will not construe isolated statements in *Whalen* and *Nixon* more broadly than their context allows to recognize a general constitutional right to have disclosure of private information measured against the need for disclosure. Analytically we are unable to see how such a constitutional right of privacy can be restricted to anything less than the general "right to be let alone". . . . "Virtually every governmental action interferes with personal privacy to some degree." . . . [The Framers of the Constitution] cannot have intended that the federal courts become involved in an inquiry [so] broad—balancing almost every act of government, both state and federal, against its intrusion on a concept so vague, undefinable, and all-encompassing as individual privacy.

Id. at 1089-90 (citations omitted).

²²⁴ *National Fed'n of Fed. Employees v. Greenberg*, 983 F.2d 286 (D.C. Cir. 1993) ("When we return to *Whalen* and look behind the Supreme Court's general remark, . . . we find ambiguity. What 'individual interests' receive protection from disclosure? . . . What 'personal information' and disclosure to whom? . . . [W]hat are the provisions in the Constitution that are said to confer [such protection]?").

²²⁵ See *supra* notes 163-80 and accompanying text. Moreover, both *Whalen* and *Nixon* indicate that limited disclosure to appropriate government or medical personnel supported by strong security provisions will weigh heavily in favor of a finding of no constitutional violation of privacy. See *Nixon v. Administrator of Gen.*

such a balancing may not be necessary to determine the constitutionality of mandatory newborn testing. The decisions of the Sixth Circuit and the District of Columbia Circuit raise a valid question as to what kind of disclosure will trigger a constitutional analysis in the first place.²²⁶ *Whalen* involved disclosures to a limited number of governmental employees and medical personnel, while *Nixon* concerned only governmental employees. In both cases, the Supreme Court found that no constitutional violation had occurred. Consequently, one interpretation of these decisions is that a disclosure of private information must be *public*, or at least sufficiently widely disseminated, to invoke constitutional protection. Under this interpretation, mandatory newborn testing would not trigger the right to confidentiality of a mother or her newborn because test results would be available only to a limited number of health care workers and state health department employees.

The second strand of privacy protected under the Fourteenth Amendment is autonomy. Unlike the confidentiality analysis, the autonomy analysis is well-developed.²²⁷ Under this analysis, the Supreme Court has created certain fundamental rights that include marriage,²²⁸ procreation,²²⁹ childbearing and childrearing.²³⁰ If a law significantly interferes with a person's decision-making with regard to these rights, it is subject to strict scrutiny analysis, i.e., the law must serve a compelling governmental interest and must be narrowly tailored to meet that interest.²³¹ Otherwise, the law need only

Servs., 433 U.S. 425, 458-59 (1977); *Whalen v. Roe*, 429 U.S. 589, 602 (1977).

²²⁶ See *Greenberg*, 983 F.2d at 293 ("What 'personal information' and disclosure to whom? To the government as employer or to the world?").

²²⁷ But see *Curnin*, *supra* note 181, at 897-98 (*Planned Parenthood v. Casey*, 112 S. Ct. 2791 (1992), may have altered the autonomy analysis).

²²⁸ *Griswold v. Connecticut*, 381 U.S. 479, 485-86 (1965).

²²⁹ *Skinner v. Oklahoma*, 316 U.S. 535, 541-42 (1942).

²³⁰ *Pierce v. Society of Sisters*, 268 U.S. 510, 532 (1925); *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923).

²³¹ See, e.g., *Griswold*, 381 U.S. at 495-96 (Goldberg, C.J., concurring, joined by Brennan, J.).

In a long series of cases this Court has held that where fundamental personal liberties are involved, they may not be abridged by the States simply on a showing that a regulatory statute has some rational relationship to the effectuation of a proper state purpose. "Where there is a significant encroachment upon personal liberty, the State may prevail only upon a subordinating interest which is compelling." The law must be shown "necessary, and not merely rationally related to, the accomplish-

be rationally related to a legitimate governmental interest.²³²

Mandatory newborn testing easily satisfies the rationality test. The state has a legitimate interest in identifying and treating HIV-infected newborns, and mandatory testing is a rational way to accomplish this purpose. Although it could be argued that identifying and treating HIV-infected newborns is also a compelling state interest, there is no need to go beyond the rationality test because mandatory newborn testing does not significantly interfere with a mother's childbearing or childrearing decisions. A woman's decision regarding whether to bear a child or how to raise a child remains her own. Critics, nonetheless, assert that women will decide not to bear children because of their fear of the test or that they will abandon their children once the results of the tests are given to them.²³³ Other factors counter these arguments, however. For example, the culture of many minority women strongly encourages them to bear children²³⁴ and in general these women are caring mothers.²³⁵ Moreover, any effect that mandatory testing has on these women must be determined in light of the high probability that, untested and untreated, an HIV-infected newborn will become sick and reveal his or her infection within the first year of life. In sum, mandatory newborn testing does not violate the privacy interests of mothers or newborns.

ment of a permissible state policy."

Id. (citations omitted).

²³² *Id.*

²³³ See Curnin, *supra* note 181, at 881; see also *supra* note 178 and accompanying text.

²³⁴ See Weiss, *supra* note 152.

Despite warnings and counseling about the risk of perinatal HIV transmission, HIV-positive and AIDS-infected women continue to have babies. Current studies indicate that women who are knowingly HIV-positive become pregnant at rates similar to those of uninfected women. Indeed, studies further disclose that HIV- and AIDS-infected women are becoming pregnant notwithstanding having already bore an HIV-afflicted child or having previously lost a child to AIDS. Although HIV infection prompts some women to seek abortions, many women do not. . . .

The persistence of pregnancies in HIV-infected women and births of HIV-afflicted children derive from underlying cultural, social, religious, and personal ideologies that indisputably dictate a woman's reproductive decisions.

Id. at 670-71 (footnotes omitted).

²³⁵ See *supra* note 178 and accompanying text.

VI. ANALYSIS OF THE NEW YORK STATE ASSEMBLY BILL

As currently proposed, Assemblywoman Mayersohn's bill amends the New York State Public Health Law by adding a new subdivision under the confidentiality and disclosure section of Article 27-F.²³⁶ This section allows a parent or pro-

²³⁶ In pertinent part, § 2782 of Article 27-F provides:

1. No person who obtains confidential HIV related information in the course of providing any health or social service or pursuant to a release of confidential HIV related information may disclose or be compelled to disclose such information, except to the following:

(a) the protected individual or, when the protected individual lacks capacity to consent, a person authorized pursuant to law to consent to health care for the individual;

[Other exceptions relating to health care providers, authorized foster care or adoption agencies, insurance providers, persons authorized pursuant to court orders, and parole, probation or correctional agents.]

2. A state, county or local health officer may disclose confidential HIV related information when:

(a) disclosure is specifically authorized or required by federal or state law; or

(b) disclosure is made pursuant to a release of confidential HIV related information; or

(c) disclosure is requested by a physician pursuant to subdivision four of this section; or

(d) disclosure is authorized by court order pursuant to the provisions of section twenty-seven hundred eighty-five of this article.

3. No person to whom confidential HIV related information has been disclosed pursuant to this article shall disclose the information to another person except as authorized by this article, provided, however, that the provisions of this subdivision shall not apply:

(a) to the protected individual; or

(b) to a natural person who is authorized pursuant to law to consent to health care for the protected individual; or

(c) to a protected individual's foster parent as defined in section three hundred seventy-one of the social services law and subject to regulations promulgated pursuant to paragraph (a) of subdivision two of section twenty-seven hundred eighty-six of this article, for the purpose of providing care, treatment or supervision of the protected individual; or

(d) a prospective adoptive parent as specified in section three hundred seventy-three-a of the social services law and subject to regulations promulgated pursuant to paragraph (a) of subdivision two of section twenty-seven hundred eighty-six of this article with whom a child has been placed for adoption.

4. (a) A physician may disclose confidential HIV related information under the following conditions:

(1) disclosure is made to a contact or to a public health officer for the purpose of making the disclosure to said contact; and

(2) the physician reasonably believes disclosure is medically ap-

spective adoptive parent to receive the result of a newborn's HIV test. While this Note supports Assemblywoman's Mayersohn's bill, it finds the bill has some shortcomings that should be addressed before it is re-introduced to the New York State Assembly. The following analysis critiques the bill on its lack of clarity of purpose, its inappropriate inclusion of contact notification, its failure to amend the New York State HIV informed consent section, and its omission of counseling requirements.

propriate and there is a significant risk of infection to the contact; and

(3) the physician has counseled the protected individual regarding the need to notify the contact, and the physician reasonably believes the protected individual will not inform the contact; and

(4) the physician has informed the protected individual of his or her intent to make such disclosure to a contact and has given the protected individual the opportunity to express a preference as to whether disclosure should be made by the physician directly or to a public health officer for the purpose of said disclosure. If the protected individual expresses a preference for disclosure by a public health officer or by the physician, the physician shall honor such preference.

N.Y. PUB. HEALTH LAW § 2782 (McKinney Supp. 1993).

Under this section, the bill would add a new subdivision:

10. The department shall disclose to the mother, the prospective adoptive parents or the appropriate official of an authorized agency having the care, custody or guardianship of a newborn child confidential HIV related information obtained as a result of any testing done for any purpose whatsoever on such child, including epidemiological research, done by the department or any person, partnership, corporation or association authorized to obtain confidential HIV related information including, but not limited to, a subsidiary agency of the department, a health care provider or a health facility. If the mother of a newborn child cannot be located in order to receive such information, the father or the appropriate guardian of such child shall receive such notification.

New York State Assembly Bill No. 6747-C, 215th Gen. Assembly, 1st Sess. § 2 (1994). The bill also would add another subdivision under N.Y. Pub. Health Law § 1781 (McKinney Supp. 1993) to provide for testing of foster children:

7. The provisions of this section shall not apply to the performance of an HIV related test by a health care provider or health facility upon a foster child when such test has been deemed necessary for the protection of the health of such child or such child's foster parents or other members of such child's foster family by the appropriate official of the authorized agency having the care, custody or guardianship of such child.

New York State Assembly Bill No. 6747-C, 215th Gen. Assembly, 1st Sess. § 1 (1994).

A. *Need to State Clearly the Purpose of Newborn Testing*

The purpose of newborn testing is to identify HIV-infected newborns as early as possible so that these children can receive the maximum benefits from available treatments. As obvious as this purpose may seem, it needs to be clearly enunciated in the bill or legislative material because some commentators have raised the concern that the real purpose of testing is to identify HIV-infected mothers, not infants.²³⁷ Unfortunately this suggestion has been bolstered by a New York State Assembly memorandum and a newsletter from Assemblywoman Mayersohn's office that place undue emphasis on the prevention of HIV infection through breastfeeding as a benefit of newborn testing.²³⁸ Since only uninfected newborns benefit from the prevention of this mode of infection, the emphasis on this benefit bolsters the incorrect inference that the bill seeks to identify HIV-infected mothers, regardless of the status of the child.²³⁹

Another factor that has tended to support the inference that newborn testing seeks to identify infected mothers instead of children is that infection in children currently is tested by the presence of maternal antibodies. It should be made clear that, at the present time, newborn testing by means of maternal antibodies is the result of medical limitations and does not indicate a hidden purpose behind the test. Ideally, as the new-

²³⁷ See *HIV Infection, Pregnant Women, and Newborns*, *supra* note 42, at 2418 ("Currently, and for the foreseeable future, programs of newborn screening are defacto programs testing for HIV infection in the mother, not the infant."); Hunter, *supra* note 8.

Suspicion about the motivation for mandatory testing of either pregnant women or newborns is heightened by the context of such programs. The government has shown no great zeal for insuring the health of babies in the African-American and Hispanic communities, which would be the most affected. Infant mortality rates among those communities in the United States compare to the rates in impoverished nations, and normal prenatal and pediatric care is often unavailable.

Id. at 17.

²³⁸ New York State Assembly Memorandum in Support of Legislation, New York Assembly Bill No. 6747 (1993) (on file with author); Newsletter from Assemblywoman Mayersohn's Office (July 1993) (on file with author).

²³⁹ This is not to say that the prevention of HIV infection through breastfeeding is not important. This mode of transmission may be averted, however, by simply informing all mothers of the risk of transmission and advising them not to breastfeed their children unless they have tested negative for HIV.

est tests become more widely available, only those newborns who are themselves infected will be identified by the tests.

To eliminate misconceptions and allay fears regarding the purpose of the bill, the New York Assembly should clarify its legislative memorandum regarding the bill. The Assembly should begin by clearly stating the purpose of the bill—to identify infected newborns. It should then eliminate references to the prevention of infection through breastfeeding as a benefit of testing. Finally, the Assembly should direct the NYSDOH to review available testing methods each year and quickly authorize newer, more selective, methods when they become available.

B. *Need to Eliminate Contact Notification*

Under the current Public Health Law, a doctor has the authority to disclose confidential HIV information if the “physician reasonably believes disclosure is medically appropriate and there is a significant risk of infection to the contact.”²⁴⁰ A contact is defined as a spouse, a sexual partner or a person who has shared a hypodermic needle with the protected individual.²⁴¹ Normally, an individual may circumvent this potential disclosure by requesting an anonymous HIV test.²⁴² This option, however, is not available to the mother whose HIV status is revealed as a result of mandatory newborn testing. Therefore, she may be powerless to prevent her doctor from disclosing her status to others. This result is unjust. It allows greater protection to an individual who voluntarily consents to be tested than to an individual who has not consented to be tested. Thus, although identified women should be counseled about the necessity to notify contacts, involuntary contact notification should be inapplicable when women are identified as a result of mandatory newborn testing.

²⁴⁰ N.Y. PUB. HEALTH LAW § 2782(4) (McKinney Supp. 1993). For the full text of this provision, see *supra* note 236.

²⁴¹ N.Y. PUB. HEALTH LAW § 2780(10) (McKinney Supp. 1993).

²⁴² *Id.* § 2781(4).

C. *Need to Amend the Informed Consent Section*

Under current law, except in certain narrow circumstances, written, informed consent is required before an HIV test may be administered.²⁴³ The current blinded newborn testing falls within the ambit of § 2781(6)(b) of Article 27-F of the Public Health Law, which provides an exception to the requirements of informed consent "for the purpose of research if the testing is performed in a manner by which the identity of the test subject is not known and may not be retrieved by the researcher."²⁴⁴ Thus, it is the anonymity of the newborns that validates the current blinded testing scheme. Once this anonymity is removed, newborn testing will no longer satisfy the informed consent requirements of the law. In order to achieve its goal, therefore, the bill must provide an explicit exception to informed consent. Otherwise, a mother's consent will still be required prior to the testing of her newborn.

D. *Need to Incorporate Counseling Requirements*

Both pre-test and post-test counseling serve many essential functions. For example, effective pre-test counseling serves to educate the individuals tested about HIV infection and to reduce anxiety while they await their test result.²⁴⁵ In the case of mandatory newborn testing, pre-test counseling also serves to make the mother aware that her infant will be tested. Post-test counseling is critical as well and helps individuals who receive positive results cope with the emotional and physical stresses associated with that result.²⁴⁶

Under the current Public Health Law, pre-test and post-test counseling are required for testing performed pursuant to written, informed consent.²⁴⁷ Since these provisions do not apply to mandatory newborn testing, the bill must explicitly provide for counseling requirements.²⁴⁸ Again, it would be un-

²⁴³ *Id.* § 2781(1), (6); see also *supra* notes 67-77 and accompanying text.

²⁴⁴ N.Y. PUB. HEALTH LAW § 2781(6)(b) (McKinney Supp. 1993).

²⁴⁵ See Closen, *supra* note 162, at 471. See generally STINE, *supra* note 5, at 321-23.

²⁴⁶ See Closen, *supra* note 162, at 471. See generally STINE, *supra* note 5, at 321-23.

²⁴⁷ N.Y. PUB. HEALTH LAW § 2781(3), (5) (McKinney Supp. 1993).

²⁴⁸ A Senate bill was introduced this past session that would mandate counsel-

fair to provide persons who voluntarily consented to be tested with more support than persons who did not consent to be tested. Furthermore, in the context of newborn testing, counseling is especially important because the result affects a whole family, not just one person.²⁴⁹

CONCLUSION

Given the significant advantages of early treatments available for HIV-infected newborns, it is imperative that New York State adopt a newborn testing program. Moreover, the program must be mandatory: data collected from voluntary testing programs over the last several years shows that such programs have failed to identify over one-half of the infected children that were born in the state. Notwithstanding these statistics, however, opponents of mandatory testing cling to the success of the Harlem Hospital program as a model for future voluntary programs. Other arguments aside, it must be realized that the Harlem Hospital program is a true anomaly—it has been the only successful voluntary program in the entire state. Therefore, there is no reason to believe that it can be replicated on a larger scale. In addition, arguments by opponents of mandatory testing relating to the costs and problems of such testing are flawed. The costs of HIV infection and the problems with the health care system must be addressed responsibly by any testing program, whether mandatory or voluntary. Finally, arguments relating to the privacy interests of the mothers of newborns are also flawed. The privacy interests of mothers are largely protected by the strict confidentiality laws in New York State. Moreover, because an HIV-infected newborn faces a high risk of developing deadly opportunistic infections early in life, such privacy most likely would be short-lived even if a newborn were not tested. One mother, who discovered too late that her child was HIV-infected, has aptly summed up the current state of affairs by describing the current, blinded testing pro-

ing of pregnant women. New York State Senate Bill No. 6775, 215th Gen. Assembly, 2d Sess. (1994). While this bill was intended to be an alternative to Assemblywoman Mayersohn's bill, this Note argues that both bills are necessary components of a newborn testing scheme.

²⁴⁹ Moreover, pre-test counseling would have the desirable, collateral effect of educating non-infected people and people in low-risk groups about HIV.

gram as "sacrificing infants on the altar of privacy."²⁵⁰

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²⁵⁰ Nat Hentoff, *Sacrificing Infants on the Altar of Privacy*, VILLAGE VOICE, May 10, 1994, at 16.

²⁵¹ The author gratefully acknowledges the assistance of Professor Colin Crawford of Brooklyn Law School for constructive criticisms on drafts of this Note.

