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# DISCLOSURE OF AN ADOPTEE'S HIV STATUS: A RETURN TO ORPHANAGES AND LEPER COLONIES?

## I. INTRODUCTION

The following quotation, taken from a 1993 Center for Disease Control and Prevention (hereinafter "CDCP") report, fulfills its own prophecy, and remains the most accurate, concise, and prophetic statement on the growth and ramifications of pediatric AIDS in the United States:

By 1994, an estimated 7,500 children in the United States will have developed AIDS from being infected before or during birth, or from breast feeding after birth. During the next decade, at least 125,000 children will become orphans of this epidemic and will need to be cared for by family members, caring adults, or extended family members - or placed in foster care. These orphaned children, three-fourths of them not infected with HIV, will require our care, financially and socially.<sup>1</sup>

The CDCP's release of these demographics toll another warning bell in the HIV/AIDS<sup>2</sup> epidemic.<sup>3</sup> The statistics are particularly alarming be-

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1. CENTERS FOR DISEASE CONTROL AND PREVENTION, SURGEON GENERAL'S REP. TO THE AMERICAN PUBLIC ON HIV INFECTION AND AIDS 3 (1993). As of the publication date of this Comment, the most recent pediatric AIDS statistics indicate that the CDCP prognostications were too conservative. THE NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES, PEDIATRIC AIDS 2 (1994). In fact, the World Health Organization estimates that as of April 1994, 10,000 children in the United States were infected with HIV, 1 million children were infected worldwide, and by the end of the decade, 10 million children will be infected worldwide. *Id.*

2. The acronym HIV/AIDS means Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome. For a brief discussion on why this abbreviation is preferred over HIV or AIDS, see Michael L. Clozen, *Mandatory Disclosure of HIV Blood Test Results to the Individuals Tested: A Matter of Personal Choice Neglected*, 22 LOY. U. CHI. L.J. 445, n. 2 (1991) (discussing the inadequacy of using just HIV or AIDS to describe the full course of the disease).

3. The discrimination that people encounter who are part of the HIV/AIDS epidemic can be seen in all areas of life. See generally MICHAEL L. CLOZEN ET AL., AIDS CASES AND MATERIALS (Michael L. Clozen ed., John Marshall Publishing Company 1989). There have been documented cases of HIV positive individuals losing their job, health insurance, access to public education, or simply their ability to go out into public. See ROBERT M. JARVIS ET AL., AIDS LAW IN A NUTSHELL 3 (Robert M. Jarvis ed., West 1991). Some HIV infected individuals have suffered the indignity of an involuntary HIV test that has ultimately caused them to be refused medical treatment, nursing home care, housing and funeral

cause recent statutory<sup>4</sup> and common law<sup>5</sup> trends in adoption<sup>6</sup> facilitate access to an adoptee's medical history,<sup>7</sup> possibly including an HIV antibody test result.<sup>8</sup> However, upon closer examination, the movement

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services. *Id.* It is not uncommon to look in a daily newspaper and find an article about HIV/AIDS discrimination. See Rebecca Carr & Art Golab, *Court Orders Doctor to Treat HIV Patient*, CHICAGO SUN-TIMES, Apr. 13, 1994, at 4 (This article involved an individual who traveled from California to Arlington Heights, Illinois, to receive a special blood cleansing treatment for hepatitis B which was brought on by HIV/AIDS. At the appointment, the patient informed the doctor he was HIV positive and the doctor told the patient his staff would be uneasy treating him. Curiously, in the process of attempting to obtain a court order to compel treatment, the doctor called the patient's mother and "outed" him. However, a couple weeks later, a judge entered a court order pursuant to the American's with Disabilities Act compelling the doctor to treat the patient. This was believed to be the first time in the Chicagoland area that a judge had to order a doctor to treat a patient with HIV/AIDS. The patient died four days later).

One author suggests that the vast discrimination associated with HIV/AIDS is due to its initial stigmatization as a disease of homosexuals, minorities, intravenous drug users, and sexually promiscuous people. Michael L. Closen, *HIV/AIDS in 1990s* 27 J. MARSHALL L. REV. 239, 240 (1994). As a result of these stigmas, people living with HIV/AIDS contemplate suicide, and statistics indicate that the suicide rate among HIV positive individuals is significantly higher than the general population. *Id.* at 242.

4. Almost all states in the last decade except Idaho, Mississippi, Nevada, Rhode Island, and the District of Columbia, have enacted legislation making it easier for prospective parents to get an adoptee's medical history. D. Marianne Brown Blair, *Lifting the Genealogical Veil: A Blueprint for Legislative Reform of the Disclosure of Health-Related Information in Adoption*, 70 N.C. L. REV. 681, 686 n. 17 (1992).

5. See *Michael J. v. County of Los Angeles, Department of Adoptions*, 247 Cal. Rptr. 504 (Cal. Ct. App. 1988) (holding that adoption agencies must make a good faith disclosure of material facts concerning existing or past conditions of the child's health); *Burr v. Board of Commissioners*, 491 N.E.2d 1101 (Ohio 1986) (holding that adoption agencies could be held liable for fraud or misrepresentation in the disclosure of an adoptee's medical history); *County Department of Public Welfare v. Morningstar*, 151 N.E.2d 150 (Ind. Ct. App. 1958) (holding that adoptive parents could annul adoption because County Department of Public Welfare induced adoption through misrepresentation of child's background); *Roe v. Catholic Charities of the Diocese*, 588 N.E.2d 354 (Ill. App. Ct. 1992) (recognizing a new common law cause of action for adoption agency malpractice founded on principles of fraud and negligence in disclosure of health related matters).

6. Adoption is defined as, "[a]n act by which one person who is not the natural parent of another, creates between himself and that other a complex or aggregate of legal relationships, rights, powers, immunities, etc., which are identical with those which the law creates between a natural parent and his child." *Robertson v. Cornett*, 225 S.W.2d 780, 784 (Mo. 1949). Adoption law has also been defined as, "[a] judicial act creating between two persons certain relations, purely civil, of paternity and filiation." *Grimes v. Grimes*, 178 S.E. 573, 574 (N.C. 1935). Some courts have defined adoption in terms of property, hence, "[t]he taking of a child of another in manner provided by and with consequences specified in statute." *Fischer v. Robinson*, 198 A. 81, 82 (Pa. 1938).

7. Throughout this Comment the phrase medical history can mean any condition which is physical or mental that is active, dormant, acute, chronic or congenital.

8. Contemporary scholarly work in the adoption field also reflects this trend by advocating the need for broad disclosure policies. See Blair, *supra* note 4 (advocating enactment of mandatory disclosure statutes for adoptees' medical history but limiting disclosure of a

toward greater disclosure of an adoptee's medical history reveals an almost complete failure to address the HIV/AIDS epidemic in this area.<sup>9</sup> Accordingly, the need to develop an HIV/AIDS adoption disclosure policy, that accounts for the unique social and clinical characteristics of the disease, is warranted.<sup>10</sup> Failure to do so will result in many adoptees becoming unnecessary statistics of the CDCP or possibly members of a leper-like colony for children with HIV/AIDS.<sup>11</sup>

The need for a distinct and comprehensive HIV/AIDS adoption policy arises from the conflict among statutes governing adoption, the common law, and AIDS confidentiality laws.<sup>12</sup> Specifically, adoption statutes regulating adoption are silent or ambiguous on the disclosure of HIV/AIDS.<sup>13</sup> Whereas, the common law now encourages disclosure by recognizing a new cause of action — adoption agency malpractice.<sup>14</sup>

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birth mother's HIV status to a court order); Mary E. Schwartz, *Fraud in the Nursery: Is the Wrongful Adoption Remedy Enough?*, 26 VAL. U. L. REV. 807 (1992)(concluding that common law cause of action for adoption agency malpractice is not enough to foster disclosure, rather legislative reform is the only means to insure adoptees' best interests are pursued); Paula K. Bebensee, *In the Best Interests of Children and Adoptive Parents: The Need for Disclosure*, 78 IOWA L. REV. 397 (1993)(concluding that adoption statutes do not go far enough to protect parents' interests because disclosure laws are not broad enough).

9. States' adoption statutes do not address the disclosure of HIV to adoptive parents; for example, in Illinois, to find any statutes that discuss HIV disclosure to adoptive parents, one must look in the Children and Family Services Act, ILL. ANN. STAT. ch. 20 para. 505/22.3 (Smith-Hurd 1993). See also *infra* notes 98-104 and accompanying text (discussing the legislative reform movement toward greater disclosure coming before the discovery of HIV/AIDS).

10. See *infra* notes 97-182 and accompanying text (analyzing the failure of the laws affecting adoption to address HIV/AIDS disclosure).

11. The analogy of HIV/AIDS to leprosy or leper colonies comes from a variety of legal sources. See Jarvis, *supra* note 3, at 1 (comparing HIV/AIDS to leprosy, syphilis, herpes, and hepatitis). See also Closen, *supra* note 3, at 301 (tracing the history of social diseases that have found much disfavor in the twentieth century including leprosy). The leprosy analogy has also found its way into case law. See *South Florida Blood Service v. Rasmussen*, 467 So.2d 798, 802 (Fla. Dist. Ct. App. 1985) (stating that AIDS is the modern day equivalent to leprosy).

12. See *infra* notes 97-182 and accompanying text (analyzing deficiencies with current laws and proposing solutions).

13. See Abigail English, *The HIV-AIDS Epidemic and the Child Welfare System: Protecting the Rights of Infants, Young Children, and Adolescents*, 77 IOWA L. REV. 1509, 1538 (1992)(stating that HIV disclosure laws come from a variety of sources, such as, HIV specific statutes, medical and record laws, licensing laws for professionals and facilities, tort law, social services and child welfare statutes, educational and vocational rehabilitation laws, laws related to drug and alcohol treatment, developmental disability statutes, and a broad range of statutes governing the provision of health care, but makes no specific mention of adoption statutes).

14. See *Roe v. Catholic Charities of the Diocese*, 588 N.E.2d 354 (Ill. App. Ct. 1992) (creating the tort of adoption agency malpractice which finds its genesis in negligence and fraud). HIV/AIDS has not yet been a basis of an action for adoption agency malpractice, but the sweeping range of the common law decisions indicate that failure to disclose HIV/

What completes the adoption disclosure paradox is the recent enactment of special confidentiality laws that forbids HIV/AIDS disclosure.<sup>15</sup> Accordingly, the difficulty for adopting parents and adoption agencies is knowing which law to apply, while at the same time, giving proper deference to the adoption process's paramount concern of pursuing the child's best interests.<sup>16</sup> To illustrate the difficulty of resolving these conflicting positions and the devastating effect HIV/AIDS will have on the adoption industry, consider the following scenario.

After extensive investigation into the adoption process, Mr. and Mrs. Smith decide to adopt a newborn baby. However, they only want to adopt a "healthy" baby. The adoption agency introduces them to Mark, a seemingly healthy three-month old boy. The Smiths are immediately charmed and inquire about Mark's medical history.

The Smiths' inquiry poses a dilemma for the adoption agency. The agency knows Mark tested positive for HIV. If the agency does not reveal this information to the Smiths, it faces a malpractice suit for fraudulent or negligent misrepresentation. If, on the other hand, the agency does disclose this information, it runs the risk of the Smiths not adopting Mark.

Now assume the Smiths fail to ask questions about Mark's medical history, specifically, whether or not he was tested for HIV. The independent adoption agent, a lawyer in this case, relies on the jurisdiction's AIDS confidentiality act and does not disclose Mark's HIV positive status. One year later, the Smiths learn of Mark's condition after Mark begins manifesting symptoms of HIV/AIDS. Unable to afford Mark's medical treatment, the Smiths annul the adoption and place Mark in the custody of the state.

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AIDS could reasonably be encompassed within the scope of malpractice. See *infra* notes 152-182 and accompanying text (analyzing failure of common law to account for disclosure of HIV/AIDS).

At the time this Comment was written, no common law jurisdiction had reported any action brought against an adoption agency, state, private or independent, which claim was based on HIV/AIDS.

15. Only Alaska, Louisiana, Minnesota, Mississippi, Pennsylvania, and Tennessee have failed to enact HIV/AIDS protection statutes. Blair, *supra* note 4, at 753. In Illinois, see generally ILL. ANN. STAT. ch. 410, para. 305 (Smith-Hurd 1993) (forbidding the disclosure of HIV testing and results with enumerated exceptions).

16. Statutory adoption law requires all actors in the adoption process, including judges and agencies, to act in the best interests of the child. 2 C.J.S. *Adoption of Persons* § 6 (1972)(hereinafter C.J.S.). C.J.S. states that adoption statutes are to be construed, "to promote the welfare of the child, if necessary at the expense of the rights of natural parents and of adoptive parents." *Id.* In Illinois, the Adoption Act, ILL. ANN. STAT. ch. 750 para. 50 (Smith-Hurd 1993) states, "[t]he best interests and welfare of the person to be adopted shall be of paramount consideration in the construction and interpretation of this Act."

This hypothetical, which is subject to a myriad of permutations, illustrates how the laws affecting adoption omit to equitably address HIV/AIDS disclosure.<sup>17</sup> This failure is the result of an inability to integrate and balance the interests represented by each area of the law affecting today's adoptee: adoption statutes, common law, and HIV/AIDS confidentiality laws.<sup>18</sup> The consequence of the tension among these laws and policies is a system that does not always reflect its universal theme, to pursue the best interests of the child.<sup>19</sup>

Therefore, the purpose of this Comment is to propose a resolution to the current HIV/AIDS adoption conundrum.<sup>20</sup> Part II of this Comment briefly discusses the background of the adoption process, its history, and the conventional arguments for and against disclosure.<sup>21</sup> Subsection A, the adoption process, identifies the two types of adoptions, but more importantly, provides a time line for the analysis in answering the crucial question of when it is appropriate to disclose the HIV status of a newborn.<sup>22</sup> Subsection B explores the history of adoption. Historical background is important because HIV/AIDS which was not known to exist, could not possibly have been considered in the evolution of the child's best interests standard.<sup>23</sup> Historical background is useful in developing

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17. For a resolution to the hypothetical dilemmas posed *see generally infra* Appendix, at i.

18. The implementation of these competing interests in isolation, rather than collectively, further complicates the disclosure dilemma by promoting the pervasive discrimination associated with HIV/AIDS. *See supra* note 3 (discussing the various ways HIV positive individuals are discriminated).

Only considering one of these three conflicting areas of law also ignores the profound socioeconomic ramifications of this rapidly spreading disease. *See* Erin McBreen, *The High Cost of Living*, POSITIVELY AWARE, Mar. 1994, at 18 (The average cost of monthly medication which an adult with HIV/AIDS must take is \$682.75. Of course, if an adoptee is in the custody of a state agency, taxpayers incur the cost of the drugs). Furthermore, Deborah Weimer, *Beyond Parens Patriae: Assuring Timely, Informed Compassionate Decision Making for HIV Positive Children in Foster Care*, 46 U. MIAMI L. REV. 379, 380 (1991), states that of all known cases of children with HIV in 1990, 26% were living in foster care.

19. As more children come into the world from HIV positive mothers this assertion is distressing because nearly 365,000 people were expected to have contracted HIV by 1993. Deborah A. Wierczorkowski Wanamaker, *From Mother to Child . . . A Criminal Pregnancy: Should Criminalization of the Prenatal Transfer of AIDS/HIV be the Next Step in the Battle Against this Deadly Epidemic?*, 97 DICK. L. REV. 383, 385 (1993). Furthermore, it was estimated that between the years 1990 and 1993, 215,000 people died of AIDS. Marsha F. Goldsmith, *Centers for Disease Control's Survey Succumbs*, THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, Feb. 20, 1991, at 838.

20. For a comprehensive solution to these problems *see generally* Appendix, at i.

21. *See infra* notes 29-96 and accompanying text.

22. *See infra* notes 29-46 and accompanying text (describing state and private adoption process).

23. *See infra* notes 47-56 and accompanying text (discussing the historical development of the adoptee's best interests standard).

a new standard which more aptly addresses the complexity of HIV/AIDS.<sup>24</sup> Subsection C makes the traditional arguments for and against medical disclosure.<sup>25</sup> In the process, it articulates the benefits and harms attendant to HIV/AIDS disclosure, and non-disclosure.<sup>26</sup>

Part III of this Comment analyzes the present day deficiencies in the laws affecting adoption and proposes remedies to these inadequacies.<sup>27</sup> Part IV concludes with a short commentary and forecast of the dangers HIV/AIDS presents to the institution of adoption in the United States.<sup>28</sup> Finally, the appendix, contained at the conclusion of this text, codifies the remedies to this portion of the adoption crisis in a uniform HIV/AIDS disclosure statute proposed by this author.

## II. ADOPTION

### A. PROCESS

The adoption process does not provide a specific time when an adoptee's medical conditions are to be disclosed to adopting parents, if medical conditions are to be disclosed at all.<sup>29</sup> This section highlights such uncertainty by detailing the protocol followed by adoption agencies and independent adoption agents.<sup>30</sup> More importantly, it represents a blueprint for the analysis in pinpointing a time when disclosure of HIV/AIDS is appropriate.<sup>31</sup>

Adoption may occur through a state or private agency; both are regulated by statute.<sup>32</sup> The adoption process begins when biological parents die or surrender their rights to their child.<sup>33</sup> Until the parental rights

24. *Id.*

25. *See infra* notes 57-96 and accompanying text (discussing conventional arguments for and against disclosure).

26. *Id.*

27. *See infra* notes 97-182 and accompanying text (analyzing deficiencies with current laws affecting adoptions and HIV/AIDS disclosure).

28. *See infra* notes 183-185 and accompanying text (concluding remarks).

29. *See infra* notes 98-134 and accompanying text (discussing disclosure standards for medical conditions and the uncertainty of disclosure).

30. *See infra* notes 32-46 and accompanying text (describing state and private adoption protocol).

31. *Id.*

32. 2 C.J.S. *Adoption of Persons* § 3 (1972) (discussing generally the origins and mechanics of adoption law). In Illinois, for example, para. 50/4.1 of the Adoption Act, ILL. ANN. STAT. ch. 750 (Smith-Hurd 1993), grants the state exclusive authority over the placement of an adoptee by requiring all agents engaged in adoption to register with the state.

33. Surrendering rights to a child can occur voluntarily or involuntarily. *See* ILL. ANN. STAT. ch. 750, para. 50/1 (Smith-Hurd 1993). Generally, involuntary surrender is only done when a parent is adjudicated unfit. *Id.* Although this Comment is concerned primarily with HIV positive adoptees, there is an interesting discussion about HIV positive adults who wish to adopt, In the Matter of Erica Johnson, 612 N.E.2d 569 (Ind. Ct. 1993) (concluding that it would not be in the best interests of the child to have HIV positive parents).

terminate, the child remains in the temporary custody of an agency.<sup>34</sup> Unless the child is fortunate enough to be allowed to reside with extended family or family friends, the child is eventually placed in a foster home while the matching process for adoptive parents begins.<sup>35</sup>

The adoption agency, generally working from a waiting list of prospective parents, extensively questions and interviews the candidates.<sup>36</sup> During their meetings, the agency encourages prospective parents to learn about the adoptive process and to understand what they should expect.<sup>37</sup> Thereafter, the adoptee lives with the parents for a probationary period.<sup>38</sup> If the agency and adoptive parents conclude that a compatible match exists, a judge will finalize the adoption.<sup>39</sup> Once the judge issues a decree,<sup>40</sup> the adoption records including the adoptee's medical history are sealed.<sup>41</sup>

Another procedure, termed independent adoption, occurs when the

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34. JOAN H. HOLLINGER ET AL., *ADOPTION LAW AND PRACTICE* §1.05[3][a] (Joan H. Hollinger ed. 1991).

35. Foster parents can be given preference in an application for adoption over all others, provided that a period of time elapses, usually one year since the child was placed in the foster home. See ILL. ANN. ST. ch. 20, para. 50/15.1 (Smith-Hurd 1993). It was estimated in 1991 that there were nearly 20,000 HIV positive children in the United States; and almost 5,000 in foster care. Weimer, *supra* note 18.

36. Besides a general interview, an extensive investigation is done by a child welfare agent of the petitioner's character, reputation, health, general standing in the community, and religious affiliation. ILL. ANN. ST. ch. 20, para. 50/6 (Smith-Hurd 1993). All information collected in this report is confidential. *Id.*

37. *Id.*

38. Probationary periods give a case worker an opportunity to observe the adoptee and prospective parents interacting in the home. Joseph Evall, *Sexual Orientation and Adoptive Matching*, 25 FAM. L.Q. 347 (1991). More importantly, it gives the child and parent a real opportunity to see how compatible they are before adoption is final. *Id.* The observations of the case worker are often submitted with the investigative report to the judge deciding if a decree should be granted. *Id.*

39. When a final decree becomes effective, the rights and responsibilities of the natural parents are relieved. See ILL. ANN. ST. ch. 20, para. 17 (Smith-Hurd 1993). In addition, the adoption record is impounded and can only be reopened upon a court order in which the petitioner demonstrates good cause. *Id.* at para. 15/18(c).

40. Once a judge issues a final decree it becomes very difficult to reopen an adoption file. Interview with John W. Darrah, DuPage County Circuit Court Judge of the Chancery Division, in Wheaton, Illinois (April 15, 1994). Judges generally disfavor piercing an impounded adoption file because it may create tension among the adoptee, adoptive parents, and the biological parents. *Id.* Since it is in the interests of the state to place these children in homes and not in the custodial care of taxpayers, any procedure which jeopardizes a placement is frowned upon. *Id.* See *In Re Roger G.*, 84 Ill.2d 323, 418 N.E.2d 751 (1981) (denying an adult adoptee the right to view his adoption and birth records because the state's interest in promoting adoption through confidentiality was deemed superior).

41. *Id.*



biological parents seek to surrender their baby at birth.<sup>42</sup> A third party, such as a doctor, lawyer, or clergy member, arranges for the adoptive parents to take the newborn home from the hospital.<sup>43</sup> Shortly thereafter, the state requires an assessment report performed by a certified agency and the state petitions the court to finalize the adoption.<sup>44</sup> When the court orders the decree,<sup>45</sup> the adoption record and the adoptee's medical history are sealed.<sup>46</sup>

## B. HISTORY

History reveals that adoption did not always serve the best interests of the child.<sup>47</sup> However, today adoption disclosure decisions are made in accordance with the child's best interests standard.<sup>48</sup> This standard

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42. Unlike agency adoptions, the consent to surrender rights usually occurs before the birth of the child, but the effect is the same. Jeffery S. Loomis, *An Alternative Placement for Children in Adoption Law: Allowing Homosexuals the Right to Adopt*, 18 OHIO N.U. L. REV. 631, 633 (1992).

43. Colorado, Connecticut, Delaware, Massachusetts, Michigan and Minnesota are the only states which do not permit independent adoptions. *Id.* Normally, a third party intermediary is not required to be licensed by the state. *See also* Bebensee, *supra* note 8 at 397.

44. *See* Evall, *supra* note 38 at 349.

45. *See supra* note 40.

46. *See* Bebensee, *supra* note 8 at 397.

47. Before states began passing adoption legislation, destitute children were commonly abandoned and left in an orphanage. *See* Stephen B. Presser, *The Historical Background of the American Law of Adoption*, 11 J. FAM L. 443 (1971). A parental death or severe poverty, caused in part by the industrial revolution, usually caused a child to become indigent. *See* Jan Ellen Rein, *Relatives by Blood, Adoption, and Association: Who Should Get What and Why (The Impact of Adoptions, Adult Adoptions, and Equitable Adoptions on Intestate Succession and Class Gifts)*, 37 VAND. L. REV. 711 (1984). Consequently, children were at the mercy of orphanages with respect to welfare and placement. *Id.* Alternatively, children were left with a blood relative but those without any suitable taker usually went to an almshouse. *Id.* Almshouses made enough of an effort to educate these orphans so they could be shipped out as indentured servants or apprentices. *Id.* As a result, many so-called adopters used orphaned children as servants or apprentices. *Id.* Many of these children were also exploited as labor in the factories of the early Industrial Age. *Id.* However, as philanthropic reformers rose in prominence, the evolution and purpose of adoption gradually took on a more familiar posture. Presser, *supra*. Private agencies with religious affiliations to Christian philanthropists began to take in these children and educate them. Rein, *supra*.

48. Despite the fact that adoption can be traced to the earliest civilizations of Egypt, Babylon and Greece, it did not become part of the United States legal fabric until the mid-nineteenth century. 2 C.J.S. *Adoption of Persons* § 3 (1972). The late arrival of adoption law in this country is attributable to its foundation in Roman civil law, rather than English common law. *See* McNamara v. McNamara, 135 N.E.410 (1922) (discussing the historical development of adoption law in the United States and also in Illinois). England did not formally recognize adoption until it was codified in 1926. *See* Adoption of Children Act, 1926, 16 & 16 Geo. 5, ch. 29.

presents a particular problem when considering the disclosure of HIV/AIDS.

As the hypothetical illustration in the Introduction suggests, disclosure of HIV/AIDS does not fit neatly into the current standard of acting in a child's best interests.<sup>49</sup> Therefore, an examination of adoption's history which predates the discovery of HIV/AIDS is necessary to understand and justify a departure from the current standard.<sup>50</sup> In addition, an historical account also identifies a viable alternative standard, such as the family's best interests, which is employed in the proposed statute in the Appendix to this Comment.<sup>51</sup>

Early in history, adoption agencies centered on the adoptive family's interests rather than the adoptee's best interests.<sup>52</sup> Pursuant to that system, agencies were more willing to grant adoptive parents access to medical information of a potential adoptee.<sup>53</sup> However, as the concept of child rights expanded, the focus of adoption shifted to the child's interests being tantamount to the family's interests.<sup>54</sup> This portrays adoption's present theme that the child's best interests prevail.<sup>55</sup> A residual

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49. See *supra* pp. 5-6.

50. See *infra* notes 97-104 and accompanying text (noting the reform movement to ease disclosure requirements occurred before the discovery of HIV/AIDS).

51. See *infra* Appendix §1/1 (stating purpose of statute is to place adoptive parents' interests and adoptees' interests on equal level).

52. See *infra* notes 53-56 and accompanying text (discussing development of child's best interests standard in the absence of considering the disclosure of HIV/AIDS).

53. Although agencies were concerned with the welfare of their children, the adoptees' best interests were still considered subordinate to the adoptive families' interests. See Rein *supra* note 47 at 717. This can be seen in the agencies matching methods and the language of the early adoption statutes. See Evall *supra* note 67. At a time when the concept of child rights had not taken hold, the interests of the adults desiring to adopt were superior. *Id.* For example, in the Midwest during the mid to late 19th Century, it was not uncommon for children to be displayed on large platforms and auctioned off to farm families. *Id.* The first adoption statutes in Texas (1850), Vermont (1850), Tennessee (1851), Missouri (1857), and Iowa (1858) merely formalized a child's relationship with the adoptive parents with whom the child had been living for a number of years. *Id.* at 811.

54. See Evall, *supra* note 38 at 349. Massachusetts in 1951 was the first state to enact an adoption statute that was constructed with the interests and welfare of the child being tantamount. *Id.* Modern adoption statutes have clearly enumerated this standard. See Rein *supra* note 47 at 717. For example, the California adoption statute states, "[i]f satisfied that the interests of the child will be promoted, the court may thereupon make and enter a decree of adoption of the child. . ." CAL. CIV. CODE §227 (West 1982). In New York the language is practically identical. See N.Y. DOM. REL. LAW §114 (McKinney 1988). Texas, however, is more explicit in stating the standard: "[i]f the court is satisfied that the requirements for adoption have been met and the adoption is in the best interests of the child, the court shall make a decree granting the adoption." TEX. FAM. CODE ANN. § 16.08.(a) (West 1986). See also *supra* note 16 and accompanying text (quoting Illinois adoption statute's recitation of child's best interests standard).

55. See *supra* notes 16, 47-56 and accompanying text (discussing child's best interest standard).

effect of this present theme is greater disclosure protection for an adoptee's medical history.<sup>56</sup> However, whether or not health related nondisclosure is truly in the best interests of the child is the source of much debate.

### C. ARGUMENTS FOR AND AGAINST DISCLOSURE

Consideration of the traditional arguments for and against disclosure serves two purposes. First, it illustrates the benefits and harms of disclosure which are generally applicable to HIV/AIDS.<sup>57</sup> Second, it demonstrates the danger of oversimplifying the child's best interest standard.<sup>58</sup> Factors and interests other than a child's best interests need to be balanced in the disclosure of HIV/AIDS.<sup>59</sup>

The conventional wisdom among adoption agencies in the twentieth-century has been to withhold any information from adoptive parents that might jeopardize a possible match.<sup>60</sup> Although the statutes are designed to foster the child's best interests, their ultimate pragmatic goal is to place every child with a family.<sup>61</sup> Thus, the disclosure of any information that might compromise a child's opportunity to move into an adoptive home is inconsistent with adoption goals.<sup>62</sup> Fear of not placing children in homes forms the backbone of arguments of the proponents of nondisclosure.<sup>63</sup>

Based on this premise, disclosure critics advance philosophical and practical concerns about broad disclosure policies.<sup>64</sup> Ideally, adoption is seen as a new beginning for a child.<sup>65</sup> The formal process recognizes this view by legally severing all ties with the birth parents and replacing the biological parents' names on the birth certificate with the adoptive parents' names.<sup>66</sup> Furthermore, agencies attempt to match the physical

56. See Blair, *supra* note 4 at 684.

57. See *infra* notes 60-96 and accompanying text (analyzing disclosure of HIV/AIDS in adoption context).

58. *Id.*

59. See *infra* notes 97-182 and accompanying text (discussing failure of laws in emphasizing child's best interests).

60. See generally Blair, *supra* note 4.

61. *Id.*

62. Interview with Elizabeth Monk, Administrator of the AIDS Project for the Illinois Department of Children and Family Services in Chicago, Illinois. (April 15, 1994) (Ms. Monk stated that the practical effects of HIV/AIDS disclosure makes adoptees more difficult to place). See also *supra* note 40 (Judge Darrah explaining state's interest in not piercing an impounded file to reveal potentially disruptive information).

63. See *infra* notes 65-77 and accompanying text (discussing arguments against disclosure).

64. *Id.*

65. See Blair, *supra* note 4 at 695.

66. Although this may seem a symbolic gesture, the change of parental names on the birth certificate played a significant role in succession and inheritance issues. See *gener-*

characteristics of the child with the adoptive parents.<sup>67</sup> Agencies do this to project an image of blood lineage (or to make the appearance of an outsider within the family less noticeable).<sup>68</sup> Obviously then, allowing adoptive parents, and possibly the adoptee, access to the medical history stands in opposition to the philosophy that adoption is a rebirth.<sup>69</sup>

From a practical standpoint, the release of an adoptee's biological history concerns nondisclosure advocates because it could unfairly stigmatize a newborn.<sup>70</sup> A medical condition present in a birth parent may never pass to his or her child, and even if it does, the condition may not necessarily manifest in the child.<sup>71</sup> Unfortunately, the mere possibility that an infant is a carrier or has the slightest chance of manifesting an illness is enough to cause an otherwise satisfactory adoption match to fail.<sup>72</sup> Disclosing a medical history may result in stigmatization and render a child "unadoptable."<sup>73</sup>

Critics of disclosure argue that since biological parents are unable to select their child's genealogical traits, adoptive parents should not be privy to that selection either.<sup>74</sup> In essence, permitting wholesale disclosure of genealogical traits is a form of "baby shopping" granted to prospective parents.<sup>75</sup> Any prospective parent concerned with combing a

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*ally*, Rein *supra* note 47. The common laws first encounters with adoption arose out of inheritance issues. *Id.* See also *McNamara v. McNamara*, 135 N.E. 410 (Ill. 1922) (discussing the effect an adoption had on intestate succession of real estate).

67. Evall, *supra* note 38 (discussing how agencies emphasized matching physical characteristics, e.g., skin color, hair color, eye color, body type, so that the outside world would be less suspecting of an adoptee's presence in a family and promote unity).

68. *Id.*

69. See Blair *supra* note 4 at 695.

70. See *infra* notes 71, 72 and accompanying text.

71. For example, if only one birth parent is a carrier of sickle cell anemia, that genetic condition will never manifest in the child, but the child could still be a carrier. Interview with Dr. Gregorio Chejfec, Professor of Pathology and Medicine, Loyola University - Strick School of Medicine, in Maywood, Ill. (March 15, 1994). HIV is analogous to sickle cell anemia in that only one in four children born to an HIV positive mother will contract the virus. Erin McBreen, *AZT slows mother-to-child transmission; benefit shown as early intervention*, POSITIVELY AWARE, Apr. 1994, at 8.

72. Interview with Elizabeth Monk, Administrator of AIDS Adoption Project for the Illinois Department of Children and Family Services, in Chicago, Ill. (April 11, 1994).

73. *Baby Neal v. Casey*, 821 F. Supp. 320 (E.D. Pa. 1993) (discussing the issue of whether or not an HIV positive infant should be classified as "unadoptable").

74. With the advent of DNA manipulation and genetic engineering there is a serious argument to be made about biological parents being able to predetermine many physical characteristics of their child and ascertain if a child will manifest any symptom of a congenital condition. Interview with Dr. Gregorio Chejfec, Professor of Pathology and Medicine, Loyola University - Strick School of Medicine, in Maywood, Ill. (March 15, 1994).

75. Blair, *supra* note 4 at 712. The author seems to dismiss this contention rather easily by citing statistics from the National Committee for Adoption which estimates that there are twenty adoptive couples for every prospective adoptee. *Id.* However, the ratio of HIV exposed adoptees to waiting couples is not given. *Id.*

medical history in search of the perfect child is unfit for parenthood.<sup>76</sup> Finally, advocates of nondisclosure argue that birth parents' privacy rights are infringed upon because the child's medical history is indelibly linked to their own.<sup>77</sup>

Recently, disclosure advocates have undermined nondisclosure theories and have begun to gain favor with the state legislatures.<sup>78</sup> Disclosure proponents claim that withholding background information could physically or mentally harm the adoptee.<sup>79</sup> An adoptee could suffer more harm from not receiving treatment at an early stage than from not being adopted.<sup>80</sup> In fact, neglecting a condition until it has manifested itself sufficiently to prompt treatment could do irreparable harm or even result in premature death.<sup>81</sup> Accordingly, if a child has a condition that could be controlled or cured with proper medical attention, it should not go untreated for fear of frightening off prospective parents.<sup>82</sup>

Disclosure reformers' success in broadening adoption statutes has

76. *Id.* This contention would appear unfair if analogized to natural parents seeking genetic counseling. *Id.* It raises the question of whether biological parents who seek amniocentesis are less worthy of becoming parents than those who do not. *Id.*

77. See generally, Timothy N. O'Connell, *Disclosure of Social and Medical History of the Biological Parents of an Adopted Child*, 4 U. DAYTON L. REV. 533 (1979). (criticizing Ohio's statute which does not adequately protect medical and social history of biological parents). This Comment eliminates parental privacy issues altogether in the proposed statute. See generally Appendix §1/2 (requiring mandatory testing and disclosure of HIV throughout an adoptee's first eighteen months).

78. See *infra* note 108 (surveying the relaxed disclosure standards adopted by the states).

79. A recent study has shown that the drug azidothymidine (AZT) not only inhibits the spread of HIV in pregnant mothers but it also decreases the possibility of passing HIV in utero. McBreen, *supra* note 71, at 8. The study concluded that pregnant women who take AZT are two-thirds less likely to transmit HIV in utero than those who do not. *Id.* AZT is a synthetic thymidine. JEFFERY T. HUBER, *DICTIONARY OF AIDS RELATED TERMINOLOGY* 21 (Jeffery T. Huber ed., Neal-Schuman Publishers, Inc. 1993). AZT is "one of the basic components of DNA that inhibits the growth and development of the human immunodeficiency virus, which causes acquired immunodeficiency syndrome." *Id.*

80. See *infra* note 81. This argument is especially compelling because as one case stated, "the mortality rate of persons diagnosed with HIV ten years ago is very high, in fewer than five per cent still are alive." *Commonwealth v. Leno*, 616 N.E.2d 453, 455 (Mass. 1993). The expert witness in this case, a professor of epidemiology, further explained that there is presently no cure for HIV/AIDS. *Id.*

81. In *Burr v. Board of Commissioners*, 491 N.E.2d 1101 (Ohio 1986), an adopted child developed symptoms of Huntington's disease at a much earlier age than he would have, had the adoption agency disclosed the information to the adoptive parents. Not only could the symptoms have been repressed and some of the pain alleviated, but the child's life expectancy would have increased had there been earlier intervention. *Id.*

82. See *supra* notes 78-81 and accompanying text (discussing the harms of delayed disclosure of medical conditions).

also been bolstered by their appeals to fairness.<sup>83</sup> It was manifestly unfair in the second scenario of the Introduction to both the Smiths and to Mark to let an adoption proceed and then result in an annulment because Mark's HIV status was not disclosed.<sup>84</sup> Disclosure of Mark's HIV status may instead have enabled him to live with a family that was willing to care for a child with a terminal condition and that could also afford treatment.<sup>85</sup> A complete medical history for the prospective parents' edification prior to adoption, better prepares families for future financial hardship and emotional trauma.<sup>86</sup>

An equally compelling position in favor of disclosure is the emotional support argument.<sup>87</sup> A child's sickness is taxing both financially and emotionally.<sup>88</sup> A family must be willing and able to provide the necessary emotional support which can only be discerned through disclosure before adoption is final.<sup>89</sup> Broad disclosure permits pre-emptive treatment of a medical condition and prevents the financial and emotional devastation to the adoptive parents and adoptee when undisclosed circumstances cause an adoption to go awry.<sup>90</sup>

Although the disclosure reform movement succeeded in gaining broader disclosure laws, it failed to provide for the unique characteristics and nature of HIV/AIDS.<sup>91</sup> This result is apparent whether HIV/AIDS

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83. See *infra* notes 84-86 and accompanying text (discussing harms and benefits of HIV/AIDS disclosure).

84. See *supra* pp. 5-6.

85. See *McBreen supra* note 18 (citing average monthly cost of HIV drugs at \$682.75).

86. Ironically, it may not always be in the best interests of the child or adoptive parents to know of a current or possible future condition at the time of adoption, because it may be more difficult to obtain health insurance. See generally Benjamin Schatz, *The AIDS Insurance Crisis: Underwriting or Overreaching?*, 100 HARV. L. REV. 1782 (1987). Some states make it possible for insurance companies to test for HIV. *Id.* Missouri allows insurers to test individuals prior to granting coverage. MO. ANN. STAT. §191.671 (Vernon Supp. 1993). The statute also places a duty upon the insurer to disclose to the Missouri Department of Health any HIV positive results. *Id.*

87. John R. Maley, *Wrongful Adoption: Monetary Damages is a Superior Remedy to Annulment for Adoptive Parents Victimized by Adoption Fraud*, 20 IND. L. REV. 709 (1987). Often times the emotional trauma of discovering an undisclosed genetic condition is compounded by the fact it could have been prevented or suppressed if it were initially disclosed. *Id.* at 725.

88. Blair, *supra* note 4 at 706, 707. Social scientists have found that failure to disclose an adoptee's illness can emotionally traumatize the adoptive parents as much, if not more, than the adoptee. *Id.*

89. See *infra* note 146 (Judge Dahara stating that emotional support is a factor he would consider in determining if good cause had been shown to grant an order disclosing the HIV status of an adoptee).

90. See Maley, *supra* note 87 at 725. See also *supra* notes 78-82 and accompanying text.

91. See *infra* notes 97-182 and accompanying text.

disclosure or nondisclosure is done pursuant to an adoption statute,<sup>92</sup> a common law action,<sup>93</sup> or an AIDS confidentiality act.<sup>94</sup> The following section supports this assertion by exposing the inadequacies of the current adoption laws when HIV/AIDS becomes a factor in the adoption process.<sup>95</sup> In addition, the analysis proposes a means to cure these deficiencies.<sup>96</sup>

### III. ANALYSIS

This section identifies the inadequacies vexing the HIV/AIDS disclosure dilemma and offers the corrective measures to establish a more equitable adjudication of adoptions.<sup>97</sup> The analysis breaks down each deficient area of the adoption statutes, AIDS confidentiality laws, and common law in subsections A, B, and C, respectively. Preceding these subsections, however, is a discussion of an important deficiency in the current HIV/AIDS adoption disclosure laws; the laws affecting HIV/AIDS disclosure in the adoption context exist in a vacuum.<sup>98</sup>

The majority of the states which amended their adoption statutes to permit greater disclosure, did so prior to the discovery of HIV/AIDS.<sup>99</sup> Even legislatures which have subsequently amended their adoption statutes failed to directly address the HIV/AIDS issue.<sup>100</sup> Similarly, the AIDS confidentiality acts make no specific reference to adoption.<sup>101</sup> Finally, the common law decisions involving adoption agency malpractice

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92. See *infra* notes 98-134 and accompanying text.

93. See *infra* notes 98-104, 152-182 and accompanying text.

94. See *infra* notes 98-104, 135-151 and accompanying text.

95. See *infra* notes 97-182 and accompanying text.

96. See *infra* notes 97-182 and accompanying text. See also generally Appendix at i.

97. See *infra* notes 98-182 and accompanying notes.

98. See *infra* notes 99-104 and accompanying text.

99. The first known cases of AIDS related death were published in MORBIDITY AND MORTALITY WEEKLY REPORTS between October 1980 and May 1981. MICHAEL L. CLOSEN ET AL., AIDS CASES AND MATERIALS 47 (Michael L. Clozen ed., John Marshall Publishing Company 1989). All but four states had amended their adoption statutes by 1980 to permit greater disclosure of medical conditions. See Blair *supra* note 4.

100. See notes 47-56 and accompanying text (discussing historical development of adoption statutes before HIV/AIDS discovery). See also *infra* notes 101-104 and accompanying text (discussing the various laws affecting adoption as existing in isolation). Although there are reports of people manifesting symptoms of HIV/AIDS back to the mid-1970's, the disease was not identified until the early 1980's. MARTIN GUNDERSON, ET AL., AIDS: TESTING AND PRIVACY 9-10 (M.P. Battin & L.P. Francis eds., University of Utah Press 1987). The first known case of pediatric HIV/AIDS was in 1982. CENTERS FOR DISEASE CONTROL AND PREVENTION PEDIATRIC HIV INFECTION ON THE INCREASE, HIV/AIDS PREVENTION 2 (1991).

101. See *infra* notes 135-151 and accompanying text (analyzing AIDS confidentiality laws role in adoption disclosure).

were drafted before the full extent of HIV/AIDS was understood.<sup>102</sup> The natural consequences are conflicting laws which pursue their own limited agenda, e.g., a child's best interests, confidentiality, and civil liability.

This deficiency is remedied in the Appendix of this Comment which equitably incorporates the three competing interests into a comprehensive HIV/AIDS adoption statute.<sup>103</sup> The following subsections extract the key factors and interests from each area of the law and reconcile them accordingly.<sup>104</sup>

#### A. ADOPTION STATUTES

Because HIV/AIDS is not separately addressed within adoption statutes, it is categorized as any other medical condition.<sup>105</sup> Accordingly, it is subject to the same relaxed disclosure regulations as any other medical condition.<sup>106</sup>

Most state adoption statutes, including that of Illinois, require that an adoptee's medical history be disclosed to prospective parents.<sup>107</sup> While arguably "shall"<sup>108</sup> is not necessarily obligatory, the point is moot

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102. The Ohio Supreme Court in 1986 became the first jurisdiction to recognize adoption agency malpractice for which money damages could be recovered. *See Burr v. Board of Commissioners*, 491 N.E.2d 1101 (Ohio 1986). Shortly thereafter, California (in 1988), and Illinois (in 1992) also recognized this cause of action. *See Roe v. Catholic Charities of the Diocese*, 588 N.E.2d 354 (Ill. App. Ct. 1992)(noting chronology of wrongful adoption as cases of first impression). Technically, Indiana recognized wrongful adoption in 1958 but its remedy was annulment not money damages. *See County Department of Public Welfare v. Morningstar*, 151 N.E.2d 150 (Ind. Ct. App. 1958)

103. *See generally infra* Appendix at i.

104. *See infra* notes 105-182 and accompanying text. *See also* Appendix at i.

105. For example, Texas requires a "health history" which includes birth, neonatal, and other medical conditions. TEX. FAM. CODE ANN. §16.032(b) (West 1986). The statute does not specifically reference any medical condition. *Id.* California requires a "background" report which includes medical reports and psychological evaluations but does not identify any medical conditions by name. CAL. CIV. CODE §224s (West 1982).

106. In Virginia, the physical and mental health histories of the adoptee are disclosed without any attempt to categorize or single out a specific genealogical trait. VA. CODE ANN. §631.223(D)(ii) (Michie 1991).

107. The Illinois Adoption Act, ILL. ANN. ST. ch. 750 para. 50/18.4(a) (Smith-Hurd 1993), reads in relevant part:

The agency, Department of Children and Family Services, Court supportive Services, Juvenile Division of the Circuit Court, or the Probation Officers of the Circuit Court involved in the adoption proceedings shall give in writing the following information, if known, to the adoptive parents not later than the date of placement with the petitioning adoptive parents . . . (viii) detailed medical and mental health histories of the child, the biological parents, and their immediate relatives.

108. According to Blair, *supra* note 4, at 714, Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Missouri, Montana, New



in Illinois and many states.<sup>109</sup> For example, from Section 50/18.4(a) of the Illinois Adoption Act, the relevant provision on disclosure, it appears that any conflicting law, such as an AIDS confidentiality law, abrogates disclosure of an HIV test result.<sup>110</sup> Because the language of the statute begins, “[n]otwithstanding any other provision of the law to the contrary,” it acknowledges that any other laws standing in conflict will supersede the statute.<sup>111</sup> This effectively cuts off an adoptive parent from learning the HIV status directly from the child, but does not preclude harmful inferences which can be made from the natural parents’ medical and social history report.<sup>112</sup>

Harmful inferences are possible because most state adoption statutes mandate disclosure of numerous characteristics about the natural parents, including medical and mental health histories.<sup>113</sup> If the pro-

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Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, South Dakota, Texas, Utah, Vermont, Virginia, Washington and Wisconsin all have “shall” as the standard for disclosing background information. While Delaware, New Mexico, Oklahoma, South Carolina and West Virginia leave disclosure decisions to the discretion of the state agency facilitating the adoption. *Id.* Finally, the District of Columbia, Maine, Nevada, Rhode Island, and Delaware require a court order to release background information. *Id.* It should be noted, however, that these standards do change. *See infra* note 109 (noting changes in Florida and Washington).

109. Although the majority of states make medical history disclosure mandatory, some statutes do limit disclosure by allowing the adoption agency or independent adoption agent to include whatever information it deems appropriate in a medical history report. *See* TEX. FAM. CODE ANN. § 16.032(a) (West 1986). New York, like Illinois, is more explicit in recognizing a limitation. N.Y. SOC. SERV. LAW § 373-a (McKinney 1992). New York prefaces its disclosure law by recognizing the possibility of a contrary provision of law that would negate HIV/AIDS disclosure. *Id.* In Florida, to disclose medical information that identifies the adoptee, a petitioner must obtain a court order by showing good cause. FLA. STAT. ANN. § 63.162 (West Supp. 1994). Washington is more subtle in its limitation. WASH. REV. CODE ANN. § 26.33.350 (West Supp. 1994). Washington requires disclosure of all “available” information or in the case of natural parents, only information that “needs” to be disclosed. *Id.* The limitation then is the discretionary power given adoption agencies and agents in choosing what will be disclosed. *Id.*

110. The Illinois Adoption Act, ILCS 750 50/18.4(a) (Smith-Hurd 1992), reads in relevant part: “Notwithstanding any other provision of law to the contrary, to the extent currently in possession of the agency, the medical and mental health histories of a child legally freed for adoption and of the biological parents . . . [Emphasis added].”

111. *Id.*

112. *See infra* note 62 and accompanying text (Elizabeth Monk stating that HIV/AIDS in natural parents makes it harder to place adoptees notwithstanding conclusive test results).

113. Many adoption statutes make it easier to obtain health information about a natural parent than an adoptee. *See* VT. STAT. ANN. tit. 15 § 436(c) (1989). States justify this more relaxed disclosure standard for biological parents’ health related information by excluding any identifying information. *Id.* Vermont’s statute states, “A relinquishment [of a child] shall also be accompanied by a separate certificate containing the following *nonidentifying* information about each birth parent. . . [Emphasis added].” *Id.* Other states, like Ohio, are less concerned with the natural parents’ anonymity. OHIO REV. CODE ANN.

spective parents learn that the natural mother is HIV positive, they may erroneously conclude that the adoptee is HIV positive.<sup>114</sup> In fact, less than 30% of all infants born to HIV positive mothers will contract the AIDS virus.<sup>115</sup> Regardless, this prospect could only serve to decrease an adoptee's chances of being placed, irrespective of the test results.<sup>116</sup> Consequently, permitting adoptive parents to learn the HIV status of the biological parents stigmatizes an adoptee.<sup>117</sup>

While a prospective parent may want additional information concerning the circumstances of an HIV/AIDS transmission, this would be an intrusion into a biological parent's privacy.<sup>118</sup> In addition, it may invoke unfair inferences about the adoptee, such as, a predisposition toward drug usage, promiscuity, or homosexuality.<sup>119</sup> The logical solution to avoid unfair exposure of a natural parent's medical and social history surrounding his or her HIV status is to directly test the child.<sup>120</sup> Even

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§ 3107.12(c)(3) (Anderson 1989). In fact, Ohio requires identifying information without exception; the statute states in relevant part, "[t]he report of investigation shall contain . . . [t]he minor families background including names and identifying data regarding the biological parents. . ." *Id.*

114. Personal interview with Elizabeth Monk, Administrator of the AIDS project for the Illinois Department of Children and Family Services (DCFS) in Chicago, Ill. (April 11, 1994). Ms. Monk related that the initial screening process of prospective parents includes questions about a willingness to adopt HIV/AIDS children. *Id.* Most prospective parents are unwilling to adopt HIV/AIDS children. *Id.* Even an adoptee testing negative for HIV will sometimes scare off adoptive parents. *Id.* However, there are couples who exclusively request to adopt HIV/AIDS children. *Id.* Some of those couples return to adopt again even after their previously adopted child has passed away. *Id.* Ms. Monk characterizes couples who adopt HIV/AIDS children as "spiritual" people, who wish to provide some quality of life to HIV/AIDS children for the relatively short period they are alive. *Id.*

115. CENTERS FOR DISEASE CONTROL AND PREVENTION, SURGEON GENERAL'S REP. TO THE AMERICAN PUBLIC ON HIV INFECTION AND AIDS 3 (1993).

116. The long standing trend in adoption is that as (healthy or HIV/AIDS) adoptees grow older, the difficulty in placing them increases. Interview with Elizabeth Monk, Administrator of the AIDS project for the Illinois Department of Children and Family Services, in Chicago, Ill. (April 11, 1994).

117. *See supra* notes 113-116 and accompanying text.

118. For a complete discussion on the issues involving natural parents' privacy rights concerning the disclosure of HIV/AIDS *see* MARTIN GUNDERSON ET AL., AIDS: TESTING AND PRIVACY 59-93 (M.P. Battin & L.P. Francis eds., University of Utah Press 1987). For a discussion about natural parents' privacy rights with respect to the disclosure of other medical conditions in adoption *see* Blair, *supra* note 4, at 687. This Comment negates the natural parents' HIV/AIDS privacy issue by requiring mandatory HIV testing of all infants designated for adoption. *See infra* Appendix § 1/2 (requiring all infants designated for adoption to be tested for HIV so that natural parents' HIV status becomes irrelevant.)

119. Personal interview with Elizabeth Monk, Administrator of the AIDS project for the Illinois DCFS in Chicago, Ill. (April 11, 1994). Ms. Monk believes that the only way to dispel these stigmas is through education. *Id.* She feels that counseling and education about HIV are the only effective means to combat the epidemic. *Id.*

120. *See infra* notes 139-143 and accompanying text (discussing the inability of infants to consent to HIV testing).

though this may not be possible,<sup>121</sup> if it is permitted, a great injustice could occur to the adoptee due to the clinical nature of HIV/AIDS.<sup>122</sup>

An HIV positive mother can transmit the virus to her infant in utero, during delivery, and by breastfeeding.<sup>123</sup> Because the mother's antigens can remain in the infant for its first eighteen months, an HIV test during this period is inconclusive.<sup>124</sup> More importantly, the child could test positive but in reality be negative.<sup>125</sup> This revelation is devastating to the child's chances of being adopted.<sup>126</sup> By the time an adoptee learns that the test result was a false positive the chances of adoption have decreased.<sup>127</sup> Therefore, the primary deficiency of the adoption statutes is their silence on HIV/AIDS disclosure.<sup>128</sup> This absence permits a "back door" approach to inferring an adoptee's HIV status vis a vis the biological parents' medical or social histories.<sup>129</sup> However, this only serves to prejudice the adoptee and produce unreliable test results.<sup>130</sup>

The solution to these problems is to make HIV testing mandatory for all newborns designated for adoption.<sup>131</sup> Mandatory HIV testing for all adoptees eliminates the need to disclose the natural parents' HIV status and the circumstances surrounding their contraction of the virus.<sup>132</sup> This also prevents adoptive parents from drawing any prejudicial infer-

121. See *infra* note 140 (discussing hospitals and doctors unwillingness to test individuals without consent). See also *supra* note 120.

122. See *infra* notes 123-131 and accompanying text.

123. Interview with Dr. Gregorio Chejfec, Professor of Pathology and Medicine, Loyola University-Strick School of Medicine, in Maywood, Ill. (March 15, 1994). Furthermore, a recent study indicates that the likelihood of the HIV virus being transmitted in utero is directly related to the progression of HIV/AIDS in the natural mother. See Stephanie Blanche, *Relation of the Course of HIV Infection in Children to the Severity of the Disease in Their Mothers at Delivery*, THE NEW ENGLAND JOURNAL OF MEDICINE, Feb. 3, 1994, 308-312. The less symptomatic the natural mother is of HIV/AIDS, the less likely she is to transmit the virus in utero to her fetus. *Id.*

124. Interview with Dr. Gregorio Chejfec, Professor of Pathology and Medicine, Loyola University-Strick School of Medicine, in Maywood, Ill. (March 15, 1994).

125. *Id.*

126. See *supra* note 62 (noting stigmatization of being tested for HIV).

127. See *supra* note 116 (noting trend in adoption that as adoptee gets older the difficulty in placement increases).

128. See *supra* notes 105-127 and accompanying text.

129. *Id.*

130. The two tests most often used in screening for HIV are the Enzyme Linked Immunoabsorbent Assay (ELISA) and Western Blot Assay. SCOTT H. ISAACMAN, GOVERNMENTAL INSPECTION OF THE BABY FACTORY 72, 77 (2nd ed. 1991). The ELISA test measures the amount of antibodies to the HIV proteins. *Id.* at 72. The test is highly sensitive and produces only a small number of false positive and false negative results. *Id.* In the event of two positive results under ELISA, a more sensitive Western Blot Assay test is performed. *Id.* at 77. Only when a person has two positive ELISA results and a positive Western Blot Assay will they be considered HIV positive.

131. See *infra* Appendix § 1/2.

132. See *supra* notes 105-127 and accompanying text.

ences from the natural parents' medical or social background.<sup>133</sup> Furthermore, if mandatory HIV testing is the established protocol rather than the exception, it will not be possible for a prospective parent to raise the ugly specter of discrimination associated with HIV/AIDS by asking, "why was this child tested for HIV when this one was not?"<sup>134</sup>

### B. AIDS CONFIDENTIALITY LAWS

AIDS confidentiality laws<sup>135</sup> are unfair and inadequate in the current methodology of disclosure.<sup>136</sup> First, newborns cannot consent to subjugation.<sup>137</sup> Second, their protection is often times illusory.<sup>138</sup>

The AIDS Confidentiality laws require informed consent of all subjects who are to be tested.<sup>139</sup> Obviously, a newborn cannot give the req-

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133. *Id.*

134. *See supra* note 62 (Monk discussing stigma of HIV testing).

135. In Illinois, as with many other states, the AIDS Confidentiality Act was passed to protect the public health by promoting a greater awareness of HIV/AIDS through testing. ILL. ANN. ST. ch. 410, para. 305/2 (Smith-Hurd 1988). The Act recognizes, however, that many people are reluctant to submit to a voluntary test. *Id.* *See also* Application of Multimedia KSDK, Inc. 581 N.E.2d 911 (Ill. App. Ct. 1991) (stating the purpose of the AIDS Confidentiality Act was to control the spread of HIV by encouraging the public to voluntarily test through strict anonymity). Therefore, complete anonymity is assured to an individual throughout the testing process. *See* Illinois AIDS Confidentiality Act para. 305/6. As a general rule, the results of the test are kept confidential as well. *Id.* *See* Blair, *supra* note 4, at 373 (listing Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming as states which have enacted AIDS confidentiality statutes).

136. *See supra* notes 137-151 and accompanying text (discussing the deficiencies of the AIDS confidentiality laws).

137. *See infra* notes 139-143 and accompanying text (discussing an infant's inability of consent to an HIV test and its possible ramifications).

138. *See infra* notes 144-148 and accompanying text (analyzing the illusory effect of the AIDS confidentiality laws through the grant of a court order).

139. California concurs with Illinois law insofar as requiring everyone tested for HIV/AIDS to give their written informed consent: "no person shall test a person's blood for evidence of antibodies to the probable causative agent of AIDS without the written consent of the subject of the test." CAL. HEALTH & SAFETY CODE § 199.22(a)(West 1990). In Florida, the applicable statute merely requires "informed consent", and makes no reference to written consent. FLA. STAT. ANN. § 381.004(3)(a) (West 1993). Illinois defines written informed consent as a written agreement executed by the test subject or the subject's legally authorized representative which states that the subject has been given a fair explanation of the test including its use, purpose, limitations, and the meaning of its results. ILL. ANN. ST. ch.410, para. 305/3(d)(1)(2) (Smith-Hurd 1993). The section further requires informing the subject of the nature of the test, and the possible exceptions to disclosing a positive result. *Id.*

uisite consent and must rely on its legally authorized representative.<sup>140</sup> This means either a birth parent, guardian, adoption agency, or independent adoption agent would have to authorize the test.<sup>141</sup> Since these parties have an interest in not disclosing harmful information to prospective parents, they may be reluctant to authorize a test that would jeopardize placement.<sup>142</sup> Consequently, an adoptee's interests could easily be disregarded under AIDS confidentiality laws by legally authorized

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140. See CAL. HEALTH & SAFETY CODE §199.27(a)(1) (West 1990)(listing test subject's parents, guardians, conservators, or other persons lawfully authorized to make health care decisions as an alternative to an incompetent person needing to be tested). See also FLA. STAT. ANN. §381.004(3)(b) (West 1993)(listing legal guardian or other person authorized by law to permit HIV testing as an alternative to an infant).

141. Alternatively, a physician may order an HIV test if it is "medically indicated" in order to offer a proper diagnosis or treatment. ILL. ANN. ST. CH. 410, para. 305/8 (Smith-Hurd 1993). It would be difficult, however, for a doctor to justify an HIV test on a newborn if the mother has not disclosed her HIV status prior to birth or manifested any symptoms of HIV/AIDS. Interview with Dr. Gregorio Chejfec, Chief of Laboratory Services and Department of Pathology at Hines Veterans Administration Hospital, Maywood, Ill. (March 15, 1994). Moreover, hospitals are generally reluctant to unilaterally order an HIV test without good cause for fear of violating a patient's privacy rights. *Id.* Dr. Chejfec related a case in which the Chief of Infectious Diseases at Hines V.A. would not permit him to perform an HIV test on a cadaver. *Id.* The origin of the decedent's demise was unknown but symptomatic of HIV/AIDS. *Id.* The next of kin requested the HIV test, not because of curiosity about the decedent's sexual orientation, but because as a grandfather, he had close personal contact with his grandchildren. *Id.* Nevertheless, the Chief of the Department of Infectious Diseases refused to permit the test claiming no consent could be given, and cited possible privacy intrusions. *Id.*

If a hospital does test an individual for HIV, the results are supposedly kept between the doctor and patient. See ILL. ANN. ST. CH. 410, para. 305/9 (Smith-Hurd 1993). Yet, Illinois law, as with every other state having HIV confidentiality laws, specifies several circumstances under which a third party could be notified of a patient's HIV status. *Id.* at para. 305/9(a-j) (listing spouses, legally authorized representatives, authorized health facility agents, people securing a court order, law enforcement officer, health care workers, and the Department of Children and Family Services (DCFS) as exceptions entitled to HIV test results).

Even though the DCFS exception, cited in para. 305/9(j) above is silent on the issue of whether the DCFS must disclose an adoptee's HIV status to prospective parents, this question was answered in the Children and Family Services Act (CFSA). See ILL. ANN. STAT. CH. 20, para. 505/22.3 (Smith-Hurd 1993) (providing adoptive parents with the opportunity to test an adoptee with an enzyme-linked immunosorbent assay (ELISA) test, and upon a positive result, a follow-up Western Blot Assay test). Thus, the CFSA compels the DCFS to provide HIV testing and disclosure of the results upon request of any prospective parent. *Id.* It should be noted that this mandatory disclosure provision only applies to DCFS adoptions and not to private agencies or independent adoption agents. *Id.*

142. If adoptive parents request an HIV status report, but are denied in accordance with a state's AIDS confidentiality laws, they will probably pursue another adoptee or no adoption at all. Interview with Elizabeth Monk, Administrator of the AIDS project for the Illinois Department of Children and Family Services, in Chicago, Ill. (April 11, 1994). Indeed, it is doubtful that a prospective couple would risk adopting an HIV positive baby, unless they could receive assurances to the contrary. *Id.*

representatives acting in their own interests.<sup>143</sup>

Most AIDS confidentiality laws implicitly recognize the rights of prospective parents to discover the HIV status of an adoptee pursuant to a court order.<sup>144</sup> In Illinois, for example, paragraphs 305/9(g)(i-v) of the AIDS Confidentiality Act permit a prospective parent to obtain a court order on a proper showing of good cause.<sup>145</sup> To demonstrate good cause a petitioner must convince a judge that the need for disclosure outweighs the subject's privacy interest.<sup>146</sup> A petitioner could fashion compelling arguments about needing to know if an infant is HIV positive.<sup>147</sup> If a court order is granted, the AIDS Confidentiality Act, a vehicle originally created to protect HIV test results, would become the very means of disclosing them.<sup>148</sup>

This author proposes eliminating the possibility of a court order which authorizes disclosure of a newborn's HIV status.<sup>149</sup> By removing

143. See *supra* notes 139-142 and accompanying text (discussing the likelihood of a child's best interests not being represented when another party can give consent to test the infant for HIV/AIDS).

144. In Florida, See FLA. STAT. ANN. §381.004(3)(f)(9)(a-e) (West 1993).

145. ILL. ANN. ST. ch.410, para. 305/9(g)(i) (Smith-Hurd 1993) states:  
§9.

No person may disclose or be compelled to disclose the identity of any person upon whom a test is performed, or the results of such a test in a manner which permits identification of the subject of the test, except to the following persons:

(g) A person allowed access to said record by a court order which is issued in compliance with the following provisions:

(i) No court of this State shall issue such order unless the court finds that the person seeking the test results has demonstrated a compelling need for the test results which cannot be accommodated by other means. *In assessing compelling need, the court shall weigh the need for disclosure against the privacy interest of the test subject and the public interest which may be deserved by disclosure which deters blood, organ and semen donation and future HIV related testing* [Emphasis added].

During and after the court order proceedings, the identity of the test subject is afforded absolute anonymity by the use of a pseudonym. ILL. ANN. ST. ch.410, para.305/9(g)(i-v) (Smith-Hurd 1993). Any violation of this Act could result in criminal sanctions, civil liability, or a combination thereof. *Id.* (awarding liquidated or actual damages for negligent disclosure up to \$1,000.00; awarding liquidated damages for intentional disclosure up to \$5,000.00; awarding reasonable attorney fees; allowing possible injunctive relief; and disclaiming any limitation this Act may have on any other relief theory).

146. The Honorable John W. Darrah stated that in assessing the possible disclosure of an adoptee's HIV status to prospective parents he would consider the medical expenses to be incurred by the prospective parents, the threat of transmission to other family members, and the emotional trauma involved with raising a child with HIV/AIDS. Interview with John W. Darrah, DuPage County Circuit Court Judge of the Chancery Division, in Wheaton, Ill. (April 15, 1994).

147. *Id.*

148. See *supra* notes 144-148 and accompanying text.

149. See *infra* Appendix §1/4 (requiring disclosure of HIV status throughout an adoptee's first eighteen months).

the disclosure device, legal guardians may be more willing to authorize HIV testing, and enable HIV positive newborns to receive necessary medical attention.<sup>150</sup> It would also shield adoptees from unfair stigmas associated with HIV tests and the consequences of a false positive.<sup>151</sup>

### C. COMMON LAW ADOPTION AGENCY MALPRACTICE

The common law cause of action for adoption agency malpractice injects elements into the HIV/AIDS equation that raise critical concerns about the substantive law and its pragmatic effects.<sup>152</sup> First, the common law is too broad and does not focus on HIV/AIDS.<sup>153</sup> Second, the law does not address the crucial timing of HIV/AIDS disclosure.<sup>154</sup>

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150. See *supra* notes 78-82 and accompanying text (discussing harm of nondisclosure and the failure to treat a medical condition before it manifests).

151. Furthermore, it precludes the possibility of a petition to the court, requesting information about an adoptee's HIV test results, becoming a routine procedure in every adoption. See *infra* notes 171-175 and accompanying text (discussing the proliferation of litigation in the adoption process and its movement away from statutory law).

152. Adoption agency malpractice or wrongful adoption, did not become part of the legal lexicon until in the 1980s. See *Richard P. v. Visa Del Mar Child Care Service*, 165 Cal. Rptr. 370 (Cal. Ct. App. 1980) (alleging defendants negligently or intentionally misrepresented the adoptee's medical history at time of placement). The court in *Roe v. Catholic Charities of the Diocese*, lists states recognizing adoption agency malpractice as: California, Illinois, Indiana and Ohio. 588 N.E.2d 354, 357 (Ill. App. Ct. 1992). Later, Minnesota in *M.H. and J.L.H. v. Caritas Family Services*, 475 N.W.2d 94 (Minn. Ct. App. 1991) (concluding that an adoption agency could be liable if it negligently misrepresents an adoptee's health), and Wisconsin in *Meracle v. Children's Service Society of Wisconsin*, 437 N.W.2d 532 (Wis. 1989) (holding that adoption agency negligently breached its duty to disclose the medical condition and risks of their adopted child) became states recognizing this tort.

153. The basis of an adoption agency malpractice claim is the allegation that an agency either intentionally or negligently misrepresented a child's medical history. See *Roe v. Catholic Charities of the Diocese*, 588 N.E.2d 354, 357 (Ill. App. Ct. 1992). Depending on the jurisdiction, intentional misrepresentation could also be called fraud. *Id.* Underlying the negligent or fraudulent allegation is the concept of an adoption agency's duty to disclose relevant medical information to prospective parents. See *Meracle v. Children's Service Society of Wisconsin*, 437 N.W.2d 532 (Wis. 1989) (holding the adoption agency has a duty to disclose relevant medical history). Whether a claim is brought in negligence or fraud, courts hold that the duty to disclose relevant medical history is based on foreseeable harm to either party. See *Michael J. v. County of Los Angeles, Department of Adoptions*, 247 Cal. Rptr. 504, 513 (Cal. Ct. App. 1988). In a claim based on HIV/AIDS, proving the reasonableness of foreseeable harm is not a difficult burden to sustain because the mortality rate of HIV/AIDS is very high, and the cost of care is astronomical. See *supra* note 80 (finding that only five percent of people with HIV/AIDS ten years ago are still alive). See also *McBreen* note 18 (determining average cost of monthly medication for HIV/AIDS as \$682.75).

154. Instead, the court's reasoning focused on the fact that withholding or misrepresenting information concerning a child's health, harmed the adoptive parents because they incurred additional expense in diagnosing a condition, and harmed the child by denying immediate or preventive treatment. See *Roe v. Catholic Charities of the Diocese*, 588 N.E.2d 354, 360 (Ill. App. Ct. 1992). The court only ambiguously addressed the timing of disclosure by concluding it should be earlier rather than later:

Third, the law perpetuates litigation and results in adoption law moving away from statute, its originally intended regulator.<sup>155</sup>

The common law cause of action for adoption agency malpractice is so broad that it does not distinguish among medical conditions.<sup>156</sup> It appears from the language of the court holdings that failure to disclose or misrepresenting a congenital condition such as color blindness is treated the same as HIV/AIDS.<sup>157</sup> As long as the alleged fraud or negligence fits neatly within its respective elements, it is actionable.<sup>158</sup> However, the

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Early detection and treatment may lead to a greater change of cure or effective treatment. The children deserve the opportunity for early treatment. Here, as in Burr, the adoptive parents spent a great deal of time and money duplicating diagnostic work already accomplished. . . . These children could have received proper treatment at a much earlier time.

*Id.* As noted previously, early disclosure of HIV/AIDS can be as harmful as nondisclosure due to the viruses clinical nature. See *supra* notes 123-125, 165-167 and accompanying text (discussing the possibility of a false positive and negative).

155. See *infra* notes 157-159 and accompanying text (analyzing the breadth of the common law holdings and the likelihood of HIV/AIDS falling within it).

156. In *Burr v. Board of County Commissioners*, 491 N.E.2d 1101 (Ohio 1986), the court makes no effort to distinguish the facts which are misrepresented. Indeed, the court states very generally that "facts" misrepresented concerning a child's "background and condition", give rise to liability. *Id.* at 1107.

157. In *Michael J. v. County of Los Angeles, Department of Adoptions*, 247 Ca. Rptr. 504, 513 (Cal. Ct. App. 1988), the court merely describes the disease (Surge-Weber Syndrome) as a "material fact" withheld that gave rise to liability.

158. In *Roe v. Catholic Charities of the Diocese*, 588-9 N.E.2d 354, 358 (Ill. App. Ct. 1992) the court cited the elements of fraud as follows: (1) a false statement of material fact, (2) known or believed to be false by the party making it, (3) intent to induce the other party to act, (4) action by the other party in reliance on the trust of the statement, and (5) damage to the other party resulting from such reliance. The court then applied the facts directly to these elements and held defendants liable. *Id.* The court did the exact same procedure with regard to the negligence elements: (1) that defendant owed a duty, (2) that defendant failed to perform or breach that duty, (3) that the breach was the proximate cause of plaintiff's injuries, and (4) damages, and held the defendant liable in negligence for failing to disclose all characteristics concerning health-related matters. *Id.* at 363.

However, courts have repeatedly stated in dicta that they are unwilling to impose a duty on adoption agencies to collect, verify, and disclose every snippet of an adoptee's medical past. See *Michael J. v. County of Los Angeles, Department of Adoptions*, 247 Cal. Rptr. 504 (Cal. Ct. App. 1988) (holding duty of good faith disclosure of material facts concerning existing or past conditions). Moreover, courts "join[ed] in the view that an adoption agency cannot be made the guarantor of an infant's future good health and should not be liable for mere negligence in providing information regarding the health of a prospective adoptee." *Id.* at 513. Finally, in refusing to recognize all claims for adoption agency malpractice, the court considered public policy issues; judges expressed fear that any ruling against an agency with regard to medical disclosure would implicate them as guarantors of an adoptee's health and placement. See *Burr v. County Commissioners of Stack County*, 491 N.E.2d 1101 (Ohio 1986). The court further stated, "In no way do we imply that adoption agencies are guarantors of their placements. Such a view would be tantamount to imposing an untenable contract of insurance that each child adopted would mature to be healthy and happy." *Id.* at 1109. Nevertheless, an adoption agency will be held liable in negligence



clinical complexity of HIV/AIDS and the inseparable discrimination that accompany it, do not lend themselves to such a simplistic disclosure approach.<sup>159</sup>

Another deficiency in the common law is its failure to make an allowance for the timing of disclosure.<sup>160</sup> If an agency is forced to disclose an HIV/AIDS test result before it can confirm its accuracy, it could result in an adoptee's unfair disposition.<sup>161</sup> Unlike color blindness, HIV/AIDS is not a condition which can be discerned accurately at birth.<sup>162</sup> In fact, HIV/AIDS cannot accurately be discerned for the first eighteen months of a child's life.<sup>163</sup> Thus, premature disclosure could lead to an adoptee's failed placement regardless of the HIV test results.<sup>164</sup>

Although less frequent than a false positive, it is plausible to have a false negative.<sup>165</sup> There is a window within the first eighteen months when the mother's antigens have left the infant's body and the child is not producing enough of its own antigens for an accurate test result.<sup>166</sup> If an adoptee is tested during this interim, it is possible to get a negative HIV antibody test result although the adoptee is actually positive.<sup>167</sup> Meanwhile, the prospective parents have adopted what they believe to be a healthy baby. Eventually, the error will be discovered; but the adop-

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if it fails to disclose information that could cause a foreseeable harm. *See generally supra* note 5. An agency will also be liable for fraud if it fails to exercise reasonable care in asserting the truth of an adoptee's medical condition. *Id.*

159. *See supra* notes 3, 123-125 and accompanying text (discussing the societal stigmas associated with HIV/AIDS and the possibility of false positive). *See also infra* notes 165-168 and accompanying text (discussing the clinical nature of a false negative).

160. It could be inferred from the decisions of the relevant cases that the time for disclosure is when the parent asks a question or for documentation regarding the health of an adoptee. *See generally supra* note 156. From a practical standpoint, however, a failure to disclose would not give rise to liability until damages could be casually related. *Id.* This means that nondisclosure could continue up until the adoptive parents take actual possession of the adoptee. *Id.*

161. *See supra* notes 124, 142 and accompanying text (discussing the inevitability of inaccurate test results for the first eighteen months and the stigma of having had an HIV test regardless of its results).

162. *Id.*

163. *Id.*

164. The mere knowledge that an HIV test was performed is enough to doom an otherwise satisfactory match. *See supra* note 142 and accompanying text (Elizabeth Monk discussing the stigma and ramifications attached to adoptees tested for HIV).

165. "[w]ith HIV infection, a false negative occurs when an HIV-infected individual fails to test positive on any one of a series of HIV antibody tests-usually two ELISAs and a Western Blot Assay." *See Isaacman, supra* note 130, at 73.

166. The process of the human body converting over from an HIV negative to positive status, or positive to negative is called seroconversion. *Id.* at 75. The seroconversion process can take anywhere from three weeks to six months. *Id.*

167. A false negative is also referred to as seronegative. *Id.*

tive parents are now in a precarious position.<sup>168</sup> The adoptive parents could annul the adoption or sue the adoption agency for the medical costs associated with treating HIV/AIDS and any other related damages.<sup>169</sup> This proliferation of litigation is the last major deficiency in the common law mandate of disclosure.<sup>170</sup>

Adoption law was intended to be the exclusive domain of the legislature.<sup>171</sup> However, court orders for examining HIV test results, and litigation concerning disclosure policies have caused adoption to move away from statutory law and into the courts.<sup>172</sup> While judges are capable of deciding disclosure issues, there is a high degree of inconsistency that could develop from jurisdiction to jurisdiction.<sup>173</sup> Adoptive parents could shop for states with broad disclosure laws in which to proceed with their

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168. The liability an agency incurs for its malpractice can range from money damages to annulment. *See Burr v. County Commissioners of Stark County*, 491 N.E.2d 1101 (Ohio 1986) (allowing actual damages for medical bills and emotional distress); *See also County Department of Public Welfare of St. Joseph County v. J. Morningstar*, 151 N.E.2d 150 (Ind. Ct. App. 1958) (allowing annulment of adoption as remedy). Usually, a family will seek money damages to compensate for the medical expenses incurred in treating HIV/AIDS, but occasionally parents will petition the court for annulment. *See generally Maley, supra* note 87, for a complete discussion about wrongful adoption remedies.

169. *Id.*

170. *See infra* notes 171-175 and accompanying text (discussing the effects of proliferating litigation of the adoption process).

171. The court in *Roe v. Catholic Charities of the Diocese* stated the following:

It is true that adoptions are creatures of statute. As such, if this were a case dealing with who may adopt a child, who may be adopted, whether the placement complied with the law, or any of a number of other subjects addressed by the Act all proceedings would be controlled by that Act. This is not such a case however.

*Roe v. Catholic Charities of the Diocese*, 588 N.E.2d at 359. It would not seem a stretch for disclosure issues to fall under the "compliance with the law" category enumerated above; however, the court did not feel that medical disclosure matters were sufficiently addressed in the statute, and consequently brought it under the common law jurisdiction. *Id.*

172. Traditionally, courts were reluctant to entertain any type of claim dealing with the adoption process because adoption was exclusively a creature of statute. *See Schwartz, supra* note 8 (concluding that courts do not want to impose additional duties on agencies that are not required in the statute). Moreover, the courts were reluctant to invade such a realm, not wanting to presume to know more about a child's welfare than an adoption agency which is regulated by statute. *Id.* However, as agencies began to handle more adoptions and the pressure to place children mounted, the courts recognized that placement for the mere sake of getting a child out of foster care was not operating in the child's best interests; especially, if the adoptee was currently or eventually in need of medical treatment. *Id.* The courts supported their holding by claiming that trustworthiness between prospective parents and adoption agencies would better serve a child's interest. *See Roe v. Catholic Charities of the Diocese*, 558 N.E.2d 354, (Ill. App. Ct. 1992). Agencies answering questions honestly and being forthright was paramount "so that adoptive parents assume the awesome responsibility of raising a child with their eyes wide open." *Id.* at 355. Most importantly, the courts did not want a child in need of medical or emotional support to be placed with a family unable to provide such needs. *Id.*

173. *See infra* note 174.

adoption.<sup>174</sup> Unlike adoptive parents, adoptees obviously do not have the luxury of forum shopping. Consequently, they may be adversely affected for residing in a jurisdiction with narrow disclosure laws.<sup>175</sup>

These deficiencies can be remedied if disclosure of HIV test results are mandatory on all babies designated for adoption during their first eighteen months.<sup>176</sup> In other words, test a newborn adoptee immediately or reasonably after birth and then once more after the expiration of his or her eighteenth month.<sup>177</sup> The purpose of the initial test is to make prospective parents aware of what may be the adoptee's HIV status during the adoption screening process and probationary period.<sup>178</sup> The follow-up examination eighteen months later would answer the possibility of a false negative or false positive.<sup>179</sup> Furthermore, by forbidding adoptions to be finalized until after the eighteenth month follow-up exam, prospective parents will not adopt a child under false pretenses.<sup>180</sup> This type of mandatory disclosure throughout the adoption process, accompanied by HIV/AIDS counseling,<sup>181</sup> would eliminate any malpractice claims based on a negligent or fraudulent misrepresentation of an adoptee's HIV status.<sup>182</sup>

## VI. CONCLUSION

Physical harm to the adoptee, emotional and financial trauma to the adoptive parents, proliferating litigation, and HIV/AIDS colonies and orphanages are the inevitable results of our legal system's failure to ad-

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174. In this sense, adoption is analogous, ironically, to abortion and divorce forum shopping issues. See Lea Brilmayer, *Interstate Preemption: the Right to Travel, the Right to Life, and the Right to Die*, 91 MICH. L. REV. 873, 878 (1993) (discussing the forum shopping aspects of abortion and divorce). The prospect of forum shopping for states with the most lenient adoption disclosure laws inevitably invokes the traditional arguments about equal access to the laws. *Id.* An adoptive couple that can provide a loving, nurturing home for an adoptee should not be precluded from adoption because they do not have the resources to travel, incur court expenses, or hire a private out of state adoption service. *Id.*

175. See *supra* note 108 (surveying states' disclosure standards).

176. See *infra* Appendix §1/2.

177. *Id.*

178. This would nullify any opportunity for adoptive parents to bring a civil action because the agency or agent would not be negligently or fraudulently representing the HIV status of an adoptee. See *infra* Appendix §1/5.

179. See *infra* Appendix §1/3.

180. See *infra* Appendix §1/5 (granting immunity to adoption agencies and agents who disclose the HIV status of an adoptee in good faith).

181. See *infra* Appendix §1/4 (requiring counseling for adoptive parents about HIV/AIDS).

182. See *supra* notes 177-180 and accompanying text (discussing remedy for a false negative HIV test result). See also Appendix §1/5 (granting immunity for good faith disclosure of HIV).

dress the disclosure of HIV/AIDS in the adoption setting.<sup>183</sup> Therefore, the present adoption laws which are insufficient to deal with the complexity of HIV/AIDS disclosure demand reform.

Although not a panacea, this author's proposed statute brings elements of fairness and equity to the adoption process when HIV/AIDS becomes a factor. The proposed statute mandates HIV/AIDS testing and disclosure throughout an adoptee's first eighteen months. This permits an infant to receive proper medical treatment and informs prospective parents of an adoptee's HIV status before an adoption is finalized. These measures acknowledge that more than just a child's best interests need to be considered in the disclosure of HIV/AIDS. Specifically, the proposed statute adheres to the physical, mental, and financial interests of the adoptive parents as well.

The issues discussed in this Comment are not merely applicable to adoptees, adoptive parents, and adoption agencies and agents. The reality is that many HIV/AIDS adoptees will never leave the custodial care of the state.<sup>184</sup> Therefore, these issues also affect taxpayers who will ultimately bear the financial burden of orphaned HIV positive infants.<sup>185</sup> It is not beyond the realm of possibility to eventually have hospital wards, supported by taxpayers, devoted entirely to children dying from HIV/AIDS. However, these images do not have to emerge. This author's proposed statute mandates the intervention of the only proven treatment against the spread of HIV/AIDS: preventive medicine in the form of education and disclosure.

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183. The urgency to act is underscored by the fact that there is no relief in sight. 'Worse to come' in *HIV Epidemic*, CHICAGO TRIBUNE, March 22, 1994, at § 1, p. 10 (quoting the World Health Organization as saying there is no cure for HIV/AIDS in sight. Furthermore, the HIV/AIDS epidemic should continue to escalate well into the twenty-first century).

184. Telephone interview with Diane Bouyer, AIDS Coordinator for the Illinois Department of Children and Family Services, in Chicago, Ill. (April 15, 1994). Ms. Bouyer stated that by 1995 there will be approximately 100,000 children in the United States orphaned by HIV/AIDS. *Id.*

185. All 100,000 children in the United States orphaned by HIV/AIDS in 1995 will receive some kind of funding from the state. *Id.*

## Appendix

### UNIFORM ADOPTION STATUTE FOR DISCLOSURE OF HIV/AIDS

#### §1/1. PURPOSE

The purpose of this Act is to ensure the fair and equitable treatment of an adoption candidate tested for HIV. Further, this Act also recognizes that prospective parents while engaged in the adoption process, have interests which must be protected. This Act does not rank these two interest nor does it seek to oppose them, rather it strives for a balance which results in the most favorable outcome to both parties.

*Commentary:* Unlike the adoption statutes, this Act does not necessarily place the best interests of the adoptee above all else. It implicitly acknowledges that placing an HIV positive adoptee with unsuspecting parents serves no one's better interests. Placement for the mere sake of placement is counterproductive, and often emotionally destructive.

#### §1/2. HIV TESTING - WHOM SHALL BE TESTED - WHEN TESTS SHALL BE PERFORMED - METHODS.

(a) Any individual, hospital, clinic or other establishment in the business or practice of delivering babies, shall be required to perform an HIV test on all infants designated for adoption by the natural mother or an individual acting as her legal representative. The test shall be done in a reasonable time after birth but before the newborn leaves the birthing facility.

(b) Any person surrendered to a public or private adoption agency or to any individual acting in that capacity, shall be required to have a test performed on the surrendered person before being placed with a prospective parent or within 30 days of temporary custody being taken by the adoption agent.

(c) All persons in accordance with Section 1/2(a) and 1/2(b), shall be subject to an enzyme-linked immunoabsorbent assay (ELISA) test and upon a positive reading, a Western Blot Assay or one of equal reliability. This initial test occurring at or reasonably after birth, shall be followed by the same procedures eighteen months later. It shall be the responsibility of the adoption agent, agency or whoever has temporary custody of the person to be adopted to ensure the follow-up test is performed. No adoption shall be finalized until a second test is performed eighteen months after birth or a child beyond the eighteen month who was not initially tested is so tested.

*Commentary:* Section 1/2(a) makes HIV testing mandatory for all newborns designated for adoption. While this may seem discriminatory, it in fact prevents discrimination and possible privacy intrusions. First, mandating HIV testing for all adoptees eliminates completely the need

to disclose the natural parents HIV status and the circumstances surrounding their contraction of the virus. This prevents adoptive parents from drawing any prejudicial inferences from a natural parents' social background. Second, if mandatory HIV testing is the established protocol rather than the exception, it will not be possible for a prospective parent to raise the ugly specter of discrimination associated with HIV by asking, "Why was this child tested for HIV when this one was not?"

Section 1/2(b) prevents infants not designed for adoption at birth from avoiding HIV testing before being placed with a prospective parent.

Section 1/2(c) directly addresses the possibility of a false negative or false positive. By forbidding adoptions to be finalized before the follow-up exam is performed, no prospective parent will ultimately take in a child under false pretenses. The purpose of the initial test is to make prospective parents aware during the screening process and probationary period of the adoptee's HIV status.

§1/3. HIV TESTING DISCLOSURE - ANONYMITY.

(a) The current HIV status of the adoptee shall be disclosed to the prospective parent prior to taking temporary custody of the child to be adopted or when the initial meeting of the two parties occurs. It shall be left to the sound discretion of the adoption agent what time prior to the two aforementioned events is appropriate for disclosure.

(b) At no time prior to disclosure of the current HIV test results and the prospective parents manifested consent to a probationary period, shall the full legal name of the person to be adopted be used.

*Commentary:* While one of the objectives is to prevent the exclusion of adoption solely on the basis of an HIV status, it would be unfair to the prospective parents who desire to adopt a healthy baby to go through the entire adoption process only to learn the child they have grown attached to is HIV positive. Therefore, the initial meeting or the time immediately prior to taking the adoptee for a probationary period, represents the last possible time prospective parents could decide lucidly if they want to adopt a child with HIV/AIDS. In the event they decide in the negative, the child's identity is protected by Section 1/3(b).

§1/4. HIV/AIDS COUNSELING.

(a) It shall become part of the adoption process protocol to inform all prospective parents of the following:

(1) Every child is tested for HIV.

(2) Prior to an infants eighteenth month, the possibility exists for an HIV antibody test to render a false positive or false negative.

(3) Notwithstanding human error in the testing process, HIV antibody test results are 100% accurate only after the infant's eighteenth month.

(4) The methods of transmitting the HIV virus.

- (5) The expense associated with HIV/AIDS treatment.
- (6) The mortality rate of individuals infected with HIV/AIDS is very high.

*Commentary:* Simply, this is to promote education about HIV/AIDS and to ensure that all prospective parents enter into an adoption fully appraised of HIV/AIDS.

§1/5. RIGHT OF ACTION.

(a) No party acting in their lawful capacity as an adoption agent shall be liable for good faith compliance with the above provisions of this Act.

(b) Any person, including the person to be adopted, who is aggrieved by any violation of this Act shall have a right of action:

- (1) Against any individual who negligently violates any provision of this Act for recovery of a sum up to \$1,000.00.
- (2) Against any individual who intentionally violates any provision of this Act for recovery of a sum up to \$10,000.00.
- (3) For reasonable attorney fees.
- (4) For equitable relief, including an injunction.

*Commentary:* Section 1/5(a) shields an agent from liability who is acting in good faith even though something in the process may be amiss, e.g., a false positive or false negative. Section 1/5(b) acts as a deterrent to unlawful conduct so that all interests in the adoption process are protected. Naturally, those acting wilfully will incur greater liability.