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PERINATAL TRANSMISSION OF HIV: CAUSE FOR THE RESURRECTION OF WRONGFUL LIFE

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Although HIV infection¹ continues to grow at a rapid pace,² behavior modification can, by and large, constrain the spread of HIV. Some modifications, such as encouraging sexual abstinence and utilizing safer sex practices, as well as scientific changes such as screening blood and blood products for HIV, are not too difficult to implement.³ Other modifications which would also act to reduce

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1. I will use the phrase "HIV-positive" or "HIV" to designate individuals infected with the human immunodeficiency virus. At times, the term "AIDS" will be used. Since HIV-related illnesses run a broad spectrum of opportunistic infections and diseases, the term "AIDS" may be somewhat misleading.

2. *The New Frankness in AIDS Ads*, WASH. POST, Jan. 5, 1994, at A18. Nationwide, the deadly AIDS virus is taking more than 90 lives a day. The national statistics help tell the tale: nearly 400,000 reported AIDS cases since the epidemic started a decade ago, 202,000 AIDS related deaths, and now from nowhere in the early 1980s, AIDS is ranked as the third-leading killer of Americans between 25 and 44 years old.

Id.

In 1992, HIV-related illnesses became the leading cause of death in men 25 to 44 years old in the United States. *Id.* 1992 estimates reveal that 33,590 people died from HIV-related illnesses in the United States. *Update: Mortality Attributable to HIV Infection Among Persons Aged 25-44 Years—United States, 1991 and 1992*, 270 JAMA 2672, 2672 (1993) (citing statistics from the United States Centers for Disease Control). Approximately 12 million individuals worldwide are HIV-positive. D'Arcy Jenish, *A Deadly Debate*, MACLEAN'S, Apr. 1992, at 58 (quoting statistics from World Health Organization). By the year 2000, the World Health Organization predicts this figure will approach 40 million individuals. *Id.*

3. Many of these behavior modifications and other efforts that would help control the spread of HIV will not be immediately effective on a wide scale. The efforts to educate and inform must be aggressive and on-going. In the past, early education, as well as the dissemination of frank and often graphic information to homosexual men in the United States, helped control the spread of HIV in that population. Cynthia G. Wagner, *AIDS and the Year 2000: The World's Struggle Against AIDS*, FUTURIST, May-June 1989, at 17.

The fear of offending certain groups has impeded the dissemination of relevant information to those in danger of contracting or spreading HIV. Jeffrey McCullough, *The Nation's Changing Blood Supply System*, 269 JAMA 2239, 2243 (1993). In addition, some groups also viewed AIDS as a political vehicle and cloaked the medical epidemic in terms of morality and God's will. MICHAEL L. CLOSEN ET AL., AIDS: CASES & MATERIALS 180 (1989). However, these actions only made the dissemination of scientifically based information more difficult. John Corry, *In God They Trust*, AM. SPECTATOR, July 1993, at 42. For a discussion of the politics of AIDS, see CLOSEN, *supra*, at 177-262.

the spread of HIV are more difficult and expensive to maintain. These include problems associated with devising methods to effectively counsel intravenous drug users to change their behavior in order to avoid the possibility of transmitting HIV by sharing hypodermic needles.⁴

Adults and adolescents have been the focus of these behavior modifications and educational efforts and these changes have yielded varying degrees of success. However, HIV-positive newborns create a troublesome by-product of the HIV pandemic since these modifications are minimally effective in curtailing the number of infants born HIV-positive. Although behavior modification may affect the number of adults or adolescents that become HIV-infected, the HIV status of a newborn is directly related to the HIV status of the mother. Reducing the potential number of HIV-positive mothers would, necessarily, reduce the number of HIV-positive newborns. However, regarding the population of HIV-positive pregnant women at any point in time, efforts to educate and modify their behavior are too late. Thus, the HIV status of the child is left largely to fate.

The risk of perinatal transmission of HIV, from mother to child, has not been conclusively determined. Studies have suggested the risk of perinatal transmission ranges from seven percent to seventy one percent of all births by HIV-positive women.⁵ HIV-positive newborns, perhaps the most "innocent"⁶ of all HIV-positive

Today, testing blood and insuring the safety of blood products is a relatively easy and inexpensive act. However, there has been a great deal of criticism surrounding the manner in which the blood industry dealt with testing at a time when scientists first determined the nation's blood supply could be a means of transmitting HIV. RANDY SHILTS, AND THE BAND PLAYED ON 307-08 (1987); see *Kirkendall v. Harbor Ins. Co.*, 698 F. Supp. 768 (W.D. Ark. 1988); see also *Kozup v. Georgetown*, 663 F. Supp. 1048 (D. D.C. 1987) (describing the problems of the blood products industry in detecting HIV).

4. Dick Thompson, *Getting to the Point in New Haven*, TIME, May 25, 1992, at 55, 55 ("Today one-third of the nation's AIDS cases originate from IV drug use. More specifically, 71% of all females with AIDS are linked directly or indirectly to IV drug use, as are 70% of all pediatric AIDS cases."). Some have proposed controversial remedies such as dispensing needles to intravenous drug users, decriminalizing possession of hypodermic needles and distributing condoms to inmates in prisons. *Id.* at 56. It is worth noting that aggressive outreach and education programs can reach even the vast population of prison inmates. HANDBOOK ON THE RISK OF AIDS 519-50 (1993).

5. Michael E. St. Louis et al., *Risk for Perinatal HIV-1 Transmission According to Maternal Immunologic, Virologic, and Placental Factors*, 269 JAMA 2853, 2853 (1993). Another recent study found an HIV infection rate of 23.9%. Clara Gambino et al., *Mother-to-Child Transmission of Human Immunodeficiency Virus Type 1: Risk of Infection and Correlates of Transmission*, 90 PEDIATRICS 369 (1992).

6. The author does not intend for the word "innocent" to be judgmental. Rather, it merely connotes that an HIV-positive newborn has not engaged in any act or omission that led to her infection. The newborn was an innocent bystander. Of course, the same could be said of persons that have become HIV-positive by receiving infected blood transfusions or blood products.

individuals, generally live short, tortured lives necessitating expensive and intrusive medical intervention.⁷

Although a few HIV-positive children may "seroconvert,"⁸ many will not.⁹ The mothers of these infants are often, or will become, quite debilitated from HIV-related illnesses and may be unable to care for these children. Medical care and maintenance of these children during their short lives will fall upon already seriously overburdened social institutions such as community hospitals and public service organizations.¹⁰

As a result of the need to reduce the incidence of HIV-positive newborns, this author proposes what at first glance may seem radical and reactionary: a child born HIV-positive should be able to maintain a tort cause of action for "wrongful life" when a physician or medical professional has failed to test and disclose to the pregnant mother that she is HIV-positive, as well as failing to disclose the ramifications of an HIV-positive mother giving birth. Although this author does not propose mandatory abortion, physicians should have a duty to test for HIV and to disclose relevant HIV information to pregnant mothers.¹¹

7. Although the actual number of HIV-positive children is still small in comparison to the number of adults with HIV, HIV is growing more rapidly among children than in adult populations. Richard Conviser et al., *Pediatric Acquired Immunodeficiency Syndrome Hospitalizations in New Jersey*, 87 *PEDIATRICS* 642 (1991).

8. Seroconverting defines the process where an individual initially tests HIV-positive and subsequently tests HIV-negative.

9. Some percentage of infants testing positive for HIV may in fact be false positive. False positive defines a test result that detects antibodies from the mother's system that are also present in the infant. See Conviser, *supra* note 7, at 642. If the infant is not truly HIV-positive, she will later test negative. *Id.* Generally, an infant that seroconverts to HIV-negative is free of the virus and should suffer no ill effects in the future. *Id.* It may take up to 15 months for an infant to seroconvert to HIV-negative. *Id.*

10. See Conviser, *supra* note 7, at 642. "Some HIV-infected infants have been abandoned at hospitals to become 'boarder babies' by parents unable or unwilling to care for them. For both medical and social reasons, then, children with AIDS are believed to utilize hospital resources differently than adults with AIDS." *Id.* HIV affects children differently than the way in which it affects adults. James D. Hegarty et al., *The Medical Care Costs of Human Immunodeficiency Virus - Infected Children in Harlem*, 260 *JAMA* 1901 (1988). "Boarder babies" may not need immediate medical care even though they are HIV-infected. *Id.* at 1902. However, they have no other place to go. *Id.*

Estimates reveal that from 72,000 to 125,000 children could be orphaned by the year 2000 if the epidemic spreads at its current rate. David Michaels & Carol Levine, *Estimates of the Number of Motherless Youth Orphaned by AIDS in the United States*, 268 *JAMA* 3456, 3458 (1992).

The problem of "boarder babies" is not necessarily limited to large urban centers. Even as early as 1990, a study found that 1 of every 70 women giving birth in New Haven, Connecticut was HIV-infected. Christine Russell, *Not One, But Several Epidemics: Children*, *WASH. POST*, June 19, 1990, at z18.

11. Near the publication date of this Article, the Centers for Disease Control released a ground breaking study indicating that the perinatal transmission rate of HIV was dramatically reduced in HIV-positive pregnant women

The creation of a wrongful life cause of action imposes a duty of accountability upon physicians to the pregnant women they treat. A wrongful life cause of action makes it possible to impose an industry-wide standard that would diminish the transmission of HIV to newborns. In addition, permitting actions for wrongful life would provide an effective means of generating the necessary funds to treat HIV-infected newborns in the event a physician fails to comply with the minimum standard.

An infant plaintiff should be able to proceed on a tort cause of action when his or her birth could have been avoided had a physician engaged in adequate counseling and testing during the pregnancy of the mother. Liability may also exist where a laboratory or other testing facility negligently ran a test and failed to correctly detect that a pregnant woman was HIV-positive. However, these tort actions may not only be legally difficult to maintain given the current state of tort law, but they also present serious ethical and moral concerns.

A major assumption underlying the arguments set forth in this Article is that a pregnant woman needs to know her HIV status; she has an obligation to protect her potential child from acquiring HIV.¹² A pregnant woman should not be permitted to keep her head buried in the sand. Her willful ignorance can have an immediate impact on her child.¹³ Nevertheless, some argue a woman

treated with AZT. Lawrence K. Altman, *Major Finding, Drug Limits H.I.V. Infection in Newborns*, N.Y. TIMES, Feb. 21, 1994, at A1 [hereinafter *Drug Limits HIV*]. In fact, this study lends even stronger support for establishing the HIV testing of pregnant women as a minimum standard for health care providers. Adequate testing, counseling and drug therapy could significantly reduce the number of HIV-infected newborns. *Id.*

12. Michael L. Closen, *Mandatory Disclosure of HIV Blood Test Results to the Individuals Tested: A Matter of Personal Choice Neglected*, 22 LOY. U. CHI. L.J. 445 (1991). Actually, the physician would have the obligation to test and counsel the mother. This obligation would then run to the potential child. However, the physician would not be able to delegate his duty to the woman. The reason is that the woman should not act as an obstacle to the physician by preventing him from executing his duty to test and counsel the mother. Thus, although a woman may elect not to undergo HIV testing and normally, therefore, assume the risks of misdiagnosis or mistreatment, the potential mother cannot "assume the risk" of HIV transmission to the newborn.

13. Although it may appear sexist and gender-biased, there would not necessarily be any parallel responsibility on potential fathers since a man cannot bear children and intimately affect the HIV status of his unborn child. There could be an argument that all persons who engage in sexual activity have an obligation to know and disclose their HIV-status. *Cf. Doe v. Roe*, 267 Cal. Rptr. 564, 567 (Cal. Ct. App. 1990) (holding that a person had an obligation to warn potential sexual partners that he had contracted genital herpes in the past); *see also Kathleen K. v. Robert B.*, 198 Cal. Rptr. 273, 276-77 (Cal. Ct. App. 1984) (ruling that the fraudulent concealment of the risk of infection of a venereal disease vitiated a person's consent to sexual intercourse).

However, an argument could be made that both sexual partners have a corresponding obligation to avoid infection, and their failure to do so would indicate they each "assumed the risk" of contracting HIV. *But see Donald H.J. Her-*

should have complete discretion as to whether to inform herself of her HIV status by taking the appropriate tests.¹⁴ The decision of a pregnant woman to be informed affects not only herself, but also the potential child. Therefore a physician has a duty to inform the woman of a potential risk just as the physician would with regard to any other obvious or readily ascertainable health concern.

A second assumption made in this Article is that once a pregnant woman arms herself with knowledge of her HIV status, she should make reasoned decisions regarding whether or not to terminate her pregnancy.¹⁵ Presumably, the testing should be done early enough in the pregnancy so the woman could freely exercise her right to an abortion as determined in *Roe v. Wade*.¹⁶ The woman must consider the possibility that her infant may be born HIV-positive. She must also weigh the likelihood of survival for both the infant and herself. A woman must also consider her own moral and ethical beliefs in determining whether to abort her fetus.¹⁷ Finally,

mann, *Liability Related to Diagnosis and Transmission of AIDS*, 15 L. MED. & HEALTH CARE 36 (1987) (arguing assumption of risk would not apply since a defendant would have to demonstrate the plaintiff's subjective knowledge of the defendant's HIV and would not be able to rely on common community knowledge of the possibility of contracting HIV through intercourse). Also, even if assumption of risk was not a complete defense, there could be determinations made with regard to the comparative negligence of the plaintiff which would reduce the defendant's liability. Nonetheless, the defense of assumption of risk would not be applicable to an HIV-positive newborn.

14. At times, even persons displaying classical symptoms of AIDS may refuse testing for HIV. The harm that may result from their willful ignorance will fall almost exclusively on the patient. In the event an individual spreads the HIV infection to a sexual partner, the partner may have a cause of action against such a willfully ignorant person. Willful ignorance implies that a person cannot escape liability when a reasonable person would have made an inquiry. See *Glover v. Hardeman County Highway Dep't*, 713 S.W.2d 73 (Tenn. Ct. App. 1985); cf. *C.A.U. v. R.L.*, 438 N.W.2d 441 (Minn. Ct. App. 1989) (noting that based upon information available to the public since 1985 the defendant would not have reason to know of his HIV status). The reason for such an action is that the willful ignorance of the HIV-positive mother would have intimately affected the health of her HIV-positive newborn. Consequently, tort law should serve as an impetus to overcome the willful ignorance, at least in the situation of an HIV-positive mother.

15. The reader should only construe this proposition to mean that the woman has been advised of the problems associated with bearing an HIV-positive child. Although this proposition comes close to imposing mandatory abortion for a woman once her physician notifies her that she is HIV-positive, this author is not prepared to carry this argument to that extreme. The imposition of mandatory abortion raises issues of personal autonomy and privacy that are beyond the scope of this paper.

The wrongful life cause of action proposed in this essay addresses only actions based on some form of professional malpractice. This author is not prepared to extend the reach of the wrongful life cause of action by providing the HIV-positive newborn with an action against his mother for her failure to abort.

16. 410 U.S. 113, 164-65 (1973).

17. Presumably, until a physician tests a woman for HIV, she may have had no knowledge that she is HIV-positive. Thus, after the tests are taken, the woman faces a panoply of critical psychological and social issues. However, the

a woman may choose to incur the risk of having the child that may be minimized by drug therapies.¹⁸

In any event, regardless of the position of the woman on abortion, a treating physician must advise her of her HIV status in order to allow her to make a reasoned decision. If she then elects to adhere to her prior position in opposition to abortion, she will then at least proceed with the pregnancy having received more meaningful information. In addition, she will have been given a clear opportunity to terminate her pregnancy and eliminate the birth of an HIV-positive newborn. Furthermore, disclosure of this information to the pregnant mother is also essential since there may be certain treatments her physician could recommend to reduce the possibility that she would give birth to an HIV-positive infant.¹⁹

Since this Article focuses on a wrongful life cause of action, the physician would satisfy his duty to the fetus upon informing the woman of her HIV status and adequately counseling the pregnant woman. Although this perhaps seems harsh and imposes an unnecessary emotional burden on the pregnant woman as to whether or not to abort her fetus or to begin drug therapies,²⁰ in the absence of this knowledge, the woman would only consider abortion in the abstract. The woman would not be aware of potential drug therapies or other concerns with regard to impeding transmission. Objecting to abortion in principle and "hoping for the best," and not being informed are not sufficient given the ease of determining the HIV status of the mother and the potentially dire consequences to the newborn.

The first obstacle that would have to be overcome would be the creation of a wrongful life cause of action for an HIV-positive infant. Tort law has long recognized a cause of action in medical malpractice when the negligence of a physician or laboratory leads to the

scope of the duty the physician may owe to the woman relating to these psychological and social issues is not within the purview of this essay.

For an example of a particularly troublesome fact pattern, consider *Estate of Jane Doe and John Doe v. Vanderbilt Univ.*, 824 F. Supp. 746, 747 (M.D. Tenn. 1993). In *Estate of Jane Doe*, the mother discovered she was HIV-positive on the same day her infant died from an HIV-related illness. *Id.*

18. *Drug Limits HIV*, *supra* note 11.

19. *Id.* If the woman elects to proceed with the birth, she should also consider issues such as breast feeding. This would allow the woman to prepare herself emotionally for the possibility of giving birth to an HIV-positive infant. An ancillary benefit of receiving this knowledge from a physician is that the woman may hopefully begin to deal with her own HIV-condition and its potential impact on her life and that of the child.

20. *Id.* Ideally, a woman could submit herself to HIV testing before the woman actually becomes pregnant. However, this proposition may not reflect reality since many HIV-positive women are not inclined to seek testing or counseling for a possible HIV-infection if they are merely "considering" motherhood, particularly if they are asymptomatic. In addition, many women do not have planned pregnancies.

birth of a child with physical or mental disabilities. Assuming the negligence of the physician or laboratory has led to a disability, conventional tort wisdom would dictate that the damages of the child should be measured by comparing the condition of the child after the negligence against the hypothetical condition of the child if the negligence had not occurred. The difference would be the damages suffered by the child, and some attempt would then be made to economically quantify these damages.²¹

Although wrongful life cases are well accepted, they are still problematic. Theoretically, the conventional negligence tort analysis of duty, breach, causation and damages lends itself to a cause of action for wrongful life. However, in reality each of these elements are difficult to apply to such legal actions.

First, issues of medical malpractice by physicians or laboratories causing a disability to a newborn are often difficult to determine or prove. The "victim" in these situations is, by definition, a disabled newborn. Accordingly, the newborn will not be able to recognize the acts or omissions which led to the disability. Likewise, those persons closest to the victim, most likely the parents, may also not be cognizant of the acts or omissions which caused the disability. At least initially, they may be inclined to defer to the judgment of the very person who may be liable for the malpractice. Normally, the parents may view the disability of the child as a tragedy imposed by fate. Furthermore, the parents may even harbor feelings of guilt, believing the disability must be the result of something they did or did not do.

Likewise, a second hurdle involves the issue of whether a potential defendant breached his duty to the newborn.²² For example, in the context of a conventional medical malpractice action, a physician is entitled to exercise his professional judgment. However, it does not necessarily follow that the physician deviated from the applicable standard of care merely because his judgment was incorrect. However, this may be less true in a setting involving erroneous lab results since those situations should call for less judg-

21. Juries have a great deal of discretion in awarding noneconomic damages in these types of cases. However, despite the difficulty in quantifying noneconomic damages, juries have awarded sizeable damages. *See, e.g.*, *Scott v. United States*, 884 F.2d 1280, 1283 (9th Cir. 1989) (awarding infant who was born with spastic quadriplegia \$2 million in noneconomic damages); *1st of Am. Bank, Mid-Michigan, N.A. v. United States*, 752 F. Supp. 764, 780 (E.D. Mich. 1990) (awarding a brain damaged child \$2 million in general damages for pain and suffering, disability and disfigurement).

22. One justification for disallowing actions for wrongful life is that the physician owes no duty to the infant. The physician only owes a duty to the mother. However, it does not appear that the absence of a duty to the infant has been a major obstacle in infant medical malpractice cases. As a result, the infant clearly is a foreseeable plaintiff in an action for wrongful life.

ment on the part of a laboratory technician as well as an objective standard for determining whether one is HIV-positive.

Nevertheless, even though a disabled newborn plaintiff may be able to prove a physician or laboratory breached a duty to the newborn, the plaintiff must still confront the problem of proving that it was the physician or laboratory whose breach *caused* the injury. Needless to say, it may be nearly impossible to ascertain exactly what caused the disability of the infant. A number of factors may exist that have nothing to do with the acts or omissions of the physician or the laboratory. This is more likely to occur in situations where there is no demonstrable link between the breach by the physician or laboratory and the resulting injury to the infant plaintiff. The defendant would argue that even if his acts or omissions deviated from the accepted standard of care, the disability is attributable to other unrelated factors not within the control of the defendant.

The newborn will also face other problems inherent in medical malpractice actions. First, the plaintiff may have difficulty finding competent medical professionals to testify against the physician or laboratory. In addition, the plaintiff will likely have to confront the expenses associated with medical malpractice litigation. However, despite the obstacles faced by plaintiffs in actions for damages for the disability of a newborn, these problems are magnified when presented in the context of a cause of action for wrongful life.

The plaintiff in a cause of action for wrongful life alleges that "but for" the negligence of the physician, the child would not have been born. Wrongful life is viewed from the perspective of the newborn. A cause of action for wrongful life may arise from the negligent performance of an abortion, the misdiagnosis of a pregnancy, the negligent performance of sterilization procedures on the parents of the newborn, or any other act or omission by the physician or laboratory which caused the parents to believe they would not conceive or give birth to a child, and yet, a viable child is born. More importantly, these actions have been allowed in situations in which an infant is born with serious disabilities as a result of the negligence of the physician in diagnosing the condition that caused the disability. The negligence of the physician did not cause the disability *per se*. Rather, the physician simply failed to advise the mother of the condition that caused the disability. As a result, the mother did not have the opportunity to consider whether to abort her fetus that would likely have a serious disability.

A parallel cause of action to wrongful life is that of wrongful birth which focuses on the unexpected conception or birth of a child. Under a wrongful birth theory of liability, the acts or omissions are essentially the same as an action for wrongful life. However, in an

action for wrongful birth, a physician breaches his duty of care to the *parents* rather than the newborn. Thus, the parents claim the negligence of the physician caused them to have a child they did not desire.

Unlike the conventional medical malpractice cause of action in which the negligence of the physician is the direct cause of the disabling condition of the newborn, in an action for wrongful life or wrongful birth the alleged injury is the actual presence of life. At least in theory, an action may be brought for wrongful life or wrongful birth when the infant is born free of any disabilities.²³ However, these actions are usually brought when the infant is born with significant disabilities. The major assumption underlying an action for wrongful life is that the *infant* would have been "better off" not to have been born as opposed to suffering the disabilities inflicted upon him as a result of his birth. The critical assumption underlying an action for wrongful birth is that the *parents* would have been "better off" not having had a child than having a child with the disabilities suffered by the infant.

This Article presents no determination as to whether the "theoretical" wrongful life cause of action, in which there is no disability to the newborn, is a viable tort cause of action. The reason for setting aside any present evaluation of the propriety of this "theoretical" cause of action is that, with regard to an infant born with HIV that does not seroconvert, the infant has clearly suffered a sufficient disability. In addition, this author makes no assertions regarding other disabling conditions, such as genetic abnormalities, that may serve as the basis for a wrongful life cause of action as they are outside the scope of this Article.²⁴

The following hypothetical scenarios illustrate the difference between traditional medical malpractice actions involving an infant plaintiff and an action based upon wrongful life. The first example illustrates conventional medical malpractice leading to a disabling

23. Some courts have named these actions "wrongful conception" or "wrongful pregnancy." See, e.g., *Zehr v. Haugen*, 855 P.2d 1127, 1128 (Or. Ct. App. 1993). In these actions, conception itself gives rise to the cause of action. *Id.* Thus, the fact that a child is born free of disabilities is not particularly relevant to the "injury." See *Gallagher v. Duke*, 852 F.2d 773, 776 (4th Cir. 1988) (holding that an action for wrongful conception could stand where the negligence of the physician caused the parents to give birth to a child with defects).

For a collection of cases in which juries awarded parents damages for unwanted, yet healthy children, see George C. Christie & James E. Meeks, *CASES & MATERIALS ON THE LAW OF TORTS* 799-800 (2d ed. 1990).

24. Michael B. Kelly, *The Rightful Position in "Wrongful Life" Actions*, 42 *HASTINGS L.J.* 505 (1991). Professor Kelly argues that an action for wrongful life should exist when a physician fails to provide adequate genetic counseling to the parents. *Id.* at 511. Although this author concurs in the argument advanced by Professor Kelly, the failure to perform an appropriate HIV test or to properly counsel a woman presents an even more compelling argument for the creation of a wrongful life cause of action.

injury to the newborn. Assume a physician negligently injects a mother with a drug during birth that denies a substantial amount of oxygen to the brain of the child during the birth process resulting in brain damage. This would be a situation in which, had the physician not been negligent, the infant would have been born "normal," free of the defects associated with the oxygen deprivation.

Now assume a physician fails to test a pregnant woman for HIV. If the physician had tested the woman, he would have found she was HIV-positive. The physician would then have been able to inform the woman that carrying the child to term presented a significant likelihood that the child would be born HIV-positive and live a short life characterized by chronic, debilitating illnesses. Assuming the physician correctly detected the HIV status of the woman and counseled her regarding the probabilities of delivering an HIV-positive child, the woman may have chosen to abort the fetus rather than to give birth. However, unlike the conventional medical malpractice cause of action, the disabilities imposed upon the newborn were not "caused" by the negligence of the physician. Rather, the injury caused by the negligence of the physician is that the physician did not provide the woman with the knowledge necessary to make the decision of whether or not to abort the fetus and avoid the birth altogether. The injury to the newborn is that he is now alive. The newborn never had the option to be born without HIV.

The courts that have addressed these issues have had a great deal of difficulty articulating and quantifying the injury visited upon the newborn and the parents. Even though a physician or laboratory may have unquestionably deviated from the applicable standard of care, courts have been entrenched in a quagmire regarding duty and, more importantly, the resulting injury.

However, whether a physician or laboratory owed a duty to the unborn fetus is a misdirected inquiry. In conventional medical malpractice actions involving newborns, courts have consistently viewed the injured newborn as the "right" party even though the acts or omissions of the physician or laboratory may have been directed solely at the mother.²⁵ The newborn is clearly a "foreseeable" plaintiff under this theory. Any attempt to disregard the duty owed to the newborn is a misdirected return to the abandoned requirement of privity between tortfeasor and plaintiff.²⁶ Thus, there

25. See *infra* note 23 and accompanying text.

26. The more viable test is whether the infant is a "foreseeable plaintiff," and not whether the infant is in privity with the physician. See, e.g., *Andalon v. Superior Court*, 208 Cal. Rptr. 899, 903 (Cal. Ct. App. 1984) (indicating that a father was a foreseeable plaintiff in a medical malpractice action based upon the injuries suffered by his son due to the role of the father in the "reproductive life of the marital couple."). The seminal case of *Palsgraf v. Long Island R.R.*,

is no need to resurrect the requirement of privity in the context of a wrongful life cause of action.

The more fundamental stumbling block to application of tort analysis to wrongful life situations is the difficulty in determining the injury to the HIV-positive newborn. A central concern is the difference in value to the newborn of an HIV-positive life as opposed to not having a life at all. Is nonexistence "worth more" than existence with HIV?

Wrongful birth presents similar problems involving damages. The injured plaintiff parents are now confronted with the costs and responsibilities of raising and caring for a child due to the negligence of the defendant. It is clear that the presence of disabilities may make their claim for damages more compelling since the cost of raising the child rises significantly. However, in reality, the parents have arguably been injured by the mere presence of the newborn since the parents will incur the ordinary costs of raising and caring for a new child. The underlying injury is the birth itself. Courts and commentators have wrestled with the application of tort law to wrongful life and wrongful birth actions.²⁷ However, to the extent there appears to be a consensus forming, it appears as though courts are not inclined to find a valid cause of action in wrongful life.²⁸ The "victim" simply suffers no injury. Since the infant has a life she would not otherwise have, she is better off than being deprived of all life.²⁹ In fact, courts seem to support this proposition even when the newborn has significant disabilities.³⁰

On the other hand, some courts have indicated a willingness to find at least the potential for recovery in wrongful birth situations.³¹ However, these courts strayed from the conventional deter-

162 N.E. 99 (N.Y. 1928), established that the critical inquiry in tort law is the foreseeability of the plaintiff.

Furthermore, the "special relationship" of the physician to the newborn, as well as the view that the newborn is a third party beneficiary of the physician's treatment of the mother, should provide sufficient justification for a finding of potential liability in the absence of contractual privity. See *Hegyesh v. Unjian Enters. Inc.*, 286 Cal. Rptr. 85, 93 (Cal. Ct. App. 1991) (noting circumstances may exist where a newborn has a cause of action for negligence that occurred before birth); see also RESTATEMENT (SECOND) OF TORTS § 324A (1965) (imposing liability on one who undertakes to render services to another which he should recognize as necessary for the protection of a third person when he fails to exercise reasonable care).

27. *Keel v. Banach*, 624 So. 2d 1022 (Ala. 1993); *Reed v. Campagnolo*, 630 A.2d 1145 (Md. 1993); *Procanik by Procanik v. Cillo*, 478 A.2d 75 (N.J. 1989); *Kelly*, *supra* note 24.

28. W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 55, at 371 (5th ed. 1984).

29. *Id.* at n.45.

30. See *Kelly*, *supra* note 24, at 506-07.

31. See, e.g., *Keel v. Banach*, 624 So. 2d 1022, 1024 (Ala. 1993) ("Wrongful birth cases are now widely recognized. An action exists when physicians fail to warn prospective parents that they are at risk of conceiving or giving birth to a

mination of tort damages.³² Courts have analogized the calculation of damages in wrongful birth actions to the method of determining damages in medical malpractice actions with injuries to the newborn. As a result, these courts awarded damages to the parents in order to compensate them for the costs associated with the disability of the newborn.³³ In addition, a defendant may not offset the amount of damages by any benefit conferred on the parents due to the birth of a child, such as the ability to enjoy a parent-child relationship, as well as the companionship and comfort afforded by the presence of the child.³⁴ Parents can experience the same pleasures whether rearing a disabled child or one that does not suffer from a particular affliction. Furthermore, since parenthood comes with few guarantees, many "normal" children may also present a multitude of problems, costs and heartaches to parents.

Plaintiffs bringing actions based on theories of wrongful life and wrongful birth have been most successful, by and large, when physicians have failed to correctly diagnose certain conditions relevant to the fetus or the parents which cause the newborn to have a seriously disabling condition.³⁵ In addition, litigation will most likely increase under these two theories as developments in science and technology allow physicians to discover genetic defects or even the propensities for certain inherited debilitating illnesses.

However, the formulation of more clearly defined parameters of liability in wrongful life and wrongful birth actions should not be postponed merely to await further advances in genetic technology. The looming presence and rapid spread of HIV presents an all-too-common situation where physicians may, to some extent, detect and

child with a serious genetic disorder."); *Reed v. Campagnolo*, 630 A.2d 1145, 1152 (Md. 1993); *Glascok v. Laserna*, No. 930182, 1994 WL 2889, at *3 (Va. Jan. 7, 1994).

32. The concept of damages in conventional tort law seeks to place the plaintiff in the position she would otherwise have been in absent the tortious acts of the defendant. In tort actions for wrongful birth, as well as wrongful life, absent the tortious acts of the defendant, the infant would not have been born. Realistically, judges and juries cannot calculate the difference in damages between life and the absence of life. Therefore, in actions for wrongful birth involving a disabled child, courts customarily award the extraordinary medical expenses associated with the disabilities of these infants. *See supra*, note 31.

33. Currently, a dispute exists as to the appropriate measure of damages in a wrongful birth actions. *Keel*, 624 So. 2d at 1029. Some courts apply general principles of tort law and compensate the parents for all damages proximately related to the negligence of the physician, such as extraordinary medical expenses of the infant, costs of caring for the disabled infant, emotional distress suffered by the parents, and pain and suffering of the mother due to the birth procedure. *Id.* Other jurisdictions limit the damages to the extraordinary medical expenses of the disabled infant. *Id.*

34. Courts disregard any benefit as a set off of damages. *See Keel*, 624 So. 2d at 1022; *Glascok v. Laserna*, No. 93-0182, 1994 WL 2889 (Va. Jan. 7, 1994).

35. W. PAGE KEETON ET AL., *PROSSER AND KEETON ON THE LAW OF TORTS* § 55, at 372 (5th ed. 1984); *see also Robak v. United States*, 658 F.2d 471 (7th Cir. 1981); *Gallagher v. Duke Univ.*, 638 F. Supp. 979 (M.D.N.C. 1989).

avert the infliction of a seriously debilitating illness upon a child. However, physicians do not have the present ability to insure that a child will not be born with HIV. Currently, the only options available to the parents are either no child or a child born with the significant possibility of acquiring HIV.

The courts' continued preference to allow parties to proceed with actions for wrongful birth, while generally disallowing actions for wrongful life, is troublesome. For instance, the process of measuring damages in a wrongful birth action is just as difficult as in a wrongful life action.³⁶ Thus, the difficulty in ascertaining an appropriate amount of damages in an action for wrongful life should not justify the elimination of any possible recovery.

The courts and legislatures must reevaluate the methodology of assessing the amount of damages recoverable in actions for wrongful birth and wrongful life. In reevaluating the methodology, the courts and legislatures must understand the inequities of allocating damages to the wrong party, the parents. This caveat extends, in particular, to the allocation of damages for extraordinary medical expenses. Despite the fact that the parents' claim for damages derives from the injury visited upon the infant in an action for wrongful birth, they would not have a fiduciary obligation to use the damage award for the care and treatment of the disabled infant.³⁷ Even though the parents may be able to recover damages separately for the mental anguish associated with the responsibility of rearing a disabled child, the actual damages awarded for the increased medical expenses seem more appropriate for the injuries incurred by the newborn.

Although these issues illustrate the difficulty involved in fitting wrongful life and wrongful death into the parameters of conventional tort law, it defies any concept of justice to allow a physician or laboratory to escape liability for failing to detect the agent causing the disability of a child.³⁸

36. See *supra* notes 31-32 and accompanying text.

37. Since the basis for a wrongful birth cause of action is the perceived injury to the parents, the damages recovered would be for the benefit of the parents. This results even though a significant portion of the damages awarded to the parents may include compensation for the extraordinary medical expenses of the infant. Technically, the infant does not recover in his or her own right. Thus, absent some statutory obligation, the parents are not compelled to spend any recovered damages for the benefit of the child. In addition, parents of an HIV-positive newborn may out of necessity or choice abandon the child at the hospital. See *supra* note 10 and accompanying text. Also, since the mother is HIV-positive, she may die shortly after the birth of the child.

38. Assessing damages for intangibles is always, at best, highly speculative. For example, no objective standard exists for assessing damages for pain and suffering, emotional distress, defamation or wrongful death. However, the inability to accurately measure these types of damages should not serve as a justification for the denial of recovery in these actions.

Nevertheless, allowing an HIV-positive infant to pursue an action for wrongful life, and forcing a defendant to pay some damages, furthers two primary objectives. First, it is more appropriate to shift some of the costs incurred by the plaintiff onto the defendant.³⁹ Cost-shifting serves as the foundation for actions based on a theory of strict liability since it is appropriate in certain circumstances to shift the costs of any resulting harm to those who are in a better position to prevent the harm from occurring. As a result, since actions for wrongful life are not premised upon a theory of strict liability, an even stronger case for cost-shifting exists. Thus, cost-shifting would provide for the well-being of the HIV-positive infant. Although the child cannot be made "whole" or have his birth undone, he will at least receive a more comfortable life to the fullest extent money and technology can provide the child. As between the innocent disabled newborn and the potentially negligent, reckless or willful defendant, it is undoubtedly more sound for the wrongdoer to bear the costs of caring for the HIV-positive newborn.

Furthermore, by pursuing an action for wrongful life, the source of funds would be available to the infant in his own right. The infant would not be dependent upon the goodwill of the parents or a third party.⁴⁰ Any person administering the funds for the child would act in a fiduciary capacity with an obligation to insure the funds are spent in the best interests of the child. As a result, these children would not become wards of the state and increase the burden on already financially strapped medical and social institutions currently attempting to manage the escalating problem of children born with HIV.⁴¹

Imposing liability on the physician or laboratory for the child born HIV-positive would force health care providers to adopt more reasonable standards for testing and counseling pregnant women. By implementing consistent testing and counseling procedures, many otherwise HIV-positive newborns would simply not be born

39. Cost-shifting becomes of particular importance in the context of an HIV-positive newborn and a negligent physician or laboratory since the costs of caring for the HIV-positive newborn fall upon already overburdened social institutions or parents who may not be able to provide for their HIV-positive child as a result of their own health problems. See *supra* note 10 for a discussion of "boarder babies."

40. Actions to recover medical expenses of the HIV-positive newborn may have to be brought posthumously since many newborns may die prior to the initiation or completion of the lawsuit. Nevertheless, such actions would provide a potential source of funds to compensate the persons or entities that cared for the HIV-positive newborn.

41. Boarder babies had an average length of stay of 339 days at care institutions. Hegarty, *supra* note 10, at 1903. 49.5% of these newborns received services from care institutions that was not medically necessary. *Id.* Thus, the institutions could have otherwise discharged the newborns but no one was able or willing to take responsibility for the children. *Id.* Hence, the newborns simply remained in the hospital. *Id.*

due to the diligent foresight and care of the physicians treating their mothers. This is a rational goal to pursue in light of the reality that HIV-positive infants that fail to seroconvert will live short, tortured lives at great expense.⁴² In the absence of potential liability for health care providers, there is presently no impetus for improving the current *ad hoc* administration of competent methods for testing and counseling pregnant women who are at risk of HIV.

These arguments do not delineate a complete resolution to the problems presented by infants born HIV-positive. Situations will still exist where children are born HIV-positive. For instance, even though a woman may have undergone all of the appropriate tests, a physician or laboratory may not have been able to discover her HIV status in a time to provide the option of an abortion.⁴³ In addition, a woman may simply choose not to abort her fetus. Thus, some children would not have a party from whom to seek relief. Consequently, these children will have to rely on the ability of their families and society to generate enough support for their care.

A second benefit that would arise from the imposition of a duty on physicians and laboratories to test pregnant women for HIV is that it would force health care providers to further educate themselves. Hopefully, this knowledge concerning perinatal HIV would spread not only to the patients, but also to society as a whole. The compelled education would eliminate many current preconceptions and falsehoods attributed to both children born HIV-positive and persons that may unknowingly carry HIV. Physicians would no longer be able to determine whether a woman is potentially HIV-positive merely based upon her marital status, physical appearance, and employment. Since medical technology has advanced to the point where a simple blood test may quickly, accurately, and inexpensively determine whether an individual is HIV-positive, it is archaic to rely upon these assumptions. Mandatory HIV testing for all pregnant women that employs a reasoned and methodical analysis would displace the need for stereotypical assumptions as to who may be in a "high risk" group for acquiring HIV. Furthermore, even if an individual is in a "high risk" group, this fact is not relevant to the HIV status of the newborn.⁴⁴ Allowing these preconceptions

42. In addition to the well-known symptoms of advanced HIV in adults, "recurrent episodes of bacteremia, meningitis and other bacterial infections," as well as "chronic growth and developmental problems" also characterize pediatric HIV. Hegarty, *supra* note 10, at 1901.

43. As is well known, the testing mechanisms for HIV are not perfect. The use of the current protocol entails a minute possibility of a false result. More importantly, a "window" period exists in which a person who has been infected with HIV will not test positive for the HIV antibodies. Steven E. Locke et al., *Computer-based Interview for Screening Blood Donors for Risk of HIV Transmission*, 268 JAMA 1301 (1992).

44. Whether a pregnant woman is in a "high risk" group is not determinative of the HIV status of the newborn. It is the actual HIV status of the woman

and assumptions to set the standard for determining whether or not to test a pregnant woman for HIV is analogous to permitting blood banks to decide whether to accept blood based upon the appearance and lifestyle of an individual.⁴⁵

At times, courts may be unwilling to eliminate the standard of care within an industry despite the fact that a newer standard would be reasonable given the current state of technology.⁴⁶ In addition, an industry itself may not be willing to proclaim the adoption of a new standard due to the fear of "creating" liability that did not previously exist.⁴⁷ This results since generally, in particular with regard to medical malpractice, the industry standard would determine reasonable behavior. Currently, many physicians believe it is unnecessary to provide HIV testing and counseling for pregnant women even though the services would clearly be simple and reasonable to adopt.⁴⁸

Despite this opposition, the acceptance of a wrongful life cause of action for the HIV-positive newborn would clearly force health care providers to rapidly adopt minimum standards for the provision of HIV testing to pregnant women. However, once physicians arm themselves with the requisite knowledge and provide testing and counseling as a regular part of their obstetric services, they will have taken a major step towards compliance with this new standard. The imposition of a duty on physicians to commence mandatory HIV testing for pregnant women would eliminate the need for a case-by-case determination of whether the physician acted "reasonably" in failing to test a woman for HIV.

Moreover, imposing mandatory testing would remove any apprehension a physician may have in suggesting an HIV test to a pregnant woman. A physician would explain he is under a legal

that is important. She will not transmit the HIV infection to her newborn if she is HIV-negative, despite the fact that she may be in a "high risk" group. As a result, just as it would be patently unreasonable not to test blood donations for the presence of HIV, it is unreasonable not to test all pregnant women for HIV.

45. See *supra* note 3 for a discussion of blood testing and a criticism of the manner in which those in the blood industry dealt with the contagion.

46. See, e.g., *Helling v. Carey*, 519 P.2d 981, 983 (Wash. 1978) (rejecting an industry standard that required testing for glaucoma).

47. Since the medical profession can, to some extent, set its own standard of care by adopting or refusing to adopt certain practices, it has the ability to determine its own liability. See W. PAGE KEETON ET AL., *PROSSER AND KEETON ON THE LAW OF TORTS* § 32, at 189 (5th ed. 1984).

48. See *Drug Limits HIV*, *supra* note 11.

Until now[,] testing for HIV infection in the United States has been recommended for those who consider themselves at risk. But testing is not mandatory, and there is no general recommendation to test all pregnant women. The American Academy of Pediatrics recommends testing of pregnant women in areas where the prevalence of H.I.V. is high. But compliance among health officials varies.

Id.; see also *HIV Infection, Pregnant Women, and Newborns: A Policy Proposal for Information and Testing*, 264 JAMA 2416 (1990).

obligation to test the woman and that she should not infer it as a prejudgment of her HIV status. In fact, a physician may be able to strengthen his relationship with patients by informing women that HIV testing is a basic requirement of good obstetrical care.

Nevertheless, the imposition of tort liability may be an imperfect tool in the effort to stem the spread of HIV. In fact, commentators surely will criticize its effectiveness. Yet, the imposition of a new duty on physicians serves a useful societal objective, the minimization of infants born with HIV. Ultimately, the forces that will effectively stem the spread of HIV will be more comprehensive educational programs as well as increased acceptance of behavior modifications.⁴⁹

As for the infants born HIV-positive, the education and behavior modification of their parents may be too late. In all likelihood, the infants will never have to be concerned with AIDS education or methods to alter their behavior since they will not reach an age where such methodologies will be effective.

The removal of current obstacles to actions for wrongful life will serve the ultimate goal of tort law by providing compensation to an injured party. Furthermore, requiring health care providers to test and counsel all pregnant women serves as a stepping stone to help minimize the birth of infants born with HIV and its attendant devastating effects. Society can no longer afford to fight HIV only in research laboratories. The rapid spread of HIV has forced society to fight it in the context of our most intimate social relationships involving sex and procreation. The devastating history of HIV has shown that society cannot afford another puritanical approach to the issue. Subtlety may be less "offensive," but it can also cost thousands of lives.

Education, counseling, and effective advertising may help curb the spread of HIV from sexual contact or from the sharing of needles by intravenous drug users. Comprehensive HIV testing of blood and blood products will also impede the spread of HIV infection from transfusion and the use of blood products. By reducing the number of HIV-infected people, these efforts will likewise reduce the incidence of HIV-infected newborns.

However, when a woman is already HIV-positive, the only means of minimizing the risk of perinatal HIV transmission is to impose a duty on those providing health care to the woman to test her for HIV and to provide counseling. Absent this duty, health care providers will, at best, resort to an *ad hoc* methodology of testing a woman only when they "think" she may be HIV-positive.

49. See *The New Frankness in AIDS Ads*, *supra* note 2, at A18 (noting the announcement of Donna Shalala, Secretary of Health and Human Services, of a "bolder and more candid federal AIDS prevention campaign").

The ultimate objective should be the mandatory and uniform testing and counseling of pregnant women. Fortunately, tort law provides a mechanism for achieving this objective through the broad scale adoption of such a duty: a cause of action for wrongful life by the infant against the negligent health care provider. Although an action for wrongful life does present problems, it is also the most effective mechanism for the rapid and consistent imposition of a duty to test.