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## Meeting the AIDS Epidemic in the Courtroom: Practical Suggestions in Litigating Your First AIDS Case

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# Meeting the AIDS Epidemic in the Courtroom: Practical Suggestions in Litigating Your First AIDS Case

William L. Earl and Judith Kavanaugh

## **Abstract**

From Anaheim to Arcadia, from Wall Street to Steubenville, America's lawyers - like it or not - are confronting the AIDS epidemic.

**KEYWORDS:** AIDS, epidemic, courtroom



## Meeting the AIDS Epidemic in the Courtroom: Practical Suggestions in Litigating Your First AIDS Case

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Judith Kavanaugh\*\*

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...[s]ociety's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairment.<sup>1</sup>

From Anaheim to Arcadia, from Wall Street to Steubenville, America's lawyers — like it or not — are confronting the AIDS epidemic. Whether advising a corporate CEO whose AIDS—positive son has been evicted from his apartment or filing suit to halt mandatory testing of Union members, lawyers not normally engaged in civil rights or medically related practices are advising, counseling, and representing persons impacted by AIDS. As the epidemic moves into the mainstream and consciousness of America, more lawyers will encounter the disease in their practice.

Legal issues associated with AIDS permeate the workplace, schools, housing, public accommodations, health care, insurance and other areas. Although polls show more and more Americans are beginning to deal with the disease rationally, pockets of panic and prejudice still exist: swimmers deserted a West Virginia community swimming pool when an AIDS patient showed up, immigration employees wore plastic gloves when handling Haitian applicants, a mid-Atlantic state school district barred a theater group because it once performed with AIDS patients on stage, and a Connecticut school cancelled a basketball game on rumors that an opposing player might have AIDS.<sup>2</sup>

This article is not an analysis of existing statutes and case law. Many other articles have undertaken that effort.<sup>3</sup> Rather, this article is

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1. School Board of Nassau County, Florida v. Arline, 107 S. Ct. 1123 (1987).

2. N.Y. Times, February 17, 1988, § 1, at 12, col. 1.

3. See, e.g., Wasson, *AIDS Discrimination Under Federal, State, and Local Law*



intended to provide the practicing lawyer — not engaged in a civil rights or day-to-day AIDS related practice — with helpful resource materials and useful answers to practical questions. It briefly reviews the law in several areas in which lawyers may encounter AIDS cases, gives non-technical answers to basic questions about the disease, and suggests how to deal with expected problems in your first AIDS case.

The authors gratefully acknowledge the time and assistance of Mark J. Magenheimer, M.D., M.P.H., in reviewing and revising the medical, AIDS related terminology and analysis in this article.

## I. Scope and Nature of the AIDS Epidemic

The AIDS epidemic has become a grim fact of life. The first cases of what we now call AIDS or Acquired Immune Deficiency Syndrome were reported to the Public Health Service's Centers for Disease Control in Atlanta ("CDC") in 1981.<sup>4</sup> As the epidemic enters its eighth year, the number of persons infected with AIDS in the United States exceeds sixty thousand. By 1991, more than one hundred seventy-two thousand patients are expected to be receiving treatment for AIDS.<sup>5</sup> Estimates of Americans currently infected with the virus range from one to four million.<sup>6</sup> In some areas of Equatorial Africa, the disease is reported to have reached "holocaust" proportions.<sup>7</sup>

Although a cure has not yet been found, medical science has identified a virus which causes AIDS and its modes of transmission. Legally, there are still more issues than answers. To date, the absence of a comprehensive national policy<sup>8</sup> has forced the courts to resolve AIDS-

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after *Arline*, 15 FLA. ST. U.L. REV. 221 (1987); Bodine, *Opening the Schoolhouse Door for Children With AIDS: The Education for all Handicapped Children Act*, 13 ENVTL. AFF. 583 (1986); Note, *Protecting Children with AIDS Against Arbitrary Exclusion from School*, 74 CALIF. L. REV. 1373 (1986); Note, *Safeguarding Quality for the Handicapped: Compensatory Relief Under Section 504 of the Rehabilitation Act*, 176 DUKE L. J. 197 (1986).

4. *Pneumocystis Pneumonia — Los Angeles*, 30 MORBIDITY & MORTALITY WEEKLY REP. 250 (June 5, 1981) (hereinafter "MMWR").

5. N.Y. Times, February 17, 1988, § 1, at 12, Col. 1; *AIDS 1991 Economic Burden Projected to be 66 Billion*, AIDS POL'Y & L., May 6, 1987, at 3, quoting the INTERNIST. (a journal of the American Society of Internal Medicine).

6. See Dannemeyer Raps Mayers, *Public Health Officials*, AIDS POL'Y & L., August 12, 1987, at 8.

7. SHILTS, R., AND THE BAND PLAYED ON: POLITICS, PEOPLES AND THE AIDS EPIDEMIC (1987).

8. As this article was submitted for publication the Congress had approved and



related issues on a case-by-case basis. Discrimination in the workplace, school, housing, insurance coverage, and tort liability relating to AIDS will continue to generate disputes which the courts must resolve.

## II. Basic Questions and Answers on AIDS

To understand and seek to resolve the legal issues, it is first necessary to understand the medical evidence to date on AIDS, its transmission, its various stages, and the prognosis for those infected by the disease.

### 1. *What is AIDS?*

AIDS is a disease characterized by a defect in a person's natural immunity system. Those who contract AIDS are susceptible to many otherwise rare illnesses which do not threaten those with normally functioning immune systems.<sup>9</sup> Thus, it is not AIDS but a disease to which you would otherwise be immune—absent infection with the AIDS virus which actually kills you. AIDS is caused by a retrovirus, the human immunodeficiency virus now referred to as HIV.<sup>10</sup> Chillingly, there is no known cure for the HIV or AIDS virus and none is expected in the short term.

### 2. *How is AIDS Transmitted?*

The virus is a blood-borne or sexually transmitted disease. According to the American Medical Association, HIV transmission occurs in three ways: (1) sexual contact with an infected person; (2) invasive exposure to contaminated blood (i.e., introduction of infected blood or blood products into the bloodstream occurring as a result of intrave-

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overridden a Presidential veto of the Civil Rights Restoration Act as part of an effort to overcome the Supreme Court's decision in the *Grove City* case. The legislation includes anti-discrimination provision for AIDS. More specific national legislation to expressly bar AIDS-related discrimination and mandate confidentiality of HIV testing results has passed the House of Representatives, but has not passed the Senate.

9. United Public Health Service SURGEON GENERAL'S REPORT ON ACQUIRED IMMUNE DEFICIENCY SYNDROME (October 1986) [hereinafter SURGEON GENERAL'S REP.].

10. See Update: *Acquired Immuno Deficiency Syndrome — United States*, 35 CENTERS FOR DISEASE CONTROL MORBIDITY & MORTALITY WEEKLY REP. 758 (December 12, 1986).



nous drug abuse, blood transfusions, or hemophilia treatment; or (3) perinatal exposure from infected mother to infant.<sup>11</sup> The virus is not transmitted through casual contact such as hugging, kissing, sneezing, crying, from toilet seats, sharing dishes or silverware, or other casual or community contact.<sup>12</sup>

The AIDS virus is fragile and is easily destroyed by even weak cleaning solutions such as dish soap or diluted (ten to one) bleach water solutions. More importantly, there continues to be no evidence of non-specific transmission of the AIDS virus through environmental factors such as insect bites, food, water, or other media,<sup>13</sup> and there are no known cases of AIDS transmission through bites from dogs, cats and other domestic animals, or transmission through tears and saliva.<sup>14</sup>

### 3. *What Are the Different Stages of AIDS?*

Although there are several, sophisticated medical classification systems, an analysis of legal issues generally need only recognize three stages in which the disease manifests itself. Your AIDS case is likely to involve a person in one of the following three stages of the disease:<sup>15</sup>

(a) *Asymptomatic HIV-antibody positive.* This is the stage at which there are no symptoms, but the person is infected with HIV.

11. Amicus Brief, American Medical Association in Support of Plaintiffs' Motion for Injunctive Relief, *Ray v. School District of DeSoto County*, Case No. 87-88-CIV-FtM-17-C, July 24, 1987 (hereinafter "AMA Brief"). The AMA Brief in the *Ray* case is attached hereto as Appendix I, because it contains medical authorities which the new AIDS practices will need. (Citing Institute of Medicine, National Academy of Sciences, *Confronting AIDS: Directions for Public Health, Health Care and Research*, 50-57; Mueller, *The Epidemiology of the Human Immunovirus Infection*, 14 LAW, MED. & HEALTH CARE 250, 256 (1986)).

12. See SURGEON GENERAL'S REP. *supra* note 9, at 9 (1987) (hereinafter "Surgeon General's Report").

13. See, e.g., Fischl, *Evaluation of Heterosexual Partners, Children and Household Contacts of Adults With AIDS*, 257 J.A.M.A. 640, 644 (1987); Friedland, *Lack of Transmission of HTLV-III/LAV Infection to Household Contacts of Patients With AIDS or AIDS-related Complex With Oral Candidiasis*, 314 NEW ENG. J. MED. 344, 347 (1986); Kaplan, *Evidence Against Transmission of Human T-Lymphotropic Virus/Lymphadenopathy Associated Virus (HTLV-III/LAV) in Families of Children With Acquired Immuno Deficiency Syndrome*, 4 PED. INFEC. DISEASE 468, 471 (1985).

14. SURGEON GENERAL'S REP. *supra* note 9, at 21.

15. Appendix II to this article contains excerpts from the actual proposed findings submitted to the court in the *Ray* case. This will provide the practitioner with an awareness of both the range of available medical authority and procedural devices that can be employed to marshal evidence as to medical findings and conclusions.



Because the disease has an extended latency period, an otherwise healthy individual may carry the AIDS virus for several years with no associated symptoms.

(b) *Symptomatic HIV-Antibody Positive Infection* (Formerly referred to as *ARC* or *AIDS-Related Complex*.) *ARC* is used to describe those who manifest several laboratory or clinical symptoms, but do not meet the criteria included in the definition for *AIDS* accepted by the Centers for Disease Control. *ARC* is an informal classification which is not applied to pediatric patients.

(c) *Full Blown or "Frank" AIDS*. This category denotes the presence of one or more opportunistic diseases indicative of immunodeficiency coupled with seropositive test results for *HIV* infection.<sup>16</sup>

#### 4. *Can an Asymptomatic HIV-Antibody Positive Person Transmit the Disease?*

Yes. A person who is *HIV*-antibody positive is infectious and can transmit the *AIDS* virus.<sup>17</sup> The important thing to remember, however, is that in this or the other subsequent stages of the disease, the virus can only be transmitted by very limited modes, i.e., sex, blood-to-blood contact, or perinatal mother to child exposure.<sup>18</sup> Remember, there is no known risk of casual transmission. Even in the most intimate family settings where one family member is infected with the virus and is living in intimate contact with other family members, including using the same toilets, dishes, family kissing, etc., there is no known case of non-sexual transmission.<sup>19</sup> In fact, studies of several hundred such family or household members show there is no evidence of casual transmission.<sup>20</sup>

Although there is some disagreement in the medical community as to whether enough time has transpired to make a definite prognosis on *all* *AIDS* patients, data to date shows that most antibody positive persons will progress to develop *AIDS* within 5 to 7 years. It is therefore prudent to anticipate that if your client is *HIV* positive, he or she may move into full blown *AIDS* and may die within a few years.<sup>21</sup> It is now

16. See 258 J.A.M.A. 1143 (Sept. 4, 1987).

17. See generally, SHILTS *supra* note 7.

18. See AMA Amicus Brief *supra* note 11, and authorities cites therein.

19. AMA Amicus Brief, *supra* note 11, at 7. "Extensive and numerous studies have consistently found no apparent risk of *HIV* infection by individuals exposed through close, non-sexual contacts with *AIDS* patients." *Id.*

20. AMA Amicus Brief, *supra* note 11, at 6-10, and authorities cited therein.

21. See AMA Form, *Told that HIV May Always Lead to AIDS*, AIDS POLICY



generally accepted that the probability of AIDS increases about ten percent per year from the time of confirmed HIV seropositivity.

5. *What Are the Legal Areas in Which a Practitioner Will Most Likely Encounter AIDS Cases?*

Given the deadly nature of AIDS and the costs to society of lost productivity and medical treatment,<sup>22</sup> it is not surprising that some individuals and institutions have sought to avoid or shift the costs of AIDS or prior to learning the medical facts have reacted irrationally or discriminated against PLWA's (Persons Living with Aids). The venue for such discrimination and cost shifting or avoidance includes insurance, contracts, schools, the workplace, housing, and tort liability.

(a) AIDS and Insurance

The enormous costs and the swift, silent onset of the AIDS epidemic have made insurance an active area of conflict over such issues as confidentiality, mandatory testing, and exclusion from coverage. Insurance companies may seek to screen out AIDS victims through a variety of devices including requiring applicants to disclose whether they have undergone HIV-antibody testing as a condition precedent to providing insurance.<sup>23</sup> One court<sup>24</sup> upheld a District of Columbia statute which prohibited health, life and disability insurers from discriminating against individuals on the basis of any test screening for AIDS, ARC or HIV infection and from denying benefits because the individual develops those disease stages. The statute, however, permitted insurers to exclude from coverage applicants diagnosed as having AIDS.<sup>25</sup> While California, Maine, and Wisconsin have enacted similar legislation, Florida and most other legislatures have not yet addressed the issue. New York has sought to bar such action through regulation.

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& L., May 6, 1987, at 6.

22. Some experts have estimated that the economic burden of AIDS by 1991 may reach 66 billion dollars. *AIDS 1991 Economic Burden Projected to Be \$66 Billion*, supra note 5, at 3.

23. See Clark and Tuculano, *AIDS and Insurance: The Rationale for AIDS Related Testing*, 100 HARV. L. REV. 1806-25 (1987); Schatz, *The AIDS Insurance Crisis: Underwriting or Overreaching?*, 100 HARV. L. REV. 1782 (1987).

24. *American Council of Life Insurance v. District of Columbia*, 645 F. Supp. 84 (D.C. 1986).

25. D.C. Act 6-170, § 6.



Gay rights advocates have charged that insurance companies are attempting to weed out gay men through underwriting guidelines.<sup>26</sup> Because AIDS is still viewed by many as a predominately gay disease, gay rights advocates argue this constitutes gender-based class discrimination.<sup>27</sup> Regulations recently proposed by the Florida Department of Insurance would prohibit insurers from testing individuals who participate in group policies unless the entire group is tested.<sup>28</sup> These issues remain to be resolved.

Insurance carriers may also seek to exclude AIDS as a covered illness under the policy. It might be asserted, for example, that in those states which criminalize homosexual sex, AIDS is excludable because it was developed during commission of a crime.<sup>29</sup> Gay rights advocates also contend that insurance companies have refused to pay AIDS-related claims by distorting the definition of "pre-existing condition" and claiming that treatment for AIDS-associated symptoms such as flu or diarrhea constituted knowledge of the pre-existing condition. The failure to disclose positive testing for HIV antibodies by an otherwise asymptomatic individual may also be claimed to be a pre-existing condition. Insurance carriers, of course, contend that they should not be saddled with costs for which they did not contract just to avoid burdening public health programs. The validity of such assertions by both gay rights advocates and insurance carriers await a definitive judicial determination.<sup>30</sup>

### (b) AIDS in Public Schools

None of the identified HIV cases in the United States are known to have been transmitted in the school, day care or foster care setting or through other casual or community person to person contact.<sup>31</sup> Nev-

26. See *Insurers Use AIDS Test in Screening Applicants*, N.Y. Times, Feb. 18, 1988, § 1, at 15, col. 4.

27. *Supra* note 23, at 1786-92. See Shatz, *supra* note 23, at 1786-92.

28. See 2 AIDS POL'Y & L. 3 (Dec. 2, 1987).

29. See Schatz, Position Paper on AIDS and Insurance, National Gay Rights Advocates, San Francisco, California (1987) (unpublished).

30. See Hoffman and Kincaid, *AIDS, the Challenge to Life and Health Insurers Freedom of Contract*, 35 DRAKE L. REV. 709-71 (1986).

31. See Centers For Disease Control Guidelines, Education and Foster Care of Children Infected with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus, MMWR 517-21 (hereinafter "CDC Guidelines"), see SURGEON GENERAL'S REPORT ON AIDS *supra* note 9.



ertheless, there has and continues to be litigation over the exclusion of HIV positive children and teachers from classrooms. All of the cases involving children, to date, have followed the CDC Guidelines, which recommend that absent special circumstances, HIV-positive children should remain in the classroom.<sup>32</sup>

The Rehabilitation Act of 1973 prohibits discrimination against "otherwise qualified individuals" by institutions receiving federal financial assistance.<sup>33</sup> In most, if not all cases, public schools receive federal financial assistance. The Act also requires institutions receiving federal financial assistance to provide "reasonable accommodation" to handicapped individuals.<sup>34</sup> AIDS appears to be a handicap under the Rehabilitation Act of 1973. In *Chalk v. United States District Court*,<sup>35</sup> the Ninth Circuit Court of Appeal recently answered the question left open by the United States Supreme Court in *School Board of Nassau County v. Arline*,<sup>36</sup> and held that AIDS constitutes a handicap under the Rehabilitation Act. Individuals with "ARC" or who are asymptomatic, antibody positive may also be protected because they are "regarded as having . . . an impairment,"<sup>37</sup> or because they have been misclassified as handicapped under the Rehabilitation Act.<sup>38</sup>

A student with AIDS whose physical condition does not affect the ability to learn or do required classwork is not handicapped within the meaning of the Education of All Handicapped Children Act, and need not exhaust administrative remedies prior to suit under the Rehabilitation Act.<sup>39</sup> Children with AIDS may not be excluded from school with-

32. See, e.g., *Thomas v. Atascadero Unified School Dist.*, 662 F. Supp. 376 (Cal. 1986); *Phipps v. Saddleback Unified School Dist.*, Case No. 47-4981, Orange County, Supreme Court (Feb. 18, 1986); *Board of Education of the City of Plainfield v. Cooperman*, 523 A.2d 655, 105 N.J. 587 (1987); *District 27 Community School B. v. B. of Educ. of City of New York*, 502 N.Y.2d 325 (1986 Supp.); *C.C. v. Dade County School B.*, Case No. 86-1513, (S.D. Fla., July 11, 1986); *Ray v. School B. of DeSoto County*, 666 F. Supp. 1524 (M.D. Fla. 1987); *White v. Western School Corp.*, IP85-1192C (S.D. Ind., Aug. 23, 1985).

33. See 29 U.S.C. § 794 (1986).

34. See *Alexander v. Choate*, 105 S. Ct. 712, 720 (1985).

35. Case No. 87-6418 (9th Cir., Nov. 18, 1987).

36. 107 S. Ct. 1123 (1987).

37. 29 U.S.C. § 706(7)(B).

38. See *Georgia State Conference of Branches of NAACP v. State of Georgia*, 775 F.2d 1403, 1477 (11th Cir. 1985).

39. See *Doe v. Bellevill Public School District No. 18*, 56 U.S.L.W. 2290 (Nov. 6, 1987). Moreover, public schools may not discriminate against students either on the basis of HIV-antibody positive status, see, e.g., *Ray*, 666 F. Supp. 1524, or because the



out first evaluating them to determine if they fall within established medical guidelines.<sup>40</sup> While the Rehabilitation Act assures injunctive relief to return a child with AIDS to the classroom, the extent of the right to damages under the Act is still being defined.<sup>41</sup> Damages for AIDS discrimination may also be available under 42 U.S.C. Section 1983 for violations of civil rights protected by the United States Constitution and statutes.<sup>42</sup>

To date, it appears that all schools seeking to exclude HIV-positive children have been unsuccessful. Nevertheless, practitioners should be aware that whether representing the student or the school board, generally accepted medical guidelines and opinions should be presented to the school boards so that they are aware that all "mainstream" medical opinion and all recognized medical bodies knowledgeable on the subject have taken the position that HIV-positive children should be allowed to attend a normal classroom environment absent extraordinary circumstances.<sup>43</sup> If a school board is made aware of these medical facts and

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individual has full blown AIDS, *Thomas*, 662 F. Supp. 376.

40. *B. of Educ. of the City of Plainfield v. Cooperman*, Case No. A-45-46 N.J. Sup. Ct. (April 15, 1987); *Dist. 27 Community School B.*, 502 N.Y.S.2d 25.

41. *Compare* *Drayden v. Needville Indep. Sch. District*, 642 F.2d 129 (5th Cir. 1981) (remedies under Section 504 limited to injunctive relief), and *Shuttleworth v. Broward County*, 649 F. Supp. 35 (S.D. Fla. 1986) (Section 504 limited to "equitable remedy of backpay") with *Meiner v. Missouri*, 673 F.2d 969, 977 (8th Cir. 1982) (damages are available under Rehabilitation Act of 1973).

42. *See e.g. Moore v. Warwick Pub. Sch. Dist. No. 29*, 794 F.2d 322, 324 (8th Cir. 1986) (Section 1983 action may be brought under the Rehabilitation Act as well as in conjunction with constitutional claims brought alongside Section 504). *See generally* R.P. Wasson, *supra* note 3.

43. This position has been taken by the CDC, which recognized that the benefits of an unrestricted school setting outweigh the risk of the acquisition of potential harmful infections and the apparent non-existent risk of transmission of the AIDS virus. CDC Guidelines at 56. The U.S. Surgeon General's office has recommended that these guidelines be followed and that even fewer limitations be placed on regular school attendance by children infected with the AIDS virus. REPORT OF THE SURGEON GENERAL'S WORKSHOP ON CHILDREN WITH HIV-INFECTION AND THEIR FAMILIES, April 6-8, 1987. In addition, the American Red Cross, *AIDS in Children: Information for Teachers and School Officials*, the National Hemophilia Foundation, Letter from President, National Hemophilia Foundation dated July 7, 1987, and the American Academy of Pediatrics have all taken the position that HIV-positive children should be placed in a regular classroom environment. Red Book, American Academy of Pediatrics. AM. RED CROSS in AIDS in CHILDREN: INFORMATION FOR TEACHERS AND SCHOOL OFFICIALS, NAT'L. HEMOPHILIA FOUND., in LETTER FROM PRESIDENT, NAT'L. HEMOPHILIA FOUND. (July 7, 1987) and AM. ACAD. OF PEDIATRICS in RED BOOK, AM. ACAD. OF PEDIATRICS.



nevertheless proceeds to seek to exclude HIV-positive children from a normal classroom education, the attorney representing a school board should advise them of their liability. The attorney seeking admission of the children should institute injunctive relief actions to halt further continuing discrimination under established precedents hereinabove cited and should consider actions for compensatory and punitive damages.<sup>44</sup>

### (c) AIDS and Housing

The discrimination provisions of the Rehabilitation Act and other provisions of federal discrimination law apply to public housing.<sup>45</sup> Federal discrimination law will probably also apply in private housing where FHA or VA loans are involved. Private entities in the home loan market deny discriminating against applicants solely on the basis of AIDS or those in "high risk" categories.<sup>46</sup>

In Florida, the Florida Fair Housing Act prohibits discrimination in housing based on handicap. The Florida Commission on Human Relations affords both administrative redress and a civil cause of action.<sup>47</sup> It should be noted that the Florida Commission on Human Relations has made a determination that AIDS may be a handicap.<sup>48</sup>

Housing raises some unique issues with respect to AIDS discrimination. For example, in *Seitzman v. Hudson River Associates*,<sup>49</sup> physicians obtained specific performance of a contract to buy an office after the defendant refused to cooperate in obtaining an amended certificate of occupancy when it learned that the doctors treated AIDS patients. Gay rights advocates also contend that landlords have sought to evict gay life partners of AIDS victims who have died, because the partners' names are not on the lease and are not considered immediate

44. See, e.g., Comment, *Smith v. Wade: A Green Light for Punitive Damages in Civil Rights Actions*, 61 DEN. U. L. REV. 861 (1984); Nahmod, *Damages and Injunctive Relief Under Section 1983*, 16 URB. L. 201 (1984); Cambron-McCabe, *School District Liability Under Section 1983 for Violation of Federal Rights*, 10 NOLPE SCH. L. J. 99 (1982).

45. See, e.g., *Sullivan v. Pittsburgh, Pa.*, 617 F. Supp. 1488, 1489 (W.D. Pa. 1985) (city receiving federal community block grants may not discriminate on the basis of handicap).

46. See Coles, *AIDS - No Bar to Home Loans*, 137 NEW L. J. 761 (1987).

47. See FLA. STAT. §§ 760.20-37 (1985).

48. See *Shuttleworth*, 639 F. Supp. at 656.

49. 513 N.Y.S.2d 148 (A.D. 1, Dept. 1987).



family members.<sup>50</sup> Because housing is so important, it can be expected to continue to generate litigation on AIDS.

#### (d) AIDS in the Workplace

An employer walks a tightrope between discrimination against a person with AIDS and charges of endangerment or asserted tort liability or statutory liability by other employers.<sup>51</sup> Practitioners representing employers should be aware that AIDS issues arise in the context of workmans compensation laws, contract law, National Labor Relations Act, and state and local laws previously referenced regarding prohibition of discrimination. Your employer/client may also be faced with charges of defamation and breach of confidentiality.<sup>52</sup> Occupational Safety and Health Act provisions may also be asserted by employees. Similarly, an employer may face problems with pre-employment physical exams, blood test legislation, or policies. Conversely, if you are representing the employee with AIDS you should invoke the full range of remedies and protection afforded by applicable state and federal law.<sup>53</sup> Workplaces will be a fertile source of AIDS litigation if for no other reason than the economic value of and availability of remedies for back pay, and other job entitlements and benefits.

#### (e) Tort Liability and AIDS

A developing area of practice will be AIDS tort liability. Claims may be instituted for transmission of the AIDS virus under a number of tort theories, including negligence, assault and battery, and fraud.<sup>54</sup>

50. Telephone interview with David Barr, attorney with Lambda Legal Defense and Education Fund, Inc. (January 20, 1988).

51. Saad, *AIDS - Legal Implications for the Employer*, 66 MICH. B. J. 164 (1987).

52. See generally, R. WEXLER, *AIDS IN THE WORKPLACE* (study materials published March, 1986); Brandt, *Coping With AIDS in the Workplace*, THE AMERICAN LAWYER (1987); Comment, *AIDS and Employment: An Epidemic Strikes the Workplace and the Law*, 8 WHITTIER L. REV. 651 (1986); Leonard, *AIDS And Employment Law Revisited*, 14 HOFSTRA L. REV. 11 (1985).

53. See *Shuttleworth*, 649 F. Supp. at 35; Department of Fair Employment and Housing v. Rathan & Co., [27 Calif. FEHC, No. FEP 83-84, LI-031P, 1-336786, 07-04 (Feb. 5, 1987)]; Note, *AIDS: Does It Qualify as a "Handicap" Under the Rehabilitation Act of 1973?*, 61 NOTRE DAME L. REV. 572 (1986).

54. See generally, Baruch, *AIDS in Courts: Tort Liability for the Sexual Transmission of AIDS*, 22 TORT INS. L. J. 165-193 (Winter 1987); Comment, *Tort Liability*



A cause of action has been held to exist for negligent transmission of venereal disease.<sup>55</sup> In one well known instance, in *Estate of Rock Hudson*, the plaintiff seeks recovery on grounds that he was not informed of his partner's AIDS status. The deadly, unforgiving nature of AIDS seems to guarantee its enshrinement as a basis of tort liability.

"Bloodshield" laws seek to characterize manufacture and sale of blood products as a service rather than a product so as to protect manufacturers of blood products from implied warranty claims.<sup>56</sup> Their applicability in the AIDS context, however, remains to be tested. Bloodshield laws may not protect the manufacturer in an action brought under negligence or other theories where fault is a requisite element.<sup>57</sup> In *Kozup v. Georgetown University*,<sup>58</sup> the court held that negligence would not lie for an infant who received AIDS-contaminated blood prior to 1983 because of an asserted lack of knowledge concerning the disease at that time made it impossible to detect. It should be noted, however, that the facts apparently presented to the court in *Kozup* differ substantially from other sources which seem to describe the direct or indirect participation of the blood products industry in an attempt to "cover up" the facts regarding AIDS and its transmission via blood products.<sup>59</sup> A blood bank may also be liable for failure to use due care in selecting, testing, processing, and handling the blood or in screening or selecting the donor.<sup>60</sup>

It has also been asserted that physicians may have a duty to third parties to warn them that a patient may spread AIDS.<sup>61</sup> *Knier v. Albany Medical Center Hospital*,<sup>62</sup> held that this duty should not be ex-

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for AIDS?, 24 HOUS. L. REV. 957 (1987).

55. See Annotation, *Tort Liability for Infliction of Venereal Disease*, 40 A.L.R. 4th 1089 (1985).

56. See e.g. FLA. STAT. § 672.316(5) (1985); *Williamson v. Memorial Hospital*, 307 So. 2d 199, 201 (Fla. 3d Dist. Ct. App. 1975). See also *Roberts v. Suburban Hosp. Ass., Inc.*, Md. Ct. Spec. App., No. 201 (Nov. 9, 1987) (hospital found not liable for AIDS-contaminated Factor VIII blood product).

57. See *Williamson*, 307 So. 2d at 201 (blood bank may be negligent in failing to detect or remove the "defect" through reasonable use of scientific procedure).

58. 663 F. Supp. 1048 (D. D.C. 1987).

59. See SHILTS, *supra* note 1.

60. See e.g. *Hoder v. Sayet*, 196 So.2d 205 (Fla. 3d Dist. Ct. App. 1967).

61. See generally *Tarasoff v. Regents of the University of California*, 551 P.2d 334 (Cal. 1976) (psychotherapist has duty to warn third parties of dangerous proclivities of patient); see also *The Therapist's Duty to Disclose Communicable Diseases*, 14 WASH. ST. L. REV. 957 (1987).

62. 500 N.Y.S.2d 490 (Spec. Term 1986).



panded beyond the patient's family and health care personnel. Moreover, in an analogous setting<sup>63</sup> a physician was held liable to a patient's daughter when the physician's failure to diagnose tuberculosis resulted in the transmission of the disease to the daughter.

Malpractice liability may also exist for physicians who conduct AIDS blood tests without prior approval of patients under an informed consent theory.<sup>64</sup> In *Barlow v. Superior Court*,<sup>65</sup> a criminal court refused to allow disclosure of a blood test that was acquired without consent and without probable cause.

Tort liability may also lie for breach of confidentiality in disclosing AIDS test results.<sup>66</sup> The common law tort of invasion of privacy, or "public disclosure of private facts" is recognized in Florida, but may be limited to widespread publication.<sup>67</sup> Thus, in *Doe v. Roe*,<sup>68</sup> a physician was held to have violated a patient's right to privacy by publishing the patient's case history.

In Florida, the confidentiality of results of AIDS tests which are required to be submitted to state agencies is protected under recent amendments to the Sexually Transmissible Disease Act.<sup>69</sup> Section 395.017(3), Florida Statutes (1985), also provides that, except under limited circumstances, hospital patient records are privileged and confidential and may not be disclosed without a patient's consent. Section 455.241, Florida Statutes, prohibits physicians from disclosing medical information without a patient's consent. On the other hand, however, Section 395.0147, Florida Statutes, enacted in 1985, requires hospitals to notify emergency medical technicians and paramedics of exposure to an infectious disease. In *Rasmussen v. South Florida Blood Service*,

63. *Hoffman v. Blackmon*, 241 So. 2d 752 (Fla. 4th Dist. Ct. App. 1970), *cert. denied*, 245 So. 2d 257 (Fla. 1971).

64. See FLA. STAT. § 768.46 (1985) (providing standards for consent).

65. 236 Cal. Rptr. 134 (Cal. App. 4th Dist. 1987).

66. See Annotation, *Physician's Tort Liability for Unauthorized Disclosure of Confidential Information About Patient*, 48 A.L.R. 668 (1986). See also Note, *Privacy in Personal Medical Information: A Diagnosis*, 33 U. FLA. L. REV. 394 (1981). Florida is one of the few states which has not established a doctor-patient evidentiary privilege. See *Fidelity & Casualty Co. of New York v. Lopez*, 375 So. 2d 59 (Fla. 4th Dist. Ct. App. 1979).

67. See *Santiesteba v. Goodyear Tire & Rubber Co.*, 306 F.2d 9 (5th Cir. 1962); but see *Horne v. Patton*, 287 So. 2d 824 (Ala. 1973) (physician liable despite limited publication).

68. 400 N.Y.S.2d 668 (Supp. Ct. 1977).

69. FLA. STAT. § 384.29 (Supp. 1986).



*Inc.*,<sup>70</sup> the court held that privacy interests of blood donors and societal interest in the volunteer blood donation system outweigh AIDS victims' interest in obtaining names and addresses of blood donors through the discovery process.

In what is claimed to be the first reported malpractice case involving AIDS, an AIDS victim was recently awarded \$750,000.00 when her doctor failed to diagnose and treat her condition.<sup>71</sup> Given such dollar amounts and the rapid spread of the epidemic, it is not unreasonable to expect a sharp increase in both the number and sophistication of AIDS tort liability cases.

### III. Practical Suggestions for Lawyers with Their First AIDS Case

Given early indications as to the range of legal issues and the mushrooming scope of the AIDS epidemic, practitioners can expect involvement in some facet of an AIDS case, whether representing plaintiff or defendant, counselling corporate clients, or dealing with other aspects or impacts of the disease. Set forth below are some practical suggestions. When that first AIDS case or request for advice comes to your office, consider the following steps:

#### 1. Educate Yourself and Your Staff About HIV infection, AIDS and Its Transmission.

Attorneys, legal secretaries, paralegals, and law clerks are no different from anyone else: they too fear the unknown. It is not unlikely that someone in your office will be unaware of the medical facts described above as to the absence of casual transmission of HIV infection and AIDS. Obtaining and providing your staff with generally available information regarding the virus and its routes of transmission is important.

Among the best general publications you and your staff should read are the American Red Cross brochure entitled *AIDS: The Facts*, American Red Cross, and the Surgeon General's Report on AIDS, and the eight page brochure mailed to all households in May 1988.<sup>72</sup> These

70. 500 So. 2d 533 (Fla. 1987).

71. Miami Herald, January 21, 1988.

72. See U.S. PUB. HEALTH SERV., SURGEON GENERAL'S REP. ON ACQUIRED IMMUNE DEFICIENCY SYNDROME (1986); AMERICAN RED CROSS, AIDS: THE FACTS (1986); AMERICAN RED CROSS, AIDS AND CHILDREN: INFORMATION FOR PARENTS OF SCHOOL-AGE CHILDREN (1986).



brochures are available from local health departments and set forth, in plain language, the causes and modes of transmission of the disease.<sup>73</sup>

## 2. Don't Reinvent the Wheel.

By now, most major AIDS issues have either been written about in the legal literature or litigated. Use available resources and establish your own "network" of attorneys working on similar matters. Consider subscribing to BNA's *AIDS Policy and the Law* service to keep abreast of developing cases, litigation, and regulation. If you are representing plaintiffs, you may want to consider calling the ACLU office in New York, which coordinates AIDS cases. In addition, the Los Angeles ACLU office has substantial experience in AIDS related cases. Other interest groups including gay rights groups publish newsletters.

If you are representing a defendant, consult with trade associations such as hospital associations or hospital attorney associations at the state or national level. If you are defending a public entity, contact such associations as the National School Board Association or the state school board associations, municipal attorneys associations, and other similar organizations. Such organizations publish valuable monographs on AIDS issues, as well as newsletters and pamphlets. Save your time and your client's money by availing yourself of such resources.

## 3. Invest the Time Necessary to Understand the Specific AIDS-Related Medical Issues of Your Case.

Beyond understanding the basic transmission facts referenced above, early on in the case spend the necessary time to understand the specific AIDS-related medical issues applicable to your case. For example, if your case involves hemophiliacs, contact the National Hemophilia Foundation and obtain literature. Identify and obtain the names of physicians in your area who are members of this association or who will assist you in the learning process about hemophilia and its relationship to AIDS.

A good starting point as to medical literature is the AMA's Brief in the *Ray* case, attached as Appendix A to this article. You should contact your state and county public health organizations. If possible,

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73. More specific detailed information can be found from a number of sources such as Branson, *The Acquired Immune Deficiency Syndrome: Information for the Attorney*, 20 MARYLAND B. J. 2 (June 1987); and Ginzburg, *The Acquired Immuno-Deficiency Syndrome, Human Immuno-Deficiency Viruses, and the Community and the Workplace — a Medical Precipis*, Proceedings of the 39th Annual National Conference on Labor Chapter 15, New York University 1986.



meet with public health directors at the local and state levels and gain the insight of their experiences with your particular AIDS-related situation. Obtain and spend some time reviewing the CDC's *Morbidity and Mortality Weekly Reports*. You will find these to be a valuable step in understanding the epidemic and its present status as well as the most recent reported medical developments. If you are to argue effectively either a plaintiff's or defendant's case, you must understand the specific medical facts. Requests for admission, requests for judicial notice, and testimony of local health authorities should be considered. Appendix B to this article is an extract of proposed finding of medical and other facts submitted to the court in the *Ray* case. This will provide a practitioner with additional medical authorities' and ideas as to the sources of factual finding on AIDS issues.

#### 4. Keep Client HIV Information Strictly Confidential.

Damages or injuries arising from breaches of confidentiality of AIDS patients can range from school expulsion, social stigmatization, mental anguish, emotional distress, loss of a job, eviction from housing, and the inability to obtain insurance. You and your staff should, therefore, be very careful not to exacerbate your client's damages by your own actions or to increase your defendant—client's liability by causing further torts or discrimination against the plaintiff.

Staff should also be reminded of ethical constraints and the importance of confidentiality of client information. The health status of clients is particularly important when dealing with AIDS. Breaches of confidentiality can have not only ethical and liability ramifications for the lawyer, but far-reaching adverse impacts on the lives of your clients should the information become generally known.<sup>74</sup> It should also be remembered that breaches of confidentiality can result in civil liability for breaches of the right to personal privacy, recognized at common law and by the constitution.<sup>75</sup>

#### 5. Impacts on Your Practice.

Should you decide to represent a PLWA, you may well consider the impact on your practice as a whole.

If you have clients who express concern, provide them with the

74. Note, *The Constitutional Right of Informational Privacy: Does It Protect Children Suffering From AIDS?*, 14 FORDHAM URB. L. J. (1986) (Public Disclosure of Private Facts).

75. See RESTATEMENT (SECOND) OF TORTS, § 652A (1977); *Stanley v. Georgia*, 394 U.S. 557 (1969); *Eisenstadt v. Baird*, 405 U.S. 438 (1972).



educational materials previously discussed. The AMA and most physicians have shown courage and leadership in dealing with the AIDS epidemic. Should the ABA and individual lawyers do less? The ABA has also begun to show leadership on the AIDS issue. The ABA's House of Delegates at its mid-year meeting in Philadelphia voted to support the enactment of federal legislation barring AIDS-related discrimination and protecting the confidentiality of the AIDS test results. The ABA's call for federal legislation to protect AIDS patients and persons infected with the HIV virus follows the prior support of the American Medical Association.<sup>76</sup>

#### **6. Obtain and Carefully Evaluate Experts.**

Whether representing plaintiff or defendant in an AIDS action, the practitioner will be confronted with a wide array of available "experts," including epidemiologists, public health experts, psychologists, physicians, and others. As in other litigation, your case may well rise or fall on the qualifications, credibility, competency, lack of bias, and believability of the expert you select.

Predisposition or bias of an expert in the AIDS area can be a fertile area of inquiry. Bias may be reflected in prior testimony, correspondence or public actions. In one case, a defense epidemiologist had a history of letter writing to the President of the United States and others advocating quarantining of persons with AIDS. While this may well be within that individual's First Amendment right, it could adversely reflect upon his or her ability to provide objective, scientific testimony to the court. The qualifications of AIDS "experts" on both sides of the case should be carefully reviewed. The AIDS epidemic is relatively new. Many self-appointed "experts" do not have the background, experience, training or publications to support their asserted expertise.

After taking your first AIDS case, contact other lawyers around the country working on similar cases to obtain the names of expert witnesses that have been used in their cases. For example, one defense physician has testified in several major cases around the country, notwithstanding the fact that his opinion is isolated medically and does not reflect the great weight of medical authority or opinion in the country. Consult with other lawyers to determine if such an expert shows up in your case. If you are defending a client engaged in medically unwarranted, clearly discriminatory activities, you may have difficulty in obtaining truly qualified, competent medical experts who will testify con-

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76. See *American Bar Association Meeting*, 56 U.S.L.W. 2447 (1988).



trary to the great weight of medical authority.

As noted by the court in *Arline*, the focus of the inquiry when dealing with contagious diseases should be a medical determination, not a legal determination. Expert opinion is, therefore, critical. In discrimination cases, the American Medical Association has shown exemplary leadership in providing amicus briefs in the *Arline*, *Ray*, and other cases and has generally helped educate and shape sound public policy in the courts.

#### 7. Carefully Consider Special Interest Groups and Their Impact on Your Client and His Case.

The practitioner should be aware of the politicization of the AIDS issue by both the right and the left. The viewpoint of the right wing on AIDS is often reflected by Congressman Dannemeyer and certain fundamentalist groups. The radical left wing viewpoint is sometimes reflected by one or more of the more strident gay rights advocacy groups. Prior to seeking the assistance of such groups on either side of the issue or allowing such entities to align themselves with his client's case, the practitioner should carefully consider the impact on his or her client and the case.

In some cases, a dying person with AIDS may well want to give added meaning to his last years by using his predicament to promote a cause and benefit a class of similarly situated persons. In other cases, the client may not want the turmoil of intense publicity and protracted litigation to mar his or her final years. If your case presents new or novel AIDS issues, you should consult with your client regarding whether the client desires to make his case a national issue. In short, is the client most interested in a "cause," or in obtaining prompt relief and compensation for his or her own injuries or predicament. If your client's interest is the latter, you should avoid groups primarily concerned with advancing the "cause." This decision is and should remain the client's decision. The practitioner, however, should carefully monitor the activities and interests asserted by any group seeking to assist or use his client.

If your client is a defendant or an entity seeking to defend or establish AIDS policy, it will most likely desire to avoid media attention, much less be involved in a test or "cause" case for the National Association of Manufacturers or the Chamber of Commerce. In fact, the avoidance of publicity is the reason many businesses settle AIDS complaints before litigation.

Experts or consultants should also be interviewed carefully as to the "politics of AIDS." Defense lawyers should be aware of "AIDS



Defense" experts with excess political baggage, i.e., are they consultants to this or that political group on AIDS. Pretrial discovery can often uncover embarrassing political tie-ins or prior testimony of such "experts." If shown to be advocates for one or the other end of the political spectrum, the effectiveness of such witnesses will be eliminated or greatly reduced.

### **8. Settlement Agreements.**

In addition to all normal settlement provisions, confidentiality and medical benefits are usually key issues in the settlement of any AIDS-related dispute. In representing a defendant, you can expect that payment of past and future medical expenses will be a major objective of most plaintiffs. Freedom from the enormous costs of medical treatment for AIDS-related illness and a desire not to burden loved ones with medical costs are strong motivating factors for a person with AIDS. Defendants seeking to reach a resolution of an AIDS dispute should recognize this as a key incentive in any settlement proposal.

Confidentiality is also an important element for both parties to an AIDS dispute settlement. A defendant is seeking to avoid embarrassing publicity. The plaintiff with AIDS seeks to avoid further unwarranted isolation or discrimination in the community. A suggested key ingredient in any "confidentiality" settlement of an AIDS-related dispute is a mandatory confidential arbitration clause. Thus, should post-settlement disputes arise, the parties will have agreed to mandatory arbitration with an arbitrator who can confidentially resolve the matter. Resort to judicial proceedings on the agreement is therefore unnecessary and confidentiality remains in tact.

### **9. Medical Condition of Client.**

If you are representing a person with AIDS, be sensitive to your client's physical and mental condition. The impact of litigation on your client's health in terms of physical limitations, time, and the strain of media attention, depositions, court appearances and testimony should be carefully considered. Your client should be advised of the time requirements and the emotional and physical stress he or she can expect from the litigation process. Your client's decision to pursue or not pursue litigation should be made in consultation with his or her doctor and others relied upon by the PLWA.

When representing a defendant, counsel should also be sensitive to the plaintiff's physical and mental condition. It ill serves your defendant if defense counsel unnecessarily exacerbates the plaintiff's condition or subjects the plaintiff to further embarrassment, humiliation or ridi-



cule. This is true, if for no other reason, than to avoid subjecting the defendant to additional liability as a result of the actions of counsel. Such actions by defense counsel are unnecessary, improper, and can result in the filing of supplemental pleadings seeking punitive damages. Whether representing a plaintiff or defendant, the sensitivity of an AIDS case, the importance of the issue being litigated, and the publicity and media attention devoted to such cases, require a high degree of professionalism by counsel for both sides.

#### 10. Attorneys' Fees.

If you are representing a corporate officer with an HIV positive son or a corporate or governmental entity seeking to defend AIDS claims, your fees, of course, will be a matter of contract. On the other hand, when representing an indigent intravenous drug user with AIDS, an HIV positive welfare mother, or poor elementary age school children who have been expelled from school because of their HIV positive status — your fees, if any, will have to be based upon a statutory right. Both the Civil Rights Act of 1871 and Section 794(a) of the Rehabilitation Act of 1973 provide for the award of attorneys' fees and expenses to prevailing parties.<sup>77</sup>

Standards governing the award of attorneys' fees under Section 505 of the Rehabilitation Act are the same as those under the Civil Rights Attorneys' Fee Award Act of 1976.<sup>78</sup> The standards used in Section 1988 cases are generally applicable in "all cases"<sup>79</sup> in which Congress has authorized an award of fees to a single 'prevailing party'.<sup>80</sup>

Two tests guide the court in its analysis of determining a reasonable attorneys' fee: (1) Fees should be awarded to a prevailing party as

77. See 42 U.S.C. § 1988; 29 U.S.C. § 701.

78. 42 U.S.C. § 1988.

79. In *Smith v. Robinson*, 468 U.S. 992 (1984), the Supreme Court held that one who succeeds on the substantive claim under the Education of the Handicapped Act ("EHA"), 20 U.S.C. § 1400 *et seq.*, for which statutory attorneys' fees were not authorized at the time, cannot recover § 1988 attorneys' fees on the basis of a substantial, undecided equal protection claim seeking essentially the same relief. Congress thereafter quickly overruled this result by the enactment, on August 5, 1986, of the Handicapped Childrens Protection Act ("HCPA"), Pub. L. No. 99-372, 100 Stat. 796 (1986), which amended 20 U.S.C. § 1415, to empower the court to award attorneys' fees for judicial success of EHA claims and, as well, for success on § 1983 constitutional claims that overlap EHA claims.

80. *Hensley v. Eckerhart*, 461 U.S. 424, 433 n.7 (1983).



a matter of course absent special circumstances;<sup>81</sup> (2) In the Eleventh Circuit, at least, the standard of reasonableness in determining the amount of fees is to be given a liberal interpretation.<sup>82</sup>

The specific standards for determining the reasonableness of fees and the applicability of fee enhancement, etc., are not within the scope of this article. Nevertheless, before embarking upon representation of persons with AIDS, the practitioner should consult an authoritative, current article on the subject.<sup>83</sup> The practitioner should also be aware of the Supreme Court's decision last term in *Pennsylvania v. Delaware Valley Citizens Council*,<sup>84</sup> where the Court, in a confounding series of concurring opinions, reaffirmed prior rulings.

### Conclusion

Lawyers, as officers of the court, have an obligation to educate themselves on the AIDS epidemic. It is hoped that the suggestions and resource materials noted herein will aid in that task. Once practitioners have educated themselves, they can more effectively argue, persuade, and educate the courts so as to shape rational, reasoned public policy on AIDS.

In the long term, the only answer to AIDS is medical research and education and political leadership at the local, state and national level. Until elected officials — school boards, town councils, city and county commissions, state legislators, and the Congress and the President — show such leadership and provide the necessary education, lawyers and the courts will be forced to make policy on a case-by-case basis. Absent comprehensive national legislation, it will continue to be the job of practitioners and the courts to strip away fear, superstition, and the mythology of AIDS so that rational decisions can be made. In so doing, the practitioners and courts must work to establish a basic framework of rights and obligations in the workplace, schools, health care, insurance, and tort areas.

81. See, e.g., *Id.*; *Doe v. Busbee*, 684 F.2d 1375, 1378 (11th Cir. 1982).

82. See, e.g. *Johnson v. Univ. C.*, 706 F.2d 1205, 1211 (11th Cir. 1983); *Yates v. Mobile County Personnel Bd.*, 719 F.2d 1530, 1532 (11th Cir. 1983).

83. E.g., *Kirklin, The Recovery of Attorneys' Fees in Civil Rights Cases Pursuant to 42 U.S.C. § 1988*, PLI Section 1983 Civil Rights Litigation & Attorneys' Fees 1987 Current Developments (1987).

84. 478 U.S. 546 (1986).







the CDC's case definition for AIDS had been reported.<sup>3</sup>

AIDS is caused by infection with human immuno-deficiency virus (HIV), a human retrovirus that penetrates chromosomes of certain human cells which combat infection throughout the body. The virus destroys those cells, thereby weakening the victim's immune system.<sup>4</sup> The earliest indications of HIV infection are (1) the detection of antibodies to the virus in the blood or (2) actual isolation of HIV in the blood. The appearance of antibodies is known as *seroconversion*, and can be detected before there is any noticeable immunological damage. National Academy of Sciences at 44. It is not known what proportion of those individuals who are seropositive for HIV antibodies will ultimately develop clinical AIDS.<sup>5</sup>

### TRANSMISSION PATTERNS

1. The medical community's understanding of AIDS and its pattern of transmission has grown immensely in the seven years since initial incidence reports were received by CDC concerning the presence of an opportunistic form of pneumonia in five homosexual men. *Pneumocystis carinii pneumonia* — *Los Angeles*, 30 MMWR 250 (June 5, 1981). Since then other risk groups have been identified, including hemophiliacs, transfusion-recipients, intravenous (IV) drug users, sexual partners of risk-group members and children of risk-group

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3. 2 Centers for Disease Control, *Update: Acquired Immuno-Deficiency Syndrome - United States*, MMWR Reports on AIDS, 36 (1986) [hereinafter "2 CDC Reports"]. CDC defines a case of AIDS as an illness characterized by (1) the presence of one or more specifically identified opportunistic diseases that are at least moderately indicative of an underlying impairment of cellular immunity and (2) the absence of any other cause of reduced resistance. In addition, the patient must test positive for serum antibody to human immunodeficiency virus (HIV), have a depressed count of T "helper" cells (CD4 T-cells) and a low ratio of CD4 to CD8 ("suppressor") T-cells. See 1 CDC Reports at 18.

4. Institute of Medicine, National Academy of Sciences, *Confronting AIDS: Directions for Public Health, Health Care and Research*, 43 (1986) [hereinafter "National Academy of Sciences"]. HIV has also been variously identified as human T-cells lympho-tropic virus type III (HTLV-III) or lymphadenopathy-associated virus (LAV). The designation "human immunodeficiency virus" (HIV), however, has been accepted by a subcommittee of the International Committee for the Taxonomy of Viruses as the appropriate name for the retrovirus that has been implicated as the causative agent of AIDS. 232 SCIENCE 697 (1986).

5. The U.S. Public Health Service has estimated that 20 to 30 percent of the people who are seropositive today may develop AIDS by 1991. *PHS Plan for Prevention and Control of AIDS and the AIDS Virus*, 101 Public Health Reports 341 (1986).



members.

HIV transmission occurs in three ways: (1) intimate sexual contact with an infected person;<sup>6</sup> (2) invasive exposure to contaminated blood (i.e., introduction of infected blood or blood products into the bloodstream occurring as a result, *inter alia*, of IV drug use,<sup>7</sup> blood transfusions or treatment of hemophilia); or (3) perinatal exposure (i.e., from infected mother to infant).<sup>8</sup> Mueller, *supra* at 256; National Academy of Sciences, *supra* at 6, 50-57.

2. The hemophilic children in this case were exposed to the virus either by a transfusion of blood or by receipt of blood products designed to promote the blood clotting qualities of their blood.

*Transfusions:* Transfusion-associated HIV infection accounts for only 2 percent of all AIDS cases. Where HIV infections have resulted from transfusion of blood or blood products, follow-up investigations have identified at least one donor who was a member of a high-risk group. National Academy of Sciences, *supra* at 53. Since mid-1985, when screening of the nation's blood supply began, risk of transfusion-associated infection has been reduced by more than 95 percent, but the risk has not been totally eliminated. *Id.*<sup>9</sup>

*Treatment with Clotting Factor:* HIV infection of hemophiliacs was first noted in 1981.<sup>10</sup> 1 CDC Reports at 14. Until recently, the

6. By far the most frequent HIV transmission route is through homosexual or heterosexual receptive anal sex or vaginal intercourse with ejaculation of semen. See 2 CDC Reports at 36. See also National Academy of Sciences, *supra* at 51; Mueller, *The Epidemiology of the Human Immunodeficiency Virus Infection*, 14 LAW, MED. & HEALTH CARE 250, 256 (1986).

7. The second most frequent means of HIV transmission is through the sharing of needles and syringes contaminated by blood residue. 2 CDC Reports at 36; National Academy of Sciences, *supra* at 53.

8. HIV can be transmitted from an infected mother to her baby *in utero* or at birth. La Pointe, *Trans-placental Transmission of HTLV-III Virus*, 312 NEW ENG. J. MED. 1325 (1985). However, not all children born to infected mothers become infected. Parks & Scott, *Pediatric AIDS: A Disease Spectrum Casually Associated with HTLV-III Infection*, 45 CANCER RES. 46595-615 (Supp. 1985).

9. Some risk of HIV infection from transfusions is still present because HIV transmission may occur while the virus is present but prior to the appearance of HIV antibodies in the donor's blood. Additionally, the test is not sensitive to the presence of HIV antibodies in 100 percent of cases.

10. Hemophilia A is a sex-linked, inherited disorder characterized by a deficiency of Factor VIII (a blood clotting factor). Hemophilia is classified as mild, moderate or severe. According to their physician, the Ray children are moderate hemophiliacs. Affidavit of Dr. Jerry L. Barbosa, ¶ 5 (July 15, 1987).

Lack of the requisite blood proteins required for normal clotting results in



procedures used in manufacturing the blood clotting concentrates required for treatment of hemophilia failed to screen out the causative agent of AIDS. Prior to 1984, plasma was pooled from many donors, allowing HIV to be transmitted from an infected plasma donor to recipients of the blood clotting concentrate. Since 1984, however, heat-treatment procedures have been adopted which inactivate HIV. Those procedures, in combination with screening potential donors of the blood from which Factor VIII concentrates are extracted, appear to have eliminated the risk of infection from this source.<sup>11</sup>

It is estimated that 80-90 percent of hemophiliacs now test positive for HIV antibodies, with one recent study showing that 92% had HIV antibodies in their blood. 2 CDC Reports at 32. Despite the high incidence of HIV-exposure, only about *one percent* of AIDS cases involve simply hemophiliacs. Furthermore, studies on HIV sero-conversion in household members of hemophiliacs show no reported incidents of HIV infection for those who share close, non-sexual contacts with HIV positive hemophiliacs.<sup>12</sup>

3. The most recent statement by CDC on HIV transmission emphasizes that:

There continues to be no evidence of nonspecific transmission through casual contact; insect bites; or foodborne, waterborne, or environmental spread among AIDS cases. The situation is most clear in the 5- to 15-year-old age group, which lies between the

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hemophiliacs experiencing severe and prolonged *internal* bleeding. Deep tissue bleeding, hemorrhage into joints (e.g. knees, ankles, etc.) and presence of blood cells in the urine are the most common forms of clinical bleeding in hemophilia A. Schrier, *Hematology*, SCIENTIFIC AMERICAN MEDICINE VI-31 (Rubenstein & Federman) (1986).

Factor VIII deficiency can be treated with intravenous administration of Factor VIII concentrated from human plasma. 1 CDC Reports at 15. For this reason, children such as plaintiffs who suffer moderate hemophilia and who receive treatment for blood clotting are no more likely to bleed externally or to bleed in larger quantities from an external wound than children who are not hemophilic.

11. Current CDC guidelines state that "donor-screened, heat-treated factor concentrates remain the recommended therapy for patients requiring factor replacements." CDC, *Survey of Non-U.S. Hemophilia Treatment Centers for HIV Seroconversions Following Therapy with Heat-Treated Factor Concentrates*, 36 MMWR 121 (March 13, 1987).

12. See, e.g., *HTLV-III/LAV Antibody and Immune Status of Household Contacts and Sexual Partners of Persons with Hemophilia*, 255 J.A.M.A. 212 (1986); Kreiss, *Nontransmission of T-Cell Subset Abnormalities From Hemophiliacs to Their Spouses*, 251 J.A.M.A. 1450 (1984); Ragni, *An Immunologic Study of Spouses and Siblings of Asymptomatic Hemophiliacs*, 62 BLOOD 1297 (1983).



youngest children for whom perinatal transmission is the most important and the adult groups where sexual and drug related transmission predominates. Five to 15 year olds, who include the majority of school children, comprise 16% of the U.S. population. However, only 62 AIDS cases (0.2% of total cases) have occurred in this large group, which is exposed like other groups to casual contact with HTLV-III/LAV-infected persons, insects and environmental factors. Of these, 61 (98%) fit into established risk categories. The risk factor investigation is incomplete on the remaining case.

## 2 CDC Reports at 38.

Extensive and numerous studies have consistently found no apparent risk of HIV infection by individuals exposed through close, non-sexual contact with AIDS patients. These studies have demonstrated that contacts involving sharing of household items, such as tooth brushes, eating utensils, baths or toilets, do not lead to HIV-infection. Similarly, there is no evidence that close personal, but non-sexual interaction, such as giving a bath, shaking hands or kissing (even on the lips), will cause HIV-infection.<sup>13</sup> In a number of these studies, household contacts were followed for periods ranging up to three years without evidence of seroconversion from casual contacts. The New England Journal of Medicine recently reported that as of early 1986, other sexual partners or children born to infected mothers, *none* of the family members in more than 12,000 cases reported to CDC had contracted AIDS. See Friedland, *supra*.

Two studies concerning transmission have particular relevance because of their focus on hemophilic populations. The first reported the findings of a three-year study of the HIV status of hemophilic and non-hemophilic children attending a boarding school in France. The students — average age 10 years — lived full-time in the school and shared all the school and dormitory facilities (e.g. classrooms, swim-

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13. See, e.g., Fischl, *Evaluation of Heterosexual Partners, Children and Household Contacts of Adults with AIDS*, 257 J.A.M.A. 640, 644 (1987); Friedland, *Lack of Transmission of HTLV-III/LAV Infection to Household Contacts of Patients with AIDS or AIDS-Related Complex with Oral Candidiasis*, 314 NEW ENG. J. MED., 344, 347 (1986); Berthier, *Transmissibility of Human Immunodeficiency Virus in Haemophilic and Non-Haemophilic Children Living in a Private School in France*, 1986 LANCET 598, 601; Kaplan, *Evidence Against Transmission of Human T-Lymphotropic Virus/Lymphadenopathy Associated Virus (HTLV-III/ LAV) in Families of Children with the Acquired Immunodeficiency Syndrome*, 4 PED. INFEC. DISEASE 468, 471 (1985).



ming pools, dining halls, lavatories, sleeping areas). By the end of the three-year study period, half of the hemophiliac children were seropositive. *See*, pages 4-6, *supra*. By contrast, *none* of the non-hemophiliac children had seroconverted, despite close casual contact extending in many cases for several years. Berthier, *supra*, at 601.

A second study measured the HIV antibody status of individuals who assisted hemophiliacs with home infusions of blood clotting factor. The study analyzed whether such exposure to blood products might increase the risk of HIV infection. Despite approximately 44 person-years of exposure through close casual contact and through assistance with injections, none of the household members became infected. Lawrence, *HTLV-III/LAV Antibody Status of Spouses and Household Contacts Assisting in Home Infusion of Hemophilia Patients*, 66 BLOOD 703, 704-05 (1985).<sup>14</sup>

Based on these and other studies, the CDC and the American Academy of Pediatrics have issued guidelines concerning school attendance for children infected with HIV. According to CDC:

None of the identified cases of HTLV-III/LAV infection in the United States are known to have been transmitted in the school, day-care or foster-care setting or through other casual person-to-person contact. . . . Based on current evidence, casual person-to-person contact as would occur among school children appears to pose no risk.

CDC, 34 MMWR 517-21 (Aug. 30, 1985).<sup>15</sup>

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14. Finally, there is no evidence of HIV transmission through casual contact with saliva, *see, e.g.*, Saviteer, *HTLV-III Exposure During Cardiopulmonary Resuscitation*, 313 NEW ENG. J. MED. 1606-07 (1985); Drummond, *Seronegative After Being Bitten By A Patient with AIDS*, 256 J.A.M.A. 2342 (1986); *see generally* Ho, *Infrequency of Isolation of HTLV-III Virus from Saliva in AIDS*, 313 NEW ENG. J. MED. 1606 (1985), although it is sometimes possible to identify HIV in saliva. Groopman, *HTLV-III in Saliva of People with AIDS Related Complex and Healthy Homosexual Men at Risk for AIDS*, 226 SCIENCE 447-49 (1984).

15. The findings in the CDC's May, 1987 health-care worker case study, *Update: Human Immunodeficiency Virus Infection in Health-Care Workers Exposed to Blood of Infected Patients*, 36 MMWR 285-89 (May 22, 1987), "does not in any way change or qualify" the CDC position on school attendance. Letter from Dr. James W. Curran, Director, AIDS Program, CDC to Dr. Jerry Barbosa (July 1, 1987).

Relying upon this study, defendants' experts assert that the children's status as hemophiliacs increases risk to classmates and teachers because hemophiliacs will bleed more and more often than other children. As we explained previously (page 5, n. \*, *supra*), these assumptions are baseless. Further, as reiterated in the May, 1987 CDC



In summary, there is no evidence that the virus is transmitted through casual contact, that is, close, nonsexual involvement between persons in the course of daily activities. "There is no evidence that the virus is transmitted in the air, by sneezing, by shaking hands, by sharing a drinking glass [or eating utensils], by insect bites, or by living in the same household with an AIDS sufferer or an HIV-infected person." National Academy of Sciences, *supra* at 6.

## ARGUMENT

### SECTION 504 OF THE REHABILITATION ACT FORBIDS DENIAL OF ADMISSION TO PUBLIC ELEMENTARY SCHOOLS ON THE BASIS OF UNFOUNDED, SPECULATIVE ASSERTIONS CONCERNING THE RISK OF CONTAGION

The present case provides a compelling example of the need for the legal protection from irrational discrimination on the basis of fear and misperception concerning disability and disease that Congress provided in Section 504 of the Rehabilitation Act of 1973. The DeSoto County School Board summarily excluded the three Ray children from public schools without the benefit of any legitimate medical evidence and in the face of the unanimous recommendations of public health agencies that the children should be admitted to their regular classrooms in light of the minimal risk of HIV transmission in the school environment. Although each of the Ray children has been exposed to the virus, and is seropositive, none has manifested any symptoms of acquired immune deficiency syndrome. Neither the school board nor anyone else has presented evidence of any realistic risk posed by these children to their classmates. Instead, the Board has offered *post hoc* rationalizations concerning theoretical possibilities of HIV transmission under circumstances that are not likely to occur in an elementary school setting. The Board's exclusion of these children is precisely the sort of "unthinking and unnecessary discrimination" Section 504 was enacted to forbid. *Arline v. School Board of Nassau County, Florida*,

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report, when there is a possibility of exposure to blood or other bodily fluids, "routine precautions" appropriate to the nature and extent of likely contact should be followed. Hands and other skin surfaces that are accidentally contaminated should be washed thoroughly with household soap or a diluted bleach solution, and gloves should be worn to clean up spills of blood or other bodily fluids.



772 F.2d 759, 764 (11th Cir. 1985), *aff'd*, 107 S. Ct. 1123 (1987).

Section 504 provides that: "[n]o otherwise qualified handicapped individual in the United States, as defined in section [7(7) of the Rehabilitation Act], shall, solely by reason of 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. . . ." 29 U.S.C. Section 794.<sup>16</sup> Congress broadly defined the term "handicapped individual" as used in Section 504 to protect persons who suffer from physical or mental conditions that actually limit their ability to function in some respect *and* persons whose ability to function is limited only by the misperception of others, and not by any physical or mental condition. Congress was well aware that "society's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairment." *School Board of Nassau County, Florida, v. Arline*, 107 S. Ct. 1123, 1129 (1987). The broad definition of "handicapped individual" promotes the fundamental goal of Section 504 to protect individuals against "deprivations based on prejudice, stereotypes, or unfounded fear, while giving appropriate weight to such legitimate concerns . . . as avoiding exposing others to significant health and safety risks." *Id.* at 1131. The Board's exclusion of the Ray children from the classroom clearly violates the command of Section 504.

#### A. *An Asymptomatic HIV-infected Child Is A "Handicapped Individual," As Defined In The Rehabilitation Act*

1. An asymptomatic, HIV-infected person is a "handicapped individual" for purposes of Section 504 of the Rehabilitation Act. The plain language of the statute, its legislative history, and the governing regulations demonstrate that Congress intended no distinction between individuals who are in fact impaired and thus limited in their ability to carry on some major life functions and those, like the children in this case, whose ability to carry on major life functions is limited only by the perceptions of others concerning their physical condition. Under the Rehabilitation Act, any person who (1) has or is regarded as having a physical condition (2) that substantially limits or is regarded as sub-

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16. Defendants admit the school board receives "Federal financial assistance" and therefore is subject to the requirements of Section 504 (Answer, ¶ 74); defendants also have not contested that the "program or activity" requirement is satisfied in this case.



stantially limited his ability to attend school or learn is a "handicapped individual," and entitled to the protection of Section 504 of the Act.

Section 7(7)(B) of the Rehabilitation Act defines the term "handicapped individual" as:

any person who (i) has a physical or mental impairment which substantially limits one or more of such person's major life activities, (ii) has a record of such an impairment, or (iii) *is regarded as having such an impairment.*"

29 U.S.C. Section 706(7)(B) (emphasis added). For purposes of Section 504 of the Act, the term "handicapped individual" thus clearly includes individuals who are not, in fact, limited by their physical condition at all, but are "regarded" as having a condition that limits their ability to carry on major life activities. *School Board of Nassau County, Florida v. Arline*, 107 S. Ct. 1123, 1126-1127 (1987); *South-eastern Community College v. Davis*, 442 U.S. 397, 405-406 & n. 6 (1979).

The legislative history of the Rehabilitation Act emphasizes the intended breadth of the definition of "handicapped individual," as amended in 1974. Congress made clear its

intention to include those persons who are discriminated against on the basis of handicap, whether or not they are in fact handicapped.

... This subsection includes within the protection of sections 503 and 504 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 Clause [i] in the new definition.* Members of both of these groups may be subjected to discrimination on the basis of their being regarded as handicapped."<sup>17</sup>

In broadening the definition of "handicapped individuals" in 1974, therefore, Congress specifically intended to protect such persons against

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17. S. Rep. No. 1297, 93d Cong., 2d Sess. (1974), reprinted in 1974 U.S. CODE CONG. & ADMIN. NEWS 6373, 6389-90 (emphasis added); see *id.* at 6389 ("The amended definition . . . takes cognizance of the fact that handicapped persons are discriminated against in a number of ways. First, . . . when they are, in fact, handicapped. . . . Second, . . . when they are classified or labelled, correctly or incorrectly, as handicapped. . . . Third, . . . if they are regarded as handicapped, regardless of whether they are in fact handicapped. . . .").



"the effects of erroneous but nevertheless prevalent perceptions about the handicapped. . . ." *Nassau County v. Arline*, 107 S. Ct. at 1126-27; see *Southeastern Community College v. Davis*, 442 U.S. 397, 405-406 & n. 6 (1979).

The implementing regulations adopted in 1977 provide an "important source of guidance" in interpreting the scope of Section 504. *Alexander v. Choate*, 469 U.S. 287, 304 n. 24 (1985); see, e.g., *Nassau County v. Arline*, 107 S. Ct. at 1127. These regulations eliminate all doubt as to the intended breadth of the statutory definition of "handicapped individual."<sup>18</sup> In particular, the phrase "[i]s regarded as having an impairment"

means (A) has a physical or mental impairment that does not substantially limit major life activities 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.

45 C.F.R. Section 84.3(j)(IV) (1986); see *id.*, App. A, p. 326; 41 Fed. Reg. 29548, 29551-29552 (July 16, 1976).

2. Asymptomatic HIV-infected persons, such as the Ray children, meet the requirements of Section 7(7)(B) of the Rehabilitation Act. First, each of the Ray children has been exposed to the human immunodeficiency virus. For purposes of Section 7(7)(B), it is immaterial whether the children are in fact carriers of the virus, for they are demonstrably "regarded" as HIV-infected.<sup>19</sup> Second, while the children are asymptomatic, and therefore the infection has not resulted in any limitation of their ability to carry on major life activities, the action of the Board in excluding them from school and placing them in a learn-

18. The regulations give content to each of the significant phrases used in the definition. 45 C.F.R. § 84.3(j) (1986). The subsequently adopted regulations of the Department of Education are identical. 34 C.F.R. § 104.3(j) (1986).

19. A viral infection is quite clearly a physical "impairment" in the ordinary sense of the term. Consistent with Congress' manifest intention, see pages 13-14, *supra*, the 1977 regulations expressly reject the notion that the definition of "handicapped individual" limits the protection of Section 504 to individuals afflicted with conditions "most commonly regarded as handicaps," 41 Fed. Reg. 29599, and define "physical . . . impairment" to include "any physiological disorder or condition . . . affecting . . . [the] hemic and lymphatic" systems. 45 C.F.R. § 84.3(j)(2)(i)(A) (1986) (emphasis added); see *Nassau County v. Arline*, 107 S. Ct. at 1127 n. 5.



ing environment intended for handicapped children demonstrates that the children are "regarded" as having suffered a substantial limitation due to their condition. Moreover, the school board's exclusionary act directly imposes a substantial limitation on the Ray children's ability to carry on critically important major life activities, namely, school attendance and learning. See *Nassau County v. Arline*, 107 S. Ct. at 1129 n. 10. The Ray children thus fall squarely within the class of persons Congress intended to protect from irrational discrimination on the basis of their physical affliction. See *District 27 Community School Board v. Board of Education of the City of New York*, 502 N.Y.S. 2d 325, 335-337 (Sup. Ct. 1986).<sup>20</sup>

B. *An Asymptomatic, HIV-infected Child Is "Otherwise Qualified" To Attend Public School*

Under Section 504 of the Rehabilitation Act, an "otherwise qualified handicapped person: is one who meets the requirements of the particular program "in spite of" his handicap. *Southeastern Community College v. Davis*, 442 U.S. 397, 406 (1979). There is no question that the Ray children would benefit from placement in their regular classrooms and that they can do regular classroom work. The only question is whether they are not qualified because they pose a serious health risk to classmates or teachers. In order to make that determination, the Supreme Court has held that there must be specific findings of medical fact with respect to:

- (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),

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20. The definition of "handicapped children" provided in the Education of the Handicapped Act, 20 U.S.C. §§ 1401, *et seq.*, is significantly narrower than § 7(7) of the Rehabilitation Act. See *District 27 Community School Board v. Board of Education of the City of New York*, 502 N.Y.S. 2d 325, 339 (Sup. Ct. 1986). Under the Education of the Handicapped Act, the term "handicapped children" is defined as "mentally retarded, hard of hearing, deaf, speech, or language impaired, visually handicapped, seriously emotionally disturbed, or children with specific learning disabilities, who by reason thereof require special education and related service." 20 U.S.C. § 1401(1). There is no evidence that any of the Ray children suffer from any learning disability, other than that imposed by the school board's exclusion. Accordingly, the EHA is inapplicable, and *Smith v. Robertson*, 104 S. Ct. 3457, 3474 (1984), which requires resort to the administrative and judicial remedies provided for under the EHA, is irrelevant.



and (d) the probabilities the disease will be transmitted and will cause varying degrees of harm.

*Nassau County v. Arline*, 107 S. Ct. at 1131 (quoting AMA brief as *amicus curiae*).<sup>21</sup> This analysis requires a federal fund recipient to balance the interests of the individual who is "handicapped" by a contagious condition and the public's need to be protected from real health risks in deciding whether to exclude the individual from a program or activity. The school board has failed to satisfy its burden to show that the Ray children are not "otherwise qualified" to attend regular classes.

There is no evidence, either in the record in this case or in the relevant medical literature, that demonstrates any appreciable risk of transmission of the virus under the circumstances likely to occur in a school setting. Nor is there substantial evidence in this case of any of the special circumstances that might justify prohibiting these children from attending their regular classes. Individuals in hundreds of households in which family members have been infected with the virus have been tested, without producing any evidence of transmission through the kinds of casual contact which occur in a school setting. Pages 7-9, *supra*. The probability of harm, therefore, is virtually nonexistent. See *District 27 Community School Board v. Board of Education of the City of New York*, 502 N.Y.S. 2d 325, 329-332, 334-335, 337 (Sup. Ct. 1986). Accordingly, recognizing the "severity" of the potential harm if the HIV infection is transmitted, the Ray children are "qualified" to attend public school, because they pose no significant risk of transmission to anyone. See *Nassau County v. Arline*, 107 S. Ct. at 1131 & nn. 16-17. Moreover, when the Board decided to exclude the Ray children, it relied on no informed medical judgment about the risks the children actually posed to their classmates.<sup>22</sup> Accordingly, the Board's decision cannot withstand scrutiny under Section 504.

21. See also *New York State Association for Retarded Children, Inc. v. Carey*, 612 F.2d 644, 650-651 (2d Cir. 1979); *District 27 Community School Board v. Board of Education of the City of New York*, 502 N.Y.S. 2d 325, 329-332m 334-335, 337 (Sup. Ct. 1986).

22. The *post hoc* rationalization offered by the Board through Dr. Steven A. Armentrout and Mr. Anthony D. J. Robertson is far too little, and too late, to justify the Board's summary exclusion of the Ray children. In any event, absent some factual basis suggesting HIV transmission through means likely to exist in school, the Board cannot justify rejecting the overwhelming contrary evidence on which the consensus of responsible medical opinion firmly rests.



"[C]ourts normally should defer to the reasonable medical judgments of public health officials." *Nassau County v. Arline*, 107 S. Ct. at 1131. Here, deference by this Court is clearly appropriate, since the views of responsible public health officials demonstrate conclusively and unanimously that the Ray children pose no appreciable risk to their classmates and therefore are "otherwise qualified" to attend regular classes. See C.F.R. Section 84.3(k)(2) (1986); 34 C.F.R. Section 104.3(k) (2) (1986).<sup>23</sup>

### CONCLUSION

For the foregoing reasons, the Court should vacate its interim order, and enter an injunction directing the school board to admit the Ray children to regular school attendance immediately.

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23. Because Section 504 provides a statutory basis for resolving this case in favor of plaintiffs, the Court need not address the Due Process and Equal Protection issues presented by plaintiffs. The AMA therefore only notes that the defendant school authorities clearly violated plaintiffs' fundamental constitutional rights. The Due Process Clause and the Equal Protection Clause of the Fourteenth Amendment preclude public officials from engaging in arbitrary or irrational action. *E.g.*, *Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432, 439-442, 446-450 (1985). The Board excluded the Ray children on the basis of unsubstantiated fear and baseless assumptions about AIDS. Given the overwhelming evidence and consensus of medical, health and scientific opinion that the risk of HIV transmission in the circumstances likely to occur in a school environment is virtually non-existent, particularly if basic precautions appropriate in dealing with the blood or other bodily fluids of any person are observed (see pages 6-9, *supra*), the school board's exclusionary action cannot withstand even minimal scrutiny. *Id.* at 446-450.

Furthermore, the school board's summary exclusion of the Ray children offends the most fundamental principles of procedural due process. Under Florida law, the Ray children have a protected right to public education. Answer, ¶¶ 20, 24. Nevertheless, the children have been *permanently barred* from attending public schools on the basis of their supposed danger to others, without being provided any opportunity to contest the factual basis on which the Board purported to act. Given (a) the grievous harm inflicted on the children, affecting both their education and their emotional well-being, (b) the manifest risk of error when school administrators are required to make medical judgments, (c) the value of thorough consideration of all the medical evidence in making such judgments and (d) *the absence of any factual basis* for believing the children ever posed any risk to anyone, the children were entitled to an evidentiary hearing before expulsion. See *Goss v. Lopez*, 419 U.S. 565, 582 (1975); see also *Mathews v. Eldridge*, 424 U.S. 319, 332-335 (1976).



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July 24, 1987



## APPENDIX B

UNITED STATES DISTRICT COURT FOR THE  
MIDDLE DISTRICT OF FLORIDA  
FORT MEYERS DIVISION

CLIFFORD RAY and LOUISE RAY, )  
 individually, and as the )  
 parents and guardians of )  
 their minor children, )  
 RICHARD, ROBERT, and )  
 RANDY RAY, )

Plaintiffs, )

v. )

Case No. 87-88

CIV-FTM-17-C

THE SCHOOL DISTRICT OF )  
 DESOTO COUNTY, and )  
 LAWRENCE D. BROWNING, )  
 MARILYN P. MIZELL, )  
 JAMES WESTBERRY, )  
 RODNEY HOLLINGSWORTH, )  
 T. A. STRICKLAND, PHYLLIS )  
 NESMITH, RONNIE ALLEN, )  
 JAMES ABRAHAM, and )  
 DONALD E. KNOCHE, in )  
 their official capacities, )

Defendants. )

**PLAINTIFFS' PROPOSED FINDINGS OF FACT AND  
CONCLUSIONS OF LAW IN SUPPORT OF MOTION FOR  
PRELIMINARY INJUNCTION**

Plaintiffs submit proposed findings of fact and conclusions of law in support of their motion for preliminary injunction. Respectfully submitted, PEEPLES, EARL & BLANK, P.A. Attorney for Plaintiffs  
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PLAINTIFFS' PROPOSED FINDINGS OF FACT  
AND CONCLUSIONS OF LAW  
IN SUPPORT OF MOTION FOR PRELIMINARY  
INJUNCTION**

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## II. PROPOSED FINDINGS OF FACT

### A. Jurisdiction and Venue

\*1. This action arises under the Civil Rights Act, 42 U.S.C. § 1983; Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794; and the Constitution of the United States. The Court is vested with jurisdiction under 28 U.S.C. § 1331 and § 1343(3) (*Admission in Defendants' Answer*, paragraph 5).

\*2. Venue lies under 28 U.S.C. § 1391(b), and this case resides in the Fort Myers Division under Rule 1.02(b)(5) of the General Rules of the United States District Court for the Middle District of Florida (*Admission in Defendants' Answer*, paragraph 6).

### B. Parties

\*3. Clifford and Louise Ray are citizens and residents of the State of Florida (*Defendants' Response to Plaintiffs' Request for Admission No. 2*), who reside in DeSoto County (*Affidavit of Clifford Ray*, App. A38, paragraphs 4 and 5; *Affidavit of Louise Ray*, App. A34, paragraphs 12 and 13) and who are registered voters in DeSoto County (*Defendants' Response to Plaintiffs' Request for Admission No. 27*), and who are the parents and guardians of Richard Ray, age 10; Robert Ray, age 9; and Randy Ray, age 8 (*Defendants' Response to Plaintiffs' Request for Admission No. 1*).



\*4. Defendant School District of DeSoto County ("DeSoto District") is a public entity organized under the laws of the State of Florida and is the governing body of the public school system in DeSoto County, Florida. The DeSoto District is a recipient of "federal financial assistance" within the meaning of 29 U.S.C. § 794 (*Admission in Defendants' Answer*, paragraph 10).

\*5. Defendants, James Westberry, Rodney Hollingsworth, T. A. Strickland, Phyllis Nesmith, and Ronnie Allen, in their official capacities, are elected members of the DeSoto County School Board. As such, these defendants constitute the governing body of the DeSoto District and are responsible for ensuring compliance with applicable state and federal law (*Admission in Defendants' Answer*, paragraph 11).

\*6. Defendant Lawrence D. Browning, in his official capacity, is the elected Superintendent of the DeSoto District, and as such is charged by Sections 230.32-.33, Florida Statutes, with the administration and management; supervision of instruction; and recommendation to the School Board of district-wide policies, rules, regulations, and standards relating to the school system, including the admission and placement of children, and the development of educational plans and courses of study (*Admission in Defendants' Answer*, paragraph 12).

\*7. Defendant Marilyn P. Mizell, in her official capacity, is the director of the Exceptional Student Educational Program who oversees special education provided to those classified as "exceptional students" under state law. As such, said defendant is charged with evaluating children who may require special educational placement because of physical or other conditions which impair their ability to participate in normal classroom activities (*Admission in Defendants' Answer*, paragraph 14).

\*8. Defendant James Abraham, in his official capacity, is the principal of West Elementary School in the DeSoto District, where Richard and Robert Ray were enrolled in August of 1986. As principal, Mr. Abraham is charged with supervising the operation and management of the school under the supervision of Defendant Browning. At the direction of Defendant Browning, Mr. Abraham has refused to allow Richard and Robert Ray to return to their classrooms (*Admission in Defendants' Answer*, paragraph 15).

\*9. Defendant Donald E. Knoche, in his official capacity, is the principal of Memorial Elementary School in the DeSoto District, where Randy Ray was enrolled in August of 1986. As principal, Mr. Knoche is charged with supervising the operation and management of the school under the supervision of Defendant Browning. Defendant



Knoche has refused to allow Randy Ray to return to his classroom (*Admission in Defendants' Answer*, paragraph 16).

### C. *Exclusion from School*

10. The School Board of DeSoto County will not admit Richard, Robert, or Randy Ray to a regular classroom, including most recently summer school for 1987 (*Letter from Superintendent Browning dated June 12, 1987*, App. A71). Absent preliminary injunctive relief, the three boys will not be allowed into their regular classrooms for the coming 1987-88 school year.

### D. *Medical Condition of Richard, Robert and Randy Ray*

11. The general state of health of Richard, Robert, and Randy Ray is that they are normal, active children with hemophilia, who have tested positive for the HIV virus antibody (*Testimony of Dr. Barbosa*, 7/10/87; *Affidavit of Dr. Barbosa*, App. A5, paragraph 5; *Testimony of Dr. Gross*, 7/10/87). The medical records of Richard, Robert and Randy Ray demonstrate that they do not present any unusual risk (*Testimony of Dr. Good*, 7/10/87), or uncharacteristic case histories (*Testimony of Dr. Gross*, 7/10/87).

12. The Ray boys are moderate, not severe, hemophiliacs and are able to go for months without injection of the Factor 8 clotting agent (*Testimony of Dr. Barbosa*, 7/10/87). Richard, Robert, and Randy Ray's medical records are typical of hemophiliac children (*Testimony of Dr. Gross*, 7/10/87).

13. It is the treating physician's best judgment that the Ray boys came into contact with the HIV virus through the injection of the clotting agents required for their hemophilia. Since early in 1985, screening and heat treating methods for this product actively kill the virus. It is, therefore, likely that the boys have probably been infected for at least two years. None of the boys show any symptoms of AIDS, and, to date, all boys have immune functions within normal ranges (*Testimony of Dr. Barbosa*, 7/10/87; *Affidavit of Dr. Barbosa*, App. A5-6, paragraph 6).

14. There are only three contemporaneous school "accident report" records<sup>1</sup> relating to these three boys. These show that Richard

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1. Many speculative "after-the-fact" affidavits were prepared for litigation by defendants or employees of defendants and are the subject of pending motions to strike.



was involved in an incident in school in which he hurt his groin on the monkey bars, and in which there was no external bleeding. (*See Official School Accident Report*, App. A9). Robert's contemporaneous school accident report shows he hit his head and has a "slight scratch" where the "bleeding was very little." (*See Official School Accident Report*, App. A8). The only other officially reported school incident involved Randy Ray hitting his arm on the slide. There was apparently no blood. (*See Official School Accident Report*, App. A10).

## E. Reasonable Medical Judgments from Evidence of Record

### 1. What Is AIDS?

15. "AIDS" is an autoimmunodeficiency of the human immune system caused by a retrovirus known as the HIV or HTLV-III or LAV virus. The HIV virus attacks white blood cells (the T helper cells) in the human blood. There is presently no cure for AIDS and no vaccine to prevent AIDS (*Surgeon General's Report on AIDS*, App. B37-38; *Testimony of Dr. Good*, 7/10/87). The Ray children do not have AIDS (*Testimony of Dr. Barbosa*, 7/10/87; *Testimony of Dr. Gross*, 7/10/87; *Affidavit of Dr. Barbosa*, App. A7, paragraph 10).

16. Testing positive for the HIV antibodies is not the same as having AIDS. Testing positive only means that the person has been exposed to the HIV virus. Not everyone who tests positive has been shown to move to ARC, the precursor of AIDS, or so-called "full blown" or "frank" AIDS (*Testimony of Dr. Good*, 7/10/87). AIDS destroys the body's immunological (defense) system and allows otherwise controllable infections to invade the body and cause additional diseases. These diseases may eventually cause death (*Surgeon General's Report on AIDS*, App. B38).

### 2. How Is AIDS Transmitted?

17. The AIDS virus is transmitted in four ways: (1) sexual intercourse, (2) blood transfusions or injections with blood products, (3) use of contaminated needles by drug users, and (4) perinatally — mothers to children in the birth process (*see, e.g., Affidavit of Dr. Good*, App. A28, paragraph 5; *Affidavit of Dr. Hutto*, App. A25, paragraph 5). In addition, there are a small percentage of cases which are unaccounted for, but most such "unknown" cases are believed to fall into the foregoing categories (*Testimony of Dr. Good*, 7/10/87).

18. AIDS is a contagious disease but it is not transmitted through



casual contact. It is much less contagious than many other diseases such as measles, chicken pox, tuberculosis, various forms of viral hepatitis, etc. (*Affidavit of Dr. Hutto*, App. A25, paragraph 4; see *Surgeon General's Report on AIDS*, App. B36; *Affidavit of Dr. Good*, App. A28, paragraph 4).

19. There is no evidence of transmission of the AIDS virus by sneezing, crying, kissing, sweating, or transmission by contact with saliva. There is also no evidence that the virus can be transmitted by skin contact with infected blood, unless there is an opening in the skin that allows bloodstream contact (*Testimony of Dr. Good*, 7/10/87; *Testimony of Dr. Barbosa*, 7/10/87).

\*\*20. None of the identified HIV infection cases in the United States are known to have been transmitted in a school, day care or foster care setting or through other casual person-to-person contact (*Guidelines, Education and Foster Care of Children Infected with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus*, MMWR 517-21, App. B9; hereinafter "CDC Guidelines"; *Judicial Notice Stipulated to by Defendants*). There is also no reported instance of transmission of the AIDS virus in the classroom or playground environment (*Testimony of Dr. Good*, 7/10/87; *Testimony of Dr. Gross*, 7/10/87; *Affidavit of Dr. Hutto*, App. A25, paragraph 6; *Affidavit of Dr. Good*, App. A28, paragraph 6; *Surgeon General's Report on AIDS*, App. B44; *Judicial Notice Stipulated to by Defendants*).

21. Although there is now substantial data, there are no reported cases of the HIV virus being transmitted in a classroom environment and there is no evidence to support a conclusion that the virus can be transmitted in a casual or classroom context (*Affidavit of Dr. Resnick*, App. A23, paragraphs 4 and 5).

\*22. All blood spills and bleeding wounds should be treated with care, regardless of whether children infected with the AIDS virus are involved because there are other blood-borne illnesses that may be transmitted (*Defendants' Response to Plaintiffs' Request for Admission No. 90*).

23. No special precautions are needed for HIV-positive children other than normal disinfection procedures for blood spills as would be applicable if no HIV-positive condition existed (*Testimony of Dr. Good*, 7/10/87; *Testimony of Dr. Gross*, 7/10/87).

24. The three "g's" — gloves, goggles, and gowns — recommended for health-care workers dealing with HIV-positive patients or blood in the May 22, 1987, CDC health-care workers report are only



recommended for intrusive procedures which do not occur in classrooms. Such intrusive procedures include postmortem autopsies (*Testimony of Dr. Gross*, 7/10/87; see *CDC Health Care Workers Report*, App. B66, 69).

### 3. Hemophilia in Relation to AIDS

25. Hemophilia is a blood clotting disorder. The most common effect of hemophilia is internal bleeding, usually in muscles or joints. There are approximately 20,000 hemophiliacs in the United States. Ten thousand of these are severe. Ninety-five percent of all severe hemophiliacs test positive for the HIV antibody, but less than three percent to date have developed AIDS (*Affidavit of Dr. Barbosa*, App. A7, paragraph 12). It is believed that hemophiliacs came into contact with the HIV virus through injections of "Factor 8" used to treat hemophilia. Until two years ago, there was no method of screening and eliminating the HIV virus from the Factor 8 injections (*Testimony of Dr. Barbosa*, 7/10/87).

26. Hemophiliacs have a much lower incidence, shown through several studies, of transmitting the virus to spouses through sexual contact. There are no incidents of non-sexual transmission by hemophiliacs (*Testimony of Dr. Good*, 7/10/87; *Testimony of Dr. Barbosa*, 7/10/87). \*\* Household studies of hemophiliacs show no incidences of casual transmission to family members, living together intimately on a day-to-day basis, including sharing toothbrushes, dishes, toilet facilities, etc. (*Letter from National Hemophilia Association*, App. B64, *Judicial Notice Stipulated to by Defendants*; *Affidavit of Dr. Barbosa*, App. A7, paragraph 11).

27. According to the most recent research, hemophiliacs who test positive for AIDS antibodies have been less likely to develop or transmit AIDS than have members of other AIDS-infected groups. In a recent study of HIV antibody positive hemophiliacs, only 35% were found on direct culture analysis to carry live AIDS virus in their blood (*Second Affidavit of Dr. Good*, App. A3, paragraphs 10 and 11).

### 4. Public Health Judgments as to the Transmission of HIV Virus

#### a. Centers for Disease Control

\*\*28. The Guidelines of the Centers for Disease Control ("CDC"), published on August 30, 1985, represent the current position



of the CDC with respect to the educational placement of children infected with the AIDS virus (*Letter from CDC to Treating Physician dated July 1, 1987*, App. B1; *Judicial Notice Stipulated to by Defendants*). The great weight of medical evidence in this country as to the transmissibility of AIDS in a school setting is reflected in the CDC Recommendations and Guidelines (*Affidavit of Dr. Parks*, App. A18, paragraph 5).

\*\*29. The CDC Guidelines recommend that children infected with the AIDS virus remain in the regular school program unless the children lack control of their body secretions, display behavior such as biting, or have uncoverable oozing lesions (*CDC Guidelines*, App. B7-10; *Judicial Notice Stipulated to by Defendants*).

\*\*30. The CDC Guidelines recognize that the benefit of an unrestricted school setting outweigh the risks of acquisition of potentially harmful infections by infected children, and the apparent nonexistent risk of transmission of the AIDS virus (*CDC Guidelines*, App. B9; *Judicial Notice Stipulated to by Defendants*).

31. The CDC Guidelines reflect the most current medical judgment as to school attendance by HIV-infected children in a normal classroom setting (*Testimony of Dr. Good*, 7/10/87; *Affidavit of Dr. Hutto*, App. A26, paragraph 10). The CDC Guidelines are equally as applicable to hemophiliac HIV-positive children as they are to nonhemophiliac HIV-positive children (*Testimony of Dr. Good*, 7/10/87).

\*\*32. The 1987 CDC health-care workers report, entitled, *Update: Human Immunodeficiency Virus Infection in Health-Care Workers Exposed to Blood of Infected Patients*, MORBIDITY AND MORTALITY WEEKLY REPORT, Vol. 36:285-89 (May 22, 1987), does not in any way change or qualify the August 30, 1985 CDC Guidelines on school attendance by HIV-infected children (*Letter from CDC, AIDS Program Director dated July 1, 1987*, App. B1; *Judicial Notice Stipulated to by Defendants*), and does not affect the medical views reflected in the CDC Guidelines regarding school attendance of HIV-positive children (*Testimony of Dr. Good*, 7/10/87; *Affidavit of Dr. Good*, App. A29, paragraphs 9 and 10).

\*\*33. The CDC has expressed no intention of changing its recommendation as to the schooling of HIV-positive children (*Testimony of Dr. Good*, 7/10/87; see *Letter from CDC, AIDS Program Director dated July 1, 1987*, App. B1; *Judicial Notice Stipulated to by Defendants*).



b. *Surgeon General's Office*

**\*\*34.** The U.S. Surgeon General recommends that the CDC Guidelines be followed (*see Letter dated July 2, 1987, from Assistant Director, Public Health Service, Department of Health & Human Services, App. B11; Judicial Notice Stipulated to by Defendants*).

**\*\*35.** The Surgeon General's April, 1987, Workshop recommends even fewer limitations on regular school attendance by children infected with the AIDS virus (*see Letter from John H. Hutchins, M.D. on Surgeon General's Views on CDC Guidelines, App. B11; Report of the Surgeon General's Workshop on Children with HIV Infection and Their Families, April 6-8, 1987, App. B20-22; Judicial Notice Stipulated to by Defendants*).

c. *State of Florida's Governor's Task Force*

36. The State of Florida's Governor's Task Force on AIDS, of which Dr. Good is the Chairman, considered the CDC Guidelines on school attendance of HIV-positive children carefully and it concluded that they were appropriate and should be followed in Florida (*Testimony of Dr. Good, 7/10/87*).

d. *American Red Cross*

**\*\*37.** The information contained in the Red Cross pamphlets entitled, *AIDS and Children: Information for Teachers and School Officials* (App. B55-59) and *AIDS and Children: Information for Parents of School Age Children* (App. B60-63) represent the current thinking of the American Red Cross on the issue of children and AIDS and is still based upon the best available scientific and medical evidence (*see Letter from Associate General Counsel, American Red Cross dated July 7, 1987, App B54; Judicial Notice Stipulated to by Defendants*).

e. *National Hemophilia Foundation*

**\*\*38.** The Guidelines of the CDC represent the official position of the National Hemophilia Foundation with respect to the educational placement of children infected with the AIDS virus (*see Letter from President, National Hemophilia Foundation dated July 7, 1987, App. B64-65; Judicial Notice Stipulated to by Defendants*).



### f. *American Academy of Pediatrics*

\*\*39. The Guidelines of the CDC represent the official position of the American Academy of Pediatrics with respect to the educational placement of children infected with the AIDS virus (*see Letter from Chairman, Infectious Disease Committee, American Academy of Pediatrics dated July 2, 1987, App. B52; Judicial Notice Stipulated to by Defendants*).

### g. *Florida Department of Health & Rehabilitative Services*

\*40. In September, 1986, the Florida Department of Health and Rehabilitative Services advised the Defendants in writing that they should follow guidelines established by the Centers for Disease Control and the American Academy of Pediatrics (*Defendants' Response to Plaintiffs' Request for Admission No. 112*). Under these guidelines, absent special circumstances, children infected with the virus should remain in their classrooms (*Admission in Defendants' Answer, paragraph 42*).

### h. *DeSoto County Health Department*

\*\*41. The DeSoto County Public Health Department applies the CDC Guidelines in determinations concerning the regular school attendance of children infected with the AIDS virus (*see Letter from DeSoto County Health Department, App. B53; Judicial Notice Stipulated to by Defendants*).

\*42. By letter dated September 10, 1986, from Donald W. Toews, Administrator of the DeSoto County Health Department, Superintendent Browning was advised that "the DeSoto County Public Health Unit supports the position taken by both the Centers for Disease Control, U.S. Department of Health and Human Services/Public Health Service and the American Academy of Pediatrics, in reference to Acquired Immune Deficiency Syndrome and HTLV-III/LAV Infections" (*Defendants' Response to Plaintiffs' Request for Admission No. 161*).

\*43. By letter dated September 11, 1986, from S. P. Clement, M.D., DeSoto County Health Department, Lawrence D. Browning was advised that "[b]ased on current knowledge, some infected students may pose an increased risk to others in school. These include students who lack control of their body secretions, who display behavior such as biting, or who have open skin sores which cannot be covered. . . . At



this time, the Ray boys have some healing abrasions but do not fit into the above risk categories" (see *Letter from Dr. Clement, DeSoto County Health Department*, App. B71; *Defendants' Response to Plaintiffs' Request for Admission* No. 160).

\*44. On April 28, 1987, the DeSoto County Health Department issued certificates that Richard, Robert, and Randy Ray had the required physical examination and immunizations to enter school (*Defendants' Response to Plaintiffs' Requests for Admission* Nos. 170, 171, and 172).

\*45. The Public Health Department of DeSoto County has provided no certificate of contagion or otherwise declared an emergency or undertaken to quarantine Richard, Robert, and Randy Ray (*Defendants' Response to Plaintiffs' Request for Admission* No. 29).

##### 5. *The AIDS Virus Has Not Been Transmitted to Other Members of the Ray Family*

46. Despite living day-to-day much more intimately than would occur in a classroom environment, Richard, Robert, and Randy Ray have not transmitted the AIDS virus to their mother, father, or sister. Richard, Robert, and Randy first tested positive for HIV antibodies in August, 1986. Tests performed on their sister, Candy, and Mr. and Mrs. Ray showed them to be negative for the AIDS antibodies at that time. At the request of this Court, the sister, mother, and father were again tested in July of 1987. Despite continuous, intimate family living, the sister, father, and mother again tested negative or "nonreactive" in July of 1987 (see *Plaintiffs' Notice of Compliance With Testing of Family Members and Accompanying Test Results*, filed 7/23/87).

##### 6. *Lack of Handicap or Impairment of Richard, Robert, and Randy Ray*

\*47. It is the position of the DeSoto County school system that the presence of the HTLV-III virus in the bloodstream of Richard, Robert, and Randy Ray constitutes a handicap (*Defendants' Response to Plaintiffs' Request for Admission* No. 62).

48. Neither Richard, Robert, nor Randy Ray suffer any health impairment which would limit their ability to participate fully in a normal program classroom education (*Testimony of Dr. Gross*, 7/10/87; *Testimony of Dr. Barbosa*, 7/10/87). The only medically required restrictions on the boys' school activities would be no involvement in di-



rect contact sports — such as football — because of the risk of internal joint bleeding from the hemophilia (see *Affidavit of Dr. Barbosa*, App. A13-14, paragraphs 4-8).

49. Neither Richard, Robert, nor Randy Ray suffer any health impairment which requires the use of special equipment or facilities to enable them to participate in regular classroom or playground activities (*Testimony of Dr. Gross*, 7/10/87; *Testimony of Dr. Barbosa*, 7/10/87; *Affidavit of Dr. Barbosa*, App. A13-14, paragraph 4-8).

\*50. Defendants have no evidence that the AIDS virus has left Richard, Robert, or Randy Ray with diminished physical or mental capabilities (*Defendants' Response to Plaintiffs' Request for Admission* No. 86).

51. It is the opinion of the treating physician that Richard, Robert, and Randy Ray do not require special education and related services by virtue of any handicap or physical impairment and that neither as a result of their hemophilia condition nor as a result of their testing positive for the AIDS antibodies do Richard, Robert, or Randy Ray have any limited strength, vitality or alertness due to chronic or acute health problems which adversely affect their educational performance (*Affidavit of Dr. Barbosa*, App. A13, paragraphs 4-8; *Testimony of Dr. Gross*, 7/10/87).

## 7. Compliance with CDC Guidelines by Richard, Robert, and Randy Ray

52. Physical examinations of Richard, Robert, and Randy Ray show they medically fall within the CDC Guidelines for attending regular classroom programs (*Testimony of Dr. Barbosa*, 7/10/87; *Testimony of Dr. Gross*, 7/10/87; *Letter from Dr. Clement, DeSoto County Health Department*, App. B71). A review of Richard, Robert, and Randy's medical records does not show they suffered open, uncoverable bleeding wounds while in school (*Affidavit of Dr. Barbosa*, App. A5, paragraph 3).

53. There is no medical reason Richard, Robert, or Randy Ray should be kept out of the normal classroom setting (*Testimony of Dr. Gross*, 7/10/87; *Testimony of Dr. Good*, 7/10/87; *Testimony of Dr. Barbosa*, 7/10/87).

## 8. Impact of Exclusion on Children

54. Psychological and educational studies have documented the



importance to children of the synergistic relationship between education and socialization processes in the classroom environment. See, e.g., Crockenberg & Bryant, *Socialization: The "Implicit Curriculum" of Learning Environments*, 12 J. RES. DEV. EDUC. 69, 71 (1978); Coleman, *Equality of Educational Opportunity*, in *THE SCHOOL IN THE SOCIAL ORDER* 114 (F. Cordasco, M. Hillson & H. Bullock eds. 1970).

55. An isolated educational environment results in stigmatization and feelings of inferiority. Such unequal treatment may affect the children's hearts and minds in a way unlikely to be undone. See *Brown v. Board of Education of Topeka, Shawnee Co., Kan.*, 347 U.S. 483, 494 (1954). The boys should be in a normal classroom (*Testimony of Dr. Gross*, 7/10/87).

56. Richard, Robert, and Randy Ray are suffering significant emotional disorders as a result of their continued exclusion from the normal classroom setting. Each of these boys is also suffering varying degrees of educational deficiencies from their exclusion over the past year. Each day of continued exclusion from interaction of their peers and comprehensive classroom instruction will further exacerbate their emotional problems and weaken their ability to achieve acceptable academic progress (*Affidavit of Psychologist Loucks*, App. A44).

57. While the Ray children presently manifest no symptoms of the AIDS virus, they may, sometime in the future, begin to develop symptoms of AIDS which threaten their health and enjoyment of life. The present period of time, during which the children are healthy and active, is particularly precious to them. Denial of a normal education at this crucial time will result in truly irreparable harm. This Court will not lightly allow Defendants to deprive the children of this important period of their lives absent the required medical proof.

### III. CONCLUSIONS OF LAW

#### A. Controlling Law

##### 1. Residency and Right to Education

58. Under Florida law, Plaintiffs are domiciled in DeSoto County and Defendants are obligated to provide them with a free public education. FLA. STAT. § 230.232(1) (1985); *Scavella v. School Board of Dade County*, 363 So. 2d 1095, 1098 (Fla. 1978). Domicile is physical presence in a location with intent to make that location a permanent home. See, e.g., *McDougald v. Jenson*, 786 F.2d 1464, 1483 (11th Cir. 1986), cert. denied, 107 S. Ct. 207 (1986) (construing Florida law).