Women and HIV: A Gender-Based Analysis of a Disease and Its Legal Regulation

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Articles

WOMEN AND HIV: A GENDER-BASED ANALYSIS OF A DISEASE AND ITS LEGAL REGULATION

Mary Anne Bobinski*

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The rate of HIV infection is growing most rapidly in women.¹

This short, declarative sentence is obviously meant to be compelling, yet hidden in its apparently simple grammatical structure is an enormous assumption that warrants excavation and examination. Why should we worry about “women” with HIV infection as a category separate and distinct from people with HIV infection generally? Is gender² of any relevance in the legal regulation of HIV?

This Article explores the utility of applying a gender-based analysis to the problems associated with HIV infection and its legal regulation. Part I explains the theories justifying the use of gender in analyzing legal rules, thus providing the rationale for the application of a gender-based analysis in the remaining parts of this piece. Part II analyzes the effect of “gender-neutral” policies on women with HIV infection who have sought treatment or access to clinical research trials or protocols. In Part III, the same mode of analysis is applied to some of the seldom-discussed problems associated with criminal and civil tort regulation of HIV transmission. In Part IV, I conclude that a gender-based analysis is a useful tool for understanding and critiquing several aspects of the legal system’s response to HIV infection. I also conclude, however, that a gender analysis alone is inadequate to determine appropriate criminal or tort policies toward HIV.

¹ AIDS IN THE WORLD 29-30 (Jonathan M. Mann et al. eds., 1992) (estimating that worldwide “the number of HIV-infected men increased about 90-fold from 1980 to 1991; the number of HIV-infected women increased more than 225-fold during this period”). These international estimates are mirrored in the United States, where the number of reported AIDS cases can be used to estimate the rates of HIV infection. The number of AIDS diagnoses reported among men rose 2.5% between 1991 and 1992, while the number of cases in women rose by 9.1% during the same period. Centers for Disease Control and Prevention, U.S. AIDS Cases Reported through December 1992, HIV/AIDS SURVEILLANCE YEAR END SUMMARY, Feb. 1993, at 9 [hereinafter CDC, YEAR END SUMMARY]. Although the number of AIDS cases can be used to estimate the incidence of HIV infection in particular populations, the estimate should be understood as a retrospective snapshot because an AIDS diagnosis reflects an HIV infection that is several years old.

² I use the phrase “gender” instead of “sex” in this Article to establish that I am concerned with a biological and social classification rather than with an activity. But see Richard A. Epstein, Gender Is for Nouns, 41 DePaul L. Rev. 981, 982 (1992) (arguing for the use of “sex” rather than “gender” in civil rights scholarship, due to the perception of the term “gender” as “exploring the relationship between males and females as a social phenomenon and not as a biological one”).
transmission.

I. "Women" as an Analytic Category

Dutiful readers of leading law reviews will have observed the rapid growth of outsider perspectives on the law over the past twenty years. Race, gender, and class analyses of legal problems or theories have attempted to crack open the facade of objective neutrality in the law. Observers of this process tend to see either the destructive desecration of a temple or the transformative breaking of an egg, depending, at least in part, on political persuasion. A fair amount of the hostility directed at "outsider" jurisprudence arises from disputes over method and purpose. Therefore, the method of analysis and the purpose of this Article deserve description.

The feminist branch of outsider jurisprudence often employs a key methodological approach which has been termed by Katharine Bartlett as "asking the woman question." Feminist legal scholars analyze how current legal doctrines affect women and examine whether the particular

3. Professor Mari Matsuda is credited with coining the phrase "outsider jurisprudence" to refer to feminist and race scholarship; Mari J. Matsuda, Public Response to Racist Speech: Considering the Victim's Story, 87 Mich. L. Rev. 2320, 2323 (1989) (arguing that "scholars of color" should use the insights they have gained from experience as persons of color in their scholarship); see also Alex M. Johnson, Jr., The New Voice of Color, 100 Yale L.J. 2007 (1991) (arguing that, when authors draw on their experiences as persons of color in their work, they speak with the voice of color, regardless of the ideology they choose to follow). Feminist theorists have published many articles in law reviews devoted to "asking the woman question." See, e.g., Katharine T. Bartlett, Feminist Legal Methods, 103 Harv. L. Rev. 829, 837-49 (1990) (describing feminist methods for analyzing legal doctrines that exclude women); Paul M. George & Susan McGlamery, Women and Legal Scholarship: A Bibliography, 77 Iowa L. Rev. 87, 87 (1991) (including "works about women in legal education and the legal profession, as well as legal scholarship on gender equality and feminist legal theory"). Similar articles are published in other journals specifically devoted to feminist legal analyses, such as the Harvard Women's Law Journal, the Yale Journal of Law and Feminism, the Hastings Women's Law Journal, and the University of Texas Journal of Women and the Law.

Race theorists have been engaged in a similar enterprise. See, e.g., Richard Delgado, The Imperial Scholar Revisited: How to Marginalize Outsider Writing, Ten Years Later, 140 U. Pa. L. Rev. 1349 (1992) (assessing the efforts of mainstream scholars to marginalize the "outsider" scholarship of Critical Race theorists and radical feminists); Richard Delgado & Jean Stefanie, Critical Race Theory: An Annotated Bibliography, 79 Va. L. Rev. 461 (1993) (compiling a list of articles that are within the body of Critical Race Theory scholarship); Matsuda, supra (discussing racist speech).


5. Bartlett, supra note 3, at 831. "Asking the woman question" is merely the beginning of an analytic framework. Methodological disputes have arisen over a variety of matters, including the use of "storytelling" and the ability of "nonoutsiders," however described, to participate in the process.
concerns of women are recognized through legal protection.\(^6\) A gender-focused analysis of law could be viewed as a modification of the venerable “reality testing” technique advocated by legal realists in the early part of this century\(^7\) and the law and society scholars of the past two decades.\(^8\) This Article applies this technique in analyzing how legal doctrines intersect with the reality of many women’s lives.\(^9\)

Generally, analyses of this type have one or more of three goals: descriptive, predictive, or normative. The descriptive goal of a gender-based analysis of a system of legal rules involves describing either the structure of the legal rules or the real-life effects of these rules. This goal is likely to be noncontroversial as long as the system of laws being studied is specifically gender-based. In these instances, the law itself reveals that gender is an important category for determining the nature of legal regulation, and it would hardly seem daring to agree. However, few laws use gender as an overt mechanism of classification; both heightened scrutiny analysis\(^10\) and political pressure\(^11\) make their continued existence tenuous.

Using gender-based analyses to describe the law or its effects becomes more problematic when generally applicable laws are considered. Since these general laws are facially gender-neutral, they are not easily susceptible to claims that gender-based analyses can help to describe their

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\(^6\) Id. at 837-49.

\(^7\) See, e.g., Karl N. Llewellyn, Some Realism about Realism—Responding to Dean Pound, 44 HARV. L. REV. 1222, 1235-38 (1931) (outlining the beliefs and methods that the “realists” adhered to in an effort to fundamentally reconceptualize the legal system and law).

\(^8\) See, e.g., Stewart Macaulay, An Empirical View of Contract, 1985 Wis. L. REV. 465 (discussing the differences between the academic model of contract law and the way in which contracts are used in the real world); Stewart Macaulay, Non-Contractual Relations in Business: A Preliminary Study, 28 AM. SOC. REV. 55 (1963) (offering examples of how contracts used by businessmen differ from academic conceptions of “contract”).

\(^9\) Traditionalists will be happy to note, however, that I do not stray far from the typical law review format: the “reality” explored in this Article is not grounded in personal experience. For many of the issues discussed, I can only be described as an outsider: I am a white, economically privileged, currently HIV-negative woman. The “reality” discussed herein has not been subjected to rigid empirical controls.


\(^11\) The limited military role for women is an example of explicit discrimination that is legally sanctioned. See Rostker v. Goldberg, 453 U.S. 57 (1981) (upholding exclusion of women from draft registration). Yet, discrimination in the military is also politically controversial. See, e.g., Eric Schmitt, Many Women in Army Favor Ending Combat Ban, N.Y. TIMES, Sept. 11, 1992, at A24 (citing survey results indicating that 73% of female officers and 79% of enlisted women believed that women should be allowed to volunteer for combat); Eric Schmitt, Ban on Women in Combat Divides Four Service Chiefs, N.Y. TIMES, June 19, 1991, at A16 (describing how the Senate hearing on women in combat provoked different reactions on this issue from the Chiefs of the Armed Services).
structure. Yet, other useful descriptive projects still remain, such as describing the real effects of facially neutral legal schemes.12

Another quite different problem arises from taking the word "descriptive" seriously in assessing the effects of a system of legal rules. The more concerned one becomes with descriptive accuracy, the more unlikely it is that there can be meaningful discussion about the effect of laws on "women," just as it may be difficult to analyze a law's effect on "African Americans" or the "economically disadvantaged."13 Those who reject the possibility of objectivity must constantly battle against the impossibility of generalizing from the subjective. This is particularly important when considering women with HIV infection, given that many are women of color or belong to the economic underclass.14 This Article will attempt to take this problem into account by describing the effect of HIV-related regulations on women of different socioeconomic and racial backgrounds.

Prediction is the second possible goal of a feminist analysis of the law. Recognizing gender might improve the ability of scholars to predict the likely outcome of disputes or judicial decisions, even in a regime of overtly gender-neutral laws. Gender can be useful in predicting the outcomes of child custody disputes,15 the sterilization of incompetent persons,16 and

12. It is often difficult to disentangle claims about motivation from claims about effect, although saying that a law has a differential impact on persons of one gender clearly does not require a conclusion that the enactment of the law was motivated by gender prejudice. Some critics of feminist scholarship occasionally muddy these claims. See, e.g., Lasson, supra note 4, at 9-10 n.38 ("Of course it is important . . . to be cited in mainstream law reviews, and (for pedagogical purposes) to have diversity on reading lists, but proving some sort of conspiratorial motive for excluding women is purely conjectural.").

13. See Bartlett, supra note 3, at 847-49 (arguing that "asking the woman question" can become exclusionary in itself unless it is used as a model for an analysis of other types of oppression).

14. See infra text accompanying notes 27-29 (offering statistics on the incidence of AIDS in different racial groups of women).

15. Many feminist scholars have argued that the movement to gender-neutral child custody laws has injured women. See Elizabeth S. Scott, Pluralism, Parental Preference, and Child Custody, 80 CAL. L. REV. 615, 619-30 (1992) (discussing why gender-neutral approaches to child custody arrangements have been problematic for children and unfair to mothers). Yet, the gender of the parent may still be a good predictor of the ultimate custody determination in jurisdictions that apply some variant of the primary caretaker standard, even though that standard is facially gender-neutral. The primary caretaker standard holds that the parent who has fulfilled the day-to-day needs of the children during the marriage should be granted custody of the children. See, e.g., Martha Fineman, Dominant Discourse, Professional Language, and Legal Change in Child Custody Decisionmaking, 101 HARV. L. REV. 727, 773 (1988) ("The rule is gender neutral on its face. As with most gender-neutral rules, its impact may not be gender neutral, but this result only reflects the fact that women are the primary nurturers of children in our society."); Laura Sack, Women and Children First: A Feminist Analysis of the Primary Caretaker Standard in Child Custody Cases, 4 YALE J.L. & FEMINISM 291 (1992) (arguing that the primary caretaker standard generally benefits women except that the "unfit" parent exception to the standard is selectively applied to penalize women for nonmarital sexual relationships).

16. A LEXIS search for reported cases concerning sterilization of incompetents, for example,
right-to-die requests. It can also be used to predict areas of likely legal dispute. Areas in which women differ from men, such as in their reproductive capacity, provide fertile ground for legislative and judicial debate. Applying a gender-based analysis might improve our ability to predict potential areas of legal controversy in the regulation of HIV infection.

Third and finally, gender-based analyses of legal doctrines are often critical and sometimes normative in their approach to legal analysis. This Article will describe critically the negative effects of some legal rules on many women with HIV infection. It will explore some normative questions concerning the appropriate methods of structuring legal doctrines to achieve both adequate access to health care and appropriate protection of the public health.


18. See infra notes 74-97 and accompanying text.

19. Feminist scholars have been involved in numerous projects which are at least critical, if not normative. Areas of great activity include abortion regulation, see, e.g., Ruth Colker, Feminist Litigation: An Oxymoron?—A Study of the Briefs Filed in William L. Webster v. Reproductive Health Services, 13 HARV. WOMEN'S L.J. 137 (1990) (discussing critically and normatively abortion-related litigation); sexual harassment, see, e.g., Susan Estrich, Sex at Work, 43 STAN. L. REV. 813 (1991) (discussing how feminist analyses of rape statutes could be used to improve judicial response to sexual harassment litigation); Wendy Pollock, Sexual Harassment: Women's Experience vs. Legal Definitions, 13 HARV. WOMEN'S L.J. 35 (1990) (arguing that the legal definition of sexual harassment is inadequate to cover what most women perceive and experience as harassment); and surrogate parenting, see, e.g., Joan Mahoney, An Essay on Surrogacy and Feminist Thought, 16 LAW, MED. & HEALTH CARE 81 (1988) (discussing how the different schools of feminist jurisprudence may resolve questions about surrogacy agreements); Maura A. Ryan, The Argument for Unlimited Procreative Liberty: A Feminist Critique, HASTINGS CENTER REP. 6, July-Aug. 1990, at 6 (examining infertility, procreative autonomy, and the right to assistance in reproduction).
II. Medical Policies Toward Women with HIV: Discrimination and Gender Neutrality

A. Medical Neglect

Can women be diagnosed with AIDS? Do women with HIV infection have access to treatment equal to that of men? These are important questions with some surprising answers. The first United States cases of what came to be known as AIDS were identified in gay men in 1981. The public's perception of AIDS and HIV infection as a "gay" disease has remained rooted in the epidemic's beginnings. Thus, the popular press publishes pieces on the "myth" of heterosexual transmission and a woman with AIDS is viewed as a deviation from the norm that requires some explanation.

The epidemiological facts simultaneously confirm and challenge these popular stereotypes. Worldwide, about forty percent of those infected with HIV are women. In the United States, the infection rate is more...
skewed, with women constituting one-eighth of those infected\(^{24}\) and just over thirteen percent of those persons diagnosed with AIDS in 1992.\(^{25}\) This relatively low ratio, however, disguises the fact that the rate of infection is increasing most rapidly in this group.\(^{26}\) The growing prevalence of HIV infection among women is masked by social and economic factors:\(^{27}\) about seventy-five percent of the women with AIDS are African-American or Hispanic.\(^{28}\) This epidemiological reality reinforces the complacency of middle-class white women.\(^{29}\)

For the first twelve years of the HIV epidemic, medical policies failed to deal adequately with HIV-infected women. Women were confronted with two types of discrimination: medical researchers, clinicians, and regulators tended either to discriminate against women because they were adults in the world in 1992, 4.7 million were women).\(^{24}\) Kenneth H. Mayer & Charles C.J. Carpenter, Women and AIDS, Sci. AM., Mar. 1992, at 118.

\(^{25}\) CDC, YEAR END SUMMARY, supra note 1, at 15. Data on the incidence of AIDS tend to underinclude women because of definitional problems. See infra text accompanying notes 33-38. Another major problem with using information about the rate of AIDS is that it reflects the incidence of HIV infection five to ten years ago.

According to the Centers for Disease Control, there were 6,255 newly reported AIDS cases in adolescent and adult women during 1992, an increase of about 9% over 1991 data. CDC, YEAR END SUMMARY, supra note 1, at 9. Women made up 13.5% of the total number of AIDS cases reported in 1992. Id. This represents an increase over the 12.7% of cases reported in women in 1991, and the 11% of female cases reported since the beginning of the epidemic. See id. (noting that, of the 249,199 persons who have been diagnosed with AIDS, 27,485 have been women); see Tedd V. Ellerbrock et al., Epidemiology of Women with AIDS in the United States, 1981 through 1990, 265 JAMA 2971, 2972 (1991) (noting that women accounted for 8.6% of AIDS cases in 1985 and 11.5% in 1990); Spread of AIDS Expected to Slow, N.Y. TIMES, Jan. 15, 1993, at A12 (estimating that "by 1995, 55,000 to 75,000 women will have AIDS").

\(^{26}\) See supra note 1.

\(^{27}\) Larry Thompson, Alarming Spread of AIDS Among Women; Psychologically and Physically, Activists Say, the Problems Differ, WASH. POST, Dec. 11, 1990, at Health 7.

\(^{28}\) Of the 27,485 women diagnosed with AIDS through December of 1992, 25.2% were Anglo (compared to 56.3% of men); 52.94% were African-American but not Hispanic (compared to 26.67% of men); 20.9% were Hispanic (compared to 15.98% of men); 0.52% were Asian/Pacific Islander (compared to 0.65% of men); and 0.22% were American Indian/Alaska Native (compared to 0.17% of men). CDC, YEAR END SUMMARY, supra note 1, at 11. This can be compared to the whole population in which about 21% of women are African-American or Hispanic. See United States Department of Commerce, Economics and Statistics Administration, Bureau of the Census, 1990 Census of Population: General Population Characteristics: United States, 1990 CP-1-1 tbl.16, Nov. 1992, at 23-24 (listing the population of all women as 127,470,455, with black women numbering 15,815,909 and Hispanic women totaling 10,966,000).

\(^{29}\) Cf. Allan M. Brandt, From Social History to Social Policy, in AIDS: The Burdens of History 147, 155 (Elizabeth Fee & Daniel M. Fox eds., 1988) (suggesting that many "respectable middle class" Americans associate AIDS with a "deviant ethnic, working-class 'sexual underworld'"). But see Monroe E. Price, Shattered Mirrors: Our Search for Identity and Community in the AIDS Era 65-66 (1989) (arguing that the general public, including white women, have not yet fully appreciated AIDS as a disease that has a major impact on minorities because of the prevailing view that it is a homosexual disease).
different from men or to mistakenly equate women with men in applying policies that had differential effects.

First, some medical policies explicitly discriminated against women or had a disproportionate impact on women. In some cases, for example, women were excluded from research protocols because it was believed that their hormonal cycles might have a negative effect on the results.³⁰ Often, women have been excluded from research programs because of the possibility or reality of pregnancy.³¹ Women’s differences from men have provided the basis for denying women access to these important sources of medical care and hope.³² The second type of discrimination occurred when even apparently gender-neutral medical policies had differential

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³¹ See Mayer & Carpenter, *supra* note 24, at 118 (“Many research protocols mandate routine pregnancy tests and eliminate women from trials if they become pregnant.”); see also Bowles, *supra* note 30, at 881-85 (explaining that increased costs and fear of liability for injured fetuses are the main reasons that women, and especially pregnant women, are excluded from clinical research); Paul Cotton, *Women’s Health Initiative Leads Way as Research Begins to Fill Gender Gaps*, 267 JAMA 469, 470 (1992) (noting the ongoing debate about the inclusion of women of childbearing age in research protocols); Council on Ethical and Judicial Affairs, *Gender Disparities in Clinical Decision Making*, 266 JAMA 559, 559 (1991) (outlining the fears some researchers have in using women as participants in medical experiments and studies).

Activists also have reported that women with HIV infection are often denied access to reproductive services, such as abortions or infertility treatments, based on their HIV infection. See, e.g., *Survey: Clinics Rejecting Women with AIDS Virus*, Hous. Post, Mar. 21, 1990, at A9 (describing the number of New York City abortion clinics turning away pregnant women infected with the AIDS virus). Such discrimination might violate the nondiscrimination requirements of the Americans with Disabilities Act. See 42 U.S.C. §§ 12181-82 (Supp. III 1991) (disallowing discrimination against persons with disabilities in places of accommodation, which include the offices of health care providers and private hospitals); see Taunya L. Banks, *The Americans With Disabilities Act and the Reproductive Rights of HIV-Infected Women*, 3 Tex. J. Women & L. 57 (1993) (discussing how the ADA may protect women with HIV from discrimination in the area of reproductive services); see also Josephine Gittler & Sharon Rennert, *HIV Infection Among Women and Children and Antidiscrimination Laws: An Overview*, 77 Iowa L. Rev. 1313, 1361-83 (1992) (noting the current discrimination in the delivery and financing of health services).

³² Access to research protocols is the prerequisite for access to health care for many women. This is obviously true for research protocols exploring treatments for currently untreatable conditions; in these cases access to a research protocol is the only source of hope. Access to research protocols is also important for lower income women who may not be able to secure access to basic health care in any other way. See U.S.F.D.A., *Activists Protest Exclusion of Women from Testing*, AIDS Wkly., Dec. 21, 1992, at 5 (discussing the idea that the best or only access poor women will have to AIDS health care is through research protocols).
effects. The medical definition of “AIDS,” for example, was initially devised by studying the opportunistic infections suffered by gay men. The resulting definition assumed that men and women were the same for purposes of HIV infection and would be vulnerable to the same types of opportunistic infections. This assumption was false. Women tended not to suffer from Kaposi’s Sarcoma, one of the leading indicators of AIDS in gay men. Women with HIV infection instead contracted a wide range of reproductive system conditions which men were biologically incapable of developing.

These policies had serious medical and economic effects. Women with HIV infection were very sick, yet had no “AIDS” diagnosis; the result was diminished access to clinical trials for AIDS treatments and more difficulty in obtaining disability benefits. Thus, women with HIV infection historically received less medical treatment and had shorter life spans.

33. See Lawrence K. Altman, Federal Health Officials Propose An Expanded Definition of AIDS, N.Y. TIMES, Oct. 28, 1992, at B9 (stating that “because AIDS case definitions had been based on the opportunistic infections found primarily in gay men, ‘women, injection drug users, and other populations have been systematically excluded, and unable to be officially diagnosed as having AIDS’”).


35. Women with HIV infection often suffer from cervical dysplasia, invasive cervical cancer, and severe yeast infections. Id. at 959-62. See Mayer & Carpenter, supra note 24, at 118 (discussing research noting recurrent candida albicans infections, cervical cancer, and genital warts in women with HIV).

36. See Howard L. Minkoff & Jack A. DeHovitz, Care of Women Infected with the Human Immunodeficiency Virus, 266 JAMA 2253, 2257 (1991) (arguing that women have been discriminated against in trying to gain access to HIV treatment and clinical research trials); Mark D. Smith, Zidovudine: Does It Work for Everyone?, 266 JAMA 2750 (1991) (noting the low numbers of women and minorities in studies of treatment effectiveness). But see Rhoda S. Sperling et al., A Survey of Zidovudine Use in Pregnant Women with Human Immunodeficiency Virus Infection, 326 NEW ENG. J. MED. 857 (1992) (describing results of a study involving HIV-infected women who took Zidovudine during their pregnancies); Stefano Vella et al., Survival of Zidovudine-Treated Patients with AIDS Compared with That of Contemporary Untreated Patients, 267 JAMA 1232, 1234-35 (1992) (illustrating the low number of women—14-16%—used in testing HIV drugs, but suggesting that female subjects have better survival rates than their male counterparts in such tests).

37. Initially, persons diagnosed with AIDS were deemed presumptively disabled and therefore were entitled to receive Supplemental Security Income (SSI) benefits while a final determination of disability was pending. 20 C.F.R. § 416.934(k) (1989). This presumptive eligibility for benefits was later withdrawn. See infra text accompanying note 72.

38. HIV-infected women with clinical indicators for AZT or PCP prophylaxis, for example, tend not to receive those treatments. See, e.g., Hankins & Handley, supra note 34, at 965-67 (discussing some of the factors, such as diagnosis at a relatively late stage and lack of access to health care, that contribute to the shorter survival rate of women after an HIV diagnosis); Marilyn Chase, Men in Study of AIDS Cases Outlive Women, WALL ST. J., June 19, 1992, at B5 (acknowledging the existence of a “gender gap” in survival rates because women are allegedly
Activists, lawyers, and academics responded to these medical policies in two ways. First, they exerted political pressure on Congress and on federal agencies involved in HIV-related research to improve medical treatment for HIV-infected women. Second, they used the legal system to challenge the permissibility of differential treatment. On this front, the modest successes achieved demonstrate both the advantages and the problems of using the legal system to address differential treatment based on differences between the genders. In fact, the threat of litigation was not as effective as political pressure in changing these policies.

underrepresented in AIDS drug trials); Mayer & Carpenter, supra note 24, at 118 (noting that doctors are often slow to diagnose women with HIV, even though their symptoms indicate presence of the virus). But see Ellerbrook et al., supra note 25, at 2791 (finding equivalent survival times between AIDS diagnosis and death for women and heterosexual men); Vella et al., supra note 36, at 1234 (stating that 14-16% of persons in study were women and that women had slightly better survival times).

39. Congress held hearings on the problem of lack of access to treatment for women. See, e.g., Women and HIV Disease: Falling Through the Cracks: Hearing Before the Subcomm. on Human Resources and Intergovernmental Relations of the House Comm. on Government Operations, 102d Cong., 1st Sess., 1-247 (1991) (focusing on the issues related to women and HIV—the AIDS case definition and its functions, research on disease progression in women, and access to benefits through the Social Security Administration). Several bills dealing with the problems of women in medical research have been repeatedly introduced in Congress. See, e.g., H.R. 4, 103d Cong., 1st Sess. (1993) (revising and extending the programs of the National Institutes of Health in order to promote clinical research equity regarding women and minorities); H.R. 695, 103d Cong., 1st Sess. (1993) (establishing an Office of Research on Women’s Health). This political activity resulted in the passage of legislation attempting to improve the access for women and minorities to clinical trials and research. See S. 1, 103d Cong., 1st Sess. § 492B (1993) (promoting the participation of women and minorities as subjects in clinical research).

40. See Rosetti v. Sullivan, 788 F. Supp. 1380 (E.D. Pa. 1992) (litigating the failure of the Social Security Administration to issue final regulations governing HIV disability determinations); Tim Stephens, AIDS in Women Reveals Health-Care Deficiencies, 3 J. NIH RFs. 28, 29 (1991) (discussing a lawsuit filed in New York challenging the Social Security Administration's disability determinations made under the CDC's old AIDS definition which excluded many of the symptoms found only in women); U.S.F.D.A., supra note 32, at 5 (discussing a petition to the FDA filed by several activist organizations to change the rules concerning testing of experimental drugs).


There is widespread evidence, however, of the influence of political pressure. See, e.g., Philip J. Hilts, AIDS Definition Excludes Women, Congress Is Told, N.Y. TIMES, June 7, 1991, at A19 (describing the congressional hearings on disability payments for AIDS patients in which witnesses reported that many of the symptoms affecting women with AIDS are not recognized in the CDC's definition); Mireya Navarro, Dated AIDS Definition Keeps Benefits From Many Patients,
B. The Law of Discrimination and Gender Neutrality

Persons who have attempted to use the legal system to improve the position of women with HIV infection have had few effective tools because the contested policies are often facially gender-neutral and because discrimination based on reproductive capacity or status had not been recognized as gender-based discrimination. Several different constitutional or statutory claims have been advanced to challenge medical policies which have a negative impact on women with HIV infection.42 An analysis of these claims reveals that a policy's negative impact on women does not always translate into an actionable legal wrong.

Federal constitutional claims are initially problematic because of the need to identify a federal or state actor subject to constitutional constraints.43 This requirement is easily met where governmental employees determine eligibility for programs or benefits. It is more difficult to identify a state actor where the challenged act of discrimination occurs in a private doctor’s office, since mere governmental funding or regulation may not be sufficient to find state action.44 Assuming that a


42. See Roe v. Fauver, Civ. No. 88-1225, 1988 U.S. Dist. LEXIS 4272 (D.N.J. May 13, 1988) (examining the claims of a female plaintiff that her Eighth Amendment and equal protection rights were violated when she was removed from a corrections facility and placed in a medical center in solitary confinement because she was diagnosed as having AIDS); cf. Doe v. Centinela Hosp., No. CV 87-2514, 1988 U.S. Dist. LEXIS 8401 (C.D. Cal. July 7, 1988) (refusing to grant summary judgment against a plaintiff who argued that being discharged from a drug treatment program because he tested positive for the HIV virus violated the Federal Rehabilitation Act).

43. Federal constitutional provisions which require equal protection of the laws apply to federal and state actors. U.S. CONST. amends. V, XIV.

44. The decisions of governmental actors are subject to constitutional constraints:

Our cases have accordingly insisted that the conduct allegedly causing the deprivation of a federal right be fairly attributable to the State. These cases reflect a two-part approach to this question of "fair attribution." First, the deprivation must be caused by the exercise of some right or privilege created by the State or by a rule of conduct imposed by the State or by a person for whom the State is responsible. ... Second, the party charged with the deprivation must be a person who may fairly be said to be a state actor. This may be because he is a state official, because he has acted together with or has obtained significant aid from state officials, or because his conduct is otherwise chargeable to the State.


It is not enough to show that private actors are regulated or heavily subsidized by the government. See Blum v. Yaretsyk, 457 U.S. 991, 1009-12 (1982) (finding that extensive state regulation and funding of nursing homes is not sufficient to render nursing home decisions to discharge or transfer patients subject to due process notice and hearing requirements); Rendell-Baker
state actor can be found, the next step is to apply the appropriate standard
of review to the objectionable policy.

Although the Supreme Court has previously applied an intermediate
scrutiny standard to laws which overtly distinguish between men and
women, the contested medical policies concerning HIV have not taken
this form. Some research policies do overtly discriminate against pregnant
or fertile women, but the Court has not regarded differential treatment of
pregnancy as gender-based discrimination for constitutional purposes. In
Geduldig v. Aiello, the Supreme Court noted that discriminating between
pregnant people and nonpregnant people did not constitute gender-based
discrimination because women could also be found among the set of
nonpregnant persons. In this foray into the problems of pregnancy
discrimination, the Court held:

Normal pregnancy is an objectively identifiable physical condition with
unique characteristics. Absent a showing that distinctions involving
pregnancy are mere pretexts designed to effect an invidious
discrimination against the members of one sex or the other, lawmakers
are constitutionally free to include or exclude pregnancy from the
coverage of legislation such as this on any reasonable basis, just as with
respect to any other physical condition.

Although the Geduldig decision elicited a barrage of criticism, it has
retained its constitutional vitality, most recently appearing in the Supreme

government by reason of their significant or even total engagement in performing public contracts.").

45. Craig v. Boren, 429 U.S. 190, 197 (1976) (holding that "classifications by gender must
serve important governmental objectives and must be substantially related to achievement of those
objectives").

46. See Hayley Gorenberg & Amanda White, Off the Pedestal and into the Arena: Toward and
Including Women in Experimental Protocols, 19 N.Y.U. REV. L. & SOC. CHANGE 205, 205 (1991-
92) (stating that pregnant women are frequently denied the opportunity to participate in research
because they are presumed to be incapable of correctly balancing the risks to the fetus with their own
needs).


48. Id.

49. The Court's reasoning was challenged in a strong dissent by Justice Brennan:

In my view, by singling out for less favorable treatment a gender-linked disability
peculiar to women, the State has created a double standard for disability compensation:
a limitation is imposed upon the disabilities for which women workers may recover,
while men receive full compensation for all disabilities suffered, including those that
affect only or primarily their sex, such as prostatectomies, circumcision, hemophilia,
and gout. . . . Such dissimilar treatment of men and women, on the basis of physical
characteristics inextricably linked to one sex, inevitably constitutes sex discrimination.

Id. at 501. This criticism has been echoed almost uniformly in academic commentaries. See, e.g.,
Ruth Colker, An Equal Protection Analysis of United States Reproductive Health Policy: Gender,
Race, Age, and Class, 1991 DUKE L.J. 324 (discussing the effects of U.S. reproductive health
policies on pregnant adolescents).
Court's decision barring the application of the Ku Klux Klan Act to antiabortion protestors. Thus, the exclusion of pregnant women from HIV treatment programs that pose reproductive risks is unlikely to give rise to a cognizable equal protection claim unless the treatment program poses similar risks to the offspring of the men who are permitted to participate.

50. See Bray v. Alexandria Women's Health Clinic, 113 S. Ct. 753, 760-62 (1993) (holding that antiabortion demonstrators cannot be charged with a class-based conspiracy under 42 U.S.C. § 1985(3) because opposition to abortion is not discrimination based on sex); see also Harris v. McRae, 448 U.S. 297, 322-24 (1980) (finding that the Hyde Amendment, which barred federal funding for medically necessary abortions, is subject only to rational basis review because it is not based on discrimination against a suspect class); Maher v. Roe, 432 U.S. 464, 470-74 (1977) (describing why restrictions on federal funding for abortion are subject to a rational basis review); General Elec. Co. v. Gilbert, 429 U.S. 125, 135-37 (1977) (holding that a refusal to provide pregnancy benefits is not discrimination under Title VII of the Civil Rights Act).


One commentator has argued that the Supreme Court's decision in *International Union, UAW v. Johnson Controls, Inc.* represents an "implicit[] recognition [that] . . . discrimination on the basis of the ability to become pregnant is a gender classification." Bowles, supra note 30, at 903. This interpretation of the Court's decision might be too optimistic. In *Johnson Controls*, the Court was concerned with the application of Title VII to the defendant's fetal protection policies, which barred fertile women from employment in certain positions. *UAW v. Johnson Controls,* 111 S. Ct. 1196, 1198 (1991). The Court held that the defendant's fetal protection policies were classifications based on gender under two different theories.

First, the Court noted that the policies were gender-specific because they applied only to the potential offspring of female employees "[d]espite evidence in the record about the debilitating effect of lead exposure on the male reproductive system. . . ." *Id.* at 1203. This reasoning could be useful where potentially fertile women, but not fertile men, are excluded from participating in medical trials in situations where potentially fertile men also face risks from participation. The Court's reasoning here does not, however, undermine its historic unwillingness to equate pregnancy with gender.

The second basis for the Court's decision was the explicit language of the Pregnancy Discrimination Act (PDA). *Id.* The PDA amended Title VII's prohibition against sex discrimination in employment to explicitly incorporate pregnancy discrimination. 42 U.S.C. § 2000e(k) (1988). The Court's adherence to the specific terms of the statute does not require a reversal of its prior constitutional interpretation.

51. *UAW v. Johnson Controls,* 111 S. Ct. at 1203 (1991) (holding that differential treatment of male and female reproductive risks constitutes sex discrimination under Title VII). If the exclusion of women is perceived as discrimination based on sex, then the courts will apply an intermediate standard of review. Gender-based classifications are constitutional only if they are necessary to serve an important state interest. *Heckler v. Matthews,* 465 U.S. 728, 744-45 (1984). Any policy distinguishing between male and female reproductive risks must therefore be deemed necessary to serve an important governmental interest. Since a finding of sex discrimination is predicated on a determination that men face equivalent reproductive risks, it is difficult to imagine a circumstance in which the differential treatment of those risks would be necessary to serve an
A different sort of problem is presented in the apparently gender-neutral definition of AIDS. When a gender-neutral statute is challenged in constitutional discrimination cases, the Court requires a showing of intent. A demonstration of a policy’s differential or negative impact on a protected group is generally insufficient to support such a constitutional claim absent a showing of intent. The medical policies at issue here do not classify on the basis of gender; if anything, activists argue that gender-specific definitions should be imposed. Consequently, the inequities resulting from a male-oriented definition of AIDS and the discrimination based on women’s reproductive status might not be amenable to direct federal constitutional attack.

Other federal statutory civil rights challenges strike, at most, glancing blows to these medical policies. The federal Civil Rights Act of 1964 important governmental objective. See Bowles, supra note 30, at 903-07 (arguing that exclusion of fertile women from drug trials fails both intermediate and rational scrutiny standards).

52. Disparate impact alone is not sufficient to meet the intent requirement in Equal Protection Clause cases:

When a statute gender-neutral on its face is challenged on the ground that its effects upon women are disproportionally adverse, a twofold inquiry is thus appropriate. The first question is whether the statutory classification is indeed neutral in the sense that it is not gender based. If the classification itself, covert or overt, is not based upon gender, the second question is whether the adverse effect reflects invidious gender-based discrimination. In this second inquiry, impact provides an “important starting point” but purposeful discrimination is “the condition that offends the Constitution.”

Personnel Adm'r of Mass. v. Feeney, 442 U.S. 256, 274 (1979) (citations omitted). In Feeney, the Court upheld a lifetime veterans’ preference granted to applicants for state employment, despite the fact that over 98% of the veterans were male. Id. at 270. The veterans’ preference was upheld because the female plaintiffs were unable to show any specific intent by the State to discriminate against women. Proof of the statute's discriminatory effects was insufficient because of the need to show that "the decisionmaker ... selected or reaffirmed a particular course of action at least in part 'because of,' not merely 'in spite of,' its adverse effects upon an identifiable group." Id. at 279 (citations and footnote omitted).

The Court recently reaffirmed this approach by rejecting a claim that the activities of antiabortion demonstrators constituted an "invidiously discriminatory animus" against women, despite the fact that the demonstrations disproportionally affected women. Bray v. Alexandria Women's Health Clinic, 113 S. Ct. 753, 760-62 (1993). While this case is not directly applicable because it involved the application of 42 U.S.C. § 1985(3) (1988) (conspiracy to interfere with the civil rights of another), rather than an interpretation of the Equal Protection Clause, Justice Scalia’s opinion for the majority linked the intent requirement in the Ku Klux Klan Act to that found in the Equal Protection Clause. Bray v. Alexandria Women's Health Clinic, 113 S. Ct. at 758, 760-62. Two dissenting opinions in Bray included arguments supporting the use of effects or impact to find discriminatory animus. Id. at 787-89 (Stevens, J., dissenting), 802-04 (O'Connor, J., dissenting).

53. See Navarro, Dated AIDS Definition, supra note 41, at B5 (noting that many doctors and advocates argue that diseases such as cervical cancer should be included in the AIDS definition).

54. Many states have adopted an equal rights amendment to their state constitutions prohibiting gender-based discrimination. See, e.g., TEX. CONST. art. I § 3a. These provisions are of limited utility because much of AIDS policy is determined at the federal level.
explicitly prohibits discrimination on the basis of sex, but the prohibited discrimination must occur in the employment context. The Pregnancy Discrimination Act (PDA) amendments to the Civil Rights Act similarly apply only to discrimination in employment based on pregnancy. Thus, federal gender-based challenges to discrimination are difficult to apply to medical policies adversely affecting women.

State laws prohibiting gender-based discrimination in places of public accommodation might be more effective in providing remedies for at least some types of HIV-related discrimination against women. Under these provisions, physicians or hospitals could be prohibited from denying women access to research trials based on gender or pregnancy. In *Elaine W. v. Joint Diseases North General Hospital*, several female plaintiffs challenged the defendant hospital’s policy of barring pregnant women from participation in the hospital’s drug treatment program. New York’s public accommodation law specifically prohibited discrimination on the

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Gender-based discrimination by research programs in educational institutions receiving federal funds might be subject to attack under Title IX, which states that “[n]o person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance.” 20 U.S.C. § 1681(a) (1988). The broad language of this statute could conceivably be used by women who are rejected from research protocols conducted by educational institutions receiving federal funds. Potential research participants excluded by reason of their gender might be entitled to relief under this provision, but would have to establish that they are “persons” protected from discrimination under the Act and that their exclusion from research trials constituted “discrimination.” *Id.*

56. Congress amended the Civil Rights Act to prohibit pregnancy-based discrimination in employment after the Supreme Court’s decision in *General Electric Co. v. Gilbert*, which held that failure to provide pregnancy benefits was not discrimination under Title VII of the Civil Rights Act. 429 U.S. 125, 135-37 (1976). The Pregnancy Discrimination Act (PDA) amended the Civil Rights Act to provide that:

The terms “because of sex” or “on the basis of sex” include, but are not limited to, because of or on the basis of pregnancy, childbirth, or related medical conditions; and women affected by pregnancy, childbirth, or related medical conditions shall be treated the same for all employment-related purposes . . . as other persons not so affected but similar in their ability or inability to work . . . .


basis of sex in places of public accommodation; the law had previously been found applicable to both pregnancy-based discrimination and the actions of hospitals.

North General Hospital defended its policy of discrimination against pregnant addicts by relying on the fact that the facility did not have any on-site obstetrical services and on the contention that such services were medically necessary for pregnant addicts. The hospital's motion for summary judgment was ultimately rejected by the New York Court of Appeals. While the court rejected the defendant's motion for summary judgment, it did agree with a critical aspect of the hospital's defense. The court held that the hospital could permissibly discriminate against pregnant women if the facility could show that "it is medically unsafe to treat pregnant women at its facility, either because all pregnant addicts require immediate on-site obstetrical services or because it cannot be predicted with reasonable medical certainty which ones might require such services. . . ." This holding, while technically favorable for plaintiffs seeking to challenge the exclusion of women from drug treatment centers, is nevertheless quite limited. It provides no support for the argument that hospitals which purport to provide drug treatment programs should make available the full range of medical services that might be needed by program participants, including obstetrical services.

Interestingly, some of the most promising statutory modes of challenging medical policies which have a negative impact on women with HIV infection are not gender-based. The linkage between the discriminatory AIDS definition and the receipt of social security benefits can be challenged procedurally by arguing that the regulatory agency failed to comply with the appropriate notice and comment requirements of the Administrative Procedure Act. A substantive argument can be made under the disability insurance statutes' provisions which require appropriate

58. The statute "provides that it is 'an unlawful discriminatory practice for any . . . place of public accommodation, because of . . . sex . . ., directly or indirectly, to . . . deny to such person any of the accommodations, advantages, facilities or privileges thereof.'" Id. at 525 (quoting Executive Law § 296[2][a] (McKinney 1992)).

59. Id. (citing cases).

60. Id. at 525 n.1.

61. Id. at 524.

62. Id.

63. Id. at 526.

64. In this case, the defendant hospital was not licensed to provide obstetrical care. Id. at 524.

65. 5 U.S.C. § 553 (1988); see Rosetti v. Sullivan, 788 F. Supp. 1380, 1386-87 (E.D. Pa. 1992) (finding that the court had jurisdiction over plaintiffs' claims that the Social Security Administration had violated the Administrative Procedure Act in issuing substantive regulations governing the determination of disability without proper notice and comment); cf. Lincoln v. Vigil, 113 S. Ct. 2024, 2030-35 (1993) (discussing judicial review of administrative determinations under the APA along with the APA's notice and comment requirements).
determinations of disability. The only effective gender-based claims arise under nondiscrimination regulations promulgated by the National Institutes of Health—the major funder of HIV-related research. These regulations could be used to contest discrimination against women in clinical trials.

Political and legal activists have met with some success in improving the medical system’s response to women with HIV infection. The Centers for Disease Control has revised its definition of “AIDS” in ways that make it easier for women to obtain the diagnosis. The National Institutes of Health is now enforcing regulations which require an explicit justification for research protocols that exclude women. The Food and Drug Administration recently revised its policies to encourage drug developers specifically to evaluate gender differences and to permit the greater inclusion of potentially fertile women in early clinical trials. More generally, medical problems specifically affecting women have been recognized and are being studied.

Despite efforts to eliminate the negative impact of certain medical policies upon women, the progress is slow and numerous problems remain. These problems are indicative of three weaknesses inherent in gender-based critiques of social systems. First, eliminating a gender-biased system does not guarantee access to a coveted benefit; instead, the benefit may become restricted for everyone. The CDC’s expansion of the AIDS definition may not help women with HIV infection gain access to disability programs because the Social Security Administration has been reluctant to use the expanded definition to determine whether an applicant for benefits is “totally disabled.”

67. See Cotton, supra note 31, at 469 (discussing the enforcement of a 9 year-old policy that requires explicit justification for research protocols excluding women).
68. Centers for Disease Control and Prevention, 1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults, 41 MORBIDITY & MORTALITY WKLY. REP., RECOMMENDATIONS & REPS. 1 (1992). Women with HIV infection with CD4 + t-cell counts below 200 will be diagnosed as having AIDS. Id. at 2. Women whose t-cell counts are above 200 will be included in the AIDS surveillance definition if they have experienced invasive cervical cancer or pulmonary tuberculosis. Id. at 6-8.
70. Merkatz et al., supra note 30, at 294-95; see also Symposium, Women in Clinical Trials of FDA-Regulated Products: Who Participates and Who Decides?, 48 FOOD & DRUG L. J. 161 (1993) (including seminars addressing the issue of HIV-infected women in clinical trials).
71. The Journal of the American Medical Association, for example, recently devoted a special issue to research on women. 268 JAMA 1867 (1992).
72. The Social Security Administration (SSA) responded to the CDC’s proposed expansion of
Second, elimination of gender bias does little to change the economic and social realities of women's lives. Women remain underrepresented in research trials and among those receiving ordinary medical care. This persistent lack of access appears to be caused by many factors, some of which do not fall neatly under the "gender" rubric. Women with HIV infection may have difficulty complying with treatment or research protocols that require repeated medical visits for several reasons: the need to stay in the home to supervise children; the presence of cultural barriers to pursuing self-interest; or the impact of other problems generally associated with poverty.

The third weakness apparent in gender-based arguments is their relative ineffectiveness when applied to areas where biological differences are viewed as socially significant. It is largely because of this view that political and legal challenges only now are beginning to improve access to research protocols for the thirty percent of women with HIV infection who are or who may become pregnant. Federal policies which were attempting to support the exclusion of pregnant or fertile women from studies are rapidly changing, but some formidable barriers still exist. The FDA has only recently revised its policies to permit potentially fertile women to participate in early clinical trials. The FDA also has encouraged the inclusion of pregnant women with HIV infection in research protocols. Moreover, NIH regulations allow the participation of pregnant women in some research protocols as long as certain conditions are met and formal consent from both parents of a fetus is obtained.


73. One provider has estimated that in Newark, New Jersey, "there are 10 HIV-infected women untreated in the community for every one that is in the clinic for care." Marsha F. Goldsmith, Specific HIV-Related Problems of Women Gain More Attention at a Price—Affecting More Women, 268 JAMA 1814, 1816 (1992).

74. Based on one study, about 30% of women with HIV infection intend to get pregnant. Mayer & Carpenter, supra note 24, at 118.

75. Merkatz et al., supra note 30, at 294-95.

76. Id. at 295-96. The FDA’s policy regarding the participation of pregnant women in other types of research trials is, at best, murky. See id. at 296 (“The FDA intends to explore [this issue] further.”).

77. The regulation states:

(a) No pregnant woman may be involved as a subject in an activity covered by this subpart unless: (1) The purpose of the activity is to meet the health needs of the mother and the fetus will be placed at risk only to the minimum extent necessary to meet such needs, or (2) the risk to the fetus is minimal.
Private actors may not respond to these current changes in governmental policy and may continue to limit participation of potentially fertile women in research protocols. Their primary concern is tort liability: both researchers and manufacturers argue that children who were injured by experimental drugs as fetuses could sue for damages. Researchers contend that their discriminatory actions are based on reproductive status rather than on gender, and that any discrimination committed is necessary to protect fetuses and the financial viability of research efforts. The one major research study that included pregnant women was not designed for their direct benefit; the researchers involved

(b) An activity permitted under paragraph (a) of this section may be conducted only if the mother and father are legally competent and have given their informed consent after having been fully informed regarding possible impact on the fetus, except that the father's informed consent need not be secured if: (1) The purpose of the activity is to meet the health needs of the mother; (2) his identity or whereabouts cannot reasonably be ascertained; (3) he is not reasonably available; or (4) the pregnancy resulted from rape.


These paternal consent requirements may violate a woman's constitutional right to control her own medical treatment. See, e.g., Planned Parenthood of Southeastern Pa. v. Casey, 112 S. Ct. 2791 (1992) (holding that a spousal notification provision placed an undue burden on a woman's right to choose to have an abortion); Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52 (1976) (requiring the husband's consent to an abortion held unconstitutional); see also Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261 (1990) (recognizing a protected liberty interest in the ability to control one's own medical treatment). Professor Karen Rothenberg has reported that researchers evade this regulation in practice by emphasizing the "reasonably available" requirement, and finding that the father was not reasonably available if he was not present. Tape of the 1992 Association of American Law Schools Annual Meetings, Section on Health Care (Jan. 3-7, 1992) (on file with author).

78. Many studies listed in the Houston area specifically exclude fertile or pregnant women. See 4 Hous. CLINICAL RES. NETWORK HIV CLINICAL DIRECTORY 1 (presenting a comprehensive guide to available treatments and related research). But see Sperling et al., supra note 36, at 857 (analyzing the effects of an AIDS treatment drug on pregnant women). Historically, women were required to prove their inability to conceive as a result of prior sterilization or current contraceptive use in order to participate in clinical trials. The FDA's new guidelines suggest that potentially fertile women will be given greater access to early clinical trials. Under the new approach, trial designs will be altered to reduce the risk of fetal exposure and women will be counseled about the risks before participating in the trial. Merkatz et al., supra note 30, at 295. Drug companies might continue to adhere to a policy of exclusion because of tort liability concerns. Id.

79. See Bowles, supra note 30, at 907-16 (analyzing potential tort liability for damage to the fetus during clinical trials and for damage caused by releasing relatively untested drugs); Merkatz et al., supra note 30, at 295 (discussing drug manufacturers' concerns about liability for potentially fertile female clinical research participants). Drug companies often cite to a case brought by children whose mothers were given DES during pregnancy. Wetherill v. University of Chi., 565 F. Supp. 1553, 1563-66 (1983). This case is an anomaly, however, since the mothers did not give their informed consent to the administration of DES. Id.

80. See Bowles, supra note 30, at 907 (contending that drug companies perform a cost-benefit analysis, which leads them to conclude that it is less costly to release an untested drug on the market than to include fertile women in clinical trials).
hoped to discover whether the administration of AZT could reduce the rate of HIV transmission from the woman to the fetus.81

Private actors have previously asserted the threat of tort liability as a rationale for discriminating against potentially fertile women. In International Union, UAW v. Johnson Controls, the Supreme Court considered the constitutionality of an employment policy that denied certain jobs to presumably fertile women.82 The employer argued that the policy was based on the need to protect developing fetuses from exposure to lead.83 The Supreme Court held that the employer’s discriminatory conduct violated Title VII of the Civil Rights Act.84 The Court’s rejection of the employer’s exclusion of fertile women was strongly worded:

Our holding today that Title VII . . . forbids sex-specific fetal-protection policies is neither remarkable nor unprecedented. Concern for a woman’s existing or potential offspring historically has been the excuse for denying women equal employment opportunities. . . . Congress in the PDA prohibited discrimination on the basis of a woman’s ability to become pregnant. We do no more than hold that the Pregnancy Discrimination Act means what it says.

It is no more appropriate for the courts than it is for individual employers to decide whether a woman’s reproductive role is more important to herself and her family than her economic role. Congress has left this choice to the woman as hers to make.85

Johnson Controls supports the conclusion that women should be permitted to make decisions about their medical treatment without the intrusion of third parties who proclaim the right to protect fetuses.86 In fact, the case has already been cited as a basis for changes in the FDA’s policies toward the inclusion of women in clinical trials.87

The Johnson Controls decision has not, however, eliminated drug manufacturers’ concerns about liability. The decision arose in the employment context and concerned the application of Title VII and, therefore, it is not directly applicable to tort liability in the area of drug manufacturing and research.88 Additionally, the Court itself appeared
divided on the tort implications of its ruling. 89 The majority indicated that it was unlikely that employers would be held liable for fetal injuries because they would not be found negligent if they complied with Occupational Safety and Health Administration (OSHA) standards and informed women of the risks of lead exposure to their fetuses. 90 The Court also suggested that state tort liability might be preempted by the requirements of Title VII. 91 In a concurring opinion, three Justices noted their disagreement with the majority's tort analysis:

First, it is far from clear that compliance with Title VII will pre-empt state tort liability, and the Court offers no support for that proposition. Second, although warnings may preclude claims by injured employees, they will not preclude claims by injured children because the general rule is that parents cannot waive causes of action on behalf of their children, and the parents' negligence will not be imputed to the children. Finally, although state tort liability for prenatal injuries generally requires negligence, it will be difficult for employers to determine in advance what will constitute negligence. 92

The analysis of the concurring Justices offers little comfort to drug manufacturers and researchers whose fear of liability may cause them to continue to deny many women access to drug trials. 93

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89. Compare UAW v. Johnson Controls, 111 S. Ct. at 1208-09 (Blackmun, J.) (discussing the low likelihood of tort liability for employers) with 111 S. Ct. at 1210-12 (White, J., concurring) (arguing that the threat of tort liability might be a real and significant factor for employers) and 111 S. Ct. at 1216 (Scalia, J., concurring) (finding only that the employer in this case "has not demonstrated a substantial risk of tort liability"); see also John M. Tkacik, Jr., UAW v. Johnson Controls: The Supreme Court Fails to Get the Lead Out, Overlooks Fetal Harm Resulting from Workplace Exposure, 40 CLEV. ST. L. REV. 261, 270-72 (1992) (arguing that the majority in Johnson Controls was incorrect in assuming there would be no tort liability for employers); Louise Van Dyck, The Costs of Fetal Protection, 23 CONN. L. REV. 1049, 1076-78, 1081-82 (1991) (discussing the result in Johnson Controls and the potential for tort liability for employers); Jennifer Morton, Comment, Pregnancy in the Workplace—Sex-Specific Fetal Protection Policies—UAW v. Johnson Controls, Inc.—A Victory for Women?, 59 TENN. L. REV. 617, 632-34 (1992) (describing the division in the Court on the issue of tort liability); Yzta M. Murray, Note, Employer Liability After Johnson Controls: A No-Fault Solution, 45 STAN. L. REV. 453, 455-60 (1993) (discussing the flaws in the majority's assumption that tort liability would be preempted by Title VII).

90. UAW v. Johnson Controls, 111 S. Ct. at 1208.

91. Id. at 1208-09.

92. Id. at 1211 (White, J., with Rehnquist, C.J., and Kennedy, J., concurring in part and concurring in judgment) (footnotes omitted); see also id. at 1216 (Scalia, J., concurring in judgment) (restricting consideration of tort issues by noting that Johnson Controls had failed to "demonstrate[] a substantial risk of tort liability").

93. One interesting issue concerns drug company policies toward potentially fertile men. Men are not required to prove their inability to impregnate a woman in order to participate in research trials. Apparently, little attention is devoted to determining whether drug trials adversely affect the offspring of male participants. The situation resembles Johnson Controls, where the focus on female fertility may or may not have been justified from a scientific standpoint. See UAW v. Johnson
States could reduce the threat of liability by explicitly permitting parents to waive the claims of their unborn or minor children when participating in research trials. 94 Permitting waivers would increase the access of women to needed treatments. It would do so, however, by theoretically decreasing access to compensation for the cost of an infant's injuries which would otherwise be borne, at least initially, by the child's parents. Which of these possible results would be appropriate from a normative standpoint? The principles of feminist jurisprudence do not clearly indicate the answer to this question.

This analysis of evolving medical policies offers descriptive, predictive, and normative insights into problems of women with HIV infection. A gender-based analysis accurately describes certain aspects of the framework of HIV policy, particularly with respect to the differential treatment of women and men based on their procreative capacity. 95 It also provides an important descriptive framework for understanding the effects of policies that are viewed as gender-neutral. By carefully examining facially neutral policies, such as the definition of AIDS, one gains an understanding of the true gender-specific impact of these policies. 96 The predictive power of a gender-based analysis also has been demonstrated. Doctors and lawyers have had difficulty in developing policies concerning HIV-infected women precisely where theory predicts they should: in areas where women are biologically different from men, such as in their capacity to bear children. 97 Finally, the analysis has suggested both critical and normative solutions to the problems of HIV-infected women, including the adoption of a gender-inclusive definition of AIDS 98 and the elimination of discrimination based on reproductive capacity. 99 An analysis of tort liability questions, however, has also revealed the theory's normative limitations.100


95. See supra text accompanying notes 30-38.

96. See supra text accompanying notes 33-38.

97. See supra text accompanying notes 74-81.

98. See supra text accompanying notes 68-71.

99. See supra text accompanying notes 75-77.

100. See supra text accompanying notes 78-93.
III. Women as Vectors or Victims: Transmission of HIV

A. The Biological and Social Determinants of HIV Transmission

A gender-based analysis provides a useful framework for evaluating many aspects of our social policies toward HIV infection. A stated purpose of much HIV-related regulation is to protect the public health by reducing or eliminating behaviors that pose the risk of HIV transmission.\(^{101}\) States can, for example, create criminal or tort laws to deter or punish behavior that poses the risk of HIV transmission.\(^{102}\) These rules provide another important opportunity to examine the effect of facially neutral regulation on women with HIV infection. As an initial matter, the problem of HIV transmission must be examined to establish whether any unique biological properties based on gender exist. If such biological properties are present, it is necessary to determine whether and how these differences are reflected in the legal regulation of HIV transmission.

HIV is transmitted through specific types of exposure to blood or other bodily fluids of an infected person. Cases of HIV transmission occurring through heterosexual, homosexual, and lesbian sexual activity; through childbirth and breastfeeding; and through the receipt of blood, such as from a blood transfusion or from sharing needles during intravenous drug use, have been confirmed.\(^{103}\) Both men and women are capable of engaging in many, but not all, of these activities.

Gender-based differences in risk exist even when men and women are engaging in what appears to be the same activity. During heterosexual intercourse, for example, current data indicate that the risk of viral transmission from an infected male to a female is far greater than the risk of transmission from an infected female to a male partner.\(^{104}\) Estimates of

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\(^{101}\) There are two prongs to regulation: education and incentives. Through AIDS education efforts, people are informed about their own HIV status and/or the methods of HIV transmission. Education is often described as one of the most important mechanisms for protecting the public health. See Mark Barnes, Towards Ghastly Death: The Censorship of AIDS Education, 89 COLUM. L. REV. 698 (1989) (book review) (asserting that AIDS education is crucial to restricting its spread).

\(^{102}\) States can also use civil public health regulations to protect the public health. Most states have statutes permitting the civil commitment of persons with contagious diseases who present a threat to the public health. See Michael L. Clossen et al., Criminalization of an Epidemic: HIV-AIDS and Criminal Exposure Laws, 46 ARK. L. REV. (forthcoming 1994) (discussing public health laws and HIV-specific criminal statutes); see also Ex parte Martin, 188 P.2d 287 (Cal. Ct. App. 1948) (upholding the confinement of two women because of their venereal disease); State ex rel Kennedy v. Head, 185 S.W.2d 530 (Tenn. 1945) (allowing an individual to be confined because of venereal disease).

\(^{103}\) THE AIDS KNOWLEDGE BASE 1.2.1-1.2.7, 1.2.9 (P.T. Cohen et al. eds., 1990) (summarizing HIV transmission studies).

\(^{104}\) See Nancy S. Padian et al., Female-to-Male Transmission of Human Immunodeficiency
the risk of HIV transmission during intercourse appear to be based on the risk to the female partner rather than the male partner, and these estimates range from 1/500 to 1/10,000, depending on the use of safer sex practices.105

Data on the route of transmission for recently reported AIDS cases tend to confirm that a gender differential exists in the ease of HIV

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Virus, 266 JAMA 1664 (1991) (reporting a survey of heterosexual couples which found that the odds of male-to-female transmission were significantly greater than those of female-to-male transmission); see also Gerald H. Friedland & Robert S. Klein, Transmission of the Human Immunodeficiency Virus, 317 New Eng. J. Med. 1125, 1129 (1987) (noting that the "frequency of occurrence of female-to-male transmission remains controversial" and "transmission from women to men may be less efficient than that from men to women"); Larry Gostin, The Politics of AIDS: Compulsory State Powers, Public Health, and Civil Liberties, 49 Ohio St. L.J. 1017, 1044 (1989) (discussing the risks of HIV transmission with and without the use of a condom); Norman Hearst & Stephen B. Huller, Preventing the Heterosexual Spread of AIDS: Are We Giving Our Patients Bad Advice?, 259 JAMA 2428, 2429 (1988) (explaining that male-to-female infectivity may be much higher than female-to-male infectivity). The differential risk appears to be based on at least two factors: (1) HIV, while present in vaginal secretions, exists there at lower levels of concentration than in semen; and (2) heterosexual intercourse is more likely to create a portal of entry through a woman’s vaginal mucosal membranes than it is through a man’s penis. See David E.A. Clemenson et al., Detection of HIV DNA in Cervical and Vaginal Secretions: Prevalence and Correlates Among Women in Nairobi, Kenya, 269 JAMA 2860 (1993) (discussing factors which increase the infectivity of women); Mary H. Cooper, Women Dying of AIDS at Faster Rate Than Men; Female More at Risk in Heterosexual Contact, Hous. Chron., Jan. 10, 1993, at A6 (discussing why women are biologically more vulnerable to being infected with HIV through sexual contact).

Similarly, although data on the subject are so inadequate as to be nearly nonexistent, it would appear that there is a greater risk of HIV transmission during some types of male homosexual activity than during some types of lesbian sexual activity. Cf. CDC, Year End Summary, supra note 1, at 9-12 (giving data on percentage of current AIDS cases associated with male homosexual activity but no separate category for lesbian sexual activity discussed); S.Y. Chu et al., Update: Epidemiology of Reported Cases of AIDS in Women Who Report Sex Only with Other Women, United States, 1980-1991, 6 AIDS 518, 519 (1992) (reporting that, as of 1991, all reported AIDS cases among women who were sexually active only with other women could be attributed to intravenous drug use or blood transfusions and noting that woman-to-woman transmission “appears to be extremely rare” although possible modes of transmission are present).

105. See Gostin, supra note 104, at 1044 (reporting that risk from unprotected intercourse is 1/1,000; condom usage reduces risk to 1/10,000); Hearst & Huller, supra note 104, at 2429 (stating that the risk through vaginal intercourse is 1/500). Promiscuity is not necessary for HIV transmission to occur; monogamous sexual activity with an infected partner is, quite obviously, very risky. See Marilyn Chase, High HIV Rate Found in Women in Florida District, Wall St. J., Dec. 10, 1992, at B6 (reporting that “21% of infected women in the [Florida low-income population] study had ‘unremarkable’ sexual histories, with two to five partners in their lifetime—a rate similar to the majority of college women in a 1989 survey”). Safer sex practices can reduce, but not eliminate, the risk of transmission. See, e.g., Willard Cates et al., Commentary: The Quest for Women’s Prophylactic Methods—Hopes vs. Science, 82 Am. J. Pub. Health 1479 (1992) (criticizing the accuracy of current studies of female-controlled safer sex mechanisms); William L. Roper et al., Commentary: Condoms and HIV/STD Prevention—Clarifying the Message, 83 Am. J. Pub. Health 501 (1993) (discussing condom use and effectiveness in reducing transmission of HIV); Michael J. Rosenberg & Erica L. Gollub, Commentary: Methods Women Can Use That May Prevent Sexually Transmitted Disease, Including HIV, 82 Am. J. Pub. Health 1473 (1992) (summarizing STD prevention methods and their effectiveness).
transmission. Only about four percent of men recently diagnosed with AIDS acquired the HIV infection through heterosexual contact.\textsuperscript{106} In contrast, almost forty percent of women diagnosed with AIDS during 1992 acquired the infection through heterosexual contact.\textsuperscript{107} Racial and ethnic differences in the sources of infection exist as well. A larger percentage of Anglo women acquired their HIV infection from blood transfusions than did either African-American or Hispanic women, who were more likely to contract the infection through heterosexual contact or intravenous drug use.\textsuperscript{108} Most HIV infections among children are found in the children of women who have been diagnosed as HIV-infected.\textsuperscript{109}

Although the data tend to confirm the presence of differential risk, it is important to remember that they underestimate the risk associated with particular activities because the data are skewed by the incidence of HIV in particular populations. The higher rate of HIV transmission to African-American and Hispanic women does not reflect some racially or ethnically based biological vulnerability. Instead, it is an artifact of social factors that create a higher incidence of HIV infection among these women and their sexual partners.

The incidence of infection in a particular population or gender is an important factor in determining the overall risk of engaging in certain behaviors with someone of unknown HIV status. For example, sex with a man of unknown HIV status may be more risky than sex with a woman

\textsuperscript{106} CDC, \textit{YEAR END SUMMARY}, \textit{supra} note 1, at 9. More than one-third of these men had sex with a female injecting drug user, about one-fourth were born in a country where heterosexual transmission is common, and a little over one-fourth had sex with a woman with an unknown risk factor. \textit{Id.}

\textsuperscript{107} \textit{Id.} at 9. Of the female adult or adolescent AIDS cases reported in 1992, 45\% were related to injecting drug use; less than 1\% were from hemophilia/coagulation disorder; 39\% were related to heterosexual contact; 4\% followed receipt of a blood transfusion; and 12\% were from undetermined sources. \textit{Id.} Of the heterosexual contact cases, about 59\% were related to sex with an injecting drug user; 7.5\% were related to sex with a bisexual male; about 1\% were related to sex with a hemophiliac; about 8\% arose in women who were born in or had sex with a person from a country in which heterosexual transmission is a dominant mode of transmission; about 2.6\% were related to having sex with a transfusion recipient; and 21.1\% were attributed to sexual activity with an HIV-infected person whose risk was not specified. \textit{Id.} Most of the “undetermined sources” will be distributed to other categories as investigation continues. \textit{Id.} at n.4.

\textsuperscript{108} \textit{Id.} at 11. Seventeen percent of Anglo women acquired HIV infection through blood transfusions as compared to 3\% of African-American women and 5\% of Hispanic women. \textit{Id.} Thirty-three percent of Anglo women were infected with HIV through heterosexual contact, compared to 36\% of African-American women and 40\% of Hispanic women. \textit{Id.} Finally, only 42\% of Anglo women were infected through injecting drug use, compared with 54\% of African-American women and 48\% of Hispanic women. \textit{Id.}

\textsuperscript{109} Of the 4,249 pediatric (<13 years old) AIDS cases reported through December 1992, 86\% were born to women at risk for HIV infection; 11\% acquired the infection through blood (provided to treat hemophilia or through transfusions); and 2\% acquired HIV through undetermined mechanisms. CDC, \textit{YEAR END SUMMARY}, \textit{supra} note 1, at 9.
of unknown HIV status simply because the risk that a man is already infected is greater than the risk that a woman is already infected. Here, gender is relevant only in a transitory sense: women will pose a greater risk of HIV infection to others as the rate of infection among women grows.

Some modes of transmission are gender-specific. For example, only women are capable of transmitting HIV to fetuses during pregnancy or childbirth, and only women can transmit HIV through breastfeeding. The risk of HIV transmission from a woman to her infant before or during birth is estimated to be between twenty and thirty percent and the risk of transmission through breastfeeding is not known. The risk of HIV transmission from a woman to her child is much greater than the risk of HIV transmission through heterosexual activity.

110. See generally id. (indicating that a vast majority of AIDS cases were found in men).

111. See, e.g., Clara Gabiano et al., Mother-to-Child Transmission of Human Immunodeficiency Virus Type 1: Risk of Infection and Correlates of Transmission, 90 PEDIATRICS 369, 370-71, 373 (1992) (discussing an estimated overall transmission rate of 23.9% and correlations to this transmission); Michael E. St. Louis et al., Risk for Perinatal HIV-1 Transmission According to Maternal Immunologic, Virologic, and Placental Factors, 269 JAMA 2853, 2856 (1993) (offering a detailed examination of risk factors for HIV transmission which yield a range of 0%-71% risk of fetal transmission depending on the characteristics being analyzed).

112. See, e.g., D.T. Dunn et al., Risk of Human Immunodeficiency Virus Type 1 Transmission Through Breastfeeding, 340 LANCET 585, 586 (1992) (estimating that the risk of transmission from postnatally infected mothers to children through breastfeeding is 29%); Kathy I. Kennedy et al., Breastfeeding and AIDS: A Health Policy Analysis, 7 AIDS & PUB. POL’Y J. 18 (1992) (noting that breastfeeding risks are not known and discussing the need for more comprehensive research on this issue).

113. See European Collaborative Study, Children Born to Women with HIV-1 Infection: Natural History and Risk of Transmission, 337 LANCET 253, 258 (1991) (reporting a 12.9% rate of vertical transmission); Antonella A. Monforte et al., Maternal Predictors of HIV Vertical Transmission, 42 EUR. J. OBSTETRICS & GYNECOLOGY REPROD. BIOL. 131, 131 (1991) (describing a retrospective study of fifty-seven HIV-positive women which found that 28% of their infants were HIV-infected). It is not clear whether pregnancy is likely to hasten either an AIDS diagnosis or death for HIV-infected women. See, e.g., Hankins & Handley, supra note 34, at 962 (discussing previous studies which found that pregnancy does not influence the progression of AIDS); Frank D. Johnstone et al., Survival Time After AIDS in Pregnancy, 99 BRIT. J. OBSTETRICS & GYNECOLOGY 633, 633 (1992) (suggesting that survival time of women with AIDS might not be affected by pregnancy); Lisa M. Koonin et al., Pregnancy-Associated Deaths Due to AIDS in the United States, 261 JAMA 1306 (1989) (summarizing information on pregnancy complications).

114. See supra note 112; World Health Organization, Breast-Feeding Benefits Usually Outweigh the Risks, 13 WORLD HEALTH F. 372, 372 (1992) (noting that recent data indicate that some transmission of the HIV virus occurs during breastfeeding and that the risk of transmission is substantial if the mother becomes infected while breastfeeding but is somewhat lower if she was infected before she gave birth).

115. Of course, HIV-infected men create a risk of HIV transmission to children by engaging in sexual activity with fertile or pregnant women. In these cases, the woman acts as an intermediary in the transmission of HIV from man to child.
Although the transmission of HIV from woman to child is unique, some of the behaviors which create the risk of HIV transmission from woman to child can be engaged in by either gender. It is, of course, a matter of perspective. Maternal-fetal transmission is gender-specific in situations where an HIV-infected woman decides whether or not to have a child. However, one can also look beyond the woman-child relationship and consider behaviors that create the risk of infection to the woman and then to the child. In some cases, for example, a woman who is already pregnant engages in sexual activity with an HIV-infected partner. In these circumstances, both participants in the sexual activity are creating a risk that the woman will become infected and that this infection will then be transmitted to the child.\textsuperscript{116}

It is also important to understand the historical milieu in which the criminal or tort schemes of regulation of HIV transmission operate. Policies toward sexually transmitted diseases historically have embodied a bifurcated view of women.\textsuperscript{117} Some women—primarily white middle-class women—are viewed as “innocent victims” in need of the state’s protection. Other women—often women of color, lower economic classes, or users of illegal drugs—are viewed as vectors of transmission. Thus, the problems of women with HIV infection are socially complex: from one standpoint, regulation of behaviors that present a risk of HIV transmission benefits women; from another, regulation through the criminal law or tort systems constitutes yet another example of scapegoating and stigmatization.

Other important variables interact with issues of gender and class. The risk of HIV transmission is related to the gender of the participants and to the type of risky activity in which they engage.\textsuperscript{118} Different behaviors carry with them both different risks of HIV transmission and different social valuation. Heterosexual sexual activity, homosexual and lesbian sexual activity, reproductive activity, and needle-sharing during intravenous drug use are each likely to be valued differently by society. This analysis raises the possibility that our laws could treat similar risks differently or different risks similarly based on social value schemes.\textsuperscript{119}

\textsuperscript{116} Taking still another step back, one could argue that anyone who engages in sexual activity with a fertile woman creates the risk of HIV-infection in the woman and therefore, of infection in any subsequent child.

\textsuperscript{117} See Allan M. Brandt, No Magic Bullet: A Social History of Venereal Disease in the United States Since 1880 31-32 (1985) (arguing that a bifurcated view of women existed that defined women as either “innocent” victims or “fallen women”); see also Sheila Rowbotham, Hidden from History: Rediscovering Women in History from the 17th Century to the Present 52-53 (1976) (discussing British campaigns against venereal disease that included imprisoning prostitutes to prevent the spread of disease).

\textsuperscript{118} See CDC, Year End Summary, supra note 1, at 11 (reporting that the number of men that have HIV is greater than the number of women with HIV).

\textsuperscript{119} Cf. Bowers v. Hardwick, 478 U.S. 186, 196 (1986) (holding that a state can criminalize
Both history and biology suggest that gender is a relevant factor in analyzing state regulation of the types of risky conduct involved in HIV transmission. We can now examine the criminal and tort rules governing HIV transmission to determine whether a gender-based analysis of these rules has any descriptive, predictive, or normative value.

B. Criminal Law

Criminal regulation of behavior presents a particularly important area of study. The imposition of criminal penalties is a strong condemnation of behavior that carries with it not only stigmatization, but also the risk of incarceration. A gender-based analysis of criminal regulation in the area of HIV transmission provides important descriptive and predictive insights. It also suggests some normative principles that should be considered by states seeking to use the criminal law to reduce behaviors posing the risk of HIV transmission. The analysis does not, however, provide cognizable legal challenges to criminal statutes which have a disparate impact on women with HIV infection.

There are three major areas of controversy raised by a gender-based analysis of criminalization of behaviors which pose the risk of HIV transmission: (1) whether the identification of behaviors subject to criminalization is tainted by gender bias where both men and women engage in the risky behavior; (2) whether current criminalization schemes treat maternal-fetal HIV transmission appropriately; and (3) whether criminal regulation appropriately protects women from the risk of transmission from their sexual partners. Analysis of these three issues will permit an exploration of the descriptive, predictive, and normative power of “asking the woman question.”\textsuperscript{120} The problems and opportunities presented by a gender analysis in these areas are similar to those discussed earlier in this Article. A gender analysis will have both descriptive and predictive power, but it will be difficult to transform attentiveness to gender issues into actionable legal claims, or in some cases, into normative conclusions.

1. Risk and Criminal Liability

In analyzing the legal treatment of the risks associated with conduct engaged in by both men and women, such as heterosexual intercourse, the historical bifurcation of women as innocent victims or dangerous vectors suggests that current criminal law rules might exhibit gender or class bias.

\textsuperscript{120} Bartlett, supra note 3, at 831.
An analysis of the criminal regulation of risky behaviors should therefore be sensitive to the possibility that some groups could be scapegoated by policies that implement prejudice more than they penalize risk. The available medical data, which indicate that women are not as efficient as men in transmitting HIV through sexual contact, emphasize this problem.\textsuperscript{121} Whether the current criminalization regimes do or should take this information concerning differential risk into account in proscribing and punishing conduct is worth consideration.

Several different types of criminal provisions could be applied to conduct presenting a risk for HIV transmission.\textsuperscript{122} An important limitation on the use of these provisions is the intent requirement; many criminal provisions can be applied only where the person with HIV infection intends to infect another person.

Some risky behaviors, such as prostitution and drug use, were subject to criminal prosecution long before the advent of HIV.\textsuperscript{123} In addition, general rules that criminalize conduct intended to cause harm or the risk of harm to others have allowed the prosecution of conduct presenting the risk of HIV transmission as attempted murder\textsuperscript{124} and assault.\textsuperscript{125}

\textsuperscript{121} See Friedland & Klein, supra note 104, at 1125 (discussing current information related to the routes of transmission of the HIV infection).

\textsuperscript{122} States have regulated the use of HIV testing and disclosure in the criminal law context. See, e.g., CAL. PENAL CODE § 1202.6 (West Supp. 1993) (testing of those convicted of prostitution); COLO. REV. STAT. ANN. § 18-7-201.5 (West Supp. 1992) (testing of persons convicted of prostitution); COLO. REV. STAT. ANN. § 18-7-205.5 (West Supp. 1992) (testing of persons convicted of patronizing a prostitute); FLA. STAT. ANN. § 960.003 (West Supp. 1993) (testing upon the request of the victim after being charged with a sex offense which “involves the transmission of body fluids”); ILL. ANN. STAT. ch. 720, para. 5/12-18 (Smith-Hurd 1993) (testing after being charged with a sexual offense upon the request of the victim); IND. CODE ANN. § 35-38-1-9.5 (Burns Supp. 1992) (allowing confidential information about HIV status for the release of those convicted of “sex crimes” or offenses relating to “controlled substance”); KY. REV. STAT. ANN. § 529.090 (Michie/Bobbs-Merrill 1990) (requiring testing of any person convicted of prostitution or of procuring a prostitute); ME. REV. STAT. ANN. tit. 5, § 19203-E (West Supp. 1992) (testing at the request of the victim after conviction for sexual assault); MICH. COMP. LAWS ANN. § 333.5129 (West 1992) (testing permitted after conviction for prostitution or solicitation); OR. REV. STAT. § 135.139 (1990) (allowing HIV testing after conviction if requested by victim if the crime is one in which “transmission of body fluids was involved or likely to have been involved”); VA. CODE ANN. § 18.2-62 (Michie Supp. 1992) (requiring testing after arrest for sexual assault or sexual offense against a child upon a finding of probable cause); VA. CODE ANN. § 18.2-346.1 (Michie Supp. 1992) (requiring testing of those convicted of prostitution).

\textsuperscript{123} See MODEL PENAL CODE §§ 251.2, 250.5 (Proposed Official Draft 1962) (criminalizing prostitution and appearance in a public place while under the influence of drugs, respectively).

\textsuperscript{124} See State v. Weeks, 834 S.W.2d 559 (Tex. Ct. App. 1992) (affirming an attempted murder conviction of a person with HIV for spitting on a prison guard); cf. MODEL PENAL CODE § 5.01 (Proposed Official Draft 1962) (criminalizing an attempt to commit a crime, conduct designed to aid another in commission of a crime, or a substantial step toward the commission of a crime); MODEL PENAL CODE § 210.2 (Proposed Official Draft 1962) (defining criminal homicide as recklessly endangering another’s life).

\textsuperscript{125} See, e.g., United States v. Walker, A.C.M. 29757, 1993 C.M.R. LEXIS 275
About half the states have passed special HIV statutes designed to criminalize risky behavior, most of which have some intent requirement. These statutes provide a particularly good opportunity to study how state efforts to reduce the risk of HIV transmission affect women. States generally have had mixed success in attempting to create rational risk categories for criminalization. Most states have not considered whether maternal HIV transmission should be criminalized and some have failed to consider the appropriate role of consent to the risky behavior as a defense.

(A.F.C.M.R. July 6, 1993) (affirming the discharge of an HIV-positive enlisted man who violated his commander’s “safe sex” order and had sex with a woman without revealing information about his HIV status); United States v. Banks, 36 M.J. 1003 (A.C.M.R. 1993) (upholding the guilty plea of an HIV-positive soldier who admitted to having sexual intercourse without a condom and who failed to warn partner of the risk); United States v. Joseph, 33 M.J. 960 (U.S. Ct. Mil. App. 1991) (affirming the dishonorable discharge of an HIV-infected defendant who used a condom but failed to inform his partner of his infection); see also United States v. Moore, 669 F. Supp. 289 (D. Minn. 1987), aff’d, 846 F.2d 1163 (8th Cir. 1988) (convicting a person with HIV of assault with a deadly or dangerous weapon for biting guards); Brock v. State, 555 So. 2d 285 (Ala. Crim. App. 1989) (affirming the conviction of an HIV-positive inmate of third degree assault for biting a prison guard); Commonwealth v. Brown, 605 A.2d 429 (Pa. Super. Ct. 1992) (upholding the conviction of aggravated assault by an inmate with HIV who threw fecal liquid at a guard); State v. Cummings, 451 N.W.2d 463 (Wis. Ct. App. 1989) (upholding a charge against a prisoner convicted of battery of correctional officer for biting a guard). Defendants have also been charged and convicted of assault for engaging in sexual activity which presented the risk of disease transmission to others. See State v. Lankford, 102 A.63 (Del. Super. Ct. 1917) (holding that transmission of syphilis from husband to wife is assault and battery).

See infra text accompanying notes 137-158 (discussing maternal transmission and consent issues).
Although almost all criminal laws are facially gender-neutral, these facially neutral rules can have both a negative and a disparate impact on women. This negative and disparate impact may be created either in the actual application of facially neutral schemes or by the identical treatment of what are, in fact, different risks. Both problems could be present in current state criminalization schemes.

Prostitution is a familiar offense associated with the risk of HIV transmission. In response to this risk, several states have passed special statutes imposing heightened penalties for exchanging sex for money while one party is or both parties are infected with HIV. State laws criminalizing certain types of conduct, such as prostitution, are facially neutral because both men and women may engage in this conduct. In reality, prostitutes are disproportionately female. This potential gender disparity in the application of prostitution statutes is partially remedied by the existence of statutes which make it a criminal offense to solicit or engage in sexual activity with a prostitute. The issue remains whether

128. But see infra note 140 (specifying that transmitting the HIV virus through breast milk can be a felony).

129. See, e.g., COLO. REV. STAT. ANN. § 18-7-205.7 (West Supp. 1992) (criminalizing patronage of a prostitute with knowledge of being infected with HIV or AIDS); KY. REV. STAT. ANN. § 529.090(3)-(4) (Michie/Bobbs-Merrill 1990) (making the commission or solicitation of prostitution by a person who knows he or she tested positive for an immunodeficiency disease a felony); OKLA. STAT. ANN. tit. 21, § 1031 (West Supp. 1993) (making it a crime to engage in an act of prostitution with knowledge that one is infected with HIV); TENN. CODE ANN. § 39-13-516 (1993) (characterizing as aggravated prostitution the act of prostitution, being an inmate in a house of prostitution, or loitering in a public place soliciting for purposes of prostitution, while knowingly infected with HIV). Other states have specifically included prostitution in their general criminal transmission statutes. See, e.g., CAL. PENAL CODE § 647f (West 1993) (making it a felony for a person who has previously been convicted of prostitution and has tested positive for HIV to engage in prostitution); FLA. STAT. ANN. § 796.08(5) (West 1992) (providing for separate conviction and sentencing of a person who commits prostitution knowing he or she may be infected with HIV); FLA. STAT. ANN. § 796.08(6) (West 1992) (penalizing as a first-degree misdemeanor the offense of procuring another to commit prostitution knowing that he or she has tested positive for HIV); GA. CODE ANN. § 16-5-60 (Michie 1992) (penalizing engaging in a sexual act with another when the accused knows himself to be infected with HIV); NEV. REV. STAT. ANN. § 201.358 (Michie Supp. 1992) (prescribing the penalty for engaging in prostitution or solicitation after testing positive for HIV); S.C. CODE ANN. §§ 44-29-145(2) (Law. Co-op. Supp. 1992) (penalizing prostitution as a felony when committed by a person who knows himself to be HIV-positive). Some states also permit HIV testing of convicted prostitutes. See CAL. PENAL CODE § 1202.6 (West 1993) (describing when the court shall order testing and who should receive results); COLO. REV. STAT. §§ 18-7-201.5 (1990 & Supp. 1993) (mandating testing for HIV of any person convicted of prostitution); FLA. STAT. ANN. § 796.08(3) (West 1992) (specifying that those convicted of prostitution will be required to undergo testing for sexually transmitted diseases). These testing provisions also could be applied to customers. See, e.g., COLO. REV. STAT. §§ 18-7-205.5 (1986) (providing for the testing of patrons of prostitutes).

130. See, e.g., Jerry Hick et al., Crime Watch: No Surprise, Prostitution is the Most Prominent County Statistic Where Women Outnumber Men, L.A. TIMES, Feb. 15, 1992, at A1 (noting that women made up 75% of the arrests for prostitution in Orange County).

131. See MODEL PENAL CODE § 251.2(5) (Proposed Official Draft 1962) (making it illegal to
these statutes are actually applied in a manner that disproportionately impacts women.

Historically, statutes of this type were part of an effort to protect society from women who were considered to be the source of sexually transmitted diseases. Since medical data indicate that women are far less efficient at transmitting HIV through sexual activity than men, this raises the larger issue of the role of risk in state criminalization efforts. Whether the current criminalization regimes reflect this differential risk and, as a normative matter, whether they should, are important issues for gender-based analyses. To consider this question, an examination of state criminalization efforts must extend beyond the prostitution statutes and include an analysis of general offenses and HIV-specific statutes.

The special HIV-prostitution statutes do not distinguish between HIV-positive males and females and thus criminalize equally conduct that is of quite dissimilar risk. Traditional criminal prosecutions for HIV-related behavior, such as attempted murder or assault, provide little opportunity to consider differential risk because the intent of the defendant to injure is often deemed to be more important than the ability to harm. There may be room in some states to argue, on a case-by-case basis, that the risks women pose to men are not sufficient to create criminal liability. In particular, some states require that the conduct be "reasonably likely" to result in HIV transmission. As a general rule, however, sexual activity

See, e.g., ILL. ANN. STAT. ch. 720 para. 5/11-18 (Smith-Hurd 1993) (stating that patronizing a prostitute is a Class B misdemeanor); N.Y. PENAL LAW § 230.02-06 (McKinney 1989) (defining crime of patronizing a prostitute as a misdemeanor or felony, depending on the age of the prostitute); TEX. PENAL CODE ANN. § 43.02 (West 1989) (stating that a person commits solicitation if he knowingly offers to hire a person to engage in sexual conduct).

132. See supra note 104 and accompanying text.

133. See supra note 104 and accompanying text.

134. The medical evidence indicates, for example, that female prostitutes face far more risk from their male customers than their customers face from them. See supra note 104; GENA COREA, THE INVISIBLE EPIDEMIC: THE STORY OF WOMEN AND AIDS 84-87 (1992) (discussing how prostitution in various countries is more dangerous for the female prostitute than the male customer because women have a ten-times greater chance of being infected than men during heterosexual intercourse).

135. In the Weeks case, for example, a defendant was convicted of attempted murder for spitting on a prison guard, despite the negligible risk of transmission involved. State v. Weeks, 834 S.W.2d 559 (Tex. Ct. App. 1992); see also supra note 125 (discussing cases where HIV-positive defendants were held guilty of assault).

136. See, e.g., MO. REV. STAT. § 191.677 (Supp. 1992) (requiring that conduct "create [a]
by HIV-infected men and women will be treated the same, although the risks created by each group may differ.

2. The Special Problem of Maternal Risk

The legal treatment of risks that appear female-specific, such as the risks associated with childbearing, must also be examined.137 Thirty percent of women with HIV infection intend to become pregnant.138 A gender-based analysis could be used to predict problems in the legal treatment of an HIV-infected woman's capacity to bear children. This possibility is heightened by the fact that the risk of maternal transmission to a fetus, while far less than one hundred percent, is still significantly higher than the types of risks created by heterosexual intercourse.139 This leads to the inevitable question of whether states currently do or constitutionally could penalize women for putting their fetuses at risk for HIV infection.140

grave and unjustifiable risk . . . through sexual or other contact"); NEV. REV. STAT. § 441A.180 (Michie 1991) (requiring that the conduct be in "any manner likely to expose others"). The recently repealed Texas provision had similar language. TEX. PENAL CODE ANN. § 22.012 (West 1992) (repealed 1993) (requiring that "conduct reasonably likely to result in transfer of . . . blood, bodily fluids containing visible blood, semen, or vaginal secretions into the bloodstream of another").

137. See Sangree, supra note 22, at 333-62 (discussing the possibility of both the creation of prenatal transmission laws and the likelihood that current laws could be used to prosecute HIV-infected mothers); Weiss, supra note 22, at 697 (examining policies which affect HIV-positive mothers' procreative freedom and how they may violate the Equal Protection Clause).

138. Mayer & Carpenter, supra note 24, at 118 (relying on the results of a New England survey). See Ann Sunderland et al., The Impact of Human Immunodeficiency Virus Serostatus on Reproductive Decisions of Women, 79 OBSTETRICS & GYNECOLOGY 1027, 1030 (1992) (finding that HIV-positive status is correlated with the decision to terminate pregnancies but not with decisions not to conceive); Marleen Temmerman et al., Impact of Single Session Post-Partum Counselling of HIV Infected Women on Their Subsequent Reproductive Behaviour, 2 AIDS CARE 247 (1990) (noting no difference in reproductive rates between HIV-positive and -negative women after a counseling session in Kenya); see also Peter A. Selwyn et al., Knowledge of HIV Antibody Status and Decisions to Continue or Terminate Pregnancy Among Intravenous Drug Users, 261 JAMA 3567, 3568-69 (1989) (noting that about half of HIV-positive women in a study continued their pregnancies after notification of their serostatus, compared to 56% of HIV-negative women).

139. See supra notes 111-115.

140. Some sexual behavior also creates the risk of HIV transmission to a fetus. See supra text accompanying note 116. Sexual contact between an infected person and a pregnant woman puts the woman, and thus, the woman's fetus at risk for HIV. There does not appear to be any specific criminal regulation of this type of risky behavior. Apparently, it is subsumed in the general criminal regulation of sexual conduct between consenting parties.

After birth, breastfeeding by an HIV-infected woman can create the risk of HIV transmission to her child. See supra text accompanying notes 112 and 114. This behavior may be subject to criminal sanctions, assuming that the applicable intent requirements have been met. See, e.g., IDAHO CODE § 39-608 (1993) (specifying that breast milk is a "body fluid" and that "[a]ny person who . . . knowing that he or she has been afflicted with . . . AIDS . . . transfers or attempts to transfer any of his or her body fluid . . . to another person is guilty of a felony" (emphasis added).
Prosecution of HIV-infected women for having children is unlikely to occur for several reasons. A major barrier to such prosecutions is the intent requirement in the general criminal provisions. A prosecutor would have to show that an HIV-infected woman became pregnant with the purpose of causing the death or serious bodily injury of her child, or that a pregnant woman engaged in unprotected sexual activity with an HIV-positive person with the intent of injuring her fetus. Similarly, prosecution is unlikely under the HIV-specific state statutes since these often have identical intent requirements.

In addition to the intent requirement, numerous barriers to prosecution remain. Defining the criminal act in these cases would be difficult. An HIV-infected woman who gives birth or a pregnant woman who has unprotected sexual activity with an HIV-positive person does not put another "person" at risk. Prosecution of these cases would be as unavailing as earlier attempts to impose additional criminal penalties on pregnant women who use illegal drugs.

Breastfeeding is a female-specific mode of transmission that we might predict, wrongly, would be treated differently from other risks by legislatures and courts. It could be that breastfeeding is not perceived as a female-specific activity and that the courts and legislatures are prepared to criminalize HIV exposure through breastfeeding in the same way as they would criminalize exposure of another to blood or semen. For many women in the United States, at least, breastfeeding is a voluntary activity that involves a choice between alternatives in a way that pregnancy may not.

141. See supra text accompanying notes 122-126.
142. See supra note 126; see also Sangree, supra note 22, at 344-52 (analyzing the potential for applying state criminal transmission statutes to pregnant HIV-positive women).
143. Language in several state HIV statutes theoretically might be broad enough to include conduct by HIV-infected women both before and after childbirth. See Ala. Code § 22-11A-21 (1975) ("Any person afflicted with a sexually transmitted disease who shall knowingly transmit, or assume the risk of transmitting, or do any act which will probably or likely transmit such disease to another person shall be guilty of a Class C misdemeanor.") (emphasis added); Idaho Code § 39-608 (Supp. 1992) (specifying transmission through breast milk); Ill. Ann. Stat. ch. 720, para. 5/12-16.2 (Smith-Hurd 1993) (specifying "criminal transmission where person knows she is infected with HIV and she engages in intimate contact with another" and defining intimate contact as exposure of the body of one person to a bodily fluid of another person in a manner that could result in transmission of HIV) (emphasis added); Mo. Rev. Stat. § 191.677 (1992) ("[u]nlawful for any individual knowingly infected with HIV to . . . [d]eliberately create a grave and unjustifiable risk of infecting another with HIV through sexual or other contact when an individual knows that he is creating that risk") (emphasis added).
144. Only Oklahoma currently specifically excludes in utero transmission. Okla. Stat. tit. 21, § 1192.1 (1991) ("unlawful for any person knowing that he or she has . . . AIDS or is a carrier of HIV and with intent to infect another, to engage in conduct reasonably likely to result in the transfer of the person's own blood, bodily fluid, . . . except during in utero transmission of blood or bodily fluids"). The recently repealed Texas statute also contained an in utero exception. Tex. Penal Code Ann. § 22.012 (West 1992) (repealed 1993).
145. See, e.g., Johnson v. State, 602 So. 2d 1283, 1294-96 (Fla. 1992) (overturning a woman's conviction for delivering cocaine to her child through the umbilical cord shortly before birth as outside the legislature's intent and noting that prosecution of women like the defendant is the least effective response to the problem of drug use during pregnancy).
Prosecution of HIV-infected women for having children is particularly problematic from a constitutional standpoint. Despite the paucity of constitutional law in this area, bearing children is likely to be recognized as a constitutional right.\textsuperscript{146} Dicta in the abortion and contraceptives cases suggest that the right to bear children is fundamental, and can be infringed upon only to serve some compelling state interest.\textsuperscript{147} While the courts might be willing to find the state's interest in protecting fetal life compelling in the abstract,\textsuperscript{148} the state also would have to argue that it is better for a child not to be born than to be born with a thirty percent risk of being infected with HIV. However, a prosecution based on a pregnant woman's behavior in having unprotected sexual activity with an HIV-infected person might present fewer constitutional problems because of the state's interest in protecting fetal health\textsuperscript{149} and Supreme Court precedent permitting state regulation of private sexual conduct, at least between the unmarried.\textsuperscript{150}

Finally, these prosecutions would undermine common sense social and medical policy objectives. Such a prosecutorial policy would encourage abortion by women with HIV infection despite the fact that most of these women's children will not acquire HIV through maternal-fetal transmission. It would also discourage prenatal care for HIV-infected pregnant women. In fact, women would be indirectly encouraged not to discover their HIV status in order to avoid the "knowledge of risk" element of a criminal offense.

This analysis suggests that gender does have both descriptive and predictive power in this area. Maternal-fetal risks are treated differently from other behaviors that pose the risk of HIV transmission. The valence of this differential treatment is not what a reflexive feminist analysis would

\textsuperscript{146} See Skinner v. Okla., 316 U.S. 535, 541 (1942) (invalidating on equal protection grounds a statute allowing the sterilization of career criminals and noting that "the legislation involves one of the basic civil rights of man"); see also Sangree, supra note 22, at 395-414 (discussing constitutional protections of childbearing by HIV-positive women); Weiss, supra note 22, at 710, 716 (arguing that the Supreme Court should adopt the view that pregnancy-based discrimination is gender discrimination and that disparate impact ought to be sufficient to support a claimed constitutional violation). But see Buck v. Bell, 274 U.S. 200, 207-08 (1927) (upholding order to sterilize woman alleged to be mentally retarded).

\textsuperscript{147} See, e.g., Griswold v. Conn., 381 U.S. 479, 485 (1965) (holding that the decision whether to procreate is within the zone of privacy created by fundamental constitutional guarantees and denying the government the right to invade these protected freedoms).

\textsuperscript{148} See, e.g., Planned Parenthood of Southeastern Pa. v. Casey, 112 S. Ct. 2791, 2821 (1992) (plurality opinion) (noting that the state has a "profound interest in potential life throughout pregnancy").

\textsuperscript{149} See, e.g., id. (holding that the state has an interest in fetal life throughout pregnancy and therefore some restrictions on a woman's procreative freedom are permissible).

\textsuperscript{150} See, e.g., Bowers v. Hardwick, 478 U.S. 186, 196 (1986) (holding that a state prohibition of same-sex sodomy is constitutional).
predict, however, because risk creation by women in childbearing is treated more favorably than risk creation by men during sexual activity. From a critical and normative standpoint, the differential treatment of maternal risk is supported not so much by feminist analyses as by constitutional principles and policy objectives.

3. Women & Power: The Role of Consent

Exploring some of the ramifications of criminalization for women with HIV infection requires a focus on one particular aspect of criminalization: the role of consent in decriminalizing conduct. The consent defense has a particularly ambiguous role in the protection of women because of the potential conflict between the abstract protection of autonomy and the inequality of power between men and women that exists as a matter of reality. This issue provides an opportunity to consider how well the current criminal laws take into account the social reality of women’s lives. The use of consent as a defense to criminal prosecution of HIV transmission is a controversial issue that may or may not be illuminated by a gender-conscious analysis. Some states criminalize sexual behavior by an HIV-positive person regardless of whether the individual obtains the informed consent of his or her partner and/or uses safer sex methods. In contrast, other states permit the use of consent as a defense to criminal prosecution of HIV-infected individuals. Does a gender-based analysis provide any useful method for determining which is the correct approach?

One feminist response to the consent problem is to focus on the absence of power of women in relationships. Many women who know their partner is HIV-positive may not realistically be able to refuse sexual activity or to insist on the use of barrier methods. If women are

151. See supra text accompanying notes 105 and 113.
152. A gender analysis could be used to critique any policy which criminalizes maternal conduct without considering paternal creation of risk for fetuses.
generally powerless, then a consent requirement may not provide sufficient protection; perhaps criminal statutes should require both consent and the use of safer sex.\textsuperscript{156} Consent statutes merely permit women to ratify their own destruction.\textsuperscript{157}

Yet, another equally plausible normative analysis of the consent problem achieves the opposite result. Rejecting consent as a defense takes women among respondents with risky partners who were not using condoms may reflect relationships in which women feel powerless to influence the risk behaviors of their partners or to insist on protective actions that would prevent HIV transmission\textsuperscript{a}; Erica L. Gollub & Zena A. Stein, \textit{Commentary: The New Female Condom—Item 1 on a Women's AIDS Prevention Agenda}, 83 AM. J. PUB. HEALTH 498 (1993) (noting the importance of female condoms in HIV prevention because they improve the negotiating position of women in sexual encounters); Mary E. Guinan, \textit{Commentary, HIV, Heterosexual Transmission, and Women}, 268 JAMA 520, 520 (1992) (noting the difficulties women face in requiring condom use by male partners); Janet Holland et al., \textit{Risk, Power and the Possibility of Pleasure: Young Women and Safer Sex}, 4 AIDS CARE 273, 279 (1992) (noting the relevance of power in sexual relationships in a study of young women in the United Kingdom). \textit{See generally} Centers for Disease Control and Prevention, \textit{Condom Use Among Male Injecting-Drug Users—New York City, 1987-90}, 41 MORBIDITY & MORTALITY WKL. REP. 617, 619 (1992) (reporting a low rate of condom use by male intravenous drug users, with the lowest rates occurring among those with steady sex partners, and linking the infection of women to sex with drug-using males).

These arguments logically apply to men as well as women. One study reported that hustlers use condoms less than call men. See Dan Waldorf & David Lauderback, \textit{The Condom Use of Male Sex Workers in San Francisco}, 7 AIDS & PUB. POL’Y J. 108, 117 (1992). Although the authors do not hazard an explanation, hustlers are generally more economically deprived and thus may have less negotiating power. It may be, however, that women, as a group, are more vulnerable because of social and economic factors. For example, the data on the current incidence of HIV infection among women indicate that they are largely African-American and Hispanic. \textit{See supra} note 28. No current data are available on the economic vulnerability of these women. There is evidence, however, that economic vulnerability can affect behavior. Prostitutes, for example, might engage in risky sexual activity because of economic pressure. \textit{See, e.g.}, Stephen T. Green et al., Letter to Editor, \textit{Intercourse During Menstruation Among Prostitutes}, 264 JAMA 333 (1990) (noting a study in which prostitutes reported being offered more money for sexual intercourse without condoms).

Emotional factors may also play an important role in minimizing condom usage between sexual partners, even when the seropositivity of one of the persons is disclosed. One study found that 40% of female sex partners of HIV-positive hemophiliacs participating in the study did not always use condoms, in part because of emotional factors: avoiding communicating rejection, avoiding reminding her and her partner of the HIV-status, avoiding adding to her partner’s burden, or even sharing her partner’s fate. Susan Dickerson Mayes et al., \textit{Sexual Practices and AIDS Knowledge Among Women Partners of HIV-Infected Hemophiliacs}, 107 PUB. HEALTH REP. 504, 510-12 (1992).


\textsuperscript{157} \textit{See Goldsmith, supra} note 73, at 1814 (discussing the need for female empowerment to prevent the spread of HIV).
from women the power to decide whether or not to accept the risk. In essence, it perpetuates powerlessness because a woman's consent to sexual activity with an HIV-infected person would not be legally valid. In addition, rejection of the consent defense could indirectly criminalize attempts by HIV-positive persons to procreate through intercourse and might intrude too far into constitutionally protected personal decisions.\textsuperscript{158}

Consequently, use of a gender-based analysis in the context of consent provides more arguments than answers. Nonetheless, it is important to consider the questions raised regarding this apparently gender-neutral issue. Asking these questions can sensitize policy-makers to some of the real-life effects of their work and promote an awareness of the complexities of criminal regulation pertaining to HIV transmission.

C. **Tort Liability**

Tort law doctrine presents another possible area where a feminist analysis of the law might provide descriptive, predictive, or normative guidance. Two of the major purposes of tort law are deterrence and compensation.\textsuperscript{159} Tort rules create an incentive to act reasonably in order to reduce the risk to others by requiring compensation for either intentional or negligent injuries to others. This simple summary of tort doctrine obviously masks the enormous complexity involved in its implementation. The specific standards of conduct established by tort law are often difficult to discern. In part, current tort doctrine is a product of its historical development, with causes of action and theories of recovery that are determined by accidents of history.\textsuperscript{160} Yet, social and medical factors clearly have affected tort doctrine in areas relevant to HIV transmission, such as intrafamily immunity, assumption of the risk, contributory negligence, and misrepresentation. They have also undoubtedly influenced juries as they apply even the assertedly neutral rule of "reasonableness."

\textsuperscript{158} Statutes which prohibit consensual sexual activity between married persons would be particularly vulnerable to attack as an invasion of a fundamental right. Cf. Griswold v. Conn., 381 U.S. 479 (1965) (finding a constitutional protection for marital privacy in matters of conception). The state could assert a compelling interest in protecting public health, the validity of which might depend—at least in part—on the actual degree of risk associated with the prohibited sexual conduct. \textit{See, e.g.}, Elissa M. Kraus, \textit{Pregnancy in a Cohort of Long-Term Partners of Human Immunodeficiency Virus-Seropositive Hemophiliacs}, 78 OBSTETRICS & GYNECOLOGY 735, 735 (1991) (reporting that "11 of 12 women at risk for HIV transmission were able to become pregnant and remain seronegative for HIV antibody").

\textsuperscript{159} W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS \textsection 4, at 20-26 (5th ed. 1984) (discussing policies underlying tort rules).

\textsuperscript{160} \textit{See id.} at 20-21 ("Behind the history recorded in judicial opinions lie the historical influences of the social, economic, and political forces of the time.").
Constitutional rules and interpretations are one example of how imbedded social norms can shield actors from liability for injuries that they cause.\textsuperscript{161}

Feminist scholars have discussed the impact of gender-related social norms in other aspects of tort theory.\textsuperscript{162} The question remains whether a feminist analysis reveals anything new or important about the tort system's regulation of the risk of HIV transmission. Under a gender-based analysis of tort law regulation of HIV transmission, there are two major areas of controversy: (1) whether current tort law theories could or should recognize biological or social differences between men and women in regulating sexual behavior creating the risk of HIV transmission; and (2) whether tort law appropriately regulates the risk of maternal transmission.

1. \textit{Tort Regulation of Sexual Transmission of HIV}

The legal treatment of the risks associated with conduct engaged in by both men and women is of much interest. What is the tort system's response to biological differences between the genders, especially regarding differential transmission efficiencies and incidence rates? Tort law's sensitivity to social differences between men and women, such as the possible power differential between men and women in relationships, will also be considered.

There are several different sources of tort liability for HIV transmission during sexual activity,\textsuperscript{163} each of which raises some gender-

\textsuperscript{161}See, e.g., N.Y. Times Co. v. Sullivan, 376 U.S. 254, 283 (1964) (holding that the constitutional right to free speech grants some immunity to critics of the official conduct of public officials because the right to criticize the government is imbedded in the ideals of democratic government).

\textsuperscript{162}See, e.g., Leslie Bender, Feminist (Re)Torts: Thoughts on the Liability Crisis, Mass Torts, Power, and Responsibilities, 1990 DUKE L.J. 848 (discussing the need to analyze mass torts using feminist theories that recognize the unequal power relationships between the parties that are often ignored in this type of litigation); Jane Goodman et al., Money, Sex, and Death: Gender Bias in Wrongful Death Damage Awards, 25 LAW & SOC'Y REV. 263 (1991) (finding that male decedents in wrongful death cases receive higher damages than female decedents in similar cases); Ann C. Shalleck, Feminist Theory and the Reading of O'Brian v. Cunard, 57 Mo. L. Rev. 371 (1992) (discussing the need for the use of feminist theory and a gender-based perspective in the analysis of tort cases).

\textsuperscript{163}Courts have permitted tort actions based on transmission of HIV and other sexually transmitted diseases. See, e.g., Doe v. Johnson, 817 F. Supp. 1382 (W.D. Mich. 1993) (refusing to grant defendant Magic Johnson's motion to dismiss the plaintiff's claims of battery and intentional infliction of emotional distress for transmitting the HIV virus to her and her child); Martinez, Jr. v. Brazen, No. 91 Civ. 7769, 1992 U.S. Dist. LEXIS 5613 (S.D.N.Y. Apr. 22, 1992) (granting plaintiff's motion to compel discovery as to when defendant contracted AIDS); Doe v. Roe, 267 Cal. Rptr. 564 (Cal. Ct. App. 1990) (affirming a judgment against a defendant for negligent transmission of genital herpes); Kathleen K. v. Robert B., 198 Cal. Rptr. 273 (Cal. Ct. App. 1984) (reversing the trial court and allowing the plaintiff to proceed with her claim against the defendant for
based concerns. Intentional torts such as battery, fraud, and intentional infliction of emotional distress present possible avenues of recovery for persons exposed to HIV infection through sexual activity. Battery actions are appealing because they incorporate the idea of physical harm negligently and deliberately failing to inform her that he was infected with genital herpes); State v. Lankford, 102 A. 63 (Del. Ct. Gen. Sess. 1917) (convicting a man of battery for infecting his wife with venereal disease); Long v. Adams, 335 S.E.2d 852, 856 (Ga. Ct. App. 1985) (finding that the appellant has a cause of action against a woman who allegedly infected him with genital herpes); B.N. v. K.K., 538 A.2d 1175 (Md. 1988) (recognizing a cause of action for negligence and emotional distress in a case involving transmission of genital herpes); M.M.D. v. B.L.G., 467 N.W.2d 645, 647-48 (Minn. Ct. App. 1991) (affirming judgment against the defendant for negligent transmission of genital herpes and holding that the defendant had a legal duty to use reasonable care to not inflict others even when there is no medical confirmation of infection but some symptoms are present); R.A.P. v. B.J.P., 428 N.W.2d 103, 110 (Minn. Ct. App. 1988) (holding that general tort principles allow a husband an action against his former wife for negligently and fraudulently transmitting genital herpes to him); S.A.V. v. K.G.V., 708 S.W.2d 651, 652 (Mo. 1985) (en banc) (eliminating the doctrine of spousal immunity to allow a wife to sue her husband for willfully, recklessly, and negligently transmitting herpes to her); G.L. v. M.L., 550 A.2d 525, 528 (N.J. Super. Ct. Ch. Div. 1988) ("The marital privilege of sexual relations does not include immunity to personal injury suits between spouses based upon the transmittal of a sexual disease."); Maharam v. Maharam, 510 N.Y.S.2d 104, 107 (N.Y. App. Div. 1986) (holding that a person could maintain a fraud or negligence action against his or her spouse for wrongful transmission of genital herpes); Doe v. Roe, 598 N.Y.S.2d 678 (N.Y. Justice Ct. 1993) (finding that a defendant can be held liable for intentional transmission of chlamydia, but dismissing the case for lack of evidence of intent); Crowell v. Crowell, 105 S.E. 206, 210 (N.C. 1920) (permitting a wife to bring battery and fraud claims against her husband for transmission of venereal disease); De Vail v. Strunk, 96 S.W.2d 245 (Tex. Civ. App. 1936) (permitting a battery action for infection with crab lice); see also Robert A. Prentice & Paula C. Murray, Liability for Transmission of Herpes: Using Traditional Tort Principles to Encourage Honesty in Sexual Relationships, 11 J. CONTEMP. L. 67 (1984) (examining the potential causes of action and defenses to these causes of action for transmission of herpes); Louis A. Alexander, Note, Liability in Tort for the Sexual Transmission of Disease: Genital Herpes and the Law, 70 CORNELL L. REV. 101 (1984) (evaluating whether legal liability for the transmission of genital herpes is appropriate and reviewing the various causes of action available); Celia M. Fitzwater, Comment, Tort Liability for Sexual Transmission of Disease: A Legal Attempt to Cure "Bad" Behavior, 25 WILLAMETTE L. REV. 807 (1989) (discussing possible theories for holding those who transmit sexual diseases liable under tort law); Gregory G. Sarno, Annotation, Tort Liability for Infliction of Venereal Disease, 40 A.L.R.4th 1089 (1985 & Supp. 1992) (reporting that different jurisdictions have allowed tort actions based on assault and battery, fraud, seduction, and unspecified grounds).

164. These claims raise the same privacy issues that were discussed in the criminal context above. See supra text accompanying notes 146-150; cf. Paula C. Murray & Brenda J. Winslett, The Constitutional Right to Privacy and Emerging Tort Liability for Deceit in Interpersonal Relationships, 1986 U. ILL. L. REV. 779 (arguing that courts should not use the constitutional right of privacy to prevent liability in cases of sexual deceit which result in the birth of a child).

165. See, e.g., State v. Lankford, 102 A. 63 (Del. Ct. Gen. Sess. 1917) (involving battery claim by wife against husband for infection with venereal disease); Crowell v. Crowell, 105 S.E. 206 (N.C. 1920) (permitting wife to bring battery and fraud claims against husband for transmission of venereal disease); De Vail v. Strunk, 96 S.W.2d 245 (Tex. Civ. App. 1936) (allowing a battery action for infection with crab lice); see also Fitzwater, supra note 163, at 819-24 (analyzing possible theories of tort liability in sexually transmitted disease cases).
caused by physical contact, but they require a determination that the defendant knew of his or her HIV status. A battery action would ordinarily be barred by a finding that the plaintiff consented to the physical contact, unless the consent can be vitiated through a showing of fraud or illegality. A person who was unaware that his or her partner was HIV-infected, for example, could argue that any apparent consent to sexual contact was not of the type necessary to bar a battery claim. Fraud actions offer another source of recovery that require a showing that the defendant intentionally made some false representation to induce the plaintiff's participation in the risky sexual activity. Intentional infliction of emotional distress claims generally rest upon a finding that the defendant's conduct was "extreme and outrageous."

166. Keeton et al., supra note 159, at 39.

167. Doe v. Johnson, 817 F. Supp. 1382, 1396 (W.D. Mich. 1993) (refusing to dismiss a battery claim because "plaintiffs have alleged that defendant knew 'with substantial certainty' that he could transmit the HIV virus to Ms. Doe").

168. Keeton et al., supra note 159, at 113. The defense of consent might not bar a battery claim if the plaintiff could show that he or she "was mistaken about the nature and quality of the invasion intended by the conduct, or . . . [that] the conduct was the kind of conduct to which no one can give a valid consent so as to avoid liability." Id. at 114.

169. This claim could be based on an assertion that the presence of the HIV infection essentially changed the act that was consented to or on the existence of criminal prohibitions against sexual behavior by HIV-infected persons. See, e.g., id. at 120 (asserting that a woman who consents to sexual intercourse may recover for infection with a venereal disease). In one recent case, the court rejected a battery claim where a woman contended that her consent to sexual intercourse was premised on her husband's fidelity:

Where a person's consent to physical contact is given based upon a substantial mistake, known to or induced by the actor, concerning the nature of the contact itself or the extent of the harm to be expected therefrom, the consent is deemed to be ineffective, and the actor may be held liable as if no consent had been given . . . For this rule to apply, however, the mistake must extend to the essential character of the act itself, rather than to some collateral matter which merely operates as an inducement.

Neal v. Neal, No. 19086, 1993 Idaho LEXIS 98, at *27 (Idaho Ct. App. June 29, 1993) (citations omitted); see also Kathleen K. v. Robert B., 198 Cal. Rptr. 273 (Cal. Ct. App. 1984) (involving a woman seeking damages from a man from whom she contracted genital herpes). The Neal court also rejected the woman's claim for damages due to fear of AIDS because the court held that the plaintiff's fear must be based on more than the "mere possibility of exposure to a disease." Neal v. Neal, 1993 Idaho LEXIS at *24-*25. An implicit part of a battery claim might be that the risk of HIV transmission was high enough to change the essential nature of the act. This type of argument might be more or less successful depending on the actual degree of risk. See id. at *30-*32 (Silak, J., concurring) (suggesting that a battery claim would have been sufficient if there had been proof of actual exposure to a sexually transmitted disease); see also infra text accompanying notes 183-198 (discussing tort treatment of the risk of maternal transmission).

170. See Doe v. Johnson, 817 F. Supp. 1382, 1386-96 (W.D. Mich. 1993) (discussing the defendant's state of knowledge about his infection as related to fraud claims); Keeton et al., supra note 159, at 728 (discussing the elements for a cause of action based on the tort of deceit).

171. Keeton et al., supra note 159, at 60-65; see, e.g., B.N. v. K.K., 538 A.2d 1175 (Md. 1988) (permitting a claim of intentional infliction of emotional distress where a man knowingly exposed a woman to herpes); Doe v. Roe, 598 N.Y.S.2d 678 (Justice Ct. 1993) (dismissing a claim
Apparently, these intentional tort claims could be defeated by the actor’s disclosure of his or her HIV status.\(^{172}\) In that respect, tort liability is consistent with the criminal law rule discussed earlier and raises the same dispute about whether it would be desirable—from the feminist jurisprudential standpoint—for the legal system to recognize the existence of power differentials between women and men.\(^{173}\) Once again, a feminist analysis of the legal rule suggests that it might be applied to bar tort recovery for women who have consented to sexual activity with a person they know to be infected, even though consent was given because of a sense of powerlessness. A feminist analysis also might lead to the conclusion, however, that the recognition of women as persons demanding respect requires that the legal system give effect to a woman’s “yes” as much as it does to her “no.”\(^{174}\)

A plaintiff seeking to recover for the negligent transmission of HIV or for negligent exposure to the HIV infection\(^{175}\) will generally have to
show that the defendant violated a duty to exercise care.\textsuperscript{176} Individuals may be held to different standards of care depending on whether they knew or should have known of their HIV status.\textsuperscript{177} In addition, once individuals know that they are HIV-positive, the duty to exercise care might be affected by the degree of risk created by their HIV-positivity. The gender of the actor might be relevant in both contexts. First, in a statistical sense, many women do not know and have no reason to suspect that they are HIV-positive.\textsuperscript{178} Second, perhaps the duty of care associated with HIV-positivity in women should be less than the degree of care imposed on men because of the differential risk of transmission to others through sexual behavior.\textsuperscript{179} These gender-based differentials could be translated into different standards of conduct under tort law. Similar arguments could be made defensively. Perhaps women, more than men, should be aware of the greater risk of HIV transmission during heterosexual intercourse and should be held to have assumed the risk or to have been contributorily negligent.\textsuperscript{180}

\textsuperscript{176} The existence of a criminal prohibition against the sexual act—such as a statute making it a felony to expose another to HIV through sexual contact—could support a claim of negligence per se. KEETON et al., supra note 159, at 220; see also supra note 126.

\textsuperscript{177} In Doe v. Johnson, the district court opinion contains a lengthy analysis of the “knew or should have known” requirement. 817 F. Supp. 1382 (1993). Initially, the court held that:

[A] defendant owes a plaintiff a legal duty to, at the very least, disclose the fact that s/he may have the HIV virus, if: (1) the defendant has actual knowledge that s/he has the HIV virus; (2) the defendant has experienced symptoms associated with the HIV virus; or (3) the defendant has actual knowledge that a prior sex partner has been diagnosed as having the HIV virus.

\textit{Id.} at 1393. The court then considered whether there was any duty to disclose the risk of HIV when the defendant has engaged in “high risk” activity, and held that there was no duty to disclose such activity unless the high risk activity was accompanied by one of the three other factors discussed above. \textit{Id.} at 1393-96. One appeals court has applied this theory in the criminal context, finding that a sexually active gay man should have known that he was likely to have HIV. Cooper v. State, 539 So. 2d 508, 510-11 (Fla. Dist. Ct. App. 1989); see also M.M.D. v. B.L.G., 467 N.W.2d 645, 647 (Minn. Ct. App. 1991) (holding that defendant had a legal duty to warn of possible herpes infection even if it had not been medically confirmed).

\textsuperscript{178} \textit{See supra} text accompanying notes 23-29.

\textsuperscript{179} \textit{See supra} text accompanying notes 104-107.

\textsuperscript{180} As one New York court recently observed:

Although the doctrine of “assumption of risk” was abolished in New York as an
Negligence claims provide an opportunity to examine whether the tort system can or should be sensitive to the different risks of HIV transmission associated with male and female sexual behavior. The fact that one could make these arguments does not mean that they should be made or even that they are likely to succeed. Although a gender-based analysis reveals the possibility of arguing for a gender-differential in the standard of care, it might also be used to contend that the legal rules governing conduct for men and women should be the same regardless of biological variation. On a more practical note, courts and juries are unlikely to be receptive to the notion that a woman with HIV infection has a lesser duty to inform her partner of her HIV status. In these cases, the enormity of the possible harm is likely to overshadow any differential in the risk of transmission. As in the criminal law area, then, a feminist analysis of the application of tort law rules raises, but does not necessarily resolve, interesting questions about the legal treatment of risks that vary by gender.

2. Tort Law and Reproduction

Finally, we can analyze the tort treatment of the risk of maternal transmission. In both descriptive and predictive senses, feminist jurisprudential theory suggests that maternal transmission would be separated and treated differently by the tort system. The critical or absolute bar to recovery... it does bear upon defendant's duty and its alleged breach. A person assumes the risk where he voluntarily subjects himself to a peril known to him or generally observable by a person of ordinary prudence in his situation... In the same vein, persons who engage in unprotected sex, at a time of the prevalence of sexually transmitted diseases, including some that are fatal, assumes the risk of contracting such diseases. Both parties in an intimate relationship have a duty to adequately protect themselves. When one ventures out in the rain without an umbrella, should they complain when they get wet?

Doe v. Roe, 598 N.Y.S.2d 678, 681 (Justice Ct. 1993) (citations omitted). There are other defenses to claims of negligent transmission of illness that have been omitted in this brief discussion. See, e.g., Fitzwater, supra note 163, at 824 (noting interspousal immunity as a possible defense in sexually transmitted disease tort cases); Mark Wilkerson, Note, The Dirt on the Clean Hands Doctrine, 56 UMKC L. Rev. 791, 795-96 (1988) (discussing the defenses of illegality of the sexual relationship and right to privacy in negligent transmission cases).


Put another way, a court or jury is likely to find a duty to disclose HIV status even given the relatively low risk of HIV transmission from a woman. They will also impose the same duty to disclose on men with HIV infection. The two different risks will be treated the same because of the high degree of harm associated with the risk if it comes into fruition.

Maternal creation of risk to a fetus was discussed in the context of medical treatment in Part III.A., supra. In that section, I noted that the threat of third party liability for fetal injuries played a role in restricting women's access to medical treatment and experimental protocols. See also supra text accompanying notes 82-93.
The normative application of feminist theory in this area is a bit more ambiguous. Efforts have been largely devoted to ensuring that women's life choices and opportunities are not diminished by the vesting of rights in fetuses. These efforts suggest that many feminist theorists would object to imposing a civilly enforceable duty on women to modify their behavior in order to reduce the risk of HIV transmission to an unborn child. The actual development of tort doctrine in this area conforms to feminist theory's descriptive, predictive, and normative assertions, sometimes even for what might be viewed as traditionally feminist reasons.

Although only women are capable of transmitting HIV directly to their fetuses before or during childbirth, both women and men can engage in behaviors that place their offspring at risk for HIV transmission. One can imagine the somewhat distinguishable claims that could be brought by an HIV-infected child: (1) my mother (and possibly father) were negligent in permitting my conception because of the risk of HIV transmission; (2) my mother learned that she was HIV-positive while pregnant with me and negligently failed to terminate the pregnancy; and (3) my mother (and possibly her sexual partner) knew or should have known of her pregnancy and knew or should have known of the risk of HIV transmission to me and negligently failed to exercise care. The first two claims are related both in theory and in their probable outcomes: the infected child would be asserting the ultimate wrongful life tort claim for negligent conception or negligent failure to abort. The third claim is analogous to a tort claim.

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185. See, e.g., Dawn Johnsen, Shared Interest: Promoting Healthy Births Without Sacrificing Women’s Liberty, 43 HASTINGS L.J. 569 (1992) (arguing that the government should not punish pregnant women but rather should facilitate access to health care and prenatal care so that women can bear healthy children); Lawrence J. Nelson et al., Forced Medical Treatment of Pregnant Women: “Compelling Each to Live as Seems Good to the Rest,” 37 HASTINGS L.J. 703, 749-62 (1986) (discussing the constitutional right of a pregnant woman not to undergo medical procedures against her will). But see John A. Robertson, Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth, 69 VA. L. REV. 405, 437-43 (1983) (arguing that restrictions on maternal behavior are consistent with Roe v. Wade).

186. Usually, wrongful birth and wrongful conception claims are brought by parents against third parties based on the theory that their child's birth was due to the defendants' negligence. See, e.g., Smith v. Cote, 513 A.2d 341, 344 (N.H. 1986) (concerning a wrongful birth action against a doctor who failed to discover that a mother had rubella before and during childbirth); Jennifer Mee, Note, Wrongful Conception: The Emergence of a Full Recovery Rule, 70 WASH. U. L.Q. 887, 887 (1992) (defining the term “wrongful conception”). A wrongful life claim is a claim brought by a child who asserts that she would not have been born but for the negligence of another person. Smith v. Cote, 513 A.2d at 344. These claims have traditionally been brought by children against physicians who negligently failed to warn the parents of the probability that the child would be born with some serious birth defect or impairment. See, e.g., Gami v. Mulliken Medical Ctr., 22 Cal. Rptr.2d 819 (Cal. Ct. App. 1993) (holding that a child born with spina bifida may bring a suit...
brought against a third party for prenatal injuries.\textsuperscript{187}

Despite the theoretical existence of these claims, parents of HIV-infected children are unlikely to face tort liability. Practically speaking, there is little likelihood of a suit unless there is an otherwise inaccessible fund from which damages will be recoverable.\textsuperscript{188} From a legal
standpoint, plaintiffs bringing the first two types of claims will face difficulties establishing that a parent was negligent in failing to prevent conception or in failing to abort. Actions based on failure to prevent conception or failure to abort will also confront judicial hostility toward wrongful life claims. Almost all jurisdictions that have confronted this issue have rejected wrongful life claims made by children against third parties. Judicial hostility toward these actions is based, in part, on the difficulty of showing that someone has been injured by being born and on the problems associated with determining the appropriate measure of damages. Courts are likely to be even less hospitable to wrongful life claims asserted against parents.

Finally, even claims based on postconception negligent conduct are unlikely because of the continuing vitality of the parental immunity doctrine in areas involving parental discretion and because of the general recognition that the imposition of tort liability creates the risk of diminishing maternal freedom. There are few reported cases concerning a child's claim against her parents based on negligent prebirth conduct. In Grodin v. Grodin, the court indicated that a mother could

negligence. See, e.g., id. at 382 (remanding for a determination of whether an insured homeowner knew "with substantial certainty that he would transmit herpes to S.S." and if so, intentional tort exclusion in homeowner's insurance policy may be applied).

189. See, e.g., Walker v. Mart, 790 P.2d 735 (Ariz. 1990) (denying a wrongful life action to a child born with severe defects); Turpin v. Sortini, 643 P.2d 954 (Cal. 1982) (refusing to allow a child to recover general damages in a wrongful life claim for being born with a genetic disability and allowing her to recover only special damages for extraordinary expenses); Garrison v. Medical Ctr. of Del., 581 A.2d 288 (Del. 1990) (denying a child with Down's Syndrome recovery for "wrongful life" because her disability was not the result of the defendant's negligence); Kuh v. Lloyd, 616 So. 2d 415 (Fla. 1992) (disallowing wrongful life actions in Florida); Smith v. Cote, 513 A.2d 341 (N.H. 1986) (denying a wrongful life action to a child exposed in utero to rubella); Procanik v. Cillo, 478 A.2d 755 (N.J. 1984) (permitting only a limited damages recovery for a wrongful life claim); Harbeson v. Parke-Davis, Inc., 656 P.2d 483 (Wash. 1983) (allowing only limited damages for wrongful life); see also Michael B. Kelly, The Rightful Position in "Wrongful Life" Actions, 42 HASTINGS L.J. 505 (1991) (discussing wrongful life claims in general and focusing on liability for errors in genetic counseling); Philip G. Peters, Jr., Rethinking Wrongful Life: Bridging the Boundary Between Tort and Family Law, 67 TUL. L. REV. 397, 400-07 (1992) (summarizing current judicial treatment of wrongful life claims).

190. Compare Turpin v. Sortini, 643 P.2d 954 (Cal. 1982) (permitting a wrongful life action but allowing the child to recover only special damages for the extraordinary cost of treating the ailment) with Garrison v. Medical Ctr. of Del., 581 A.2d 288 (Del. 1990) (refusing a wrongful life claim because the child suffered no injury as a result of the defendant's negligence); see also Peters, supra note 189, at 401-02 (discussing reasons for judicial hostility to wrongful life claims).

191. For example, California specifically prohibits such actions by statute. See CAL. CIV. CODE § 43.6 (West 1982) ("No cause of action arises against a parent of a child based upon the claim that the child should not have been conceived or, if conceived, should not have been allowed to have been born alive.").

192. See Stallman v. Youngquist, 531 N.E.2d 355 (Ill. 1988) (holding that there is no claim against a mother for allegedly negligent prebirth conduct in operation of motor vehicle); Grodin v. Grodin, 301 N.W.2d 869 (Mich. Ct. App. 1980) (refusing to grant summary judgment because a
be held liable for injuries caused by the use of tetracycline during her pregnancy if her conduct constituted an unreasonable exercise of parental discretion.\textsuperscript{193} The \textit{Grodin} decision has been strongly criticized.\textsuperscript{194} In \textit{Stallman v. Youngquist}, the court noted the unwise and potentially unconstitutional intrusion into maternal judgment that tort liability would probably create and held that fetuses could not bring claims against their mothers for prenatal negligence.\textsuperscript{195} The \textit{Stallman} court relied upon a number of arguments associated with feminist theory, including the diminishment of maternal autonomy that would be created by tort liability and the strong possibility that broadly applicable tort rules would be applied in a racially or economically discriminatory fashion.\textsuperscript{196}

A feminist jurisprudential approach to the tort regulation of HIV transmission initially suggested two possible areas of interest: (1) tort doctrine’s responsiveness to biological or social differences between men and women; and (2) tort law’s recognition of the special problems presented by HIV transmission to fetuses before or during birth. The feminist approach proved to have some descriptive and predictive power: while tort law does not currently take into account social and biological differences between men and women in the sexual transmission of HIV, there is some evidence that the doctrine will treat maternal risks differently (and in fact, more favorably) than other types of risks.\textsuperscript{197} The critical and

\textsuperscript{193} Under Michigan law, parental immunity had been abrogated except for parental acts involving “reasonable parental authority over the child” or “an exercise of reasonable parental discretion with respect to the provision of food, clothing, housing; medical and dental services and other care.” Grodin v. Grodin, 301 N.W.2d at 870. The court remanded the case for a determination of the reasonableness of the mother’s conduct in taking the tetracycline, which was to be made by balancing the utility of the drug for the mother and the risk to the unborn child. \textit{Id.} at 871.


\textsuperscript{195} 531 N.E.2d at 361 (Ill. 1988).

\textsuperscript{196} \textit{Id.} at 360 (arguing that, because the socioeconomic backgrounds of women differ, the decision to impose a duty of care on pregnant women is better left to legislatures in their policymaking capacity).

\textsuperscript{197} This apparently differential treatment of maternal risk might actually reflect a disinclination to hold \textit{parents} (rather than just mothers) liable for fetal injuries. The language in some court opinions, however, has focused directly on the woman’s unique relationship with her fetus. In \textit{Stallman}, for example, the court noted that “[h]olding a mother liable for the unintentional infliction
normative implications of this analysis are more problematic. Treating men and women equivalently when considering the risk of HIV transmission through sexual activity may conflict with biological reality, but it preserves the important goal of gender neutrality. The differential treatment of maternal risks appears to conform to, and even to rely on, feminist theory concerning the inappropriateness of maternal regulation, but in actuality, it may merely reflect judicial adherence to the "cult of motherhood." In a normative sense, then, a feminist jurisprudential analysis of tort law creates questions to ponder but few determinative answers.

IV. Conclusions

The problems of women with HIV infection are numerous and, to a dishearteningly large extent, beyond the domain of legal scholars. Yet, as this analysis has revealed, asking the woman question is a useful tool for understanding and critiquing several aspects of the legal system's response to HIV infection. The analysis has both descriptive and predictive power in several different areas. However, this analytic process cannot establish ideal criminal or tort policies toward HIV transmission for women any more than science can currently resolve the more pressing need for effective HIV treatments. In both cases, theory provides useful questions, and from there it becomes an ongoing struggle to develop answers.

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of prenatal injuries subjects to State scrutiny all the decisions a woman must make in attempting to carry a pregnancy to term, and infringes on her right to privacy and bodily autonomy." Stullman v. Youngquist, 531 N.E.2d at 360.