AIDS IN THE CLASSROOM

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INTRODUCTION

Acquired Immunodeficiency Syndrome (AIDS)\(^1\) was reported among children soon after the disease was identified,\(^2\) and school officials began to inquire about how to handle such children as early as the 1982-83 school year.\(^3\) However, health and school officials did


The authors represented the City of New York and its agencies in the defense of their policy of not excluding children with AIDS from school in District 27 Community School Bd. v. Board of Educ., 130 Misc. 2d 398, 502 N.Y.S.2d 325 (Sup. Ct. 1986). The views expressed in this Article are those of the authors and do not necessarily reflect the position of New York City.


3. The New York City Department of Health received its first letter from a school requesting information on how to handle a child with AIDS or an AIDS-related illness in the spring of 1983. The Department of Health responded to these inquiries by providing a set of guidelines that had been prepared for foster care agencies, and that recommended that the same precautions used for children who were hepatitis-B carriers be applied to children with AIDS. See New York City Department of Health, Personal Hygiene Guidelines for Acquired Immune Deficiency Syndrome (AIDS)—Homes & Schools (1983) (on file at Hofstra Law Review).
not begin to formulate a policy with respect to school children infected with HTLV-III/LAV/HIV, the virus associated with AIDS, until late 1984 and early 1985. At that time, sufficient epidemiological data, especially in the form of family studies, first became publicly available to form the basis of a sound and supportable public health policy.

In June 1985, the Centers for Disease Control (CDC) held a meeting in Atlanta, Georgia to consider the issues raised by the presence in classroom settings of children infected by HIV. As a result of that meeting, on August 30, 1985, the CDC published a report containing information and recommendations relating to the education, day care, and foster care of such children. The stated purpose of that document was "to assist . . . local health and education departments in developing guidelines for their particular situations and lo-

4. HTLV-III is the acronym used for the human T-lymphotropic (retro)virus type III, which was identified by investigators at the National Institutes of Health in 1984, in patients with AIDS. See Rogers, supra note 2, at 230. LAV is the acronym used for lymphadenopathy-associated virus, named by French researchers at the Pasteur Institute in Paris. Food and Drug Administration, Dep't. of Health & Human Servs., 15 FDA Drug Bull. 27 (1985). Human immunodeficiency virus (HIV), the most recent name for the AIDS virus, was announced by the International Committee for the Taxonomy of Viruses in 1986. The Advocate, Aug. 19, 1986, at 23. Hereinafter this Article will refer to the virus as HIV.

5. A draft entitled Children with AIDS or ARC Attending Public School—Areas of Concern was prepared by the State of Florida Department of Health and Rehabilitative Services in July 1984. See Memorandum From Jeffrey J. Sacks, M.D., M.P.H., Acting State Epidemiologist, Preventive Health Services to Don Darling, Department of Education, Student Services Section (July 26, 1984) [hereinafter cited as Sacks Memorandum] (on file at Hofstra Law Review). The question of school attendance by children with AIDS was discussed at a conference on pediatric AIDS held in Miami, Florida in November 1984, which was cosponsored by the University of Miami, the U.S. Department of Health and Human Services, the National Institutes of Health, and the CDC. The first state guidelines to be issued were published in March 1985. See State of Conn. Dep't of Educ. and Dep't of Health Services, Information and Guidelines, Prevention of Disease Transmission in Schools—Acquired Immune Deficiency Syndrome (AIDS) (March 1985) [hereinafter cited as Connecticut Guidelines].

6. An international conference on AIDS, which was cosponsored by the U.S. Public Health Services and the World Health Organization, was held in Atlanta, Georgia in April 1985. At that time, a large number of studies on the issue of transmission, including family studies, were presented for the first time. These unpublished studies included a discussion of the communicability of AIDS in a foster care setting, a comparison of the general health status of children whose mothers have AIDS with children of healthy inner city mothers in New York, and an evaluation of adult patients with AIDS and their household contacts. For a summary of additional studies on transmission of AIDS, see CDC, Memorandum From Martha F. Rogers, M.D., Evidence for Lack of Casual Transmission (Sept. 17, 1985) [hereinafter cited as CDC Memorandum] (on file at Hofstra Law Review).

The basic thrust of the CDC's recommendations is that infected school-age children should be permitted to attend school in an unrestricted setting unless they are neurologically impaired and lack control of their bodily secretions or display behavior such as biting.\(^8\)

The New York City Health Department, like other state and local health departments, received an advance copy of the CDC's recommendations on August 29, 1985. On August 30, 1985, the City announced its policy of not automatically excluding children with AIDS from the public schools and of reviewing such children on a case-by-case basis. Pursuant to the CDC's recommendation, a panel was appointed to review the condition of all school-age children with AIDS or ARC\(^9\) to determine if their health, development, and behavior permitted them to attend school in an unrestricted setting.\(^10\)

After receiving the findings and recommendations of the panel, the Commissioner of Health decided that one seven-year-old child who had been reported as having AIDS,\(^11\) and who had been in school for three years prior to the panel's findings, would be permitted to continue in school and that the child's identity would remain confidential. That decision was announced by the City on September 7, 1985.

Even before that announcement, strong opposition had been expressed to allowing children suspected of having AIDS to attend school. Two community school boards in Queens had passed a reso-

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8. Id. at 517.
9. Id. at 519.
10. ARC is the acronym for AIDS-Related Complex, which encompasses "[a]ny disease associated with HTLV-III infection that does not fall far enough into the spectrum to be classified as AIDS." Sicklick & Rubinstein, *A Medical Review of AIDS*, 14 Hofstra L. Rev. 5, 6 (1985).
11. The panel consists of a pediatrician employed by the New York City Department of Health who is an expert on pediatric AIDS, a medical social worker employed by the Health Department who acts as its liaison to the Board of Education, an executive employee of the Board of Education whose area of responsibility includes school health, and a parent who is the president of a major parents' organization and a member of a community school board.
12. The panel considered seven cases in all. Three of the children did not reside in New York City. The fourth child was ill and in a hospital where he/she was receiving instruction. The fifth child, although healthy, was living in a hospital and receiving instruction there, pending resolution of a family problem. The sixth child was physically and emotionally capable of attending school, but because of a breach of confidentiality concerning that child's illness, the panel recommended that the family consider alternative educational opportunities. The seventh child was permitted to remain in school and was the focus of the District 27 case. A second panel, consisting of seven physicians, later determined that the child did not meet the CDC surveillance definition of AIDS but had been infected with HIV and had clinical and laboratory evidence of immune suppression. For the CDC surveillance definition of AIDS, see *Education and Foster Care*, supra note 7, at 518.
ution on August 27, 1985 that no child who had AIDS or who lived in a household with someone who had AIDS could attend public school in those districts. After the City's policy was announced, some parents in those districts organized a school boycott, and on September 9, 1985, the day schools opened, a lawsuit was brought in state supreme court, District 27 Community School Board v. Board of Education, seeking to enjoin the admission of the child with AIDS or, in the alternative, to have the child's identity revealed to school board members and school officials.

The trial of the action commenced immediately and lasted more than a month. In addition to Dr. David Sencer, the City's Commissioner of Health, and Nathan Quinones, the Chancellor of the Board of Education, eleven medical experts were called as witnesses. The trial was wide-ranging—more like a legislative hearing than a court proceeding—and the record includes a great deal of medical data relating to the transmissibility of AIDS.

On February 11, 1986, the Supreme Court of Queens County issued the decision in District 27, upholding the policy of New York City in not automatically excluding children with AIDS from public school. The court held that this policy did not violate any law relating to communicable or contagious disease and, in light of the medical data, was not arbitrary and capricious or an abuse of discretion. Indeed, because of the overwhelming evidence that AIDS is

13. 130 Misc. 2d 398, 502 N.Y.S.2d 325 (Sup. Ct. 1986) (Portions of the opinion were omitted for publication purposes. Citations to the slip opinion are given where necessary.).

14. Petitioners' witnesses were Dr. Ronald Rosenblatt, an internist at Flushing Hospital, Queens, New York; Dr. Arye Rubinstein, a pediatrician and immunologist at Albert Einstein Medical Center, Bronx, New York; Dr. Lionel Resnick, a dermatologist at the Mount Sinai Medical Center, Miami Beach, Florida; and Dr. Jose Giron, Chief of Infectious Diseases at Flushing Hospital, Queens, New York. The City's non-party witnesses were Dr. Donald Armstrong, Chief of the Infectious Disease Service and Director of the Microbiology Laboratory at the Memorial Sloan-Kettering Cancer Center, New York, New York; Dr. Louis Cooper, Director of Pediatrics at St. Luke's Roosevelt Hospital Center, New York, New York; Dr. Margaret Hilgarter, Director of the Division of Pediatric Hematology and Oncology and the Hemophilia Clinic at New York Hospital-Cornell Medical Center, New York, New York; Dr. Rand Stoneburner, Director of the AIDS Program at the New York City Department of Health; Dr. Pauline Thomas, Director of Immunization at the New York City Department of Public Health; and Dr. Richard Goldstein, Commissioner of Health of the State of New Jersey. The intervenor (the child in question) called Dr. Edward Sperling, Chief of the Division of Child Psychiatry at the Bronx Municipal Hospital Center, Bronx, New York.

15. A copy of the transcript of the trial can be obtained from the New York City Law Department.


17. Id. at 410, 502 N.Y.S.2d at 334.

18. Id. at 412, 502 N.Y.S.2d at 335.
not transmissible in a classroom setting, the court declared that a policy of excluding all children with AIDS from school would violate the federal Rehabilitation Act of 1973 and their rights "to equal protection of the laws."

In addition to the threshold issue of whether children with AIDS should ever be permitted to attend school, the court also decided three subsidiary issues. First, the court held that the routine hygiene and first aid precautions in effect in the New York City public schools were adequate to deal with any theoretical risk of transmission of AIDS through bites or bleeding injuries. Second, the court held that it was not an arbitrary or capricious action for the Commissioner of Health to form a multidisciplinary panel to determine, on a case-by-case basis, if there is something special about the medical condition, neurological development, or behavior of each child with AIDS that would warrant an exception to the policy of nonexclusion. Third, the court held that, since the information about the children reviewed by the panel was derived from the surveillance reports required on all cases of AIDS or suspected AIDS, the policy of not revealing the identity of the child with AIDS to anyone within the school system was required by the confidentiality provision of the state and city laws governing those reports. Further, the court indicated that, in its view, those laws had been violated by the use of the surveillance reports to determine which children should be reviewed, even though the review was carried out without revealing the children's identities to anyone outside the Department of Health.

The decision in the District 27 case is the first in the nation to consider in such depth many of the factual and legal issues surrounding AIDS. This Article will analyze the basis for each aspect of the holding in District 27 and will consider the far-reaching implications of its conclusion, especially in the education setting.

20. District 27, 130 Misc. 2d at 413, 502 N.Y.S.2d at 335.
21. Id. at 407-08, 502 N.Y.S.2d at 332.
24. Id. at 422, 502 N.Y.S.2d at 341.
25. Cf. La Rocca v. Dalsheim, 120 Misc. 2d 697, 467 N.Y.S.2d 302, 310-11 (Sup. Ct. 1983) (giving a more limited treatment of the issues surrounding AIDS in prisons and finding that the New York State Correctional Services acted reasonably in segregating prisoners with AIDS and implementing the same precautionary measures used in hepatitis-B cases).
I. THE THRESHOLD ISSUE: ADMISSION V. EXCLUSION

A. The Epidemiological Evidence

The court began its analysis with a review of the epidemiological evidence on the transmission of HIV. Central to that review were two crucial facts unanimously agreed upon by experts in the field as to the mode of transmission of HIV, based on current available data:

1. HIV can be transmitted by sexual intercourse with an infected partner, by injection of infected blood and blood products (especially by drug addicts who share needles and syringes), and by transmission from an infected mother to her child in utero or during the birth process. There is also one reported case of transmission via breast feeding.

2. HIV is not transmitted as a result of a casual or routine contact, such as breathing, sneezing, coughing, shaking hands, hugging, or sharing toilets, food, water or utensils.

These facts about the transmission of HIV, as found by the court, are derived from the surveillance data collected by local and state departments of health and forwarded to the CDC, as well as from epidemiological studies of families that include AIDS patients, and of health care workers who have been exposed to AIDS patients.

The surveillance data, both nation-wide and in New York City, demonstrate that AIDS patients fall into several well-recognized risk groups: (a) homosexual and bisexual men, especially those with multiple sex partners; (b) intravenous (IV) drug users who share needles and syringes; (c) persons who received HIV-infected blood and blood products before the late spring of 1985 (e.g., hemophiliacs and recipients of blood transfusions); (d) infants born to infected mothers; and (e) sex partners of persons at risk for AIDS. Among the 5,210 re-

27. Id. at 405, 502 N.Y.S.2d at 330. See also Education and Foster Care, supra note 7, at 518-19; Curran, Morgan, Hardy, Jaffe, Darrow & Dowdle, The Epidemiology of AIDS: Current Status and Future Prospects, 229 Sci. 1352, 1355 (1985) [hereinafter cited as Curran]; N.Y. STATE DEP'T OF HEALTH, ACQUIRED IMMUNE DEFICIENCY SYNDROME: 100 QUESTIONS & ANSWERS 2 (1985) [hereinafter cited as 100 QUESTIONS].
29. Id. at 405, 502 N.Y.S.2d at 330-31. See also Education and Foster Care, supra note 7, at 519; 100 QUESTIONS, supra note 27, at 2, 4-5.
30. District 27, 130 Misc. 2d at 404, 502 N.Y.S.2d at 330. See Education and Foster Care, supra note 7, at 518; Curran, supra note 27, at 1352; 100 QUESTIONS, supra note 27, at 1. See also sources cited infra note 31.
ported cases of AIDS in New York City, only one percent of the cases that have been fully investigated do not fall into one of the recognized risk groups. That one percent figure can be explained by the fact that some persons are understandably reluctant to admit that they are homosexuals or drug abusers or are ignorant of the fact that their sex partner might be in one of the risk groups. Most important for present purposes, the one percent figure has remained constant over time. This fact strongly suggests that the HIV virus is not transmitted through casual contact, since if it were transmissible in that way, the percentage of persons who do not fall into one of the recognized risk groups would have risen dramatically.

The family studies demonstrate even more conclusively that HIV is not transmitted through close personal contact other than sexual contact. Over five hundred family or household members have been studied who lived together with persons who were infected with HIV. Approximately half of those studied were children. Those family members were in close daily contact with the infected patients and, in many cases, shared beds, food, baby bottles, toothbrushes, and eating utensils with them. In addition, in many of those families, the fact that one of the members was infected was not dis-

31. New York City Dep't of Health Surveillance Office, AIDS—Surveillance Update 1, 2 (Dec. 26, 1985). Nationwide, there have been 16,138 reported cases of AIDS of which only 6% fall into the category of "None of the Above/Other." See CDC, Acquired Immunodeficiency Syndrome (AIDS) Weekly Surveillance Report—United States AIDS Activity (Jan. 6, 1986). The reason for the discrepancy between the New York City figure of 1% and the national figure of 6% is that the CDC lumps together cases that have not been fully investigated (e.g., because of death, lack of cooperation, or on-going investigation) and cases of "persons born in countries in which most AIDS cases have not been associated with known risk factors" (e.g. Haitians) with cases that have been fully investigated but do not fall within a recognized risk group.

32. District 27, 130 Misc. 2d at 405, 502 N.Y.S.2d at 330.

33. Id. at 405-06, 502 N.Y.S.2d at 331, For a summary of the most recent unpublished family studies, see CDC Memorandum, supra note 6. Among the published family studies are: Jason, McDougal, Dixon, Lawrence, Kennedy, Hilgartner, Aledort & Evatt, HTLV-III/LAV Antibody and Immune Status of Household Contacts and Sexual Partners of Persons With Hemophilia, 255 J. A.M.A. 212 (1986); Friedland, Saltzman, Rogers, Kahl, Lesser, Mayers & Klein, 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 (1986); Redfield, Markham, Salahuddin, Sarngadharan, Bodner, Folks, Ballou, Wright & Gallo, Frequent Transmission of HTLV-III Among Spouses of Patients With AIDS-Related Complex and AIDS, 253 J. A.M.A. 1571 (1985); Kaplan, Oleske, Getchell, Kalyanaraman, Minnefor, Zabala—Ablan, Joshi, Denny, Cabraddilla, Rogers, Sarngadharan, Sliski, Gallo & Francis, Evidence against transmission of human T-lymphotropic virus/lymphadenopathy-associated virus (HTLV-III/LAV) in families of children with the acquired immunodeficiency syndrome, 4 Pediatric Infectious Disease 468 (1985).

34. District 27, 130 Misc. 2d at 405, 502 N.Y.S.2d at 331.
covered for some time, and thus no special precautions were taken. Nevertheless, blood tests performed in these family studies revealed that there had not been a single case of transmission of HIV other than to those family members who were sex partners of the infected patients, children infected perinatally, or recipients of blood transfusions.  

The studies of health care workers further demonstrate that HIV is not easily transmitted, even by regular exposure to the blood of infected patients. Over the past few years, studies have been conducted of 1,758 health care workers in the United States who have cared for AIDS patients, including many who had accidentally stuck themselves with needles or other instruments containing HIV-infected blood. Of the twenty-six who were found to be antibody-positive, only two were reported as not falling into a recognized risk group. Even as to those two, the evidence that they became infected as a result of needle-stick injuries is questionable. In addi-

35. Id. at 406, 502 N.Y.S.2d at 331.

Since the conclusion of the trial in the District 27 case, two reports have been published indicating possible cases of AIDS transmission where a friend or family member performed health care functions and was exposed to large amounts of infected blood and bodily fluids of an AIDS patient. One case in England involved a woman who had open cuts and lesions on her hand and who was found to be infected with HIV after handling the bodily fluids of a neighbor who was dying of AIDS and for whom she was caring. See Grint & McEvoy, Two Associated Cases of the Acquired Immune Deficiency Syndrome (AIDS), COMMUNICABLE DISEASE REP. Oct. 18, 1985 at 4. Since no preexposure blood sample was taken, the possibility that the HIV infection derived from other sources cannot be ruled out. A more recent case in the United States involved a mother who was found to be infected with HIV after caring for her child, who probably contracted AIDS from a blood transfusion and whose care involved regular exposure to large quantities of blood and other body secretions and excretions. See Epidemiologic Notes and Reports, Apparent Transmission of Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus from a Child to a Mother Providing Health Care, 35 Morbidity & Mortality Weekly Rep. 76 (Feb. 7, 1986). In its Editorial Note following the report, the CDC pointed out that “transmission of HTLV-III/LAV infection from child to parent has not previously been reported. The contact between the reported mother and child is not typical of the usual contact that could be expected in a family setting.” Id. at 78.


38. Id.

39. Id. See also supra note 36. In neither of the two cases was a preexposure blood sample available to verify the time of infection. District 27, 130 Misc. 2d at 406, 502 N.Y.S.2d at 331. In addition, there was no evidence that the blood and pooled platelets to which one of the health care workers had been exposed came from persons infected with HIV, and the other health care worker (according to testimony at trial) refused to be interviewed by anyone from the CDC or the New York City Department of Health. Id.
There was considerable testimony at trial as to whether HIV can be transmitted in a classroom setting through (a) a child with AIDS biting another child or teacher, or (b) blood from an injured child with AIDS getting into an open cut of another child or teacher. The court found that there is no evidence that HIV has ever been transmitted in either of these ways and the preponderance of the medical testimony was that such transmission is highly unlikely.

As the court found, the medical witnesses at trial were nearly unanimous that biting is an unlikely route of HIV transmission in

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41. In one reported case, a health care worker who was stuck with a needle that contained lung tissue of a patient who had both hepatitis-B and AIDS became infected with hepatitis-B but did not get infected with HIV. Gerberding, Hopewell, Kaminsky & Sande, Transmission of Hepatitis B Without Transmission of AIDS by Accidental Needlestick, 312 NEW ENG. J. MED. 56 (1985).

42. District 27, 130 Misc. 2d at 407-08, 502 N.Y.S.2d at 332.

43. Id. The CDC, in its recommendations, referred generally to “the apparent nonexistent risk of transmission of HTLV-III/LAV” in the classroom setting. Education and Foster Care, supra note 7, at 519. Some confusion was caused at trial by the fact that the CDC suggested a more restricted environment “for some neurologically handicapped children . . . who display behavior, such as biting,” and mentioned “bleeding injury” as an example of a situation “where the potential for transmission may increase.” Id. at 520. However, the CDC made clear that these references to biting and bleeding injuries derive from experience with diseases other than AIDS. Thus, in discussing preschool-age children and neurologically handicapped children, the CDC stated that “[b]ased on experience with other communicable diseases, a theoretical potential for transmission would be greatest among these children.” Id. at 519. Similarly, the CDC stated that general blood precautions should be followed “[b]ecause other infections in addition to HTLV-III/LAV can be present in blood . . . .” Id. at 520. In the course of the trial the CDC sought to clear up any possible misunderstanding in this regard by stating, with respect to the “theoretical risks associated with bleeding and biting in the classroom,” that “[t]here are no known cases attributed to either of these hypothetical modes of transmission, and the risk from a practical standpoint is nonexistent.” Letter from Harold W. Jaffe, M.D., Medical Epidemiologist, Center for Infectious Disease, to David J. Sencer, M.D., Commissioner of Health, City of New York (Oct. 10, 1985) (interpretation of the CDC’s recommendations concerning AIDS in the classroom).
the classroom setting. There were several reasons offered for that opinion. First, although the virus has been isolated from saliva, there is no evidence that saliva has ever been a means of transmission, and the family studies strongly indicate that the virus is not transmitted through saliva. Second, it has proven to be much more difficult to culture HIV from saliva than from blood, thus suggesting that HIV is present infrequently in the saliva of infected persons. Third, it is quite uncommon for serious biting to occur in school-age children. Fourth, it is quite easy to destroy HIV through the normal first aid techniques applicable to any human bite—i.e., washing with soap and water followed by the application of alcohol.

Similarly, the court found a very narrow range of opinion among the medical experts on the issue of whether HIV could be transmitted by AIDS-infected blood getting into an open cut or wound in another person. A number of experts regard the potential for contracting AIDS through infected blood as theoretically possible, but unlikely. Others saw it as presenting essentially no risk at all, since the natural healing process of a cut or wound would prevent any virus from reaching the lymphocytes in the bloodstream. In addition, the court found that whatever minimal theoretical risk exists can be completely obviated by the most simple, routine precautions: bites, cuts, and soiled hands should be washed with soap and water followed by the application of alcohol, and blood spills on the floor or other surfaces should be cleaned up with ordinary household bleach.

On the basis of the epidemiological evidence, the CDC recommended that school-age children infected with HIV be permitted to attend school unless their medical, neurological, developmental, or

44. District 27, 130 Misc. 2d at 407, 502 N.Y.S.2d at 332.
45. See supra note 33.
46. See Ho, Byington, Schooley, Flynn, Rota & Hirsch, Infrequency of Isolation of HTLV-III Virus From Saliva in AIDS, 313 Proc. Nat. Acad. Sci. U.S.A. 1606 (1985). In that study, only one out of 83 saliva samples taken from 71 infected men was positive for HIV, while 28 out of 50 blood cultures yielded the virus. The one sample of virus-positive saliva was obtained from a patient infected with AIDS-related opportunistic oral infections (thrush and candidiasis). In addition, the HIV titer of that patient’s saliva was substantially less than that of his blood. Id.
49. Id. at 407-08, 502 N.Y.S.2d at 332.
50. Id. at 408, 502 N.Y.S.2d at 332.
51. Id. See also Education and Foster Care, supra note 7, at 520; Rogers, supra note 2, at 235.
behavioral condition makes it necessary for them to be educated in a more restricted setting. All of the state departments of health and/or education that have issued guidelines on the subject are in basic accord with the CDC.

Despite the surprising unanimity among public health specialists that children with AIDS need not be excluded from school, local school districts have not always agreed. Apart from New York City, where the decision to permit a child with AIDS to remain in school was met with boycotts and litigation, some local school districts have barred the entry of children with AIDS to school, even in those states that have issued guidelines against exclusion. In the District 27 case, the court made clear that, although parental fears are understandable, there is no factual or legal basis for excluding

52. See Education and Foster Care, supra note 7, at 519. The three critical recommendations of the CDC are:

1. Decisions regarding the type of educational and [day] care setting for HTLV-III/LAV-infected children should be based on the behavior, neurologic development, and physical condition of the child and the expected type of interaction with others in that setting. These decisions are best made using the team approach including the child's physician, public health personnel, the child's parent or guardian, and personnel associated with the proposed care or education setting. In each case, risks and benefits to both the infected child and to others in the setting should be weighed.

2. For most infected school-aged children, the benefits of an unrestricted setting would outweigh the risks of their acquiring potentially harmful infections in the setting and the apparent nonexistent risk of transmission of HTLV-III/LAV. These children should be allowed to attend school and after-school day-care and to be placed in a foster home in an unrestricted setting.

3. For the infected preschool-aged child and for some neurologically handicapped children who lack control of their body secretions or who display behavior, such as biting, and those children who have uncoverable, oozing lesions, a more restricted environment is advisable until more is known about transmission in these settings. Children infected with HTLV-III/LAV should be cared for and educated in settings that minimize exposure of other children to blood or body fluids.

Id.

53. See Sacks Memorandum, supra note 5; Connecticut Guidelines, supra note 5. See also New York State Dep't of Health, Guidelines for the Education and Day-Care of Children Infected with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus (HTLV III/LAV), (Series 85-92, Public Health Series PH-15) (Sept. 4, 1985) [hereinafter cited as N.Y.S. Guidelines]; New Jersey State Dep't of Health, Department of Health Recommendations to the Department of Education Concerning the Admissibility to School of Children with AIDS/ARC or HTLV-III Antibody (Aug. 30, 1985) [hereinafter cited as N.J. Guidelines]; Virginia Dep't of Health, Acquired Immunodeficiency Syndrome (AIDS)-Recommendations for School Attendance (Nov. 1985).

54. See Education and Foster Care, supra note 7, at 517-19.

children with AIDS from school.\textsuperscript{56}

B. The Legality of Admission

In a proceeding to challenge a nonadjudicatory administrative decision made by an agency acting within its jurisdiction, the only questions that may be raised under New York law\textsuperscript{57} are whether "the body or officer failed to perform a duty enjoined upon it by law"\textsuperscript{58} or whether "a determination was made in violation of lawful procedure, was affected by an error of law or was arbitrary and capricious or an abuse of discretion . . . ."\textsuperscript{59} In light of the narrow scope of judicial review of administrative decisions, the court in District 27 had no difficulty in upholding the decision to allow children with AIDS to enter or continue in public school.

The court first held that the decision not to exclude children with AIDS did not violate any substantive or procedural duty imposed by law.\textsuperscript{60} Substantively, the court held that the state and local laws providing for the control of communicable disease\textsuperscript{61} were not applicable since AIDS has never been defined or designated as a communicable disease by the New York State Public Health Law,\textsuperscript{62} the New York State Sanitary Code,\textsuperscript{63} or the New York City Health Code.\textsuperscript{64} Accordingly, the court concluded that neither the Depart-

\textsuperscript{56} District 27, 130 Misc. 2d at 413, 502 N.Y.S.2d at 335.
\textsuperscript{57} The law at issue is an Article 78 proceeding which seeks a writ of mandamus or prohibition to control the actions of administrative bodies or officers. N.Y. CIV. PRAC. LAW § 7801 (McKinney 1981).
\textsuperscript{58} Id. § 7803(1).
\textsuperscript{59} Id. § 7803(3).
\textsuperscript{60} District 27, 130 Misc. 2d at 410, 502 N.Y.S.2d at 334.
\textsuperscript{61} See 10 N.Y.C.R.R. §§ 2.25-.29 (1983); N.Y.C. HEALTH CODE §§ 11.01-.67, 49.15(d), 49.17 (1981).
\textsuperscript{62} N.Y. PUB. HEALTH LAW § 2(1) (McKinney 1971) defines "communicable" as an "infectious contagious or communicable disease."
\textsuperscript{63} N.Y. SANITARY CODE 10 N.Y.C.R.R. § 2.1 (1983) defines the term "infectious, contagious or communicable disease" to include 54 enumerated diseases. AIDS is not one of them. This was not an oversight. The State Public Health Council addressed the AIDS issue by an emergency measure which made cases or suspected cases of AIDS reportable to the State Department of Health on a strictly confidential basis. 10 N.Y.C.R.R. § 24-1.2 (filed June 21, 1983, effective Oct. 6, 1983). In doing so, the Public Health Council chose not to classify AIDS as a communicable disease. Moreover, in its guidelines relating to the education of children with AIDS, the State Department of Health specifically provided that children with AIDS should be allowed to attend school. See supra note 53.
\textsuperscript{64} The New York City Health Code does not define or enumerate communicable diseases, but only sets forth a list of diseases that are reportable. N.Y.C. HEALTH CODE § 11.03 (1981). Cases or suspected cases of AIDS are reportable under a special section that accords such reports strict confidentiality. Id. § 11.07 (as amended Sept. 26, 1983). The fact that AIDS is "reportable" does not mean that it has been classified as "communicable." For exam-
ment of Health nor the Board of Education had a statutory duty to exclude children with AIDS from school.68

Procedurally, the court held that the City’s policy was not improper because of the failure of the Commissioner of Health or the Board of Education to hold public hearings.66 The court rejected the contention that either the New York City Charter67 or the State Education Law68 required public hearings.69 As for the Open Meetings Law,70 the court concluded that it was inapplicable to the Commissioner of Health,71 and that although the decision of the Board of Education should have been reached at a public meeting rather than in executive session, the court would not require an open meeting to be rescheduled since the Board of Education did no more than endorse the policy of the Commissioner of Health.72

The court then turned to the issue of whether the policy of not excluding children with AIDS from school was arbitrary and capricious or an abuse of discretion. The court recognized that, under this test, the appropriate standard of review of agency action is whether it is “without foundation in fact[,]”73 and that it is not the function

ple, falls from windows and instances of food poisoning are reportable, id. § 11.03, but certainly are not communicable. In fact, the term “communicable disease” is not defined at all in the Health Code. Instead, each disease for which special precautions must be taken is treated separately under Article 11. For instance, specific restrictions apply to cases and contacts of diphtheria (§ 11.19), measles (§ 11.29), and smallpox (§ 11.43). See id. §§ 11.11—.55. However, there are no similar restrictions for AIDS cases or carriers.

65. District 27, 130 Misc. 2d at 408-10, 502 N.Y.S.2d at 332-34.
66. District 27, slip op. at 36-40.
67. N.Y.C. CHARTER § 1105 (1976). New York City Charter § 1105(b) provides that an opportunity for written comment by interested persons must precede the promulgation of any formal rule or regulation. However, as the court held, § 1105(a) gives the head of an agency broad discretion in deciding whether to make formal rules or regulations. District 27, slip op. at 37.
68. N.Y. EDUC. LAW § 2590-g(4) (McKinney 1981) provides that the city Board of Education has the power and duty to hold public hearings “whenever required to do so by law, or whenever in its judgment the public interest will be served.” The court held that, in light of the permissive language, the Board of Education had no duty to hold public hearings on AIDS. District 27, slip op. at 38.
69. District 27, slip op. at 37.
70. N.Y. PUB. OFF. LAW §§ 100-11 (McKinney 1986).
71. The opening meetings requirement of Public Officers Law § 103(a) is applicable only to a “public body” which is defined in Public Officers Law § 102(2) as an entity for which a quorum of two or more persons is required for the performance of a governmental function. N.Y. PUB. OFF. LAW § 102(2) (McKinney 1986). Since the policy determination in District 27 was made by the Commissioner of Health and not by a public body, the court held that the Commissioner was not covered by the Open Meetings Law. District 27, slip op. at 40.
72. District 27, slip op. at 40.
of a court to weigh the conflicting evidence or to substitute its judgment for that of the agency. In light of the medical evidence and the guidelines and policy recommendations of the CDC, New York, and other states, the court held that the Commissioner's policy of not excluding children with AIDS from school was well within his discretionary authority and was not arbitrary and capricious or an abuse of discretion. In particular, the court rejected the argument of petitioners based on the reluctance of medical experts to guarantee that HIV cannot be transmitted except through those routes of transmission that have been already identified. As the court found, "it is not the nature of medical science to be governed by a 'no risk' standard." The court therefore concluded that:

Since "the apparent nonexistent risk of transmission of HTLV-III/LAV" in the school setting finds strong support in the epidemiological data accumulated over the five years of experience with this disease, as exhaustively explored on the record, and because the automatic exclusion of children with AIDS from the regular classroom would effect a purpose having no adequate connection with the public health, safety or welfare, it would usurp the function of the Commissioner of Health if this court adjudged, as a matter of law, that the nonexclusion policy was arbitrary and capricious or an abuse of discretion simply because in the court of public opinion, that particular policy was—perhaps, or possibly—not the best choice. Although this court certainly empathizes with the fears and concerns of parents for the health and welfare of their children within the school setting, at the same time it is duty bound to objectively evaluate the issue of automatic exclusion according to the evidence gathered and not be influenced by unsubstantiated fears of catastrophe.


75. District 27, 130 Misc. 2d at 413, 502 N.Y.S.2d at 335.
76. Id. at 412, 502 N.Y.S.2d at 335.
77. Id.
78. Id. at 413, 502 N.Y.S.2d at 335 (emphasis added).
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C. The Legality of Exclusion

Although not strictly necessary to its decision, the court in upholding New York City's policy of not excluding children with AIDS from school, declared that a contrary policy would violate the rights of such children under the Rehabilitation Act of 1973 and the equal protection clause of the fourteenth amendment. In reaching this conclusion, the court relied, in part, on a federal appellate decision that dealt with hepatitis, a communicable disease, and the exclusion of children from the classroom.

In New York State Association for Retarded Children, Inc. v. Carey, the United States Court of Appeals for the Second Circuit held that the exclusion or isolation of students merely because they have a medical condition that may pose a theoretical risk of transmission to other students violates the Rehabilitation Act.

Section 504 of the Rehabilitation Act of 1973 provides that:

No otherwise qualified handicapped individual in the United States, as defined in section 7(7) [29 U.S.C. § 706(7)], 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 the Federal financial assistance . . . .

In Carey III, the New York City Board of Education had refused to allow certain mentally retarded students who had been identified as carriers of hepatitis-B to attend public school classes on the ground that their integration into the school population would result in other children acquiring the hepatitis-B viral infection. The Board's original plan was to exclude hepatitis-B carrier children from attending public school at all; the plan was later amended to permit the carrier students to be placed in nine isolated classes, with at least one such class per borough. The district court held, in two separate opinions, that either exclusion or isolation of these students

79. Id.
84. Id. at 648. See also Carey II, 466 F. Supp. at 492-93.
would violate their rights under the Rehabilitation Act, the Education of the Handicapped Act, and the fourteenth amendment to the United States Constitution. The Second Circuit affirmed the district court's holding that the Board's plan violated the Rehabilitation Act, since the students were handicapped within the meaning of the Act, were being excluded from participation in a federally assisted activity on the basis of that handicap, and there was no substantial justification for that exclusion.

Relying on Carey III, the court in the District 27 case concluded that the exclusion of children with AIDS from school would also violate the Rehabilitation Act. The three critical elements of a Rehabilitation Act violation were present: (1) students with AIDS are handicapped within the meaning of the Act; (2) their exclusion from public school would deprive them of the benefits of a public education; and (3) such exclusion would be without substantial justification.

The Rehabilitation Act defines the term "handicapped individual" to mean:

[A]ny 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 impairment, or (iii) is regarded as having such an impairment.

The regulations that have been promulgated under the Rehabilitation Act define "physical or mental impairment" to mean:

(A) any physiological disorder or condition . . . affecting one or more of the following body systems: . . . hemic and lymphatic . . .

Since HIV destroys certain lymphocytes, a person with AIDS clearly has such a "physical impairment." Further, the regulations define the phrase "is regarded as having an impairment" to mean any person who:

88. Carey III, 612 F.2d at 649-50.
89. District 27, 130 Misc. 2d at 413, 502 N.Y.S.2d at 355.
90. District 27, slip op. at 50-56.
92. 34 C.F.R. § 104.3(i)(A) (1985).
If students with AIDS were automatically excluded from school, they would clearly be "treated . . . as having such an impairment." Accordingly, the court found that children with AIDS are handicapped within the meaning of the Rehabilitation Act.

With regard to the second element necessary to establish a Rehabilitation Act violation, there can be little doubt that if children with AIDS were automatically excluded from school, they would be

94. 34 C.F.R. § 104.3(i)(A) (1985).
96. Id. at 415, 502 N.Y.S.2d at 336. This finding is in accord with Arline v. School Bd., 772 F.2d 759 (11th Circuit 1985), cert. granted, 106 S. Ct. 1633 (1986). In Arline, the court found that a schoolteacher susceptible to tuberculosis was handicapped within the meaning of the Act. Id. at 764. When not affected by tuberculosis, the schoolteacher still falls within the purview of the Act "because she 'has a record of such impairment,'" and "'is regarded as having such an impairment' . . . by her employer." Id. (quoting 45 U.S.C. § 84.3(j)(2)(iii) and (iv) (1982)).

Since the court's decision in District 27, the Department of Justice has reached the contrary conclusion. See Department of Justice Memorandum For Ronald E. Robertson, Application of Section 504 of the Rehabilitation Act to Persons with AIDS, AIDS-Related Complex, or Infection with the AIDS Virus (June 20, 1986). In that memorandum, the Department of Justice concluded that section 504 prohibits discrimination based on the "disabling effects that AIDS and related conditions may have on their victims," but that "an individual's (real or perceived) ability to transmit the disease to others is not a handicap within the meaning of the statute and, therefore, that discrimination on this basis does not fall within section 504." Id. at 1. By contrast, an earlier memorandum from the Civil Rights Division of the Department of Justice to William Bradford Reynolds concluded that (1) persons with diagnosed AIDS are handicapped individuals under the Act; (2) persons who test positive for the antibody to the AIDS virus, or ARC-affected individuals, may be handicapped under the Act "as a result of the attitudes of others, or because others perceive these conditions as the equivalent of AIDS"; and (3) members of high risk groups may similarly be regarded as having an impairment. Department of Justice, Civil Rights Division, Draft Memorandum From Stewart B. Oneglia To William Bradford Reynolds, Coverage of Acquired Immune Deficiency Syndrome (AIDS) Under the Rehabilitation Act of 1973, at 1-2 (Apr. 1, 1986).

For an analysis and critique of the June 20, 1986 Department of Justice Memorandum, see Memorandum To Edward I. Koch, Mayor, From Frederick A. O. Schwarz, Jr., Corporation Counsel, AIDS Related Discrimination (July 25, 1986) (concluding that workplace discrimination against (i) persons suffering from AIDS, (ii) persons suffering from ARC, (iii) asymptomatic individuals who test positive for the HTLV AIDS virus, or (iv) individuals falsely perceived as carrying the virus is illegal under federal, state and city laws relating to handicap discrimination).
excluded from the participation in, be denied the benefits of, or be subjected to discrimination under" a federally funded program.97 As the court held in Carey III, the exclusion or isolation of children can have severe detrimental effects on their educational and emotional development, including "a decrease in the curricular options" available to those students.98 In addition, the Carey III court noted that:

Separation of the carrier children will also limit the extent to which they can participate in school-wide activities such as meals, recesses, and assemblies, and will reinforce the stigma to which these children have already been subjected.99

Similarly, if students with AIDS were excluded from school and placed on home instruction, they would have few curricular options,100 they would be unable to participate in any school-wide activities, and their social ostracism would be complete. Indeed, this point seemed so obvious that the court in the District 27 case did not find it necessary to analyze this element of a Rehabilitation Act claim.

Finally, the last element necessary to establish a violation of the Rehabilitation Act was satisfied when the District 27 court found that the medical data does not provide a "substantial justification" for the automatic exclusion of children with AIDS from school.101 The court also noted several parallels between the facts in District 27 and those in Carey.102

First, in Carey I, one of the central medical issues was whether the disease could be transmitted by saliva. Although the hepatitis-B virus had been isolated in saliva, there was no evidence of its transmission by that route.103 Nor was there evidence that any of the children who were being isolated engaged in the type of behavior which theoretically might transmit hepatitis-B through saliva in the class-

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98. Carey III, 612 F.2d at 650-51.
99. Id. at 651.
100. For students at the elementary school level, home instruction can be for as little as five hours per week. See Regulations of the State Education Commissioner, 8 N.Y.C.R.R. § 200.6(g) (1984).
101. District 27, 130 Misc. 2d at 415, 502 N.Y.S.2d at 337. In Kampmeier v. Nyquist, 553 F.2d 296, 299 (2d Cir. 1977), the court held that "exclusion . . . from a school activity is not improper if there exists a substantial justification for the school's policy." The burden of proving "substantial justification" is on the party seeking to justify exclusion. Carey III, 612 F.2d at 649-50.
102. District 27, 130 Misc. 2d at 416, 502 N.Y.S.2d at 337.
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room setting. A similar lack of proof existed in the District 27 case. The court held that the petitioners failed to establish that transmission of HIV in the classroom was anything more than a remote theoretical possibility, or that the child in question engaged in any behavior that might increase the theoretical risk.

Second, in Carey I the district court found that "there are prophylactic measures . . . which can be taken in order to reduce the risks to a de minimis level. It is not necessary to close the schoolhouse door to these children." As the court in the District 27 case found, that conclusion applies to AIDS as well.

Third, in Carey II, the evidence established that there were substantial numbers of children in the school system who were infected with the hepatitis-B virus and who were not being excluded or isolated. The district court found that the Rehabilitation Act requires that handicapped students be given the same opportunities as those afforded to other students, and that "the segregation of retarded hepatitis-B carriers without imposing a similar restriction on nonhandicapped persons would constitute unlawful discrimination.

104. Carey II, 466 F. Supp. at 498-99, 503. As the Court of Appeals noted in Carey III: At trial, the Board was unable to demonstrate that the health hazard posed by the hepatitis B carrier children was anything more than a remote possibility. There has never been any definite proof that the disease can be communicated by nonparenteral routes such as saliva. Even assuming that there were, the activities that occur in classroom settings were not shown to pose any significant risk that the disease would be transmitted from one child to another.

Carey III, 612 F.2d at 650.

105. District 27, 130 Misc. 2d at 415, 502 N.Y.S.2d at 337.

106. Id. Later studies have shown that hepatitis-B, unlike AIDS, can be transmitted by nonparenteral routes, and that both teachers and students in the same classroom with hepatitis-B carriers are at a substantially increased (although still very slight) risk of infection compared to the general population. See Brever, Friedman, Millner, Kane, Synder, & Maynard, Transmission of Hepatitis B Virus to Classroom Contacts of Mentally Retarded Children, 254 J. A.M.A. 3190 (1985); Oleske, Minnefor, Cooper, Ross, & Gocke, Transmission of hepatitis-B in a classroom setting, 97 J. PEDIATRIC MED. 770-72 (1980); Sacks Memorandum, supra note 5, at 4-5. However, it remains the policy of the New York City Board of Education not to exclude or isolate children known to be carriers of hepatitis-B because of the availability of a safe and effective vaccine. See Recommendations for Protection Against Viral Hepatitis, 34 MORBIDITY & MORTALITY WEEKLY REP. 313 (June 7, 1985); Krugman, Hepatitis B Carriers in the Classroom, 254 J. A.M.A. 3218 (1985).

107. Carey I, 466 F. Supp. at 486 (emphasis in original). Precautionary measures suggested by the CDC and endorsed by the court included good hygienic practices, no sharing of personal toilet articles, careful handling of blood-contaminated items, informing teachers of the risk and instructing them as to the precautions, as well as careful classroom management and structure. Id. at 484, 486.

108. District 27, 130 Misc. 2d at 415, 502 N.Y.S.2d at 337.


110. Id. at 502.
within the meaning of the Rehabilitation Act . . . .”111 The court of appeals did not adopt the district court’s per se rule, since it recognized “that a governmental agency is not legally required to ‘choose between attacking every aspect of a problem or not attacking it at all.’”112 However, the court went on to state that “[w]hen the program involves quarantining those with an allegedly infectious disease, the adoption of a step-by-step approach, if not necessarily impermissible, at least suggests that the Board did not regard its own evidence of risk as particularly convincing.”113 Similarly, it is recognized that children who are infected with HIV, but do not have AIDS, are at least as capable of transmitting the virus as those who have AIDS,114 and that there are many times more school children infected with HIV than the number who actually have AIDS.115 Nevertheless, the CDC has recommended against the mandatory testing of all school-age children, and no one appears to have suggested such a program.116 The court in District 27 therefore found that a policy of excluding children with AIDS, while not excluding those with ARC or those merely infected with HIV, “would constitute discrimination under section 504 of the Rehabilitation Act.”117

Several arguments could be advanced to distinguish Carey from the District 27 case, or to defend a decision to exclude children with AIDS from schools against a claim that such a policy violates the Rehabilitation Act. There is no doubt that AIDS is a far deadlier illness than hepatitis-B and that fact is entitled to some weight in determining whether there is substantial justification for a policy of exclusion. Nevertheless, the gravity of the illness does not change the rule that exclusion must be supported by concrete evidence that AIDS may be transmitted in the classroom setting.118

111. Id.
112. Carey III, 612 F.2d at 650 (quoting Dandridge v. Williams, 397 U.S. 471, 487 (1980)).
113. Carey III, 612 F.2d at 650.
115. It is estimated that there are 500,000 to 1,000,000 persons in the United States who have been infected with HIV. See Curran, supra note 27, at 1354. One witness at trial stated that estimates of the number of children infected with HIV who are in the New York City schools range from 200 to 2,000 not counting those who are sexually active or use IV drugs. District 27, 130 Misc. 2d at 416, 502 N.Y.S.2d at 338.
116. District 27, 130 Misc. 2d at 416-17, 502 N.Y.S.2d at 338; Education and Foster Care, supra note 7, at 520.
117. District 27, 130 Misc. 2d at 415, 502 N.Y.S.2d at 337.
118. See, e.g., Fannie Mae Jackson v. New York State Urban Development Corp., 110 A.D.2d 304, 494 N.Y.S.2d 700 (1985), where the court rejected a challenge to the Times Square redevelopment project on the ground that it might damage one of the two water tun-
Furthermore, it may be argued that there is currently insufficient data on the transmissibility of AIDS to permit anyone to conclude with certainty that it is absolutely safe to admit children with AIDS to school. However, despite the recent discovery of AIDS, there is already an impressive amount of epidemiological data which establishes that the pattern of transmission has not changed significantly over the past five years.\textsuperscript{119} It is obviously impossible to provide a guarantee that no new means of transmission will be discovered. However, medical science almost never provides 100\% certainty, and it is unrealistic and impractical to measure public health decisions by a no-risk standard.\textsuperscript{120} The CDC, a number of state health departments, and nearly all of the expert witnesses in the \textit{District 27} case (including two of petitioners' four witnesses) are of the opinion that, within a reasonable degree of medical certainty, the risk of transmission in a classroom setting is so slight or nonexistent that exclusion of children with AIDS is not necessary.\textsuperscript{121} As the court of appeals noted in \textit{Carey III}, if new medical information becomes available, the responsible agency will be free to reassess its policy; courts, however, must decide cases on the record before them.\textsuperscript{122} Thus, unsubstantiated fears based on a demand for absolute certainty are not sufficient to justify a policy of exclusion.\textsuperscript{123}

\begin{itemize}
\item \textsuperscript{119} One new and as yet undecided issue relating to transmission is whether woman can transmit HIV to men during sexual intercourse. That question, however, has little relevance to the appropriate educational placement of children with AIDS. \textit{See District 27, 130 Misc. 2d at 404 n.1, 502 N.Y.S.2d at 330 n.7.}
\item \textsuperscript{120} \textit{See District 27, slip op. at 48} (statements of Dr. Cooper regarding accepted risk factor without which treatment of disease and medical research would come to a halt).
\item \textsuperscript{121} \textit{District 27, 130 Misc. 2d at 410-13, 502 N.Y.S.2d at 334-36; District 27, slip op. at 45-49.}
\item \textsuperscript{122} \textit{Carey III, 612 F.2d at 651. See also LaRocca v. Dalscheim, 120 Misc. 2d 697, 710, 467 N.Y.S.2d 302, 312 (Sup. Ct. 1983)} (in light of scientific uncertainty about AIDS, the court will not require the continuation of a particular set of precautions).
\item \textsuperscript{123} \textit{See Arline v. School Bd., 772 F.2d 759 (11th Cir. 1985), cert. granted, 106 S. Ct. 1633 (1986)} (which held that a teacher with a history of tuberculosis was protected against discrimination by the Rehabilitation Act, noting:

\begin{quote}
The Court is obligated to scrutinize the evidence before determining whether the defendant's justifications [for discriminating against the handicapped] reflect a well-informed judgment grounded in a careful and open-minded weighing of the risks and alternatives, or whether they are simply conclusory statements that are being used to justify reflexive reactions grounded in ignorance or capitulation to public prejudice. \textit{Id. at 764-65.}\end{quote}

The risk of public prejudice regarding AIDS is particularly acute in light of its association with homosexuals and intravenous drug users. \textit{See generally D. ALTMAN, AIDS IN...}
Finally, Carey involved a situation in which the initial decision of the Board of Education to exclude children who were carriers of hepatitis-B was contrary to the recommendations of the Department of Health. Moreover, although the subsequent decision to isolate those children in special classes followed the recommendations of the Department of Health, those recommendations were not contained in properly issued formal regulations, and thus, according to the district court, were entitled to little weight in an action seeking to enforce federal rights in a federal court. The court of appeals did not find it necessary to decide the precise weight to be given to state administrative fact-finding by a federal court enforcing section 504 of the Rehabilitation Act; it merely held that where plaintiffs had proven a *prima facie* case of discrimination, the Board was required to make at least a “substantial showing” that its plan was justified. However, the court did state that that requirement was not intended to denigrate the expertise of state administrators and that “[w]hen the validity of challenged governmental action turns on an assessment of technical matters foreign to the experience of most courts, it may be entirely appropriate to resolve closely contested disputes in favor of the responsible administrators.”

In its opinion in the District 27 case, the court considered and rejected all of the above arguments except the last, which was not at issue since the responsible administrator with the relevant expertise—the Commissioner of Health—had recommended against exclusion or isolation. However, the court’s conclusion that the exclusion of children with AIDS from public school would necessarily violate the Rehabilitation Act may be too broad. Carey III leaves open the possibility that a decision to exclude children with AIDS from school, if adopted by a health department through the promulgation of formal regulations, upon notice and an opportunity for public comment or hearings, might be valid and enforceable under the Rehabilitation Act.

Even more questionable was the court’s declaration that a policy of excluding children known to have AIDS or ARC or to be infected

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126. *Carey III*, 612 F.2d at 650.
127. *Id*.
130. See *Carey III*, 612 F.2d at 644, 648.
with HIV would deny them equal protection of the laws. The court based that conclusion on the fact that, as in Carey, nothing was being done to identify or exclude the large numbers of children who had not been identified as carriers of the virus but were as capable of transmitting it. However, the fact that, for good medical and policy reasons, no one is recommending a mandatory screening program for all school children does not make it an unconstitutional discrimination to exclude children who are known to have been infected with HIV. In Carey III, the court of appeals, unlike the district court, did not reach this issue; the court's statement, however, that it is constitutionally permissible for the government to deal with a problem in a step-by-step manner, strongly suggests that the court in the District 27 case erred in stating that it would violate the equal protection clause to exclude "known carriers of HLTV III/LAV while untested and unidentified carriers still remain in the classroom where they pose the same theoretical (though undocumented) risks of transmitting the virus to normal children."

II. THE SUBSIDIARY ISSUES: PRECAUTIONS, REVIEW PROCEDURES, AND CONFIDENTIALITY

A. Precautions

There appears to be substantial agreement about the precautions necessary to guard against any theoretical risk of transmission of HIV in the classroom setting and to protect the health of the children with AIDS: routine hygiene and first aid procedures should be followed with respect to blood spills and bites, and the treating physicians of children with AIDS should be notified of the outbreak of infectious diseases such as chicken pox and measles, so that they can decide whether to remove those children from school and/or give them a passive immunization. Although there were some disputes about the details of these precautions, the principal issue at trial was whether New York City had, in fact, implemented a procedure

131. District 27, 130 Misc. 2d at 416, 502 N.Y.S.2d at 337.
132. Id.
133. Carey III, 612 F.2d at 650.
135. District 27, slip op. at 59-61.
136. District 27, slip op. at 60-61. Some of the medical experts thought that it was sufficient to clean up blood spills with soap and water while others recommended the use of a bleach solution. Similarly, some of the witnesses thought that gloves are necessary for cleaning blood spills only by persons with open cuts or lesions on their hands while others believed that gloves should always be worn.
to ensure that such precautions were carried out in the schools.  

Petitioners questioned whether New York City was fully prepared, when school opened, to deal with the presence of children with AIDS. The court found, however, that the policies in effect at the beginning of the 1985-86 school year conformed, for the most part, with the recommended precautions, and that during September and October additional precautions were implemented. These precautions included the distribution of alcohol swabs (for disinfecting bites), the revision and distribution of first aid manuals and charts to deal more completely with bites and blood spills, confirmation of the availability of gloves and disinfectant, and most important, a two-hour educational forum on AIDS for all school employees.

B. Procedures for Case-by-Case Review

The CDC recommended that each child known to be infected with HIV be reviewed by a multi-disciplinary team to determine if there were anything special about that child's behavior, neurologic development, and physical condition that would make his/her education in an unrestricted setting inappropriate. The CDC's recommendations are not a model of clarity as to the precise criteria that are to be applied to make this determination. Theoretically, at least, such a review might entail two aspects: (1) a determination that the child is well enough to attend school without undue risk to his/her own health, and (2) a determination that the child's behavior does not pose any increased risk of the transmission of HIV to others within the classroom. The CDC's recommendations focus primarily on the latter concern. However, the only guidance they offer in that regard is to suggest that the panel consider whether the child is neurologically handicapped and lacks control of his/her body secretions or displays behavior such as biting.

137. District 27, slip op. at 59-61.
138. Id.
139. Id. at 60-61.
140. Id. This educational forum featured a videotaped presentation concerning AIDS followed by a question and answer session involving school employees and medical experts. A videotape cassette of this program, along with the 33-page special report distributed to all school personnel, may be obtained from the New York City Board of Education.
141. See supra note 52.
142. Indeed, the CDC specifically recommends that the "[a]ssessment of the risk to the immunodeficient child is best made by the child's physician who is aware of the child's immune status." Education and Foster Care, supra note 7, at 519.
143. See supra note 52. The state guidelines that deal with this issue follow the same basic approach as the CDC's recommendations. See supra notes 5 & 53.
In District 27 the court held that New York City had complied with the substance of the CDC's recommendations on a case-by-case review, and that the decision not to exclude the child in question was based on a consideration of the appropriate factors and was correct.\(^ {144}\)

Of particular interest was the court's rejection of petitioner's claim that such case-by-case review should have been conducted by the local school district's Committee on the Handicapped (COH) established under the federal Education for the Handicapped Act (EHA).\(^ {145}\) The EHA was enacted to assure that all educationally handicapped children are provided with "a free appropriate public education which emphasizes special education and related services."\(^ {146}\) In New York State, one of the agencies involved in fulfilling this goal is the local school district's COH, which is a multi-disciplinary team responsible for determining which students are educationally handicapped and in need of special education programs and services, and for recommending the appropriate educational placement and services for these students.\(^ {147}\) For the purpose of these programs and services, "handicapped" is defined in terms of the educational development and needs of the students under both federal and state law.\(^ {148}\) Thus, as the court held, children with AIDS are not educa-

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144. District 27, slip op. at 64-68. The information gathered by the panel and stipulated to at trial demonstrated that the child's physical condition was good, that his/her neurologic development and behavior were normal, that he/she had no history of biting, and that there was nothing special about his/her condition that required exclusion from school. Id. at 64-65.


148. The EHA defines the term "handicapped children," including those who are "health impaired," as children "who by reason [of their handicapping condition] require special education and related services." 20 U.S.C. § 1401(1) (1982). The federal regulations promulgated under the EHA further define "handicapped children" as "those children evaluated . . . as being . . . health impaired . . . who because of those impairments need special education and related services." 34 C.F.R. § 300.5(a) (1985). "[H]ealth impaired" means "having limited strength, vitality or alertness, due to chronic or acute health problems . . . which adversely affects a child's educational performance." 34 C.F.R. § 300.5(b)(7)(ii) (1985). New York State Education Law and regulations thereunder contain similar definitions. N.Y. Educ. Law § 4401(1) (McKinney 1981 & Supp. 1986) defines a "child with a handicapping condition" to mean a child "who, because of mental, physical or emotional reasons can receive appropriate educational opportunities from special services and programs. . . ." The regulations add to that definition the requirement that the child "has been identified as having a handicapping condition" and include among the list of handicapping conditions any chronic or acute health problem "which adversely affects a pupil's educational performance." Regulations of the State Education Commissioner 8 N.Y.C.R.R. §
tionally handicapped merely because of their illness; rather, as with all other children, their status in this regard depends upon whether their ability to function in an ordinary educational setting has been impaired.\textsuperscript{149}

The court also rejected petitioners' challenge to the composition of the review panel and the procedures it followed.\textsuperscript{150} Although the composition of the panel differed slightly from that recommended by the CDC,\textsuperscript{151} the court found that the divergence was of no significance since the CDC's recommendations were merely advisory.\textsuperscript{152} Similarly, although the court was critical of certain deficiencies that it perceived in the panel's methods of evaluation,\textsuperscript{153} it held that it was not arbitrary or capricious for the Health Commissioner to establish those procedures.\textsuperscript{154}

\section*{C. Confidentiality}

The CDC's recommendations provide little guidance as to whether anyone within the school system should be informed of the identity of children with AIDS,\textsuperscript{155} and the state guidelines, to the extent they mention this issue, are in conflict.\textsuperscript{156} In New York City, this information was obtained from the surveillance reports made to the Department of Health, and its disclosure to anyone other than

\textsuperscript{200.1(cc), (cc)(10). As the court recognized, such functional definitions of a handicap under the laws relating to educational services are narrower than the definition contained in the Rehabilitation Act. \textit{District 27}, 130 Misc. 2d at 418, 502 N.Y.S.2d at 339.

\textsuperscript{149}. \textit{District 27}, 130 Misc. 2d at 418-19, 502 N.Y.S.2d at 339.

\textsuperscript{150}. \textit{District 27}, slip op. at 67-68.

\textsuperscript{151}. In order to keep the identity of the children confidential, even from the panel, neither the parents nor the treating physicians were made members. The treating physicians, however, were interviewed by the panel over the telephone and considerable weight was given to their opinions. \textit{District 27}, slip op. at 67.

\textsuperscript{152}. \textit{Id.} at 67-68.

\textsuperscript{153}. \textit{District 27}, slip op. at 68-70. This criticism focused primarily on the exclusive reliance of the reviewing panel on data provided by each child's treating physician.

\textsuperscript{154}. \textit{District 27}, slip op. at 68. The court explained that "mere displeasure" with the panel members or the procedures they employed "cannot be translated into arbitrary and capricious" conduct. \textit{Id.}

\textsuperscript{155}. The CDC recommends that:

Persons involved in the care and education of HTLV-III/LAV-infected children should respect the child's right to privacy, including maintaining confidential records. The number of personnel who are aware of the child's condition should be kept at a minimum needed to assure proper care of the child and to detect situations where the potential for transmission may increase (e.g., bleeding injury).

\textit{Education and Foster Care, supra} note 7, at 520.

\textsuperscript{156}. Connecticut permits disclosure to a teacher, principal, or nurse, while New Jersey prohibits disclosure to anyone. \textit{See supra} notes 5 & 53.
the Commissioner of Health was prohibited by both state and local law. The court therefore upheld the decision of the Commissioner of Health not to reveal the identity of the child with AIDS who is attending school to anyone within the school system. Indeed, the court went on to criticize the Commissioner for using the surveillance reports to identify children to be reviewed by the panel. As the court stated, the use of the surveillance data was inconsistent with the purpose for which it was collected and risked breaching the confidentiality guaranteed by law. If the court is correct that the surveillance data may not be used for this purpose, then the panel will be able to review only those children who are referred to it by parents, teachers, and school personnel.

Since the court’s ruling on confidentiality was based entirely on the legal provisions governing surveillance reports, it did not need to reach the issue of who, if anyone, within the school system should know the identity of the children with AIDS known to the Department of Health or the Board of Education from sources other than surveillance reports. The argument usually advanced in favor of disclosure is that it enhances the effectiveness of precautions to prevent any risk of transmission of HIV and to protect the health of the child with AIDS. It is not clear, however, that disclosure is necessary for this purpose, and, indeed, it may be counterproductive. For example, there is virtual unanimity that school personnel should be trained to follow proper procedures for handling bites or bleeding

158. District 27, 130 Misc. 2d at 419-23, 502 N.Y.S.2d at 339-42.
159. Id. at 422, 502 N.Y.S.2d at 341.
160. Id. N.Y. State Pub. Health Law § 206(1)(j) (McKinney 1971) provides not only that surveillance reports “shall be kept confidential” but also that they “shall be used solely for the purposes of medical or scientific research or the improvement of the quality of medical care through the conduction of medical audits.”
161. No breach of confidentiality occurred since the children's identities were not, in fact, revealed to anyone outside the Department of Health. Indeed, only one member of the review panel knew the names of the children or their treating physicians. However, the court noted that if the panel had recommended that the identity of any child with AIDS be made known to someone within the school system, that recommendation could not have been carried out without violating the legal requirement of confidentiality. District 27, 130 Misc. 2d at 422, 502 N.Y.S.2d at 341.
162. This is the procedure in New Jersey. See District 27, slip op. at 67; N.J. Guidelines, supra note 53.
injuries, regardless of the presence of a child with AIDS in the classroom, because there may be asymptomatic carriers of HIV present and because other diseases may be transmitted through blood or saliva. It is possible that a teacher who is informed of the identity of a child with AIDS in his/her classroom will pay special attention to such procedures, but it is equally possible that that teacher will refrain from following them, out of fear, and that, due to a false sense of security, other teachers who have not been informed that a child with AIDS is in their class will feel free to ignore them altogether.

Similarly, disclosure may not always be necessary to protect the health of the children with AIDS. The treating physician of an AIDS patient can request notification from the Health Department of an outbreak of an infectious disease in the school or district where the child is enrolled, without disclosing the identity of the child. The decision whether or not to disclose the identity of the child, therefore, properly rests with the parents and treating physician, whose responsibility it is to protect the child.

Disclosure of the identity of children with AIDS to school personnel would not only produce doubtful benefits, but is likely to produce enormous harm, for it is unrealistic to expect that, in the current atmosphere, teachers (or principals or superintendents) will be able to adhere to the strict confidentiality required. And once the identities of children with AIDS become more widely known, they are likely to be ostracized, if not excluded, from school entirely.

164. In the District 27 case, the treating physician did not request such notification since the child in question had been immunized against measles and had already had chicken pox.

165. According to the testimony of the Commissioner of Health, a system of notification can best be implemented by the physician making the request directly to the Department of Health, which in turn would notify school nurses to report the outbreak of chicken pox or measles to the Department’s immunology unit. Upon receiving such a report from the community where the child with AIDS attends school, the central immunology unit would contact the treating physician so that the child with AIDS could be removed from school and, if necessary, given appropriate treatment. In this way, the child’s physician would receive notification when there is an outbreak of infectious disease anywhere in the community (not just in the particular school of his/her patient), and yet the identity of the child would not be revealed to anyone. With implementation of this procedure, the central office of the Health Department would need to know only the community where the child was in school and the name of the child’s physician.

166. The difficulty in maintaining confidentiality within the school system is compounded by the fact that, if the reason for disclosing the child’s identity is to protect the health of both the particular child and other children, such disclosure cannot be limited to one teacher but must include every school employee with whom he/she comes into contact, from bus drivers to cafeteria workers.

167. See Education and Foster Care, supra note 7, at 518.
Even if their identities remain confidential, the reaction of their teachers to them might be just as harmful.\textsuperscript{168}

The disclosure of the identities of school children with AIDS will injure not only the children themselves, but the public health system in general. Doctors who report cases of AIDS, and the patients who come to them, do so with an unqualified understanding that confidentiality will not be compromised. If that confidentiality is breached, physicians will be inhibited from reporting cases, and people who may have AIDS will be inhibited from coming forward. If cases of AIDS are not reported out of fear that a confidence will be violated, the health departments will be unable to carry out their surveillance activities, and research into the epidemiology of the disease and efforts to prevent its spread will be damaged.

Thus, in light of the current climate of hysteria,\textsuperscript{169} the probable harm from disclosing the identities of children with AIDS to persons within the school system far outweighs any possible benefit.

CONCLUSION

The District 27 case arose out of the natural concern of parents for the health of their children. It also arose out of unjustified fears founded in ignorance and misconceptions. The decision, like the trial, should serve to educate the public, to correct some of those misconceptions, and, hopefully, to allay some of those fears. While this process will undoubtedly have to be repeated a number of times in cities and towns across the country, the opinion in this case should serve as a beacon of reason in this highly charged area of public policy and law.

\textsuperscript{168} The teacher, out of fear of the disease, might not go near the child or might isolate the child within the classroom or otherwise limit the child's interaction with others at school. In fact, there might be resistance to the child's coming into the classroom or even into the school at all. Indeed, petitioner Samuel Granirer, President of District 27 Community School Board, stated during a press conference at trial that he had polled 100 teachers in that District, who said emphatically that if they found out a child with AIDS was in their classrooms, they would walk out. A copy of the video tape and transcript was received into evidence.

\textsuperscript{169} At one time, reports and records concerning tuberculosis were given complete confidentiality similar to that now accorded AIDS. N.Y. CITY HEALTH CODE § 11.07 (1974). The "special degree of confidentiality" is no longer required, "[i]n the light of the changed public attitude towards tuberculosis." Id. § 11.07 (Notes). By contrast, in placing AIDS within the protection of § 11.07, the Board of Health clearly recognized that the current public attitude towards AIDS simply does not permit disclosure.