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Reading, Writing, but No Biting: Isolating School Children with AIDS

Carolyn J. Kasler

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READING, WRITING, BUT NO BITING: ISOLATING SCHOOL
CHILDREN WITH AIDS

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I. INTRODUCTION

Imagine two scenarios: Two third graders, playing at recess, decide to form a club. Initiation to be a member is to become a blood brother for life . . . or death. Later one child is found to have AIDS and the second child is added to the list of carriers. Or, two high school students certain that they are in love, make a decision to consummate their relationship for better . . . or worse. Perhaps the young man was unaware of his illness, or perhaps he was told not to publicize the fact that he had AIDS. He was an innocent victim of a blood transfusion, and he has a right to privacy, to avoid being ostracized, until his symptoms actually get the best of him. His needs have now caused the disease to get the best of another innocent victim.

Seclusion of children with Acquired Immune Deficiency Syndrome, (AIDS), whether it be by total prohibition from public education, careful monitoring or home tutoring, is said to be based on irrational public fear.¹

¹ Comment, *Undoing a Lesson of Fear in the Classroom: The Legal Recourse of AIDS-Linked Children*, 135 PA. L. REV. 193, 194 (1986).

If this is true, then supporters of AIDS victims' rights should be able to guarantee that events like those described here do not occur in our schools. In fact, incidents like these, and innumerable other risky situations occur every day when children meet.

Public fear about AIDS is not hysteria and is not unreasonable fear, but fear of the unknown and of what is yet to be learned about this "young" disease. It is a fear based on many real possibilities not as unlikely to occur as the medical profession, government officials and politicians would have us believe. Until more is positively known about AIDS, its causes, its risks, and the effects of the disease on children, schools should provide an education to children with AIDS in a restricted setting. The basis of the fear surrounding AIDS, the resulting need for restrictive measures in a school setting, and the obstacles to overcome when attempting to assert these restrictions will be discussed in this article.

II. WHY THE FEAR IS REAL

A. *Impact of the Medical Profession*

In the early 1900s, the medical profession assumed responsibility for certain diseases which, before this time, inflicted guilt and confusion on its victims. Deviant behavior such as alcoholism and drug abuse were approached as diseases. This approach freed people from their guilt and caused society and the medical profession to bond, and perpetrate a myth of medical supremacy. The medical profession became one of great prestige and power, and doctors became known as "academic elite."² However, the 1960's approach to psychiatry served to breach this trust. Doctors began speaking in medical uncertainties about mental illness categories and causes.

Specialization left volumes of people whose illnesses did not clearly fit into any special area of medicine, unattended.³ As the cost of obtaining this specialized medicine rose, society's faith in the profession waned. A general feeling of discontent prevailed when doctors in their specialization mode, treated a list of illnesses, rather than a group of people. "It is significant that socially minded physicians throughout the first half of the twentieth century repeatedly warned that patients had families . . . sickness comes in units of people and families — and not discrete, codable diagnostic entities."⁴ The cost of treating a family became prohibitive, while many physicians still had not stepped down from the pedestal of prestige of the 40's to deal with family-related problems. In addition, the profession began making changes which were appealing at a glance, such as to provide prenatal intensive care units in hospitals, yet failed to find the causes and preventions for prematurity and low birth weight babies.⁵

² Rosenberg, *Disease and Social Order in America: Perception and Expectations*, 64 MILBANK Q. 34, 44 (D. Willis ed. 1986).

³ *Id.* at 49.

⁴ *Id.* at 48.

⁵ *Id.* at 49.

In the midst of this nagging skepticism and even resentment toward medicine, enters AIDS, a deadly disease. "So far as we are aware, clinically identifiable cases of AIDS have a mortality rate approaching one hundred percent . . ." ⁶ Doctors have attempted to discover a cause and treatment for the disease, and have done so unsuccessfully, while society demands to know what can be done to effectively prevent the spread of AIDS, and who will bear the cost of research. The answers are yet unclear. Dr. Robert Redfield, an infectious disease specialist with Walter Reed Army Medical Center in Washington, states that the public health approach should be to "focus on the spread of the virus itself," and that too much emphasis is being placed on the "fatal stages." He went on to say that we must respond to the "1 million to 3 million Americans who are infected today."⁷

Societal skepticism concerning medicine has resulted in some very negative reactions to medical statements on AIDS. The medical profession which society trusted for so long, has provided indefinite answers to questions concerning a deadly disease. The certainty and exact responses to which we became accustomed in the heyday of medical discovery of the 30's and 40's, are nonexistent. If courts attempt to apply tenuous medical findings concerning AIDS, they may be facing a society in a mood of distrust.

B. Medical and Societal Uncertainties About AIDS

The critical question concerning AIDS and school children is the risk of transmission in the school setting. To fully understand this risk, a brief history of the disease and recent discoveries concerning AIDS should be analyzed.

The first cases of AIDS in the United States may have been as early as 1977. At this time, two of the opportunistic diseases⁸ associated with AIDS were tracked. Pneumonia and Kaposi's disease appeared to spread in a pattern and began to attack healthy men and women. Coupling the short period of time since discovery, with the long incubation period associated with the disease,⁹ we are only at the beginning of realizing the full ramifications of AIDS. It is doubtful that medical certainties can be established in such a short period of time.

The best guess is that the disease came from an animal — not necessarily from primates. This virus has relatives that cause

⁶ *Id.* at 41.

⁷ Morganthau, Hager, Cohn, Raine, Reese, Anderson, & Ernsberger, *Future Shock*, NEWSWEEK, Nov. 24, 1986, at 31.

⁸ A. FETTNER & W. CHECK, *THE TRUTH ABOUT AIDS: EVOLUTION OF AN EPIDEMIC*, 22 (1984). Opportunistic infections are other diseases to which AIDS patients are susceptible and are called opportunistic because they "come when the body's defense mechanism — the immune system — is caught off guard." *Id.*

⁹ A. Finkbeiner, *AIDS, Just the Facts . . . from specialists at Johns Hopkins* at 1, Col. 3 (from a symposium on AIDS Education: Effective Policies and Practices at Cleveland State University, Nov. 13, 1987).

diseases in lots of different animals. Maybe this virus mutated and, at the same time it was undergoing mutation, it came into contact with humans. Maybe someone got bitten, or got blood in a cut while butchering infected animals. The best guess is that this happened in Central Africa, probably in the early 70's.¹⁰

This language demonstrates the uncertainties concerning this disease and its methods of transmission. We are left with countless questions as to its ultimate transmission to humans, the "relatives" of the virus, how many "relatives" and "mutations" exist, and how they effect transmission. "AIDS is a deadly disease that kills within a very short period of time. The mode of transmission is not precisely known; there is no cure for AIDS and . . . [it is] no longer confined to specific groups."¹¹

The National Center for Disease Control (CDC) in Atlanta, Georgia has published information concerning AIDS transmission. They have narrowed the mediums containing the virus to semen, blood, saliva, and tears and reduced the risk groups to gay and bisexual men (73% of those with AIDS),¹² and intravenous drug users (17%), and those who have received transfusions, sexual partners of AIDS victims and prostitutes (10%).¹³ The CDC claims that incidents outside of these risk groups are about 0.1 per 100,000.¹⁴ This figure is based however, on a five-year tracking of the disease. "AIDS has a long incubation period."¹⁵ Considering this fact, along with the relatively young age of the disease and the new strains of the virus arising even today,¹⁶ have we really seen all there is to see? Will another strain of the virus occur which will be concentrated in saliva, making kissing a risky activity? The scope and potential of the HIV virus is literally unknown and at this point obviously scientifically unpredictable. Former Surgeon General C. Everett Koop, M.D., Sc.D., in his special report on AIDS recently stated, "[t]he first cases of AIDS were reported in this country in 1981. We would know by now if AIDS were passed by casual, non-sexual contact."¹⁷ Inconsistent with the five-year pattern used by the CDC, the Surgeon General was satisfied with a six-year period of observation, when in reality five or six years may not even be a full incubation period.

¹⁰ *Id.* at 4, col. 2. (quote by Thomas Quinn, Immunologist at National Institute of Allergy and Infectious Disease).

¹¹ Note, *Quarantine: An Unreasonable Solution to the AIDS Dilemma*, 55 U. CIN. L. REV. 217, 219 (1986).

¹² *But see* A. Finkbeiner, *supra* note 9, at 2. These percentages differ however, in Africa, where the disease is said to have begun. Nearly one half of the cases of AIDS in Africa are found in women who contracted it through normal, heterosexual intercourse. *Id.*

¹³ A. Finkbeiner, *supra* note 9, at 2.

¹⁴ *Id.*

¹⁵ *Id.* It may be as long as fifteen years from the time the initial symptoms and antibodies develop, until a victim is actually diagnosed as having AIDS. *Id.*

¹⁶ Cleveland Plain Dealer, Jan. 29, 1988, at A5, col. 2. "U.S. Public Health Officials said yesterday that a New Jersey hospital's diagnosis of a second AIDS virus in the United States posed no threat of a new epidemic." *Id.* Although no known threat is apparent yet, there remains the question of how many more strains exist, some of which may be dangerous.

¹⁷ Koop, *From the Surgeon General, U.S. Public Health Service*, 256 J.A.M.A. 2783 (1986).

Despite any disagreement as to incubation and new strains of the virus, the former Surgeon General Koop and the CDC both relied on the fact that the disease is not transmitted through "casual contact," and that it is limited to certain risk groups. The risk of contracting AIDS from a child in the classroom is "much less than the chance of the boiler that heats the building blowing up."¹⁸ This example was used on a TV talk show where attorneys and the doctors of children with AIDS were interviewed. Dr. Mervyn Silverstein spoke on transmission and used the boiler blowup possibility, fast becoming a canned example, adding that the risk of transmission in schools was as unlikely as being struck by lightning. She went on to say that the chance of these events occurring was greater than exchanging body fluids in schools, and that "[g]enerally, it's sex and drugs, and I hope that doesn't take place in schools these days."¹⁹ The naivete of such a statement is startling.²⁰ Such activities exist and perhaps are even promoted by the school setting. In many cases such activities may even occur on school property during school hours when supervision is at a minimum and control is deemed unnecessary. In researching this topic, no definition for "casual contact" is ever clearly stated. Dr. James Oleski of St. Michael's Hospital in Newark, New Jersey, stressed that "AIDS is not spread by casual contact. It is not in the water or the air."²¹ He was also quoted as saying however that, "the AIDS agent may be passed by other secretions — saliva, urine and so on."²² Thus far urine had not been mentioned as a medium for transmission. If Surgeon General Koop was referring to handholding, drinking fountains, toilet seats, and even kissing on the cheek, the definition of casual contact is clear. However, anything beyond these activities which provide a possibility for exchange of bodily fluids, accidental or otherwise, may pose a risk. Schools full of children offer a threat of far more than "casual contact" each day with bloody noses, cuts and bruises on a playground or in a gymnasium, biting, fighting, blood brothers, menstruation, and later on sexual activity among teens in schools.²³ "Direct contact with blood is potentially infectious, especially when there are breaks in the skin, as in chapping or eczema."²⁴ Any number of scenarios are easily imaginable in a crowded

¹⁸ Comment, *supra* note 1, at 198.

¹⁹ *Phil Donahue* (Multimedia Entertainment, Inc.) (transcript No. 09107) (1987).

²⁰ Bowen, *Getting Tough*, TIME, Feb. 1, 1988, at 54. ("In St. Louis, one of four girls in public schools becomes pregnant before reaching her senior year."). A California study theorizes that the 1940's school problems of talking, chewing gum, getting out of line, and running in the halls, have been replaced in the 1980's by drug abuse, alcohol abuse, pregnancy, rape, and countless other troublesome activities. *Id.*

²¹ A. FETTNER & W. CHECK, *supra* note 8, at 159.

²² *Id.*

²³ A safety patrol guard at a local school recently stopped a fight between two students and went home with blood spattered over his coat and on his winter-chapped hands. This may not be "casual contact," and yet it is perhaps a very common and predictable occurrence within the school setting.

²⁴ OHIO DEPT OF HEALTH, GUIDELINES AND RECOMMENDATIONS FOR ELEMENTARY AND SECONDARY SCHOOLS (K-12) REGARDING CHILDREN WITH ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) (1987) [hereinafter OHIO DEPT OF HEALTH GUIDELINES].

inner-city school where cleanliness and precautions are not adhered to for one reason or another. It is a fact that if a child with AIDS is a known biter, or demonstrates a "lack of control of his bodily functions," he will be eliminated from the school setting.²⁵ This supports the theory that a risk does exist of transmitting the disease through those activities which obviously are not within the definition of "casual contact." Even though the CDC has found the risk to be small, it is considered enough in known cases to eliminate a child from school.

The fact that a child's behavior cannot always be predetermined or totally controlled, in addition to the fact that new strains of the virus are constantly being discovered,²⁶ gives rise to the logical conclusion that the risk groups are and will be changing.²⁷ "Until recently AIDS seemed to be limited to adults, predominantly those with abhorrent life-styles AIDS may now have taken an ominous new turn, with otherwise normal infants and children as additional victims. Since 1984, pediatricians are calling 'new' disease in children 'pediatric acquired immune deficiency syndrome . . .'"²⁸ and the CDC is collecting information on possible cases of childhood AIDS.²⁹

The CDC has been trying to inform the public without overly alarming them, but we outside the government are freer to speak. The fact is that dire predictions of those who have cried doom haven't been far off the mark . . . [I am] convinced that the peril of AIDS reaches far beyond the high risk groups of homosexuals and intravenous drug users.³⁰

If we find that risk groups are in fact expanding, any existing policies on AIDS must be reassessed.³¹

²⁵ *Id.*

²⁶ Cleveland Plain Dealer, *supra* note 16.

²⁷ Sicklick & Rubinstein, *A Medical Review of AIDS*, 14 HOFSTRA L. REV. 5, 10 (1985) ("The AIDS virus can change and thus affect its clinical course for the better or for the worse.").

²⁸ A. CANTWELL, AIDS. THE MYSTERY AND THE SOLUTION 66 (1986).

²⁹ *Id.* See also Sicklick & Rubinstein, *supra* note 27, at 8, reciting a case where transmission through breastmilk is a possibility. An inference of insufficient knowledge of the intricacies and potentials of AIDS exists.

³⁰ Rubenstein, *Schooling for Children with Acquired Immune Deficiency Syndrome*, 109 J. PEDIATRICS 242, 243 (1986). Dr. Essex is an expert on AIDS at Harvard School of Public Health.

³¹ See Cleveland Plain Dealer, *supra* note 16. Evidence of Surgeon General Koop's supposition of a risk group change is reflected in his proposal to set up a test group in an urban university setting to test a community of college students for the virus. This type of random testing caused a local news station to project, in its report of this project, that a significant percentage of people have been found to be infected with the virus who are outside the accepted risk groups. *W.J.W. News*, (W.J.W. Broadcasting, Jan. 28, 1988, 11:00 broadcast). It is a reasonable conjecture that the fear of changing risk groups and then a change in transmission risks, preceded this study.

III. PRESENT POLICIES CONCERNING AIDS VICTIMS IN THE SCHOOLS

A. *The Center for Disease Control and the United States Department of Health*

The United States Public Health Service maintains that transmission of AIDS can occur only through "exposure of open cuts to the blood or other body fluids of the infected child . . ." ³² It recommends that "each case should be considered separately and individualized to the child and the setting," ³³ and that decisions should be made through an evaluation of the child's health by the school board, the child's parents, public health officials, and the child's physician. ³⁴ The CDC made an exception to an unrestricted environment where children "lack control over bodily secretions or who display behavior such as biting, either of which could significantly increase the risk of contact with infected body fluids." ³⁵ Individual states, through their departments of health, have adopted these government standards when creating their own individual guidelines. ³⁶ Specifically reflected in these standards of behavior is the necessity to evaluate the "health status of the child as determined by his/her physi-

³² Koop, *supra* note 17, at 2787.

³³ *Id.*

³⁴ *Id.*

³⁵ Hughes & Bailey, *AIDS From a School Health Perspective*, 13 PEDIATRIC NURSING 155, 156 (1987).

³⁶ *E.g.*, OHIO DEPT OF HEALTH GUIDELINES, *supra* note 24. The guidelines developed by the Center for Disease Control are followed and further refined by individual state health departments. Ohio has developed one such typical list of requirements and precautions:

OHIO DEPARTMENT OF HEALTH
GUIDELINES AND RECOMMENDATIONS FOR
ELEMENTARY AND SECONDARY SCHOOLS (K-12)
REGARDING CHILDREN WITH ACQUIRED
IMMUNODEFICIENCY SYNDROME (AIDS)

In 1981, when Acquired Immunodeficiency Syndrome (AIDS) was first reported, specific populations were identified as "high risk groups" for developing and transmitting the disease. These risk groups include homosexual/bisexual men, intravenous drug users, persons transfused with contaminated blood or blood products, and sexual contacts of persons infected with HTLV-III virus, the causative agent of AIDS. Relatively few children have been diagnosed with AIDS in the United States. In Ohio, only three cases have been reported in children under age 19 since 1981. Two were hemophiliacs and one was infected either during pregnancy or at birth.

The Centers for Disease Control have reported that *none* of the identified AIDS cases have been contracted in the school setting, or through other casual person-to-person contact. However, exposure of teachers and children to potentially infectious body fluids from children with AIDS has raised several issues regarding school admission. The following information and guidelines have been prepared to assist Ohio's schools in the formulation of policies to protect children and faculty from AIDS or any other body fluids. It is prudent to treat all blood and body fluids with caution regardless of the apparent health of a person.

AIDS is transmitted by two mechanisms: sexual contact (genital, vaginal and anal intercourse) and inoculation of blood or blood components from one individual into the bloodstream of another. Transmission of AIDS through casual contact such as kissing, sharing of food, or sharing eating utensils has not occurred. No family members of AIDS cases other than sexual contacts have developed AIDS.

SCHOOL ADMISSION RECOMMENDATION

Based on current evidence, casual person-to-person contact as would occur among school children and staff poses no risk in the transmission of AIDS. Children with AIDS should be allowed to attend school in a regular classroom setting provided:

1. The health status of the child, as determined by his/her physician, allows participation in regular school activities.
2. The child behaves acceptably, i.e., does not bite other individuals or exhibit other violent behaviors. Although very unlikely, significant human bites may inoculate trace amounts of blood directly into the bloodstream.
3. The child does not have open sores and skin eruptions that cannot be covered.

Experience with other communicable diseases suggests that the potential for AIDS transmission would be greatest through contact between younger children and neurologically handicapped children who lack control of their bodily secretions and/or exhibit violent behavior. Decisions to exclude handicapped children who have AIDS from a public school setting should be made only after careful evaluation of each child's individual risk of transmitting the disease. Decisions regarding the type of educational setting for children with potentially infectious diseases should be based on the behavior, neurologic development, and physical condition of the child and the expected type of interaction with others in the school setting.

Due to the small number of children with AIDS anticipated in Ohio within the next few years, individual evaluation of each case is possible. School officials, the private physician and parents are encouraged to consult public health officials to assist in this process. When a child with AIDS is admitted to school, personnel who are aware of the child's condition should be the minimum necessary to assure proper care of the child. The number of informed staff should be sufficient to observe the child for behavioral and/or medical problems that could heighten the potential for AIDS transmission.

RECOMMENDATIONS FOR THE HANDLING OF BLOOD AND BODY FLUIDS IN SCHOOLS

Blood or other body fluids from any child or adult may harbor a number of organisms besides HTLV-III that are potentially infectious to others. All schools should therefore evaluate current procedures for handling spilled blood and body fluids to insure proper cleaning and disinfection. It is recommended that:

1. Surfaces soiled with blood, urine, feces, vomitus, etc. should be thoroughly washed with soap and water, then disinfected with a 10% solution of household bleach and water (1 part bleach to 9 parts water). This solution should be freshly prepared for each use.
2. Personnel cleaning the spill should wear gloves and wash hands thoroughly when finished.
3. Disposable towels should be used whenever possible.
4. Mops should be thoroughly rinsed in the disinfected solution.

For an injury that results in bleeding, nosebleeds, menstrual accidents, etc., the person assisting the child should wear gloves whenever possible. Direct contact with blood is potentially infectious, especially when there are breaks in the skin, as in chapping or eczema. Proper handwashing (soap and running water for 15 seconds) significantly reduces the risk of infection from contact with all potentially infectious body fluids.

Id.

cian,³⁷ as well as to determine whether “the child behaves acceptably, i.e., does not bite or exhibit other violent behavior. Although very unlikely, significant human bites may inoculate trace amounts of blood directly into the bloodstream.³⁸ In addition, the child must not “have open sores or skin eruptions that cannot be covered.”³⁹

A decision to exclude a child from the school setting must be made after an evaluation of a “child’s individual risk of transmitting the disease . . . and the expected type of interaction with others.”⁴⁰ “Among the reasons to consider removing an infected pupil from school is if the youngster is incontinent or might fight with or bite other children.”⁴¹ Public Health officials should be contacted, and a case-by-case evaluation pursued. The CDC also provides recommendations for handling blood and body fluids in the schools.⁴² These guidelines as well as those of the American Academy of Pediatrics⁴³ provide a basis for individual school board policies.

³⁷ *Id.*

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ Farkas, *Ohio Schools Make Their Way Cautiously in H.I.V. Cases*, Cleveland Plain Dealer, Oct. 25, 1987, at B7. However, these precautions usually result in the child’s attendance. See *Thomas v. Atascadero Unified School District*, 662 F. Supp. 376 (C.D. Cal. 1986) (allowing a kindergarten child who bit his classmates to return to school). The guidelines are prepared to analyze and evaluate the child’s present status. They do not appear to take into account, and perhaps cannot address completely, any changes in behavior and the resulting ill effects that might occur subsequent to evaluation and readmission.

⁴² Hughes & Bailey, *supra* note 35. The following is a “Table of Recommendations for Preventing Transmission of HTLV-III in the School Environment” prepared by the Center for Disease Control, Atlanta, Georgia:

1. Stress meticulous handwashing for all children, teachers and others as a regular practice.
2. Disinfect surfaces soiled with blood or other body fluids using a solution of 1 part bleach to 10 parts water.
3. Rinse mops in solution of 1 part bleach to 10 parts water after use.
4. Cover all open lesions and avoid contact of blood or body fluids with others who may have open lesions or exposed mucous membranes.
5. Use disposable towels, tissues, and napkins.
6. Take precautions to prevent needle stick injuries.

Id.

⁴³ *School attendance of Children and Adolescents with Human T Lymphotropic Virus III/Lymphadenopathy-Associated Virus Infection*, 77 PEDIATRICS 430, 431 (1986) (distributed by the American Academy of Pediatrics) [hereinafter *School Attendance*] (providing a similar list of guidelines for evaluating a child’s case and for handling procedures). The Academy’s Committee on School Health and Infectious Diseases recommends that children with suspect behavior be placed in a restricted setting “until more is known about the transmission of the virus under these conditions.” *Id.*

B. Analysis of Existing Policies

The guidelines have some inherently critical problems in reference to using a child's health status and behavior as a basis for admission. In a special article written by Dr. Ayre Rubenstein, M.D., in the *Journal of Pediatrics*, she openly states that the disease may not be static in children.⁴⁴ In observing children with AIDS, she has seen "progressive neurologic disease, with changes in their psychomotor development and behavioral patterns. A decision of today may therefore need to be reversed tomorrow."⁴⁵ Dr. Rubenstein's theory strongly suggests that the behavior of a child with the AIDS virus is not predictable, cannot be preassessed, and therefore does not lend itself to guidelines. At the minimum, her research suggests that perhaps research in area of AIDS, children and school activities is not yet conclusory.⁴⁶

A second concern relates to the precautions being taken in handling body fluids in the schools. "Direct contact with blood [of a victim with the AIDS virus] is potentially infectious, especially where there are breaks in the skin, as in chapping or eczema."⁴⁷ If, in a setting where hygiene is not routinely practiced, e.g., overcrowded, under-financed schools, a school board must go a step further to insure good hygiene. This raises further problems of educating students and more importantly, informing those involved that an AIDS victim is present.⁴⁸

The questions of prevention and proper guidelines were the basis for concern in a recent situation in Elyria, Ohio, where a child was admitted to Jefferson Elementary School's second grade class.⁴⁹ The thrust of the objections to the child's attendance focused on the use of separate bathroom facilities. The policy set by the superintendent of schools and his administration was under review after receiving objections from the American Civil Liberties Union that the administration had set unnecessary preventative measures, and had discriminated against this child.⁵⁰ Although the Ohio Board of Health Guidelines⁵¹ were in place at the time of this incident, they failed to provide the specific guidance needed.

Although school officials consulted medical experts to help make a determination in Dade County, Florida,⁵² officials originally prohibited

⁴⁴ Rubenstein, *supra* note 30, at 244.

⁴⁵ *Id.*

⁴⁶ Hughes & Bailey, *supra* note 35, at 156. In a discussion concerning normal school activities and risks of transmission involved in biting and bodily secretions, the authors claim "[l]imited research has been done in this area; the risk of transmission is unknown at this time . . ." *Id.*

⁴⁷ OHIO DEPT OF HEALTH GUIDELINES, *supra* note 24.

⁴⁸ See *infra* § V(C) and accompanying text.

⁴⁹ Strohmeyer, *Uncle Fears Girl Who Had HIV to be Ostracized*, Cleveland Plain Dealer, Oct. 22, 1987, at B1, col. 6.

⁵⁰ Strohmeyer, *Plan for HIV Pupil Reviewed*, Cleveland Plain Dealer, Oct. 24, 1987 at A1.

⁵¹ OHIO DEPT OF HEALTH GUIDELINES, *supra* note 24.

⁵² *C.C.'s Children v. Dade County School Board*, No. 86-1513 Civ. (S.D. Fla. July 18, 1986) (reaching a decision on May 20, 1987, in which the children were readmitted into the Dade County schools as posing "no danger to others." AIDS awareness training and federal jurisdiction over the matter for two years were part of the settlement.)

triplets, diagnosed as having AIDS-related complex,⁵³ from attending school.⁵⁴ The school board was left with several doubts as a result of these consultations.⁵⁵ School officials commented that "[T]he problem we had was that all the doctors continually maintained that the children would not be infectious, but they kept qualifying that by saying that they didn't know too much, and they recommended extraordinary precautions with the children."⁵⁶ "Until the medical profession can put in greater detail and in writing the degree of infectiousness, we will continue to isolate them."⁵⁷ Although officials were ordered to allow these children to return to school, the court maintained jurisdiction over the situation, affirming the school administrator's doubts. The original decision to isolate these children seems to reflect the natural reaction of the public toward this deadly disease. Since "infectious diseases have a way of breaking out of their pocket,"⁵⁸ it seems necessary to address public fear and school board policy making by finding the most effective method of preventing the spread of AIDS, whether it be by isolating its victims, or by methods more or less restrictive.

IV. RATIONALE FOR RESTRICTING SCHOOL CHILDREN WITH AIDS

A. Quarantine

Quarantine, obviously the most drastic and severely restrictive measure of disease control, has been considered for AIDS victims.⁵⁹ Quarantine has been enforced in the past to protect the general public health and safety as a valid exercise of state police power.⁶⁰ Interference with indi-

⁵³ A. Finkbeiner, *supra* note 9. The AIDS infection takes on various forms or stages. The first stage resembles infectious mononucleosis, with fever, diarrhea, and weakness. After these symptoms disappear, the victim may test positive to the antibodies for HTLV-III virus in the blood and yet remain healthy but infectious. After six months to fifteen years, a small percentage of carriers go on to develop the third stage of HTLV-III, ARC. With ARC, or AIDS-related complex, a victim suffers from swollen lymph glands, fatigue and weight loss. These symptoms persist, and within five years fifteen to thirty percent of those with ARC will develop AIDS.

⁵⁴ N.Y. Times, Sept. 8, 1985, § 1 at 1, 22.

⁵⁵ *Id.* at 22.

⁵⁶ *Id.* A question arises as to whether having notice of these extraordinary precautions would place an additional burden on the school board concerning liability.

⁵⁷ N.Y. Times, *supra* note 54.

⁵⁸ Barnes & Hollister, *The New Victims*, LIFE, July, 1985, at 12.

⁵⁹ Pagano, *Quarantine Considered for AIDS Victims*, 4 CALIF. LAW. 17 (Mar. 1984). In San Francisco clinics where AIDS patients were advised to abstain from further sexual encounters, public health officials had the authority to quarantine disobedients. The department even suggested posting a sign on the victim's home; a method "repealed twenty years ago." *Id.*

⁶⁰ *In re Halko*, 246 Cal. App. 553, 54 Cal. Rptr. 661 (1966) (holding that a health officer may isolate or quarantine a person with tuberculosis if he feels "isolation is necessary for the protection of public health," and denying a writ by the petitioner to be released. The court reiterated the principle that it is a primary duty of a state to do all that it can for the protection of the health and safety of its citizens.). See also *Ex parte Martin*, 83 Cal. App. 2d. 164, 188 P.2d 287 (1948) (quarantining a suspected victim of venereal disease was a legitimate police power), *In re King*, 128 Cal. App. 27, 16 P.2d 694 (1932) (detaining a woman in quarantine when a medical examination following her arrest revealed a venereal disease. was legitimate due to the presence of an infectious disease).

vidual rights is justified by the advancement of the best interests of society.⁶¹ When objections arose in the courts, this power was traditionally justified by judicial deference to legislative action which prevailed unless it was "arbitrary, oppressive and unreasonable."⁶²

The problem of quarantining AIDS victims, however, is obvious. AIDS is incurable, and although the seriousness of that statement may make quarantine seemingly more plausible, the last time quarantine was used in this country was fifty years ago to prevent the spread of tuberculosis,⁶³ a highly contagious, yet curable disease. Since quarantine is defined as the "restriction of a person or animal who has been exposed to a communicable disease during the period of communicability . . ."⁶⁴ the quarantining of an AIDS victim would be for an indefinite period of time, until death perhaps, and would be oppressive. Yet the power of the state to protect public health is one that AIDS victims must contend with, and in fact in some settings, the victims must succumb to it.⁶⁵

The police power derives its strength from history. *Jacobson v. Massachusetts*,⁶⁶ led the way in legitimizing state police power for community safety. In *Jacobson*, the plaintiff refused to be vaccinated against smallpox, in violation of a Massachusetts statute for mandatory vaccination. The statute was upheld as a legitimate state power, and Jacobson was fined for failure to be vaccinated, even though he feared physical complications as a result of the vaccine.⁶⁷ The Court found Jacobson's indi-

⁶¹ 39 AM. JUR. 2d *Health* §§ 29, 30. See also 53 OHIO JUR. 3d *Health* §§ 44, 45 (quarantine theory).

⁶² Note, *supra* note 11, at 221.

⁶³ Pagano, *supra* note 59, at 17.

⁶⁴ OHIO ADMIN. CODE, § 3701-3-01(T) (1980).

⁶⁵ See Rowe, *Death Row. AIDS is Turning a Prison Term into a Potential Death Sentence*, 7 CALIF. LAW. 49, 50 (Sept. 1987) ("California is one of eight states that segregates inmates with any AIDS infection. Thirty-nine other states segregate AIDS patients or patients with either AIDS or AIDS-related complex."). See also *Cordero v. Coughlin*, 607 F. Supp. 9 (S.D. N.Y. 1984) (holding that separating AIDS victims from the rest of the prisoners had a rational relation to the prison objective of protecting all prisoners from "tensions and harm resulting from rising fear in the institution."); *LaRocca v. Dalsheim*, 120 Misc. 2d 697, 467 N.Y.S.2d 302 (Supp. 1983) (allowing isolation of AIDS victims within the prison but if the inmates were unable to have isolation would extend isolation further, to remove three victim inmates from the facility). Quarantining AIDS prisoners and isolation in the school setting may not appear analogous at first glance. They do not share the same risk factors; e.g., homosexuality and drug abuse, making control more legitimate within the prison confines. However, if the occurrence of sexuality among teenagers, drug abuse within schools, and even accidental blood contact were found to be statistically high, a public school setting, with its varied social and ethnic backgrounds, may become as great a problem as in a prison. Fear and tension among faculty, students, and parents, thereby legitimized, would have to be addressed.

⁶⁶ 197 U.S. 11 (1905).

⁶⁷ *Id.* at 37.

We are not prepared to hold that a minority, residing or remaining in any city or town where smallpox is prevalent, and enjoying the general protection afforded by an organized local government, may thus defy the will of its constituted authorities, acting in good faith for all, under the legislative sanction of the State. If such be the privilege of a minority, then a like privilege would belong to each individual of the community, and the spectacle would be presented of the welfare and safety of an entire population being subordinated to the notions of a single individual who chooses to remain a part of that population.

vidual interests to be insignificant and held that "[t]he safety and health of the people of Massachusetts are . . . for that commonwealth to guard and protect."⁶⁸ In *Jacobson*, this state action was triggered by the court's use of a medical standard approach.⁶⁹ This approach consisted of the court's use of current medical research and determinations to analyze the necessity and extent of state intervention into individual rights. If the state of medical knowledge was such that physicians generally promoted this vaccine to prevent the spread of smallpox, the court relied on this medical knowledge to trigger state police power. In *Jacobson*, the medical question was the effectiveness of a vaccine which could be tested and proven, with predictable statistical effects, providing a sound foundation upon which to base a court ruling. In a case concerning AIDS, however, the court deals in uncertainties. The medical "statistics" it must utilize include the fact that there are no reported cases of transmission through casual contact,⁷⁰ or in the school setting, that there is a low risk of transmission, but not a no-risk situation, that AIDS is a devastating disease with no cure, requiring severe precautionary measures,⁷¹ and that the disease is without tolerance for biting, fighting, or exposed skin lesions.⁷²

The very affirmations made by the medical community and relied upon by the courts, perhaps for lack of a clearer standard, infer doubt. The community should be unwilling to accept this as the sole basis for a court's decision. If the existing medical standard of the day is the guideline, it is by its very nature changeable. If courts rely on this standard to determine that children across the board should be admitted to schools because there is no risk of transmission, then they are issuing a standard which is tentative, and which is in conflict with the medical exceptions which are available on a case-by-case basis to eliminate children who bite or fight. If saliva does not transmit, and blood exchange is so minimal in the school setting, we must question why these exceptions exist. A victim of AIDS would never be restricted by a court ruling if the medical standard, with all its inconsistencies, continued to be used to avoid police power authority to protect the public from communicable disease. In *New York State Association for Retarded Children v. Carey*,⁷³ the court ordered children with hepatitis-B to be admitted to school since only a few simple hygienic precautions were necessary. AIDS, by contrast, has been distinguished by the "severe precautions" taken in the case of the Dade County triplets.⁷⁴ The presence of the disease requires not only simple hygienic precautions, but behavioral precautions as well,⁷⁵ and yet the use of the present medical standard has been accepted by the courts and can be used to assess the state action.⁷⁶ In *Carey*, the state action to eliminate

⁶⁸ *Id.* at 38.

⁶⁹ See 197 U.S. 11 (1905).

⁷⁰ Lecture, Sheldon Gelman on Psychiatry and the Law at Cleveland Marshall Law School (Feb. 2, 1988) [hereinafter Gelman].

⁷¹ N.Y. Times, *supra* note 54.

⁷² OHIO DEPT OF HEALTH GUIDELINES, *supra* note 24.

⁷³ 612 F.2d 644 (2d Cir. 1979).

⁷⁴ N.Y. Times, *supra* note 54.

⁷⁵ OHIO DEPT OF HEALTH GUIDELINES, *supra* note 24.

⁷⁶ Burris, *Fear Itself: AIDS, Herpes and Public Health Decision*, 3 YALE L. & POLY REV 479, 483 (1985).

these children from school was found to be more restrictive than medically necessary to address the existing risk.⁷⁷ However, the court did allow the Board of Education to reserve the right to return to court in the future should the medical risk change;⁷⁸ a unique ruling with anticipatory overtones.

Even with such an open approach,⁷⁹ the medical standard approach developed in *Jacobson*,⁸⁰ where it worked favorably to protect and preserve the police power of the state, has served to weaken that power in perfect synchronization with the deterioration of reliance on the medical profession. The standard is valid if it is a proven, predictable one as in *Jacobson*, thereby enforcing state police rights to protect the majority.⁸¹ Although this police power has been criticized and perhaps abused in the past,⁸² it has also been unfairly avoided by courts which still strike down a state action for the public health and safety if they can hang their hats on even a tenuous medical standard such as that which exists with AIDS. The problems with relying on the present state of medical knowledge when forming a judicial decision were expressed by the lawyers in *Buck v. Bell*.⁸³ In that case a Virginia statute permitting inmates of institutions with hereditary insanity to be sterilized was upheld. The State's purpose in sterilizing inmates was to prevent future generations of imbeciles. In what appears to be an abuse of the state police power, the underlying reason for enforcing this power is the issue. The lawyers for Carrie Buck were very concerned that the decision to sterilize was based on a medical standard which was unclear, and resulted from too much deference to the medical profession. There was a definite fear that this deference might lead to a "reign of doctors."⁸⁴ Using a tenuous medical standard, whether it serves to trigger the police power as in *Buck*, or prohibit the state intervention as it does with AIDS children seeking to attend school,⁸⁵ is

⁷⁷ *Carey*, 612 F.2d at 650.

⁷⁸ *New York State Ass'n for Retarded Children v. Carey*, 612 F.2d 644 (2d Cir. 1979). "Medical Knowledge expands rapidly, and an agency responsible for the well being of children must have some latitude both in monitoring current conditions and assessing those conditions in light of the most current medical information. The District Court disapproved the Board's plan on the record that was presented. New facts might well warrant a different result in the future." *Id.* at 651.

⁷⁹ *Id.*

⁸⁰ 197 U.S. 11 (1905).

⁸¹ *See, e.g., Viemeister v. White*, 179 N.Y. 235, 72 N.E. 97 (1904).

⁸² *See Buck v. Bell*, 274 U.S. 200 (1927), in which Justice Holmes ordered the salpingectomy (sterilization) of a feeble-minded woman, upholding the Virginia statute which permitted inmates of institutions with hereditary insanity to be sterilized. Holmes stated that "three generations of imbeciles are enough" and upheld the state's police power to protect against a future generation of imbeciles. *Id.* at 207. *See also State v. Feilin*, 70 Wash. 65, 126 P. 75 (1912) (sterilization of a rapist). *But cf. Skinner v. Oklahoma*, 316 U.S. 535 (1942) (striking down a state measure to sterilize habitual criminals and requiring more convincing classifications of individuals for such a severe biological intervention by the state).

⁸³ 274 U.S. 200 (1927).

⁸⁴ Gelman, *supra* note 70 (comment relating back to the power which the medical professional attempted to wield).

⁸⁵ *See, e.g., C.C.'s Children v. Dade County School Board*, No. 86-1513 Civ. (S.D. Fla. July 18, 1986).

a dangerous procedure. If legal decisions are to be based on standards set by those outside the judicial setting, more caution must be taken to ascertain the precision of the standard being used. If doctors and the medical profession present the courts with medical facts, perhaps they must meet the *Jacobson* test of proven, statistical knowledge, rather than the tenuous presumptions surrounding AIDS.

Even if the courts addressed the problem of prohibiting school attendance by squarely analyzing the state's interest in protecting the public's welfare, the state police power might still be struck down as oppressive should school boards attempt to totally prohibit a child from attending school. The theory behind quarantining as a valid exercise of police power has been refined to include some form of limited isolation of a victim of a contagious disease.⁸⁶ In fact, if quarantining children with AIDS is not a medical necessity and is oppressive, partial isolation is a less restrictive option.

B. Isolation

School children can be isolated for various minor illnesses.⁸⁷ A common denominator seems to be that these diseases are of a determinable length due to healing, cure, or effective treatment. AIDS is unlike these illnesses in that it carries with it a package of unique problems which appear to warrant some type of isolation. The problem with AIDS, as opposed to isolating for measles, chickenpox and other highly transmittable diseases,⁸⁸ is that it requires longer isolation for less risk of transmission. However, it carries with it a harm which is far more devastating should transmission occur. The diminished risk relates to the percentage possibility of transmission. Having proceeded on the assumption that this risk in the school setting may be rising and, in combination with the added burden of death as a result of contracting AIDS, unlike the relative inconvenience of fever and itching from other less serious diseases, the scales should be balanced to include AIDS on the isolation list. Restrictions can be legally placed on individuals suffering from isolation illnesses, and are lifted after the risk of transmission passes.⁸⁹ The

⁸⁶ OHIO ADMIN. CODE, § 3701-33-13 (1983).

⁸⁷ *Duffield v. School District of Williamsport*, 162 Pa. 476, 29 A. 742 (1894). This case established a power within school boards to establish policies prohibiting attendance by children who had not been properly vaccinated. This power was derived from the board's authority to prohibit the attendance of a child with a communicable disease. See also *Stone v. Probst*, 165 Minn. 361, 206 N.W. 642 (1925) (a young girl with a sore throat not admitted to school without proof of a negative throat culture).

The teacher could not be expected to determine if it was ordinary or streptococcal or the early stage of some other contagious or infectious children's disease. We must recognize that one child may quickly spread a disease among the many children it comes in contact with in school. It seems more reasonable to us to have the rules applicable in preventing as well as in controlling an epidemic.

Id. at 365, 206 N.W. at 644. But cf. *Potts v. Breen*, 167 Ill. 67, 47 N.E. 81 (1897) (where local officials had the authority to exclude children from school only if it was a necessary public health measure).

⁸⁸ OHIO ADMIN. CODE § 3701-3-13(E, K).

⁸⁹ OHIO ADMIN. CODE § 3701-3-13 (1983). See also OHIO DEPT OF HEALTH, COMMUNICABLE DISEASE CHART FOR SCHOOLS (1987).

determination to isolate a victim is initiated when a high risk of transmission exists. Quarantine arguments generally address illnesses of more severity and include not only the risk of transmission, but also the danger of the illness as a predominate factor.⁹⁰ If measles results in the restriction of its victims from the school setting due to its high risk of transmission, yet the ill effects are very minimal, the corollary is to consider eliminating students whose illness, although not easily transmitted, has devastating effects: death without available treatment or cure.

This reduced emphasis on the risk of transmission of disease, a disease which is a death sentence to anyone who contracts it, was recently analyzed in *Stewart v. Stewart*,⁹¹ at a custody hearing. In the Indiana Superior Court, the divorced father of a two-year-old girl filed for custody of his child. The mother countered by claiming that custody by the father would endanger the child since he was infected with the AIDS virus. Despite testimony by medical witnesses who discredited reports of transmission through household contact, and even though the father merely tested positive for the virus, and did not yet have the disease, the judge terminated the father's parental rights "because of physical danger to the child." "[E]ven if there's a one percent chance that this child is going to contract [AIDS] from [petitioner], I'm not going to expose her to it."⁹²

This analysis disregarded the low risk of transmission and instead focused on the grave danger of the disease, and the fact that even a small risk of transmission was significant. The analysis demands a judicial balance, favoring the state's interest in protecting the public from danger and allowing restrictions to be placed on victims of AIDS.

Quarantine and isolation decisions must lie with local public health officials.⁹³ "[T]heir task is to measure risk to the public and to seek for what can reassure and, not finding it, to proceed reasonably to make public health secure. They deal in a terrible context and the consequences of mistaken indulgence can be irretrievably tragic."⁹⁴ When danger is factored into the equation, caution in avoiding the danger is of utmost importance. In *People v. Robertson*,⁹⁵ health officials were given sweeping authority to keep a woman quarantined in her home until the community was immunized against typhoid. This restriction was approved after officials received letters and calls alleging that the woman had been exposed to the highly contagious disease. The court held that this measure was justified since "it is not necessary for the health authorities to wait until the person infected with a contagious disease has actually caused others

⁹⁰ 53 O. JUR. 3d Health §§ 44, 45 (Ohio as a typical model, quarantining of vessels, railroads and public vehicles is permitted "in time of epidemic, or threatened epidemic, or when a dangerous communicable disease is unusually prevalent . . .").

⁹¹ No. 2485-1128 (Ind. Super. Ct. Oct. 24, 1987).

⁹² *Id.*

⁹³ *E.g.*, *United States v. Shinnick*, 219 F. Supp. 789 (E.D. N.Y. 1963) (holding that a woman suspected of being exposed to smallpox was isolated for the duration of the incubation period upon her return to the United States from Stockholm by the authority of public health officer).

⁹⁴ *Id.* at 791.

⁹⁵ 302 Ill. 422, 134 N.E. 815 (1922).

to become sick by contact with him before placing him under quarantine."⁹⁶ *Robertson* gives broad authority to health officials.

The methods which states employ may be modified downward, tailoring them to a specific purpose without being overly restrictive. Since education is not a fundamental right,⁹⁷ the court, in analyzing a state action to restrict a child in or out of the school setting, will look for means which rationally relate to the legitimate end of the public health and safety. Through its power, a state might provide for home tutoring, or limit a student's presence in the school by restricting activities in which he may participate. In this way, the state is using the least restrictive means to achieve its end, satisfying a compelling state interest and protecting the public. The individual victim is not deprived of an education in the strictest sense of the word. However, even if the state police power prevailed here as a legitimate power, or if the court determined that prohibiting or restricting a child's attendance was a medical necessity, federal supremacy may intervene, allowing the AIDS victim a right to attend school freely, thus effectively breaking down the state police power. The Rehabilitation Act of 1973 is an obstacle which school boards face when seeking to restrict a child with AIDS.

V. LEGAL RECOURSE FOR SCHOOL CHILDREN WITH AIDS

A. *The Rehabilitation Act of 1973*

The strongest argument for prohibiting school attendance of a child with AIDS is the recognized police power behind quarantine. However, AIDS victims have federal legislative protections which address the constitutional rights of the victims.⁹⁸ The Rehabilitation Act⁹⁹ and the Education of All Handicapped Children Act ("EAHCA")¹⁰⁰ are of primary importance to the child with AIDS.

The Rehabilitation Act of 1973, § 504, reads as follows: "This section prohibits discrimination, exclusion, or denial of benefits to otherwise qualified handicapped individuals by any program or activity receiving federal financial assistance."¹⁰¹ Although this act began as a Vocational Rehabilitation Act,¹⁰² it has routinely been applied to the school setting. The

⁹⁶ *Id.* at 434, 134 N.E. at 820.

⁹⁷ *San Antonio Indep. School Dist. v. Rodriguez*, 411 U.S. 1 (1973). If a fundamental right existed, the courts would be likely to analyze any restrictions of that right with a stricter scrutiny.

⁹⁸ *See, Skinner v. Oklahoma*, 316 U.S. 535 (1942) (where certain categories of criminals cannot be sterilized); *see also In re Grady*, 85 N.J. 235, 426 A.2d 467 (1981) (holding that parents of a mentally ill girl could not give consent for her sterilization, and the daughter's rights were protected by a court investigation).

⁹⁹ 29 U.S.C. § 794 (1982).

¹⁰⁰ Pub. L. No. 94-142, 20 U.S.C. §§ 1400-1461 (1976).

¹⁰¹ 29 U.S.C. § 794 (1982).

¹⁰² *See Dep't of Health and Human Services v. Charlotte Memorial Hosp., No. 04-84-3096* (filed with the U.S. Dep't of Health and Human Services, Office for Civ. Rts. Aug. 5, 1986) (involving employment discrimination against a nurse with AIDS).

Supreme Court of Queens, New York in *District 27 Community School Board v. Board of Education*,¹⁰³ held that by admitting AIDS victims to their schools, the city had not violated any state health laws. The holding effectively avoided public health interests and used § 504 of the Rehabilitation Act to establish AIDS victims as handicapped under its definition,¹⁰⁴ thereby protecting them under its rule of no discrimination.¹⁰⁵

The limitations of the Rehabilitation Act are twofold. First, what is the definition of "handicapped" under the Act? Does a child with a communicable disease fit into the definition? Second, the Act bans discrimination only as to the handicap itself, the fact that a child has AIDS, but does it address the rising concern of harm to others and the possibility that a child may be eliminated for this reason rather than for the status of being ill?¹⁰⁶

In a Justice Department Memorandum of June 20, 1986,¹⁰⁷ the definition of "handicap" did not include infectious disease, making it clear that Congress did not intend to protect victims of communicable diseases from discrimination.¹⁰⁸ The memorandum provided protection for the individual who suffered from a mental or physical handicap, but would permit termination if there was a reasonable and valid fear of significant "communicability," also providing "protection for others."¹⁰⁹ However, the United States Supreme Court thereafter upheld tuberculosis as a hand-

¹⁰³ 130 Misc. 2d 398, 502 N.Y.S.2d 325 (1986). When the New York City Board of Education ruled to admit children with AIDS into New York schools, there was boycott by approximately 18,000 children. The individual school boards and parents were dissatisfied with this decision and endorsed a contrary policy. One policy drafted and passed by a school board in Queens read,

[T]he health and safety of the pupil/staff population of the thirty-five schools under its jurisdiction would be endangered by a case, contact or carrier, or suspected case, contact or carrier of AIDS . . . said children shall not be admitted to any school register and/or shall be removed from any school register.

Comment, *supra* note 1, at 199. However, the Queens Supreme Court found AIDS children to be handicapped within the meaning of the Rehabilitation Act and ordered their re-entry into New York schools. See also *Board of Education Plainfield v. Cooperman*, 523 A.2d 655 (N.J. 1987) (local school board's decision to exclude a child with AIDS was overruled).

¹⁰⁴ See Comment, *supra* note 1, at 208.

¹⁰⁵ *Id.*

¹⁰⁶ *Robinson v. California*, 370 U.S. 660 (1962) (striking down a statute which made it a criminal offense to have an addiction to narcotics). But see *Doe by Gonzales v. Maher*, 793 F.2d 1470 (9th Cir. 1986). This court based its reasoning on whether the offensive behavior was handicapped-related. The court infers that a handicapped child may display disruptive violent, aggressive behavior, and if it is related to his handicap the child is protected and remains in school. However, a non-victim child may display this same aggressive violent behavior and be expelled. This form of reverse discrimination does not focus on the behavior and its potential harm to others but on protecting the status of handicapped.

¹⁰⁷ Feldman, *AIDS: A Medical-Legal Nightmare*, 15 AM. COLLEGE OF LEGAL MED. 7 (1987) "The Justice Department believes that Congress did not intend to protect victims of communicable diseases when it outlawed discrimination against the handicapped, and it says that workers with AIDS may be summarily fired because of concern that other employees are at risk."

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

icap under the Act,¹¹⁰ making the Justice Department theory void. AIDS must be distinguished from this decision. Tuberculosis, possibly like AIDS, has a low risk of transmission. However, tuberculosis is treatable and controllable, while AIDS stands alone in its potential to harm others through lack of treatment, progressiveness of the disease, and uncertainty as to transmission. The United States Supreme Court upheld AIDS as a handicap in *Department of Health and Human Services v. Charlotte Memorial Hospital*,¹¹¹ however, the basis for discrimination must be examined. In *Charlotte* a registered nurse was diagnosed as having AIDS and given an involuntary leave of absence. The hospital would not permit re-employment until she was cured of AIDS. The Office of Civil Rights ("OCR") of the Department of Health and Human Resources claimed the dismissal to be a violation of the Rehabilitation Act § 504 since the nurse was handicapped and being discriminated against. The OCR stated that the hospital's decision was based on the fact that the nurse had AIDS and not on an individualized investigation of the possibility of harm to others.¹¹² The case turns on the fact that discrimination of a handicapped individual was made due to a diagnosis of AIDS. If this holding is narrowly confined to discrimination due to the status of having AIDS, then it meets § 504 requirements. However, if "danger" is factored into the judgment and proof is shown of potential harm to others, protection of individual rights may be outweighed by the harm shown.¹¹³

In *Carol A. ex rel Victoria L. v. District Board of Lee County, Florida*,¹¹⁴ there was no finding of discrimination when a handicapped child was removed from school after threatening violence against her classmates. In *Jackson v. Franklin County School Board*,¹¹⁵ it was held that a child was rightfully suspended for disruptive sexual conduct. The court noted that the school system had a duty to ensure a safe school environment and balanced the possible harm to the handicapped student against the harm to the other students. The potential harm to the handicapped student was held to be less than the potential harm to the other students since the handicapped child had been offered educational services.¹¹⁶ AIDS is unique in the uncertainty of its potential harm to others, and this harm must be given weight. The court in *Jackson* added another supporting factor to balance the scales. It considered the educational options offered to the handicapped child in determining to what extent his rights were violated by prohibiting his school attendance. If some educational opportunities are provided, depending on the adequacy of these opportunities as defined under the EAHCA, the individual rights of the child may not be violated.

¹¹⁰ *Arline v. School Bd. of Nassau County*, 772 F.2d 759 (11th Cir. 1985) (holding that a staff member with tuberculosis was considered handicapped under the Act and was not to be discriminated against in his employment in the Nassau County Schools), cert. granted, 475 U.S. 1118 (1986).

¹¹¹ No. 04-84-3096 (filed with the U.S. Dep't of Health and Human Services, Office for Civ. Rts., Aug. 5, 1986).

¹¹² *Id.*

¹¹³ See *Stewart v. Stewart*, No. 2485-1128 (Ind. Super. Ct. Oct. 24, 1987).

¹¹⁴ 741 F.2d 369 (11th Cir. 1984).

¹¹⁵ 606 F. Supp. 152 (S.D. Miss. 1985).

¹¹⁶ *Id.*

B. Education for All Handicapped Children Act ("EAHCA")

1. Scope of the Act

The Rehabilitation Act § 504 is limited in its remedial effect. In fact, it offers no remedy to a handicapped child. To actually obtain a remedy in the form of an equal education, and to achieve more than just a declaration of discrimination due to AIDS as a violation of § 504, a child must fit into the EAHCA definition of handicapped. Handicapped as defined under the EAHCA includes "mentally retarded, hard of hearing, deaf, speech impaired, visually impaired . . . or other health impaired"¹¹⁷ children. AIDS may feasibly be viewed as a handicap if it falls under "other health impaired" children.¹¹⁸ An interpretation of legislative intent supports the theory that Congress added these words to handle a "laundry list" of unaddressed diseases.¹¹⁹ "Other health impaired" is defined as "having limited strength, vitality or alertness, due to chronic or acute health problems."¹²⁰ If AIDS fits into this category, it must be in the very general sense of "chronic health problem."

The EAHCA further provides handicapped children with a remedy. It protects the child from total exclusion for the time that he is not seriously ill or demonstrating behavior patterns which trigger evaluation and possible exclusion. The Act requires that handicapped children have "free appropriate education in a classroom with their peers to the maximum extent possible."¹²¹ The EAHCA requires the best education possible under the circumstances.¹²² The "free appropriate education" referred to is not

¹¹⁷ 20 U.S.C.S. § 1401(1) (1976).

¹¹⁸ Bodine, *Opening Schoolhouse Door, For Children With AIDS: The Education For All Handicapped Children Act*, 13 BOSTON COLLEGE ENVTL. AFF. L. REV. 583 (1986).

¹¹⁹ *Id.* at 614. However, the Act specifically tests tuberculosis, so often compared to AIDS. Why then not include all diseases specifically, rather than allow an inference of exclusion?

¹²⁰ Brockman, *Enforcing the Right to a Public Education for Children Afflicted with AIDS*, 36 EMORY L.J. 603, 632 (1987).

¹²¹ *Doe by Gonzales v. Maher*, 793 F.2d 1470 (9th Cir. 1986). "As the Supreme Court has stated, the individualized educational program — or I.E.P. — is the EAHCA's modus operandi. An I.E.P. is a written program of educational goals and services, tailored to meet the child's unique needs which are developed at an I.E.P. meeting according to the proper procedures." *Id.* at 1479.

¹²² *See Id.* *See also* Hendrich Hudson Dist. Bd. of Ed. v. Rowley, 458 U.S. 176, 198 (1982). The E.A.H.C.A. does not set forth a specific standard for educating handicapped children. It is understood that providing the same services for handicapped children as are provided for non-handicapped children is not sufficient. Justice Rehnquist said, "the 'basic floor of opportunity' provided by the act consists of access to specialized instruction and related services which are individually designed to provide educational benefit to the handicapped child." *Id.* at 201.

However, the determination of when handicapped children are receiving sufficient education to comply with this requirement was seen as a more difficult question. The Court did not establish any one test which would determine the sufficiency of educational benefits conferred on children covered by the act and confined its analysis to the factual situation presented.

Jones, *infra* note 123, at 201.

clearly defined within the Act. "[N]oticeably absent from the language of the statute is any substantive standard prescribing the level of education to be accorded handicapped children."¹²³ This language is open to interpretation and was examined in the landmark case involving the EAHCA, *Hendrick Hudson District Board of Education v. Rowley*.¹²⁴ In *Rowley*, a hearing impaired child was furnished with a special hearing device and tutors, both which resulted in her performing at a better-than-average level in the classroom. However, without her handicap it was established that she could be performing at still a higher level. An action was brought by her parents who requested that a sign language interpreter be provided for the child. Their request was refused. The District Court found this denial to be a deprivation of the free appropriate education guaranteed to this child by the EAHCA. The United States Supreme Court overruled this decision, defining "adequate education" within these facts as performing "better than the average child in her class and . . . advancing easily from grade to grade."¹²⁵ The education of children under the EAHCA is further individualized by the requirement of a consultation with parents and teachers to develop an IEP¹²⁶ (individualized education program) for each child. Therefore, depending on the facts, the EAHCA gets children into the schools, or at least guarantees them an education. However, the method of mainstreaming may be determined by the interpretation of "appropriate education" and "maximum extent possible."¹²⁷ Is "appropriate education," as related to the circumstances of an ill child, satisfied by home tutoring or restricted classroom activity? Does it provide an education to the child, while protecting the public from disease simultaneously? The "maximum extent possible" may

¹²³ Jones, *The Education for All Handicapped Children Act: Coverage of Children with Acquired Immune Deficiency Syndrome (AIDS)*, 15 J. LAW & EDUC. 195, 201 (1986).

¹²⁴ 458 U.S. 176 (1982).

¹²⁵ *Id.* at 210.

¹²⁶ *Id.* at 182. The IEP is a written document containing the following: (A) a statement of the present levels of educational performance of such child, (B) a statement of annual goals, including short-term instructional objectives, (C) a statement of the specific educational services to be provided to such child, and the extent to which such child will be able to participate in regular educational programs, (D) the projected date for initiation and anticipated duration of such services, and (E) appropriate objective criteria and evaluation procedures and schedules for determining, on at least an annual basis, whether instructional objectives are being achieved. § 1401(19).

Id.

¹²⁷ Jones, *supra* note 123, at 200. The purpose of the EAHCA is stated as follows: to assure that all handicapped children have available to them . . . a free appropriate public education which emphasizes special education and related services designed to meet their unique needs, to assure that the rights of handicapped children and their parents and guardians are protected, to assist States and localities to provide for the education of all handicapped children, and to assess and assure the effectiveness of efforts to educate handicapped children.

Id. In light of this purpose, it appears that a free appropriate education is a tailored program to meet each child's needs. Mainstreaming the child into the regular classroom as often as possible may serve to satisfy the "maximum extent possible" regulation.

be limited by the reasonable assumption of harm to others. It appears that while the EAHCA prohibits total exclusion, it espouses, and even requires, restrictive measures which are sufficient to satisfy an "appropriate" education.

2. EAHCA and Equal Protection

The equal protection rights of children are not based on a fundamental right to an education.¹²⁸ *Brown v. The Board of Education*,¹²⁹ held that once a school begins the educational process, it must continue to educate all students on equal terms. *Brown*, dealing with racial segregation, can be distinguished in several ways from cases involving disease related handicaps. First, race is a suspect class, while AIDS is not.¹³⁰ The results in *Brown*, therefore, occurred after a more strict analysis. Also, equal protection demands similar treatment of similarly situated individuals.¹³¹ The presence of a white or black student in a white or black school presents a problem no deeper than the color of someone's skin. As students and human beings there is a "sameness" which must be recognized. A child who is ill, on the other hand, is different from one who is not, especially when he is a child with a fatal disease of unknown potential. Other diseases require temporary exclusion.¹³² Whether AIDS should be one of these is not paramount here, but rather, the question is whether there is an equal protection problem. Children with diseases are not similarly situated with non-victims and may necessarily, for the protection of everyone, be addressed separately. Disparate impact and unfair application of the law is discussed in *Jacobson v. Massachusetts*.¹³³ In *Jacobson*, a statute made children an exception for smallpox vaccinations. However, adults were never exempt. No equal protection violation existed, since all adults were alike and all children were alike, but adults and children were different as to each other and could be treated differently. In *Skinner v. Oklahoma*,¹³⁴ the Court indicated that a state is not "prevented by the Equal Protection Clause from confining its restrictions to those classes of cases where the need is deemed to be the clearest."¹³⁵ The Court in *Buck v. Bell*,¹³⁶ lent support to the separate treatment of individuals by the law when it stated: "[T]he law does all that is needed when it does all that

¹²⁸ *San Antonio Indep. School Dist. v. Rodriguez*, 411 U.S. 1 (1973).

¹²⁹ 347 U.S. 483 (1954).

¹³⁰ *Bodine*, *supra* note 118, at 605. The courts have not recognized "children with AIDS or any type of disease as a suspect class for the purposes of strict scrutiny equal protection analysis." *Id.*

¹³¹ "The equal protection clause guarantees that no state shall 'deny to any person within its jurisdiction the equal protection of the laws,' U.S. CONST. amend. XIV, § 1, thereby mandating that 'all persons similarly circumstanced shall be treated alike.'" *C.F.S. Royster Guano Co. v. Virginia*, 253 U.S. 412, 415 (1920). Comment, *supra* note 1, at 213.

¹³² OHIO ADMIN. CODE § 3701-3-13 (1983).

¹³³ 197 U.S. 11 (1905).

¹³⁴ 316 U.S. 535 (1942).

¹³⁵ *Id.* at 540 (quoting *Miller v. Wilson*, 236 U.S. 373, 384 (1915)).

¹³⁶ 274 U.S. 200 (1905).

it can . . . and seeks to bring within the lines all similarly situated"¹³⁷ AIDS victims argue that an attempt to prohibit children with AIDS from attending school openly violates equal protection due to the fact that unknown carriers of AIDS present the same potential for harm to others, but are not similarly restricted. The *Buck* analysis destroys this argument. The law can be expected to work only with that which it knows to be certain, and to protect or treat equally those whom it recognizes as needing attention. Unknown AIDS carriers are presently undetectable, even by those in the medical profession. Therefore, treating known carriers differently from unknown carriers does not violate equal protection as long as all known carriers are treated alike.

The EAHCA is thus open to interpretation. If a child was deemed to be a potential risk to others, restrictions placed on that child may be reasonable if he is still receiving an "appropriate" education under the circumstances. This may not mean an unrestricted classroom education, but to the "maximum extent possible" a child may be tutored, or restricted as to what classes he may attend. Although these restrictions may still meet the educational requirement of the EAHCA, AIDS victims have one last right to which they cling — the right of individual privacy.

C. Right to Privacy and Confidentiality

1. Is It a Constitutional Right?

Consider the possibility that a school board may use its discretion to provide home tutoring in biology and general science, and will provide an exercise program for a child with AIDS in order to eliminate the risk of physical education or playground activities, but will allow the child to attend other relatively conservative and restricted classroom studies. Assuming the school board has satisfied the "adequate education" provision of the EAHCA, it still faces a serious constitutional problem of confidentiality. It will be difficult for this child to be on a restricted schedule without other students knowing about his illness and identifying him with AIDS. More importantly and specifically, should other students, parents, teachers and staff be told of the victim's presence in the building? How far does the right of privacy extend?

The right to privacy has been broken down into two elements; one being the interest in making an independent decision, the other in avoiding disclosure of personal information.¹³⁸ In attempting to fine tune this right into a reliable, constitutionally supported right, examine *Paul v. Davis*.¹³⁹ After being charged with shoplifting and having the charges dismissed, Davis found that his picture had still been included on a flyer of shoplifters

¹³⁷ *Id.* at 208.

¹³⁸ Note, *The Constitutional Right of Informational Privacy: does It Protect Children Suffering From AIDS?*, 14 *FORDHAM URBAN L.J.* 927 (1986). See also *Whalen v. Roe*, 429 U.S. 589 (1977).

¹³⁹ 424 U.S. 693 (1976).

which had been given to local merchants. The Court found that damage to his reputation, absent any real governmental action against him, was insufficient to constitute an invasion of his privacy. The *Davis* case established that "reputation alone, apart from some more tangible interest such as employment, is [n]either 'liberty' [n]or 'property' by itself sufficient to invoke the procedural protection of the Due Process Clause."¹⁴⁰ In *Davis*, the state's interest in preventing crime outweighed any privacy right Davis may have had, making it necessary to expose Davis's name as a potential criminal in order to accomplish its purpose of informing merchants. Considering the state's interest in public health, the right of privacy for AIDS could not extend to protection of their "reputation." School children with AIDS would be identified in order to preserve the public health. Although their "reputation" or status among their classmates may suffer due to the seriousness of the disease, their right to this form of privacy could not prevail under *Davis*. In addition, the government has considerable latitude in accomplishing its interests.¹⁴¹ Individual privacy rights are not violated if a state chooses to experiment with various solutions.¹⁴²

In *Davis*,¹⁴³ the Court was still referring to a general right of privacy and never really addressed confidentiality and avoiding disclosure of personal information separately from an individual's interest in making independent decisions.¹⁴⁴ The case of *Griswold v. Connecticut*,¹⁴⁵ analyzes the concept of the penumbra theory of constitutional guarantees, privacy being one.¹⁴⁶ This did not really serve to clarify matters since a "penumbra" is an illusive term with unlimited scope and bearing no real language of rights to be respected. *Roe v. Wade*¹⁴⁷ was helpful in its bal-

¹⁴⁰ *Id.* at 701.

¹⁴¹ *Whalen v. Roe*, 429 U.S. 589, 597 (1977).

¹⁴² *Id.* at n.20.

To stay experimentation in things social and economic is a grave responsibility. Denial of the right to experiment may be fraught with serious consequences to the Nation. It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country. This Court has the power to prevent an experiment. We may strike down the statute which embodies it on the ground that, in our opinion, the measure is arbitrary, capricious or unreasonable. We have power to do this because the due process clause has been held by the Court applicable to matters of substantive law as well as to matters of procedure. But in the exercise of this high power, we must be ever on our guard, lest we erect our prejudices into legal principles. If we would guide by the light of reason, we must let our minds be bold.

Id.

¹⁴³ 424 U.S. 693 (1976).

¹⁴⁴ Note, *supra* note 138, at 935. See *Olmstead v. United States*, 277 U.S. 438 (1928) (attempting to distinguish physical privacy from confidentiality. Justice Brandeis dissented with an acclamation for a broad, general right to privacy free from governmental intrusions). See also *Katz v. United States*, 389 U.S. 347 (1967) (*Olmstead* overruled and privacy found to include an interest in confidentiality).

¹⁴⁵ 381 U.S. 479 (1965).

¹⁴⁶ Note, *supra* note 138, at 933. This theory is based on the idea that from the express guarantees of the Bill of Rights stem other personal rights "not expressly enumerated in the first eight amendments." *Id.*

¹⁴⁷ 410 U.S. 113 (1973) (Having an abortion is in the category of a fundamental personal privacy right.).

ancing of the personal rights of individuals against the interests of the state.¹⁴⁸ Although the Court found privacy to be a fundamental right, it cautioned that such a right is not absolute but could be limited by the compelling state interest of protecting the public health and "maintaining medical standards."¹⁴⁹ This balancing test, whether demanding that the state show a compelling interest as in *Roe*, or merely a rational basis for its actions, "weighed the scope of the intrusions against the interests which the intrusions advanced."¹⁵⁰ This analysis becomes critical in a case involving AIDS. The "scope of the intrusion"¹⁵¹ against children with AIDS is the intrusion which may result in a stigma, ostracizing him from other students who become aware of his illness as a result of restrictive treatment. However, whenever balancing is used, the interest which the intrusion advances also carries weight. The fact that medical questions are involved here calls for close examination of the balance of intrusion and interests. If in fact a right to confidentiality exists, in a medical situation this right is nearly obliterated by the (1) legitimate breakdown of doctor-patient confidentiality,¹⁵² (2) a physician's duty to report patients with infectious diseases to the Department of Health,¹⁵³ (3) the right of the non-victim to self-preservation, and (4) with AIDS in particular, the necessity for the victim's condition to be exposed in order to provide adequate protection against communicable diseases uniquely dangerous to an AIDS victim.

2. Duty to Report

In the face of confidentiality, rights in a doctor-patient relationship must sometimes be deferred to the legitimate right of doctors to breach that confidentiality for the public good.¹⁵⁴ Doctors have a duty to report cases of AIDS to Public Health Officials.¹⁵⁵ The Supreme Court in *Cox Broadcasting Corp. v. Cohn*,¹⁵⁶ held that privacy interests in tort law

¹⁴⁸ *Id.*

¹⁴⁹ *Id.* at 154

¹⁵⁰ Note, *supra* note 138, at 937. See also *Jacobson v. Mass.*, 197 U.S. 11, 26 (1905) (It is a fundamental principle "that persons and property are subjected to all kinds of restraints and burdens in order to secure the general comfort, health and property of the State . . ."). *Id.* at 26.

¹⁵¹ Note, *supra* note 138, at 937.

¹⁵² Note, *Reportability of Exposure to the AIDS Virus: An Equal Protection Analysis*, 7 CARDOZO L. REV. 1102, 1113 (1986).

The rights of individuals are often subordinated to the good of the community in order to halt the spread of communicable disease. The breach of doctor-patient confidentiality that takes place when medical records are disclosed to the state department of health pursuant to a reporting law is generally accepted as a matter of public health necessity.

Id.

¹⁵³ *Id.* This duty causes the identification of the victim to be a matter of necessary public record. For the purposes of furthering research for a cure to AIDS, these reports bear vital information and are part of the state's interest in disease prevention and public health.

¹⁵⁴ Note, *supra* note 152.

¹⁵⁵ *Id.* ("AIDS itself is a reportable disease in most states").

¹⁵⁶ 420 U.S. 469 (1975).

diminish when information appears on public record.¹⁵⁷ It again becomes a decision for the courts as to whether information is personal and protected and to what extent that protection can be intruded upon without being state abuse. Once again a tone of balancing exists between the intrusion placed on an individual and the societal interest promoted.¹⁵⁸ Perhaps the strongest blow to a patient's right to confidentiality came in *Whalen v. Roe*.¹⁵⁹ A New York statute required the identification of all patients, doctors and pharmacists involved in the sale and use of legitimate dangerous drugs. The purpose of the statute was to prevent drugs from being diverted into unlawful areas. The objection by patient subscribers to these drugs concerned the list of names to be placed in a computerized data bank. Their objection was based on the violation of the doctor/patient zone of privacy as a constitutionally protected privacy and the stigma that would result should anyone mistakenly see their names on this list. The United States Supreme Court held the statute to be constitutional, and held that a patient identification requirement was a reasonable exercise of state police power, requiring no proof as to its necessity. No invasion of privacy exists merely because the state is attempting a new, even if slightly intrusive, measure in effecting their police power.

Applying this rationale to a case concerning AIDS, *Whalen* stands for the fundamental proposition that the state's police power does exist and is dominant over individual rights in cases of, and interest in controlling dangerous activities concerning the public health and welfare.¹⁶⁰ In addition, an intrusion as severe as revealing the identity of patients, although admittedly in *Whalen* it was only to the public health officials who worked on the data bank, is not unconstitutional. If this information were to be needed for investigative purposes, the *Whalen* court implied that this information would be released. In a school setting, revealing the identity of the victim is necessary in order to protect the health of both the victim and the non-victim, to promote the goal of finding a cure for this disease, and to permit the community to enforce precautions against the spread of AIDS. The right of a child with AIDS to remain anonymous fails under *Whalen*.

It appears that medical issues are unique in that, if a patient has a privacy right to avoid disclosure of the presence of disease, the physician's duty interferes, demanding that he report an infectious disease.¹⁶¹ Stem-

¹⁵⁷ *Id.* at 494.

¹⁵⁸ See, e.g., Note, *Formalism, Legal Realism and Constitutionally Protected Privacy Under the Fourth and Fifth Amendments*, 90 HARV. L. REV. 945 (1977). "When determining whether a potentially protected type of evidence is in fact related to the private person, courts should focus on the relationship of the persons and on the nature of the activities implicated." *Id.* at 988.

¹⁵⁹ 429 U.S. 589 (1977).

¹⁶⁰ *Jacobson v. Mass.*, 197 U.S. 11, 26 (1905) (holding that individual rights may be necessarily sacrificed in the face of a state's interest in preserving the health of its citizens).

¹⁶¹ Note, *supra* note 152. In 1985, Colorado's State Rules and Regulations Pertaining to Communicable Disease Control states that all positive ELISA test results would be reportable. This controversial blood sampling test allegedly reveals the presence of HTLV-III virus in your body. The controversy stems from

ming from this is an additional duty of a physician or public health official to tell all those in contact with the AIDS patient of the fact that this individual has AIDS.¹⁶² Interestingly, the CDC recommends that only those directly involved with the student, who must "provide for the child's best interests," can be told of his/her illness.¹⁶³ In an effort to preserve privacy rights, this exaggerated right to confidentiality defeats the goal of disease prevention, is detrimental to the victim's best interests of protection and care, and attempts to override the theory of openness behind the long existing duty on the part of doctors to report infectious diseases in order to preserve public health.¹⁶⁴

3. Is the Stigma Real?

First, examine the intrusion which allegedly stigmatizes the victim. Children with AIDS are said to be innocent or accidental victims, most often having contracted the disease through an infected parent or a blood transfusion.¹⁶⁵ The stigma of AIDS is most often attached to the high risk

the inaccuracy of results and the use of the test as a diagnostic tool. If the test were correctly positive, it demonstrates only that the patient has been exposed to the virus. However, in making the positive results of this test reportable, the State of Colorado was attempting to develop a system for disease control. The regulation purpose was:

- a) to alert responsible health agencies to the presence of persons likely to be infected with a highly dangerous virus;
- b) to allow responsible health agencies to insure that such persons are properly counseled as to the significance of their laboratory test, and as to what they need to do to prevent further transmission of the virus;
- c) to allow responsible health agencies to monitor the occurrence and spread of infection with this virus in the population of Colorado;
- d) to allow responsible health agencies to identify and contact persons with likely or proven HTLV-III infection when specific anti-viral treatment becomes available.

Id. at 1114, 1115.

¹⁶² Gostin, Curran, & Clark, *The Case Against Compulsory Casefinding in Controlling AIDS - Testing, Screening and Reporting*, 12 AM. J. LAW & MED. 7 (1987) (Doctor as a holder of information must breach his confidentiality and, by another duty, disclose information to anyone to whom his patient threatens harm.) See also *Tarasoff v. Regents of California*, 17 Cal. 3d 425, 55 P.2d 334, 131 Cal. Rptr. 14 (1976) (liability imposed on a psychologist who failed to warn a third party of his patient's expressed intention to kill that third party, when the murder was later committed).

¹⁶³ *School Attendance*, *supra* note 43, at 431.

¹⁶⁴ See 25 AM. JUR. Health § 44.

§ 44. Giving Information as to Existence of Disease. It is the duty of any citizen acting in good faith and on reasonable grounds to report to the health authorities all suspected cases of contagious disease, so that proper examination may be made by experts and the public health protected, and one cannot be held liable in damages in case the suspicion is unfounded.

Id.

¹⁶⁵ See *Rosenburg*, *supra* note 2, at 52 ("[I]t is only to have been expected that patients who contracted AIDS through blood transfusions or in utero are casually referred to in news reports as innocent or accidental victims of a nemesis both morally and epidemiologically appropriate to a rather different group."). *Rosenburg* was contrasting patients who have contracted AIDS in a manner which was through no fault of their own, to those who transmit the disease sexually.

groups associated with it; i.e., homosexuals and intravenous drug users. Stigma is an inappropriate tag for a terminally ill child. Fear of contagion exists. However, if the approach to these children and their peers was an honest and open one, perhaps the stigma would dissipate. If AIDS was clearly and thoroughly explained, and if physical contact was cautiously limited and monitored, the child could eat and breathe in the same room with others without unreasonable fears. Children, victims and non-victims, and parents would more easily adapt and would be less likely to ostracize a child if they felt assured of the precautions taken, both in restrictions and hygiene, and were educated as to the exact, and even remote possibilities against which they must protect themselves. In this way public fear is calmed, health is protected, and the child is still provided with an education and limited socialization. Any limitations on the victim are far outweighed by the positive effects of an accurate depiction of a situation to all concerned. In a recent article concerning a teacher with AIDS, the public demonstrated compassion, not hatred, toward the victim, their friend.¹⁶⁶ Honesty has that effect.

Specifically dealing with AIDS, courts must look long and hard at enforcing a privacy right and keeping a child's identity a secret for one other very critical reason. The only weapon we have as a society against this devastating, incurable, fatal disease is preventing its spread. "The number of personnel aware of a child's condition should be kept to minimum . . . [i]t is essential to respect a student's right of privacy.¹⁶⁷ This is inconsistent with the goal of preventing the spread of disease. With AIDS, as with any illness, it is a public necessity to have precautions taken literally and seriously by all public institutions. Children carrying the AIDS virus displaying no symptoms and in unrestricted attendance, are not easily identifiable. There is a difficult line between protecting this child's well being and protecting his or her confidentiality.¹⁶⁸ It is nearly impossible to help a child with AIDS to be aware of symptoms

¹⁶⁶ See Breckenridge, *Shaker Teacher Stricken by AIDS*, Cleveland Plain Dealer, Oct. 31, 1987 at A10, col. 1. Upon learning of this teacher's illness, several parents of children attending his school phoned school officials. "Nobody was frantic at all. They were interested, concerned, and sad, too."

¹⁶⁷ *School Attendance*, *supra* note 43, at 431.

¹⁶⁸ Rubenstein, *supra* note 30, at 243.

For those children with HTLV-III infection who have no symptoms and whose attendance in an unrestricted school setting has been approved by a panel of experts, we must walk a thin line between protection of their confidentiality and their well-being. Immuno-compromised children cannot always interact in an unrestricted environment. Any unusual illness in the school should immediately be reported to the Health Department and to the parents of all students. From a practical point of view, these measures are hard to accomplish if confidentiality is maintained.

Id. See also *Doe by Gonzales v. Maher*, 793 F.2d 1470, 1476 (9th Cir. 1986) ("[T]hose who love their children must sometimes make sacrifices in order to accommodate the interests of other children and their equally loving parents, and that those of us who administer the law must recognize the limits of our capacity to achieve perfect justice."). John Doe was an emotionally disturbed child with aggressive behavior protected under EAHCA and the Rehabilitation Act. The court went to great lengths to establish programs for this child which enabled him to continue his education at a center for the handicapped.

which may quickly arise, when a school is not aware that the child is at risk and school officials are uneducated about the disease. Keeping students and staff in the dark is damaging to both victims and non-victims and deters the prevention machine.¹⁶⁹

For victims, confidentiality eliminates the chance of early detection of symptoms and jeopardizes their existing health status. For non-victims, it jeopardizes their right to self preservation.¹⁷⁰ Not informing everyone who may be in daily contact with an AIDS victim is a paternalistic deprivation of the non-victim's right to protect himself.¹⁷¹

Good hygiene is mandatory if an AIDS victim is present, and specific precautions must be taken.¹⁷² These specific precautions will not be taken if the school's staff is unaware of the necessity to practice these methods. It is critical that everyone fully understand the problem of AIDS, and having knowledge of its dimensions is the first step. Without knowledge, the community and the non-victims are truly the handicapped parties. "Not only does the child [the victim] have civil rights, but so do the other children. You have to be concerned about both sides of the issue."¹⁷³

Is the stigma real? The answer is uncertain. However, the intrusion caused by identifying children with AIDS in schools is a constitutional,¹⁷⁴ even if experimental,¹⁷⁵ method of accomplishing a state's purpose of controlling this deadly disease.

VI. CONCLUSION

AIDS is a unique disease with unknown, unproven risks and undetermined potential for affecting our society's well being. Due to the age and uncertainty of the disease, it must be addressed differently from any other diseases with which we have been faced in the past. The problems are severe, and barriers facing both victims and non-victims in the school setting are phenomenal. We must not be without compassion for the victims, children innocently contaminated by this devastating disease, for the victims in this country may soon outweigh the unaffected citizens. Presently, we have a duty to prevent the spread of this disease. We must balance this duty by protecting both the victim and the potential victim.

The approach taken by our schools, our public institutions, our courts, and our society as a whole must be a complete and careful one in order to control the outcome and arrive at the desired result of prevention until a cure is found. We must begin with the understanding that if the risk

¹⁶⁹ See Rubenstein, *supra* note 30, at 243.

¹⁷⁰ See *Jacobson v. Mass.*, 197 U.S. 11, 27 (1905) ("Upon the principle of self-defense, of paramount necessity, a community has the right to protect itself against an epidemic of disease which threatens the safety of its members.")

¹⁷¹ See Rubenstein, *supra* note 30, and accompanying text ("We outside the government are free to speak.")

¹⁷² Hughes & Bailey, *supra* note 35.

¹⁷³ Cleveland Plain Dealer, *supra* note 53.

¹⁷⁴ See *Whalen v. Roe*, 429 U.S. 589 (1977).

¹⁷⁵ *Id.* at 597 n.20.

of transmission of AIDS is slight, this is outweighed by the fact that its effect is a death sentence.

Approaching the problem rationally, children with AIDS in schools must be reasonably restricted in their attendance and participation. Certain school-related activities which present a higher risk of transmission, i.e., physical education, biological sciences, free play, and even bathroom visits, must be curtailed, monitored, and/or prohibited. In extreme cases of behavioral threats, home tutoring must be an accepted standard of adequate education of these children.

Developing such a program, under current law, will be difficult. The technical and constitutional problems for individual states and school boards in handling a group of children individually and educating them adequately in a restricted setting could become cost prohibitive as the number of victims rises. States face an uphill battle unless there is a necessary federal intervention into the problem. In January of 1986, President Reagan called AIDS "one of the highest public health priorities", but at the same time proposed reduced spending for AIDS research¹⁷⁶ The burden of cost must be taken up by the federal government, first to begin an initial attack on this disease and second, to create consistency by developing a national standard for the approach to and the control and prevention of AIDS. The program must begin at the federal level in order to overcome the hurdles faced by the courts and school systems in attempting to handle the predicament facing a child with AIDS.

The federal government must begin by eliminating the supremacy they have established in allowing courts to hang their hat on a handicap distinction. AIDS is unique in its elements, and "handicap" is hardly a word to apply when insisting that a child with an infectious disease be able to attend school without restrictions. A fine distinction must be made here. Discriminating against someone for having AIDS differs from the idea of restricting the possible transmission of a dangerous disease.

A national standard for educating victims and non-victims about the disease must be established. From this education flows a resulting standard for prevention measures to be taken by all states and all school systems. Mandatory prevention measures, such as restricted activity of a child with AIDS and notification of all those in contact with the child to promote an effective hygiene program, must be in place if we are to treat each victim fairly and maintain control of the spread of this disease.

Based on these proposed mandatory control measures, courts will treat equally all cases of AIDS in the schools with a uniform hand. They will be better able to address the problem with rules and tangible standards rather than with the tenuous medical findings on this changeable new disease. The prevention measures must be based on preventative, precautionary themes, sometimes infringing on an individual's desire to remain discrete, in order to promote the even greater good of future public health.

¹⁷⁶ FOX, *AIDS and the American Polity: The History and Prospects of a Crisis of Authority*, 64 MILBANK Q. (D. Willis ed. 1986).

“[W]e may recall the 1980’s as a time when many Americans became increasingly complacent about the consequences of a dreaded disease and unwilling to insist that the individuals and institutions of the health policy struggle against them.”¹⁷⁷

CAROLYN J. KASLER

¹⁷⁷ *Id.* at 30.

