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The Application of Section 504 of the Rehabilitation Act to the Segregation of HIV-Positive Inmates

Ayesha Khan

THE APPLICATION OF SECTION 504 OF THE REHABILITATION ACT TO THE SEGREGATION OF HIV-POSITIVE INMATES

Ayesha Khan*

Abstract: Acquired Immune Deficiency Syndrome has posed a formidable challenge to correctional administrators because of the perception that prisons and jails hold high concentrations of individuals at risk of developing the disease. Housing decisions are particularly difficult. Administrators often segregate inmates who have AIDS, ARC or asymptomatic HIV infection from the general prison population by housing them in a separate unit. This Article analyzes whether such a practice violates section 504 of the Rehabilitation Act, which forbids programs which receive federal financial assistance from discriminating against "otherwise qualified" handicapped persons. The analysis focuses on three issues: the epidemiology of HIV in correctional facilities; whether HIV-positive inmates are "handicapped" under the Act; and whether HIV-positive inmates are "otherwise qualified" to be integrated into the general prison population.

Acquired Immune Deficiency Syndrome (AIDS)[1] is a major policy concern for public health officials everywhere. It poses a formidable challenge to correctional administrators because of the perception that prisons and jails hold high concentrations of individuals at risk of developing AIDS as a result of prior intravenous drug use, and because correctional inmates frequently engage in behavior likely to

* National Women's Law and Public Policy Fellow, working with the Intrafamily Offense Unit of the Juvenile Section of the Criminal Division of the District of Columbia's Corporation Council. B.A., 1984, University of Michigan; J.D., 1989, Boalt Hall School of Law, University of California at Berkeley. I wish to thank Martin Eskenazi for his encouragement and editorial suggestions.

1. AIDS is a communicable disease, caused by the Human Immunodeficiency Virus (HIV), that undermines the human body's ability to combat infections and malignancies. W. MASTERS, V. JOHNSON & R. KOLODNY, CRISIS: HETEROSEXUAL BEHAVIOR IN THE AGE OF AIDS 17 (1988). AIDS is the end-stage of HIV infection. In earlier stages of infection, many people have no visible symptoms, while others experience various types of mild illness or more serious problems that do not fit the diagnosis of a full-blown case of AIDS. *Id.* Why some people remain asymptomatic for long periods of time while others progress rapidly into symptomatic infection is unclear. *Id.* at 35–36. Once a person develops symptoms, he or she crosses into a category called AIDS-related complex (ARC). *Id.* at 39. Again, some people with ARC develop AIDS within months, while others have a more stable condition. *Id.* at 40. However, while estimates vary, it is likely that a majority of HIV-infected persons will ultimately develop AIDS and die. *Id.*

The great majority of cases in the United States have been among homosexual men and intravenous drug users. Other methods of transmission include heterosexual activity and transfusion of blood products. Friedland & Klein, *Transmission of the Human Immunodeficiency Virus*, 317 NEW ENG. J. MED. 1125–35 (1987).

spread the disease, particularly homosexual activity and intravenous drug use.[2]

Deciding where to house inmates who have AIDS, ARC, or asymptomatic HIV infection is one of the most critical and difficult decisions for prison administrators. Medical considerations and correctional management considerations both figure prominently in such decisions. One of the available options is to segregate infected inmates from the general prison population by housing them in a separate unit. As of October 1, 1988, 39% of state and federal correctional systems segregated inmates with AIDS; 16% segregated inmates with ARC; and 12% segregated those with asymptomatic HIV infection.[3] Forty-six percent of city and county jail systems nationwide segregated those with AIDS; 21% segregated those with ARC; and 11% segregated those with asymptomatic HIV infection.[4]

Inmates have challenged segregative policies on various constitutional grounds. They have argued that segregation, even when "separate but equal," violates equal protection;[5] that conditions in segregation are inferior to those in the general prison, thereby violating equal protection;[6] that due process is violated by segregation;[7] that conditions in segregation amount to a violation of the eighth amendment's prohibition against cruel or unusual punishment;[8] and that denial of access to, among other things, religious services and group

2. NATIONAL INSTITUTE OF JUSTICE ISSUES & PRACTICE, AIDS IN CORRECTIONAL FACILITIES: ISSUES AND OPTIONS iii (3d ed. 1988) [hereinafter AIDS IN CORRECTIONAL FACILITIES]; NATIONAL INSTITUTE OF JUSTICE ISSUES & PRACTICE, 1988 UPDATE: AIDS IN CORRECTIONAL FACILITIES iii (1989) [hereinafter 1988 UPDATE].

3. 1988 UPDATE, *supra* note 2, at 34; *see also* Appendix A. For further breakdown and discussion of these statistics, see *infra* notes 55–58 and accompanying text.

4. 1988 UPDATE, *supra* note 2, at 34; *see also* Appendix B.

5. *See, e.g.*, Lewis v. Prison Health Servs., Inc., No. 88-1247 (E.D. Pa. Sept. 13, 1988) (LEXIS, Genfed library, Dist file); Judd v. Packard, 669 F. Supp. 741 (D. Md. 1987).

6. *See, e.g., Lewis,* No. 88-1247 (E.D. Pa. Sept. 13, 1988) (LEXIS, Genfed library, Dist file); Cordero v. Coughlin, 607 F. Supp. 9 (S.D.N.Y. 1984).

7. *See, e.g., Lewis*, No. 88-1247 (E.D. Pa. Sept. 13, 1988) (LEXIS, Genfed library, Dist file); Powell v. Department of Corrections, 647 F. Supp. 968, 970 (N.D. Okla. 1986); *Cordero,* 607 F. Supp. at 10.

8. *See, e.g., Cordero,* 607 F. Supp. at 11.

activities while in segregation constitutes a first amendment violation.[9] All challenges have failed.[10]

Constitutional law is stacked against prisoners. Generally, prison officials have broad discretionary authority to administer prisons,[11] while prisoners retain only those rights that are not inconsistent with either their status as prisoners or with the legitimate penological objectives of corrections systems.[12] Specifically, under equal protection, AIDS victims are not a suspect class and official discrimination against the mentally retarded, and arguably against all handicapped people, is not invidious discrimination and not subject to heightened scrutiny under the Constitution.[13] So long as there are legitimate government ends, and the means are rationally related to those ends, the equal protection clause is not violated.[14] Under due process, prisoners have no fundamental constitutional right to reside in the general prisoner population, and retain only a narrow range of protected liberty interests.[15] Indeed,

> "administrative segregation," . . . appears to be something of a catchall: it may be used to protect the prisoner's safety, to protect other inmates

9. *See, e.g., Powell,* 647 F. Supp. at 971; *Cordero,* 607 F. Supp. at 11. Inmates have raised additional constitutional claims, for example, the claim that conditions in segregation deny inmates their right of access to the courts. *See, e.g., Powell,* 647 F. Supp. at 971.

Interestingly, inmates have also argued that they have a right to be free from the *risk* of contracting AIDS. Indeed, one might argue that the right of inmates with AIDS to be integrated may be on a collision course with the right of uninfected inmates to be free from the risk of contracting the disease. Courts find that a colorable claim is stated only if it is shown that there exists " 'a pervasive risk of harm to inmates of contracting the AIDS virus and if there is a failure of prison officials to reasonably respond to that risk.' " Glick v. Henderson, 855 F.2d 536, 539–40 (8th Cir. 1988) (quoting Martin v. White, 742 F.2d 469, 472 (8th Cir. 1984)); *accord* Brown v. Delaware County Prison, No. 87-3596 (E.D. Pa. June 30, 1987) (LEXIS, Genfed library, Dist file). And in Harris v. Thigpen, 727 F. Supp. 1564, 1572 (M.D. Ala. 1990), the court found that allowing inmates with AIDS to be introduced in the general population *"may"* violate the eighth amendment rights of the general prison population. Similarly, in *In re* La Rocca, 120 Misc. 2d 697, 467 N.Y.S.2d 302, 310 (Sup. Ct. 1983), the court found that the segregation of prisoners with AIDS was a reasonable manner for the Department of Correctional Services to fulfill its statutory obligation to provide a safe and humane place of confinement for its inmates. No section 504 challenge was made by those subjected to the segregation; instead, uninfected inmates were arguing that inmates with AIDS should be housed in a separate building and that intensive screening of incoming inmates ought to be imposed. 467 N.Y.S.2d at 304.

10. *Cf.* Roe v. Fauver, No. 88-1225 (D.N.J. Oct. 7, 1988) (LEXIS, Genfed library, Dist File) (holding that the segregation of prisoners with AIDS under conditions inferior to those in the general population raises genuine issues of material fact in a challenge based on, inter alia, equal protection, due process, and the eighth amendment).

11. Hewitt v. Helms, 459 U.S. 460, 467 (1983); Wolff v. McDonnell, 418 U.S. 539, 566 (1974).

12. Pell v. Procunier, 417 U.S. 817, 822 (1974); Price v. Johnston, 334 U.S. 266, 285 (1948).

13. Cleburne v. Cleburne Living Center, 473 U.S. 432, 440–42 (1985).

14. Massachusetts Bd. of Retirement v. Murgia, 427 U.S. 307, 312 (1976).

15. Hewitt v. Helms, 459 U.S. 460, 466–67 (1983).

> from a particular prisoner, to break up a potentially disruptive group of inmates, or simply to await later classification or transfer. . . . [It] is the sort of confinement that inmates should reasonably anticipate receiving at some point in their incarceration.[16]

Under the eighth amendment, only "deliberate indifference to the serious medical needs of prisoners is proscribed."[17] Finally, prisoners' first amendment rights are analyzed in terms of the legitimate policies and goals of the institution involved and the Supreme Court has looked upon such claims disfavorably.[18]

An avenue for challenging the segregation of HIV-positive prisoners that might prove promising is section 504 of the Rehabilitation Act[19] (the Act), which provides in pertinent part: "[n]o otherwise qualified individual with handicaps[20] . . . shall, solely by reason of her or his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

Thus, a violation of the Act requires that segregated HIV-positive inmates be (1) otherwise qualified, (2) handicapped individuals, who (3) suffer discrimination[21] under a program receiving federal financial

16. *Id.* at 468 (citation omitted).

17. Estelle v. Gamble, 429 U.S. 97, 104 (1976).

18. *See, e.g.*, Bell v. Wolfish, 441 U.S. 520, 550 (1979); Jones v. North Carolina Prisoners' Union, 433 U.S. 119, 129–32 (1977); Pell v. Procunier, 417 U.S. 817, 822 (1974).

19. 29 U.S.C. § 794 (1988). The only case that has decided the issue is Harris v. Thigpen, 727 F. Supp. 1564, 1582–83 (M.D. Ala. 1990), where the court found that HIV-positive inmates were not "otherwise qualified" for integration because of the risk of transmission and that reasonable accommodation would not eliminate the risk. However, the court's analysis was extremely cursory.

20. Prior to 1986, the Act used the term "handicapped individual." The term was changed in response to the perception that the term had negative connotations. H. R. REP. NO. 571, 99th Cong., 2d Sess. 17, *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 3471, 3487. However, no change in meaning was intended, and old cases are applicable to the Act as currently worded.

21. Discrimination can be established by showing that segregation deprives the inmates of access to facilities and programs of the same caliber. Alternatively, even if the facilities and programs are "separate but equal," discrimination will still be established, i.e., segregation itself constitutes discrimination under section 504. Indeed, the Act was partially motivated by a concern for the segregation of the handicapped from the rest of society. *See, e.g.*, 118 CONG. REC. S525 (daily ed. Jan. 20, 1972) (statement of Sen. Humphrey).

Various regulations promulgated pursuant to the Act recognize this form of discrimination. For example, Department of Health and Human Services regulations provide that:

> (1) A recipient, in providing any aid, benefit, or service, may not . . . on the basis of handicap:
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> . . .
>
> (iv) Provide different or separate aid, benefits or services to handicapped persons or to any class of handicapped persons unless such action is necessary to provide qualified handicapped persons with aid, benefits, or services that are as effective as those provided to others.

assistance, and that (4) the correctional facility practice such discrimination solely on the basis of handicap.

There is little dispute that section 504 applies to state prisons that receive federal funding. Regulations contemplate the Act's application to inmates of federal penal institutions,[22] and offer the "department of corrections" as an example in the definition of the word "program."[23] Moreover, federal courts have entertained challenges to both federal and state prison conditions by handicapped prisoners under section 504.[24]

This Article analyzes the relationship between Section 504 of the Rehabilitation Act and the segregation of HIV-positive inmates when the segregation is justified on grounds that integration poses a risk of transmission of the virus to other inmates and prison staff. Part I discusses the dynamics of the segregation of HIV-positive inmates in four sections. The first section covers the epidemiology of HIV infection in correctional facilities, including statistics on the incidence and growth of the virus. The second section contains a discussion of the various responses of prisons to HIV infection, with an emphasis on the different types of segregation. The third section discusses the significance of the segregation of HIV-positive inmates, focusing on the harm that segregation causes. Finally, the fourth section addresses arguments other than the prevention of transmission that are asserted in defense of segregation.

The remainder of the Article concentrates on the first and second prongs of a section 504 violation.[25] Part II addresses whether HIV

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45 C.F.R. § 84.4(b) (1989). *See also* 28 C.F.R. § 42.503(b)(iii), (d) (1989) (Department of Justice regulations).

Finally, courts assume that the segregation of handicapped individuals is governed by section 504. *See, e.g.*, New York State Ass'n for Retarded Children v. Carey, 612 F.2d 644 (2d Cir. 1979).

22. 28 C.F.R. § 39.170(d)(ii) (1989). These regulations were promulgated by the Justice Department, pursuant to an amendment to the Act extending its application to programs conducted by all executive agencies.

23. 28 C.F.R. § 42.540(h) (1989).

24. *See, e.g.*, Bonner v. Lewis, 857 F.2d 559 (9th Cir. 1988) (whether failure to provide deaf inmate with qualified interpreter violates section 504 presents triable issue of fact); Harris v. Thigpen, 727 F. Supp. 1564, 1582–83 (M.D. Ala. 1990) (section 504 not violated by segregation of seropositive inmates); Kendrick v. Bland, 541 F. Supp. 21, 39–40 (W.D. Ky. 1981) (court ordered a study of measures needed to ensure the state penitentiary's compliance with section 504); Sites v. McKenzie, 423 F. Supp. 1190, 1197 (N.D. W. Va. 1976) (denial to plaintiff-prisoner of access to vocational rehabilitation programs for the allegedly mentally ill violates section 504).

25. I do not analyze what are the most easily answered and least interesting issues in this context—the third and fourth requirements mentioned above (that the discrimination occur in a program receiving federal financial assistance and be practiced on the basis of handicap). The analysis of this Article is only applicable where the prison in which the inmates are housed

positivity is a "handicap" under the Act. The discussion in Part II is divided into three sections: (1) formal definitions contained in the Act and implementing regulations; (2) coverage of symptomatic infection; and (3) coverage of asymptomatic HIV positivity. Part III considers whether HIV-positive inmates are "otherwise qualified" to be integrated into the general prison population. The discussion is divided into four sections: (1) who bears the burden of proving that the plaintiff is "otherwise qualified"; (2) the appropriate level of scrutiny to be given to the justifications offered by prison authorities; (3) whether the integration of HIV-positive inmates poses a significant risk of transmission of the virus in both the non-prison and prison contexts; and (4) the requirement that recipients of federal financial assistance provide reasonable accommodation for the handicapped.

I. THE DYNAMICS OF SEGREGATION: *WHO* IT AFFECTS, *WHAT* IT ENTAILS, AND *WHY* IT IS EMPLOYED

A. The Epidemiology of HIV Infection in Correctional Facilities

As of October 1, 1988, there had been a total of 3,136 AIDS cases among inmates in seventy responding federal, state, and local correctional systems in the United States.[26] The incidence rate of AIDS is higher in correctional systems than in the population at large because of the concentration in inmate populations of persons with histories of

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receives federal financial assistance, and the challenged segregation is practiced solely on the basis of HIV positivity. The definition of federal financial assistance has been construed broadly. *See, e.g.*, Consolidated Rail Corp. v. Darrone, 465 U.S. 624, 633 (1984) (antidiscrimination provision "should not be limited to programs that receive federal aid the primary purpose of which is to promote employment"); Arline v. School Bd. of Nassau County, 772 F.2d 759, 763 (11th Cir. 1985), *aff'd*, 480 U.S. 273 (1987) (where impact aid is deposited into a general fund, Act applies to all activities paid for out of that fund).

"Solely on the basis of handicap" refers to differential treatment of a handicapped individual by reason of the individual's status as a handicapped individual, i.e., a recipient of federal funds is not free to argue that the granting of benefits to the handicapped will lead to other burdens and it is because of those other burdens that the recipient is treating the handicapped person differently. *See* United States Dep't of Transp. v. Paralyzed Veterans of Am., 477 U.S. 597, 605 (1986) (" 'Congress apparently determined that it would require . . . grantees to bear the costs of providing employment for the handicapped . . . .' ") (quoting *Darrone*, 465 U.S. at 633 n.13). *See also* Kohl v. Woodhaven Learning Center, 672 F. Supp. 1226 (W.D. Mo. 1987) (refusal to admit hepatitis-B carrier to vocational program because of increased costs required to inoculate staff designated to work with plaintiff constitutes discrimination solely on the basis of handicap). If Congress had not intended this to be the case, section 504 would be ineffective because recipients could always try to justify failure to extend equal benefits to an individual with handicaps on the grounds of consequential burdens such as increased costs.

26. 1988 UPDATE, *supra* note 2, at 9.

high-risk behavior, particularly intravenous drug use.[27] The incidence rate of AIDS in the entire United States population was 13.3 cases per 100,000 persons in 1988, up from 8.6 in 1987 and 3.4 in 1985.[28] Incidence rates for individual states ranged from zero to thirty-nine per 100,000, with most states under ten. In state and federal correctional systems, incidence rates ranged from zero to 536 per 100,000, although more than one-half of the states had rates less than twenty-five and only eight had rates over 100. The aggregate incidence rate for these systems was seventy-five cases per 100,000 inmates in 1988, up from fifty-four in 1987.[29] Rates in city and county jail systems varied from zero to 2,038 cases per 100,000 in 1988, but one-half of the jurisdictions had rates under twenty-five. The aggregate incidence rate for all responding city and county systems was 183 per 100,000 inmates.[30] The growth in AIDS cases in correctional systems was slightly lower than that in the population at large from 1985 to 1986, 1986 to 1987, and 1987 to 1988.[31]

Ninety-five percent of inmate AIDS cases in the United States have been among men as of October 1988.[32] Virtually all inmate AIDS cases are thought to be related to intravenous drug use or sexual activity, with approximately two-thirds attributed to the former mode of transmission.[33] Accordingly, intravenous drug use is a much more critical transmission category in correctional AIDS cases than in AIDS in the population at large.[34]

The distribution of AIDS cases across the United States is very uneven,[35] although correctional AIDS cases have increased in all regions since 1985 and the regional distribution is less uneven than it was several years ago.[36]

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27. AIDS IN CORRECTIONAL FACILITIES, *supra* note 2, at 25; 1988 UPDATE, *supra* note 2, at 11.

28. 1988 UPDATE, *supra* note 2, at 11.

29. *Id.*

30. *Id.*

31. *Id.* at 9. The actual statistics are a 61% increase in correctional cases from 1985 to 1986 and a 79% increase in the population at large; a 59% increase in correctional cases from 1986 to 1987 and a simultaneous 61% increase in the general population; and a 60% increase in correctional cases from 1987 to 1988 and a 76% increase in the population at large. *Id.*

32. *Id.* at 11.

33. AIDS IN CORRECTIONAL FACILITIES, *supra* note 2, at 26; 1988 UPDATE, *supra* note 2, at 11.

34. AIDS IN CORRECTIONAL FACILITIES, *supra* note 2, at 26–28.

35. *Id.* at 23–24; 1988 UPDATE, *supra* note 2, at 11–12.

36. AIDS IN CORRECTIONAL FACILITIES, *supra* note 2, at 24; 1988 UPDATE, *supra* note 2, at 11–12.

These statistics are not necessarily reliable. Most correctional systems do not keep statistics on cases by year reported. Indeed, using the current number of AIDS cases among inmates may slightly underestimate the actual annual incidence rate in a correctional system.[37] Moreover, rapid population turnover makes statistics from city and county jail systems extremely suspect.[38] Finally, the method of calculating incidence rates per 100,000 population guarantees that a correctional system with a very small number of AIDS cases, the typical case, will have a somewhat higher rate than a much larger outside population with substantially more AIDS cases.[39]

The number of ARC cases among inmates is unclear because of definitional variations and uneven record-keeping. Those with ARC test positive for HIV, however, so they are included in statistics on HIV prevalence among correctional inmates. Although statistics on HIV prevalence are also not entirely clear, an increasing number of jurisdictions have instituted HIV antibody screening and testing programs. The aggregate results of mass screening programs by fourteen states and the Federal Bureau of Prisons show that HIV-prevalence rates among inmates varied from 0% to 5.2% with over half of the groups under 1%.[40] Figures derived from mass testing are generally comparable to estimated HIV-prevalence rates in the population at large.[41] Of those ten states that conducted and reported the results of blind epidemiological studies on new inmates, rates varied from 0% to 17%.[42] However, more than half the states reported rates of less than 1%.[43]

B. Prisons' Responses to HIV Infection

Responses to HIV infection in correctional facilities are diverse. Many systems still segregate all inmates with AIDS, while only a few segregate all asymptomatically infected inmates from the general population.[44] Several systems maintain HIV-positive inmates in the gen-

37. AIDS IN CORRECTIONAL FACILITIES, *supra* note 2, at 33 n.7.

38. *Id.* at 25.

39. *Id.*

40. 1988 UPDATE, *supra* note 2, at 13. These figures involved mandatory, identity-linked testing of all incoming inmates, all current inmates, or all releases. *Id.* at 14. However, these statistics must be viewed with caution because the correctional systems in the states with the largest number of AIDS cases have not undertaken mass screening programs. *Id.*

41. AIDS IN CORRECTIONAL FACILITIES, *supra* note 2, at 28.

42. 1988 Update, *supra* note 2, at 15.

43. *Id.*

44. *Id.* at 34; *see also* Appendices A & B.

eral population.[45] Moreover, in the past few years, there has been a trend away from blanket segregation policies toward case-by-case placement decision-making.[46] Increasingly, correctional systems base housing decisions on multiple objectives: providing care consistent with medical need, protecting the inmate from harm at the hands of others, and preventing transmission of HIV within the institution. At the same time, however, many systems are coming under significant pressure to segregate all asymptomatic HIV-positive and ARC inmates.[47]

1. Maintaining Inmates in the General Prison Population Without Special Programming or Restrictions

No state or federal systems maintain inmates with AIDS in the general population without special programming or restrictions. Sixteen percent have adopted such a policy for ARC victims, and 47% have adopted such a policy for asymptomatic HIV-infected inmates.[48] Four percent of city and county jail systems take this approach for AIDS victims, 14% for ARC victims, and 54% for asymptomatic HIV-positive inmates.[49]

As these statistics reveal, many systems maintain HIV-positive inmates, particularly those without symptoms, in the general prison population without any special provisions. A number of these prisons maintain all asymptomatic HIV-positive inmates and all inmates with ARC in the general population without special restrictions. A few systems presumptively house all three categories of HIV-infected inmates in the general population unless an individual's medical needs, safety, or high-risk behavior dictate otherwise. It is more common, however, to segregate AIDS cases and to presumptively house asymptomatic HIV-positive inmates and inmates with ARC in the general population with provision for their segregation when the above mentioned considerations dictate otherwise. This is the approach taken by the Federal Bureau of Prisons.[50]

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45. *Id.* at 34. Some of these systems provide special programming for these inmates or impose restrictions on them. *See infra* notes 53–54 and accompanying text (discussing what is meant by special programming).

46. *Id.* at 33.

47. AIDS IN CORRECTIONAL FACILITIES, *supra* note 2, at 84; 1988 UPDATE, *supra* note 2, at 33.

48. *See* Appendix A.

49. *See* Appendix B.

50. AIDS IN CORRECTIONAL FACILITIES, *supra* note 2, at 84–85. The 1988 UPDATE, *supra* note 2, did not update this information.

2. *Maintaining Inmates in the General Population with Special Programming*

Two percent of state and federal systems maintain AIDS victims in the general population with special programing, 18% take this approach for ARC victims, and 24% for inmates with asymptomatic HIV infection;[51] in city and county jail systems, 7% take this approach for AIDS, 7% for ARC and 11% for asymptomatic HIV infection.[52]

Special programming is designed to reduce the possibility that infected inmates will transmit HIV to others. For example, in a jurisdiction where housing two inmates per cell is prevalent, special programming may include housing inmates with HIV together. Other jurisdictions simply house them in single cells, as they do non-infected inmates.

Special programming may also include restrictions on work assignments. Forty-five percent of federal and state systems and 36% of city and county systems have adopted such a policy.[53] Restrictions include the exclusion of HIV-positive inmates from, among other things, food service, medical, dental, and laundry duties. Although correctional systems generally acknowledge that such restrictions are not medically necessary, they have been instituted to forestall any potential alarm in the prison population. Some systems exclude infected inmates from work release programs in the community in order to maintain public support for such programs.[54]

3. *Segregation*

Thirty-nine percent of state and federal prisons segregate all inmates with AIDS; 16% segregate all those with ARC; and 12% segregate all asymptomatic HIV-positive inmates.[55] Forty-six percent of city and county jails segregate all inmates with AIDS; 21% segregate all those with ARC; and 11% segregate all those with asymptomatic HIV infection.[56]

Every jurisdiction places inmates with confirmed AIDS diagnoses in some hospital or infirmary setting when they are seriously ill. Some states place these inmates in community hospitals; others states main-

51. *See* Appendix A.
52. *See* Appendix B.
53. AIDS IN CORRECTIONAL FACILITIES, *supra* note 2, at 86. The 1988 UPDATE, *supra* note 2, did not update this information.
54. AIDS IN CORRECTIONAL FACILITIES, *supra* note 2, at 85–86.
55. *See* Appendix A. These figures include hospitalization.
56. *See* Appendix B. Again, these figures include hospitalization.

tain them in correctional medical facilities, as does the Federal Bureau of Prisons; and still other states do both. Within medical facilities, some jurisdictions isolate and quarantine inmates with AIDS. At least two jurisdictions, California and New York City, have centralized the treatment of all inmates with AIDS in a single correctional medical facility.[57]

Though hospital and infirmary settings are generally designed for medical treatment and evaluation, some jurisdictions also use these facilities to separate inmates with AIDS from the general correctional population.

Of those jurisdictions adopting segregative policies, some admit AIDS cases to hospital facilities when the prisoners are acutely ill but return them to a non-hospital special unit in the correctional facility when they are in remission. Others mainstream them into the general prison population when the disease is in remission.

Some jurisdictions permanently segregate confirmed AIDS cases in either hospitals or administrative settings immediately upon diagnosis. Others apply this policy only to AIDS and ARC cases. Finally, a few systems, including Texas, permanently segregate all three categories of HIV-infected inmates.[58]

4. Case-by-Case Determination

Fifty-nine percent of state and federal systems employ a case-by-case policy for AIDS, 45% for ARC, and 16% for asymptomatic infection. Forty-three percent of city and county systems employ such a policy for AIDS, 50% for ARC, and 25% for asymptomatic infection.[59]

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57. AIDS IN CORRECTIONAL FACILITIES, *supra* note 2, at 87 (Vacaville State Prison in California and Rikers Island Hospital in New York).

58. *Id.* at 86–87. California's policy of housing all its HIV-positive inmates in one wing at the Correctional Medical Facility in Vacaville was challenged in the Second Amended Complaint at 23–24, 27–30, Gates v. Deukmejian, No. CIVS 87-1636 LKK-JFM (E.D. Cal. filed January 27, 1989) (on file with the *Washington Law Review*). The case settled and the consent decree provided for institution of a "pilot program" to determine the feasibility of placing HIV-positive inmates in a general population program at the prison. Screening for eligible inmates was to be done on a case-by-case basis, according to various criteria including: history of assaultive behavior; history of sexual behavior of a kind that poses a risk of transmission of the HIV virus; history of drug use or possession of intravenous drug paraphernalia; history of propensity to prey or be preyed upon; medical condition of the inmate, and the inmate's preference for segregation or integration. Consent Decree at 25–27, Gates v. Deukmejian, No. CIVS 87-1636 LKK-JFM (E.D. Cal. filed Dec. 8, 1989, approved by Judge Karlton Feb. 1990) (on file with the *Washington Law Review*). The decree also requires evaluation of the program nine to 11 months after the effective date of the agreement. *Id.* at 26. The outcome of that evaluation was not available before publication of this Article.

59. *See* Appendices A & B.

A range of considerations factor into such decisions, including the inmate's medical situation, safety, and likelihood of infecting others. Some jurisdictions make *all* housing and programming decisions on a case-by-case basis. Other jurisdictions have blanket policies of segregation for one or two of the three categories, with a policy of integrating others except when particularized considerations dictate otherwise. Some jurisdictions attempt to identify prisoners who might be victimized and to offer them special housing.[60]

A policy based on case-by-case determinations is flexible and recognizes that each case is unique. However, the lack of uniform policies may lead to concerns of arbitrary in decision-making.

C. The Harm Caused by Segregation

The burdens imposed by the segregation of HIV-positive inmates vary, depending on the circumstances of the segregation.[61]

1. Inferior Programs, Facilities, and Services

Experience has shown that it is difficult to offer a full range of programs and activities to segregated or separated inmates. Such inmates are commonly denied access to various programs and facilities, including work, education, religious services, recreation, law libraries, visits and conjugal visits.[62] For example, inmates in the "AIDS Wing" at Vacaville Prison in California alleged that they were subjected to worse housing conditions; they were denied access to the law library, the main exercise yard, and other facilities; they had less access to medical, psychiatric, and other services; their contact with peers and families was limited and often denied; and finally, they were deprived of opportunities for various therapeutic, occupational, educational, and rehabilitative activities and support services.[63]

One might argue that a denial of access to various benefits is a small hardship to impose to protect other inmates from a deadly disease. While this may be true where integration poses a significant risk of transmission of the disease, when transmission is not a threat, as the discussion below reveals, this denial of benefits is difficult to justify.

60. AIDS IN CORRECTIONAL FACILITIES, *supra* note 2, at 88.

61. In those situations where HIV-infected inmates remain in the general prison population, with or without special programming, they are generally treated like non-infected inmates, with like access to programs, facilities, and work assignments. *See supra* notes 48–54 and accompanying text.

62. 1988 UPDATE, *supra* note 2, at 36.

63. Second Amended Complaint, *supra* note 58, at 23–24, 28.

As the amount and extent of denied benefits decrease, the situation moves toward a "separate but equal" one. In such situations, it arguably takes a lower risk of transmission to justify segregation. Indeed, it is at least theoretically possible that HIV-infected inmates could be segregated in an entirely separate but equal setting. In such a situation, the harm to the segregated inmates is not a loss of services. However, other harms result.

2. Stigma

Judicial review of official segregation began with the separate but equal doctrine. In *Plessy v. Ferguson,*[64] the Supreme Court upheld a state statute requiring the racial segregation of railroad car passengers. The rationale for the decision was the lack of cognizable harm to the black plaintiffs because the facilities were objectively "equal."[65] More than half a century later, the Court was presented with the constitutionality of an objectively equal school system segregated on the basis of race in the landmark case of *Brown v. Board of Education.*[66] The Court found segregated public education to be "inherently unequal" because it imposed irreparable harm on the black minority, "generat[ing] a feeling of inferiority as to their status in the community."[67] Although *Brown* involved a racial classification and thus is not controlling in this situation, the case presumed that a segregative classification imposes stigma on the racial minority.

Perpetuation of a system that separates and isolates those infected with HIV can be based on a variety of stigmatic assumptions. Society has responded to AIDS with a concern bordering on hysteria.[68] AIDS has become a national obsession.[69] The repeated assertions of medical specialists that large quantities of the virus are needed to transmit the disease, that those quantities are transmitted only through blood and semen, and that casual contact does not result in infection, has not quieted the public's anxiety.[70]

This hysteria is exacerbated in the prison setting where drug abuse and homosexual activity are more common and where inmates and

64. 163 U.S. 537 (1896).

65. *Id.*

66. 347 U.S. 483 (1954), *supplemented,* 349 U.S. 294 (1955).

67. *Brown,* 347 U.S. at 494.

68. *Disease Detectives: The AIDS Hysteria,* TIME, July 4, 1983, at 50; J. Schwartz, *The AIDS Scare—Fear of Contracting Disease Spreading Across the Country,* Poughkeepsie J., July 4, 1983, at 9.

69. Pear, *Health Chief Calls AIDS Battle 'No.1 Priority',* N.Y. Times, May 25, 1983, at A1, col. 3.

70. Langone, *AIDS Special Report,* DISCOVER, Dec. 1985, at 28–32.

staff live and work in close and often unsanitary quarters. When patients with AIDS are discovered in the prison setting, there is a crescendo of concern leading to panic on the part of prisoners, correctional staff, and medical staff.[71] In Tallahassee, Florida, prisoners almost rioted when prison guards ordered them to remove the mattress of a prisoner believed to have AIDS.[72] In New Jersey, prisoners fear contracting AIDS from dirty dishes and often bring their own utensils to meals.[73] A Minnesota prison imposed a ten-day lockup to prevent panic after the state prison's first AIDS-related case was diagnosed. The diagnosis caused unrest among inmates and rumors of such demonstrations as mass movements to sick call.[74]

These responses lay bare the stigma associated with this disease. Moreover, the societal groups most heavily hit by the disease, homosexuals and intravenous drug users, are themselves socially stigmatized groups. In sum, the disease presents a grave risk that responses are motivated by panic and fear, rather than by judgments based on a careful assessment of the risks involved in integration. "The isolation of the chronically ill and of those perceived to be ill or contagious appears across cultures and centuries, as does the development of complex and often pernicious mythologies about the nature, cause, and transmission of illness."[75] HIV infection is susceptible to repetition of that pattern. For this reason, decisions that single out those with the disease for special treatment must be tested against reality rather than myth.

3. Diminished Rehabilitation and Reintegration

Prison systems and corrections experts are split between rehabilitation-oriented systems and punishment-oriented ones, with the current trend favoring the latter.[76] Because release follows incarceration for most prisoners, however, under any set of correctional objectives society must be concerned about the reintegration of inmates into society as a matter of sound policy. Segregation of HIV-positive inmates is inimical to reintegration because it produces an environment that does

71. Pear, *Prisons Are on the Alert Against AIDS,* N.Y. Times, Jan. 12, 1986, at 28E, col. 1.

72. Patton, *Prison Health and AIDS,* Gay Community News, Apr. 7, 1984, at 6.

73. *Id.*

74. Williams, *AIDS in Prison: Coping with a Strange New Death Penalty,* CORRECTIONS COMPENDIUM, Feb. 1986, at 1–2.

75. School Bd. of Nassau County v. Arline, 480 U.S. 273, 284 n.12 (1987) (citing R. DUBOS & J. DUBOS, THE WHITE PLAGUE (1952); S. SONTAG, ILLNESS AS METAPHOR (1978)).

76. *See* Frank, *The American Prison: The End of an Era,* FED. PROBATION, Sept. 1979, at 3, 5.

not correspond to the world that prisons are preparing inmates to reenter and thereby makes the readjustment more difficult.

Although AIDS is classified as a fatal disease, the concern about reintegration remains applicable: many HIV-infected people remain asymptomatic for many years and even full-fledged AIDS cases can go into remission for extended periods of time.

Moreover, the segregation of these inmates may run counter to the goals of rehabilitation by further souring the infected prisoners against society both because of the perceived message that these inmates are not "fit" for integration and because an environment characterized by a fatal disease is unlikely to be a regenerative one.

4. Punishment of Status

American jurisprudence is characterized by a distaste for a penal system that imposes punishment on the basis of status. In *Robinson v. California,*[77] the Supreme Court ruled that it violated the cruel or unusual punishment clause to punish someone for being a narcotics addict. The Court focused on the illegitimacy of punishing someone for having a disease:

> It is unlikely that any State at this moment in history would attempt to make it a criminal offense for a person to be mentally ill, or a leper, or to be afflicted with a venereal disease. A State might [require treatment]. But . . . a law which made a criminal offense of such a disease would doubtless be universally thought to be an infliction of cruel and unusual punishment in violation of the eighth and fourteenth amendments.[78]

Although cruel and unusual punishment challenges to segregation have failed,[79] *Robinson* reveals a fundamental value of our penal system. Segregation on the basis of a fatal, contagious disease, about which little is known, presents a high risk of being a fearful, ignorant effort to punish the victims of the disease. Accordingly, prison authorities ought to explore alternatives to segregation and the courts ought to carefully examine segregative policies.

D. Other Arguments Supporting Segregation

Various justifications other than the prevention of transmission of HIV are asserted on behalf of blanket segregation: (1) hospitalization is medically indicated for infected inmates; (2) segregation protects HIV-infected inmates from the attacks of other inmates; and (3) segre-

77. 370 U.S. 660 (1962).
78. *Id.* at 667.
79. *See supra* note 8 and accompanying text.

gation protects the infected inmates from common viruses that occasionally sweep through the general prison population, to which HIV-infected individuals are more susceptible.

It is difficult, and perhaps unwise, to assess these justifications in the abstract. A decision on whether to segregate, as with all other policy decisions, involves a balancing of competing interests. My thesis is not that segregation is *never* justified; rather, it is that intelligent, reasoned policy choices, instead of ignorant, rash decisions, are warranted in response to a disease like AIDS. Moreover, the gravity of the burdens imposed by segregation militate in favor of segregation only when other reasonable procedures cannot eliminate the feared danger.

In some situations, the harms detailed above are outweighed by the interest in segregation, for example, when hospitalization is required for medical reasons. In such cases, the prison authorities' justification for segregation is to protect the health of the inmate rather than to protect other inmates from the risk of transmission. Moreover, the ramifications of hospitalization can be minimized by returning an HIV-infected person whose symptoms have gone into remission into a different facility so other inmates would not be aware that the inmate was infected. Various jurisdictions have experimented positively with this approach.[80]

When segregation is justified on the ground that it protects HIV-positive inmates from the attacks of other inmates, there are means less discriminatory than a blanket policy of segregation. For example, the segregation of aggressors rather than their victims, increased surveillance, and segregation on a case-by-case basis when other options are either unreasonable or ineffective, more adequately accommodate the competing interests.

A blanket segregation policy is difficult to justify in terms of protecting infected inmates from viruses. Inmates whose disease has progressed to the point of inability to fight off infection are generally hospitalized, while those who are asymptomatic manage without incident in the general population. If the individual is particularly susceptible to common viruses, segregation may be justified—but the individual risk does not justify a blanket segregation policy.

In sum, prisons quite readily resort to blanket segregation policies for one or more of the AIDS-related categories. Such segregation has grave consequences. Moreover, a blanket policy of segregation is not justifiable as a means to protect infected inmates from other inmates or

80. AIDS IN CORRECTIONAL FACILITIES, *supra* note 2, at 87–88.

from common viruses. Whether it is justifiable as a means to prevent transmission of the virus is discussed later in this Article.

II. HIV POSITIVITY IS A "HANDICAP" UNDER THE ACT

A. Definitions Under the Act

The Act defines "handicapped individual"[81] as "any person who (i) has a physical . . . impairment which substantially limits one or more of [his or her] major life activities, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment."[82] Department of Health and Human Services regulations define "physical impairment" to mean any "physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine."[83] In addition, the regulations define "major life activities" as "functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."[84]

Individuals "regarded as having . . . an impairment" include:

> those persons who do not in fact have the condition which they are perceived as having as well as those persons whose mental or physical condition does not substantially limit their life activities and who thus are not technically within [the first clauses of the definition]. Members of both of these groups may be subjected to discrimination on the basis of their being regarded as handicapped.[85]

The regulations state:

> "Is regarded as having an impairment" means (A) has a physical or mental impairment that does not substantially limit major life activities

81. The only case that has addressed whether the segregation of HIV-positive inmates violated section 504 assumed that the plaintiffs were "handicapped." Harris v. Thigpen, 727 F. Supp. 1564, 1582 (M.D. Ala. 1990). The court offered no analysis of this issue, although the issue poses interesting questions especially as to asymptomatic carriers.

82. 29 U.S.C. § 706(8)(B) (1989). This section begins with the substantive requirements under this element rather than with a discussion of which party bears the burden of proof on the issue. Unlike the discussion of the "otherwise qualified" element, the law in this area is clearly established and not muddled by a split of authority: the plaintiff's prima facie case must include a showing that he or she is handicapped under the Act. Pushkin v. Regents of Univ. of Colo., 658 F.2d 1372, 1387 (10th Cir. 1981); Doe v. New York Univ., 666 F.2d 761, 776 (2d Cir. 1981).

83. 45 C.F.R. § 84.3(j)(2)(i)(A) (1989).

84. *Id.* § 84.3(j)(2)(ii).

85. S. REP. NO. 1297, 93d Cong., 2d Sess. 39, *reprinted in* 1974 U.S. CODE CONG. & ADMIN. NEWS 6373, 6389–90.

> but that is treated by a recipient as constituting such a limitation; (B) has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment; or (C) has none of the impairments defined in paragraph (j)(2)(i) of this section but is treated by a recipient as having such an impairment.[86]

B. Symptomatic Disease that Limits Major Life Activity

In *School Board of Nassau County v. Arline,*[87] the Supreme Court decided that the Act covered symptomatic, contagious diseases. In *Arline*, the plaintiff was hospitalized in 1957 for tuberculosis. The disease went into remission for the next twenty years, during which time the plaintiff began teaching school. After a series of relapses, she was discharged by the defendant school board because of the continued recurrence of the disease. She brought suit alleging a section 504 violation. The Court found that the plaintiff's hospitalization for a respiratory illness in 1957 sufficed to establish that she had a record of impairment which substantially limited one or more of her major life activities.[88] In response to the defendant's argument that the contagious nature of the handicap removed it from section 504's coverage, the Court ruled that Congress was as concerned about the effect of an impairment on others as it was about its effect on the individual.[89] The Court reasoned that Congress' inclusion of those who are regarded as impaired reveals its acknowledgement that "society's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairment."[90]

HIV infection has no independent symptoms except dementia similar to that found in Alzheimer's Disease. Otherwise, an AIDS diagnosis is based on the presence of "indicator diseases" found in individuals whose immune systems are compromised. The two most common indicator diseases are pneumonia and Kaposi's sarcoma, a form of skin cancer. Other AIDS indicator diseases include progressive, seriously disabling, and even fatal conditions.[91]

Thus, both symptomatic AIDS sufferers and those who were formerly symptomatic but whose symptoms have relapsed are covered by

86. 45 C.F.R. § 84.3(j)(2)(iv) (1989).
87. 480 U.S. 273 (1987).
88. *Id.* at 281.
89. *Id.* at 284.
90. *Id.*
91. AIDS IN CORRECTIONAL FACILITIES, *supra* note 2, at 5.

the Act. The former have, and the latter have a record of, a physical impairment, here, a physiological disorder that affects the hemic, lymphatic, and reproductive systems.[92] Moreover, this impairment substantially limits one or more of his or her major life activities. When an impairment is serious enough to require hospitalization, it is "more than sufficient to establish" a substantial limitation on one or more of the major life activities.[93] And even when symptoms do not lead to or necessarily require hospitalization, once HIV positivity has progressed to an AIDS diagnosis, one or more seriously disabling conditions are present. Accordingly, both prior and subsequent to *Arline,* lower courts have ruled that symptomatic AIDS is a handicap under the Act.[94]

C. ARC and Asymptomatic HIV Infection

Those who have tested positive for the virus and are either asymptomatic or whose symptoms are not grave enough to require hospitalization, or to substantially limit one or more major life activity, pose a more difficult question.[95] Specifically mentioning AIDS, the *Arline* Court expressly did not rule on whether a carrier of a contagious disease could be considered to have a physical impairment, or whether such a person could be considered, solely on the basis of contagiousness, a handicapped person as defined by the Act.[96] In *Arline,* the handicap gave rise both to a physical impairment and to contagiousness.[97]

It is clear that HIV positivity, whether symptomatic or not, is a "physical impairment" under the Act. Regulations defining "impairment" do not require symptoms as evidence of adverse physiological effects.[98] While the disorder or condition must affect the body in some way, the regulations do not say this effect must be perceptible to the afflicted individual.[99] The use of such neutral terms as "condition" and "affect," which do not speak of symptoms or adverse physiologi-

92. Brief Amici Curiae of Doctors for AIDS Research and Education at 43, *Arline,* 480 U.S. 273 (No. 85-1277) [hereinafter Brief Amici Curiae].

93. *Arline,* 480 U.S. at 281.

94. *See, e.g.,* Martinez v. School Bd., 861 F.2d 1502 (11th Cir. 1988); Chalk v. United States Dist. Court, 840 F.2d 701 (9th Cir. 1988); Thomas v. Atascadero Unified School Dist., 662 F. Supp. 376 (C.D. Cal. 1987); District 27 Community School Bd. v. Board of Educ., 130 Misc. 2d 398, 502 N.Y.S.2d 325 (Sup. Ct. 1986).

95. For additional discussion of this subject, see Note, *Asymptomatic Infection with the AIDS Virus as a Handicap Under the Rehabilitation Act of 1973,* 88 COLUM. L. REV. 563 (1988).

96. *Arline,* 480 U.S. at 282 n.7.

97. *Id.* at 282.

98. *See supra* note 83 and accompanying text.

99. *Id.*

cal effects, suggests that "impairment" can cover both symptomatic and asymptomatic illness.

Even when asymptomatic, HIV infection adversely affects the hemic, lymphatic, and reproductive systems.[100] The mere presence of the virus results in a heightened risk of future symptomatic illness and in an impaired ability to fight infection and a consequential increased risk of contracting outside infection.[101] Moreover, the danger of contagion makes reproduction and sexual intercourse dangerous activities because of potential transmission.[102] Thus, asymptomatic HIV infection would qualify as a "physical impairment" under the Act.

In order to be a "handicap," the physical impairment must substantially limit a major life activity.[103] These activities are those that are a normal and integral part of life.[104] Asymptomatic disease would qualify as substantially limiting a major life activity on either of two alternate grounds: HIV positivity is a physical impairment that substantially limits a major life activity although not outwardly so; or HIV-positive persons, when they are treated differently than uninfected persons and are thereby substantially limited, or perceived to be limited, in a major life activity, are being "regarded as having . . . [such] an impairment."[105]

In support of the former argument, asymptomatic HIV infection limits the major life activities of sexual intercourse and reproduction because of the risk of transmission in these activities.[106] While the regulations do not explicitly include these activities as "major life activities," that list is not exhaustive. The fundamental importance generally attached to sexual and reproductive activity mandates their inclusion.

Courts have accepted this reasoning, albeit in dicta. In *Thomas v. Atascadero Unified School District,*[107] the court stated that "[e]ven those who are asymptomatic have abnormalities in their hemic and reproductive systems making procreation and childbirth dangerous to themselves and others." And in *Local 1812, American Federation of*

100. Brief Amici Curiae, *supra* note 92, at 43.

101. Redfield, Wright & Tramont, *The Walter Reed Staging Classification for HTVL-III/LAV Infection,* 314 NEW ENG. J. MED. 131, 132 (1986).

102. *See infra* notes 182–83, 188 and accompanying text.

103. *See supra* notes 82–84 and accompanying text.

104. 45 C.F.R. § 84.3(j)(2)(ii) (1989).

105. That is, the first two sections of the regulations defining "is regarded as having an impairment" would apply. 45 C.F.R. 84.3(j)(2)(iv)(A)–.3(j)(2)(iv)(B) (1989). *See supra* note 88 and accompanying text.

106. *See infra* notes 182–83, 188 and accompanying text.

107. 662 F. Supp. 376, 379 (C.D. Cal. 1987).

Government Employees v. United States Department of State,[108] the court found that the "great majority of HIV carriers are physically impaired and handicapped . . . due to measurable deficiencies in their immune systems, even where disease symptoms have not yet developed."[109]

Case law, legislative history and controlling regulations also support the second argument, that is, that differential treatment of one with a contagious disease on the basis of fear of contagion, such that he or she is thereby rendered unable, or perceived as unable, to engage in a major life activity, renders that person handicapped under the Act.

The definition of "handicapped individual" under section 504 was amended to include one "regarded as having . . . an impairment [which substantially limits one or more of a person's major life activities]." This change reflected congressional concern with protecting the handicapped against discrimination stemming not only from simple prejudice, but from "archaic attitudes and laws" and from "the fact that the American people are simply unfamiliar with and insensitive to the difficulties confront[ing] individuals with handicaps."[110] Thus, this section precludes discrimination against "those persons who do not in fact have the condition which they are perceived as having, as well as those persons whose mental or physical condition does not substantially limit their life activities."[111] Moreover, the regulations define "is regarded as having an impairment" to include actual as well as perceived impairment.[112]

While explicitly avoiding the issue of asymptomatic infection, the *Arline* Court implicitly supported its inclusion by stressing that the attitudes of others towards a handicap, and not merely the effect of the handicap on the afflicted individual, were important in determining the Act's coverage.[113] In response to the defendant's argument that the contagiousness of plaintiff's tuberculosis removes the disease from coverage as a "handicap," the Court wrote:

> [S]ociety's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairment. Few aspects of a handicap give rise to the same level of public fear and misapprehension as contagiousness. Even those who

108. 662 F. Supp. 50, 54 (D.D.C. 1987).

109. *Id.*

110. S. REP. NO. 1297, 93d Cong., 2d Sess. 50, *reprinted in* 1974 U.S. CODE CONG. & ADMIN. NEWS 6373, 6400.

111. *Id.* at 39, *reprinted in* 1974 U.S. CODE CONG. & ADMIN. NEWS at 6389–90.

112. 45 C.F.R. § 84.3(j)(2)(iv) (1989).

113. School Bd. of Nassau County v. Arline, 480 U.S. 273, 282 (1987).

> suffer . . . from noninfectious diseases . . . have faced discrimination based on the irrational fear that they might be contagious. The Act is carefully structured to replace such reflexive reactions to actual or perceived handicaps with actions based on reasoned and medically sound judgments. . . . [E]xclusion [of contagious persons] would mean [they] would never have the opportunity to have their condition evaluated in light of medical evidence and a determination made as to whether they were "otherwise qualified."[114]

In *Arline,* the plaintiff was denied her job because school authorities feared contagion;[115] "working" is included in the regulations' list of "major life activities."[116] On such a reading, the fear or prejudice is seen either as the cause of a substantial limitation of a major life activity, or as leading to treatment of the handicapped individual as substantially limited in a major life activity.

Under such a rationale, asymptomatic HIV-positive inmates who are segregated from the general prison population would also qualify as "handicapped." The segregation is denying these inmates their right to, among other things, speak and interact with other inmates. Moreover, the inmates are being *treated* as substantially limited in their ability to speak and interact with the other inmates.

Courts have adopted such reasoning. In *Doe v. Centinela Hospital,*[117] the court found that an asymptomatic HIV-positive plaintiff excluded from the defendant's residential school and drug rehabilitation program was handicapped under the Act because the defendant perceived the plaintiff as having a substantially limited ability to learn how to deal with dependency problems in that particular program. Similarly, in *Doe v. Dolton Elementary School District No. 148,*[118] the court found that denial of interaction with other schoolchildren substantially limited the major life activity of interaction. Although the child in *Dolton* had developed AIDS by the time the court issued its determination of whether a preliminary injunction should issue, the court made clear that the plaintiff child qualified as "handicapped" on grounds that the child's impairment itself limited a major life activity, and on alternate grounds that the child was being regarded as limited in a major life activity.[119]

114. *Id.* at 284–85.

115. *Id.* at 291 n.3 (Rehnquist, J., dissenting).

116. 45 C.F.R. § 84.3(j)(2)(i)(A) (1989).

117. No. 87-2514 (C.D. Cal. July 7, 1988) (LEXIS, Genfed library, Dist file).

118. 694 F. Supp. 440 (N.D. Ill. 1988).

119. *Id.* at 444–45.

Cases analyzing asymptomatic conditions other than HIV infection also support this reasoning. In *Kohl v. Woodhaven Learning Center,*[120] the court held that asymptomatic infection with the contagious virus hepatitis-B is a handicap because others' fear of the impairment substantially limited the plaintiff's ability to work and learn.[121] Finally, other cases support a general finding that asymptomatic HIV infection is considered a "handicap" under the Act although the cases were not explicit about the rationale. In *Ray v. School District,*[122] the district court granted a preliminary injunction on behalf of two asymptomatic HIV-positive children who had been barred from attending public school. The children claimed discrimination under both the Act and the Constitution. The court did not consider the merits of any particular legal theory, but concluded that the children were likely to succeed on the merits.[123] And in *District 27 Community School Board v. Board of Education,*[124] the court stated that asymptomatic HIV carriers were protected by the Act because they "ha[ve] a history of, or ha[ve] been misclassified as having" a handicap.[125]

In conclusion, HIV infection, whether symptomatic or asymptomatic, ought to be considered a "handicap" under section 504. Such a finding would follow from congressional concern that the response of society to a handicap is as debilitating as a handicap itself.

III. THE "OTHERWISE QUALIFIED" ELEMENT

The most critical issue in this context is whether HIV-positive inmates are qualified for integration in spite of their HIV positivity. Section 504 does not prohibit an institution from requiring physical qualifications for admission to a program.[126] "Section 504 . . . does not compel . . . institutions to disregard the disabilities of handicapped individuals or to make substantial modifications in their programs to allow disabled persons to participate . . . . An otherwise qualified person is one who is able to meet all of a program's requirements *in spite of* his handicap."[127]

120. 672 F. Supp. 1226 (W.D. Mo. 1987).

121. *Id.* at 1236.

122. 666 F. Supp. 1524 (M.D. Fla. 1987).

123. *Id.* at 1536.

124. 130 Misc. 2d 398, 502 N.Y.S.2d 325 (Sup. Ct. 1986).

125. *Id.* at 415, 502 N.Y.S.2d at 336 (quoting Department of Education regulations).

126. Southeastern Community College v. Davis, 442 U.S. 397 (1979).

127. *Id.* at 405–06 (emphasis added).

A. Burden of Proof

This section begins with a discussion of who bears the burden of proving that the plaintiff is or is not otherwise qualified—that is, qualified in spite of his or her handicap—for three reasons: the issue is somewhat muddled; there is a split of authority; and it would prove pivotal in a challenge to the segregation of HIV-positive inmates.

In cases where the defendant disclaims reliance on the handicap as a factor in the alleged discrimination, courts typically rely on authority developed under Title VII.[128] Thus, in such section 504 cases, the plaintiff must establish a prima facie case of a violation by showing that she was otherwise qualified and that she was discriminated against because of her handicap. The burden of production then shifts to the defendant, who must demonstrate a legitimate, nondiscriminatory reason for his action.[129] The plaintiff retains the "ultimate burden of proving by a fair preponderance of the evidence that the defendant discriminated against her on the basis of an impermissible factor."[130]

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128. Under Title VII, once the plaintiff establishes a prima facie case of discrimination, by showing, inter alia, that he or she was qualified for the job, the burden shifts to the defendant to articulate some legitimate, nondiscriminatory reason for rejecting the plaintiff. The plaintiff then bears the burden of proving that the defendant's stated reason is a pretext for a racially discriminatory decision. McDonnell Douglas Corp. v. Green, 411 U.S. 792, 802–04 (1972).

129. *See, e.g.*, Reynolds v. Brock, 815 F.2d 571, 574 (9th Cir. 1987).

130. Doe v. New York Univ., 666 F.2d 761, 776 (2d Cir. 1981). This paradigm applies to "disparate treatment" cases, where the plaintiff alleges that the defendant intentionally discriminated against the particular plaintiff on the basis of an impermissible factor.

Contrast this with "disparate impact" cases, where the plaintiff challenges otherwise neutral criteria on grounds that the criteria disproportionately exclude members of a protected group. In Title VII cases, the plaintiff must make out a prima facie case of discrimination by demonstrating that the application of a specific or particular employment practice creates a significant disparate impact on a protected group. Wards Cove Packing Co. v. Atonio, 109 S. Ct. 2115, 2124–25 (1989). The burden then shifts to the employer to produce evidence of a business justification for the employment practice. *Id.* at 2126. There is no requirement that the challenged practice be indispensable or essential to the employer's business, but it must serve, in a significant way, the legitimate employment goals of the employer. *Id.* at 2125–26. The burden of proving that discrimination against a protected group has been caused by a specific employment practice remains with the plaintiff at all times. *Id.* at 2126. If the plaintiff cannot persuade the trier of fact on the question of the defendant's business necessity defense, the plaintiff can still prevail by persuading the factfinder that other tests or selection devices, without a similarly undesirable effect, would also serve the employer's legitimate interests, thereby demonstrating that the employer was using the test as a pretext for discrimination. *Id.*

Now that the law on burden-shifting in disparate impact cases is clear in the context of Title VII, section 504 may follow suit. At present, jurisdictions are not in accord on the burden of proof allocation in section 504 disparate impact cases. In Sisson v. Helms, 751 F.2d 991, 992–93 (9th Cir. 1985), the court applied the burden shifting scheme adopted in *Wards Cove* in the context of section 504. However, in Prewitt v. United States Postal Service, 662 F.2d 292, 309–10 (5th Cir. 1981), the court held that once a plaintiff makes out a prima facie case of handicap discrimination, the burden of *persuasion* shifts to the federal employer to show that the

However, in cases where the defendant acknowledges that the handicap was a central factor in the decision, as in the case of the segregation of HIV-positive inmates, this analysis is inapplicable. In such cases, the pivotal issue is whether the defendant was justified in relying on the handicap, rather than whether the defendant relied on a handicap at all. The analogue to this type of case under Title VII would be the bona fide occupational qualification (BFOQ) exception:[131] the defendant admits that the plaintiff was disparately treated but argues that the treatment is justified. An employer can rely on the BFOQ exception only by proving that "he had reasonable cause to believe, that is, a factual basis for believing, that all or substantially all [members of the protected group] would be unable to perform safely and efficiently the duties of the job involved."[132]

There is a good argument that the burden of proof ought to be allocated similarly in a section 504 challenge to the segregation of HIV-positive inmates. The allocation of the burden of proof in disparate treatment cases is the same for both statutes.[133] However, because section 504 does not expressly create a BFOQ defense, the analogy is not entirely persuasive. Furthermore, the analogy is complicated by the fact that "otherwise qualified" has two potential meanings: that the plaintiff is qualified apart from the handicap, or that the plaintiff is qualified in spite of the handicap. The Supreme Court in *Southeastern Community College v. Davis*[134] interpreted the "otherwise qualified" element under section 504 to have the latter meaning rather than the former.[135] Thus, some courts that impose the burden of proof of the "otherwise qualified" element on the defendant nevertheless require the plaintiff to prove that he is qualified apart from the handicap.[136]

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physical criteria offered as justification for refusal to hire the plaintiff are job related such that persons who suffer from the handicap cannot safely and efficiently perform the essentials of the position in question. The plaintiff may then show that other selection criteria without a similar discriminatory effect would also serve the employer's legitimate interest. Moreover, the burden of proving the inability to reasonably accommodate the handicap remains on the employer. *Id.*

131. 42 U.S.C. § 2000e-2(e) (1982) provides in pertinent part:

> Notwithstanding any other provision of this subchapter, (1) it shall not be an unlawful employment practice for an employer to hire and employ employees . . . on the basis . . . [of a covered classification] where [the classification] is a bona fide occupational qualification reasonably necessary to the normal operation of that particular business or enterprise.

132. Weeks v. Southern Bell Tel. & Tel. Co., 408 F.2d 228, 235 (5th Cir. 1969), *quoted with approval in* Dothard v. Rawlinson, 433 U.S. 321, 333 (1977); *see also* Phillips v. Martin Marietta Corp., 400 U.S. 542 (1971).

133. *See supra* notes 128–30 and accompanying text.

134. 442 U.S. 397 (1979).

135. *Id.* at 406.

136. *See, e.g.*, Pushkin v. Regents of the Univ. of Colo., 658 F.2d 1372, 1387 (10th Cir. 1981).

There is a split of authority as to where the burden of proving that the plaintiff is or is not qualified in spite of the handicap falls. Many courts follow the BFOQ burden of proof allocation although none draw the analogy. In the Ninth Circuit, an employer has the burden of proving that a blanket policy of exclusion is reasonably required to protect the health and safety of those who are denied jobs or terminated from employment.[137] Notwithstanding that the Ninth Circuit relied on regulations pertaining specifically to "job qualifications" and the importance of preserving job opportunities for the handicapped in so holding,[138] California federal district courts, even in non-employment contexts, impose the burden of proof on the defendant. In one case, the court interpreted *Bentivegna* to stand for the proposition that whenever the defendant based his decision on a blanket policy of exclusion, he has the burden of proof on the "otherwise qualified" element.[139] In another case, the parents of a child infected with AIDS challenged the school officials' decision not to allow the child to attend regular kindergarten classes. The court held that the school had the burden of demonstrating that the child was not "otherwise qualified" to attend kindergarten.[140]

Various other circuits agree with this determination. The Tenth Circuit held that once the plaintiff establishes a prima facie case of discrimination by showing that he was qualified apart from his handicap and was rejected on the basis of that handicap, the burden of proof shifts to the defendant to show that the plaintiff was not otherwise qualified, i.e., was not able to meet all of the program's requirements in spite of his handicap.[141] The court found that such a holding followed from *Southeastern Community College v. Davis*.[142] Similarly, in *Treadwell v. Alexander*,[143] the Eleventh Circuit held that once the

137. Bentivegna v. United States Dep't of Labor, 694 F.2d 619, 622 (9th Cir. 1982) (City of Los Angeles's policy of terminating diabetics who did not have their blood sugar under "control" did not pass such a test).

138. *Id.* at 621.

139. Doe v. Centinela Hosp., No. 87-2514 (C.D. Cal. July 7, 1988) (LEXIS, Genfed library, Dist file) (whether defendant hospital's exclusion of all HIV-positive patients from its residential alcohol and drug rehabilitation program discriminated against patients who are "otherwise qualified" presented a triable issue).

140. Thomas v. Atascadero Unified School Dist., 662 F. Supp. 376, 381 (C.D. Cal. 1986).

141. Pushkin v. Regents of the Univ. of Colo., 658 F.2d 1372, 1387 (10th Cir. 1981) (university violated Act when it denied plaintiff admission to psychiatric residency program because he suffered from multiple sclerosis).

142. 442 U.S. 397 (1979), *cited in Pushkin*, 658 F.2d at 1386. *See also* Daubert v. United States Postal Serv., 733 F.2d 1367, 1368–70 (10th Cir. 1984) (burden met by defendant in discharge of employee with serious back injury where job required strenuous physical activity).

143. 707 F.2d 473 (11th Cir. 1983).

plaintiff shows that an employer denied him employment because of a physical condition, the burden of persuasion shifts to the employer to show that the criteria used were job related and that the plaintiff could not safely and efficiently perform essential job requirements.[144] The court went on to find that the defendant met this burden in rejecting the plaintiff's application for an engineering position due to his nervousness and heart conditions.[145]

Not all courts, however, agree with such an allocation of the burden of proof. In *Doe v. New York University,*[146] the plaintiff challenged her discharge from medical school for psychiatric and medical disorders. The court agreed that the plaintiff must first make out a prima facie case of discrimination by showing that she was qualified apart from her handicap and was denied admission or employment. However, once the burden shifts to the defendant, the institution or employer need only produce evidence that the handicap was relevant to qualifications for the position sought. The plaintiff bears the ultimate burden of showing by a preponderance of the evidence that she was qualified in spite of the handicap.[147]

In sum, a determination of who bears the burden of proof on the otherwise qualified element would depend on the law in the jurisdiction where the case is brought.

B. The Level of Scrutiny

To assess the justification that segregation is required to protect the health of other inmates and prison staff, a court would need to determine what level of scrutiny it will apply to justifications offered by prison authorities.

1. Non-Prison Context

In *Southeastern Community College v. Davis,* the Court waffled on the issue of the appropriate level of scrutiny in section 504 cases, asking whether the physical qualifications being demanded of the plaintiff

144. *Id.* at 475.

145. *Id.* at 477.

146. 666 F.2d 761 (2d Cir. 1981).

147. *Id.* at 776–77; *see also* Strathie v. Department of Transp., 716 F.2d 227, 230 (3d Cir. 1983) (holding that the reasons advanced for suspension of the handicapped plaintiff must go to the essential purpose of the program); *cf.* New York State Ass'n for Retarded Children v. Carey, 612 F.2d 644, 649 n.5 (2d Cir. 1979) (not reaching the issue of where burden of proof falls but noting that the Act's enactment within a few months of the Supreme Court's Title VII decision in McDonnell Douglas Corp. v. Green, 411 U.S. 792 (1973), must imply that Congress was aware of the case's implications for section 504).

were necessary for participation in the program,[148] yet stating its holding as "an educational institution [can] require reasonable physical qualifications for admission to a clinical training program."[149] Although many courts address claims of section 504 violations without a determination of what level of scrutiny is due the offered justifications, the weight of the little authority there is on the issue in the non-prison context holds that heightened scrutiny is appropriate. The Ninth Circuit has explicitly rejected the rational scrutiny test, finding that "[a]n action challenged as discriminatory under the Rehabilitation Act must be given rigorous scrutiny."[150] Similarly, the Tenth Circuit has held that application of rational basis scrutiny would "ignore the plain statutory language of § 504."[151] The Second Circuit refused to determine the precise level of scrutiny appropriate in section 504 cases, but required "at least some substantial showing" that the challenged action or scheme is justified.[152] Finally, in *Garrity v. Gallen,*[153] the court issued two conflicting holdings on this issue in the same case: the rules under section 504 governing discrimination against the handicapped appear to be governed by a " 'reasonableness' standard,"[154] and "Congress implicitly requires courts to apply heightened judicial scrutiny—at least equivalent to that degree of scrutiny applied in sex discrimination cases—to allegations of discrimination against the mentally retarded under Section 504."[155] To reconcile the two holdings, one may limit the second holding to discrimination against the mentally retarded; under such a construction, that holding would be inapplicable to the case at hand and *Garrity* would stand for the more general proposition that the scrutiny appropriate under sec-

148. 442 U.S. 397, 407 (1979). The plaintiff, who suffered from a serious hearing disability, challenged her rejection from defendant's nursing program. The court concluded that the ability to understand speech without reliance on lip reading was necessary for patient safety during the clinical phase of the program and the performance of a nurse's regular duties. *Id.*

149. *Id.* at 414.

150. Jacobson v. Delta Airlines, Inc., 742 F.2d 1202, 1205 (9th Cir. 1984); *accord* Bentivegna v. United States Dep't of Labor, 694 F.2d 619, 621 (9th Cir. 1982).

151. Pushkin v. Regents of Univ. of Colo., 658 F.2d 1372, 1384 (10th Cir. 1981) (denying admission to medical school on grounds that the plaintiff suffered from multiple sclerosis constitutes a violation of the Act).

152. New York State Ass'n for Retarded Children v. Carey, 612 F.2d 644, 650 (2d Cir. 1979) (rejecting justification of health hazards posed by integration of retarded children infected by hepatitis-B with other retarded children as too remote and insubstantial).

153. 522 F. Supp. 171 (D.N.H. 1981).

154. *Id.* at 207 (relying on differences between discrimination on basis of race and discrimination against handicapped).

155. *Id.* at 237 (relying on a determination that section 504 incorporates the level of scrutiny due the classification under the Constitution; at the time, prevailing view was that discrimination against mentally retarded individuals was subject to intermediate scrutiny).

tion 504 is that due the classification under the Constitution. Such a holding is suspect. The Supreme Court apparently considered this issue in its decision in *Campbell v. Kruse.*[156] There, the plaintiffs brought an action pursuant to the Rehabilitation Act and the equal protection clause, alleging the invalidity of a Virginia statute on the ground that it denied handicapped children of poor parents the ability to obtain an appropriate education. The district court found a violation of equal protection in the challenged policy.[157] The Supreme Court memorandum opinion remanded the case to the district court with directions to decide the issue in accordance with section 504,[158] thereby implying that a different analysis applies to section 504 claims than to constitutional claims.

Thus, at least in the non-prison context, some form of heightened scrutiny appears appropriate because of the unanimity of the federal courts of appeals' decisions and the limited force of half a lower court opinion to the contrary.

2. Prison Context

American jurisprudence draws a distinction between the law applicable to general society and that applicable to prisons.[159] Because penological objectives may be hindered by the application of the law without this distinction, and prisoners have a unique relationship with the state, this is a wise policy. For these reasons, one may argue, the balance among competing considerations ought to be struck differently in this context. Accordingly, the argument continues, the existing non-prisoner cases interpreting section 504 are not applicable to the prison context. Instead, a decision on whether segregation is justified should give great deference to the determination of prison authorities and minimal attention to the "right" of prisoners to be free from handicap discrimination.

While prisoners are generally understood to possess diminished rights and prison authorities are generally granted great latitude in decision-making, the courts have not abdicated all review of policy in this area. The judiciary stands as a neutral decision-maker between prisoners and prison authorities. In an area such as this, where fear and ignorance can so easily influence decisions, the judiciary must

156. 434 U.S. 808 (1977) (mem.)

157. Kruse v. Campbell, 431 F. Supp. 180, 186 (E.D. Va.), *vacated and remanded,* 434 U.S. 808 (1977).

158. *Campbell,* 434 U.S. at 808.

159. *See, e.g.,* Bell v. Wolfish, 441 U.S. 520, 546 (1979) (legitimate objectives of the penal institution curtail the constitutional rights of prisoners).

ensure that the system remains true to its commitment to justifiable policy choices.

The first issue is whether prisoners retain the "right" of protection against handicap discrimination. Prisoners only retain those rights that are not "fundamentally inconsistent with imprisonment itself or incompatible with the objectives of incarceration."[160] Limitations on very significant rights are justified in the prison context "both from the fact of incarceration and from valid penological objectives—including deterrence of crime, rehabilitation of prisoners, and institutional security."[161] Under this doctrine, the Supreme Court has held that a prisoner does not have a reasonable expectation of privacy under the fourth amendment in his prison cell, because it would otherwise be impossible to accomplish the prison objectives of preventing the introduction of weapons, drugs, and other contraband into the premises.[162] However, "prisons are not beyond the reach of the Constitution."[163] For example, the Court has held that prisoners have the constitutional right to petition the government for redress of their grievances, and a reasonable right of access to the courts.[164] Prisoners enjoy limited protection of religious freedom,[165] free speech,[166] due process,[167] and the eighth amendment.[168] Most importantly, "invidious racial discrimination is as intolerable within a prison as outside, except as may be essential to 'prison security and discipline.' "[169]

The above case law, as well as the statute's clear application to prisons,[170] support the argument that inmates retain their right to be free from handicap discrimination. This right is neither "fundamentally inconsistent with imprisonment itself [nor] incompatible with the objectives of incarceration."[171]

The second issue is the level of scrutiny to be applied to the justifications offered by prison authorities for segregation. In the constitu-

160. Hudson v. Palmer, 468 U.S. 517, 523 (1984) (interest of society in the security of its penal institutions outweighs the privacy interest of the prisoner within his cell).

161. O'Lone v. Estate of Shabazz, 482 U.S. 342, 348 (1987); *accord* Procunier v. Martinez, 416 U.S. 396, 412 (1974).

162. *Hudson,* 468 U.S. at 528.

163. *Id.* at 523.

164. Johnson v. Avery, 393 U.S. 483 (1969).

165. Cruz v. Beto, 405 U.S. 319 (1972) (per curiam).

166. Pell v. Procunier, 417 U.S. 817 (1974).

167. Wolff v. McDonnell, 418 U.S. 539 (1973); Haine v. Kerner, 404 U.S. 519 (1972).

168. Estelle v. Gamble, 429 U.S. 97 (1976).

169. Hudson v. Palmer, 468 U.S. 517, 523 (1983) (quoting in part from Lee v. Washington, 390 U.S. 333, 334 (1968) (per curiam)).

170. *See supra* notes 22–24 and accompanying text.

171. *Hudson,* 468 U.S. at 523.

tional arena, even if inmates retain a right, a prison regulation can abridge that right if it is reasonably related to legitimate penological objectives.[172] One might argue that such a weak standard of scrutiny ought not to apply in section 504 cases for two reasons. First, the holding ought to be limited to the constitutional context, and perhaps extended to general statutory provisions, but not to specific statutory rights of which Congress has deemed prisoners deserving. Second, under Title VII, a statute to which courts often turn to interpret section 504, courts do not accord deference to the justifications offered by prison authorities. In *Dothard v. Rawlinson,*[173] the Supreme Court held prison authorities to the same standards as other employers in evaluating the defendant's claim that it was a BFOQ for prison guards in contact positions in all-male penitentiaries to be men.[174] Similarly, in *Torres v. Wisconsin Department of Health & Social Services,*[175] the plaintiffs, who were men, challenged the creation and implementation of a policy that designated certain correctional officer positions in an all-women prison as open to women only. In evaluating the defendant's response that the requirement was a BFOQ, the court wrote that under Title VII "the claims of prison authorities about the needs of the institution must satisfy the same burdens of proof as are imposed on any employer attempting to meet the 'extremely narrow' BFOQ exception to Title VII."[176] The applicability of these cases is suspect, however, because they involved the assertion of rights by prison employees rather than by inmates.

Even if a court determines that "rational basis" scrutiny applies, the court ought to be diligent and uncompromising in its requirement that reason, rather than fear and ignorance, guide prison authorities' decisions. Indeed, a court may find segregation violates even rational basis scrutiny, given the state of the medical evidence discussed below.

172. Turner v. Safley, 482 U.S. 78, 89 (1987); O'Lone v. Estate of Shabazz, 482 U.S. 342, 348 (1987).

173. 433 U.S. 321 (1977).

174. *Id.* at 334 (the Court went on to find legitimate BFOQ where, among other things, violence is extremely common in prison and a substantial portion of population is composed of sex offenders).

175. 838 F.2d 944 (7th Cir. 1988).

176. *Id.* at 949 n.4.

C. *The Risk of Transmission*

1. *Legal Background*

In *School Board of Nassau County v. Arline,*[177] the plaintiff challenged the defendant's discharge of the plaintiff, an elementary school teacher, after her third relapse of tuberculosis, a disease that had gone into remission twenty years earlier. The Supreme Court recognized the legitimate concern of the school board in avoiding the exposure of others to significant health and safety risks. The Court held "[a] person who poses a significant risk of communicating an infectious disease to others in the workplace will not be otherwise qualified for his or her job if reasonable accommodation will not eliminate that risk."[178] In determining whether an employee poses such a risk, "courts normally should defer to the reasonable medical judgments of public health officials."[179] The basic factors to be considered in the context of a contagious disease include:

> [findings of] facts, based on reasonable medical judgments given the state of medical knowledge, about (a) the nature of the risk (how the disease is transmitted), (b) the duration of the risk (how long is the carrier infectious), (c) the severity of the risk (what is the potential harm to third parties) and (d) the probabilities the disease will be transmitted and cause varying degrees of harm.[180]

A challenge to the segregation of HIV-positive prisoners presents no genuine dispute over the first three of these factors: the HIV virus is transferred only through the exchange of bodily fluids;[181] the carrier is infectious for as long as he or she has the virus and, until a cure is found, this is perpetual; and the severity of the risk is catastrophic, because the disease is, at this time, fatal. The dispute would lie in the fourth factor: the court's decision would hinge on its assessment of the probability or risk of transmission. The risk must be significant, as determined by the reasonable medical judgments of public health officials.[182]

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177. 480 U.S. 273 (1987).

178. *Id.* at 287 n.16.

179. *Id.* at 288.

180. *Id.* (citations omitted); *see also* Mantolete v. Bolger, 767 F.2d 1416, 1422–23 (9th Cir. 1985) (applicant for employment is not "otherwise qualified" if there is "a reasonable probability of substantial injury to the applicant or others").

181. *See infra* notes 182–88 and accompanying text; *see also* Chalk v. United States Dist. Court, 840 F.2d 701, 706 (9th Cir. 1988) (referring to various articles and experts to the effect that close, non-sexual contact does not lead to transmission).

182. *Arline,* 480 U.S. at 288.

2. Methods of Transmission

The method of transmission of the disease is critical to a determination of whether HIV-positive inmates would pose a significant risk of transmission. HIV is difficult to transmit and not transmitted by any form of casual contact. Moreover, infection is highly unlikely based on a single exposure involving a small dose of the virus. The primary means of transmission are sexual intercourse, infusion or inoculation of blood, and perinatal events.[183] HIV can be transmitted through male-to-male homosexual contact and through heterosexual contact, both male-to-female and female-to-male. The risk of transmission increases as the number of potential exposures increases. Anal intercourse, especially for the receptive partner, and other practices that may involve trauma or bleeding are especially risky.[184]

The second mode of transmission most commonly occurs through the sharing of needles by intravenous drug users. This population is of particular interest to correctional administrators because it is over-represented among inmates.[185] There have also been cases of transmission through blood transfusions and hemophiliacs' receipt of blood products.[186] The risk of HIV infection due to accidental needle-sticks or puncture wounds is extremely small. Of 887 health-care workers experiencing needle-sticks with needles known to have been previously used on HIV-infected patients, only four of them became infected as a result of these exposures.[187] The risk associated with open-wound and mucous membrane exposures to HIV-contaminated blood is even lower than the risk associated with needle-sticks. In three studies totalling 435 health-care workers with such exposure, none became infected.[188]

Finally, infected mothers may transmit HIV to the fetus in utero, to the infant during labor and delivery, or to the infant shortly after birth through infected breast milk.[189]

There is absolutely no evidence that HIV can be spread by sneezing, coughing, breathing, hugging, handshaking, sharing eating and drinking utensils, using the same toilet facilities, or any other form of non-sexual contact or activity.[190] Moreover, all evidence continues to

183. AIDS IN CORRECTIONAL FACILITIES, *supra* note 2, at 8.
184. *Id.* at 8–9
185. *Id.* at 12.
186. *Id.*
187. *Id.* at 14.
188. *Id.*
189. *Id.*
190. *Id.* at 15.

point to the extreme unlikelihood of HIV transmission through other body fluids such as may occur in biting or spitting incidents.[191] Although there may be a theoretical risk involved in deep kissing in which saliva is exchanged, there have been no reports of infection through such contact.[192] Similarly, the possibility that HIV can be transmitted by mosquitoes, head lice, or other insects is extremely unlikely.[193]

3. The Risk of Transmission in Non-Prison Contexts

Most courts that have addressed the issue of AIDS transmission in a non-prison setting have found no significant risk of disease transmission. In *Chalk v. United States District Court,*[194] the court found a section 504 violation in the Orange County Department of Education's decision to bar the plaintiff from teaching in the classroom after he developed AIDS.[195] In addressing the risk of transmission, the court quoted the Surgeon General's Report on AIDS: "[t]ransmission would necessitate exposure of open cuts to the blood or other bodily fluids of the infected child, a highly unlikely occurrence. Even then, routine safety procedures for handling blood or other body fluids . . . would be effective in preventing transmission from children with AIDS to other children in school."[196] The court noted that section 504 does not require complete scientific certainty about the extent of the risk because the risk must be "significant" to justify the discrimination, and because " 'reasonable medical judgments of public health officials' " are the controlling yardstick.[197]

Cases on the exclusion of students with HIV are in accord. In *Thomas v. Atascadero Unified School District,*[198] the court granted a preliminary injunction prohibiting the school district from excluding a child with AIDS from the classroom, despite the child's involvement in a biting incident. The court found that "the AIDS virus is not transmitted by human bites, even bites that break the skin."[199]

191. Friedland & Klein, *supra* note 1, at 1132.
192. *Id.*
193. AIDS IN CORRECTIONAL FACILITIES, *supra* note 2, at 16.
194. 840 F.2d 701 (9th Cir. 1988).
195. *Id.* at 706.
196. *Id.*
197. *Id.* at 707–08.
198. 662 F. Supp. 376 (C.D. Cal. 1986).
199. *Id.* at 380; *see also* Martinez v. School Bd., 861 F.2d 1506 (11th Cir. 1988) (remote theoretical possibility of AIDS transmission does not justify exclusion of mentally handicapped child with AIDS from regular mentally handicapped classroom); Doe v. Dolton Elementary School Dist. No. 148, 694 F. Supp. 440 (N.D. Ill. 1988) (issuing a preliminary injunction allowing a student with AIDS to return to school because the student would likely be found

Similarly, a Second Circuit case ruled that segregating mentally retarded hepatitis-B carriers from other mentally retarded school children was a violation of section 504 because integration posed no significant risk of transmission.[200] This result was reached even though there is reason to believe that hepatitis-B is transmitted much more easily than AIDS.[201] The court acknowledged that proof of drooling, kissing, and mouthing of mutually used equipment by the retarded children, along with evidence that the disease can be communicated by such behavior, might have justified the segregation.[202] However, the defendant offered no such evidence in court.[203]

4. *The Risk of Transmission to Other Inmates*

The only court that has addressed the issue of whether the integration of HIV-positive inmates poses a significant risk of transmission is *Harris v. Thigpen*.[204] The court found the risk significant but offered no discussion whatsoever on the issue.

Currently available data suggest low rates of transmission of the virus within correctional facilities. The United States Army tested 542 inmates who had been incarcerated in a military prison for a period of one to two years, and who had tested negative for the virus upon intake. It found that none of them had become infected.[205]

In Maryland, voluntary follow-up testing of 393 inmates who had been HIV-negative on intake one or two years earlier revealed that two

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otherwise qualified to attend public school because there was no significant risk of transmission); Ray v. School Dist., 666 F. Supp. 1524, 1535 (M.D. Fla. 1987) (court rejected argument that "future theoretical harm" of transmission of the AIDS virus justified the exclusion); District 27 Community School Bd. v. Board of Educ., 130 Misc. 2d 398, 502 N.Y.S.2d 325, 335–37 (Sup. Ct. 1986) (upholding the Board of Education's policy of determining on a case-by-case basis whether the health and development of children with AIDS permitted them to attend school in an unrestricted setting; finding that an injunction prohibiting the board from admitting any child with AIDS into the classroom would violate section 504); *cf.* Board of Educ. v. Cooperman, 105 N.J. 587, 523 A.2d 655 (1987) (regulations allowing State Board of Education to exclude HIV-infected pupils only under very limited, individualized circumstances, with adequate provisions for review of decision including the right to call witnesses and to cross-examination, are sufficient to protect constitutional and statutory rights implicated); School Bd. v. Board of Educ., 130 Misc. 2d 398, 502 N.Y.S.2d 325 (Sup. Ct. 1986) (exclusion of children with AIDS while not excluding children with ARC or asymptomatic HIV-infection constitutes discrimination under section 504; court did not address whether exclusion of *all* of the above would violate the Act).

200. New York State Ass'n of Retarded Children v. Carey, 612 F.2d 644, 650 (2d Cir. 1979).

201. *See* Chalk v. United States Dist. Court, 840 F.2d 701, 709 (9th Cir. 1988); *see also* Friedland & Klein, *supra* note 1, at 1125.

202. *New York State Ass'n of Retarded Children,* 612 F.2d at 650.

203. *Id.*

204. 727 F. Supp. 1564, 1582–83 (M.D. Ala. 1990).

205. Kelley, Redfield, Ward, Burke, & Miller, *Prevalence and Incidence of HTVL-III in a Prison,* 256 J. A.M.A. 2198–99 (1986).

(or .4% per year) were HIV-positive. This translates into a possible sixty new infections per year in the entire Maryland inmate population.[206] A study in Nevada of 1,069 inmates, who were HIV-negative on intake, showed that two had seroconverted by the time of release. Because of the window period between infection and the appearance of detectable antibodies, it was unclear whether those conversions occurred as a result of exposure during incarceration. If both are assumed to have occurred during incarceration, the study yields an infection rate of .17% per year, which translates into eight new infections per year in the entire 1988 Nevada inmate population.[207]

Finally, testing by the Federal Bureau of Prisons showed that of 14,846 initially HIV-negative males, nine tested positive in follow-up testing. However, all six of those nine who have been investigated admitted to high-risk behavior prior to incarceration, so it is likely that some of those individuals were in the window period at the time of entry.[208]

There are many arguments, however, against reliance on these statistics. The often lengthy incubation period of the disease (progression from asymptomatic infection to end-stage AIDS usually takes two and one-half to five years or more[209]) poses problems for epidemiologic analysis. This is further complicated by the fact that an HIV-positive individual may never develop symptoms although it is generally believed that a majority of HIV-positive persons will develop ARC or AIDS or both.[210] Moreover, although on average detectable antibodies to the virus appear in the blood within six to twelve weeks after an individual's infection with HIV,[211] there have been reports of lag-times of up to six months, and recent data suggest that even longer delays in antibody appearance may not be unusual.[212]

In addition, there are significant variations across jurisdictions in the prevalence of infections and variations in the prevalence of high-risk behaviors in correctional facilities.[213] Both of these variables affect transmission rates. Known outbreaks of syphilis and other sexually-transmitted diseases in prisons suggest that HIV can also be transmitted in the correctional setting. Moreover, many inmates have

206. 1988 UPDATE, *supra* note 2, at 17.
207. *Id.*
208. Id.
209. AIDS IN CORRECTIONAL FACILITIES, *supra* note 2, at 7.
210. *Id.* at 6.
211. *Id.* at 61.
212. Ranki, Krohn, Allain, Franchini, Valle, Antonen, Leuther & Krohn, *Long Latency Precedes Overt Seroconversion in Sexually Transmitted HIV Infection,* 1987 LANCET 589–93.
213. AIDS IN CORRECTIONAL FACILITIES, *supra* note 2, at 31.

histories of intravenous drug abuse. While it is unclear how much drug abuse involving needle-sharing occurs in prison, it is probable that at least some takes place. In addition, tattooing is prevalent in many correctional facilities, and this activity may expose inmates to blood contaminated with the AIDS virus.[214]

The import of the lengthy incubation period, the possible lengthy lag-time, and the potential modes of transmission must not be exaggerated. The ultimate proof of the threat of transmission is the actual number of cases of transmission. As such, the above statistics present the best available evidence. Furthermore, if these statistics are considered too few, a determination must await the additional statistics which many jurisdictions are presently compiling. Until then, the risk of transmission is simply not "significant" as required in *Arline.*[215]

Courts also address whether "routine safety procedures . . . would be effective in preventing transmission."[216] It is the responsibility of prison authorities to ensure that inmates remain free from sexual assault or other violence. Moreover, prison authorities are charged with ensuring that prison rules and regulations are followed. One rule is the prohibition on all drug use and sexual contact. Simply put, HIV-positive inmates ought not to bear the brunt of the prison authorities' inability to perform their duties and other inmates' disobeyance of prison rules and regulations.

5. The Risk of Transmission to Prison Staff

There are no known cases of AIDS, ARC, or HIV positivity among correctional staff as a result of contact with inmates. In Minnesota, six correctional officers who claimed to have been potentially exposed to infection in on-the-job incidents were tested. These incidents included needle-sticks and fights in which blood was drawn. None of them tested positive.[217] Similarly, the Oklahoma correctional system tested ten officers involved in potential transmission incidents, and Oregon tested seven such officers. None were found to be HIV-positive.[218] Furthermore, there have not been any job-related cases of infection among police officers, firefighters, emergency medical technicians, or any other public safety workers.[219] Thus, the viability of this

214. *Id.* at 32.

215. School Bd. of Nassau County v. Arline, 480 U.S. 273, 287 n.16, 288 (1987).

216. Chalk v. United States Dist. Court, 840 F.2d 701, 706 (9th Cir. 1988) (quoting U.S. PUBLIC HEALTH SERVICE, SURGEON GENERAL'S REPORT ON A.I.D.S. 23-24 (1986).

217. AIDS IN CORRECTIONAL FACILITIES, *supra* note 2, at 22.

218. *Id.*

219. *Id.*; 1988 UPDATE, *supra* note 2, at 8.

justification is negligible. Courts have consistently found that the mere theoretical possibility of transmission, without further evidence, does not suffice to establish a significant risk.[220]

D. The Reasonable Accommodation Requirement

The Supreme Court in *School Board of Nassau County v. Arline* held that a "person who poses a significant risk of communicating an infectious disease to others in the work place will not be otherwise qualified for his or her job *if reasonable accommodation will not eliminate that risk.*"[221] If a court finds that the integration of HIV-positive inmates poses a significant risk of transmission, the inmates can argue that reasonable accommodation would eliminate that risk.

A threshold issue is whether the reasonable accommodation requirement applies to prisons. The United States Supreme Court, in both *Southeastern Community College v. Davis*[222] and *School Board of Nassau County v. Arline,*[223] looked to controlling regulations to determine that "reasonable accommodation" was required of the defendant.[224] Unfortunately, other than the bare mention of federal prisoners and the Department of Corrections,[225] no regulations specifically regulate correctional facilities. If the prison at issue, however, receives federal financial assistance from a particular agency that *has* promulgated regulations, such as the Department of Justice, those regulations can be consulted for the proposition that "reasonable accommodation" is required.

This is unnecessary, however, because a more recent Supreme Court case stands for the general proposition that a reasonable accommodation requirement applies to all programs that receive federal money

220. *See, e.g.,* Martinez v. School Bd., 861 F.2d 1506 (11th Cir. 1988); New York State Ass'n of Retarded Children v. Carey, 612 F.2d 644, 650 (2d Cir. 1979).

221. 480 U.S. 273, 287 n.16 (1987) (emphasis added). The reasonable accommodation standard is not the equivalent of an affirmative action obligation. Southeastern Community College v. Davis, 442 U.S. 397, 410 (1979). While some sections of the Rehabilitation Act impose an affirmative action obligation, section 504 does not. *Id.* "Affirmative action" refers to changes, adjustments, or modifications to existing programs that are substantial or constitute fundamental alterations in the nature of the program. Alexander v. Choate, 469 U.S. 287, 300 n.20 (1985).

222. 442 U.S. 397 (1979).

223. 480 U.S. 273 (1987).

224. In *Southeastern* the Court looked to regulations covering the education context, 442 U.S. at 408, while in *Arline* the Court consulted regulations governing employment of the handicapped. 480 U.S. at 287 n.17. *Arline* interpreted these two cases to impose the same requirement on recipients. *Id.*

225. *See supra* notes 22–23 and accompanying text.

whether or not controlling regulations impose such a requirement. Such a requirement strikes:

> a balance between the statutory rights of the handicapped to be integrated into society and the legitimate interests of federal grantees in preserving the integrity of their programs: while a grantee need not be required to make "fundamental" or "substantial" modifications to accommodate the handicapped, it may be required to make "reasonable" ones. . . . [This] requires that an otherwise qualified handicapped individual must be provided with meaningful access to the benefit that the grantee offers. The benefit itself, cannot be defined in a way that effectively denies otherwise qualified handicapped individuals with meaningful access to which they are entitled; to assure meaningful access, reasonable accommodations . . . may have to be made.[226]

The Court offered this interpretation in the context of a challenge to a provision of a state Medicaid program. No regulations appeared to control.

Moreover, regulations promulgated under section 504 consistently impose a "reasonable accommodation" requirement, which has come to be interpreted as a requirement contained within the "otherwise qualified" element.[227] Accordingly, courts typically impose this requirement on prisons without discussion. In *Bonner v. Lewis,*[228] the court assumed that state prison officials were obligated to make reasonable accommodations to assure meaningful access to the program at issue for the plaintiff inmate.[229] Likewise, in *Harris v. Thigpen,*[230] the court assumed, without discussion, that the reasonable accommodation requirement applied to prisons.

The reasonable accommodation requirement invokes a balancing process. In *Southeastern Community College,* the Supreme Court found that close, individual attention by a nursing instructor, needed to ensure patient safety if the hearing impaired plaintiff took part in the clinical phase of the program, was "a fundamental alteration in the nature of the program" and therefore more substantial than that required under section 504.[231] Because allowing the plaintiff to take only academic classes would not provide even a rough equivalent of

226. Alexander v. Choate, 469 U.S. 287, 300–01 (1985).

227. *See, e.g.,* Doherty v. Southern College of Optometry, 862 F.2d 570, 575 (6th Cir. 1988) (inquiry into reasonable accommodation is one aspect of the "otherwise qualified" analysis under section 504).

228. 857 F.2d 559 (9th Cir. 1988).

229. *Id.* at 561.

230. 727 F. Supp. 1564, 1583 (M.D. Ala. 1990).

231. 442 U.S. 397, 409–10 (1979).

the training a nursing program normally gives, the college was not required to accommodate the plaintiff.[232]

A decision on whether "reasonable accommodation" would eliminate the risk of disease transmission, like a decision on whether integration poses a significant risk of transmission in the first place, would focus on the facts. The court in *Harris* found that reasonable accommodation would not eliminate the significant risk of transmission if HIV-positive inmates were integrated with the general prison population.[233] The court reached this conclusion, however, without any discussion of feasible alternatives. The segregation of "aggressors" and the education of the general prison population about the disease and its transmission are alternatives that do not subject the HIV-positive inmates to handicap discrimination. Indeed, in the area of consensual sexual activity, there are indications that behavioral change is occurring in prisons, perhaps as a result of educational efforts.[234] As to non-consensual and quasi-consensual sexual activity, transmission can be prevented by more careful inmate classification, more intensive supervision or surveillance, and more effective prosecution of inmate rapists.

Moreover, arguably, an increase in prison staff and an elimination of overcrowding, among other things, would reduce the risk. A determination of whether such accommodations impose "undue financial and administrative burdens" on a prison, or require a "fundamental alteration in the nature" of the prison, would depend greatly on the facts surrounding the particular prison at issue.

In sum, the argument that HIV-positive prisoners are "otherwise qualified" under section 504 of the Rehabilitation Act is strong: they probably do not pose any significant risk of disease transmission that routine safety procedures or reasonable accommodation would not eliminate. However, a decision on this issue depends greatly on the level of scrutiny and amount of deference the court gives to the justifications that prison authorities offer.

IV. CONCLUSION

There is much misinformation and fear surrounding the HIV virus. The severity of the disease has fueled the dissemination of this misinformation and fear. Societal response has included calls to quarantine even *unincarcerated* members of the population who carry the virus.

232. *Id.*

233. 727 F. Supp. 1564, 1583 (M.D. Ala. 1990).

234. AIDS IN CORRECTIONAL FACILITIES, *supra* note 2, at 33.

It is no surprise that this remedy has been visited upon one of the most powerless groups in our society: the incarcerated.

There are good arguments that section 504 of the Rehabilitation Act outlaws this response. Symptomatic HIV-positive prisoners are "handicapped" under the Act and asymptomatic carriers are being treated as such. Furthermore, these prisoners are able to function adequately and safely in the general prison population, provided reasonable precautionary measures are taken, rendering them "otherwise qualified" for integration.

The legality of the segregation of HIV-positive inmates under section 504 is hardly a settled question.[235] In light of the evidence and arguments discussed above, case-by-case decision-making, rather than blanket segregation policies, more appropriately accommodates the interest of inmates in freedom from handicap discrimination.

235. The only case that has decided the question did so without any analysis. *Harris v. Thigpen*, 727 F. Supp. 1564, 1582–83 (M.D. Ala. 1990).

APPENDIX A
HOUSING POLICIES FOR INMATES WITH AIDS, ARC, AND ASYMPTOMATIC HIV INFECTION: STATE AND FEDERAL PRISON SYSTEMS[a], OCTOBER 1988

	Jurisdictions Following this Policy for:					
	AIDS		ARC		Asymptomatic HIV Infection	
Policy	n	%	n	%	n	%
◦ All maintained in general population	0	0%	8	16%	24	47%
◦ All maintained in general population with restrictions[b]	1	2	9	18	12	24
◦ All segregated/separated[c]	20	39	8	16	6[d]	12
◦ Case-by-case determination	30	59	23	45	8	16
◦ No policy	0	0	3	6	1	2
TOTAL	51	100%	51	101%[d]	51	101%[e]

[a] These figures include hypothetical policies in jurisdictions that as yet have no cases in a particular category.

[b] This category includes single-celling.

[c] This category includes hospitalization, infirmary housing, and administrative separation in medical or non-medical units.

[d] In March 1989, Colorado discontinued mass screening and segregation of seropositives. This change is not reflected in this table, which covers policies in force at the time of the October 1988 survey.

[e] Due to rounding.

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APPENDIX B
HOUSING POLICIES FOR INMATES WITH AIDS, ARC, AND ASYMPTOMATIC HIV INFECTION: CITY AND COUNTY JAIL SYSTEMS[a], OCTOBER 1988

	Jursidictions Following this Policy for:					
	AIDS		ARC		Asymptomatic HIV Infection	
Policy	n	%	n	%	n	%
• All maintained in general population	1	4%	4	14%	15	54%
• All maintained in general population with restrictions[b]	2	7	2	7	3	11
• All segregated/separated[c]	13	46	6	21	3	11
• Case-by-case determination	12	43	14	50	7	25
• No policy	0	0	2	7	0	0
TOTAL	28	100%	28	99%[d]	28	101%[d]

[a] These figures include hypothetical policies in jurisdictions that as yet have no cases in a particular category.
[b] This category includes single-celling.
[c] This category includes hospitalization, infirmary housing, and administrative separation in medical or non-medical units.
[d] Due to rounding.

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